THE SOCIALIST REPUBLIC OF VIET NAM

REPORTING PERIOD: JANUARY 2008 – DECEMBER 2009

Declaration of Commitment on HIV and AIDS adopted at the 26th United Nations General Assembly Special Session in June 2001 (UNGASS)

HANOI, MARCH 2010

PREAMBLE

The Socialist Republic of Viet Nam signed the Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) in June 2001. Having once made this commitment, each signatory nation is forthwith responsible for reporting to the United Nations General Assembly every two years on the progress of its HIV response.

With this 2008-2009 UNGASS report, Viet Nam's fourth (following reports in 2002-2003, 2004-2005 and 2006-2007), Viet Nam continues to demonstrate its strong commitment to the UNGASS reporting process and to its national response to HIV. Viet Nam considers this fourth report particularly important because it is being completed in 2010, the target year for the 2006 Political Declaration on Universal Access to HIV Prevention, Treatment, Care and Support, of which Viet Nam is also a signatory. This report presents and reflects on both Viet Nam's achievements as well as on its challenges in responding to HIV, during the 2008-2009 reporting period.

2010 also marks the 20-year anniversary of Viet Nam's national response to HIV and the end of the first phase of Viet Nam's National Strategy on HIV Prevention and Control 2004 - 2010 with a Vision to 2020. As such, this report comes at an opportune time; the epidemiological data and situational analyses herein will contribute greatly to Viet Nam's ongoing review of its National Strategy, and through that to the development of the next phase of the National AIDS response.

This report is Viet Nam's most consultative to date. Building on the strong reporting process of the third report, architects of UNGASS 2010 went even further to ensure cross-sector consultation and inputs and coordinated reporting. The information presented here is the consensus of key stakeholders in the response, including relevant sectors, national and international organizations working in the HIV field, and civil society organizations. Reporting took place from October 2009 to March 2010 and has received positive feedback from key stakeholders.

Of the many achievements reflecting Viet Nam's efforts and commitment to responding to HIV during the 2008-2009 reporting period, the most outstanding include: (1) Increased political commitment and leadership resulting in positive changes in the response; (2) Improved collaboration between ministries has ensured a stronger multisectoral response and a subsequent improvement in service delivery, most notably in the rapid increase in the number of people who have access to HIV prevention, care and support services; (3) A focus on prevention has resulted in the expansion of harm reduction programmes especially the needle and syringe programme and national pilot methadone maintenance therapy programme for drug users; (4) Rapid expansion of the antiretroviral therapy programme; and (5) Greater and more meaningful participation of civil society in the national response.

As this fourth UNGASS report goes to press, I would like to express my deep appreciation for the technical and financial support given by UNAIDS Viet Nam throughout the entire reporting process. I would also like to express my sincere thanks to those ministries,

sectors and other national and international organizations who are working in the HIV response in Viet Nam, and to the civil society organizations that participated and provided invaluable contributions during data collection and formulation. The success of our 2010 UNGASS report has been due to the efforts of these many partners.

As we draft our next National Strategy and look to the future, Viet Nam hopes that every institution, organization and individual, both inside and outside the country, who is working for an effective response to HIV in Viet Nam will continue to devote her/his support and cooperation not only today, but in the coming time.

Ha Noi, 31 March 2010

Truong Vinh Trong

Deputy Prime Minister

Socialist Republic of Viet Nam

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I. LIST OF ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Anti Retrovirus
AusAID	Australian Agency for International Development
BCC	Behavioural Change Communication
CBO	Community-based organization
CCM	Country Coordination Mechanism
CDC	Centres for Disease Control, USA
CSO	Civil Society Organizations
CUP	Condom use program
DfID	Department for International Development, UK
FBO	Faith-based organization
FHI	Family Health International
FSW	Female Sex Workers
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCMC	Ho Chi Minh City
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiative
IBBS	Integrated Biological and Behavioral Survey
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
INGO	International non-governmental organization
IOM	International Organization for Migration
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MdM	Medicines du Monde
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
NCPI	National Composite Policy Index

NGO	Non-governmental organization
NIHE	National Institute of Hygiene and Epidemiology
NORAD	Norwegian Agency for Development
NVP	Nevirapine
NSP	Needle and syringe program
OVC	Orphaned and Vulnerable Children
PAC	Provincial AIDS Center
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
POA	Program of Action
PSI	Population Services International
SAVY	National Survey on Adolescents and Youth in Viet Nam
STI	Sexually Transmitted Infections
SW	Sex Workers
TB	Tuberculosis
UCSF	University of California at San Francisco
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 Funds 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
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 Counseling and Testing
VNP+	National Network of People Living with HIV in Viet Nam
VPAIS	Viet Nam Population AIDS Indicator Survey
WB	The World Bank
WHO	The World Health Organization

II. STATUS AT A GLANCE

The Fourth Country Progress Report on Following up on the Declaration of Commitment on HIV/AIDS (UNGASS) was prepared during the period October 2009 – March 2010. This report recognizes the significant achievements and efforts made by Viet Nam in improving the quality and increasing the universal access to HIV prevention, treatment, care and support services.

Government, development partners and civil society played a major role in the preparation of this report. In October 2009, the National Composite Policy Index (NCPI) questionnaire Part A was sent to members of the National Committee for AIDS, Drugs and Prostitution Prevention and Control (Viet Nam's national AIDS coordinating authority) and related ministries/organizations, while more than 200 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 gave input to NCPI questionnaire Part B. In total, between October and December 2009 these stakeholders took part in 10 consultative workshops (one with Government partners, six with civil society representatives, one with international non-governmental organizations, one with business enterprises and one with UN agencies) and two consensus meetings, in order to complete NCPI sections A and B. The National Consensus Meeting for the overall UNGASS progress report was held on 11 March 2009 with the participation of 61 representatives from 28 organizations; Government, development partner organizations and civil society to present the findings and provide an opportunity for participants to review and validate the draft report.

The HIV epidemic in Viet Nam is still in a concentrated stage, with the highest HIV prevalence found in injecting drugs users (IDU), female sex workers (FSW) and men who have sex with men (MSM). The HIV epidemic may have begun to stabilize, as reflected by stable trends in HIV prevalence among IDUs and FSWs in many places while in other places, these trends are increasing such as in the northwest (Dien Bien and Son La).[1,2] HIV prevalence among other sentinel groups, such as male military recruits and pregnant women, is low and also shows signs of stabilizing. According to the Viet Nam HIV/AIDS Estimates and Projections 2007-2012, adult HIV prevalence (aged 15-49) was 0.43% in 2009. MOH estimates that adult HIV prevalence (aged 15-49) will be 0.44% by 2010 and, if intervention programs are sustained and scaled up, will only rise marginally to 0.47% in 2012.

The achievements that reflect Viet Nam's efforts and illustrate its commitments during the 2008-2009 reporting period include: (1) increased political commitment and leadership, which have resulted in positive changes in the response; (2) improved collaboration between ministries to ensure a stronger multisectoral response and improved service delivery, as shown by the rapid increase in the number of people accessing HIV prevention, care and support services; (3) an increased focus on prevention, which resulted in the expansion of harm reduction programs, especially the Needle and Syringe Program (NSP) and National Pilot Methadone Maintenance Therapy (MMT) Program for Drug Users; (4) rapid expansion of the Antiretroviral Therapy (ART) Program; and (5) greater and more meaningful participation of civil society in the national response.

[1] Report on HIV/AIDS Prevention and Control Programs in 2008. VAAC, 2009.

[2] Report on 2009 HIV/AIDS Epidemic report. VAAC, 2010.

Part II of this report summarizes the report preparation process, status of the epidemic and key reported indicators. Part III provides a detailed look at the status of the epidemic in Viet Nam. Part IV of this report analyzes the policies and programs that address the HIV prevention, treatment, care and support areas of the national response. Part V highlights five examples of what could be considered best practice over the reporting period. Part VI highlights 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), domestic and international AIDS spending (Annex 2), responses to the National Composite Policy Index questionnaires (Annex 3) and detailed explanations of the key reported indicators (Annex 4), which are also summarized in the table below:

Indicator	Main data source	Status: 2008-2009
National Commitment and Action – Expenditure		
1. Domestic and international AIDS spending by categories and financing sources	National AIDS Funding Matrix	2008: USD 108.7 million 2009: USD 103.0 million
National Commitment and Action – Policy Development and Implementation Status		
2. National Composite Policy Index	NCPI results	See Annex 3
National Programs		
3. Percentage of donated blood units screened for HIV in a quality assured manner	*No data available*	
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Treatment Program Report, Viet Nam Administration of AIDS Control (VAAC)	Adults 2008: 45.0% 2009: 53.7% Children 2008: 1,462 2009: 1,987
5. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	D28 routine report, VAAC	2008: 32.9% 2009: 32.3%
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	D28 routine report, VAAC	27.5%

7. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results	Viet Nam Population and AIDS Indicator Survey 2005 (VPAIS)	Male: 2.6% Female: 2.1% Total: 2.3%
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	Preliminary results of the second round Integrated Biological and Behavioral Survey (IBBS) 2009 conducted in 10 provinces for FSW and IDU, and four provinces for MSM	FSW: 34.8% Male IDU: 17.9% MSM: 19.1%
9. Percentage of most-at-risk populations reached with HIV prevention programs	Preliminary results of the second round IBBS 2009 conducted in 10 provinces for FSW and IDU, and four provinces for MSM	FSW: 47.3% Male IDU: 15.4% MSM: 24%
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	*This indicator is not included in the National Monitoring and Evaluation Framework, thus data is not available.*	
11. Percentage of schools that provided life skills-based HIV education within the last academic year	Ministry of Education and Training (MOET) 2009	34.3%
Knowledge and Behavior		
12. Current school attendance among orphans and among non-orphans aged 10–14	*This indicator is not included in the National Monitoring and Evaluation Framework, thus data is not available.*	
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	National Survey on Adolescents and Youth (SAVY) 2009	Male 15-24: 44.1% Female 15-24: 40.8% Total 15-24: 42.5%

14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Preliminary results of the second round IBBS 2009 conducted in 10 provinces for FSW and IDU, and four provinces for MSM	FSW: 51.5% Male IDU: 49.2% MSM: 60.3%
15. Percentage of young women and men who have had sexual intercourse before the age of 15	SAVY 2009	Male 15-24: 0.16% Female 15-24: 0.07% Total 15-24: 0.11%
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	SAVY 2009	Male 15-24: 2.44% Female 15-24: 0.11% Total 15-24: 1.28% *Group aged 25-49: No data available*
17. 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	Male 15-24: 92.9% Female 15-24: no risk reported Total 15-24: 92.9% *Group aged 25-49: No data available*
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Preliminary results of the second round IBBS 2009 conducted in 10 provinces for FSW and IDU, and four provinces for MSM	FSW: 77.7%
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Preliminary results of the second round IBBS 2009 conducted in 10 provinces for FSW and IDU, and four provinces for MSM	66.5%

20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Preliminary results of the second round IBBS 2009 conducted in 10 provinces for FSW and IDU, and four provinces for MSM	Male IDU: 94.6%
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	Preliminary results of the second round IBBS 2009 conducted in 10 provinces for FSW and IDU, and four provinces for MSM	Male IDU: 51.9%
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected	VPAIS 2005	Male: 0.9% Female: 0.2% Total: 0.3%
23. Percentage of most-at-risk populations who are HIV infected	Sentinel surveillance Preliminary results of the second round IBBS 2009 conducted in 10 provinces for FSW and IDU, and four provinces for MSM	FSW: 3.2% Male IDU: 18.4% MSM: 16.7%
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Treatment Program Report, VAAC	2009: Adults: 84.4% Children: 80.6% All: 84.2%
25. Percentage of infants born to HIV-infected mothers who are infected	*The country is in process of updating the national estimations and projections , thus data for this indicator is currently not available*	

Data for the reported indicators came from different sources, including the Viet Nam Population and AIDS Indicator Survey 2005 (VPAIS), National Sentinel Surveillance Survey 2008 and 2009 and program reports from 2008 and 2009. In an effort to present the latest data available, the preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) conducted in 2009 were used,

as well as data from the unpublished National Survey on Adolescents and Youth in Viet Nam from 15-24 years old (SAVY), also conducted in 2009. In many cases, gender disaggregated data was not available. Additionally, because of survey sites in which only selected provinces were included in the studies, and the differences in local-specific epidemics (e.g. IBBS was conducted in 10 provinces for FSW and IDU, and 4 provinces for MSM), the aggregated results do not always reflect the overall national situation.

Finally, Viet Nam has not reported against four UNGASS Indicators: 3, 10, 12, and 25. 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. However, not all blood screening laboratories are participating in an external quality assurance scheme therefore data for Indicator No. 3 could not be generated. Viet Nam does not report against Indicators No. 10 and 12 because they are not included in the National Monitoring and Evaluation Framework. Lastly, the country is in process of updating the national estimations and projections, thus data for Indicator No. 25 is currently not available.

III. OVERVIEW OF THE EPIDEMIC IN VIET NAM

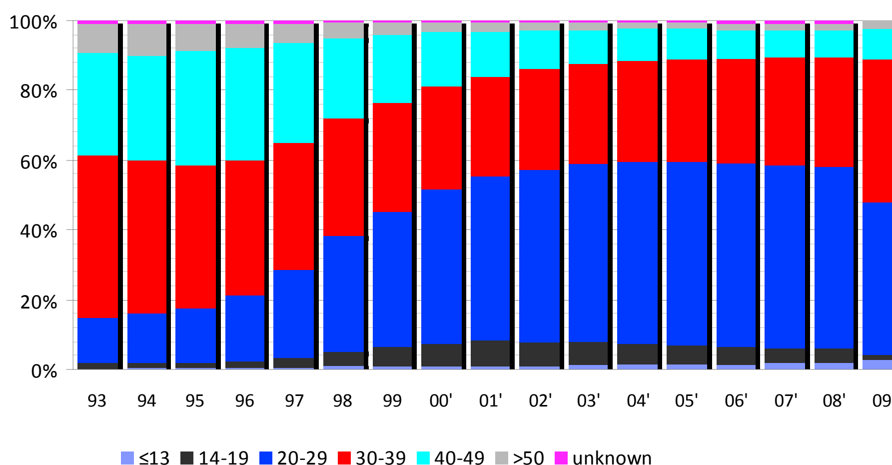
Status of the epidemic

The HIV epidemic in Viet Nam is still in a concentrated stage, with the highest HIV prevalence found in specific populations – namely injecting drugs users (IDU), female sex workers (FSW) and men who have sex with men (MSM). The HIV epidemic may have begun to stabilize, as reflected by stable trends in HIV prevalence among IDUs and FSWs in many places while in other places, these trends are increasing such as in the northwest (Dien Bien and Son La).[3],[4] HIV prevalence among other sentinel groups, such as male military recruits and pregnant women, is low and also shows signs of stabilizing. According to the Viet Nam HIV/AIDS Estimates and Projections 2007-2012, adult HIV prevalence (aged 15-49) remains low at 0.43% in 2009.[5] It is estimated there will be 254,000 people living with HIV (PLHIV) by 2010 and up to 280,000 by 2012.

HIV cases have been reported nationwide in all 63 provinces/cities, 97.5 % of districts, and 70.5% of wards/communes. As of 31 December 2009, there were 160,019 reported HIV cases and 44,050 deaths due to AIDS-related illnesses. In 2009, there were 15,713 newly-reported HIV cases and 2,010 AIDS-related deaths.

According to the available data, the majority of PLHIV are under 40. People aged 20-39 years account for more than 80% of all reported cases and the proportion of PLHIV aged 30-39 is showing signs of increasing. According to the available data, men accounted for 73.2% of all reported cases in 2009.[6]

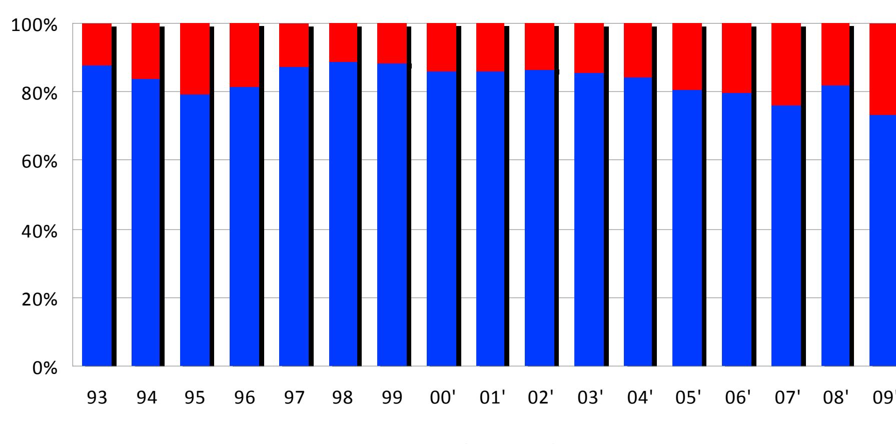
Figure 1: Distribution of reported HIV cases by age group and by year, 1993-2009



Source: *Report on HIV/AIDS epidemic by quarter 4, 2009. MOH, 2010.*

[3] Report on HIV/AIDS Prevention and Control Programs in 2008. VAAC, 2009.
[4] Report on 2009 HIV/AIDS Epidemic report. VAAC, 2010.
[5] Viet Nam HIV/AIDS Estimates and Projections 2007-2012. MOH, 2009
[6] Report on 2009 HIV/AIDS Epidemic report. VAAC, 2010.

Figure 2: Distribution of reported HIV cases by gender and by year, 1993-2009



Source: *Report on HIV/AIDS epidemic by quarter 4, 2009. MOH, 2010*

Epidemic characteristics and trends

The Vietnam HIV epidemic comprises many sub-epidemics across the country. The timing of the sub-epidemics have varied greatly. For example, the epidemic in Ho Chi Minh City (HCMC) and the northeast coast began earlier, while the epidemic in other parts of the country, such as Dien Bien, Son La and Yen Bai, are more recent.

HIV sentinel surveillance data from 40 out of 63 provinces/cities nationwide is the key tool used to monitor the HIV epidemic. However, this data is not sufficient for an in-depth analysis of the epidemic's overall status and trends. Additional insights on the HIV and STI status and risk behaviors of IDUs and FSWs in 10 provinces (Ha Noi, Hai Phong, Quang Ninh, Yen Bai, Nghe An, HCMC, An Giang, Can Tho, Dong Nai and Da Nang) and MSM in four of these provinces (Ha Noi, Hai Phong, HCMC and Can Tho) will soon be available from the second round IBBS, conducted in 2009. For this report, the preliminary results of IBBS 2009 were used for eight UNGASS indicators (indicators number 8, 9, 14, 18, 19, 20, 21 and 23). The reported rates from IBBS 2009 reflect the median or mean value of the range of rates obtained across the 10 provinces in which the IBBS was conducted. The denominator is the sample sizes obtained in the 10 provinces combined. The numerator was obtained by multiplying the median or mean value with the denominator. A detailed description of the limitations of the data used for specific indicators can be found in Annex 4.

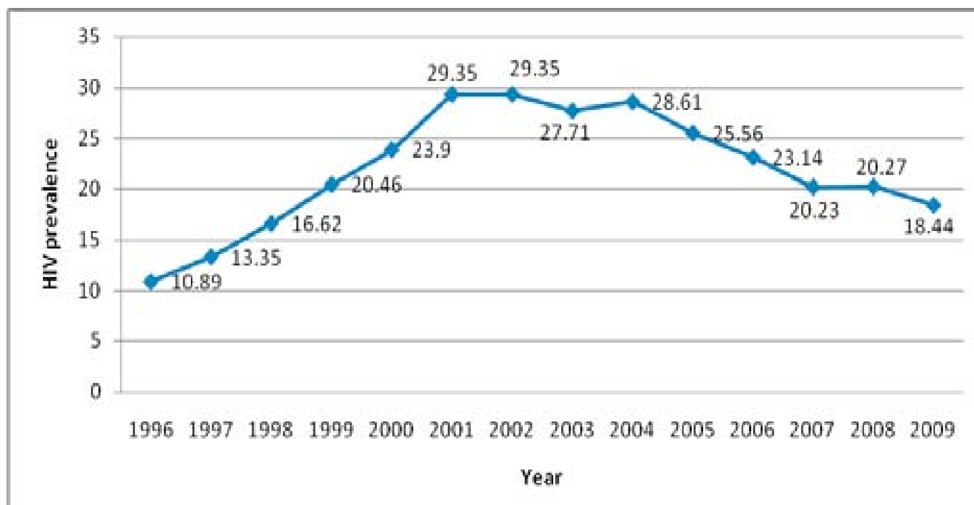
Considering this, as well as the limitations of the different data sources used in this report, the figures below offer just a snap shot of the current country HIV status.

According to sentinel surveillance, there is an indication that HIV prevalence among IDUs increased during the period 1996-2002 but thereafter decreased in numbers of provinces, dropping from 29% in 2002 to 18.4% in 2009 (aggregated numbers). HIV prevalence from the sentinel surveillance sub-samples taken in the community was about 15% (ranged from 0% to 55%). The highest HIV prevalence among IDUs in 2009 was found in HCMC (55.1%), Can Tho (41%), Dien Bien (43%), Thai Nguyen (34%), Quang Ninh (29%), Gia Lai (33.3%), and Binh Duong (32.4%).[7] IBBS 2009 shows the prevalence in

[7] Sentinel Surveillance Survey 2009: community-based samples. VAAC, 2009

this target goup as high as 29.5% with great variation from 1% (Danang) to 56% (Quang Ninh). Note that the IBBS, with its community-based random sampling strategies, gives higher estimates of prevalence than does the sentinel surveillance in many places.

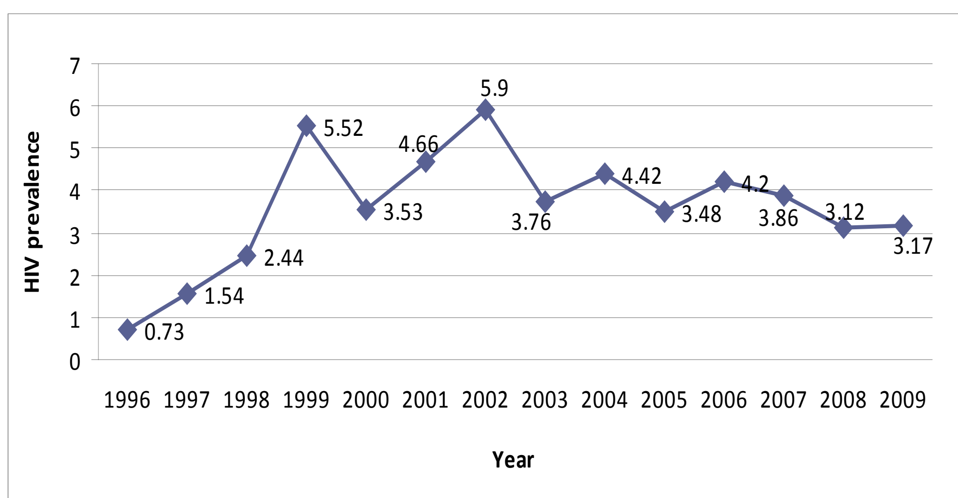
Figure 3: HIV prevalence among IDUs in Viet Nam, 1996- 2009



***Source**: Sentinel Surveillance Survey. VAAC, 2009*

Sentinel surveillance found that HIV prevalence among FSWs in the 40 surveyed provinces decreased from 5.9% in 2002 to 3.2% in 2009 (aggregated numbers). Like in the IDU population, prevalence in some provinces/cities was still high: i.e. Can Tho (19%), Hai Phong (8.5%), Thai Nguyen (7.7%), and Ha Noi (6%).[8] IBBS 2009 data also found that HIV prevalence among FSWs in 10 provinces was 8.5% varying from 0.3% (in Danang) to 23% (among street-based sex workers in Hai Phong).

Figure 4: HIV prevalence among FSWs in Viet Nam, 1996-2009



***Source:** Sentinel Surveillance Survey. VAAC, 2009*

[8] Sentinel Surveillance Survey 2009. VAAC, 2009

The IBBS 2009 data (from four provinces: Ha Noi, Hai Phong, HCMC and Can Tho), suggest that HIV prevalence among MSM populations may be as high as 16.7% (in Hanoi). It should be noted that very few studies have been conducted to obtain prevalence rates among MSM (MSM are not included in the HIV sentinel surveillance). Given increasing prevalence among MSM in other parts of Asia, surveillance of risk behaviors among this group should be expanded alongside prevention efforts.

HIV prevalence among women attending antenatal clinics and among male military recruits has begun decreasing and continues to be observed at low levels of 0.3% and 0.15%, respectively. [9]

In another positive development, the proportion of IDUs who reported using sterile injecting equipment the last time they injected reached the high level of 98% in Quang Ninh (range: 87%- 98%) (UNGASS Indicator No. 20, based on IBBS 2009 data in 10 provinces). A survey conducted in 2009 by the HIV Prevention Project in Viet Nam funded by the World Bank (hereafter, WB project) in Son La and Vinh Long provinces reported that as many as 74.5% and 87% of IDUs, respectively, had consistently used sterile injecting needles/syringes in the last month.[10] However, IBBS 2009 data suggest that a relatively low proportion of IDUs (51.9%; ranges from 26% to 94%) reported using a condom at their last sexual intercourse (UNGASS Indicator No. 21, based on IBBS 2009 data from 10 provinces). A similar result was found by a 2008 WB project survey in nine provinces/cities.

Regarding condom usage, IBBS 2009 data (from four provinces only: Ha Noi, Hai Phong, HCMC and Can Tho) reveals that only 66.5% of MSM reported using a condom the last time they had anal sex with a male partner. In IBBS, approximately 77.7% (range from 59.3% to 91.8%) of FSWs used a condom with their most recent client in 10 provinces. A survey conducted in 2008 by the WB project found that a higher proportion (94%) of FSWs reported using a condom with their last client.[11] Moreover, a 2008 UK Department for International Development (DFID) survey conducted in seven provinces showed that 97.8% of street-based FSWs and 96% of karaoke-based FSWs reported using a condom in their most recent sexual intercourse (either with a client or a regular sexual partner).[12] However, unsafe injecting drug practice among FSWs remains a key factor for HIV infection in provinces and cities with higher HIV prevalence among FSWs.

MOH estimates that adult HIV prevalence (aged 15-49) will be 0.44% by 2010 and, if intervention programs are sustained and scaled up, will only rise marginally to 0.47% in 2012. Additionally, estimates suggest that approximately 2% of male clients of sex workers will be living with HIV from 2007 to 2012. Although this prevalence is low, the number of men who visit sex workers is so large that the 2% PLHIV among them will significantly affect HIV trends in Viet Nam. Finally, MOH estimates that the male-female ratio will gradually decrease, reaching 2.6 by 2012. This change reflects the growing risk of intimate partner transmission from men who have contracted HIV through high-risk behaviors (unsafe drug injection and unsafe sex work) to their spouses or regular sexual partners. Nevertheless, men will continue to account for the majority of PLHIV and new HIV infections.[13]

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[9] Sentinel Surveillance Survey 2009. VAAC, 2009

[10] The HIV Prevention Project in Vietnam funded by the WB. Project annual report 2009. MOH, 2009.

[11] Viet Nam Universal Access report, 2008.

[12] HIV Prevention Project in Vietnam funded by DFID. Final evaluation. MOH, 2009

[13] Viet Nam HIV/AIDS Estimates and Projections 2007-2012. MOH, 2009

IV. NATIONAL RESPONSE

1. Governance and Leadership

Good governance over the past two years has contributed to the expansion and strengthening of the national HIV response in Viet Nam. This period saw increased leadership, a stronger national coordinating body, greater engagement of relevant ministries, more meaningful involvement of civil society and a visible commitment to addressing HIV-related stigma and discrimination.

In 2008-2009, under the leadership of Deputy Prime Minister Truong Vinh Trong, the National Committee for AIDS, Drugs and Prostitution Prevention and Control strengthened their coordinating role. This included increased oversight of HIV programs and provincial level activities, greater collaboration with diverse stakeholders such as people living with HIV (PLHIV) and the business community, leadership on sensitive issues such as opioid substitution therapy (Methadone Maintenance Therapy, MMT), drug use and sex work, and a stronger emphasis on multisectoral collaboration. The National Committee met formally twice each year, held special thematic meetings and opened its meetings to ministries, departments, provincial leaders, technical experts and the international community.

Increased political commitment and leadership from various ministries also resulted in positive changes in the country's HIV response. Improved collaboration between ministries has ensured a stronger multisectoral response and a subsequent improvement in service delivery – most notably the expansion of harm reduction programs, especially the Needle and Syringe Program (NSP) and national pilot MMT Program for drug users – and the rapid increase in the number of people who have access to HIV care and support services. Notably, the Ministry of Public Security (MOPS) facilitated the training of police officers and prison staff in HIV prevention and the Ministry of Education and Training (MOET) strengthened and expanded its awareness raising, life skills and anti-stigma and discrimination programs.

During the 2008-2009 reporting period, Communist Party and Government leaders worked to ensure HIV was mainstreamed into key policies and decisions. Leaders are currently working to ensure the inclusion of HIV into Viet Nam's ten-year Socioeconomic Development Plan (now under development). At the provincial level, authorities set targets and priorities, implemented programs and piloted reforms based on specific local needs. Provinces also took concrete steps to implement HIV-related decrees/resolutions. For example, HCMC piloted ART in administrative detention centers for drug users (06 Centers)[14] and both HCMC and Hai Phong implemented a MMT Program for drug users. In Can Tho and Thanh Hoa, a policy initiative of the Provincial People's Committees helped make condoms more widely available in guesthouses and entertainment establishments. These initiatives were successful thanks to the collaboration and support of local public security and health authorities.

[14] 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 centers managed by the Ministry of Labor, Invalids and Social Affairs (MOLISA). These centers are referred to as 05 Centers for female sex workers and 06 Centers for drug users.

2. Policy and legislative environment

The Government of Viet Nam acknowledges HIV is an important development and multisectoral issue and is committed to creating favorable conditions for the implementation of HIV prevention and control activities. The *Law on HIV/AIDS Prevention and Control No. 64/2006/QH11* (hereafter, the Law on HIV) passed in 2006 provides strong protections for the rights of PLHIV. During 2008-2009, numerous policies and legal documents have been amended, supplemented and newly enacted, creating a stronger and more consistent legal framework for prevention and control activities.

The past two years have seen positive changes in the legislative environment relating to the implementation of harm reduction activities, including:

- The *Law Amending and Supplementing a Number of Provisions of the Criminal Code No.37/2009/QH12* included the removal of Article 199 on the illegal use of narcotics. The revised text acknowledges that drug use is a social problem and recognizes drug users as patients rather than criminals.
- The amendment of the *Law on Drugs Prevention and Control No.16/2008/QH12* (hereafter, the Law on Drugs) and *Directive No. 32/2008/CT-TTg* permit the implementation of harm reduction interventions as defined by the Law on HIV.[15]
- *Decision No. 5073/2007 QĐ-BYT* by MOH authorized the commencement of the National Pilot MMT Program in May 2008 in Hai Phong and HCMC.

A number of decisions have also been issued enhancing the capacity of the HIV prevention and control system to implement laws, including:

- *Decision No. 1107/2009/QĐ-TTg* improved the capacity of the HIV prevention and control system to implement laws at the provincial, city and central Government levels during the period 2010 – 2015.
- *Decision No. 28/2008/QĐ-BYT* established a single routine reporting form and database for HIV activities.
- *Decision No. 14/2008/QĐ-BYT* created a *Plan of Action on the Management and Coordination of Aid for HIV Prevention and Control in Viet Nam 2008 – 2010 with a Vision to 2020*.

At present, MOH is developing other legislative documents to guide the implementation of laws.

In addition, policy and legislative documents issued in this period strengthened the rights framework for PLHIV, particularly their right to access HIV prevention, treatment, care and support services.

- The *Law on Health Insurance No. 25/2008/QH12* and its implementing decrees and circulars[16],[17],[18] removed the diagnosis and treatment of HIV from the list of exceptions for health insurance coverage.
- Under *Decree 76/2008/ND-CP* of the *Law on Amnesty*, prisoners who have advanced HIV infection may be granted special amnesty.[19]

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[15] The Law on HIV defines harm reduction measures as propaganda, mobilization and encouragement of the use of condoms, clean syringes and needles, treatment of addiction to opium-related substances with substitute substances and other harm reduction intervention measures.

[16] Decree 62/2009/NĐ-CP guides the implementation of some of the articles of the Law on Health Insurance.

[17] Interministrial Circular 09/2009/TTLT-BYT-BTC guides the implementation of the Law on Health Insurance.

[18] Circular 10/2009/TT-BYT guides primary health care and referrals for health insurance card holders.

[19] Amnesty provided by the State President at special occasions such as economic, political and cultural events.

In the reporting period, the Government prioritized the prevention, treatment, care and support for children living with and affected by HIV, e.g.:

- *Decision No. 84/2009/QD-TTg* on the *National Program of Action on Children affected by HIV until 2010 with the vision to 2020* laid out specific objectives and directions for the national HIV response as it relates to children.
- *Directive 61/2008/CT-BGDDT on Strengthening HIV Prevention and Control in the Education Sector* requested educational institutions to: strengthen their HIV steering committees, improve the quality of regular education activities on HIV prevention with a focus on stigma and discrimination reduction and improving HIV prevention skills among students, integrate HIV prevention and control into other programs, protect the rights of PLHIV (including children with HIV), and increase resource allocation for HIV prevention and control activities.

Although rapid developments in the legal and policy environment provided Viet Nam with a powerful framework, it also created a number of overlapping policy and regulatory documents. In particular, inconsistencies remain between public security measures to control drug use and sex work and public health messages trying to reach the populations engaged in these activities. For example:

- There are still inconsistencies regarding support for harm reduction interventions 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 Centers[20]. In 2009, MOLISA led a consultative review of the implementation of the Ordinance with the participation of civil society, including female sex workers (FSW). A new framework to address sex work is expected to be drafted by the end of 2010.
- While the Law on Drugs has been amended to decriminalize drug use, under the *Ordinance on Administrative Violations*, drug use still remains an administrative violation with users subject to administrative detention for up to two years. This Ordinance remains a barrier to the provision of effective HIV services.
- 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 Centers for a period of up to two years. Because detainees have limited access to HIV services, including treatment, this is a barrier to injecting drug users (IDUs) accessing HIV prevention, treatment, care and support services.

Decision 96/2007/QD-TTg of the Prime Minister covers the provision of HIV prevention, treatment and care services in correctional settings, including prisons and 05/06 Centers. However, interventions have only been implemented in a few institutions on a short-term pilot basis and prevention and treatment services are still very limited. Currently, ART is not available in any prisons and there are only fourteen 05/06 Centers providing ART under Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) Round 6.

[20] 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 centers managed by the Ministry of Labor, Invalids and Social Affairs (MOLISA). These centers are referred to as 05 Centers for female sex workers and 06 Centers for drug users.

Despite strong and progressive laws and regulations, the implementation of and compliance with them is limited by a lack of awareness and understanding on the part of rights holders and duty bearers, as well as by weak or nonexistent mechanisms to enforce adherence. For example, there have been several high profile cases recently of children living with and affected by HIV being denied schooling. Efforts have 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. In addition, programs have been developed to raise PLHIV's awareness about their rights. To date, five legal aid clinics and one hotline have been established. However the clinics require further capacity strengthening, especially as stigma and discrimination remains a significant barrier to accessing HIV prevention, treatment, care and support services.

In terms of financial assistance, the implementation of *Decree 67/2007/ND-CP AIDS* provides AIDS orphans with monthly financial support that can be used to cover some of their basic expenses. However, several implementation problems, including the weak capacity of local social welfare agencies, low awareness of the Decree, limited monitoring of its implementation and stigma and discrimination prevent those in need accessing the support have limited the Decree's positive impact.

While there are no policies that explicitly create barriers to women accessing services, the existing policies do not encourage access. A specific policy is needed to address and prioritize women's access to HIV prevention, treatment, care and support interventions – particularly FSW, who often inject drugs. Already marginalized, IDUs and FSWs living with HIV face double stigma and have difficulties in accessing alternative employment, education and social support services.

Lastly, although under Article 14 of the Law on HIV employers are responsible for HIV prevention and control in the workplace, the current taxation policy does not provide tax exemptions for business enterprises funding HIV-related activities, although this is likely to change soon.

3. AIDS Spending

AIDS spending is an important measure of the national commitment and action of countries. AIDS spending information was captured in eight categories (prevention, treatment and care, orphans and vulnerable children, program management and administration strengthening, human resources, social protection and social services (excluding orphans and vulnerable children), enabling environment and research) and across funding sources.

A survey of the main partners in Viet Nam's HIV response collected the AIDS spending data presented in this report. The National Funding Matrix form captured partners' actual AIDS expenditures in 2007, 2008 and 2009 if available.

It should be noted that AIDS spending in 2007 is included in this report as it was not available for the 2008 UNGASS report.

During the reporting period, national AIDS spending increased significantly. AIDS expenditures doubled from around USD 50 million in 2006 to USD 108.7 million in 2008. Estimated expenditures in 2009 were over USD 103 million. Total expenditures from public sources (central and local Government only) remained relatively the same as in 2006 – at USD 8 million in 2007 (12% of total AIDS spending) and almost USD 8.7 million

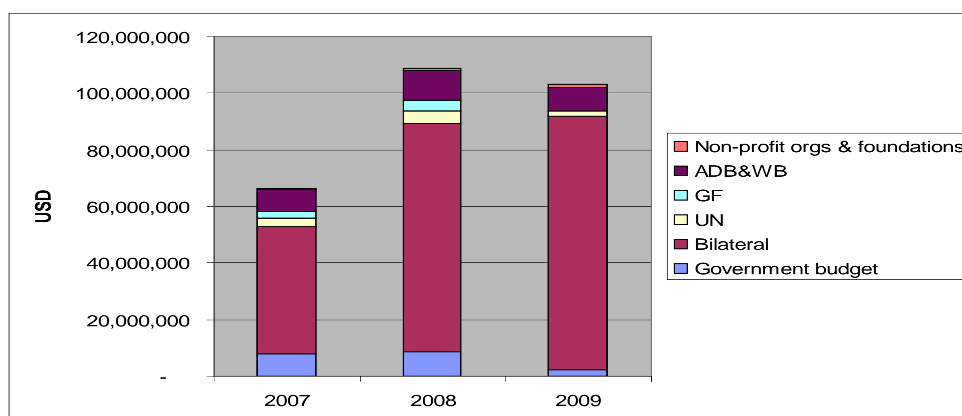
in 2008 (8% of total AIDS spending).[21] The majority of spending on AIDS programs in Viet Nam was from international sources (multilateral, bilateral, and other international sources). With this extensive international support, during this reporting period Viet Nam was able to rapidly scale up and improve HIV prevention, treatment, care and support interventions.

In 2007, at least USD 66.3 million was spent on HIV in Viet Nam, accounting for 1.5% of total national health expenditure. Compared to the Government's health expenditure, AIDS spending accounted for 6.5% or USD 0.78 per capita. Incomplete statistics on national AIDS expenditures show that spending from public sources was approximately USD 8 million, including USD 6.3 million (79%) from the central budget and USD 1.7 million (21%) from the local (provincial) budget. The AIDS spending categories of treatment and care (39%) and prevention (37%) together accounted for 76% of all national AIDS expenditures.

In 2008, total AIDS spending reached USD 108.7 million, an increase of 64% from 2007. AIDS spending accounted for 10.5% of the Government's health expenditure and 1.8% of the total national health expenditures. Compared to 2007, AIDS spending per capita increased by 62% to USD 1.26. Incomplete statistics show Government spending on AIDS was approximately USD 8.7 million, including USD 6.6 million (76%) from the central budget and USD 2.1 million (24%) from the provincial budget. Similar to 2007, 39% of resources went to treatment and care and 36% to prevention.

According to incomplete data, in 2009 USD 103 million was spent on AIDS.[22] Of this, international bilateral donors contributed USD 89.7 million, multilateral donors USD 10.4 million and non-profit organizations and foundations USD 0.8 million. It should be noted 2009 data is incomplete as a number of government partners and donors were not able to provide data because their annual balance sheets were not yet available when data collection occurred. These donors included: DANIDA, DFID, the Global Fund, UNDP, UNESCO, UNODC and WHO. For details see Annex 2.

Figure 5: Main funding sources for HIV in Viet Nam, 2007-2009



Source: *National Funding Matrix for Viet Nam 2007-2009*

During the period 2007-2008, international sources accounted for 90% and public sources almost 10% of total AIDS spending. Seventy two percent of all AIDS spending

[21] Other public sources included loans from development banks and social insurance. Other public sources were not captured in this study.

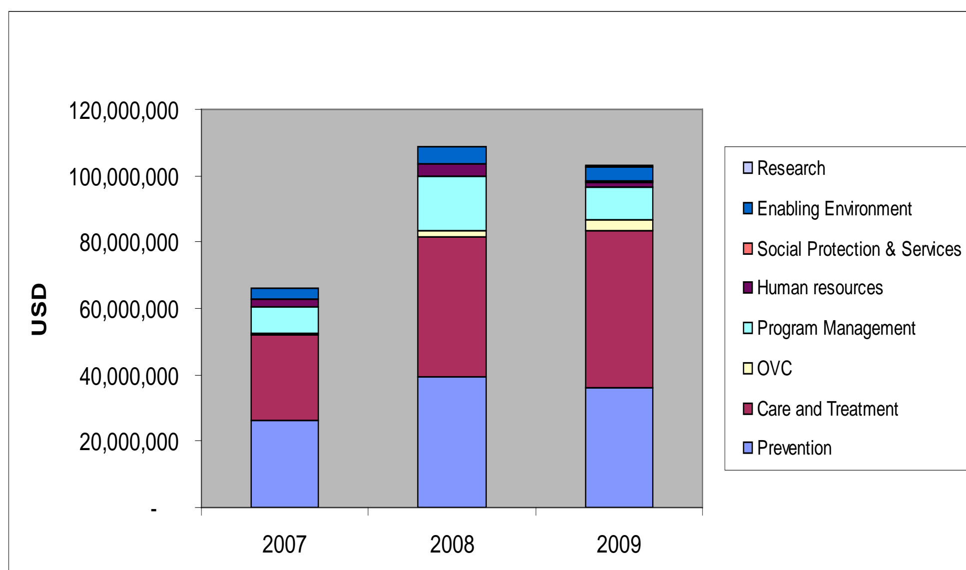
[22] Financial data reported from both public and international sources in 2009 is incomplete as data was requested before the end of the 2009 financial year of the Government of Viet Nam and other major donors.

came from bilateral grants, of which the President's Emergency Plan for AIDS Relief (PEPFAR) accounted for 63% of the total. Multilateral donors were the second largest source of funds. In this period the Global Fund provided 4%, UN agencies 4% and the two development banks, Asian Development Bank (ADB) and (World Bank) WB, 11% of total AIDS spending. Based on the available data, non-profit making organizations and foundations accounted for approximately 1% of expenditures.

As a PEPFAR focus country, Viet Nam received significant resources for the national HIV response from US Government agencies. In 2007, disbursement from PEPFAR was USD 38.7 million, equivalent to 86% of bilateral and 58% of national AIDS spending. In 2008, PEPFAR funding almost doubled. Total disbursement was USD 71.5 million, accounting for 89% of bilateral and 66% of national AIDS spending.

Prevention and treatment and care received the majority of funding in 2007 and 2008. Prevention accounted for 37% of resources in 2007 and around 36% in 2008, and treatment and care received 39% of resources in both 2007 and 2008. In these two years, 10-15% of resources were spent on program management and administration strengthening; the other spending categories accounted for only a small percentage of resources.

Figure 6: National spending on HIV by categories, 2007-2009



Source: *National Funding Matrix for Viet Nam 2007-2009*

A breakdown of spending on prevention shows that 18-20% went to behavior change communication, 14% to voluntary counseling and testing (VCT) and 11% to the prevention of mother-to-child transmission (PMTCT). Around 50% of prevention activities were not disaggregated by intervention. In the context of Viet Nam's epidemic, prevention activities should focus on key populations at higher risk (injecting drug users (IDU), female sex workers (FSW) and men who have sex with men (MSM)) and PLHIV. While there has been no official resource needs estimation study done yet in Viet Nam, expenditure data for 2007- 2009 also does not capture the proportion of funds allocated to key populations at higher risk. Therefore, it is not possible to determine whether interventions targeting these subpopulations were funded sufficiently to reach the

coverage needed to impact the epidemic.

Spending on treatment and care increased substantially from 2007 to 2009 (from USD 26 million to USD 47 million) and was consistent with the increase in ART coverage during the same period. Should the new World Health Organization (WHO) guidelines recommending the earlier initiation of treatment be implemented, there will be an increase in the number of people requiring ART. This, together with the expected withdrawal of donor support as Viet Nam approaches middle income country status, means the Government needs to plan to ensure the number of people currently on treatment can be sustained and people still in need can access treatment. This increased demand for treatment is in addition to the need to scale up and expand prevention services, particularly for key populations at higher risk.

Viet Nam's reliance on international funding sources, particularly PEPFAR, and the expectation that donor support will decrease soon, is the most important characteristic of Viet Nam's AIDS spending during the reporting period and has implications for the sustainability of the national response.

See Annex 2 for Detailed Viet Nam National AIDS Spending Matrixes for 2007, 2008 and 2009 and a description of the methodology, limitations and key findings.

4. Prevention

In the past two years, Viet Nam has scaled up its HIV prevention programs – particularly harm reduction, voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) activities – significantly. The improved HIV prevention knowledge among key populations at higher risk and the general population reflect this, as does the increase in access to services and the improvement of service quality.

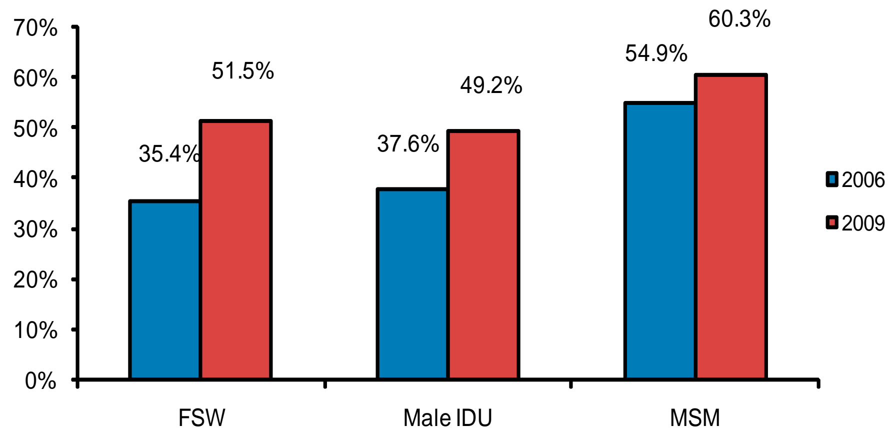
Information, Education and Communication (IEC) and Behavior Change Communication Programs (BCC)

During the reporting period, multisectoral organizations at all levels implemented IEC/BCC activities throughout the country. Magazines, newspapers, television programs, bulletins, posters, banners and leaflets delivered HIV campaign messages to key populations at higher risk as well as to the general population. IEC/BCC activities included training, peer education among key populations at higher risk, counseling, establishing hotlines and running competitions, 'edutainment' shows, stories and photo exhibitions. The Ministry of Information and Communications developed a wide range of guidelines to help the media prepare programs, news and articles relevant to HIV prevention in 2008 and 2009.

In 2006, 35.4% of female sex workers (FSWs), 37.6% of male injecting drug users (IDUs) in seven provinces and 54.9% of men who have sex with men (MSM) in two provinces correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.[23] The IBBS study three years later indicated that 51.5% of FSWs (9.9% - 80.3%) and 49.2% (11.7% - 75.1%) of male IDUs in 10 provinces and 60.3% of MSM (47.7% - 77.2%) in four provinces could do so in 2009 (UNGASS Indictor No. 14).

[23] Integrated Biological and Behavioral Survey (IBBS). MOH, 2006

Figure 7: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

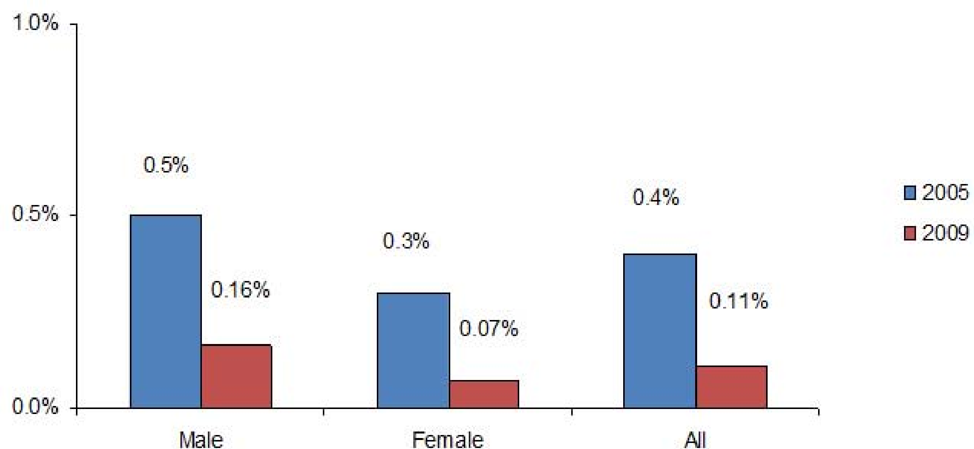


Source : IBBS 2006 and IBBS 2009 preliminary data

According to preliminary IBBS 2009 data, 47.3% of FSWs (19.2% - 77%), 15.4% (1.6% - 55.7%) of male IDUs and 24.0% (12.8% - 30%) of MSM reported having received a condom/needle and syringe in the previous 12 months and knowing where to go for a HIV test (UNGASS Indicator No. 9).

Youth are one of the priority target groups of Viet Nam's IEC/BCC Program. Results of SAVY 2009 show that 42.5% of young people aged 15-24 were able to correctly identify ways of preventing HIV transmission and correctly reject three misconceptions about HIV transmission (UNGASS Indicator No. 13). This proportion is almost the same as the proportion found in the VPAIS survey in 2005. Only 0.11% of youth reported having had sex before the age of 15 (UNGASS Indicator No. 15). Only 1.28% reported having had sexual intercourse with more than one partner in the last 12 months. 92.9% of men aged 15-24 reported using a condom in their last sexual experience with a sex worker. [24]

Figure 8: Percentage of young women and men (aged 15-24) who have had sexual intercourse before the age of 15



Source: SAVY 2009

[24] Unpublished data from the National Survey on Adolescents and Youth in Viet Nam from 14-25 years old (SAVY). GSO, 2009

During this reporting period, MOET expanded its efforts to use education channels to reach youth with HIV messages. In 2008-2009, MOET targeted teachers, school managers, students and students' families with IEC/BCC, messages through mass media channels and via workshops and trainings on reducing stigma and discrimination against children living with and affected by HIV. However, life skills-based HIV education for students is still limited. According to a MOET survey in 2008, out of the 460 schools that responded to the questionnaire, 34.3% reported that life-skills based HIV education was implemented in the last academic year in their school (UNGASS Indicator No.11). The survey also found, 22% of schools reported having at least one teacher trained to some degree in life skills-based HIV education. However, the survey showed that only 4.7% of teachers had training in comprehensive life skills-based HIV education (which includes the five required skills: communication, refusal, decision making, setting objectives and problem solving) and only 13.5% of teachers implemented a life skills-based HIV education curriculum in 2008.[25]

Following a review of existing curricula and global best practices in 2009, MOET developed a new curriculum integrating reproductive health and HIV prevention and is piloting it with encouraging results. MOET is in the process of establishing a central mechanism to coordinate the Ministry's HIV work. In addition, MOET developed and tested a booklet *'Truths about Children and HIV/AIDS'* to help teachers, parents and students better understand HIV transmission modes and deal with HIV stigma in schools. The BBC World Service Trust recently recognized the education sector response to HIV in Viet Nam as an example of global best practice in the coordination of HIV efforts. The Education Sub-group under the Joint United Nations Team on HIV (made up of UNICEF, UNFPA and UNESCO) supported MOET in their efforts.

There is recognition of the needs of children living with and affected by HIV at the national and sub-national levels. Senior political leaders, including Deputy Prime Minister Truong Vinh Trong, have spoken out in support of children's right to attend school, regardless of their or their family's HIV status. Wide media coverage of DPM Truong Vinh Trong's visit to children living in a 05 Centre brought public attention to the rights of PLHIV and to the negative effects of stigma and discrimination. Nevertheless, stigma and discrimination continues to bar children from accessing education, health and other services.

Lastly, migrants and mobile populations are target groups within the National Programs on IEC/BCC and STIs yet there is little evidence to show whether interventions are effectively reaching them. Migrants and mobile populations tend to work outside of regular working hours and in some cases in remote locations. Language also acts as a barrier as some ethnic minority migrants do not have strong Vietnamese language skills. Interventions targeting migrant workers at infrastructure sites such as roads, bridges, power plants, dams and airports do exist, however these tend to rely on media such as posters and billboards and not on more effective interventions such as BCC initiatives, increased condom availability and implementation of HIV policies in the workplace.

Harm reduction intervention programs

Viet Nam's current National HIV Strategy, the Law on HIV and Decree 108 specifically support scaling up comprehensive harm reduction interventions to reduce the HIV transmission associated with high-risk behaviors. These include the Needle and Syringe Program (NSP), Condom Use Program (CUP) and opioid substitution therapy (Methadone Maintenance Therapy, MMT).

[25] Baseline Assessment on life skills-based HIV education in 2008. MOET, 2009

These national policies identify IDUs, FSWs and their clients, MSM and mobile populations among their target populations. MOLISA estimates that in 2009 there were about 150,000 people nationwide using drugs (83% of which injected drugs) and 24,500 to 29,300 women engaged in sex work.[26] However, these figures probably underestimate the actual size of the key populations at higher risk. According to 2007-2012 Estimates and Projections, the true sizes of these populations are more likely to be: 273,579 IDUs, 87,177 FSWs, 2,878,601 clients of sex workers and 481,631 MSM. [27] These upper estimates (known as a 'high scenario') are based on several assumptions[28] for each of the key populations at higher risk.

Estimating the size of populations at higher risk is needed for better program planning, management and monitoring. In a concentrated epidemic, knowing the size of these sub-populations helps to advocate for appropriate interventions and for a better allocation of resources. In early 2010 seven provinces, with PEPFAR support, began conducting size estimations of IDU, SW and MSM populations.

A geographic expansion of NSP and CUP took place during this reporting period. In 2008, 37 of 63 provinces carried out community outreach activities, 60 implemented NSP and 57 dispensed condoms free of charge.[29] In addition, a National Pilot Program on opioid substitution therapy with Methadone (Methadone Maintenance Therapy, or MMT) was piloted in HCMC and Hai Phong in 2008 and in Ha Noi in 2009.

MOH worked with peer educators, PLHIV support groups and local police to provide harm reduction services to IDUs and FSWs. By the end of 2009, there were 4,585 peer educators (former and current IDUs and FSWs) and 8,278 collaborators[30] participating in the program.[31] These peer educators will soon be issued with identification cards to formalize and support their activities in delivering commodities to clients of harm reduction interventions. However, Viet Nam does not have a system such as the unique identifier code (UIC) to count the number of clients reached by HIV interventions and the frequency of these contacts. As a consequence, the data collected is not reliable – it reflects only the number of service contacts made, which results in double counting. A UIC should be introduced in Viet Nam to improve the monitoring system and inform program implementation.

HIV interventions for MSM were limited to six PEPFAR-supported provinces. During the reporting period, partners advocated for targeted interventions for MSM and for a scale up of current initiatives. Notably, a national workshop on MSM and HIV was organized by MOH (2008), the number of provincial MSM working groups increased from four in 2007 to six in 2009 and informal MSM clubs were established in a number of provinces. MOH, with support from development partners, is currently developing *National Guidelines on HIV Interventions for MSM*, based on the findings of a rapid assessment conducted in early 2009.

The ongoing evaluation of the National HIV Strategy and the development of the next phase of the strategy will provide an opportunity for Viet Nam to address the lack of size estimations of key populations at higher risk, develop a minimum package of services

[26] Report on detoxification, rehabilitation and anti-prostitution in 2009 and key missions for 2010. MOLISA, 2010.

[27] Estimates and Projection of HIV/AIDS in Viet Nam 2007-2012. MOH, 2009

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

[29] Report on HIV/AIDS Prevention and Control Programs in 2008. VAAC, 2009.

[30] Term coined by DFID project to describe members of staff from health or other Government departments provided with an allowance for supporting the work of peer educators.

[31] Report on HIV/AIDS Prevention and Control Programs in 2009. VAAC, 2009

and ensure the expansion of the MMT Program and the provision of HIV services in prisons and 05/06 Centers.

Condom promotion programs

During the reporting period, the CUP was implemented in 2,110 communes of 363 districts and in 57 provinces/cities. As of 2009, 24.8 million condoms were distributed.[32] Efforts were made at the provincial level to increase the availability of condoms. For example, the Department of Public Security in An Giang province actively participated in the CUP in collaboration with the AIDS Prevention Association and AIDS and TB Prevention Center. Interventions focused on getting hotels, guesthouses and entertainment establishments to have condoms always available and to collaborate with Government agencies to provide HIV prevention, care and support services, in accordance with Decree 108. Similar efforts were made in Can Tho and Thanh Hoa provinces.

Peer educator networks, including entertainment establishment owners and current/former sex workers, distributed 65% of all condoms distributed through the program. Preliminary IBBS 2009 data from 10 provinces indicates that 47.3% (19.2% - 77%) of FSW reported having received condoms in the last 12 months and knowing where to get a HIV test, higher than in 2006 (30%) (UNGASS Indicator No. 9). According to 2009 World Bank/DFID project data from 20 provinces, 45% of FSW reported having received condoms in the last 12 months.[33]

IBBS 2009 preliminary data on female sex workers' sexual behaviors in 10 provinces revealed that the proportion of those who used a condom with their most recent client was high – 77.7% (59.3% - 91.8%) (UNGASS Indicator No.18). According to World Bank project data, from 20 provinces, in 2008 most FSWs (more than 95%) reported using a condom the last time they had sexual intercourse. [34]

However, condom use among MSM and IDUs remained low. Only 66.5% (47.4% - 76.8%) of MSM reported using a condom in the last anal sex act with their male partner (UNGASS Indicator No.19), while 51.9% (26.1% - 93.9%) of IDUs reported using a condom the last time they had sexual intercourse (UNGASS Indicator No. 21).

There is a need for HIV prevention services for the primary sexual partners of PLHIV and IDUs. A survey carried out in Ha Noi in 2008 among the primary sexual partners of IDUs found that 67% live in a sero-discordant or unknown HIV status relationship, yet only 17% reported always using a condom. HIV prevalence in this population was 14%.[35] A survey of 2,600 PLHIV conducted in 22 provinces found similar results, with 21% having a primary sexual partner with either negative or unknown HIV status and 25% reporting never or not always using condoms. [36]

Needle and Syringe Programs

Due to strong political support at all levels, utilization of existing health service delivery structures and extensive mobilization of peer educators and other stakeholders, Needle and Syringe Programs (NSP) were scaled-up rapidly during the reporting period. NSP

[32] D28 routine reports. VAAC, 2009

[33] The HIV Prevention Project in Vietnam funded by the WB. Project annual report 2009. MOH, 2009

[34] Results from the survey of the HIV Prevention Project funded by WB conducted in 2008

[35] Female sexual partners of injection drug users in Viet Nam: an at-risk population in urgent need of HIV prevention services. Hammett T, Van N, Kling R, Binh K, Oanh K, 2010

[36] Sexual and Reproductive Health Needs of PLHIV in Viet Nam: A SNAPSHOT (Workshop on linkage between Reproductive Health and HIV services. Hoa Binh, 18-19 November). Khuat Thi Hai Oanh, 2009

expanded from 21 provinces/cities in 2005 to 42 provinces/cities in June 2007 and 60 provinces/cities in 2009. The number of needles/syringes distributed increased from two million in 2006 to 11 million in 2007, 22 million in 2008 and 24 million in 2009.[37]

According to preliminary IBBS 2009 data, only 15.4% (1.6%- 55.7%) of IDUs in 10 provinces were reached with prevention programs, which although still low, marks a two and a half-fold increase from 2006 (6%) (UNGASS Indicator No.9). Among those reached, 44.8% of male IDUs reported having received clean needles and syringes in the last 12 months. In contrast, in the 20 provinces implementing the World Bank/DFID project the proportion of male IDUs who reported receiving a clean needle and syringe was as high as 70%. Even more encouraging results were seen in the high proportion of IDUs who reported using sterilized injecting equipment – this increased from 88.8% in 2006 to 93.5% in 2009. However according to preliminary IBBS 2009 data, as few as 21% of male IDUs in 10 provinces reported receiving a condom in the last 12 months.

In some provinces, People's Committees established working groups at district-level to bring together healthcare workers, police officers, DOLISA and members of the Women's Union and Youth Union to support the implementation of the NSP. In another show of multisectoral coordination, law enforcement gradually shifted from targeting drug users to focusing on the arrest of drug traffickers.[38]

The service delivery models of the NSP are diverse, in order to provide services to hard-to-reach IDUs. Clients can now access the program through a variety of fixed sites such as commune health stations, street venders and pharmacies. However, the fear of being detained continues to deter some IDUs and FSWs from making use of these services.

Methadone Maintenance Therapy

Under the legal framework of the Law on HIV, Decree 108 and *Decision 5073/2007 QD-BYT* by MOH, the national pilot MMT Program began in Hai Phong and HCMC in May 2008. The first clinic in Ha Noi opened on 1 December 2009.

By the end of 2009, the program in HCMC and Hai Phong had exceeded its initial target (1,500 people), providing services for 1,735 heroin-dependent clients in three districts in each city. After nine months of treatment, the adherence rate was 96.5%[39] and clients reported positive behavior changes: only 12.5% were found to have traces of drugs in their system, only 3% were engaged in criminal activities[40] (compared to 40% before treatment), condom use with sex workers was 90% and condom use with regular sexual partners increased from 37% to 44%. Clients' quality of life also improved. Their employment rate increased from 41% to 53%, their physical health scores increased from 68 to 79 (out of 100) and their mental health scores increased from 56 to 72 (out of 100).[41]

The pilot program's success led the Government to expand it to other provinces, with the goal of providing MMT to 80,000 drug users by 2015.[42]

However, responding to HIV prevention, treatment, care and support service needs in prisons and 05/06 Centers remains a serious challenge. These facilities currently lack

[37] Report on HIV/AIDS Prevention and Control Programs in 2009. VAAC, November 2009

[38] Targeted HIV Prevention for Injecting Drug Users and Sex Workers: Viet Nam's First Large-Scale National Harm Reduction Initiative. DFID, 2009

[39] Report on progress of MMT pilot program 2009. MOH, 2010

[40] Such as robbery, theft and drug smuggling

[41] Summary Report on HIV/AIDS in 2009 and key missions for 2010. MOH, 2010

[42] Summary Report on HIV/AIDS in 2009 and key missions for 2010. MOH, 2010

basic HIV services, even though HIV prevalence within them is estimated to be as high as 50% in the Centers and 30% in prisons.[43]

It is also important to note that there are large numbers of drug users being released back into the community after serving up to two years in 05/06 Centers. With recorded drug use relapse rates of 80–90% common across the country and an absence of effective HIV prevention programming inside the Centers, the re-initiation of high-risk behaviors is a real possibility. This may correspond to an increase in HIV transmission among Center returnees and their sexual partners.

Prevention of mother to child transmission of HIV (PMTCT)

In 2009, Deputy Prime Minister Truong Vinh Trong launched a national PMTCT campaign and promoted the comprehensive approach – the UN four-pronged strategy for PMTCT that addresses a broad range of HIV-related IEC and BCC for the HIV prevention, treatment, care and support needs of reproductive age youth, pregnant women, and mothers and their children and families. This strategy is reflected in the *National Program of Action on PMTCT* (2006), the *Operational Procedures for PMTCT* (2007), and *Decision 3003/2009/QD-BYT* by MOH.

During the reporting period there was a significant improvement and scale up of the National PMTCT Program. The number of facilities providing PMTCT services increased from 107 in 2006 to 223 in 2009, and their focus changed to offering more comprehensive PMTCT services. As of 2009, there were 96 sites nationwide providing pregnant women with comprehensive PMTCT services and 127 sites providing VCT and referral.[44]

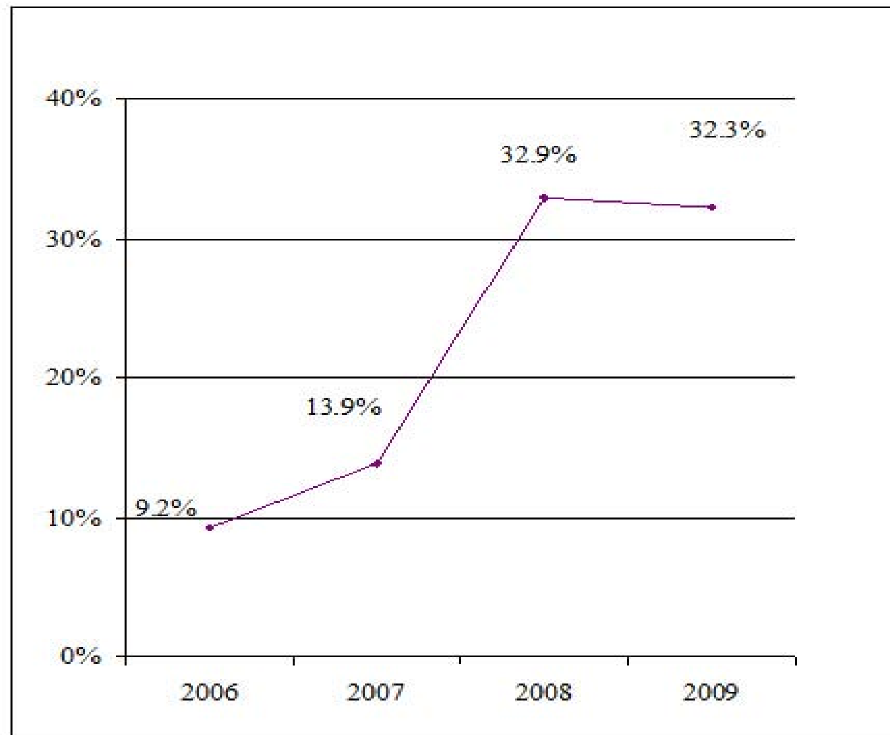
PMTCT services include administering HIV positive pregnant women with the single-dose Nevirapine (NVP) regimen that the national program stipulates, and more recently, with three-combination ARV prophylaxis (PEPFAR-supported). Women living with HIV are encouraged to consider their options for infant feeding and are offered formula free of charge if they choose to bottle feed.

The proportion of pregnant women who were tested before giving birth and the proportion of pregnant women living with HIV who got PMTCT treatment increased during the 2008-2009 period. In addition, the number of pregnant women who received HIV pre-test counseling effectively doubled, going from 351,625 in 2008 to 762,323 in 2009. The number of pregnant women tested for HIV and who know their results almost doubled, increasing from 249,278 in 2008 to 480,814 in 2009.[45] However, the majority of pregnant women received antenatal care at commune health stations where HIV testing was not available, thus only a quarter received an HIV test.

The number of HIV positive pregnant women receiving ARV prophylaxis increased significantly. In 2009, 1,372 HIV positive pregnant women received ARV prophylaxis for PMTCT, marking a 2.8 fold increase compared to 2006. It is estimated that in 2009, 32.3% of HIV positive pregnant women received treatment to reduce the risk of mother-to-child transmission - a figure that is approximately 2.3 times higher than it was in 2007 (13.9%)[46] (UNGASS Indicator No. 5).

[43] Global Fund Round 9 HIV proposal, 2009
[44] Summary Report on HIV/AIDS in 2009 and key missions for 2010. MOH, 2010
[45] D28 Routine reports. VAAC, 2008-2009
[46] Viet Nam Universal Access Report 2007

Figure 9: Percentage of HIV- positive pregnant women who receive ARV medicines to reduce the risk of mother-to-child transmission



Source: *D28 Routine reports. VAAC, 2009*

Among those receiving ART during PMTCT care: 29.4% received a single dose of NVP only, 25% received Zidovudine, 24.3% received prophylactic regimens using a combination of three ARVs, and 15.7% received ARV for pregnant people living with HIV (PLHIV) eligible for treatment. [47]

In 2009, there were 1,511 infants born to women living with HIV receiving prophylaxis to reduce the risk for mother-to-child transmission.[48]

In order to further reinforce collaboration between HIV, STI and reproductive health programs in a cost-effective manner, national guidance on the operational linkages between these programs' services are being developed. Additionally, to complement the national scale-up of PMTCT and respond to the global UNAIDS call to action on the virtual elimination of mother-to-child transmission by 2015, efforts will also be made to improve the quality and effectiveness of PMTCT services.

The implementation of a good PMTCT program is a real possibility in Viet Nam, thanks to the nation's strong health care system, widely accessible antenatal system and in particular, its public health focus on primary health care and prevention. However, the proportion of pregnant women who are tested for HIV during antenatal care, especially in mountainous and remote areas, is still low. In addition, low community awareness of PMTCT and stigma and discrimination continue to act as barriers to women accessing VCT and PMTCT services.

[47] D28 Routine reports. VAAC, 2009

[48] D28 Routine reports. VAAC, 2009.

Sexually Transmitted Infections (STI) Management Program

HIV prevalence among STI patients decreased from 2.5% in 2005 to 1.7% in 2009.[49] In total there were 809,872 STI cases reported in both public and private healthcare settings in 2009.[50]

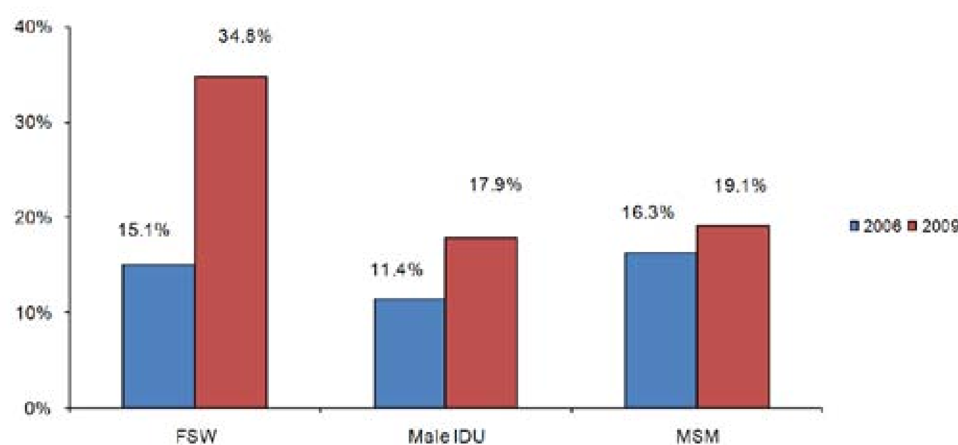
During the reporting period, various activities have been implemented to reduce STI prevalence among the general population as well as within key populations at higher risk. However, the STI Management Program still faces challenges, particularly at the provincial level, and there is a need to further invest in building the capacity of healthcare staff. There is also a lack of medicines, equipment and test kits at public health facilities. Finally, linkages between HIV and STI Programs and services targeting key populations at higher risk, such as MSM, remain limited.

Voluntary HIV counseling and testing (VCT)

2008-2009 saw a major scale-up in the VCT Program. The number of VCT sites increased from 157 in 2005 to 244 in 2008 and 256 in 2009.[51] The number of people tested for HIV increased from 200,469 in 2008 to 346,637 in 2009.

According to two rounds of IBBS, the percentage of key populations at higher risk who received an HIV test in the last 12 months and who knew the result also increased. The 2009 data showed 17.9% (8% - 39.5%) IDUs, 34.8% (9.8%- 83.2%) FSWs, and 19.1% (9.2% - 79.6%) MSM had HIV test and knew their status. (UNGASS Indicator No.8).

Figure 10: Percentage of most at risk populations that have received an HIV test in the last 12 months and who know the results



Source: *IBBS 2006 and IBBS 2009 preliminary data*

In order to scale up HIV testing and counseling and ensure the timely initiation of HIV treatment, MOH is finalizing guidelines on HIV testing and counseling in healthcare settings and putting them in line with global recommendations on provider-initiated testing and counseling.

[49] Sentinel Surveillance Survey 2009. VAAC, 2009
[50] D28 Routine reports. VAAC, 2009
[51] Report on HIV/AIDS Prevention and Control Programs in 2009. VAAC, November 2009

Blood transfusion safety

Blood safety in Viet Nam has always been one of the cornerstones of the 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 2009 Blood Transfusion Committee reports on the activities of 82 blood centers/blood screening laboratories, there were 591,414 blood units collected nationwide, with 84,648 units coming from professional blood donors and 468,790 from volunteer blood donors. One hundred percent of blood units were screened for HIV, hepatitis B, hepatitis C, syphilis and malaria. Of these, 1,522 blood units tested positive using an HIV rapid test[52].

[52] D28 Routine reports. VAAC, 2009

5. Treatment, Care and Support

HIV treatment, care and support needs in Viet Nam are rapidly increasing. According to the Ministry of Health (MOH), the estimated number of adults in need of antiretroviral therapy (ART) treatment increased from 47,516 in 2007 to 67,047 in 2009.[53]

The National Program of Action on Treatment states that 70% of eligible adults and 100% of eligible children will receive ART by 2010. In addition, the National Program of Action on Children affected by HIV, approved in June 2009, provided guidance on increasing access to HIV treatment, care and support services for children living with and affected by HIV.

A series of national normative guidelines were developed and serve as a foundation for both the coordination of different initiatives and the effective scale-up of HIV treatment, care and support services. In 2009, MOH approved the updated *National Guidelines on HIV Diagnosis and Treatment*, based on WHO guidelines. MOH is also currently working to amend its national guidelines in consideration of the new WHO treatment guidelines issued in November 2009 which recommend the earlier initiation of treatment to maximize treatment and prevention benefits.

Viet Nam's strategy focuses on developing comprehensive clinical HIV treatment, care and support services by using health service delivery systems at the provincial and district level and linking them with community/home-based care.

Over the last two years, there was a rapid scale-up and expansion of ART programs from 207 sites in 2008 to 288 sites in 2009. The increase was significant at provincial and district levels and included pediatric HIV services. In 2009, there were 14 ART treatment sites at the national/central level, 125 sites at the provincial level and 149 sites at the district level. As of 2009, there were 47 CD4 cells counting machines in 26 provinces and cities.[54]

PLHIV consider ART scale up one of the national response's biggest achievements of the past two years.[55] By the end of 2009, there were 36,008 adults and 1,987 children receiving ART. The total number of people receiving ART marked a 2.5 fold increase from to the end of the 3rd quarter of 2007, and a 14.2 fold increase from the end of 2005. Adult ART coverage increased from an estimated 30% at the end of the 3rd quarter of 2007 to 45% in 2008 and 53.7% in 2009 (UNGASS Indicator No. 4).[56]

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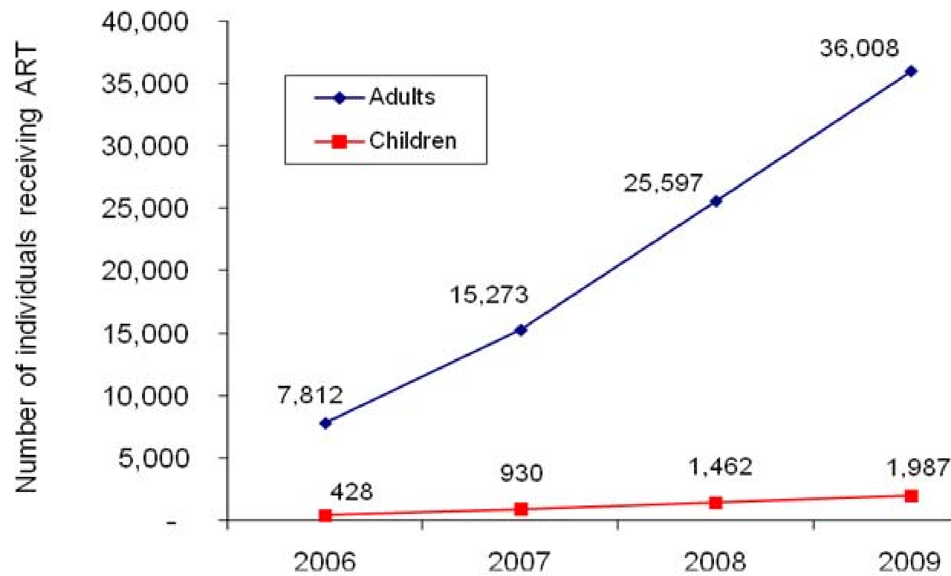
53 Estimates and Projection HIV/AIDS 2007-2012. MOH, 2009

54 Report of ARV Treatment Program, VAAC, 2009

55 NCPI Part B (Annex 3). UNGASS, 2010.

56 Report of ARV Treatment Program. VAAC, 2009

Figure 11: Number of adults and children on ART in Viet Nam from 2006 to 2009



Source: *Routine treatment program report. VAAC, 2009.*

In 2008-2009, HCMC, Ha Noi, Hai Phong and Quang Ninh provinces significantly increased the number of people receiving ART. In particular, the program in HCMC reached 14,530 patients, accounting for 38% of all patients nationwide.

The quality of ART in Viet Nam also improved. According to a cohort survey conducted by WHO at 31 ART sites, 84.4% of adults were still alive and on ART 12 months after the initiation of treatment. This proportion was a slight increase from 81% of adults in 2007. However, the proportion of children who were still alive and on ART 12 months after the initiation of the treatment decreased, from 93% in 2007 to 80.6% in 2009 (UNGASS Indicator No. 24).

In Viet Nam, health insurance is free for children under six. This includes children living with HIV. In 2009, VAAC issued 803 health insurance cards to children aged 6-15 who were living with HIV which entitles them to free treatment and care.

By 2009 there were fourteen 05/06 Centers providing ART under Global Fund Round 6 activities. These fourteen Centers, plus an additional Center, also provided voluntary testing and counseling (VCT) and information, education communication (IEC) services. Eighteen centers also received technical assistance to provide healthcare and counseling services to people living with HIV (PLHIV).[57] Currently, ART is not available in any prisons and only a few are providing TB treatment.

05/06 Centers often lack both facility-based services and continuum-of-care to link drug users to community-based HIV treatment, care and support services. Together these factors have the potential to interrupt Center returnees' ART regimens, which in turn may lead to increases in ARV drug resistance.

Collaborative activities between HIV and tuberculosis (TB) programs have been strengthened but still face several challenges. Only 27.5% of people diagnosed with TB

[57] Report on detoxification, rehabilitation and anti-prostitution in 2009 and key missions for 2010. MOLISA, 2010

and estimated to be living with HIV received treatment for TB and HIV (UNGASS Indicator No. 6).[58]

Migrants and mobile populations continue to experience difficulties accessing treatment and care as a result of their mobility, long work hours, the remote location of their work sites and their lack of official residency. Under MOH *Decision No. 3003 Guidance on Diagnosis and ARV Treatment*, access to treatment is not restricted to where a person officially lives. However, the interpretation and application of the existing regulations vary between provinces/cities due to the lack of detailed guidance. As a result, 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 a perception among PLHIV that this is the official policy.

One of the challenges affecting the performance of HIV treatment and care services is the limited implementation of continuum of care, particularly the suboptimal commitment of local health facilities, weak coordination between HIV and other health services such as sexually transmitted infections (STI), TB, and reproductive health and the limited involvement of PLHIV and other beneficiaries. Currently, HIV treatment and care services rely on a large number of contract health workers. As the majority of these positions are funded by projects, this raises the issue of sustainability once donor support is phased out. The integration of HIV services into existing health service delivery systems is crucial to addressing this. At the same time, it is essential to strengthen local coordination mechanisms involving civil society.

The following issues were raised in the previous reporting period and continue to pose challenges for the effective roll-out of treatment: implementation of the patient monitoring and HIV drug resistance surveillance in accordance with national protocols, quality assurance of ART treatment provided outside of public services, and greater harmonization of the procurement and supply chain management of ARV medicines.

During the reporting period, faith-based, mass and community organizations increased their provision of HIV care and support services. Notably, civil society organizations provided an estimated 51-75% of community/home-based care services in 2008-2009.[59]

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58 D28 routine report, VAAC 2009

59 NCPI Part B (Annex 3). UNGASS, 2010.

6. Civil society involvement

Building on the achievements and momentum generated by the participation of civil society in the previous UNGASS reporting round[60], in the last two years civil society has taken a remarkable step forward in all areas - organization, capacity, resources and participation.

More PLHIV groups have formed, bringing the total to over 120, with a national network, provincial coalitions and interest groups continuing to grow. The National Network of People Living with HIV in Viet Nam (VNP+) was founded in 2008 and legally registered in 2009 and includes over 100 groups and people living with HIV (PLHIV) coalitions. The first general assembly of the network elected a steering committee of seven members and appointed a representative board of 70 members. Alongside this, interest networks such as Bight Futures Group, *Hy Vong* (Hope) and United Friendship have become more organized and cohesive.

Several self-identified drug user groups were established in 2009 in Ha Noi (*Gach Dau Dong*, The Bullet Point and *Cat Trang*, White Sand) and Hai Phong (*Vong Tay Be Ban*, Friendship Hug). Also in 2009, the first self-organized group of female sex workers (FSW), The Peaceful Place (*Noi Binh Yen*), was founded in Ha Noi. The formation of these groups marks an important milestone for injecting drug users (IDUs) and FSWs and would not have been possible without Viet Nam's emerging enabling environment that recognizes the importance of allowing these key populations a stronger role in the HIV response.

Men who have sex with men (MSM) groups have increased in numbers and diversified in nature over the past two years. HIV interventions targeting MSM and Provincial MSM Working Groups currently operate in Ha Noi, HCMC, Hai Phong, Da Nang, Khanh Hoa and Can Tho. A number of other provinces, including Thanh Hoa, Hai Duong, An Giang, Hau Giang and Thai Nguyen, have proactively sought support for HIV interventions and formed informal MSM clubs. Some groups have been successful in gaining support from local and international organizations, projects and individuals to carry out their activities.

Regarding the partners of key populations at higher risk, a project to prevent HIV transmission to the sexual partners of drug users matured into the Returning Home Club – (*Ve Nha*), founded in Ha Noi in 2009. The HIV negative partners of PLHIV have also started to organize.

Mass organizations are also playing a major role in HIV prevention, care and support. Notably, Women's Union-led Empathy Clubs exist in over 300 communes and districts throughout the country and play an important role in mitigating the impacts of HIV by supporting PLHIV and their families.

Provincial AIDS Associations have been established in a number of provinces, forming a coalition between all partners working on HIV, including Government, civil society and PLHIV. While still in their infancy, these associations are conducting advocacy activities and trainings, and in some instances are acting as umbrella organizations under which self-help groups can register.

The Viet Nam Civil Society Partnership Platform on AIDS (VCSPA) supports the establishment of new community groups (e.g. drug users, sex workers and sexual partners of PLHIV) and conducts key civil society strengthening activities, such as developing a monitoring and evaluation framework for civil society. VSCPA counts approximately

[60] Monitoring and Evaluation of Human Rights in the HIV Response. Gruskin, S. and Ferguson, L., 2009.

200 local NGOs, community-based organizations (CBOs) and faith-based organizations (FBOs) as members.

Over the past two years, civil society organizations (CSOs), including NGOs, CBOs and FBOs, became more organized and professional. While in the past many local NGOs lacked capacity, their human resource skills and experience and the scope and quality of their work continue to grow. Some local NGOs now have up to 50 full-time staff and employ hundreds of field workers. During the reporting period, more CBOs, particularly groups and networks of PLHIV and vulnerable populations, were able to acquire their own office space and maintain core staff. For example, the Bright Futures Group in Hai Duong and *Hy Vong* in Bac Can built their offices with support from local Government and donors. The technical and organizational capacity of FBOs also improved significantly, as a result of training and their now greater experience and commitment. Finally, CSOs were able to retain staff and core members. The key to strengthening CSOs' capacity, these individuals' knowledge and experience have since become institutional knowledge and experience.

During 2008-2009, CSOs became key partners in service delivery. Many local NGOs, CBOs and FBOs signed contracts with projects to deliver harm reduction and community/home-based care services. In 2008, the STRONGER project in seven PEPFAR focus provinces (Quang Ninh, Hai Phong, Ha Noi, Nghe An, Can Tho, An Giang and Ho Chi Minh City) reached nearly 8,000 people from key populations at higher risk with information and provided nearly 380,000 condoms and community/home-based care to almost 6,400 PLHIV and over 800 orphans and vulnerable children (OVCs). Stakeholders participating in the NCPI Part B consensus meeting estimated that in 2008-2009, CSOs implemented between 25-50% of services provided to MSM and OVC, 25-50% of activities to reduce stigma and discrimination and 51-75% of community/home-based care services.

CSOs were able to improve their organizational development and increase their role in service delivery as a result of their success in mobilizing resources – mostly from international donors. For example, a number of CSOs secured funding from regional and international sources such as Collaborative Fund and Staying Alive; groups of young drug users in Ha Noi received seed funding from Irish Aid; groups of sex workers, drug users and the sexual partners of drug users were also successful in securing donor funding. Significant funding from PEPFAR enabled local NGOs to carry out research and deliver services.

During the reporting period, CSOs also participated actively in HIV-related policy development and governance and the monitoring of the national response. Local NGOs and CBOs composed of PLHIV, drug users, FSW and MSM gave inputs and comments to the *Decree on Post-Rehabilitation Management*, the review of the implementation of the *Ordinance on Prostitution Prevention and Control* and the development of the *National Guidelines on HIV Interventions for MSM*. In 2009, a local NGO become a member of the National Strategic Information, Monitoring and Evaluation Technical Working Group.

In 2008, the Country Coordination Mechanism (CCM) was restructured to facilitate the self-selection of civil society and PLHIV representatives. VNP+, the recently registered national PLHIV network, is a member of the CCM. The position of CCM chair also transitioned to a civil society representative.

One of the most important benchmarks of civil society involvement in the last two years was Viet Nam's successful Global Fund Round 9 dual track proposal. For the first time,

a civil society Principal Recipient and three civil society Sub Recipients were approved by the CCM to join Government partners in developing a proposal. This was evidence of the growing partnership between Government and civil society, as well as the active role that civil society, with the support of international organizations, is playing in the national response.

Also of note is the HIV Technical Working Group (TWG), convened by civil society representatives. The TWG serves as an information-sharing platform and coordination mechanism for all organizations working in Viet Nam's response to HIV. During this reporting period, the TWG held over 40 meetings (including regular meetings every two months, monthly lunchtime seminars and the regular meetings of nine sub-groups – usually every two months). Its listserv has a total of 755 members representing all sectors: local and international NGOs, Government, donors and the UN. Recent topics of discussion included drug treatment modalities, mobilizing young people, public health skills and the role of civil society in the HIV response. The TWG also promotes collaboration and advocacy on HIV-related issues, which plays a crucial role in the civil society response to HIV.

Despite these advances, a number of challenges to civil society participation in the HIV response still need to be addressed. First of all, since early 2009 and as a byproduct of the dialogue initiated by the 2008 UNGASS preparation process, VAAC organized quarterly meetings with local NGOs. While this is a significant step forward, CBOs that represent key populations at higher risk should play a greater role.

Secondly, civil society needs to participate more fully in the annual planning and budgeting processes of the national response. The ongoing review of the National HIV Strategy and development of the next phase in the response will provide an opportunity for civil society to be more engaged in these processes.

Thirdly, while the number of PLHIV groups is growing, further support is needed to strengthen FSW and IDU groups and encourage their representation in national and provincial level fora. Some civil society groups have difficulty meeting all requirements for registration as a legal entity (i.e., educational qualifications and capital). Therefore, in 2009 the Health Policy Initiative (HPI) and UNAIDS Viet Nam developed a handbook on legal registration procedures and HPI is now providing capacity building training for PLHIV and key populations at higher risk who wish to apply for legal registration.

Fourth, donors need to be more aware of the importance of investing in civil society development. Over the reporting period, most donor funding went to service delivery and only limited funding was available for organizational capacity development. Without support to build their organizational capacity, civil society participation has been reactive rather than systematic and proactive, and focused on service delivery rather than on advocacy and monitoring.

In summary, a more cohesive, sustainable and accountable contribution from civil society will require continuing support and appropriate mechanisms from Government, stronger commitment from donors and greater efforts from civil society itself.

Viet Nam would like to highlight five examples of what could be considered best practice during the 2008-2009 reporting period:

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, and most notably, to the implementation of a national pilot MMT Program for drug users. This pilot was possible due to a change in the attitude of senior political leaders and legislators and was reflected in the 2009 decision to decriminalize drug use.

The MMT Program is implemented at provincial level in partnership between Government agencies, civil society and development partners, with support from the national level. 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 program had exceeded its initial target (1,500) and was providing services for 1,735 drug users. After nine months of treatment the adherence rate was 96.5%[61] and clients reported positive behavior changes: only 12.5% were found to have traces of drugs in their system, only 3% were engaged in criminal activities[62] (compared to 40% before treatment), condom use with a sex worker was 90% and condom use with a regular sexual partner increased to 44% from a baseline of 37%. The quality of life of clients also improved, with their employment rate increasing from 41% to 53%, physical health scores increasing from 68 to 79 (out of 100) and mental health scores increasing from 56 to 72 (out of 100).[63]

After one year, the pilot's success led to the Government's decision to expand MMT services and set a goal of 80,000 drug users on MMT by 2015.[64] On 1 December 2009, a clinic providing MMT opened in Ha Noi. Another five clinics are expected to open in Ha Noi in early 2010 and ten more provinces are planning to open clinics in 2010-2011.

2. One Monitoring and Evaluation Framework

Viet Nam's National Monitoring and Evaluation Framework for HIV Prevention and Control Programs was strengthened over the past two years. To harmonize donor reporting, VAAC developed a single reporting form and database for HIV routine monitoring (Decision 28/QD-BYT).

Following Decision 28 in early 2008, training workshops on the implementation of the HIV routine reporting system, data management and data use were conducted by VAAC with support from technical partners. Under the new reporting system, data quality has already improved.

Other key initiatives undertaken during the reporting period included: a data triangulation exercise, an evaluation of the current National HIV Strategy, an impact assessment of the national Harm Reduction Program and a costing exercise. These activities, done in collaboration with international partners and the Joint United Nations Team on HIV, are a testament to the maturing of the One Monitoring and Evaluation System in Viet Nam.

[61] Report on progress of MMT pilot program 2009. MOH, 2010

[62] Such as robbery, theft and drug smuggling

[63] Summary Report on HIV/AIDS in 2009 and key missions for 2010. MOH, 2010

[64] Summary Report on HIV/AIDS in 2009 and key missions for 2010. MOH, 2010

3. Global Fund Round 9: Viet Nam's first dual track proposal

The success of Viet Nam's first dual track HIV proposal to the Global Fund in Round 9 was the culmination of many partners' efforts. This grant will strengthen the multisectoral response to HIV in Viet Nam because it was jointly developed and will be jointly implemented. The Ministry of Health (MOH), the Ministry of Labor, Invalids and Social Affairs (MOLISA) and the Ministry of Public Security (MOPS) will work in partnership to implement Track 1 and a consortium of four civil society organizations will implement Track 2.

The grant for USD 101 million was approved in November 2009 and is expected to scale-up effective interventions and address service delivery gaps among injecting drug users (IDUs), men who have sex with men (MSM), the primary sexual partners of people living with HIV (PLHIV) and IDUs, and prevention of mother-to-child HIV transmission (PMTCT). Under this grant, HIV treatment will be made available in selected prisons for the first time.

There is a growing recognition and appreciation of the role that civil society can play in supporting a multisectoral response, particularly through the provision of services to key populations at higher risk. Through constructive dialogue during the development of the Round 9 proposal, both Tracks recognized their comparative advantages and the benefits of jointly delivering services.

4. Scale-up of treatment and care

With support from development partners, Viet Nam significantly scaled up antiretroviral therapy (ART) treatment for adults and children living with HIV. According to estimations, ART coverage for adults increased from 30% at the end of quarter 3 in 2007 to 45% in 2008 and to 53.7% in 2009. This is a 14.2 fold increase since the end of 2005. [65] PLHIV consider ART scale one of the national response's biggest achievements of the past two years.[66]

ART is being provided in fourteen 05/06 Centers under Global Fund Round 6. Under Global Fund Round 9, due to begin implementation in 2011, ART will be available in selected prisons for the first time.

In 2009, 96% of children born to HIV-positive mothers received treatment to reduce the risk of mother-to-child transmission.[67] In addition, as of 2009, children living with HIV were issued with health insurance cards.

5. Education sector response to HIV

The education sector strengthened its planning, implementation and monitoring of a coherent sector-wide approach during the 2008-2009 reporting period. The BBC World Service Trust recently recognized the education sector response to HIV in Viet Nam as one of three examples of global best practice in the coordination of HIV efforts.

The Ministry of Education and Training (MOET) was supported in their efforts by the Education Sub-group of the Joint United Nations Team on HIV (made up of UNICEF, UNFPA and UNESCO). There have been two key achievements in this area to date: (1) the development of a new national curriculum integrating reproductive health and HIV

[65] Report of ARV Treatment Program. VAAC, 2009

[66] NCPI Part B (Annex 3). UNGASS, 2010.

[67] D28 Routine reports. VAAC, 2009

prevention, and (2) the establishment of a central coordinating mechanism in MOET. The new curriculum was developed following a review of existing curricula and global best practices and although still in the pilot phase, teachers are already seeing positive results as students start talking more openly about HIV.

In addition, during the reporting period senior political leaders spoke out on the right of children affected by HIV to attend school. Wide media coverage of Deputy Prime Minister Truong Vinh Trong's visits to children living in closed settings brought public attention to the rights of PLHIV and the negative effects of stigma and discrimination.

VI. SUPPORT FROM COUNTRY DEVELOPMENT PARTNERS

The significant increase in bilateral and multilateral support that the national HIV response experienced in the previous reporting period continued over 2008 and 2009. Overall donor assistance increased from approximately USD 66 million in 2007 to over USD 100 million in 2009.

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

- Bilateral: Australia (AusAID), Denmark (DANIDA), France, Ireland, the Netherlands Norway (NORAD), the United Kingdom (DFID) and the United States of America (PEPFAR).
- United Nations Organizations: ILO, IOM, UNDP, UNESCO, UNFPA, UNICEF, UNIFEM, UNODC, UNV, WHO and UNAIDS.
- Multilateral Organizations: Asian Development Bank (ADB), Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and The World Bank (WB).
- Non-profit making organizations and foundations: Abt Associates/Health Policy Initiative (HPI), AIDS Health Care Foundation (AHF), CARE, Chemonics, Clinton Foundation (CHAI), DKT International, Esther, Family Health International (FHI), the Ford Foundation, Harvard in Viet Nam, IntraHealth International, Management Science for Health (MSH), Medecins 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 and Worldwide Orphans and others.

Reinforced by the Accra Agenda for Action and in line with the Ha Noi Core Statement on Aid Effectiveness, development partners continue to stress the importance of harmonization and the alignment of Government strategies and donor funding.

The Ambassadors/Heads of Agency Informal HIV Coordination Group, a high-level forum made up of Ambassadors and heads from multilateral, bilateral and UN agencies that meets quarterly to coordinate and advocate on issues related to the HIV response, has been very active during this reporting period. Through collaboration with different agencies, such as the Office of Government, the Ministry of Labor, Invalids and Social Affairs (MOLISA) and local People's Committees, it has strengthened dialogue with the Government on key policy issues such as multisectoralism, drug use and HIV, and drug treatment.

As Viet Nam is a One UN Reform pilot country, 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 program and annual review meetings with national implementing partners and civil society to ensure participation and collaboration are aligned with country needs.

In 2007 and 2008, external resources accounted for approximately 90% of the national HIV budget. Therefore, the sustainability of the response is a significant issue as Viet Nam approaches middle income country status and donor funding is likely to decrease.

Experiences over the past two years indicate that development partners should: (1) advocate for more domestic resources to be allocated to the HIV response, (2) ensure their programs align with national priorities and other sectors, and (3) support better multisectoral coordination and planning.

VII. MAJOR CHALLENGES AND REMEDIAL ACTIONS

I. Efforts and achievements in resolving the challenges and difficulties mentioned in the 3rd UNGASS Report (January 2008 reporting for the period of 2006 and 2007)

Over the past two years, the Communist Party, elected bodies and local authorities strengthened their commitment to HIV and enhanced the implementation of the National HIV Strategy, i.e.: (1) improved collaboration between ministries which ensured a stronger multisectoral response and a subsequent improvement in service delivery, most notably the rapid increase in the number of people accessing HIV prevention, care and support services; (2) an increased focus on prevention resulted in the expansion of harm reduction programs, especially the Needle and Syringe Program (NSP) and the National Pilot Methadone Maintenance Therapy (MMT) Program for drug users; (3) rapid expansion of the Antiretroviral Therapy (ART) Program; (4) civil society took on a greater and more meaningful participation in the national HIV response.

2. Main challenges encountered over the period 2008-2009 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 NSP and condom use program (CUP) at the local level. In addition, despite amendments to the Law on Drugs inconsistencies remain between public security measures to control drug use and sex work and public health measures to reach the populations engaged in those activities.

Stigma and discrimination - Twenty years after the first HIV case in Viet Nam was reported, people living with HIV (PLHIV) continue to face stigma and discrimination. The 2008-2009 reporting period saw incidents of children being denied entry to school, workers living with HIV removed from their positions and people shunned by their families and communities after disclosing they were HIV positive. A lack of understanding of the illness, prejudice relating to behaviors that are still widely socially unacceptable and a lack of knowledge of the rights of PLHIV are the main reasons behind these discriminatory practices.

Prevention, treatment, care and support services - There has been progress in scaling up prevention services but sustained efforts are needed to ensure key populations at higher risk, namely injecting drug users (IDUs), sex workers and men who have sex with men (MSM), have sufficient access. There is also a lack of targeted interventions for female IDUs and the primary sexual partners of PLHIV and IDUs. Sustained efforts are needed to fill these gaps in the national HIV response. In addition, HIV prevention, treatment, care and support services are needed in prisons, where they are almost non-

existent, and in 05/06 Centers, where they are still very limited.

Human resources - Limitations in the quantity and quality of human resources inhibit the expansion of best practices at both the provincial and district level. HIV programs have limited incentives to attract and retain competent staff and the rapid turnover of staff creates a cycle of limited technical capacity. In addition, the stigmatization of HIV is a disincentive for those working in the sector. These challenges are not limited to the health sector; some of the other ministries involved in the HIV response, such as the Ministry of Public Security (MOPS), the Ministry of Labor, Invalids and Social Affairs (MOLISA) and the Ministry of Education and Training (MOET), are also affected.

Sustainable funding - The immense scale up of prevention and treatment activities in the last two years was the result of extensive donor support. As Viet Nam approaches middle income country status, this external financial support will reduce. Thus the sustainability of the response and the targeted allocation of domestic and donor funds, in particular to the maintenance and expansion of ART and MMT programs, is a challenge that requires urgent attention.

3. Concrete remedial actions planned to ensure achievement of Universal Access targets and realize the Millennium Development Goals

Achieving the eight Millennium Development Goals (MDGs), particularly MDG 6 relating to HIV, and meeting Universal Access targets will require: (1) significant scale-up of access to HIV services; (2) far greater investment in HIV prevention, treatment, care and support services, particularly for key populations at higher risk. [68]

In 2008-2009, there was a growing awareness of the key challenges that were hindering the national response to HIV. This led to the Government's decision to evaluate the *National Strategy on HIV/AIDS Prevention and Control from 2004-2010 with vision to 2020.* The purpose of this evaluation – now underway – is to review current interventions. The findings will inform the development of a more strategic, cost effective and sustainable response in the coming years. Some of the immediate remedial actions Viet Nam will undertake include:

- Continue to strengthen political commitment on HIV in order to encourage behavior change, disseminate information about HIV and improve 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
- Within the framework of the next phase of the national response, develop a minimum package of services for key populations at higher risk (IDUs, FSWs, MSM), as well as for the intimate partners of IDUs and PLHIV
- Expand the MMT Program and provide HIV prevention services in prisons and 05/06 Centers
- Develop systems and human resource capacity to provide HIV treatment, care and support services in prisons and 05/06 Centers and strengthen the linkages between these facilities, healthcare facilities and communities

[68] Viet Nam MDG report 2009

- Enhance the participation of civil society organizations and PLHIV in program and policy development and in the implementation and monitoring and evaluation of HIV programs
- Develop a human resource strategy to retain qualified staff and provide capacity building opportunities for staff at all levels, especially in the areas of provision, management and coordination of provincial level HIV efforts
- Increase domestic HIV funding and promote the targeted allocation of funds at both the national and provincial level to address the drivers of the epidemic: unsafe drug injection and unsafe sex work
- 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

VIII. MONITORING AND EVALUATION ENVIRONMENT

Key to an effective national response is an understanding of the epidemic and its features, as well as the use of strategic information for the development of targeted activities in support of the implementation of the national response. In the last two years a number of activities were undertaken to continue the work begun by the development of the National HIV Monitoring and Evaluation Framework in 2007. These activities focused on strengthening the National Monitoring and Evaluation System, standardizing central and provincial level monitoring and evaluation practices, and developing an evaluation framework for the current national strategy.

During the 2008-2009 reporting period, the above activities created a momentum among stakeholders and donors throughout the country to further harmonize their monitoring and evaluation practices with the National Monitoring and Evaluation System. Partners made efforts to use the National Monitoring and Evaluation System as their primary information source (at least for impact and outcome level indicators) rather than to create parallel systems. However, the lack of a fully integrated National Monitoring and Evaluation System that includes qualitative data and data generated by civil society is still a challenge.

Organizational structures with HIV monitoring and evaluation functions, coordination and partnerships

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

The National M&E Technical Working Group (M&E TWG), chaired by VAAC, brings together M&E practitioners from central and provincial level national institutions, international partners and the UN to share resources and experience. In the last year the group extended its terms of reference to reflect the greater number of activities its members were involved in, and added Strategic Information (SI) to its name (now the National SI, M&E TWG). In addition, a local NGO representative was welcomed as a member – an initial step to build the capacity of CSOs and ensure their active participation in monitoring and evaluating efforts. During the reporting period and with Joint United Nations Team on HIV technical support, the SI, M&E TWG focused on the development of the Evaluation Framework of the National Strategy, validation of the Country 2009 Joint Global Reporting on the Health Sector Response to HIV, and consensus building on the findings of the 2007 Estimates and Projection Report. In order to provide timely technical support to ongoing activities under the Evaluation Framework of the National Strategy, SI, M&E TWG members established three subgroups: (1) Impact Assessment and Data Triangulation; (2) Size Estimation; (3) Geographical Information System (GIS).

Human resource capacity for HIV M&E, supportive supervision and data auditing

To further strengthen the capacity of national and provincial M&E practitioners, VAAC and its technical partners (PEPFAR, WB, WHO, UNAIDS, FHI, Measure) organized a number of training workshops on the implementation of Decision 28 (the HIV routine reporting system) and on data management and use. In addition, VAAC, the National Institute of Hygiene and Epidemiology (NIHE) and four regional institutes conducted supervision and monitoring visits.

Nevertheless, some challenges do remain, i.e.: (1) data quality and accuracy, including sex and age desegregation; (2) capacity building for M&E staff at all levels, including staff retention; and (3) capacity of local NGOs

Surveys, surveillance and the dissemination and use of data

During the 2008-2009 reporting period, Viet Nam took steps to improve surveillance and build national capacity to disseminate and use data effectively. For example, revision of the National Protocol for HIV Sentinel Surveillance, supported by PEPFAR/CDC and WHO, resulted in the pilot introduction of the short questionnaire on 'HIV prevalence among new injecting drug users and young sex workers.' This questionnaire was added to the data collection of the sentinel HIV sero-surveillance in 2009 in a couple of pilot provinces.

Also, the second round of the Integrated Biological and Behavioral Survey was conducted in the last part of 2009 and its findings will offer much needed information on the epidemic and behavior patterns of key populations at higher risk in selected provinces.

In the beginning of 2009, VAAC, NIHE, PEPFAR/CDC, UNAIDS, Family Health International and the University of California at San Francisco (UCSF) initiated the 'Data triangulation exercise'. The exercise sought to answer key questions on the characterization of the HIV epidemic in Viet Nam by collating and interpreting data from multiple sources. The results of this exercise will inform policy and program decision-making. In addition, the data triangulation exercise encompassed capacity-building activities, including one-on-one mentoring, twinning between the UCSF and Viet Nam analyst teams and training stakeholders to use data for program planning.

2008-2009 also saw capacity building for sub-national partners. A wide range of institutions and practitioners were active in the provincial and district level HIV response, e.g. representatives from the Departments of Health, PACs, People's Committees, Departments for Labor and Social Policy, Departments for Education and Training, provincial and local level Women's Unions, Departments of Police and district level Preventive Medicine Centers. With support from UNAIDS and the Nha Trang Pasteur Institute, VAAC organized a series of 2-day workshops for provincial and district level authorities in two provinces. In these workshops, VAAC introduced the concept of HIV monitoring and evaluation and the use of strategic information in crafting an effective provincial response.

In addition, NIHE is completing a study to validate incidence assays for incidence surveillance, a vital component of a comprehensive surveillance system. Results of the validation study in Viet Nam will be used by WHO and US CDC to guide future international HIV-1 incidence testing guidelines. Future use of validated assays will provide key data to Viet Nam's epidemic and show program impact.

Challenges faced during the reporting period included: (1) the size of key populations at higher risk has not been systematically assessed; (2) a better understanding of key populations' complex networks is needed (this includes the regular and casual sexual partners of female sex workers, injecting drug users and men who have sex with men) in order to design well-targeted packages of services and improve monitoring; and (3) data management and data use

HIV evaluation

In response to VAAC's request to support national efforts for the evaluation of the current National HIV Strategy 2004-2010, UNAIDS Viet Nam, in close collaboration with

other partners, assisted in the development of an overall evaluation framework. Thanks to the collective efforts of multiple partners, this framework will help glean the evidence Viet Nam needs to formulate the next phase of its national HIV response. Within this framework, VAAC (in partnership with UNAIDS and WB) initiated an impact assessment of the National Harm Reduction Program. The primary objectives of this assessment were to: (1) explain HIV transmission dynamics in Viet Nam; (2) examine the coverage of harm reduction interventions in the country; and (3) evaluate the extent to which harm reduction interventions have contributed to reduced HIV transmission in Viet Nam.

VAAC, in close collaboration with PEPFAR/CDC and WHO, also implemented an assessment of the National ARV Treatment Program, with a focus on cohort-based outcome indicators and HIV drug resistance early warning indicators.

Costing exercise

In 2008-2009, with technical and financial support from development partners, VAAC conducted a number of costing exercises (e.g. costing of the National ARV Treatment Program and the pilot MMT Program and unit costing for prevention of mother-to-child transmission of HIV services) as well as a preliminary estimation of resource needs. However, there is an urgent need for further analysis of national AIDS spending and the development of financial resource needs estimates. VAAC, in partnership with PEPFAR, Health Policy Initiative, World Bank, and the Joint United Nations Team on HIV, will continue to work in this area to ensure that unit costs for a comprehensive package of services, as well as resource needs estimates, are available in time to inform the development of the next phase of the National HIV Strategy.

HIV information management system and national and sub-national HIV databases

In the last two years VAAC made great efforts to develop a single reporting form and database for routine monitoring (Decision 28) and encourage donors to mainstream their data collection activities. Furthermore, VAAC, with technical support from WHO, began piloting a computer-based tool for monitoring harm reduction services at the local level. This tool incorporates a unique identifier for individuals with high-risk behaviors – one of the critical gaps in Viet Nam's current harm reduction monitoring system.

However, more work will be needed to achieve the full integration of the different components, ensure national standards on data collection, structure and interchange.

Remedial action

The current evaluation of the National HIV Strategy offers an opportunity for the assessment of the 12 components of the National M&E System. The findings of this assessment will inform future activities regarding the quality and accuracy of data, capacity building, the integration of data generated by different partners and data synthesis, analysis and use, as well as the initiation of additional research. This will be followed by the development of a costed national M&E plan that will accompany the next phase of the HIV response in Viet Nam. The National SI, M&E TWG, together with its subgroups, will continue to be the forum that will lead national efforts in further strengthening of the National 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 programs can improve.

ANNEXES

ANNEX 1:

Consultation/preparation process for the national report on monitoring the follow-up to the declaration of commitment on HIV/AIDS

1. Which institutions/entities were responsible in filling out the indicators forms?

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

2. With input from:

Ministries:	
Ministry of Education & Traiing	Yes
Ministry of Health	Yes
Ministry of Labour, Invalids and Social Affairs	Yes
Ministry of Foreign Affairs	No
Other Ministries:	
Ministry of Finance	Yes
Ministry of Justice	Yes
Ministry of National Defence	Yes
Ministry of Public Security	Yes
Ministry of Transport	Yes
Other institutions:	
Civil Society Organizations	Yes
People Living with HIV	Yes
Private Sector	Yes
United Nations Organizations	Yes
Bilateral organizations	Yes
International NGOs	Yes
Others:	
The Party's Central Commission of Ideology	Yes
Labor Union	Yes
Vietnam Red Cross	Yes
Women Union	Yes
Youth Union	Yes

3. Was the report discussed in large forum? Yes
   On 11/03/2010

4. Are the survey stored centrally? Yes

5. Is the data available for public consultation? Yes

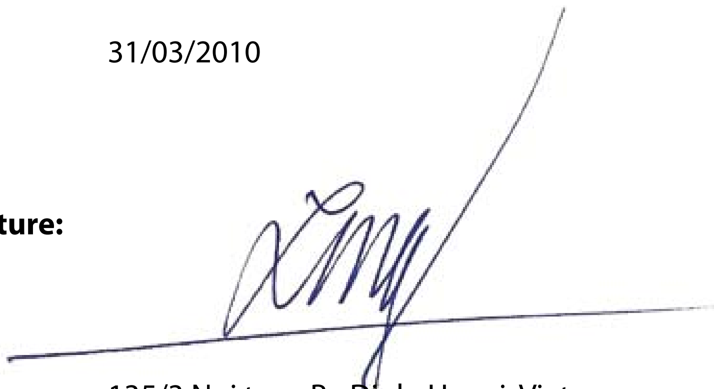
Name of National AIDS Commitetee Officer in charge of submitting report and reflecting question relating to the report

Name: Nguyen Thanh Long

Title: Director General of Vietnam Administration of HIV/AIDs Control, Ministry of Health

Date: 31/03/2010

Signature:



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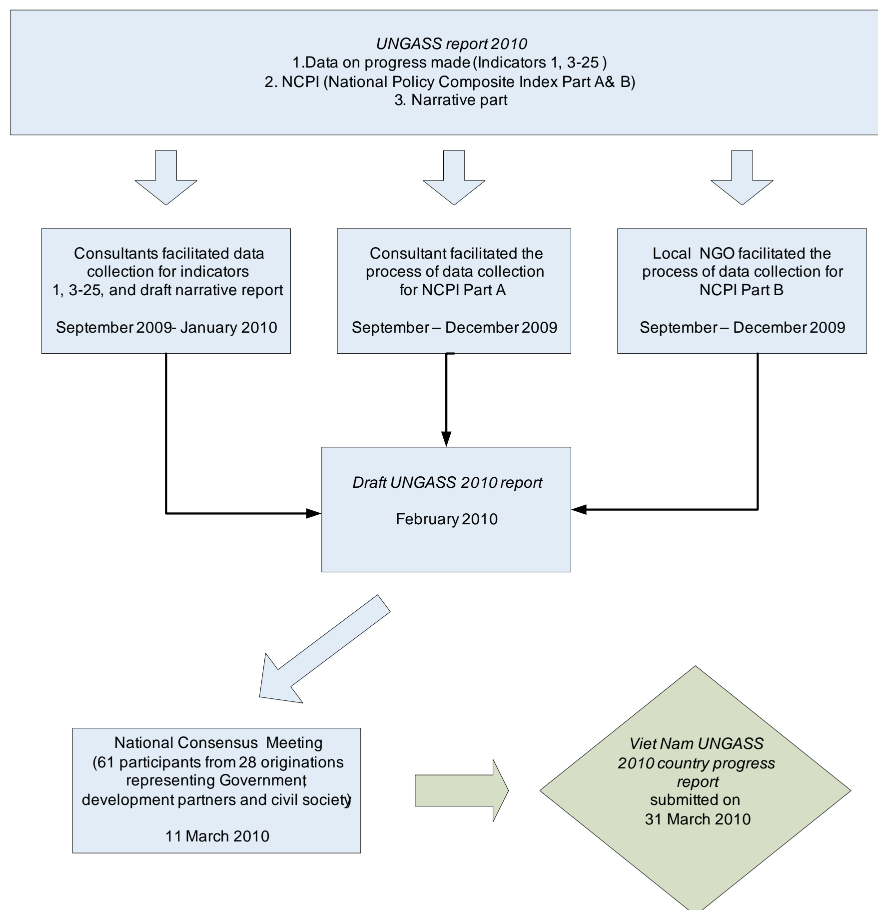
UNGASS 2010 PREPARATION PROCESS

This report was prepared with broad participation from Government, development partners and civil society. Planning for the report began in July 2009 with the development of a road map for an extensive consultation process. A total of 17 Government agencies, over 200 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 main components of the overall report preparation process.

Figure 1: Viet Nam UNGASS 2010 reporting process outline

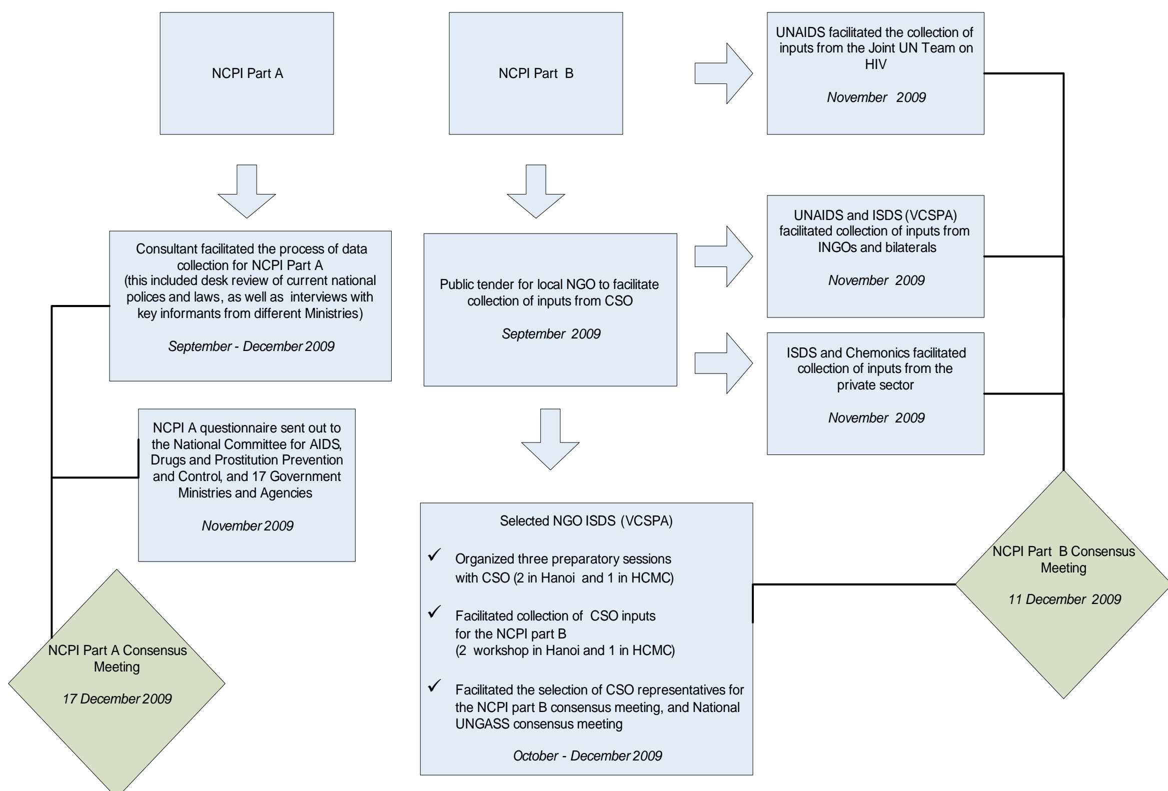


A number of consultants were engaged to support the UNGASS writing team led by the Viet Nam Administration of AIDS Control (VAAC) and consisting of a local non-governmental organization (NGO) and UNAIDS Viet Nam. Local consultants facilitated the collection of data for Indicators 1, 3-25 and National Composite Policy Index (NCPI) Part A. Without a National AIDS Spending Assessment or National Health Account to draw on, a health economist supported VAAC to collect national AIDS spending data. While incomplete, the data collected and presented in this report is the most comprehensive expenditure data available to date.

In November 2009 the NCPI Part A questionnaire was sent to members of the National Committee for AIDS, Drugs and Prostitution Prevention and Control. Seventeen Government agencies responded and participated in a consensus meeting on 17 December 2009. While the whole NCPI Part A questionnaire was sent out to all, Government agencies only filled in the sections relevant to their work.

Of particular note is the consultation and data collection process of the NCPI Part B questionnaire. A public tender for a local NGO to facilitate data collection for NCPI Part B and civil society organizations' (CSO) participation in the overall process was made in September 2009. The Institute for Social Development Studies (ISDS), on behalf of the Viet Nam Civil Society Platform on AIDS (VSCPA) successfully secured this tender. The process behind the data collection for the National Composite Policy Index is described in Figure 2.

Figure 2: NCPI Part A and B data collection outline



ISDS held three preparatory meetings, two in Ha Noi and one in Ho Chi Minh City, in October and November 2009. The aims of these preparatory sessions were to raise awareness of the UNGASS process, provide guidance on the questionnaire and familiarize participants with its content and purpose.

At these meetings, partners picked up copies of an 'UNGASS collection' in Vietnamese that included extracts of the *Declaration of Commitment*, highlights of the 2008 report, NCPI Part B questionnaire, guidelines on indicators and the NCPI Part B process, and information outlining the consultation process. After the meetings, participants returned to their constituencies to share this information and collect inputs.

Following the preparatory meetings, a series of consultation meetings (two in Ha Noi and one in Ho Chi Minh City) were held in late November and early December to gather CSO inputs and complete the NCPI Part B questionnaire. In total, 179 people representing 179 social organizations from 34 provinces throughout the country participated in the six meetings. These organizations included self-help groups, faith-based organizations and local NGOs. Participants at each consultation meeting selected a nine-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 faith-based organizations to represent them at the NCPI Part B consensus meeting in Ha Noi on 11 December 2009.

International NGOs, the Joint UN Team on HIV and business enterprises 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.

The NCPI Part B consensus meeting was held on 11 December 2009. At this meeting, facilitated by ISDS, representatives from civil society organizations, business enterprises, bilateral and multilateral agencies and the Joint UN Team on HIV engaged in a frank discussion wherein representatives of key populations at higher risk debated confidently with development partners. Together the 16 meeting participants 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 consultative process was the National Consensus Meeting for the overall UNGASS progress report in Ha Noi, hosted by VAAC on 11 March 2010. The goal of this meeting was to present the UNGASS findings and give participants an opportunity to review and validate the draft report. Sixty-one participants from 28 organizations representing Government, development partners and civil society were present. Civil society participants were drawn from the task force, who 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.

The 2008 UNGASS preparation process stimulated unprecedented engagement between Government and civil society. The lessons learned from Viet Nam's 2008 UNGASS report informed the preparation of this report.

One of the benefits of this process was that CSOs had an opportunity to measure and report on their activities and see how these fitted into the national response. It also served to raise participants' awareness of their rights and responsibilities and to meet, discuss and strengthen their relationships. Since the first UNGASS report in 2003, the role of civil society in the national response has grown and is widely acknowledged. The 2010 Country Progress Report is testament to this achievement.

For a full list of participants see the relevant Annexes.

List of participants of the National Consensus Workshop
On the UNGASS report 2010 – 11 March 2010

#	Name	Organisation
I	**Viet Nam Administration for AIDS Control**	
1	Nguyen Thanh Long	General Director
2	Phan Thị Thu Huong	Department of M&E
3	Hoang Dinh Canh	Department of M&E
4	Nguyen Duc Huy	Department of M&E
5	Quach Van Luong	Department of M&E
6	Vo Hai Son	Department of M&E
7	Vu Duc Long	Department of M&E
8	Bui Hoang Duc	World Bank project
9	Nguyen Huu Hai	Department of Care and Treatment
10	Tran Van Son	Department of Care and Treatment
11	Vu Duc Long	Department of Harm Reduction
12	Pham Duc Manh	Department of Harm Reduction
13	Do Huu Thuy	Department of Information - Education - Communication
14	Nguyen Van Hai	Department of Information - Education - Communication
15	Nguyen Dac Vinh	Department of Scientific Research & International collaboration
II	**Technical Sub-committees**	
1	Chu Thi Thu Huong	Blood Transfusion Safety Sub-Committee
2	Do Thinh Hai	Paediatrics Sub-Committee
3	Do Quan Ha	PMTCT Sub-Committee
4	Nguyen Duy Hung	STI Sub-Committee
5	Duong Cong Thanh	National Institute of Hygiene and Epidemiology
6	Le Anh Tuan	National Institute of Hygiene and Epidemiology
7	Nguyen Anh Tuan	National Institute of Hygiene and Epidemiology
8	Nguyen Tran Hien	National Institute of Hygiene and Epidemiology
III	**Related departments under Ministry of Health**	
2	Tran Quang Hung	Ministry of Health – Department of International Cooperation

2	Do Trung Hung	Ministry of Health – Department of Legislation
3	Tran Thi Xuan Hang	Ministry of Health – Department of Legislation
4	Vu Hong Ngoc	Ministry of Health – Department of Treatment
IV	**Other sectors**	
1	Vu Cong Thao	Government Office - Science, Education, Society Department
2	Phan Duong Thu Huong	Ministry of Justice- Department of Administration and Criminal Laws
3	Vu Quoc Binh	Ministry of National Defense- Department of Health
4	Nguyen Thi Thu Ba	Ministry of Public Security – Department of Health
5	Ta Thi Thao	Ministry of Public Security – Department of Health
6	Pham Duc Thu	Ministry of Transportation – Department of Health
7	Hoang Chuong	Viet Nam Fatherland Front
8	Pham Song	Viet Nam Medical Federation
V	**Civil society**	
1	Do Thi Thanh Nhan	Representative of local NGO
2	Le Tan Minh	Representative of MSM
3	Ong Van Tung	Representative of PLHIV
4	Pham Thi Minh	Representative of IDUs
5	Thich Thanh Lam	Representative of faith-based organization
	International Non-Governmental Organization	
1	Nguyen Duy Tung	Abt Associates/Health Policy Initiative (HPI)
2	Nguyen Tuan Phong	Abt Associates/Health Policy Initiative (HPI)
3	Ted Hammett	Abt Associates/Health Policy Initiative (HPI)
4	Ho Thi Van Anh	ODC
5	Vu Cong Nguyen	Institute of Population, Health and Development (PHAD)
VII	**Bilaterals**	
1	Janet Hayman	President's Emergency Plan for AIDS Relief (PEPFAR)
2	Bruce Struminger	Centres for Disease Control, USA (CDC)
3	Nguyen Bui Duc	Centres for Disease Control, USA (CDC)
4	Nguyen Nguyet Phuong	Centres for Disease Control, USA (CDC)
5	Nisha Gupta	Centres for Disease Control, USA (CDC)
6	Patrick Nadol	Centres for Disease Control, USA (CDC)

VI	**United Nations Agency**	
1	Nguyen Ngoc Trieu	The United Nations Children's Fund (UNICEF)
2	Scott Bamber	The United Nations Children's Fund (UNICEF)
3	Masaya Kato	World Health Organization (WHO)
4	Nguyen Thi Minh Thu	World Health Organization (WHO)
5	Eamonn Murphy	The Joint United Nations Programme on HIV/AIDS (UNAIDS)
6	Vladanka Andreeva	The Joint United Nations Programme on HIV/AIDS (UNAIDS)
7	Nguyen Thi Cam Anh	The Joint United Nations Programme on HIV/AIDS (UNAIDS)
IX	**Consultants**	
1	Vu Ngoc Uyen	Consultant
2	Deepa Gajjar	Consultant

ANNEX 2:

INDICATOR 1: NATIONAL AIDS SPENDING

1. Process

The method applied in this data collection was a survey of all major AIDS partners. The Viet Nam Administration of AIDS Control (VAAC), responsible for the coordination and state management of AIDS activities, sent a letter to all major partners in the national HIV response requesting them to share data on their actual HIV expenditures in the years 2007, 2008 and 2009, if available. Amongst the HIV partners reached by VAAC were donor representative offices, international non-profit organizations and foundations supporting HIV activities, major HIV projects and programs managed by the Ministry of Health (MOH), Provincial AIDS Centers (PAC) (VAAC's technical sub-units) and a number of central Government agencies and mass organizations that are implementing HIV prevention and care activities. The national AIDS spending matrix was sent to all partners together with brief guidelines adapted from the 2009 UNAIDS guidelines.[1] In the follow up process, telephone and email were used as the main communication channels to provide guidance on technical issues. In some cases and where necessary, face-to-face meetings were also held.

Data collection for this survey was done using the national AIDS spending matrix form. AIDS spending fell into eight categories, or 'ASC': 1) prevention; 2) treatment and care; 3) orphans and vulnerable children; 4) program management and administration strengthening; 5) human resources; 6) social protection and social services (excluding orphans and vulnerable children); 7) enabling environment, and 8) research. The survey also captured AIDS spending across two funding sources: public and international. Due to the limitations of this survey, as described in the following section, private sources were not captured in this study. Moreover, the term 'public sources' refers to Government sources only (central and provincial level); loans from development banks and other public sources, such as out-of-pocket expenditures, are not included.

The main reference source for the national AIDS spending matrix were the disbursement reports of financing agents. (See Excel Workbook Sum Donor 2007, 2008 and 2009). Expenditure data provided by international non-profit making organizations and foundations and local providers (PAC) that were reported by financing agents were excluded from the national spending matrix to avoid duplication.

2. Data quality

2.1. International donor disbursement reports

The response rate from donor organizations was very high. All major donors to the national AIDS program, including the President's Emergency Plan for AIDS Relief (PEPFAR), the Australian Agency for International Development (AusAID), the United Kingdom Department of International Development (DFID), the Danish International Development Agency (DANIDA) and United Nations (UN) agencies responded and

[1] National AIDS Spending Assessment (NASA): Classification and Definitions, UNAIDS 2009

openly shared their disbursement data. Inputs were also received from the Royal Netherlands Embassy (RNE) and Irish Aid, as well as from the management boards of major HIV projects funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the Asian Development Bank (ADB) and the World Bank (WB). As a result, it is estimated that this report has recorded the vast majority of international spending on HIV in Viet Nam.

The number of international non-profit organizations and foundations that replied to VAAC's request for information is modest compared to the size of the international non-Governmental organization (INGO) community operating in the country. To avoid counting the same organization more than once, PEPFAR and its subcontractors agreed that the PEPFAR representative office would take responsibility for reporting on all PEPFAR spending.[2] However, as PEPFAR partners did not send their own reports, their core funds have been missed. Based on the fact not every PEPFAR partner contributed core funding and the latter normally accounts for a very small percentage of the total project expenditure, we can estimate that the volume of omitted financial resources is very modest compared to the PEPFAR financial resources reported by the representative office and therefore the error resulting from this omission is insignificant to the total national AIDS spending.

The total spending by international non-profit organizations and foundations reported in this survey includes core funding of the AIDS Healthcare Foundation (AHF), Médecins du Monde (France) (MdM), Pact, the Clinton HIV/AIDS Initiative (CHAI), UNITAID, and a portion of the Ford Foundation support implemented by Pathfinder.

Regarding the data collected from donor reports, two sources of error are worth mentioning. First, all AIDS partners reported their expenditures by calendar year (1 January – 31 December) with the exception of PEPFAR, whose financial year starts on 1 October and ends on 30 September. Since PEPFAR data was not available by quarter, their fiscal year data was used as an exception. Thus, for 2007, this report recorded PEPFAR data from October 2006 through September 2007, for 2008, it used data from October 2007 through September 2008, and so forth.

The second source of error comes from the differences between donor disbursement and actual spending. Donor disbursement data is comprehensive and it is often not possible to disaggregate financial disbursement by ASC according to the National AIDS Spending Assessment (NASA) guidelines. This report relies heavily on donor disbursement reports. Therefore, a high percentage of the expenditures are not disaggregated by ASC.

2.2. National AIDS authority reports

- The response rate from the provincial authorities for AIDS control was not high. Out of 63 provinces, 42 PACs and one Department of Health (68%) submitted expenditure data with different degrees of detail and consistency.
- Since the data provided by VAAC and PACs on international spending is incomplete, donor reports were used as the main source of data on international spending; VAAC and PACs reports were used as the main source of data on public spending.

[2] A list of PEPFAR partners, both international and national, was not provided.

- The public spending on AIDS collected by this survey only reflects Government budgetary spending which include (1) Recurrent expenditures of the central and provincial AIDS authorities (VAAC and PACs); (2) Capital investment of the provincial budget in PACs; (3) Spending of the National Target Program for HIV/AIDS (NTP).
- This survey has been the only known effort to collect data on total actual spending of the NTP in 2008 and 2009. Using the budget plan of the Program for Social Diseases, Dangerous Diseases and HIV/AIDS released by the Ministry of Finance (MOF), it is estimated that VAAC and PACs recorded more than 90% of NTP expenditures in 2008 for this survey. Regarding 2009 spending, the survey was administered in December 2009, when the PACs 2009 balance sheets were still under preparation so only 10 PACs submitted data.
- In the national AIDS spending matrix, all NTP expenditures were added to the central budget spending, under the assumption that the central budget is responsible for the larger share of NTP expenditures.

2.3. Reports from other AIDS program implementers

Four sectors of public organizations provide HIV-related services: 1) health; 2) labor, invalids and social affairs; 3) public security, and 4) defense. In addition, other ministries and numerous mass organizations and NGOs such as the Fatherland Front, Women's Union, Youth Union, Trade Union, Red Cross and so forth have activities for HIV prevention at all four administrative levels (central, provincial, district and commune). VAAC sent a request for indicator 1 data to all relevant departments of the relevant ministries and mass organizations except the Ministry of Defense. The rate of response, however, was very low.

Only two central agencies provided inputs (excluding VAAC itself). One was the General Department for the Prevention of Social Evils of the Ministry for Labor, Invalids and Social Affairs (MOLISA), which shared data from one PEPFAR-funded project (amongst other projects managed by the Department). The other was the Youth Union, which reported on their sub-component of the NTP at the central level.

2.4. Limitations

This survey captured the public financial resources managed by the health sector's specialized AIDS authorities: VAAC and PACs. The actual AIDS spending of the Government of Viet Nam is estimated to be much higher than reported in this survey. Recognizing this, two broad and important budget items have been missed:

- AIDS-related health services provided by public health institutions other than VAAC and PACs. These institutions include national, regional, provincial and district hospitals, commune health centers, research institutes and the pharmaceutical system.
- AIDS-related services provided by non-health public sectors (for example, labor and social affairs, public security, defense, education and so forth).

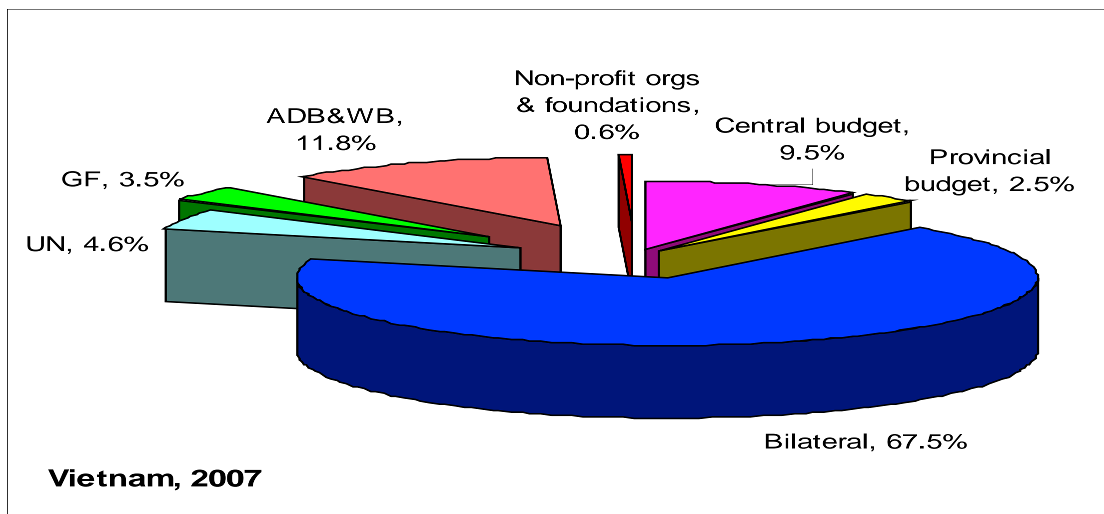
Another limitation of this survey is that it does not capture patients' out-of-pocket expenses and other private expenditures.

3. Main Findings

3.1. AIDS expenditures in 2007

In 2007, at least USD 66.3 million was spent on HIV in Viet Nam, accounting for 1.5% of total national health spending. In the context of overall Government spending on health, AIDS spending was equivalent to 6.5% or USD 0.78 per capita. Incomplete statistics on Government AIDS spending show that the Government contributed USD 8 million, of which USD 6.3 million (79%) came from central Government sources and USD 1.7 million (21%) came from local (provincial) sources.

Figure 1: Main sources of AIDS spending in Viet Nam, 2007



Source: National AIDS Spending Matrix 2007

Figure 1 summarizes the main funding sources for HIV in 2007 and illustrates each funding source's share of the total national spending.

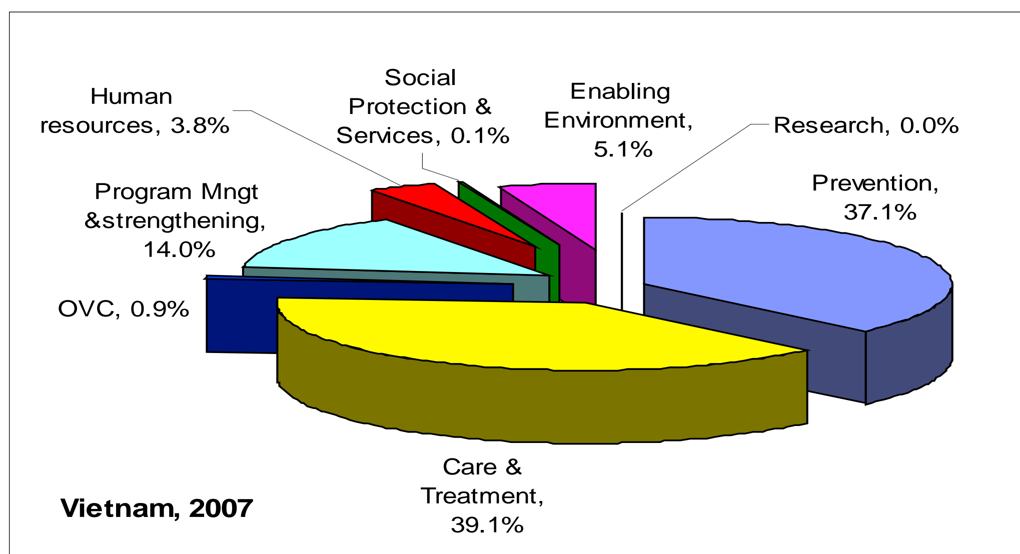
As shown, external sources accounted for 88% of total AIDS spending, while Government sources accounted for 12%.[3] Of all AIDS spending, 67.5% was financed by bilateral grants. Multilateral donors were the second largest source of funds, providing nearly 20% of all expenditures. In particular, the Global Fund provided 3.5%, UN Agencies provided 4.6% and the two development banks – ADB and WB – provided 11.8% of all financial resources.

As a PEPFAR focus country, Viet Nam received significant resources from United States donors including the United States Agency for International Development (USAID), the Centers for Disease Control, USA (CDC) and the Department of Defense (DOD). In 2007, disbursements from PEPFAR totaled USD38.7 million, equivalent to 86% of bilateral and 58% of national AIDS resources.

Incomplete statistics show that international non-profit organizations and foundations contributed 0.6% of AIDS expenditures.

[3] All calculations in this report are based on incomplete data on Government spending.

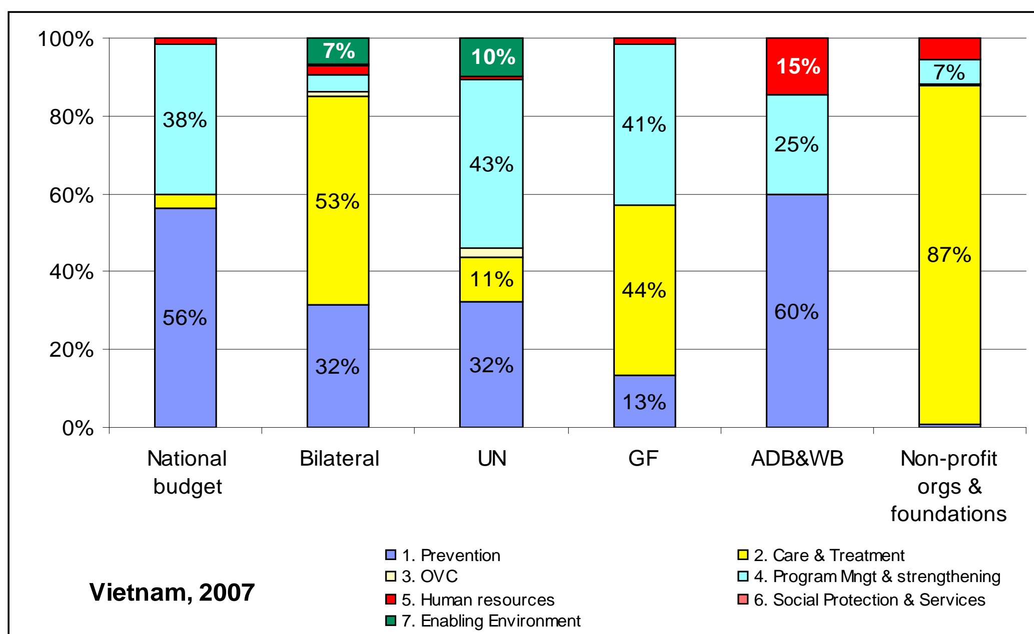
Figure 2: Total spending by ASC, 2007



Source: National AIDS Spending Matrix, 2007

Figure 2 describes the allocation of AIDS expenditures by the eight ASC. In total, 39% of resources went to treatment and care and 37% went to prevention. Program management and administration strengthening received 14%, with the remainder going to enabling environment (5%), human resources (3.8%), support to orphans and vulnerable children (0.9%) and social protection and social services (0.1%). Almost no financial resources were spent on research.

Figure 3: Distribution of spending by sources and ASC, 2007

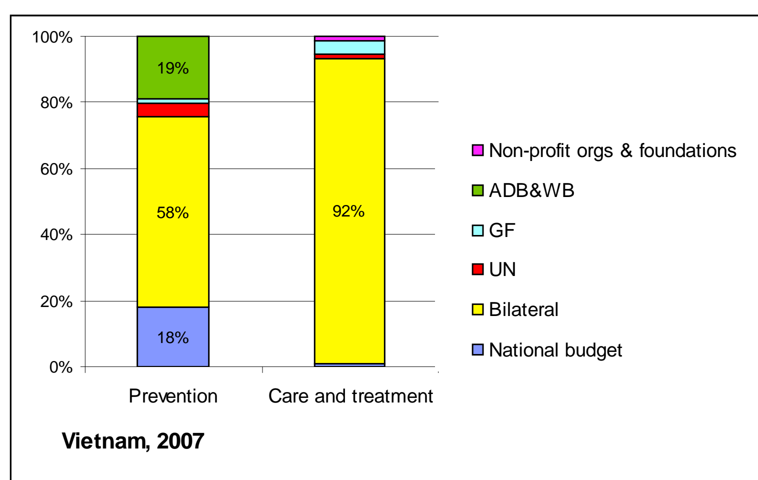


Source: National AIDS Spending Matrix, 2007

Figure 3 breaks down spending by funding source and seven ASC (research is not included because spending on research was negligible). The breakdown shows that 94% of Government AIDS expenditures were concentrated on prevention (56%) and program management (38%). The major projects funded by ADB and WB and managed by the MOH record similar expenditure patterns, with 85% of all resources channeled to the above two areas. The third priority for ADB and WB projects was human resources, which accounted for 15% of spending.

Bilateral organizations focused their resources on treatment and care (53%) and prevention (32%). Enabling environment, bilateral donors' third largest ASC, accounted for 7% of their resources. Compared to other donors, UN expenditures were more diversified. Their four largest ASC were: program management and administration strengthening (43%), prevention (32%), treatment and care (11%) and enabling environment (10%). GLOBAL FUND grants went to treatment and care (44%), program management and administration strengthening (41%) and prevention (13%). Finally, non-profit organizations and foundations spent 87% of their resources on treatment and care and 7% on program management.

Figure 4: Spending on prevention, treatment and care by different financial sources, 2007



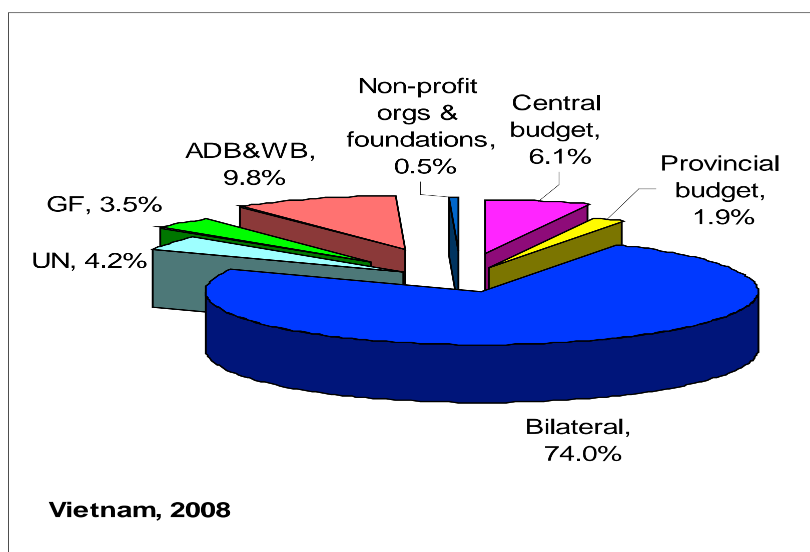
Source: National AIDS Spending Matrix, 2007

Like many other developing countries, the HIV response in Viet Nam is reliant on international financial support and on bilateral grants in particular. Figure 4 shows the degree of this reliance in the two largest ASC: prevention, and treatment and care. The breakdown of total ASC shows that 92% of treatment and care expenditures in 2007 were covered by bilateral assistance. The Government budget contributed only 1% of treatment resources. For prevention, the Government budget provided 18% of all expenditures, while 58% came from bilateral sources and the rest (26%) from multilateral grants.

3.2. AIDS expenditures in 2008

Total AIDS spending in 2008 reached USD 108.7 million, an increase of 64% from 2007. AIDS spending was equivalent to 10.5% of Government spending on health and 1.8% of total national health spending. Compared to 2007, AIDS spending per capita in 2008 increased 62%, from USD 0.78 to USD 1.26 per person.

Figure 5: Main sources of AIDS spending in Viet Nam, 2008



Source: National AIDS Spending Matrix, 2008

Incomplete statistics on national AIDS spending show that the Government budget of approximately USD 8.7 million consisted of USD 6.6 million (76%) from the central and USD 2.1 million (24%) from the provincial budget.

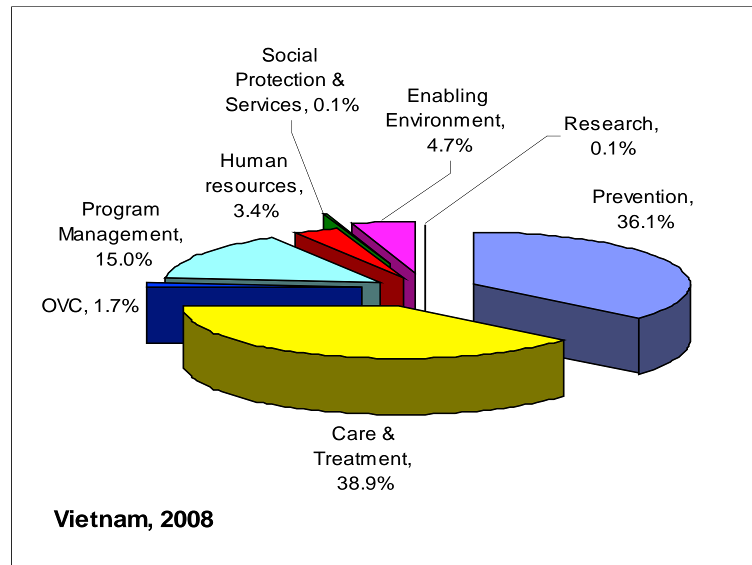
Figure 5 summarizes the main funding sources for HIV in 2008, as well as each funding source's share in the total national spending. As shown, international sources accounted for 92% of total AIDS spending (compared to 88% in 2007). Bilateral grants financed 74% of all AIDS spending (compared to 67.5% in 2007). Multilateral donors were the second largest source of funds, providing 17.5% of all expenditures. In particular, GLOBAL FUND grants covered 3.5% of expenditures, UN Agencies comprised 4.2% and the two development banks, ADB and WB, provided 9.8% of all financial resources.

The largest donor, PEPFAR, almost doubled its spending in 2008. Total disbursement from PEPFAR reached USD 71.5 million, accounting for 89% of bilateral and 66% of all national AIDS expenditures.

Compared to 2007, the Government's 2008 AIDS spending increased by 10%. However, because of the major increase in PEPFAR spending, the Government's share in overall spending actually reduced. In 2008, the central Government budget contributed 6.1% of AIDS resources and provincial budgets dedicated 1.9%.

Incomplete statistics show that international non-profit organizations and foundations contributed 0.5% of AIDS expenditures.

Figure 6: Total spending by ASC, 2008

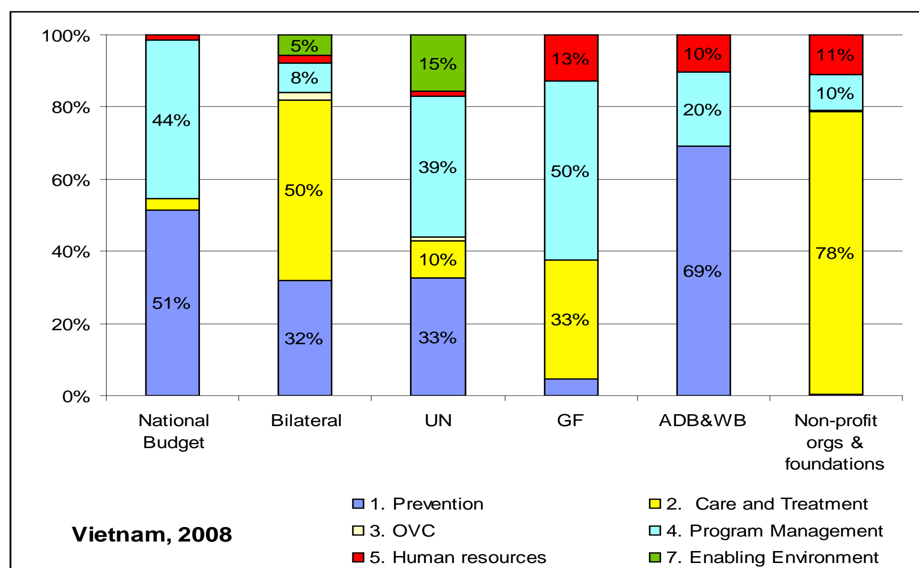


Source: National AIDS Spending Matrix, 2008

Figure 6 describes the allocation of AIDS expenditures by the eight ASC. Treatment and care remains the largest ASC, accounting for 39% of all resources. The second largest ASC is prevention, which accounted for 36% of spending, and the third is program management and administration strengthening (15%). Overall, the three largest ASC accounted for 90% of all expenditures. This is similar to the breakdown of expenditures in 2007.

In 2008, however, the least visible ASCs – orphans and vulnerable children (OVC), ASC3, and research, ASC8 – showed significant increases both in terms of volume of spending and share of total expenditures. OVC spending tripled; its share of total spending increased from 0.9% in 2007 to 1.7% in 2008. Similarly, in comparison to 2007, research spending increased more than 4 times.

Figure 7: Distribution of spending by sources and ASC, 2008



Source: National AIDS Spending Matrix, 2008

In Figure 7, spending by funding source is broken down according to six ASC (social services, ASC6, and research, ASC8, are not included as their share is insignificant).

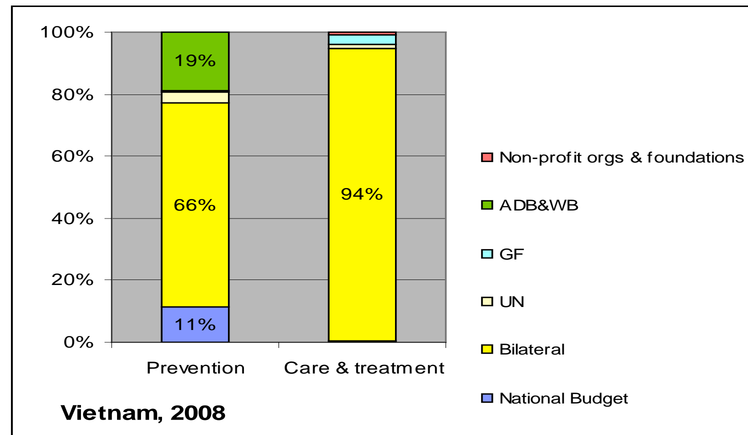
The breakdown shows that 95% of Government expenditures were concentrated on prevention (51%) and program management (44%), similar to 2007. The remaining 5% of expenditures were distributed to treatment and care (3%) and human resources (1.5%). The major projects funded by ADB and WB and managed by the MOH followed expenditure patterns similar to those of 2007. However, prevention increased its 2007 share to 69% and program management and administration strengthening reduced to 20% (from 25% in 2007). ADB and WB spent 10% of their funds on human resources.

As in 2007, bilateral grants focused mainly on treatment and care (50%) and prevention (32%). However, they did change their relative share of ASC: program management and administration strengthening surpassed enabling environment to become the third largest ASC, accounting for 8% of total bilateral spending. Moreover, compared to 2007 the OVC share of total expenditures doubled whereas enabling environment's share reduced slightly.

The breakdown of UN expenditures was unchanged from 2007, with little variation in the relative share of different ASC. The largest ASC, program management, reduced to 39% (from 43% in 2007) with prevention and enabling environment increasing as a result.

In contrast, the distribution of GLOBAL FUND expenditures changed significantly. The program management ASC surpassed treatment and care to become the largest ASC, with 50% of total expenditures, while treatment and care, which accounted for 33% of spending, dropped. The third largest ASC, human resources, accounted for 13% of spending. Resources from non-profit organizations and foundations were mainly spent on treatment and care (78% in 2008).

Figure 8: Spending on prevention, care and treatment by different financial sources, 2008



Source: National AIDS Spending Matrix, 2008

Figure 8 shows the degree of Viet Nam's reliance on international financial support in the two largest ASC: prevention, and treatment and care. The breakdown of total ASC shows that 94% of treatment and care and 66% of prevention expenditures in 2008 were covered by bilateral assistance. The ADB/WB grant provided 19% of prevention expenditures. In contrast, the Government budget contributed only 1% of treatment and care and 11% of prevention expenditures.

3.3. AIDS expenditures in 2009

Based on the data collected, more than an estimated USD 103 million was spent on AIDS in 2009. Of this bilateral donors contributed USD 89.7 million, multilateral donors USD 10.4 million and non-profit organizations and foundations USD 0.8 million. Total Government allocations were only USD 2.2 million.

A number of international donors were not able to provide full – or even partial – data because their annual balance sheets were not yet available in December 2009 when data collection occurred. These donors included: DANIDA, DFID, GLOBAL FUND, UNDP, UNESCO, UNODC and WHO. For the same reason, the survey received expenditures data from just 10 PACs; as a result, data on Government spending is very poor.

In 2009, PEPFAR continued to increase its AIDS spending, reaching a total expenditure of USD 86.75 million. Compared to 2008, this was an increase of 21%.

4. Conclusion

This is the first time that a survey of the main AIDS partners in Viet Nam, including financing agencies, national AIDS authorities and program implementers, has been conducted to collect data on indicator 1: National AIDS Spending. However, survey methods were not appropriate for the capture of actual expenditure flows throughout the broad national multisectoral HIV response in Viet Nam. Household and private expenditures on AIDS have also not been captured.

Detailed Viet Nam National AIDS Spending Matrixes for the three years 2007, 2008 and 2009 are included in the Excel Files attached to this report.

List of AIDS partners who contributed data to this survey

Funding Agency

Bilateral

1. Australian Agency for International Development (AusAid)
2. Danish International Development Agency (DANIDA)
3. United Kingdom Department for International Development (DFID)
4. The United States President's Emergency Plan for AIDS Relief (PEPFAR)
5. The Royal Netherlands Embassy (RNE)

Multilateral

1. Asian Development Bank (ADB)
2. Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)
3. The Joint United Nations Programme on HIV/AIDS (UNAIDS)
4. The United Nations Development Programme (UNDP)
5. The United Nations Educational, Scientific and Cultural Organization (UNESCO)
6. The United Nations Children's Fund (UNICEF)
7. The World Bank (WB)
8. The World Health Organization (WHO)

Non-profit making organizations and foundations

1. AIDS Healthcare Foundation (AHF)
2. Clinton HIV/AIDS Initiative (CHAI)
3. Esther
4. Medecins du Monde (MdM)
5. Pact
6. Program for Appropriate Technology in Health (PATH)
7. Pathfinder

National AIDS Authorities

1. Viet Nam Administration of HIV/AIDS Control (VAAC)
2. An Giang Provincial Centre for AIDS and Tuberculosis Prevention
3. Bac Giang Provincial AIDS Centre
4. Bac Lieu Provincial AIDS Centre
5. Binh Phuoc Provincial AIDS Centre
6. Binh Thuan Provincial AIDS Centre
7. Ba Ria – Vung Tau Provincial AIDS Centre
8. Ca Mau Provincial AIDS Centre
9. Can Tho Provincial AIDS Centre
10. Cao Bang Provincial AIDS Centre
11. Da Nang Provincial AIDS Centre
12. Dong Nai Provincial AIDS Centre

13. Dong Thap Provincial AIDS Centre
14. Gia Lai Provincial AIDS Centre
15. Ha Giang Provincial AIDS Centre
16. Ha Nam Provincial AIDS Centre
17. Ha Noi Provincial AIDS Centre
18. Hai Phong Department of Health
19. Hau Giang Provincial AIDS Centre
20. Hung Yen Provincial AIDS Centre
21. Khanh Hoa Provincial AIDS Centre
22. Kon Tum Provincial Standing Office for AIDS Prevention
23. Lai Chau Provincial AIDS Centre
24. Lam Dong Provincial AIDS Centre
25. Lang Son Provincial AIDS Centre
26. Long An Provincial AIDS Centre
27. Nghe An Provincial AIDS Centre
28. Ninh Binh Provincial AIDS Centre
29. Ninh Thuan Provincial AIDS Centre
30. Phu Tho Provincial AIDS Centre
31. Quang Nam Provincial Standing Office for AIDS Prevention
32. Quang Ninh Provincial AIDS Centre
33. Quang Tri Provincial AIDS Centre
34. Soc Trang Provincial AIDS Centre
35. Son La Provincial AIDS Centre
36. Tay Ninh Provincial AIDS Centre
37. Thai Binh Provincial AIDS Centre
38. Thai Nguyen Centre for AIDS, Dermatology and Venereology
39. Thua Thien Hue Provincial AIDS Centre
40. Tien Giang Provincial AIDS Centre
41. HCMC Provincial Standing Office for AIDS Prevention
42. Tra Vinh Provincial AIDS Centre
43. Vinh Long Provincial AIDS Centre
44. Yen Bai Provincial AIDS Centre

AIDS program implementers

1. General Department for the Prevention of Social Evils
2. Central Office of the Youth Union

ANNEX 3:

NATIONAL COMPOSITE POLICY INDEX

Country: The Socialist Republic of Vietnam

Name of the National AIDS Committee Officer in Charge: Truong Vinh Trong

Signature

Address:

Truong Vinh Trong
Deputy Prime Minister
Chairman of National Committee of AIDS, Drug and Prostitution Prevention and Control
Number 1, Hoang Hoa Tham, Ba Dinh District
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Date of submission: 31/03/2010

National Composite Policy Index (NCPI) Part A

I. STRATEGIC PLAN

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

   (Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

☑ **Yes**	No	Not Applicable (N/A)

Period covered: *2004 - 2010*

IF NO or NOT APPLICABLE, briefly explain why.

***IF YES*, complete questions 1.1 through 1.10; *IF NO*, go to question 2.**

1.1 How long has the country had a multisectoral strategy?

Number of Years: ***06 Years***

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

Sectors	Included in strategy	Earmarked budget
Health	☑ **Yes** No	☑ **Yes** No
Education	☑ **Yes** No	☑ **Yes** No
Labor	☑ **Yes** No	☑ **Yes** No
Transportation	☑ **Yes** No	☑ **Yes** No
Military/Police	☑ **Yes** No	☑ **Yes** No
Women	☑ **Yes** No	☑ **Yes** No
Young people	☑ **Yes** No	☑ **Yes** No
Other*: *Justice, Information – Communication, Planning and Investment, Agriculture and Rural Development, Finance, Trade and Industry, Farmers' Union, National Assembly Committee on Social Affairs, Ho Chi Minh Communist Youth Union Central Committee, Office of the Government, Committee for Ethnic Minorities, War Veterans Association, Vietnam Fatherland Front Central Committee, and Vietnam Customs*	☑ **Yes** No	☑ **Yes** No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. ☑ **Yes** No
b. Young women/young men	b. ☑ **Yes** No
c. Injecting drug users	c. ☑ **Yes** No
d. Men who have sex with men	d. ☑ **Yes** No
e. Sex workers	e. ☑ **Yes** No
f. Orphans and other vulnerable children	f. ☑ **Yes** No
g. Other specific vulnerable subpopulations*	g. ☑ **Yes** No
Settings	
h. Workplace	h. ☑ **Yes** No
i. Schools	i. ☑ **Yes** No
j. Prisons	j. ☑ **Yes** No
Cross-cutting issues	
k. HIV and poverty	k. ☑ **Yes** No
l. Human rights protection	l. ☑ **Yes** No
m. Involvement of people living with HIV	m. ☑ **Yes** No
n. Addressing stigma and discrimination	n. ☑ **Yes** No
o. Gender empowerment and/or gender equality	o. ☑ **Yes** No

1.4 Were target populations identified through a needs assessment?

☑ **Yes**	No

IF YES, when was this needs assessment conducted?

Year: ***2003***

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programs in the country?

- Drug users
- Female sex workers
- Men who have sex with men
- Pregnant women
- Young people
- Orphans and other vulnerable children
- People living with HIV
- People living in remote and disadvantaged regions
- Migrant workers and mobile populations
- STI patients

1.6 Does the multisectoral strategy include an operational plan?

☑ **Yes**	No

* Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

1.7 Does the multisectoral strategy or operational plan include:

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

1.8 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 organized:

IF NO or MODERATE involvement, briefly explain why this was the case:

Civil society has participated in the development of the multisectoral strategy through providing written comments and recommendations on the draft and direct contribution in meetings where the draft was examined and revised.

Nonetheless, at the time the National Strategy on HIV/AIDS Prevention and Control in Vietnam was developed in 2003, the contribution of PLHIV was limited. In addition, the capacity of these groups in HIV prevention and control was still limited.

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multilaterals)?

☑ **Yes**	No

1.10 Have external development partners aligned and harmonized their HIV-related programs to the national multisectoral strategy?

☑ **Yes, all partners**	Yes, some partners	No

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why

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

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a.	National Development Plan	☑ **Yes**	No	N/A
b.	Common Country Assessment / UN Development Assistance Framework	☑ **Yes**	No	N/A
c.	Poverty Reduction Strategy	☑ **Yes**	No	N/A
d.	Sector-wide approach	☑ **Yes**	No	N/A
e.	Other: *Drugs and prostitution prevention and control; Child protection; Gender equality; National Health Program*	☑ **Yes**	No	N/A

2.2 ***IF YES***, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	☑ **Yes**	No
Treatment for opportunistic infections	☑ **Yes**	No
Antiretroviral treatment	☑ **Yes**	No
Care and support (including social security or other schemes)	☑ **Yes**	No
HIV impact alleviation	☑ **Yes**	No
Reduction of *gender* inequalities as they relate to HIV prevention/ treatment, care and/or support	☑ **Yes**	No
Reduction of *income* inequalities as they relate to HIV prevention/ treatment, care and /or support	☑ **Yes**	No
Reduction of stigma and discrimination	☑ **Yes**	No
Women's economic empowerment (e.g. access to credit, access to land, training)	☑ **Yes**	No
Other: *Care and protection of children; Prevention and control of drugs and prostitution*	☑ **Yes**	No

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

☑ **Yes**	No	N/A

3.1 ***IF YES***, to what extent has it informed resource allocation decisions?

Low					High
0	1	2	**3** ☑	4	5

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

4.1 ***IF YES***, which of the following programs have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioral change communication	☑ **Yes**	No
Condom provision	Yes	☑ **No**
HIV testing and counseling	☑ **Yes**	No
Sexually transmitted infection services	☑ **Yes**	No
Antiretroviral treatment	☑ **Yes**	No
Care and support	☑ **Yes**	No
Others: *Prevention and control of drugs and prostitution*	☑ **Yes**	No

If HIV testing and counseling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counseling (e.g, indicate if HIV testing is voluntary or mandatory etc):

- There is mandatory HIV testing in the recruitment process for soldiers and other specific positions in the national defense and security forces.
- People who are exposed to HIV are given HIV counseling and testing

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

☑ **Yes**	No

5.1 ***IF YES,*** for which subpopulations?

a. Women	☑ **Yes**	No
b. Young people	☑ **Yes**	No
c. Injecting drug users	☑ **Yes**	No
d. Men who have sex with men	☑ **Yes**	No
e. Sex Workers	☑ **Yes**	No
f. Prison inmates	☑ **Yes**	No
g. Migrants/mobile populations	☑ **Yes**	No
h. Other: *HIV-infected children or children born to HIV-infected parent(s)*	☑ **Yes**	No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

- The Law on HIV includes several articles protecting PLHIV from stigma and discrimination . The government has enacted decrees guiding the implementation of the Law and introduced sanctions for violations. Depending on the nature and degree of the violations, there are corresponding sanctions ranging from administrative penalties to criminal trials.
- There are legal clinics providing advice and counseling on the Law on HIV. They also monitor the implementation of the Law.
- At present, the Ministry of Health is developing a draft decree on penalties for administrative violations of the Law on HIV.

Briefly comment on the degree to which these laws are currently implemented:

- Moderate, unable to generate maximum effect.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes	☑ **No**

6.1 ***IF YES,*** for which subpopulations?

a.	Women	Yes	No
b.	Young people	Yes	No
c.	Injecting drug users	Yes	No
d.	Men who have sex with men	Yes	No
e.	Sex Workers	Yes	No
f.	Prison inmates	Yes	No
g.	Migrants/mobile populations	Yes	No
h.	Other: *[write in]*	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers:

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

☑ **Yes**	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

☑ **Yes**	No

7.2 Have the estimates of the size of the main target populations been updated?

☑ **Yes**	No

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

☑ **Estimates of current and future needs**	Estimates of current needs only	No

7.4 Is HIV program 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?

- Drug users
- Female sex workers
- Military recruits
- Pregnant women
- Ethnic minority people
- Patients with AIDS-related illnesses
- People living with HIV
- Men who have sex with men

Briefly explain how this information is used:

- The information is input into software programs for estimation and projection, and is analyzed by international and national experts. The data is then used during the policy-making process and development of intervention programs.
- The information is also used for performance evaluation and to determine obstacles during the implementation of intervention measures, as well as priorities for intervention.
- The information is used for developing targets of the National Program on HIV Prevention and Control.
- The information is used as evidence for policy-making and resource allocation.

(c) Is coverage monitored by geographical area?

☑ **Yes**	No

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

- Provincial
- District
- Commune

Briefly explain how this information is used:

- The information is used for policy-making, planning, and allocation of resources to prioritize areas with a large number of PLHIV; and for future demand estimation and projection.

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

☑ **Yes**	No

Overall, how would you rate strategy planning efforts in the HIV programs in 2009?												
2009	Very poor											Excellent
		0	1	2	3	4	5	6	7	8	**9** ☑	10

Since 2007, what have been key achievements in this area:

- The action plans have been developed in detail, with allocated budget,
- Plans are developed based on evidence, with more specific objectives, and in accordance with a common framework,
- The annual work plans are submitted on time to the Vietnam Administration of AIDS Control (VAAC) by ministries, sectors and local agencies,
- There has been a monitoring and evaluation framework for the HIV program to measure and evaluate intervention activities and provide evidence for policy-making, resource allocation, and intervention planning,
- Allocated budget has been spent based on the agreed activities,
- The proportion of expired ARV is low due to appropriate planning, distribution and use of drugs,
- The capacity and competence of planning staff in most provinces has been improved,
- Evaluations of the National Strategy on HIV/AIDS Prevention and Control in 2004-2010 are in progress, and the National Strategy on HIV/AIDS Prevention and Control in 2011-2020 are now being developed,
- The human and material resources have been enhanced.

What are remaining challenges in this area:

- Data is insufficient with somewhat limited quality,
- In some provinces, the management and planning capacities of staff in charge of HIV prevention and control are still constrained due to the lack of specialized staff and/or new and poorly trained staff,
- Lack of resources resulting in the inability to meet the demand of expanding coverage of intervention programs.

II. POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programs; and, effective use of government and civil society organizations to support HIV programs.

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

President/Head of government	☑ **Yes**	No
Other high officials	☑ **Yes**	No
Other officials in regions and/or districts	☑ **Yes**	No

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

☑ **Yes**	No

IF NO, briefly explain why not and how AIDS programs are being managed:

2.1 ***IF YES***, when was it created?

In 1994: National Committee for HIV/AIDS Prevention and Control

In 2000: National Committee for AIDS, Drugs and Prostitution Prevention and Control

2.2 ***IF YES***, who is the Chair?

Name: **Trương Vĩnh Trọng** Position/Title: **Deputy Prime Minister**

2.3 ***IF YES***, does the national multisectoral AIDS coordination body:

have terms of reference?	☑ **Yes**	No
have active government leadership and participation?	☑ **Yes**	No
have a defined membership?	☑ **Yes**	No
IF YES, how many members?	**24**	
include civil society representatives?	☑ **Yes**	No
IF YES, how many?	**4**	
include people living with HIV?	Yes	☑ **No**
IF YES, how many?		
include the private sector?	☑ **Yes**	No
have an action plan?	☑ **Yes**	No
have a functional Secretariat?	☑ **Yes**	No

meet at least quarterly?	☑ **Yes**	No
review actions on policy decisions regularly?	☑ **Yes**	No
actively promote policy decisions?	☑ **Yes**	No
provide opportunity for civil society to influence decision-making?	☑ **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/programs?

☑ **Yes**	No	N/A

IF YES, briefly describe the main achievements:

- The Law on HIV has been widely disseminated and better understood among the general populations; other laws and policies of the government have also been propagated and communicated more broadly; and the rights of PLHIV are protected more effectively,
- The government has created more favorable conditions and provided technical and financial assistance to civil society to participate in HIV prevention and control. In 2009, governmental agencies collaborated and actively worked with international organizations and civil society to develop a Round 9 proposal submitted to the Global Fund. This dual track proposal was successful, with approximately USD16 million allocated to HIV prevention and control activities implemented by civil society,
- Organizations and individuals have been encouraged to participate in HIV prevention and control; and more funds have been allocated for HIV prevention and control activities,
- People living with HIV are given better care and support,
- More and more enterprises, including private ones, have actively participated in HIV prevention and control,
- Civil society has actively taken part in and provided technical support to several foreign aid projects.

Briefly describe the main challenges:

- Insufficient budget for activities,
- Lack of proper mechanism to mobilize enterprises for HIV prevention and control,
- Limited capacity of civil society.

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

Percentage: *Data not avaiable*

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

Information on priority needs	☑ **Yes**	No

Technical guidance	☑ **Yes**	No
Procurement and distribution of drugs or other supplies	☑ **Yes**	No
Coordination with other implementing partners	☑ **Yes**	No
Capacity-building	☑ **Yes**	No
Other: *Development of preferential taxation policies and other favorable ones, allocation of fund for HIV-related activities*	☑ **Yes**	No

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

☑ **Yes**	No

6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?

☑ **Yes**	No

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

- The Law on Drugs Prevention and Control. Until 2007, this Law stipulated that people found in possession of needles/syringes were considered to be violating the law. In 2008, the Law on Drugs was amended making it more consistent with the Law on HIV.
- In 2009, the National Assembly approved amendments to the Criminal Code, abolishing Article 199 on illegal use of narcotics and Article 20 on complicity in illegal use of narcotics because these provisions hindered HIV prevention and control.
- The health insurance beneficiaries have expanded to include PLHIV.
- Circular No.125 and Joint Circular No.147 guides the implementation of treatment schemes for PLHIV in prisons and 05/06 Centers.
- Legal documents providing for preferential treatment and support for enterprises employing PLHIV and former drug users (land use tax exemption, reduction of income tax and other policies) are being reviewed and revised.
- The Ordinance on Prostitution Prevention and Control is now being reviewed and revised.

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

Overall, how would you rate the political support for the HIV program in 2009?											
2009 Very poor											Excellent
	0	1	2	3	4	5	6	7	8	9	**10** ☑

Since 2007, what have been key achievements in this area:

- Several normative documents have been amended, supplemented and/or newly enacted in accordance with the Law on HIV/AIDS Prevention and Control
- The National Committee for AIDS, Drugs and Prostitution Prevention and Control has intensified its monitoring on provincial HIV prevention and control activities
- Awareness of managers in both governmental agencies and enterprises has been enhanced helping them to participate more actively and deliberately in HIV prevention and control activities
- The Law on Drugs has been amended
- Strong commitments and guidance from the Party and the State are in place
- Active participation of the civil society in HIV prevention and control
- Guiding documents of the Party, National Assembly and Government have been enacted, creating favorable conditions for the implementation of HIV prevention and control
- Other ministries and sectors have actively collaborated with the Ministry of Health in developing normative documents as well as schemes and policies relating to HIV prevention and control.
- The Government has permitted the implementation of opioid substitution therapy (methadone) for drug users.

What are remaining challenges in this area:

- Stigma and discrimination against PLHIV still exists.
- Budget allocated for HIV prevention and control has not met the demands of expanding and enhancing coverage for prevention, treatment and care activities
- Some normative documents are now being developed or amended, but are still incomplete.

III. 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	N/A

1.1 ***IF YES***, what key messages are explicitly promoted?

a. Be sexually abstinent	
b. Delay sexual debut	✓
c. Be faithful	✓
d. Reduce the number of sexual partners	✓
e. Use condoms consistently	✓
f. Engage in safe(r) sex	✓
g. Avoid commercial sex	✓

h. Abstain from injecting drugs	✓
i. Use clean needles and syringes	✓
j. Fight against violence against women	✓
k. Greater acceptance and involvement of people living with HIV	✓
l. Greater involvement of men in reproductive health programs	✓
m. Males to get circumcised under medical supervision	
n. Know your HIV status	✓
o. Prevent mother-to-child transmission of HIV	
Other:	*[write in]*

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

☑ **Yes**	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

☑ **Yes**	No	N/A

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/curriculum provide the same reproductive and sexual health education for young men and young women?

☑ **Yes**	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

☑ **Yes**	No

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

☑ **Yes**	No

IF NO, briefly explain:

3.1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?

	IDU*	MSM**	Sex workers	Clients of sex workers	Prison inmates	Other populations* detainees in 05/06 Centers	Other populations* Migrants/ mobile populations, pregnant women
Targeted information on risk reduction and HIV education	✓	✓	✓	✓	✓	✓	✓
Stigma and discrimination reduction	✓	✓	✓	✓	✓	✓	✓
Condom promotion	✓	✓	✓	✓			✓
HIV testing and counseling	✓	✓	✓	✓			✓
Reproductive health, including sexually transmitted infections prevention and treatment	✓	✓	✓	✓			✓
Vulnerability reduction (e.g. income generation)	N/A	N/A	✓	N/A	N/A		
Drug substitution therapy	✓	N/A	N/A	N/A	N/A		
Needle & syringe exchange	✓	N/A	N/A	N/A	N/A		

Overall, how would you rate policy efforts in support of HIV prevention in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 **9** ☑ 10

Since 2007, what have been key achievements in this area:

- Enhancement of Party's and State's guidance; increase in budget and strengthening of multi-sectoral coordination.
- Various policies and guidance have been promulgated.
- The successful pilot of the methadone maintenance therapy program for drug users.

What are remaining challenges in this area:

- Preventive measures have not been paid due attention in some areas; limited budget has lead to considerable constraints on expanding the scope of interventions.
- Awareness of managers and policy-makers should be enhanced on sensitive issues such as men having sex with men so that they can develop proper interventions and harm reduction policies for these groups.
- There is insufficient budget to meet the demands of coverage expansion.

* IDU = injecting drug user

* MSM = men who have sex with men

4. Has the country identified specific needs for HIV prevention programs?

☑ **Yes**	No

IF YES, how were these specific needs determined?

These specific needs were determined based on:

- Results of HIV epidemic surveillance,
- Needs assessment surveys
- Periodical reports of the program
- Budget and human resources capacity
- Feasibility of prevention activities.

IF NO, how are HIV prevention programs being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	☑ **Agree**	Don't Agree	N/A
Universal precautions in health care settings	☑ **Agree**	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	☑ **Agree**	Don't Agree	N/A
IEC* on risk reduction	☑ **Agree**	Don't Agree	N/A
IEC* on stigma and discrimination reduction	☑ **Agree**	Don't Agree	N/A
Condom promotion	☑ **Agree**	Don't Agree	N/A
HIV testing and counseling	☑ **Agree**	Don't Agree	N/A
Harm reduction for injecting drug users	☑ **Agree**	Don't Agree	N/A
Risk reduction for men who have sex with men	☑ **Agree**	Don't Agree	N/A
Risk reduction for sex workers	☑ **Agree**	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	☑ **Agree**	Don't Agree	N/A
School-based HIV education for young people	☑ **Agree**	Don't Agree	N/A
HIV prevention for out-of-school young people	☑ **Agree**	Don't Agree	N/A
HIV prevention in the workplace	☑ **Agree**	Don't Agree	N/A
Other: *[write in]*	Agree	Don't Agree	N/A

* IEC = information, education, communication

Overall, how would you rate the efforts in the implementation of HIV prevention programs in 2009?											
2009 Very poor											Excellent
	0	1	2	3	4	5	6	7	8	**9** ☑	10

Since 2007, what have been key achievements in this area:

- Expansion of the coverage of the condom use program and needle and syringe program; implementation of the national pilot methadone maintenance therapy program; and blood safety guarantee
- Increase in the proportion of key populations at higher risk having access to prevention services
- Effective control of the spread of HIV epidemic; reduction in the number of new infections reported.
- Implementation of the national strategy for the prevention of mother-to-child transmission of HIV.
- Increase in the proportion of HIV-infected mothers who are provided HIV testing before giving birth and drugs for the prevention of mother-to-child transmission of HIV, leading to the reduction in the number of children acquiring HIV from their mothers
- The HIV epidemic remains concentrated;
- Increased awareness of HIV prevention and control
- Reduction of stigma and discrimination against PLHIV.

What are remaining challenges in this area:

- Insufficient budget and limited capacity of staff to meet the demand of HIV prevention and control activities,
- The risks among men having sex with men have not been properly assessed,
- Awareness of HIV among ethnic minorities is still limited,
- The majority of HIV prevention and control activities are funded by international donors,
- Low coverage.

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care).

☑ **Yes**	No

1.1 ***IF YES***, does it address barriers for women?

☑ **Yes**	No

1.2 ***IF YES***, does it address barriers for most-at-risk populations?

☑ **Yes**	No

2. Has the country identified the specific needs for HIV treatment, care and support services?

☑ **Yes**	No

IF YES, how were these determined?

These specific needs were determined based on:

- Results of HIV epidemic surveillance,
- Needs assessment surveys,
- Periodical reports of the program,
- Results of HIV estimations and projections,
- Budget and human resources capacity,
- Feasibility of intervention activities.

IF NO, how are HIV treatment, care and support services being scaled-up?

2.1 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 acces		
Antiretroviral therapy	☑ **Agree**	Don't Agree	N/A
Nutritional care	☑ **Agree**	Don't Agree	N/A
Paediatric AIDS treatment	☑ **Agree**	Don't Agree	N/A
Sexually transmitted infection management	☑ **Agree**	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	☑ **Agree**	Don't Agree	N/A
Home-based care	☑ **Agree**	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	☑ **Agree**	Don't Agree	N/A
HIV testing and counseling for TB patients	☑ **Agree**	Don't Agree	N/A
TB screening for HIV-infected people	☑ **Agree**	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	☑ **Don't Agree**	N/A
TB infection control in HIV treatment and care facilities	☑ **Agree**	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	☑ **Agree**	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	☑ **Agree**	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	☑ **Agree**	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	☑ **Agree**	Don't Agree	N/A

Other: *[write in]*	Agree	Don't Agree	N/A

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

☑ **Yes**	No

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

☑ **Yes**	No

IF YES, for which commodities?:

- ARV: Zidovudine (AZT), Stavudine (D4T), Lamivudin (3TC), Nevirapine (NVP), Efavirenz (EFV), Didanosine (DDI)
- Condoms
- Methadone
- Drugs for opportunistic infection treatment

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programs in 2009?											
2009 Very poor											Excellent
	0	1	2	3	4	5	6	7	8	**9** ☑	10

Since 2007, what have been key achievements in this area:

- Increase in coverage and access; rapid growth in the number of PLHIV with access to ARV, treatment of opportunistic infections, and access to treatment and care services,
- Expansion of treatment, care and support services at provincial and district levels,
- PLHIV in some 05/06 Centers have access to ARV treatment; schemes to continue treatment for post-detoxification patients are in place,
- Improvement in the quality of treatment and care services,
- Appropriate coordination and management of ARV,
- ARVs have been successfully produced domestically, leading to positive effects on the sustainability of access to ARV for PLHIV.

What are remaining challenges in this area:

- Restricted resources,
- Limited capacity and competence of professional staff at district level.

5. 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

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

☑ **Yes**	No

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

☑ **Yes**	No

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

Yes	☑ **No**

IF YES, what percentage of orphans and vulnerable children is being reached?

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 **9** ☑ 10

Since 2007, what have been key achievements in this area:

- Increase in the number of orphans and vulnerable children having access to treatment, care and support services,
- Promulgation of Decree No.67 which provides support to orphans and vulnerable children,
- Promulgation of the National Program of Action on Children affected by HIV to 2010 and with visions to 2020,
- Children living with HIV are covered by health insurance . In 2009, some children living with HIV were provided with health insurance cards,
- Orphans and vulnerable children under six years old have access to free medical care according to the general regulation on the free medical examination and treatment of children under six.
- Increase in the number of children born to HIV-infected mothers being provided with preventive treatment for HIV infection.

What are remaining challenges in this area:

- Stigma and discrimination against PLHIV and affected children; there are still children who cannot go to school on reaching school-age,
- Lack of size estimate of orphans and vulnerable children, as well as of children benefiting from intervention programs,
- Lack of sufficient funds and staff.

V. MONITORING AND EVALUATION

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

☑ **Yes**	In progress	No

IF NO, briefly describe the challenges:

1.1 ***IF YES***, years covered: ***2007, 2008, 2009***

1.2 ***IF YES***, was the M&E plan endorsed by key partners in M&E?

☑ **Yes**	No

1.3 ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

☑ **Yes**	No

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

Yes, all partners	☑ **Yes, most partners**	Yes, but only some partners	No

IF YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	☑ **Yes**	No
IF YES, does it address:		
routine program monitoring	☑ **Yes**	No
behavioral surveys	☑ **Yes**	No
HIV surveillance	☑ **Yes**	No
Evaluation / research studies	☑ **Yes**	No
a well-defined standardized set of indicators	☑ **Yes**	No
guidelines on tools for data collection	☑ **Yes**	No
a strategy for assessing data quality (i.e., validity, reliability)	☑ **Yes**	No
a data analysis strategy	☑ **Yes**	No
a data dissemination and use strategy	☑ **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 program funding is budgeted for M&E activities?
Roughly 10%

3.2 ***IF YES***, has *full* funding been secured?

☑ **Yes**	No

IF NO, briefly describe the challenges:

3.3 ***IF YES***, are M&E expenditures being monitored?

☑ **Yes**	No

4. Are M&E priorities determined through a national M&E system assessment?

☑ **Yes**	No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

The national M&E assessment is conducted periodically, including:

- Assessment of training needs within M&E system,
- Rapid assessment of the standard routine HIV reporting forms
- Periodic assessment of M&E activities based on the specific indicators of the M&E plan.

Findings of these assessments contribute to the determination of M&E priorities.

IF NO, briefly describe how priorities for M&E are determined:

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

☑ Yes	In progress	No

IF NO, what are the main obstacles to establishing a functional M&E Unit?

5.1 ***IF YES***, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes	☑ **No**
in the Ministry of Health?	☑ **Yes**	No

Elsewhere?	Yes	☑ **No**

5.2 ***IF YES***, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff: **05**		
Position: Manager	Full time: 02 people	Since 2005
Position: Professional	Full time: 03 people	Since 2005
Number of temporary staff:		
Position: Professional	Full time : 05 people	Since 2006-2009

5.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

☑ **Yes**	No

IF YES, briefly describe the data-sharing mechanisms:

Mechanisms in place to ensure all major implementing partners submit their M&E data/reports to the M&E Unit in VAAC include:

- Submission of reports within the national HIV prevention and control system, according to the regular reporting scheme
- Submission of reports by donor funded programs to Provincial AIDS Centers,which are then forwarded to VAAC
- Regarding the data sharing mechanisms: Regular epidemiological updates, based on available data from the quarterly reports, are published on the VAAC website. In addition, meetings of the National SI, M&E TWG, as well as special events, are used as fora for the dissemination of data from different exercises, including annual reports of GFATM and WB/DFID project.

What are the major challenges?

Challenges in data submissions are:

- Insufficient data quality
- Late submission of reports
- Lack of skilled M&E staff
- Restricted budget for M&E activities.

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

No	Yes, but meets irregularly	☑ **Yes, meets regularly**

6.1 Does it include representation from civil society?

☑ **Yes**	No

IF YES, briefly describe who the representatives from civil society are and what their role is:
A number of international NGOs, and one local NGO, are members of the National SI, M&E TWG. Their role is to provide technical assistance to the implementation of the National HIV M&E Framework and HIV monitoring, assessment and surveillance activities in Vietnam.

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

☑ **Yes**	No

7.1 ***IF YES***, briefly describe the national database and who manages it

- VAAC, the M&E Department, manages the National Database of surveillance data (HIV Info software)
- Reports on HIV prevention and control are updated quarterly in monitoring tabulation in excel format.
- VAAC is currently piloting the online submission of data collected through D28 (routine HIV reporting System)

7.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. ☑ Yes, all of the above

b. Yes, but only some of the above:

c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	☑ **Yes**	No
At subnational level ***IF YES***, at what level(s)? Provincial, district, commune	☑ **Yes**	No

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analyzed and used at different levels)*

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

☑ **Yes**	No

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

Low — High

0	1	2	3	**4** ☑	5

Provide a specific example:

- Reports and evaluations have provided information on the coverage of intervention programs, and demands and resources contributing to the development and adjustment of the national strategy.

What are the main challenges, if any?

- Lack of national representative data about the size of the main target populations (especially men who have sex with men) and about public awareness, attitudes and practices relating to HIV prevention and control,
- Data is still insufficient in some categories,
- Lack of age and sex disaggregated data for some indicators

9.2 for resource allocation?:

Low					High
0	1	2	3	**4** ☑	5

Provide a specific example:

- Concentration of resources and assistance projects in cities/provinces with a high number of PLHIV and key populations at higher risk such as in Hai Phong, Quang Ninh, Kien Giang and An Giang.

What are the main challenges, if any?

- Difficulties in managing and finding out the exact number of drug users and sex workers,
- Many cities/provinces have not conducted assessment studies to provide necessary information for the policy-making, planning, and evaluation of intervention programs, as well as for resource allocation,
- Limited resources.

9.3 for program improvement?:

Low					High
0	1	2	3	**4** ☑	5

Provide a specific example:

- Development of evidence-informed intervention Programs,
- Training of human resources for the M&E system,
- Provision of necessary facilities and equipment for the M&E system.

What are the main challenges, if any?

- Data is still insufficient in some categories,
- Lack of human resources for data collection.

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

a. ☑ Yes, at all levels

b. Yes, but only addressing some levels:

c. No

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

At national level?	☑ Yes	No
IF YES, Number trained:	**62**	
At subnational level?	☑ Yes	No
IF YES, Number trained:	**166**	
At service delivery level including civil society?	☑ Yes	No
IF YES, Number trained:		

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

☑ **Yes**	No

IF YES, describe what types of activities:

- Surveillance and support for provincial activities
- Experience sharing
- Working with international experts and organizations

Overall, how would you rate the M&E efforts of the HIV program in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 **9** ☑ 10
Since 2007, what have been key achievements in this area: • An overall picture of the HIV situation in the whole country has been acquired, contributing to the sound evaluation of the effectiveness of the government's policies and strategies, • There has been an accurate assessment of HIV infection and spread, with analysis based on geographical areas and key populations at higher risk, • Decision No. 1107/2009/QD-TTg of the Prime Minister approved the "Capacity building for the Centers for HIV Prevention and Control in central cities/provinces in 2009-2015". *What are remaining challenges in this area:* • Capacity of M&E staff in some areas is still limited; high turnover leads to high demands of training and retraining, • Insufficient funds and resources for M&E activities.

CONSULTATION LIST FOR NCPI PART A

Reg.	Organization
	Government
	Ministry of Health - Viet Nam Administration of HIV/AIDS Control
	Viet Nam Administration of HIV/AIDS Control - Department of Communication and Community Mobilization
	Viet Nam Administration of HIV/AIDS Control - Department of Harm Reduction
	Viet Nam Administration of HIV/AIDS Control - Department of HIV, STI Surveillance, Monitoring and Evaluation
	Viet Nam Administration of HIV/AIDS Control - Department of Treatment
	Ministry of Health - Department of International Cooperation
	Ministry of Health - Department of Legislation
	Ministry of Education and Training - Department of student's welfares
	Ministry of Finance - Department of Debt Management and Foreign Finance
	Ministry of Justice - Department of Administration and Criminal Laws
	Ministry of Labor, Invalids, and Social Affairs - Department of Social Evils Prevention and Control
	Ministry of National Defense - Department of Health
	Ministry of Public Security - Department of Health
	Ministry of Transportation - Department of Health
	National Assembly - Department of Social Affairs
	National Institute of Hygiene and Epidemiology
	Viet Nam General Confederation of Labor

National Composite Policy Index (NCPI) Part B

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

☑ **Yes**	No

1.1 ***IF YES***, specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision:

- The Law on HIV/AIDS Prevention and Control 64/2006/QH11 (Law on HIV)
- Decree 108/2007/ND-CP detailing the implementation of a number of articles of the Law on HIV
- Decree 45/2005/ND-CP regulating penalties for administrative violations in the health care sector

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

☑ **Yes**	No

2.1 ***IF YES***, for which populations?

a. Women	☑ **Yes**	No
b. Young people	☑ **Yes**	No
c. Injecting drug users	☑ **Yes**	No
d. Men who have sex with men	☑ **Yes**	No
e. Sex Workers	☑ **Yes**	No
f. Prison inmates	☑ **Yes**	No
g. Migrants/mobile populations	☑ **Yes**	No
h. Other:	Yes	No
• Children	☑ **Yes**	No
• Sexual partners of PLHIV	☑ **Yes**	No
• Sexual partners of IDU	Yes	☑ **No**

IF YES*, briefly explain what mechanisms are in place to ensure these laws are implemented:*

The eight National Programs of Action (POA) are designed to operationalize the National Strategy and Law on HIV.

Decree 45/2005 regulates penalties for administrative violations in health care, with specific references to HIV.

Briefly describe the content of these laws:

The Law on HIV is considered a milestone in the protection of the rights of people living with HIV (PLHIV) as it specifies the right to employment, education and access to health care services. The Law prohibits stigma and discrimination against PLHIV, people suspected of having HIV or those associated with them.

Decree 108 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 (SW) and their clients, drug users, PLHIV, homosexual people [sic], migrant and mobile populations, and sexual partners of all these subpopulations.

The National Program of Action on Children affected by HIV (2009) identifies concrete measures to protect orphans and vulnerable children, including increasing access and availability to good quality health and education services, and social policies.

Under Decree 67/2007/ND-CP, AIDS orphans and people with AIDS-related illnesses can access monthly financial support.

Decision 38/2008/QD-TTg on the prevention and control of HIV across borders creates a space for the implementation of prevention activities across borders, experience sharing among countries, and the integration of HIV activities into drug and sex work control and anti-trafficking interventions.

Briefly comment on the degree to which they are currently implemented:

Although significant protections exist within these laws and regulations, there are gaps in their implementation in many provinces and at district/community level partly due to a lack of awareness and understanding and insufficient sanctions for violations.

Decision 96/2007/QD-TTg of the Prime Minister covers the provision of HIV prevention, treatment and care services in correctional settings including prisons, and 05/06 Centers. However interventions have only been implemented in a few institutions on a short-term pilot basis and prevention and treatment services are still very limited.

The effective implementation of Decree 67 is hindered by the weak capacity of local social welfare agencies, awareness of the decree, limited monitoring of its implementation and stigma and discrimination preventing those in need accessing the support.

The Law on Gender Equity and Law on Domestic Violence do not offer protection for sexual and other forms of violence against female sex workers (FSW).

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

☑ **Yes**	No

3.1 ***IF YES***, for which subpopulations?

a. Women	Yes	☑ **No**
b. Young people	Yes	☑ **No**
c. Injecting drug users	☑ **Yes**	No
d. Men who have sex with men	Yes	☑ **No**
e. Sex Workers	☑ **Yes**	No
f. Prison inmates	☑ **Yes**	No
g. Migrants/mobile populations	☑ **Yes**	No
h. Other:	Yes	No

IF YES, *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 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 Centers.
- 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 Centers for a period of up to two years. Due to the limited access to HIV services including treatment in 06 Centers, this is a barrier to injecting drug users (IDUs) 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 Centers. Due to the limited access to HIV services including treatment in 05 Centers, this is a barrier to IDUs accessing effective HIV prevention, treatment, care and support services.

Decision 96 mandates the provision of HIV prevention, treatment and care in correctional facilities and 05/06 Centers 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 center is one of the eligibility criteria for the current national pilot methadone maintenance therapy (MMT) program, migrants without official residency are not able to access these 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 prevents or delays 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 2009 there were fourteen 05/06 Centers providing ART under Global Fund Round 6 activities. The already mentioned fourteen centers, plus an additional center, were also providing voluntary counseling and testing (VCT) and information, education and communication (IEC) services.
- 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.

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 this HIV policy or strategy:*

The National Strategy on HIV Prevention and Control 2004 – 2010 provides for equitable access to prevention, treatment, care and support for people living with, affected by and at-risk of HIV. The National Strategy and Law on HIV prioritizes access to services for key populations at higher risk.

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, most-at-risk populations and/or other vulnerable subpopulations?

☑ **Yes**	No

IF YES*, briefly describe this mechanism:*

- Five legal aid clinics and one hotline have been established to provide free or reduced cost legal support services to PLHIV whose rights have been violated under the Law on HIV. While more PLHIV are aware of their rights, many still do not know what support is available and are reluctant to report incidences out of fear of disclosing their status.
- 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.

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and program implementation?

☑ **Yes**	No

***IF YES**, describe some examples:*

At policy level: By the end of 2009 most HIV-related policies were developed with some level of consultation with PLHIV. While this is a significant step, PLHIV are still not part of policy drafting committees and PLHIV involvement has tended to be reactive rather than organized.

In 2009 drug users were consulted in the development of a decree on community-based rehabilitation of drug users and SW representatives participated in the review of the implementation of the Ordinance on sex work. This is evidence of a more favorable legal environment and growing recognition by government of the role of civil society, as well as the development of organizations of key populations at higher risk. Men who have sex with men (MSM) groups were consulted throughout the development process of the National Guidelines on HIV interventions for MSM.

After the 2008 restructure of the Country Coordinating Mechanism (CCM), 40% of the membership is now from the non-government sector, with representatives of the three diseases, non-governmental organizations (NGOs), international NGOs (INGOs) and the private sector self-selecting their representatives. Through the CCM and the development of Global Fund Round 9, civil society organizations representing key populations at higher risk contributed to the planning of the national HIV response over the next five years.

At implementation level: While the role of civil society in HIV service delivery, particularly the provision of community/home-based care, has increased, the majority of these activities are supported by international donors. In some provinces, Provincial AIDS Centers (PAC) and other local authorities have been supporting self help groups through in kind support such as the provision of meeting space, livelihood support, consultation on HIV program design and implementation, as well as direct financial support. The Hanoi AIDS Association, supported by PAC, has acted as an umbrella for many self-help groups, including those of IDUs and SW. However funding for local community based organizations and self help groups is not widely available and is based on the discretion of local authorities.

7. Does the country have a policy of free services for the following:

a. HIV prevention services	☑ **Yes**	No
b. Antiretroviral treatment	☑ **Yes**	No
c. HIV-related care and support interventions	☑ **Yes**	No

***IF YES**, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:*

VCT services were initiated by Vietnam Ministry of Health in late 2002, targeting key populations at higher risk such as IDUs, SW, MSM and their sexual partners.

The Law on HIV stipulates "people who have been exposed to or infected with HIV due to occupational accidents, people who have been infected with HIV due to risks of medical techniques, HIV infected pregnant women and HIV infected under-six children shall be provided ARV free-of-charge by the State".

Most HIV services provided by the government and international donors are free.

Information on HIV and the risks of unsafe injecting are available through a wide variety of IEC materials.

<u>Barriers include:</u>

Those mentioned above associated with the Law on Drugs.

Prevention services targeting key populations at higher risk need to be rapidly scaled up. While coverage has increased it is still low.

The majority of services are funded by external sources raising the issue of sustainability. The number of people in need of ART is increasing and the government needs to plan to ensure the number of people currently in need can be sustained and people still in need can access treatment.

While ART is available free of charge, some medical tests required to initiate treatment are paid out-of-pocket and are not reimbursed.

The private sector has limited knowledge about care and support interventions available and where/how to refer employees to these services. Stigma and discrimination also prevents workers from accessing VCT services or disclosing their status to access treatment.

Actions being taken to improve services:

- Strengthen provincial coordination to increase access to prevention, treatment, care and support
- Scale up access to ARV treatment
- Support civil society organizations in policy development and implementation, particularly the provision of community/home base care and support
- Advocate for an increase in domestic spending and the targeted allocation of resources

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

☑ **Yes**	No

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

☑ **Yes**	No

However:

While there are currently no policies creating barriers for women to access services, a specific policy is needed to address and prioritize the particular needs of women.

There are no prevention, treatment and care services specifically targeting female IDUs.

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

☑ **Yes**	No

***IF YES**, briefly describe the content of this policy:*

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.

9.1 ***IF YES***, does this policy include different types of approaches to ensure equal access for different most-at-risk 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 IDUs, prisoners, people in administrative detention, and migrant and populations.

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

Decision 96 on support to PLHIV in prisons and administrative detention centers 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. By 2009 there were fourteen 05/06 Centers providing ART under Global Fund Round 6 activities. The already mentioned fourteen centers, plus an additional center, were also providing VCT and IEC services.

While different approaches are used for different target groups, there is no comprehensive package of services to address multiple and overlapping risks behaviors such as IDUs who are clients of SW and FSW who also inject drugs.

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

☑ **Yes**	No

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

☑ **Yes**	No

11.1 ***IF YES***, does the ethical review committee include representatives of civil society including people living with HIV?

☑ **Yes**	No

IF YES, describe the approach and effectiveness of this review committee:

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

– 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**

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	☑ **No**

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

Yes	☑ **No**

IF YES *on any of the above questions, describe some examples:*

The following human rights organizations exist within Vietnam:

- Vietnamese Institute for Human Rights in Ho Chi Minh Political Academy
- Steering Committee on Human Rights Issues of the Office of Government.

Legal aid offices have been established in Ho Chi Minh City and Hai Phong to provide legal advice and support the legal needs of PLHIV.

Viet Nam has committed to international benchmarks relating to HIV including the Convention on the Rights of the Child; Convention on the Elimination of all forms of Discrimination Against Women; International Convention on Economic, Social and Cultural Rights; and Universal Periodic Review and regular reporting. It is also a party to the UNGASS Declaration on HIV 2001 and the Political Declaration on HIV 2006.

There is an indicator on stigma and discrimination in the National HIV Monitoring and Evaluation framework.

However:

While oversight institutions exist these are not organizationally independent.

While Viet Nam has ratified a number of treaties, conventions and covenants which include performance indicators for compliance, these are not specific to HIV (internationally or domestically).

13. In the last 2 years, have members of the judiciary (including labor courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

☑ **Yes**	No

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

– Legal aid systems for HIV casework

☑ **Yes**	No

– Private sector law firms or university-based centers to provide free or reduced-cost legal services to people living with HIV

☑ **Yes**	No

– Programs to educate, raise awareness among people living with HIV concerning their rights

☑ **Yes**	No

15. Are there programs in place to reduce HIV-related stigma and discrimination?

☑ **Yes**	No

IF YES, what types of programs?

Media	☑ **Yes**	No
School education	☑ **Yes**	No
Personalities regularly speaking out	☑ **Yes**	No
Other: Workplace Religious institution	☑ **Yes**	No

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 **8** ☑ 9 10

Since 2007, what have been key achievements in this area:

The amendment of the Law on Drugs so it is more consistent with the Law on HIV is a significant achievement. The amended law now contains a reference to harm reduction as defined in the Law on HIV. The amendment also removed an article criminalizing drug use. This has created more favorable conditions for the implementation of harm reduction activities and is a reflection of an attitudinal shift where drug addiction is increasingly considered a psychosocial problem.

The National Program of Action on Children affected by HIV launched in 2009 covers all aspects of the HIV response related to children living with and affected by HIV.

As a result of the amendment of the Law on Health Insurance 25/2008/QH12, PLHIV are now no longer exempt from health insurance coverage.

What are remaining challenges 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.

- Despite the amendment to the Law on Drugs, the following issues are of concern: While 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 Centers

While the 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 Centers.

There continues to be low compliance with the Law on HIV especially in the area of stigma and discrimination.

The Law on HIV stipulates responsibilities of employers in HIV prevention, treatment and care but the current taxation policy does not provide tax exemptions for enterprises funding HIV-related activities.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?											
2009 Very poor											Excellent
	0	1	2	3	4	**5** ☑	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Key populations at higher risk have become more aware of their rights and are more organized. As a result their expectations have increased and they are more critical of the national response. Since the last reporting round, there has been more time to see the impact of the Law on HIV therefore development partners' expectations were also high.

What are remaining challenges in this area:

The implementation and enforcement of laws remains uneven due to in part:

- the lack of remedies and penalties for violations of the law
- inconsistencies between public security measures to control drug use and sex work and public health measures to reach the populations engaged in these activities
- while open stigma and discrimination against PLHIV has reduced, stigma and discrimination continues to exist including in health care settings and schools.

II. CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low					High
0	1	2	**3** ☑	4	5

Comments and examples:

The contribution of civil society is growing however remaining challenges include capacity constraints and official recognition by the government.

The CCM includes self-selected representatives from civil society. VNP+ the newly registered national network of PLHIV is a member of the CCM. Global Fund Round 9 is a dual track proposal with a civil society organization as Principal Recipient for the first time.

Groups of key populations at higher risk, NGOs and other civil society organizations (CSOs) contribute to the development of HIV-related policies and legal documents. For example, local NGOs advocated for the inclusion of harm reduction in the amendment of the Law on Drugs.

International and local NGOs have been working with self-help groups and other CSOs (Women's Union and AIDS Associations) providing technical and financial support to empower self-help groups and provide inputs to legal and/or technical documents.

Despite the progress made, civil society lacks a coordinated and targeted advocacy strategy.

2. To what extent 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:

Efforts have been made to increase the contribution of civil society in national planning and budgetary processes. Through the development of Global Fund Round 9, civil society actively contributed towards the planning and budgeting of the national response.

Civil society was also involved in the development of different national action plans. Since 2005, under the World Bank project, PLHIV have been invited to join the Technical Review Team to provide comments on the provincial annual action plans.

Since late 2008 VAAC has organized meetings with local NGOs to share information on the epidemic and VAAC plans, as well as to get feedback from local NGOs. However, requests for a government budget allocation to civil society have not been responded to. To date participation in these meetings has been limited. It is hoped the meetings will be opened to other PLHIV networks and representatives of key populations at higher risk.

The meaningful engagement of civil society in national strategic planning remains limited. There has been almost no civil society involvement in the annual planning and budgeting of the national AIDS program. The review of the current National Strategy and development of the next phase is an opportunity for civil society to play a bigger role, particularly at provincial level. However the knowledge and capacity of civil society needs to be strengthened in order for their contribution to be effective.

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

   a. the national AIDS strategy?

Low					High
0	1	**2** ☑	3	4	5

   b. the national AIDS budget?

Low					High
0	**1** ☑	2	3	4	5

   c. national AIDS reports?

Low					High
0	1	**2** ☑	3	4	5

Comments and examples:

While mass organizations such as the Women's Union and Youth Union are identified as implementing partners in the national AIDS program, other civil society organization are not and therefore not specified in the National Strategy, the annual plan and budget, and annual reports.

The involvement of civil society including self-help groups and faith-based organizations, in reporting at commune and district level is improving, with good cooperation from local authorities. However this has not been translated to national level reporting. There is a lack of data at the national level and there is no annual AIDS report apart from the biennial UNGASS reports.

The role of civil society in the implementation of Global Fund Round 9 has provided the impetus for civil society to participate in the development and implementation of the next phase of the National Strategy.

4. To what extent 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. M&E efforts at local level?

Low					High
0	1	**2** ☑	3	4	5

Comments and examples:

INGOs are very involved in national and local level monitoring and evaluation. However the involvement and capacity of local NGOs differs from province to province, with Hanoi and Ho Chi Minh City the strongest. At local level, CSOs do not participate in monitoring and evaluation activities. There is some reporting of community based organizations' activities and programs.

Civil society was consulted during the development of the National Monitoring and Evaluation Framework in 2007. INGOs are well represented in the Strategic Information, Monitoring and Evaluation Technical Working Group (SI, M&E TWG), with a local NGO joining in the second half of 2009. The SI, M&E TWG jointly developed the national Monitoring and Evaluation Plan with government counterparts and reviewed all UNGASS and Estimation and Projection data.

Civil society representation on the SI, M&E TWG is stronger from the North of Viet Nam. However the participation of key populations at higher risk is lacking.

There has been little if any effort to improve the capacity of civil society on monitoring and evaluation.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

Low					High
0	1	2	3	**4** ☑	5

Comments and examples:

The representation of civil society has been limited but has improved over the past two years.

The involvement of PLHIV has increased, assisted by the establishment of the national network VNP+, as it provides a forum for identifying representatives who can report back to their constituencies.

The number of Provincial MSM Working Groups has grown from four to six but nationally their representation is limited. Self-organized groups of SW, drug users and sexual partners of drug users were established in 2008 and become more active over 2009, although the number of these groups is still very limited.

Despite progress, the participation of IDU, SW, as well as faith-based organizations in policy development remains limited.

The Vietnam Civil Society Partnership Platform on AIDS (VCSPA) was established in late 2007 to try and assist in filling this gap by creating a channel through which under-representative groups can communicate with policy makers, donors and other stakeholders.

The low capacity of groups representing key populations at higher risk and the lack of technical and financial support available continues to prevent their meaningful participation in a response that should be targeting these groups.

6. To what extent 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:

Access: There are increasing opportunities and mechanisms for local NGOs to receive funding and technical support. Civil society organizations are able to access funds as sub-grantees under the President's Emergency Plan for AIDS Relief (PEPFAR) and World Bank/UK Department for International Development (WB/DFID) projects. Civil society organizations will also be able to access funds under Global Fund Round 9 once implementation begins in late 2010.

Most resources for community based organizations come from projects providing harm reduction services for key populations at higher risk or community/home-based care for PLHIV and orphans and vulnerable children (OVC). However it is still difficult for community based organizations to receive funding, technical assistance and implement activities if they are not legally registered. Some groups have experienced difficulties in complying with the requirements needed to register as a legal entity. These requirements include members needing certain educational qualifications and a specified amount of capital.

Absorption capacity: The capacity of local NGOs and community based organizations is still very limited as is their capacity to absorb funding and technical assistance. There have been efforts, notably from CARE and Pact, to strengthen the organizational capacity of local civil society but more needs to be done, particularly with civil society organizations working outside of PEPFAR provinces.

Most of the funding and technical support available to civil society in Vietnam comes from international donors. In the last two years, some self-help groups of PLHIV received funding from local AIDS administrations or local authorities but these were usually small one-off grants for specific events.

As the private sector in Vietnam is growing, the government could encourage businesses to provide funding to support PLHIV through corporate social responsibility programs and tax exemptions.

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

Prevention for youth	<25%	**25-50%** ☑	51–75%	>75%
Prevention for most-at-risk-populations				
- Injecting drug users	**<25%** ☑	25-50%	51-75%	>75%
- Men who have sex with men	<25%	**25-50%** ☑	51-75%	>75%
- Sex workers	**<25%** ☑	25-50%	51-75%	>75%
Testing and Conselling	**<25%** ☑	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	**25-50%** ☑	51–75%	>75%
Clinical services (ART/OI)*	**<25%** ☑	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	**51–75%** ☑	>75%
Programs for OVC**	<25%	**25-50%** ☑	51–75%	>75%

**ART = Antiretroviral Therapy; OI=Opportunistic infections*
***OVC = Orphans and other vulnerable children*

Overall, how would you rate the efforts to increase civil society participation in 2009?												
2009	Very poor											Excellent
		0	1	2	3	4	5	6	7	8 ☑	9	10

Since 2007, what have been key achievements in this area:

Key achievements include:

- The legal registration of VNP+ the national network representing PLHIV.
- The establishment and development of other civil society networks: VCSPA, Provincial MSM Working Groups, provincial coalition of PLHIV and local alliances between different CSOs.
- The growing number of community based organizations, and their increased capacity and competency compared to the previous reporting period
- The initiation of meetings between VAAC and local NGOs
- The recognition of and/or resource allocation to self-help groups by local AIDS administrations and authorities in some provinces
- The success of the Global Fund Round 9 dual track proposal
- A small but growing number of local NGOs have demonstrated increased capacity for national advocacy, technical leadership and implementation.

What are remaining challenges in this area:

Remaining challenges include:

- The existing legal framework and wide-spread stigma and discrimination limits the participation of IDUs and SW in the national response, and also prevents MSM, IDUs and SW from forming their own organizations. As a result, the representation of these groups remained limited.
- Although peer educators from civil society are hired to distribute commodities, the vast majority of IDU prevention activities (needle and syringe program and peer outreach) are funded and implemented by the government through VAAC and PACs (with the support of the WB/DFID project). The situation is similar for sex worker activities (also supported by WB/DFID, Global Fund and PEPFAR).
- For some civil society networks and community based organizations, the requirements needed to register as a legal entity prevents them from being able to access funds.
- While there is a growing recognition by government of the role of civil society in the national response, this role is not institutionalized in any national planning, budgeting or implementation processes.
- The capacity of CSOs in organizational development, financial and program 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 Vietnam approaches middle income country status and donors reduce their support.

III. PREVENTION

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

☑ **Yes**	No

IF YES, how were these specific needs determined?

The specific prevention program needs were determined by reviewing available epidemiological data to determine needs, donor coordination, and geographic locations for service sites. In addition, programmatic data was examined to determine programming needs and any necessary adjustments.

IF NO, how are HIV prevention programs being scaled-up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	☑ **Agree**	Don't Agree	N/A
Universal precautions in health care settings	Agree	☑ **Don't Agree**	N/A
Prevention of mother-to-child transmission of HIV	Agree	☑ **Don't Agree**	N/A
IEC* on risk reduction	☑ **Agree**	Don't Agree	N/A
IEC* on stigma and discrimination reduction	☑ **Agree**	Don't Agree	N/A
Condom promotion	☑ **Agree**	Don't Agree	N/A
HIV testing and conselling	☑ **Agree**	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	☑ **Don't Agree**	N/A
Risk reduction for men who have sex with men	Agree	☑ **Don't Agree**	N/A
Risk reduction for sex workers	Agree	☑ **Don't Agree**	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	☑ **Don't Agree**	N/A
School-based HIV education for young people	☑ **Agree**	Don't Agree	N/A
HIV Prevention for out-of-school young people	Agree	☑ **Don't Agree**	N/A
HIV prevention in the workplace	Agree	☑ **Don't Agree**	N/A
Other:	Agree	Don't Agree	N/A
Prevention for migrant and mobile population	Agree	☑ **Don't Agree**	N/A
Prevention for sexual partner of PLHIV	Agree	☑ **Don't Agree**	N/A
Prevention for sexual partner of IDU	Agree	☑ **Don't Agree**	N/A
Prevention in closed setting	Agree	☑ **Don't Agree**	N/A

Overall, how would you rate the efforts in the implementation of HIV prevention programs in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 **8** ☑ 9 10

Since 2007, what have been key achievements in this area:

In the reporting period, prevention interventions were significantly scaled-up and access to prevention services has increased in all provinces.

The amendment of the Law on Drugs decriminalized drug use and strengthened the already existing legal framework which supports harm reduction services for IDUs, SW and MSM.

The most significant achievements have been the rapid expansion of the needle and syringe program and condom use program, and implementation of the national pilot MMT program in Hai Phong, Ho Chi Minh City and Ha Noi.

PLHIV, IDUs, SW and MSM are increasingly involved in service delivery as peer educators.

What are remaining challenges in this area:

While there has been significant progress, the expectations of civil society and development partners have risen, partly due to this rapid progress and the increase in funds available.

Harm reduction interventions for IDUs are still limited geographically and in scale. There are no HIV prevention interventions in prisons and limited services are available in 05/06 Centers. Despite the decriminalization of drug use, some drug users do not access prevention services out of fear of being detained in 05/06 Centers. There are limited services available for female IDUs. While there are examples of local authorities implementing innovative and successful harm reduction interventions, implementation varies and is subject to the commitment of local authorities including the police. The national pilot MMT program is taking longer to scale-up than committed in the Plan of Action on Harm Reduction (2007).

Prevention services for SW are limited, with most harm reduction programs targeting street-based FSW, missing those working in informal settings. There are gaps in prevention services targeting male SW and the provision of a comprehensive package of services including needles and syringes, as well as condoms.

HIV prevention for MSM has not become an integrated part of the national AIDS program however National Guidelines on HIV Interventions for MSM are currently under development. There are still very few MSM interventions with existing activities concentrated in six PEPFAR provinces. The WB project on HIV prevention has been slow to respond to the needs of this key population at higher risk. There is also a lack of MSM-friendly sexual health services.

Prevention needs of sexual partners of PLHIV and IDUs have not been recognized and included in the national program.

The lack of size estimations for key populations at higher risk is hindering the effectiveness of the national response.

Stigma and discrimination in the community and in health care settings continues to prevent or delay people from accessing prevention services.

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

☑ **Yes**	No

IF YES, how were these specific needs determined?

These needs were determined based on available epidemiological data.

IF NO, how are HIV treatment, care and support services being scaled-up?

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

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	☑ **Agree**	Don't Agree	N/A
Nutritional care	Agree	☑ **Don't Agree**	N/A
Paediatric AIDS treatment	Agree	☑ **Don't Agree**	N/A
Sexually transmitted infection management	☑ **Agree**	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree	☑ **Don't Agree**	N/A
Home-based care	Agree	☑ **Don't Agree**	N/A
Palliative care and treatment of common HIV-related infections	Agree	☑ **Don't Agree**	N/A
HIV testing and conselling for TB patients	☑ **Agree**	Don't Agree	N/A
TB screening for HIV-infected people	☑ **Agree**	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	☑ **Don't Agree**	N/A
TB infection control in HIV treatment and care facilities	☑ **Agree**	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	☑ **Agree**	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	☑ **Don't Agree**	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	☑ **Don't Agree**	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	☑ **Don't Agree**	N/A
Other programs: *[write in]*	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programs in 2009?											
2009 Very poor											Excellent
	0	1	2	3	4	5	6	**7** ☑	8	9	10

Since 2007, what have been key achievements in this area:

There has been a rapid scale-up of ART since the previous reporting period, with the continued expansion and improvement in quality of treatment programs available to PLHIV in need across the country. PLHIV consider ART scaling up as one of the biggest achievements of the national response over the past two years.

What are remaining challenges in this area:

While there has been significant progress, the expectations of civil society and development partners have risen, partly due to this rapid progress and the increase in funds available. The biggest challenge in the area of treatment, and the reason for the lower rating compared to the previous reporting round, is access to treatment in prisons and 05/06 Centers.

By the end of 2009 ART was not available in prisons and fourteen 05/06 Centers were providing ART under Global Fund Round 6. Under the new Decree 94/2009 drug users can now be detained for up to four years further limiting their access to treatment. Drug users sent to 06 Centers often have their treatment interrupted, increasing the risk of drug resistance. Referral systems between the 05/06 Centers and the community on a detainee's release are weak and need to be strengthened.

PLHIV have access to TB screening in 05/06 Centers however do not have access to preventative therapy. TB treatment is available in a small number of prisons as part of the Global Fund TB grant. Health units located at prisons and 05/06 Centers should be strengthened to improve the quality of services and scale up ART, treatment of opportunistic infections and provision of palliative care. An incentive system could be developed to attract health staff to work in these centers.

Other treatment related challenges include the increase in the number of people in need of treatment as a result of the natural progression of the epidemic, expanded VCT and better diagnosis. As the majority of treatment programs are funded by international donors, sustainability is an issue as donor funding is expected to decrease.

2. 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

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**

IF YES, what percentage of orphans and vulnerable children is being reached? % *[write in]*

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?												
2009	Very poor											Excellent
		0	1	2	3	4	5	6	**7** ☑	8	9	10

Since 2007, what have been key achievements in this area:

- Launch of the National Program of Action on Children affected by HIV covering all aspects related to children and HIV.
- The implementation of Decree 67/2007 provides financial support to AIDS orphans as well as children living with and affected by HIV.
- Support for OVC, including nutrition and schooling is increasingly available.

What are remaining challenges in this area:

- Stigma and discrimination poses a barrier for the schooling of OVC, especially those living in institutions known to be for AIDS orphans.
- Operational models for the implementation of the National Program of Action, especially community-based models have not been fully developed or disseminated.
- In 2009, 803 children living with HIV (aged 6-15) were issued with health insurance cards by VAAC. However this is not official government policy.

CONSULTATION LIST FOR NCPI PART B- UNGASS 2010

Reg.	Unit
	Civil Society Organizations
	A New Day- Thanh Hoa
	Accompany - HCM
	Adamzone – Can Tho
	AIDS Association- Hanoi
	Alliance NT & 567 in HCMC
	Alliance NT&567 in Ho Chi Minh City
	Anise's flowers 1 – Lạng Son
	Anise's flowers 3- Van Quang- Lạng Son
	Anise's Scent Voluntary Club - Lạng Son
	Blue - HCM
	Blue Dawn Club – Lam Dong
	Blue dreams group - Hanoi
	Blue Peace - Hoa Binh
	Blue Sea Club- Hai Phong
	Blue Sky group - Hanoi
	Blue Truong Son- Hai Phong
	Bright Future -Bac Ninh 1
	Bright Future Chi Linh - Hai Duong
	Bright Future- Dong Trieu - Quang Ninh
	Bright Future Hà Nam
	Bright Future- Ha Tinh
	Bright Future Hai Duong
	Bright Future Hai Ninh – Hai Duong
	Bright Future- Hanoi
	Bright Future- Hy Vọng – Bac Ninh
	Bright Future- Kien Thuy - Thai Binh
	Bright Future- Nghe An
	Bright Future- Ninh Binh 1
	Bright Future- Ninh Binh 2
	Bright Future- Ninh Xa – Bac Ninh
	Bright Future- Phu Tho
	Bright Future Quan Lạn - Quang Ninh

	Bright Future Quy Hop – Nghe An
	Bright Future- Thai Binh
	Bright Future- Thai Nguyen 1
	Bright Future- Thai Nguyen 2
	Bright Future Tre xanh – Bac Ninh
	Bright Future Van Don - Quang Ninh
	Brothers
	Bullet Points- Hanoi
	Caritas Viet Nam - HCM
	Centre for Community Development- Dien Bien
	Centre for Consulting and Supporting for families of poor children in rural areas- Hanoi
	Centre for Legal Aids and Healthcare- Hanoi
	Centre for Researches and Actions for Community (CERAC) - Hanoi
	CEPHAD - Hanoi
	CERAC- Hanoi
	Children's Sun group- Hanoi
	Chrysopogon- Thai Binh
	Circle of Friends 1 – Hai Phong
	Circle of Friends 2 – Hai Phong
	CKT Club- Nha Trang – Khanh Hoa
	Clover group - Hai Phong
	Colleagues - HCM
	Collective Actions - Can Tho
	Committee for Reception and Coordination of aids for HIV prevention-
	Common goals Intergroup - HCM
	Compassion - HCM
	Compassion Club – Quang Nam
	Consultation of Investment in Health Promotion (CIHP) - Hanoi
	Cork Sun Flowers– An Giang
	Countryside - Hai Duong
	Da Nang
	Dawn Club - Quang Nam
	Dawn- Ha Long - Quang Ninh
	Dawn's Bell- Thai Binh
	Dawn's Sunlight 1 - HCM

	Dawn's Sunlight 2 - HCM
	Desire for Empathy - Ninh Binh
	Desire to Live group- Hanoi
	Desire to Live- Kiến An District- Hai Phong
	Diep Tree - HCM
	Dieu Giac Consulting and Support Centre for Community- HCM
	Do Son Wave- Hai Phong
	Dreams - Da Nang
	Dynamic - HCM
	Echos - HCMC
	Empathy Club - Binh Tri commune - Quang Nam
	Empathy Club – Ha Dinh Ward- Hanoi
	Empathy Club – Khuong Trung Ward- Hanoi
	Empathy Club – Kim Giang Ward- Hanoi
	Empathy Club - Thanh Xuân Trung Ward- Hanoi
	Empathy Club 1- Nhan Chinh Ward- Hanoi
	Empathy Club 2- Nhan Chinh Ward- Hanoi
	Empathy Club in Thanh Yen commune- Dien Bien
	Empathy Club- Quang Nam
	For a New Day 1 - HCM
	For a New Day 2 - HCM
	For Tomorrow Club- Lang Son
	For Tomorrow- Uong Bi - Quang Ninh
	Friendly Club- Thanh Hoa
	Friendly network - HCM
	Friends- Da Nang
	Friendship – Soc Trang
	Friendship 1 - HCM
	Friendship 2 - HCM
	Friendship 3 - HCM
	Friendship 4 - HCM
	Friendship 5 - HCM
	Friendship- Biên Hòa - Dong Nai
	Friendship Long Xuyen - An Giang
	Friendship network- HCM

	Future's Rainbow - Da Nang
	Green Hai Duong Club - Hai Duong
	Green Tra Ly- Thai Binh
	Hands in Hands – Khanh Hoa
	Headland's Belief- Ca Mau
	Helichrysum bracteatum Van Don - Quang Ninh
	HIV program of Buddhism Congregation in Hue
	Home Sweet Home- Hanoi
	Hon Gai– Quang Ninh
	Hong Duc University- Thanh Hoa
	Hope- An Giang
	Hope Club- Lạng Son
	Hope- Long An
	Hope group – Bac Kan
	Hope Network- Thai Binh
	Hope Trade Union - Da Nang
	Hue Diocese
	Lighten the Belief- Thai Binh
	LIVE - Hanoi
	Live Happily - HCM
	Live to Love – Do Son - Hai Phong
	Lotus 1 - Hai Phong
	Lotus 2 - Hai Phong
	Lotus- Hoa Binh
	Love and Serve- Da Nang
	Mai Hoa clinic - Dong Nai
	Mai Hy - Dong Nai
	Mothers and Wives Club-Ha Ly Ward- Hai Phong
	Mothers and Wives Club-Nghia Xa Ward- Le Chan district- Hai Phong
	Mothers and Wives Club-Trai Chuoi Ward- Hong Bang district- Hai Phong
	Multicolors - Nha Trang
	New Horison – Lao Cai
	New Strength - Hanoi
	New Sunshine group- Dien Bien
	New World group – Hanoi

	Night Starlight - Da Nang
	Night stars group- Cao Bang
	Online - HCM
	Peaceful Place - Hanoi
	Phuong Phuong New Horison Club- Ha Giang
	Port Land- Hai Phong
	Port Land Quang Hanh - Quang Ninh
	Post Detoxification- Cam Pha- Quang Ninh
	Project for Truck Drivers- Hanoi
	QNP+ - Quang Ninh
	Rainbow– Da Nang
	Rice's Scent Club - Hai Phong
	Rising - HCM
	Rocker - HCM
	Sea's Emotion- Hai Phong
	Sea's Flowers - Nha Trang
	Sexual Partners Long Bien - Hanoi
	Sexual Partners project- Hai Ba Trung - Hanoi
	Sharing - Hoa Binh
	Sim Flowers group- Muong Ang district- Dien Bien
	Smiles- HCM
	Southern Selfhelp group network - HCM
	SPN+ - HCM
	Sunflowers group – Dien Bien
	Sunflowers group- Cao Bang
	Tide Club - Hai Phong
	Towards the Future – Thai Binh
	Trust - HCM
	Vitality- HCM
	VNMTS- Hanoi
	White Dove - Hanoi
	White Dove - Lao Cai
	White Sand - Hanoi
	Women's Health Centre- Hanoi
	Women's Self help Group- Hai Phong

	Women's Self-help group- Kien Thuy district - Hai Phong
	Women's Self-help group- Kien Thuy district - Hai Phong
	You and Me– Dong Nai
	Young Family Club - Hai Phong
	Young Women- Cam Pha - Quang Ninh
	Young Women Fight against HIV - Hai Phong
	Youth's Dream group - Hanoi
	Business Enterprises
	Asia Travel Company- Ho Chi Minh City
	Businesswomen Council- VCCI
	Can Tho Chamber of Commerce and Industry- Can Tho
	Centre for Health and Labor- Ministry of Transportation
	Centre for Health, Environment, and Labor- Ministry of Industry
	Dai Duong Mechanics and Electricity Company- Hanoi
	Dai Viet Garment Company- Ho Chi Minh City
	Ha Tay Employers' Council- Hanoi
	Ha Tu Coal Mine- Quang Ninh
	HEMICO- Hanoi
	Khai Duyen Ltd. Company- An Giang
	Kim Bia Beer Company- Hanoi
	Minh Chau Garment Company- Ho Chi Minh City
	Nam Trieu Ship Company- Hai Phong
	Nghe An Chamber of Commerce and Industry
	Nghe An Transportation Company
	PangGa MeKong Seafood Company- Can Tho
	Small and Medium Size Enterprise Centre- Hai Phong
	Small and Medium Size Enterprise Centre- VCCI Ho Chi Minh City
	Swedfong Company- Hanoi
	Traditional Handicraft Village Association- Hanoi
	Transportation Association- Hanoi
	USAID HIV Workplace Project
	Viet Lao Joint Stock Company for Tourism and Economical Cooperation- Nghe An
	Viet Nam Cooperative Society Alliance- Hanoi
	Viet Nam Corporation of Coals and Minerals
	Viet Nam General Corporation of Steels

	Viet Nam Petrol & Gas Corporation
	Vietso Petro Vung Tau- Vung Tau
	Winter & Spring Knitwear Company- Hanoi
	Young Businessmen Association- Hai Phong
	Bilaterals
	Embassy of Australia
	Embassy of Demark
	Embassy of the Netherlands
	Embassy of the United Kingdom
	Embassy of the United States of America
	International Non- Governmental Organization
	Abt Associates
	Adventist Development and Relief Agency
	Care International
	Catholic Relief Services
	Family Health International (FHI)
	Healthright International
	Pact Viet Nam
	Pathfinder
	PEPFAR/U.S Government
	United Nations Agency
	International Labor Organization (ILO)
	International Organization for Migration (IOM)
	The Joint United Nations Programme on HIV/AIDS (UNAIDS)
	United Nations Population Fund (UNFPA)
	The United Nations Children's Fund (UNICEF)
	The United Nations Office on Drugs and Crime (UNODC)
	World Health Organization (WHO)

ANNEX 4:

NATIONAL PROGRAMS, KNOWLEDGE, BEHAVIOR AND IMPACTS

Indicator 4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

1. Method of data collection

- **Data source:**
  - 2008 and 2009 treatment program reports
  - Viet Nam HIV/AIDS Estimates and Projections 2007-2012, MOH 2009
- **Target population:** Adults and children with advance HIV infection who are currently receiving ARV
- **Study sites:** Nationwide
- **Study method:**
  - Numerator was taken from the treatment program reports
  - Denominator was taken from the Viet Nam HIV/AIDS Estimates and Projections 2007-2012

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 a big effort to scale up the ART program.
- The proportion of adults with advanced HIV infection receiving ARV has increased from 30% in 2007 to 45.0% in 2008 and 53.7% in 2009.
- The number of children with advanced HIV infection receiving ARV has increased from 789 children in 2007 to 1,462 children in 2008 and 1,987 children in 2009.

4. Limitation of the data

- Data disaggregated by gender is not available.
- Estimated number of children with advanced HIV infection is not available

Indicator 5. 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:** Reports 2008 and 2009 of PMTCT program
    - **Target population:** HIV-infected pregnant women
    - **Study sites:** Nationwide
    - **Study method:** Secondary data of program reports was collected

2. **Method of measurement**

    - **Numerator:** Number of HIV-infected pregnant women who received antiretroviral during the last 12 months to reduce mother-to child transmission
    - **Denominator:** Estimated number of HIV-infected pregnant women in the last 12 months

3. **Results**
    - In the last couple of years, the Government of Viet Nam has made a big effort to scale up the PMTCT program. By 2009, there are 157 health facilities providing PMTCT services nationwide.
    - In 2008 and 2009, 32.9% and 32.3% of pregnant women, respectively, received ARV medicines to reduce the risk of mother-to-child transmission.
    - Among those receiving ARV medicines to reduce the risk of mother-to-child transmission:
        - 29.4% received single dose NVP only
        - 25% received Zidovudine
        - 24.3% received prophylactic regimens using a combination of three ARVs
        - 15.7% received ART for HIV-infected pregnant women eligible for treatment
    - In 2009, there were 1,511 infants born to women living with HIV receiving prophylaxis to reduce the risk of mother-to-child transmission.

4. **Limitation of the data**
    - Data on the ARV prophylaxis regimen for 5.6% of HIV-positive pregnant women reported to be receiving prophylaxis treatment is missing.

Indicator 6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

1. Method of data collection

- **Data source:**
  - Annual D28 routine report, VAAC 2009
  - WHO estimated number of incident TB cases in PLHIV 2008 (http://www.who.int/tb/country/en)
- **Target population:** Incident TB cases in PLHIV
- **Study sites:** Nationwide
- **Study method:** Secondary data of program reports was collected

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 program guidelines within the reporting year
- **Denominator:** Estimated number of incident TB cases in PLHIV

3. Results

- By the end of 2009, there were 1,818 adults and 94 children with advanced HIV infection who were receiving antiretroviral therapy in accordance with the nationally approved treatment protocol and who had started TB treatment. Among those, 77.6% were male.
- It is estimated in Viet Nam by the end of 2009, there were 27.5% of estimated HIV-positive incident TB adults receiving treatment for TB and HIV.

4. Limitation of the data

- The estimated number of incident TB cases in PLHIV in 2009 is not available. This indicator was calculated using the reported number in 2009 for the numerator and estimated number in 2008 for the denominator.

Indicator 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

1. Method of data collection

- **Data source:** Viet Nam Population and AIDS Indicator Survey 2005 (VPAIS). General Statistical Office, National Institute of Hygiene and Epidemiology, and ORC Macro (2006).
- **Target population:** People aged 15-49
- **Study sites:** All 64 provinces nationwide
- **Study method:** A cross-sectional household survey was conducted among 14,157 people aged 15-49 from September to December 2005 by using the AIDS Indicator Survey (AIS) questionnaires. VPAIS 2005 was a nationally representative sample of the entire adult population of Viet Nam.

2. Method of measurement

- **Numerator:** Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results
- **Denominator:** Number of all respondents aged 15–49

3. Results

- The study indicates the proportion of people aged 15-49 who received a HIV test in the last 12 months and who know their results was 2.3% (2.1% among female and 2.6% among male).
- The highest proportion was found among people aged 25-49 (2.7%), followed by people aged 20-24 (2.5%) and youth aged 15-19 (1%).
- People with higher educational levels, higher income, being married, and living in urban areas tended to have a HIV test and received their test results more than those with lower educational levels and income, being single or divorced/separated/widowed, and living in rural areas.
- Nationally, only 5% of people aged 15-49 reported to have ever undertaken a HIV test.
- People in the targeted provinces are above the national average for prevalence of HIV testing. For instance, in Hanoi, about 12% of women and men aged 15-49 reported having a HIV test and receiving their results within the last 12 months.

4. Limitation of the data

- Nationally representative data for this indicator in 2006 and 2007 is not available. Therefore, data from 2005 is used.

Indicator 8.1. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results – Sex Workers

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population:** FSW (Women who were 18 years or older, who reported having sex for money at least once in the month prior to the survey, were working on the street or in establishments, and agree to be tested for HIV/STI and RTI).
- **Study sites:** The IBBS was conducted in ten provinces/cities Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, Ho Chi Minh City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI) applying cluster sampling methods.

2. Method of measurement

- **Numerator:** was calculated by multiplying the denominator with the mean of the 10 calculated percentages (estimated from the range of percentage sex worker who received an HIV test in the last 12 months and who know the results among 10 target provinces).
- **Denominator:** Number of sex workers included in the sample.

3. Results

- Results of the survey in 2009 indicate from 9.8% to 83.2% of FSW received an HIV test in the last 12 months and know their results. The percentages are higher than that found in 2006.
- There is no significant difference in this indicator among sex workers younger than 25 years (32.4%) and over 25 (36.2%).

4. Limitation of the data

- This data is not nationally representative because it was collected only from hot-spots of sex workers in provinces/cities with high HIV prevalence.
- Data on male sex workers is not available.

Indicator 8.2. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results – Men Who Have Sex With Men

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral 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 a survey respondent).
- **Study sites:** The IBBS was conducted in four provinces/cities Ha Noi, Hai Phong, Ho Chi Minh City, and Can Tho. In every target cities, districts considered as "hot-spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondents were selected using respondent driven sampling method (RDS).

2. Method of measurement

- **Numerator**: was calculated by multiplying the denominator with the median of the 10 calculated percentages (estimated from the range of percentage MSM who received an HIV test in the last 12 months and who know the results among 4 target cities).
- **Denominator**: Number of MSM included in the sample.

3. Results

- Results of the survey indicate that from 9.2% to 79.6% of MSM received an HIV test in the last 12 months and know their results. The aggregated proportion (19.1%) is slightly higher than that in 2006 (16.3%).
- The proportion of MSM over 25 years who received an HIV test in the last 12 months and know their results (21.8%) was higher than that among MSM younger than 25 (16.4%).

4. Limitation of the data

- This data is not representative of the national MSM population because it was collected only from hot-spots of MSM in four cities with high HIV prevalence.

Indicator 8.3. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results – Injecting Drug Users

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population**: IDUs (Men 18 years or older, who reported drug injection in the month prior to the survey, agreed to be tested for HIV/STI and RTI, and had an active referral card given by a survey respondent).
- **Study sites:** The IBBS was conducted in ten provinces/cities Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, Ho Chi Minh City, Can Tho, and An Giang. In every target provinces, districts considered as "hot-spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondent Driven Sampling (RDS) method was used to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, and Can Tho. In the other six provinces, respondents were selected using cluster sampling methods.

2. Method of measurement

- **Numerator:** was calculated by multiplying the denominator with the median of the 10 calculated percentages (estimated from the range of percentage IDUs who received an HIV test in the last 12 months and who know their results among 10 target provinces).
- **Denominator:** Number of IDUs included in the sample

3. Results

- Results of the survey indicate that from 8.0% to 39.5% of male IDUs received a HIV test in the last 12 months and know their results. The aggregated proportion (17.9%) is almost 1.6 times higher than that found in 2006 (11.4%).
- There is no significant difference in this indicator among IDUs younger than 25 years (17.6%) and over 25 (18%).

4. Limitation of the data

- This data is not representative of the national IDU population because it was collected only from hot-spots of IDUs in provinces/cities with high HIV prevalence.
- Data on female IDUs is not available.

Indicator 9.1. Percentage of most-at-risk populations reached with HIV prevention Programs – Sex Workers

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population:** FSW (Women who were 18 years or older, who reported having sex for money at least once in the month prior the survey, were working on the street or in establishments, and agreed to be tested for HIV/STI and RTI).
- **Study sites:** The IBBS was conducted in ten provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, Ho Chi Minh City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI) applying cluster sampling methods.

2. Method of measurement

- **Numerator:** was calculated by multiplying the denominator with the mean of the 10 calculated percentages (estimated from the range of percentage FSWs who were reached by intervention programs for HIV prevention including knowing a place for an HIV test and receiving condoms in the last 12 months among 10 target provinces).
- **Denominator:** Total number of sex workers surveyed

3. Results

- Results of the IBBS revealed the proportion of FSW who were reached by HIV prevention ranged from 19.2% to 77%.
- The IBBS survey indicates approximately 39.9 - 86.3% of sex workers know where to get an HIV test, and 38.5% - 90.3% of them received condoms in the last 12 months.
- Sex workers aged over 25 years are more likely to be reached by HIV prevention programs (50.1%) than those younger than 25 years (42.3%).

4. Limitation of the data

- This data does not represent for national population, because it was collected only from hot-spots of sex workers in provinces/cities with high HIV prevalence.
- Data on male sex workers is not available.

Indicator 9.2. Percentage of most-at-risk populations reached with HIV prevention Programs – Men Who Have Sex With Men

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral 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 a survey respondent).
- **Study sites:** The IBBS was conducted in four provinces/cities; Ha Noi, Hai Phong, Ho Chi Minh City, and Can Tho. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondents were selected using respondent driven sampling method (RDS).

2. Method of measurement

- **Numerator:** was calculated by multiplying the denominator with the median (estimated from the range of percentage MSM who were reached by intervention programs for HIV prevention including knowing a place for an HIV test and receiving condoms in the last 12 months.
- **Denominator:** Total number of MSM surveyed

3. Results

- The IBBS indicates 38.5% - 47.4% of MSM know where to get an HIV test, and 24.2 - 48.6% received condoms in the last 12 months; 12.8% - 30% know both where to get an HIV test and received condoms.
- MSM aged over 25 are more likely to be reached by HIV prevention programs (30.2%) than those younger than 25 years (17.7%).

4. Limitation of the data

- This data is not representative for the national MSM population because it was collected only from hot-spots of MSM in four cities with high HIV prevalence.
- This indicator only looks at the coverage of prevention programs. The quality and frequency of the programs are not measured.
- This indicator only looks at the coverage of prevention programs. The quality and frequency of the programs are not measured.

Indicator 9.3. Percentage of most-at-risk populations reached with HIV prevention Programs – Injecting Drug Users

1. Method of data collection

- **Data source:** Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population**: IDUs (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 a survey respondent).
- **Study sites**: The IBBS was conducted in ten provinces/cities Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, HCM City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondent Driven Sampling (RDS) method was applied to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, and Can Tho. In the other six provinces, respondents were selected using cluster sampling methods.

2. Method of measurement

- **Numerator:** was calculated by multiplying the denominator with the median of the 10 calculated percentages (estimated from the range of percentage IDUs who were reached by intervention programs for HIV prevention including knowing a place for an HIV test and receiving condoms, needle and syringes in the last 12 months among 10 target provinces).
- **Denominator:** Total number of IDU surveyed

3. Results

- The IBBS survey indicates approximately 26.3% - 92.3% of male IDUs know where to get an HIV test, 8.1% - 99.6% and 3.8% - 98.3% received condoms and syringes/needles in the last 12 months, respectively. There were 1.6 - 55.7% of male IDU being reached by all three HIV prevention interventions.
- Male IDUs aged over 25 years are more likely to be reached by HIV prevention programs (17.5%) than those younger than 25 years (10.4%).

4. Limitation of the data

- This data is not representative for the national IDU population, because it was collected only from hot-spots of IDUs in provinces/cities with high HIV prevalence.
- Data on female IDUs is not available
- This indicator only looks at the coverage of prevention programs. The quality and frequency of the programs are not measured.

Indicator 11. Percentage of schools that provided life skills-based HIV education within the last academic year

1. Method of data collection

- **Data source**: Baseline Assessment: National M&E Framework – Indicator 14: Proportion of schools with teachers trained on and implements life skills-based HIV education in 2008. MOET, 2009.
- **Target population**: Secondary (grades 6-9) and high school (grades 10-12) including public and private schools.
- **Study sites:** Nationwide
- **Study method**: Cross-sectional survey of 469 schools that responded out of 733 schools invited to participate in the survey

2. Method of measurement

- **Numerator:** Number of schools that provided life-skills based HIV education in the last academic year
- **Denominator:** Number of schools surveyed

3. Results

- Out of the 460 schools that responded to the questionnaire on life-skills based HIV education, 34.3% of schools reported the life-skills based HIV education was implemented in the last academic year in their school.
- 84.4% and 22% of schools reported to have at least one teacher who was trained on HIV/AIDS and life skills-based HIV education in the same year, respectively. However, only 4.7% of teachers were trained on a comprehensive life skills-based HIV education which includes five required skills (communication, refusal, decision making, setting objective, and problem solving). Moreover, only 13.5% of teachers have implemented life skills-based HIV education for their students in 2008.

4. Limitation of the data

- Only 64% of schools invited to participate in the survey responded.
- Data on primary schools is not available

Indicator 13. Percentage of young women and men aged 15–24 who both 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 years old
- **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 not had 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 proportion is almost the same with the proportion found in 2005.
- The proportion of people who both correctly identify ways of preventing the transmission of HIV through sexual intercourse and reject major misconceptions about HIV transmission aged 20-24 (47%) was slightly higher than among those aged 15-19 (40%).
- This proportion was found slightly higher among men (44.1%) than among women (40.8%).

4. Limitation of the data

- Data for 2.3% of all respondents aged 15-24 is missing.

Indicator 14.1. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission – Sex Workers

1. Method of data collection

- **Data source**: Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population:** FSW (Women who were 18 years or older, who reported having sex for money at least once in the month prior the survey, were working on the street or in establishments, and agreed to be tested for HIV/STI and RTI).
- **Study sites:** The IBBS was conducted in ten provinces/cities Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, Ho Chi Minh City, Can Tho, and An Giang. In each city or province, districts considered as "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:** was calculated by multiplying the sample size with the mean of the 10 calculated percentages (estimated from range of percentage of FSW who gave correct answers to all five questions among 10 target provinces):
    1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has not 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 sex workers who gave answers, including a response of "don't know", to all questions

3. Results

- The results show that 9.9% - 80.3% of FSW both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
- 72.2%- 100% know having sex with only one faithful uninfected partner who has not other partners reduces the risk of HIV transmission
- 83.7%- 99.0% know using condom every time having sex prevents HIV transmission
- 18.9%- 97.4% know a healthy-looking person can have HIV
- 53.1%- 93.1% know mosquitoes and other insect bites cannot transmit HIV
- 74.2%- 98.3% know one cannot get HIV by sharing food with someone who is infected

4. Limitation of the data

- This data is not nationally representative because it was collected only from hot-spots of sex workers in provinces/cities with high HIV prevalence.
- Data on male sex workers is not available.

Indicator 14.2. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission – Men Who Have Sex With Men

1. Method of data collection

- **Data source**: Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral 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 a survey respondent).
- **Study sites:** The IBBS was conducted in four provinces/cities; Ha Noi, Hai Phong, Ho Chi Minh City, and Can Tho. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondents were selected using respondent driven sampling method (RDS).

2. Method of measurement

- **Numerator:** was calculated by multiplying the sample size with the median of the 10 calculated percentages (estimated from range of percentage of MSM who gave correct answers to all five questions among 4 target cities):
    1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has not 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 MSM who gave answers, including the response "don't know", to all questions

3. Results

- The results show 47.7% - 77.2% of MSM both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
- 86%- 98.6% know having sex with only one faithful uninfected partner who has not other partners reduces the risk of HIV transmission
- 92.7%- 98.3% know using condom every time having sex prevents HIV transmission
- 73.5%- 88.9% know a healthy-looking person can have HIV
- 71%- 88.6% know mosquitoes and other insect bites cannot transmit HIV

- 84.6% - 94.9% know one cannot get HIV by sharing food with someone who is infected

4. Limitation of the data

- This data is not representative of the national MSM population because it was collected only from hot-spots of MSM in four cities with high HIV prevalence.

Indicator 14.3. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission – Injecting Drug Users

1. Method of data collection

- **Data source**: Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population**: IDUs (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 a survey respondent).
- **Study sites:** The IBBS was conducted in ten provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, Ho Chi Minh City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondent Driven Sampling (RDS) method was applied to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, and Can Tho. In the other six provinces, respondents were selected using cluster sampling methods.

2. Method of measurement

- **Numerator:** was calculated by multiplying the sample size with the median of the 10 calculated percentages (estimated from range of percentage of IDUs who gave correct answers to all five questions among 10 target provinces)
    1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has not 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 IDU who gave answers, including the response "don't know", to all questions

3. Results

- The results show 11.7%- 75.1% of male IDUs both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
- 61.4%- 100% know having sex with only one faithful uninfected partner who has not other partners reduces the risk of HIV transmission
- 60.6%- 98.3 know using condom every time having sex prevents HIV transmission
- 4.9%- 85.4 know a healthy-looking person can have HIV
- 39.3%- 97.5% know mosquitoes and other insect bites cannot transmit HIV
- 78.7%- 99.7% know one cannot get HIV by sharing food with someone who is infected

4. Limitation of the data

- This data is not representative of the national IDU population because it was collected only from hot-spots of IDUs in provinces/cities with high HIV prevalence.
- Data on female IDUs is not available.

Indicator 15. 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 years old
- **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 only 0.11% of youth aged 15-24 years reported having sex before the age of 15. This proportion is 3.6 times lower than that in 2005 (0.4%).
- This proportion is found higher among men (0.16%) than women (0.07%).
- This proportion among people aged 20-24 (0.19%) was higher than that among people aged (0.07%).

4. Limitation of the data

- As the 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 compounded the likelihood of underreporting of sexual activity.

Indicator 16. 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 years old
- **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 proportion is higher than that in 2005 (0.77%).
- The proportion of men (2.44%) was much higher than among women (0.11%). Compared to 2007, the proportion among both men and women was significantly higher.

4. Limitation of the data

- Data for the age group 25-49 is not available
- In this survey, members of the groups whose behaviors put them at highest risk for HIV would be less likely to be found in the home at the time of the survey, potentially influencing the results.
- As the 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 compounded the likelihood of underreporting of sexual activity.

Indicator 17. 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 years old
- **Study sites:** 63 provinces/cities
- **Study method**: Cross-sectional household survey

2. Method of measurement

- **Numerator:** Number 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 proportion of males aged 15-24 reporting the use of a condom in the last sex with SW was 92.9%.
- The proportion was not significantly different among men aged 15-19 (100%) and men aged 20-24 (90%), however the total number of people reported to ever have sex with SW was too small (56) to allow an accurate comparison and interpretation.

4. Limitation of the data

- Data for the age group 25-49 is not available
- The numerator was different to the UNGASS guideline. The numerator used in this report was "Number of youth aged 15-24 reported to use a condom in the last sex with SW"
- The denominator was different to the UNGASS guideline. The denominator used in this report was "Number of youth aged 15-24 reported to ever have sex with SW"
- In this survey, members of the groups whose behaviors put them at highest risk for HIV would be less likely to be found in the home at the time of the survey, potentially influencing the representativeness of the results.
- As the 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 compounded the likelihood of underreporting of sexual activity.

Indicator 18. 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**: Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population**: FSW (Women who were 18 years or older, who reported having sex for money at least once in the month prior the survey, were working on the street or in establishments, and agreed to be tested for HIV/STI and RTI).
- **Study sites:** The IBBS was conducted in ten provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, Ho Chi Minh City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI) applying cluster sampling methods.

2. Method of measurement

- **Numerator:** calculated by multiplying the sample size with the mean of the 10 calculated percentages (estimated from the range of percentage of FSWs reporting the use of a condom with their most recent client among 10 target provinces).
- **Denominator:** Number of sex workers who reported having commercial sex in the last 12 months.

3. Results

- The survey shows 59.3% - 91.8% of FSW reported using a condom with their most recent client in the last 12 month.
- There is no significant difference in this indicator among FSW younger than 25 and those aged over 25.

4. Limitation of the data

- This data is not representative of the national population because it was collected only from hot-spots of sex workers in provinces/cities with high HIV prevalence.
- Data on male sex workers is not available.

Indicator 19. 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**: Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral 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 a survey respondent).
- **Study sites:** The IBBS was conducted in four provinces/cities; Ha Noi, Hai Phong, Ho Chi Minh City, and Can Tho. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method:** A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondents were selected using respondent driven sampling method (RDS).

2. Method of measurement

- **Numerator:** calculated by multiplying the sample size with the median of the 10 calculated percentages (estimated from the range of percentage of MSM reporting the use of condom with their most recent male partner among four target cities).
- **Denominator:** Number of respondents who reported having had anal sex with a male partner in the last six months

3. Results

- This study indicates 47.4 - 76.8% of respondents reported use a condom during the last time they had anal sex with a consensual partner.
- MSM younger than 25 years were likely to use a condom during the last time they had anal sex with a consensual partner rather than those aged over 25 (59.8%).

4. Limitation of the data

- This data is not representative of the national MSM population, because t was collected only from hot-spots of MSM in four cities with high HIV prevalence.
- There is no data on the use of a condom the last time they had anal sex with a male partner, therefore, data on the use of a condom the last time they had anal sex with a male consensual partner was used to calculate the indicator.

Indicator 20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected

1. Method of data collection

- **Data source**: Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population**: IDUs (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 a survey respondent).
- **Study sites:** The IBBS was conducted in ten provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, HCM City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondents Driven Sampling (RDS) method was applied to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, 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 with median of the 10 calculated percentages (estimated from the range of percentage of IDUs who report using sterile injecting equipment the last time they injected drugs among 10 target provinces).
- **Denominator:** Number of IDUs who report injecting drugs in the last month

3. Results

- The survey indicates 87% - 98% of male IDU reported the use of sterile injecting needles/syringes the last time they injected.
- There is no significant difference in this indicator among male IDUs younger than 25 (94%) and those aged over 25 (94.9%).

4. Limitation of the data

- This data is not representative of the national IDU population because it was collected only from hot-spots of IDUs in provinces/cities with high HIV prevalence.
- Data on female IDUs is not available.

Indicator 21. Percentage of injecting drug users 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 Behavioral Surveillance (IBBS) in Viet Nam 2009.
- **Target population**: IDUs (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 a survey respondent).
- **Study sites:** The IBBS was conducted in ten provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Nghe An, Yen Bai, Da Nang, Dong Nai, Ho Chi Minh City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondent Driven Sampling (RDS) method was applied to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, 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 with median of the 10 calculated percentages (estimated from the range of percentage of IDUs reporting using a condom the last time they had sex among 10 target provinces).
- **Denominator:** Number of respondents who reported having had sexual intercourse in the last month

3. Results

- This survey indicates 26.1% - 93.9% of respondents reported that a condom was used the last time they had sex with a regular partners.
- There is no significant difference in this indicator among male IDU younger than 25 and those aged over 25.

4. Limitation of the data

- This data is not representative if the national IDU population because it was collected only from hot-spots of IDUs in provinces/cities with high HIV prevalence.
- Data on female IDUs is not available.

Indicator 22. Percentage of young people aged 15–24 who are HIV infected

1. Method of data collection

- **Data source**: Viet Nam Population and AIDS Indicator Survey 2005 (VPAIS). General Statistical Office, National Institute of Hygiene and Epidemiology, and ORC Macro (2006).
- **Target population**: People aged 15-49
- **Study sites**: Hai Phong city
- **Study method**: A cross-sectional household survey was conducted from September to December 2005 by using the AIDS Indicator Survey (AIS) questionnaires.

2. Method of measurement

- **Numerator:** Number of young people (aged 15–24) tested whose HIV test results are positive
- **Denominator:** Number of young people (aged 15–24) tested for their HIV infection status

3. Results

- Results from the survey indicates HIV prevalence among young people aged 15-24 is 0.3%. There were no cases of HIV-infection among 15-19 year olds, while the prevalence among people aged 20-24 was 0.8%.
- HIV prevalence among women aged 15-49 was 0.2%, lower than that among men aged 15-49 (0.9%).
- Among women aged 15-49, HIV-infection was found only among women aged 25-34. The survey found infection occurring among men aged 20-39, a broader age range than was found among women.
- Of note, HIV prevalence was found to be 2% among men aged 15-49 living in urban areas, and 1.1% among never-married 15-49 year-old men.

4. Limitation of the data

- Data is not nationally representative because it comes from only one city (Hai Phong).
- HIV sentinel surveillance data among antenatal clinic attendees disaggregated by age group (15-19, 20-24, and 15-24) is not available.

Indicator 23.1. Percentage of most-at-risk populations who are HIV infected – Sex Workers

1. Method of data collection

- **Data source**: HIV sentinel surveillance
- **Target population**: FSW from 05 centers and communities
- **Study sites:** 40 out of 63 provinces/cities in Viet Nam
- **Study method**: Sentinel surveillance is conducted by Ministry of Health annually from May to August. HIV testing with testing strategy II is performed as per the national guideline.

2. Method of measurement

- **Numerator:** Number of sex workers who tested positive for HIV
- **Denominator:** Number of sex workers tested for HIV

3. Results

- The HIV prevalence among FSW in 40 provinces in 2008 was 3.1% and 3.2% in 2009. HIV prevalence among this population was 3.9% in 2007.
- In 2009 the highest HIV prevalence among FSW was found in Can Tho (19%), Hai Phong (8.5%), Thai Nguyen (7.7%), and Ha Noi (6%).
- The IBBS conducted in 10 provinces/cities in 2009 showed HIV prevalence among FSW was 0.33% - 23%.

4. Limitation of the data

- Results from sentinel surveillance reflect the trend of HIV infection in sentinel sites but they are not representative of the targeted population nationwide. Additionally, most of the sentinel sites are in urban settings; therefore, data may not be representative for rural, remote, and mountainous areas.
- Data disaggregated by age group is not available.
- Data on male sex workers is not available.

Indicator 23.2. Percentage of most-at-risk populations who are HIV infected – Men Who Have Sex With Men

1. Method of data collection

- **Data source**: Preliminary results from the second round of the HIV/STI Integrated Biological and Behavioral 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 12months, agreed to be tested for HIV/STI and RTI, and had an active referral card given by a survey respondent).
- **Study sites**: The IBBS was conducted in four provinces/cities; Ha Noi, Hai Phong, Ho Chi Minh City, and Can Tho. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted in 2009 using the Questionnaire on Integrated Biological and Behavioral Surveillance Survey (IBBS of FHI). Respondents were selected using respondent driven sampling method (RDS).

2. Method of measurement

- **Numerator:** calculated by multiplying the sample size with the median of the 10 calculated percentages (estimated from the range of percentage of MSM who tested positive for HIV among four target cities).
- **Denominator:** Number of MSM tested for HIV

3. Results

- The HIV prevalence among MSM in the survey was 6.7% - 26.1%. This is higher than in 2006.
- The HIV prevalence among MSM who were younger than 25 years old is much lower than that among those older than 25 years.

4. Limitation of the data

- This data is not representative of the national MSM population because it was collected only from hot-spots of MSM in four cities with high HIV prevalence.

Indicator 23.3. Percentage of most-at-risk populations who are HIV infected – Injecting Drug Users

1. Method of data collection

- **Data source:** HIV sentinel surveillance
- **Target population:** IDUs from 06 centers and communities
- **Study sites:** 40 out of 63 provinces/cities in Viet Nam
- **Study method:** Sentinel surveillance is conducted by Ministry of Health annually from May to August. HIV testing with testing strategy II is performed as per the national guideline.

2. Method of measurement

- **Numerator:** Number of IDUs who tested positive for HIV
- **Denominator:** Number of IDUs tested for HIV

3. Results

- The HIV prevalence among IDUs in 40 provinces in 2008 was 20.3% and had decreased in 2009 to 18.4%. The HIV prevalence among this population was 20.2% in 2007.
- In 2009 the highest HIV prevalence among IDUs was found in Ho Chi Minh City (55.1%), Can Tho (41%), Dien Bien (43%), Thai Nguyen (34%), Gia Lai (33.3%), Binh Duong (32.4%) and Quang Ninh (29%).
- The IBBS conducted in 10 provinces/cities in 2009 showed HIV prevalence among IDUs was 1.0% - 56%.

4. Limitation of the data

- Results from sentinel surveillance reflect the trend of HIV infection in sentinel sites, but they are not representative for targeted population nationwide. Additionally, most of sentinel sites are in urban settings; therefore, data may not be representative for rural, remote, and mountainous areas.

Indicator 24. 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**: VAAC Treatment Program report 2009
- **Target population**: Adults and children with advanced HIV infection who are currently receiving ARV
- **Study sites:** 27 adult treatment sites and 4 pediatric 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 MOH routine reporting data, there were 84.4% of adults and 80.6% of children still alive and on ARV 12 months after the initiation of the treatment. This proportion was slightly higher among adults, compared to that in 2007 (81%) but lower among children.

4. Limitation of the data

- Data disaggregated by gender is not available.