SOCIALIST REPUBLIC OF VIET NAM

VIETNAM AIDS RESPONSE PROGRESS REPORT 2014

FOLLOWING UP THE 2011 POLITICAL DECLARATION ON HIV AIDS

Reporting period: January 2012 - December 2013

Ha Noi, March 2014

PREAMABLE

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

This report (following of 2002 - 2003; 2004 – 2005; 2006 -2007; 2008-2009; 2010-2011 reports) has been discussed with a wide number of stakeholders, cross-sectoral consultations were held with inputs received from various Ministries and organizations. The information presented here is the consensus of key stakeholders in the response, including relevant sectors of government, national and international organizations working in the HIV field, and civil society organizations.

Viet Nam has continued the excellent progress seen in the previous reporting period. The achievements reflecting Viet Nam's efforts and illustrating its commitments during the 2012-2013 reporting period include: (1) Stop detention of sex workers to Treatment - Education – Social Work Centers, change policies on management of sex workers, and successful development of the detoxification renovation plan till 2020; (2) Expansion of the Methadone Maintenance Therapy (MMT) services; (3) Improvement of HIV treatment accessibility and quality, particularly the successful pilot program of the Treatment 2.0 initiative, (4) Strengthening of the linkages between HIV services and TB, Maternal and Child Health and Sexual and Reproductive Health, and (5) the growth of civil society organizations and community-based organizations participating in the HIV prevention and control response. Multi-sectoral coordination, the strengthening of the HIV-related policy environment and moves towards a more robust response for providing support for PLHIV, sex workers and men who have sex with men are also important achievements.

Viet Nam has faced significant threats to the sustainability of the HIV AIDS prevention and control program are recognized, as international donors begin reducing their resources, national resources have not been adequate to close the gap caused by reduction of international resources, while at the same time the HIV AIDS epidemic is complicated, HIV transmission modes have changed, HIV AIDS epidemic has turned around but still at a high level and not yet stable, the epidemic has rapidly increased in mountainous areas, program coverage is still limited, the need for investment on HIV AIDS prevention and control program in the new context has become greater than that of the previous period.

These are just a few highlights of the HIV response in Viet Nam during 2012 and 2013, as well as challenges that need to be addressed in the coming years. Viet Nam commits to maintain the excellent progress that has been achieved so far, and looks forward to effective coordination between government ministries, as well as continued collaboration with international partners and civil society in order to further our success.

On behalf of the Government and National Committee for AIDS, Drugs and Prostitution Prevention and Control, I would like to end by appreciating and acknowledging all representatives of Ministries and related organizations, UN agencies, international organizations working in the HIV prevention and control program, as well as civil society for your active participating in the development of this report, and express my sincere appreciation for their important ongoing work for the national response. Through our collective efforts, we are moving closer towards our shared goal of universal access to HIV prevention, treatment and care.

Vietnam, 31 March 2014

NATIONAL COMMITTEE FOR AIDS, DRUG AND PROSTITUTION PREVENTION AND CONTROL

CHAIRMAN

Nguyen Xuan Phuc
Deputy Prime Minister
Socialist Republic of Viet Nam

Contents

LIST OF ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
AusAID	Australian Agency for International Development
BCC	Behavior change communication
CBO	Community-based organization
CCEYAC	Committee for Culture, Education, Youth, Adolescents and Children
CCM	Country Coordination Mechanism
CDC	Centers for Disease Control, USA
CSO	Civil society organizations
CUP	Condom use program
DFID	Department for International Development, UK
DOLISA	Department of Labor, Invalids, Social Affair
FBO	Faith-based organization
FHI360	Family Health International
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAARP	HIV AIDS Asia Regional Program
HBV	Hepatitis B Virus
HCMC	Ho Chi Minh City
HIV	Human immunodeficiency virus
HSS	HIV Sentinel Surveillance
HTC	HIV testing and counseling
IBBS	Integrated Biological and Behavioral Survey
IEC	Information, education and communication
ILO	International Labor Organization
INGO	International non-governmental organization
IOM	International Organization for Migration
KAPs	Key at risk populations
LGBT	Lesbian, gay, bisexual and transgender
M&E	Monitoring and evaluation
MCH	Mother and Child Health
MMT	Methadone maintenance therapy
MOET	Ministry of Education and Training
MOH	Ministry of Health
MOHA	Ministry of Home Affair
MOLISA	Ministry of Labor, War Invalids and Social Affairs

MOPS	Ministry of Public Security
MSM	Men who have sex with men
NASA	National AIDS Spending Assessments
NCPI	National Composite Policy Index
NGO	Non-governmental organization
NIHE	National Institute of Hygiene and Epidemiology
NSP	Needle and syringe programme
OPC	Outpatient clinic
OST	Opioid substitution therapy
OVC	Orphans and other vulnerable children
PAC	Provincial AIDS Centre
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
POA	Program of Action
PUD	People who use drug
PWID	Person/people who inject(s) drugs
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Entity for Gender Equality and the Empowerment of Women
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
VNPUD	Viet Nam Network of People who Use Drug
VNSW	Viet Nam Network of Sex Worker
VUSTA	Viet Nam Union of Science and Technology Associations
WB	The World Bank
WHO	World Health Organization

I. STATUS AT A GLANCE

The Global AIDS Progress Report for Viet Nam is written every two years to monitor the progress towards achieving the targets set in the Political Declaration on HIV AIDS, following the UN General Assembly High-Level Meeting on AIDS in New York in June 2011. The report recognizes the significant achievements and efforts made by Viet Nam in 2012 and 2013 in increasing access to and improving the quality of HIV prevention, treatment, care and support services.

The report has been prepared with the broad participation of Government, development partners and civil society. In February 2014, 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. In addition, more than 40 civil society organizations (self-help groups, faith-based organizations, national non-governmental organizations and international non-governmental organizations), business enterprises, bilateral, multilateral and United Nations (UN) agencies gave input to NCPI questionnaire Part B. Between January and February 2014, four consultation workshops (one with Government partners, two with civil society representatives, and one with international non-governmental organizations and UN agencies) were conducted to complete NCPI sections A and B.

The National Consensus Meeting for the overall Global AIDS Progress Report for Viet Nam was organized on 20 March 2014 with 50 participants from 34 organizations representing government and development partners, as well as civil society delegates, to present the draft report and to give an opportunity for participants to review and validate the report's findings and recommendations.

The epidemic in Viet Nam comprises many sub-epidemics across the country and remains concentrated primarily among three populations defined by high levels of HIV-transmission risk behaviors: people who inject drugs (PWID)[1], men who have sex with men (MSM) and female sex workers (FSW). The risk behaviors in these populations are not mutually exclusive; MSM and FSW who inject drugs have much higher HIV prevalence than those who do not inject. According to 2013 HIV sentinel surveillance (HSS) in 41 provinces, prevalence among PWID, FSW and MSM (8 provinces) averaged 10.3%, 2.6% and 3.7% respectively; IBBS II (2009) data among the same populations in 11 provinces ranged from 1.0% (Da Nang) to 56% (Quang Ninh) among PWID, and from 0.3% among venue-based sex workers to 23% among street sex workers. IBBS II data measured HIV prevalence among MSM in 4 cities. Prevalence ranged from 4.9% among non MSM sex workers to 19.8% among MSM sex workers. A steady rise in case reports from women, who now represent 32.5% of new cases, reflects a probably slow but steady transmission of HIV to women by men engaging in high risk behaviors. However, HIV prevalence among pregnant women and other signals from the general population are low and show no sign of increasing. Most women living with HIV report that they were infected by stable sexual partners who either inject drugs or visit sex workers. These data reinforce the need to focus HIV prevention efforts on people who inject drugs and their regular sex partners, men who have sex with men, and sex workers and their clients. It was estimated that there would be about 254,000 people living with HIV in Viet Nam at the end of 2013. Roughly 14,000 new infections have been reported annually from 2009-13.

The achievements reflecting Viet Nam's efforts and illustrating its commitments during the 2012-2013 reporting period include: (1) Successful development of the detoxification renovation plan till 2020, and stop detention of sex workers to Treatment - Education – Social Work Centers, and change policies on management of sex worker; (2) Expansion of the Methadone Maintenance Therapy (MMT) services; (3) Improvement of HIV treatment accessibility and quality, particularly successful piloting of the Treatment 2.0 initiative, (4) Strengthening of the linkages between HIV AIDS services and TB, Maternal and Child Health and Sexual and Reproductive Health, and (5) the growth of civil society organizations and community-based organizations participating in HIV prevention and control efforts.

[1] Surveys of injectors in Viet Nam include only men.

At the same time, the report presented key challenges which have hindered the implementation of HIV interventions, including: (1) Viet Nam has been gradually achieving progress in the various stages of the epidemic, but the reduction of the HIV epidemic is still insignificant and unstable. HIV prevalence in many areas is still high, and increases have even been seen in some provinces. Transmission mode and risk behaviors have become complicated and very difficult to manage. HIV remains the leading cause of heavy disease burden and death in Vietnam; (2) Education programs for community groups on policies and laws are insufficient, and there continue to be delays in implementation of these laws and policies; (3) Although there has been a great effort to increase program coverage it is still not adequate to address the current needs; (4) Stigma and discrimination remain as a key barrier for HIV service uptake by key affected populations; (5) The HIV system relies on donor funding and has not yet integrated into the health system and there is a lack of personnel, health facilities, equipment and laboratories; (6) Funding for HIV AIDS prevention and control was significantly reduced, including from both national budgets and donor funds.

In this context, the report makes recommendations on the key programmatic and policy changes that need to be introduced for achieving each target. These are: (1) Continue to raise awareness of people and leaders on the importance of HIV prevention and control, which is an important task requiring multi-sectoral collaboration; (2) Renovation of the HIV prevention and control system, which integrates into the existing health system and decentralizes to the grassroots level; (3) Increase program coverage and improve service quality, continue implementing NSP and 100% CUP, and particularly MMT; (4) Diversification of financial sources for HIV prevention and control, gradually shifting from a donor-funding based approach to a national funding and health insurance based approach.

Part III of this report provides an overview of the epidemic in Viet Nam, while the national response, including laws, policies and programs relating to prevention, treatment, care and support are analyzed in part IV. Part V highlights the national best practice and Part VI covers the major challenges faced by Viet Nam and the remedial actions that are being taken to address them, part VII summarizes key support from development partners and part VIII provides an assessment of the Monitoring and Evaluation system in Viet Nam. Finally the Annexes contain additional information on the report preparation process (Annex 1), responses to the National Composite Policy Index questionnaires (Annex 2), and the National AIDS Spending Assessment (Annex 3). The key reported indicators are summarized in the table below:

Indicator	Main data source	Status: 2012-2013
Target 1. Reduce sexual transmission of HIV by 50% by 2015		
Sex workers		
1.7. Percentage of sex workers reached with HIV prevention programs	HSS+ & IBBS 2013	2012: 55.9% 2013: 51.0%[2]
1.8. Percentage of sex workers reporting the use of a condom with their most recent client	HSS+ & IBBS 2013	2012: 83.3% 2013: 92%[2]
1.9. Percentage of sex workers who have received an HIV test in the past 12 months and know their results	HSS+ & IBBS 2013	2012: 40.1% 2013: 35.1%[2]
1.10. Percentage of sex workers who are living with HIV	Sentinel surveillance	2012: 2.7% 2013: 2.6%

[2] See Annex 3 for source and method of calculation

MSM		
1.11. Percentage of men who have sex with men reached with HIV prevention Programs	HSS+ & IBBS 2013	2012: 48.9% 2013: 42.3%[2]
1.12. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	HSS+ & IBBS 2013	2012: 66.6% 2013: 66.4%[2]
1.13. Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	HSS+ & IBBS 2013	2012: 39.4% 2013: 28.8%[2]
1.14. Percentage of men who have sex with men who are living with HIV	Sentinel surveillance	2013: 3.7%
Target 2. Reduce transmission of HIV among people who inject drugs (PWID) by 50% by 2015		
2.1. Number of syringes distributed per person who injects drugs per year by needle and syringe programs	VAAC D28 Routine report	2012: 180 2013: 98
2.2. Percentage of people who inject drugs reporting the use of a condom at last sexual intercourse	HSS+ & IBBS 2013	2012: 48.9% 2013: 41.2%[2]
2.3. Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	HSS+ & IBBS 2013	2012: 96.4% 2013: 97.3%[2]
2.4. Percentage of people who inject drugs who have received an HIV test in the past 12 months and know their results	HSS+ & IBBS 2013	2012: 31.3% 2013: 23.6%[2]
2.5. Percentage of people who inject drugs who are living with HIV	Sentinel surveillance	2012: 11.6% 2013: 10.3%
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths		
3.1. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	VAAC D28 Routine report	2012: 47.4% 2013: 57.0%
3.2. Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	VAAC D28 Routine report	2012: 24.1% 2013: 68%
3.3. Mother-to-child transmission of HIV (modeled)	Modeled	2012: 18% 2013: 19.7%
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015		
4.1. Percentage of eligible adults and children currently receiving antiretroviral therapy	VAAC D28 Routine report	2012: Coverage among eligible people Adults: 58.9% Children: 86.3% All: 59.9%

		2013: Coverage among eligible people Adults: 67.1% Children: 79.2% All: 67.6% 2013: Coverage among all PLHIV Adults: 2013: 31.8% Children:2013: 57.9% All: 2013: 32.5%[3]
4.2. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Annual data collection on ART cohorts outcome and early warning indicators for HIV drug resistance	2012: 82.6% 2013: 84.6%
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015		
5.1. Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	VAAC D28 Routine report	2012: 15.9% 2013: 29.2%
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries		
6.1. Domestic and international AIDS spending by categories and financing sources (Total national expenditures)	NASA	2011: US$ 99.8 million (not including US$ 31.1 million that is unidentified financing agents and service providers) 2012: US$ 95.4 million (not including US$ 40.6 million that is unidentified financing agents and service providers) [4]

[3] Definition of indicator 4.1 has changed since 2013, as of that the coverage was among all PLHIV nationwide, but not the eligible PLHIV as used in calculation of the GARP 2012. When using the 2012 definition, the coverage was 67.6% (67.1% among adults and 79.2% among children).

[4] See Annex 4 for details

Target 7. Critical Enablers and Synergies with Development Sectors		
7.1. National Commitments and Policy Instruments	NCPI results	See Annex 2
7.2. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		*No data available*
7.3. Current school attendance among orphans and non-orphans aged 10–14		*Not applicable*
7.4. Proportion of the poorest households who received external economic support in the last 3 months		*No data available*

Data for these indicators came from different sources, including the National HIV Sentinel Surveillance Survey 2013 with behavioral component (HSS+) conducted in 2013, HIV AIDS estimates and projections conducted by the National Technical Working Group on HIV Estimates and Projections in 2013, and program reports from 2012 and 2013. In many cases, data disaggregated by gender was not available. Furthermore, the data for the indicators on sex workers (SW) represent findings among female SWs only and the data on the indicators PWID are for male PWID only. In addition, due to the sampling methodology of surveys, in which only selected provinces were included in the studies, the results do not always reflect the overall national situation.

Data were not available for indicators 1.1-1.6 and 7.2-7.4. Indicators 1.1-1.6 apply to generalized epidemics and are therefore not applicable in Viet Nam, where there is a concentrated epidemic. Viet Nam does not report on indicators 7.2, 7.3 and 7.4 because they are not included in the National Monitoring and Evaluation Framework.

II. OVERVIEW OF THE EPIDEMIC IN VIET NAM

According to the estimates and projections of HIV, there were an estimated 256,000 people living with HIV in Viet Nam as of 2014. It was estimated that the HIV prevalence among general population would be 0.26% in 2014. [5] The number of HIV cases newly reported to the Ministry of Health decreased rapidly between 2007 and 2009 and held steady at about 14,000 reports per year from 2010 to 2013. AIDS case reports and related mortality have also remained fairly steady since 2009. These case report numbers are consistent with declining HIV prevalence among key populations at highest risk of transmission. [6] While the number of new cases has declined, it is still very difficult to reach the target of 50% reduction in new HIV infections by 2015, as committed to as part of the Political Declaration on HIV AIDS of the UN General Assembly in 2011.

Data on case reporting by geographical areas shows that HIV cases are concentrated in the Northern, Mekong River Delta and South East provinces. Provinces with a high number of HIV infections are North West mountainous provinces and mountainous districts of Nghe An and Thanh Hoa. The HIV epidemic in the two big cities of Hanoi and HCMC, has become complicated and difficult to manage.[6]

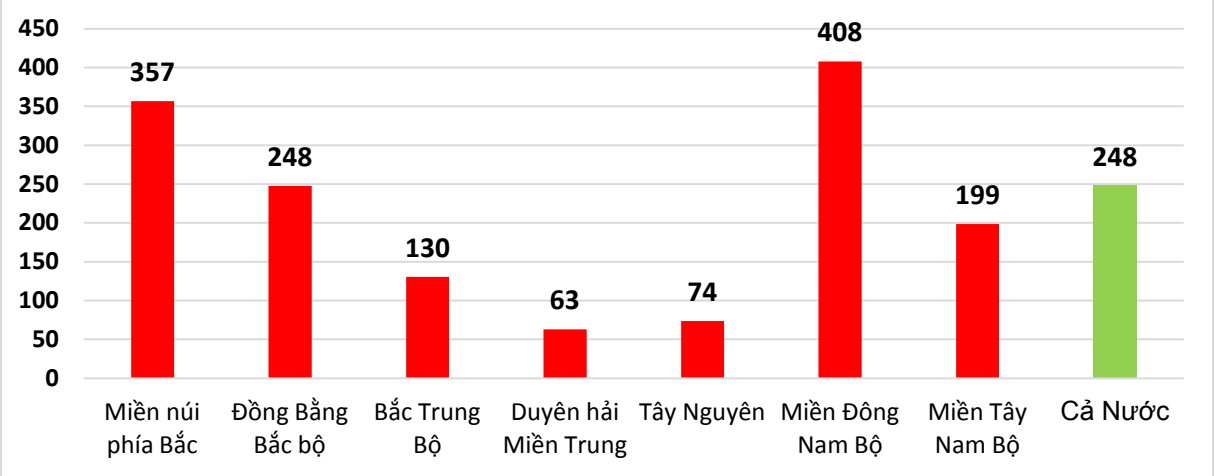


Figure 1: Number of HIV cases per 100,000 people nationwide and by geographical areas

The proportion of female HIV cases among all cases reported has been steadily increasing. The majority of PLHIV reported in 2013 are between the ages of 20-39, with this age demographic accounting for 79%.[6]

[5] Preliminary results of the HIV Estimates and Projection in Viet Nam 2013. EPP Technical Working Group, Ministry of Health, 2013.

[6] Annual Report of the HIV prevention and control program 2013 and plan for 2014. Ministry of Health, 2014.

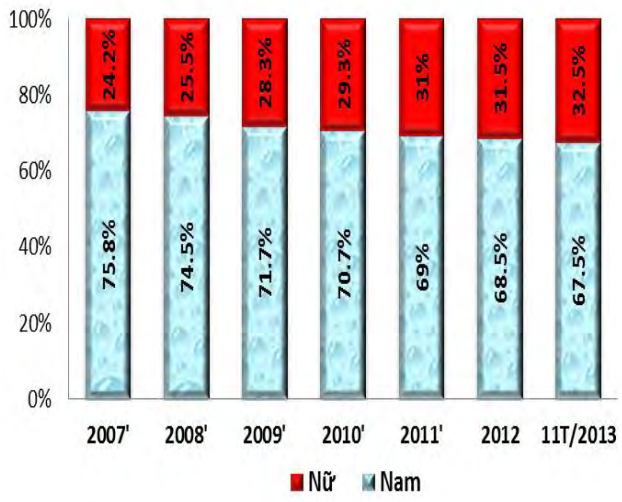


Figure 2. Distribution of PLHIV by gender by years

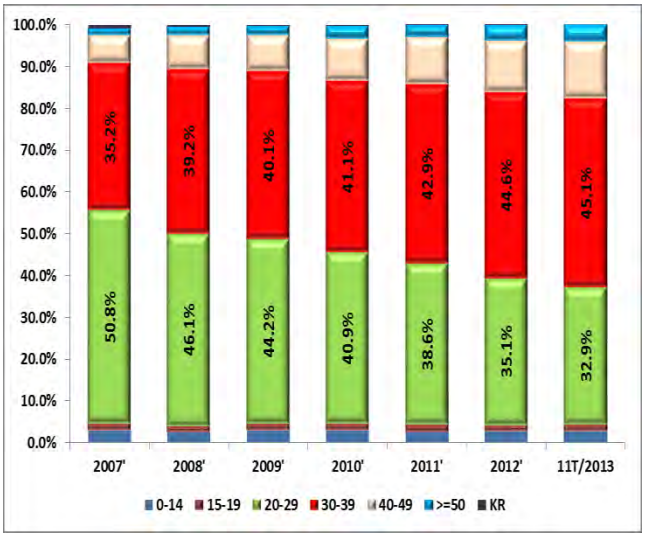


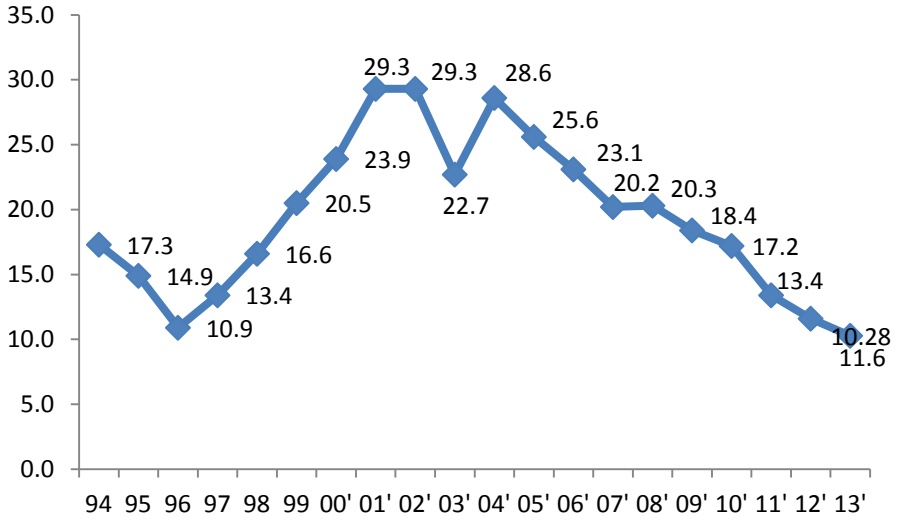
Figure 3: Distribution of PLHIV by age group by years

The epidemic in Viet Nam is comprised of many sub-epidemics across the country and remains concentrated primarily among three populations defined by high levels of HIV-transmission risk behaviors: people who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSW).

In summary, data from various surveys across multiple years were modelled to project by 2015 an overall decreasing trend in HIV prevalence among injecting drug users from 30.4% in 2005 to 22% in 2013, a slightly increasing trend among female sex workers from 4.9% in 2005 to 5.3% in 2013, and a worrisome increase in HIV infection among MSM from 1.7% in 2005 to 2.4% in 2013.

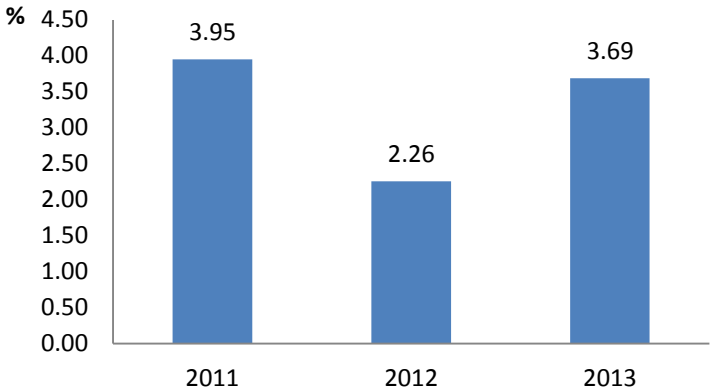
Injecting drug use is the leading contributor to the transmission of HIV in Viet Nam, further fuelled through sexual transmission. Data from the 2009 HIV/STI Integrated Behavioral and Biological Survey (IBBS) Round II and annual sentinel HIV surveillance (HSS) estimate that as many as 40% of the estimated 271,000 PWID (range: 100,000-335,000) are living with HIV. PWID are found throughout the country, but an estimated 80% of the drug using population lives in 22 of Viet Nam's 63 provinces. Recent efforts to provide PWID with sterile injecting equipment, methadone, and ART among other HIV services appear to be having an impact. According to HSS data, prevalence among PWID decreased steadily from 2004 through 2013, falling below 11% in 2013 for the first time since 1997 (Figure 4). While prevalence among PWID is decreasing in some provinces, the epidemic is still alarmingly high in most provinces surveyed. According to HSS 2013, HIV prevalence among PWID is particularly high in provinces including Thai Nguyen (34%), Lai Chau (27.7%), Ha Noi (24%), Quang Ninh (22.4%), and Ho Chi Minh City (HCMC) (18.2%).

Figure 4: HIV prevalence among men who inject drugs 1994-2013 (Source: HSS)



In recent years there has been greater recognition of an HIV epidemic among MSM. The number of studies and surveillance conducted about MSM behavior is increasing. HSS data from MSM in 2013 (n=8), found an average HIV prevalence of 3.7%.[7] HIV prevalence among MSM appears to be high in major cities. Available data indicate a growing epidemic in Hanoi and HCMC, with HIV prevalence estimated to be up to 16% in these urban centers. Unprotected anal sex is the main route of transmission among MSM. There is also a small group of injecting drug using MSM who have a very high prevalence and cannot be overlooked. In HSS+[8] provinces (n=8; 2013), HIV prevalence among MSM who inject drugs was 6% while among MSM who reported never having injected drugs, mean prevalence was 1.8%. IBBS II (n=4 provinces) found similarly discrepant results between injecting and non-injecting participants. MSM-IDU make up 7.2% of the total MSM survey population, most of whom were in HCMC and Hanoi. HIV prevalence among MSM was greater than 10% in 3 of the 4 provinces surveyed (HCMC, Ha Noi and Hai Phong), and as high as 20% among MSM who had not sold sex in Ha Noi. The estimated MSM population ranges from 191,000 to 573,000.[9] Data remain sparse for MSM in Viet Nam and the true magnitude of the epidemic will only become clear with 1-2 more survey rounds over a greater geographic area.

Figure 5: HIV prevalence among men who have sex with men 2011-2013 (Source: HSS)

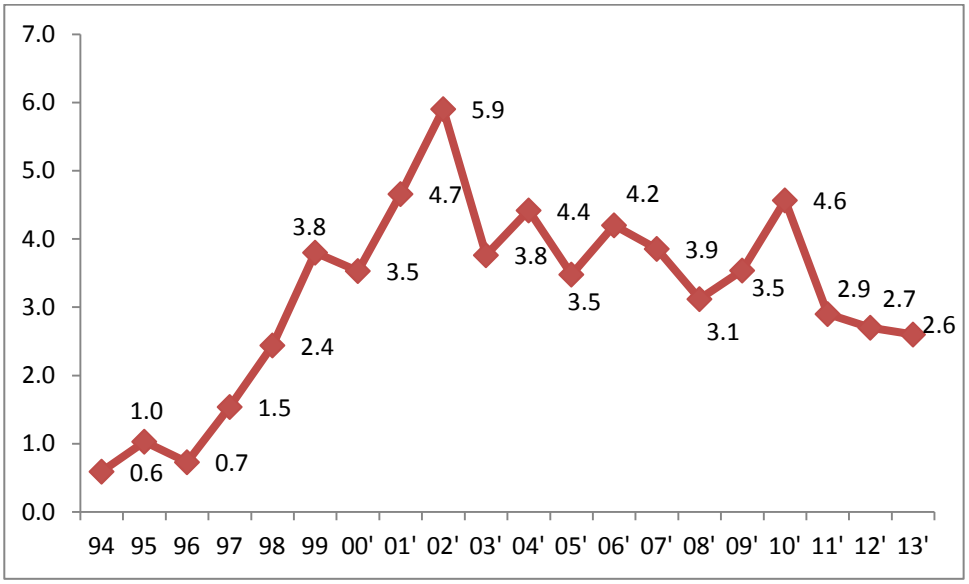


There are an estimated 72,000 FSW (range: 36,000-108,000) in Viet Nam. HIV prevalence among female sex workers (FSWs) began declining nationally in 2002. In HSS 2013, at 2.6%, it reached a level

[7] Sentinel Surveillance Survey 2013. VAAC, 2013.
[8] HSS+ = Sentinel survey sites with behavioral surveys added to prevalence.
[9] VAAC 2013. Preliminary Estimates and Projections of HIV in Viet Nam.

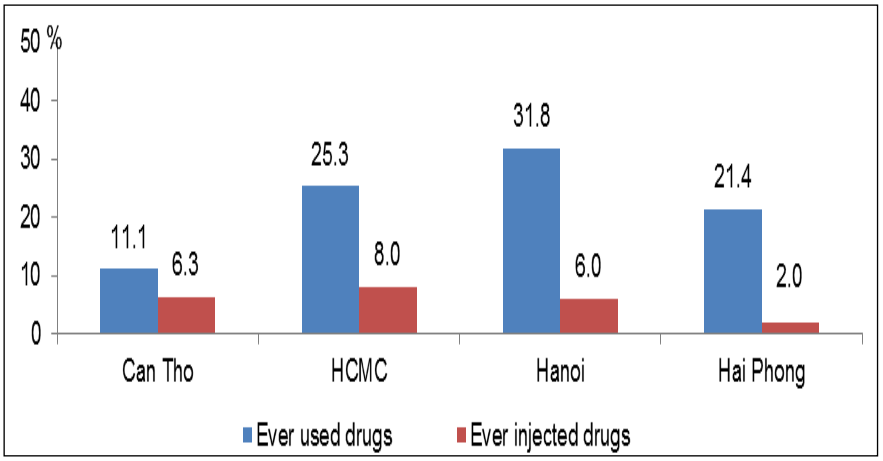
not seen since 1998 (Figure 6), however some provinces remain disproportionately affected.[10] HIV prevalence among FSW varies by province and exceeds 10% in Hanoi, Hai, Phong, Can Tho, and HCMC. Evidence also indicates that street-based FSW have a relatively higher HIV burden compared to venue-based FSWs and an estimated 3-8% of FSW also inject drugs. Among FSW who inject drugs, the HIV prevalence is 25-30%.

Figure 6: HIV prevalence among female sex workers 1994-2013 (Source: HSS)



Overlapping risk behaviors amplify HIV transmission risks for FSWs and MSM who also inject drugs, as 2009 IBBS data indicate that the odds of an FSW or MSM being infected with HIV are significantly higher among those that also report injecting drug use behavior. Figure 4 shows the percentage of MSM who reported drug use in 2009.

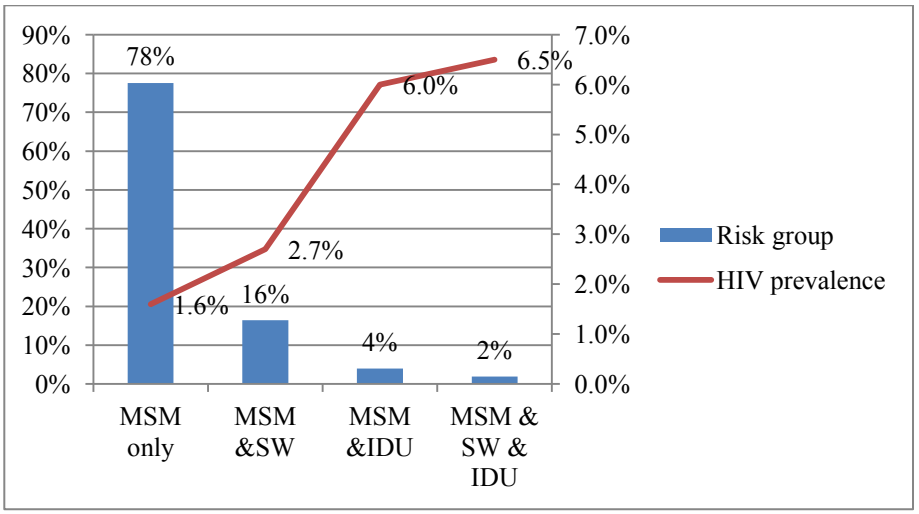
Figure 7: Proportion of MSM who ever used drugs and ever injected drugs – IBBS II



According to the HSS+ 2013, 18.3% of MSM respondents were engaged in sex work and 6% reported injecting drug use.[11] Figure 8 makes it clear that injecting drug use and unprotected anal sex are synergistic risks for HIV infection among MSM: on average, MSM who inject drugs and engage in anal sex have a higher prevalence than people who only inject drugs or only engage in anal sex.

[10] Sentinel Surveillance Survey 2013. VAAC, 2013.
[11] HSS+ 2013. VAAC, 2013.

Figure 8: Multiple risk behaviours among MSM, 2013 (Source: HSS+)



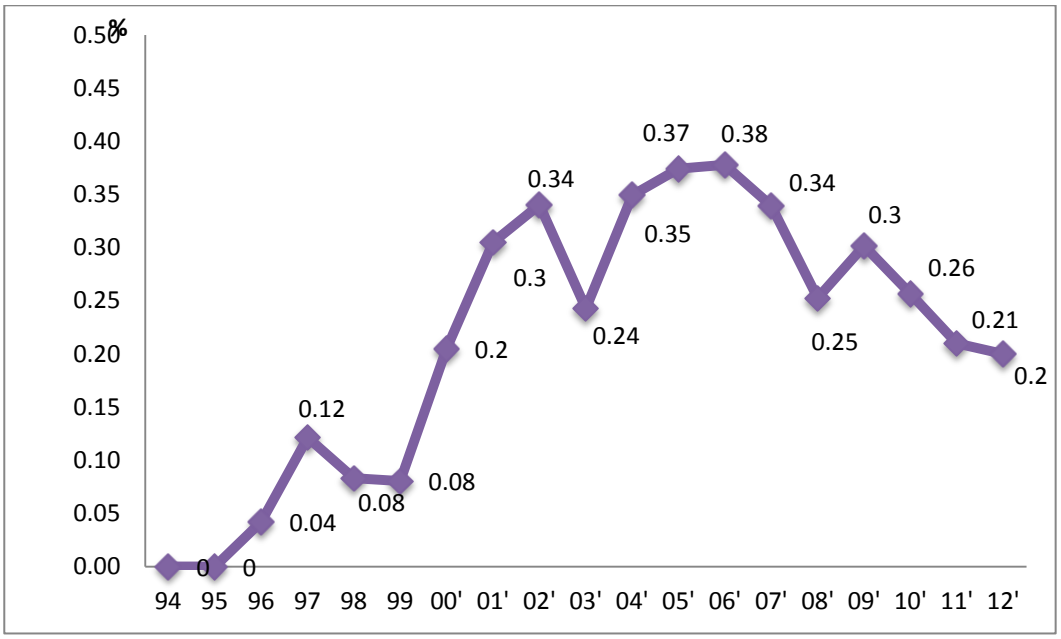
HIV prevalence among FSW who injected drugs was higher than among those who did not inject in all provinces surveyed, while figures for prevalence among injecting FSW were equal to or higher than those of men who inject drugs in the same provinces. In 2013, 1.7% of 4,284 FSW in 21 provinces reported a history of injecting drug use, and HIV prevalence among them was 7%.[12] Injecting drug use is an important risk factor for HIV transmission among FSW and should be considered in prevention mixes for FSW.

The sizes and distribution of these key populations vary across the country. PWID are concentrated in HCMC, Hanoi, the Red River Delta and the northwest region; FSW numbers are highest in HCMC, the Mekong Delta and southwestern Viet Nam; and "open" MSM are most easily accessed in the major cities of HCMC and Hanoi. The key population size estimations are currently based on government estimations using assumptions defined by relevant technical working groups. With partner and GVN support, province-specific population enumeration surveys are underway to provide more precise size estimates by population.

Sexual partners of these groups are an additional at-risk population that requires targeted program interventions. A rise in reported cases of HIV-positive women, who represented 32.5% of newly reported cases in 2013, likely reflects a slow but steady transmission of HIV to women by men engaging in highly risky behaviors. However, the scale-up of prevention of mother-to child-transmission (PMTCT) services and a high HIV-testing coverage of pregnant women mean that it is likely that some proportion of these newly reported cases comes from increased testing rather than increased transmission. The rate of HIV prevalence among pregnant women attending antenatal care clinics captured within the 2013 HIV Sentinel Surveillance (HSS) suggests a steady decline of HIV in this population. The national mean prevalence is consistently below 0.4% and falling over the past decade. HSS 2013 mean prevalence was 0.2% (Figure 9). There is no indication that a national generalized epidemic is imminent.

[12] HSS+ 2013. VAAC, 2013.

Figure 9: HIV prevalence among pregnant women 1994-2013



Analyses using national HIV testing data indicate that 54% of HIV+ women reported that their only possible exposure to HIV was through a husband/long-term partner with high-risk behavior.[13] A small on-going study in Thai Nguyen province found that nearly 70% of HIV-infected pregnant women reported that their spouse was HIV+.[14]

Some research suggests that there might be a new risk for HIV transmission among people who use Amphetamine Type Stimulants (ATS) among youth, MSM, and FSW because of the higher risk of having multiple sexual partners and unsafe sex after using these drugs.

[13] UNAIDS/UNWomen Report on Intimate Partner Transmission 2012
[14] Unpublished data. WHO/Thai Nguyen PAC

III. NATIONAL RESPONSE

1. Governance and leadership

Under the leadership of Deputy Prime Minister Nguyen Xuan Phuc, members of the National Committee on HIV AIDS, Drug and Prostitution Prevention and Control held regular meetings to review the current HIV AIDS activities and recommit to achieving future progress. The Deputy Prime Minister accompanied by National Committee members paid visits to supervise local HIV AIDS, drug and prostitution prevention and control activities in some provinces, presided at the launch of the National Action Month for HIV AIDS Prevention and Control, and attended and delivered an opening speech the 5th National Conference on HIV AIDS by the end of 2013. Notably, in September 2013, Deputy Prime Minister Nguyen Xuan Phuc and several members of the National Committee on HIV AIDS, Drug and Prostitution Prevention and Control participated in the workshop "Enhancing the participation and effective operation of civil society organizations in implementing the National Strategy on HIV AIDS Prevention and Control" organized by VUSTA. On 10/01/2014, the Deputy Prime Minister chaired the online national conference on a review of HIV AIDS prevention and control in 2013 and plans for 2014. The conference was attended by leaders of all ministries and sectors; provincial people's committees of 63 provinces and cities; and leaders of international organizations. At the conference, the Deputy Prime Minister concluded:

"…in the coming time, at the central level, the ministries and sectors should urgently develop specific plans and programs on drug and prostitution prevention and control in accordance with the Government's 01 Resolution; continue study to propose development and completion of the system of legal documents on HIV AIDS, drug and prostitution prevention and control; further improve communication, raising awareness and dissemination of legal documents and policies on prostitution prevention; promote the program of MMT, drug production, supply and management; firmly and strictly handle cases of covering or protecting drug use and prostitution; develop legal sanctions on violations; continue to strengthen coordination and focus resources on improving effectiveness of attacking, repressing crimes, destroying lines of trading and transporting drugs in key areas; promote international cooperation, learning from best practices, fully implementing international commitments, especially integration of international programs in the country, taking advantages of international support for Viet Nam; renovate detoxification programs towards voluntary access; concentrate on cooperation for fighting against cross-border drug trading and transporting and communicate on drug prevention and control in border areas.

*… **The theme for 2014 will be "Community-oriented, community-based HIV AIDS, drug and prostitution prevention and control with the motto of taking prevention as the key"**[15]*

The quotation from the Conclusion of Deputy Prime Minister Nguyen Xuan Phuc showed that the Government has identified existing difficulties facing HIV AIDS prevention and control efforts. At the same time, the Deputy Prime Minister indicated tasks for 2014 which include strengthening the leadership, completion of legal documents, improvement of the organizing system, mobilization of new resources and comprehensive implementation of technical activities.

However, despite encouraging signs showing the national commitment for HIV AIDS financing and management, there are deep concerns about sustainability. The response to HIV in Viet Nam is still heavily reliant on international aid, while the middle-income country status of Viet Nam along with the global financial crisis are leading to a reduction in funding from international sources. Many donors are already planning for closing or significantly reducing existing funding sources (such as the PEPFAR case). Unless the national funding for HIV AIDS increases to fill in the shortage, important achievements in terms of HIV prevention, treatment and care will likely be lost. At the same time, unless the country

[15] The Government Office's Official document No. 34/TB-VPCP dated 23/1/2014 regarding Deputy Prime Minister Nguyen Xuan Phuc's conclusion at the Conference reviewing HIV AIDS, drug and prostitution prevention and control in 2013 and implementation of the 2014 plan.

has measures to maintain the obtained intervention achievements, Viet Nam will face a risk that the HIV outbreak will reoccur, especially the outbreak of HIV drug-resistance.

2. Policy and legislative environment

The Government of Viet Nam acknowledges that HIV prevention and control should be treated as an important and long-term task requiring a multi-sectoral response, and the Government is committed to creating favorable conditions for the implementation of HIV prevention and control activities.

Since 2013, the National Assembly has approved the Constitution which came into effect on 01 Jan 2014, to replace the Constitution of the Socialist Republic of Viet Nam of 1992. The Constitution includes a chapter on the rights and obligations of citizens and has a provision that all citizens have equal rights without discrimination, the rights to health care, inviolability of private life, privacy, health insurance, social security, and employment. The National Assembly also requested ministries and branches to review laws and policies documents to institutionalize these rights.

Additionally, the 2013 legislative agenda of the National Assembly contains several pieces of legislation related to the HIV response, such as a Law amending and supplementing a number of articles of the Law on Health Insurance, Law on Social Insurance (amendment). Approval of the Law on the Handling of Administrative Violations, which aims to end the practice of sending sex workers to administrative detention and close these centers, and which guarantees due process rights and legal representation to people who use drugs, has been a key success. In addition to that, the government has issued a number of Decrees to guide the implementation of the Law (Decree 111/2013/ND-CP dated 30/9/2013 providing for the application of administrative sanction of education in communes, wards and townships; Decrees 81/2013/ND-CP dated 19/7/2013 elaborating penalties for administrative violations and administrative measures; Decree 221/2013/ND-CP stipulates the administrative measure on compulsory detoxification at rehabilitation centers).

In 2013, the National Assembly reviewed the Law on Family and Marriage and considerations of legalization of same-sex marriage. In 2013 UNAIDS supported a study on the current status of same-sex couple's cohabitation in Viet Nam, their expectations, the stigma and discrimination they have experienced and consequences of not having legitimate rights for cohabitation. This is an effort to promote equal rights for LGBT people, including their right to healthcare. The study seeks active engagement by people in positions to make decisions through the establishment of an advisory group comprising of representatives of Ministry of Justice, Office of the National Assembly, Office of the Government and Ministry of Culture, Sports and Tourism. Recommendations from the study include the legalization of same-sex marriage, a review of relevant laws to ensure equal rights for LGBT people and more active reduction of stigma and discrimination against LGBT people in all contexts. The draft amended Law on Family and Marriage is expected to be finalized and approved by the National Assembly in 2014.

Notably, the new National Strategy on HIV AIDS Prevention and Control to 2020, with a vision to 2030 was approved on 25/5/2012. The new Strategy was written in consultation with government ministries, civil society, the United Nations and international partners, and contains ambitious targets that resonate with the Political Declaration on HIV AIDS: Intensifying our Efforts to Eliminate HIV AIDS, which was agreed at a special session of the UN General Assembly in June 2011. Decision No. 4548/QĐ-UBQG50 of the Chairman of the National Committee on HIV AIDS Prevention and Control granted in 20/11/2012 approved four Projects of the National Strategy for HIV AIDS prevention and control until 2020 with a vision to 2030.

The National Targeted Program on HIV 2011-2015 was also approved by the government in August 2012, which secured more state budget for HIV activities, while the Communist Party reviewed Directive 54 on HIV, leading to Party Notice 27-TB/TW renewing the Party's commitment to continued leadership on HIV prevention and control at both the central and local levels. The Joint Circular 163/2012/TTLT-

BTC-BYT was approved by the Ministries of Finance and Health regulating the management and usage of funding for the National Target Program on HIV AIDS prevention and control in 2012- 2015.

Over the past two years there have also been further positive changes in the legislative environment relating to the implementation of harm-reduction activities. For example the Government's Decree 96/2012/ND-CP dated 15/11/2012 regulating Substitution Treatment for Opioid Dependence. Circular 12/2013/TT-BYT dated 12/04/2013 provides detailed guidance on the implementation of some articles of the Government's Decree 96/2012/ND-CP dated 15/11/2012 regulating Substitution Treatment for Opioid Dependence. The framework to guide the implementation of the fee of MMT services under the provisions of Decree 96/2012/ND-CP, Circular No. 154/2013/TT-BTC providing for the level of collection, regime of collection, remittance, control and use of appraisal fees for issuance of operation licenses and fees for issuing the operation license to establishments providing substitution treatment for opium dependence was approved in November 2013. Several good points could be listed from this Decree such as:

- It is not limited to methadone, but to all medication and covers "medication assisted treatment for opioid dependence".
- It Simplifies the admission procedure: the patient comes directly to the clinic to register. There are simplified administration supporting documents including only: (1) signed application form verified by commune People's Committee: that states the patient is not on the list to be sent to compulsory treatment according to Decree #94 and certifies the address where the patient lives; and (2) notarized national ID or household registration or birth certificate. It also sets a time limit from receiving application of a patient until the date to be enrolled in treatment to less than 15 days.
- It also deals with the expansion of MMT to closed settings such as detention camps and private health establishments; the investment and implementation responsibility under the People's committees for provinces and cities; incentive policies for patients enrolled in the treatment and treatment providers under the public health sector.

The Prime Minister issued Decision No. 1899/QD-TTg of 16/10/2013 approving the Project on Financing HIV AIDS prevention and control activities in the period of 2013- 2020 in which the Prime Minister assigned ministries and sectors to develop many legal documents to urgently mobilize resources for HIV AIDS prevention and control and provides guidelines on using the mobilized resources in an effective and economical manner. Plan No. 967/KH-BYT of 10/12/2013 provides directions on the implementation of the Project on "Financing HIV AIDS prevention and control in the 2013-2020 period" (herein after referred to as Plan 967). Plan 967 assigned responsibilities to MoH departments to implement groups of solutions which were mentioned in the Project; they include organizing conferences, workshops for raising funds from new resources, leading and collaborating with relevant ministries to develop guiding documents to create a mechanism for resource mobilization for the program, developing a roadmap and a plan to mobilize new funding resources. developing plans for the implementation of groups of solutions on program management, and effective management and usage of mobilized resources. In 2013, the MoH issued the Guidelines No. 999/HD-BYT of 18/12/2013 providing guidance on implementation of the Project "Financing HIV AIDS prevention and control activities in the 2013-2020 period" at provinces and central-level cities. This Guideline aims at indicating roles and importance of the Project to local HIV AIDS prevention and control, specifying responsibilities of the People's Committees and sectors of all levels in developing the Plan of financing for HIV AIDS activities in provinces/ cities for the period of 2014-2020.

Moreover, improvements have been made in the policy and legislative framework for treatment and care allowing simplyfied procedures for ARV treatment and supported early access to HIV AIDS treatment, expansion of care and treatment services, and allowing prisoners who are AIDS patients with opportunistic infection temporary suspension of the imprisonment sentence, through the following policy documents:

- Circular 32/2013/TT-BYT dated 17/10/2013 guiding management and supervision of treatment of HIV infected people and people who are exposed to HIV.
- Joint Circular 03/2013/TTLT-BCA-TANDTC-VKSNDTC-BQP-BYT dated 15/5/2013 guiding implementation of regulations on temporary suspension of the imprisonment sentence to offenders
- Decision No. 4817/QĐ-BYT dated 28/11/2013 of the Minister of Health guiding diagnosis and treatment of Hepatitis C.
- Decision No. 153/QD-AIDS dated 27/6/2013 of the Director of the VAAC providing Guidance on counseling for HIV infected children.
- Circular 06/2012/TT-BYT dated 20/4/2012 of the MoH stipulating conditions of establishment and operational contents for HIV AIDS prevention and control counseling organizations.

Collaboration between HIV and TB programs has been enhanced to improve TB prophylaxis, TB diagnosis and treatment among PLHIV, through the issuance of

- Circular 02/2013/TT-BYT dated 15/01/2013 stipulating collaboration between health establishments in TB management.
- Decision No. 2495/QĐ - BYT on 18/7/2012 of the Minister of Health on promulgation of guidance for active diagnosis of tuberculosis and preventive treatment using isoniazid (INH) for HIV-infected people.
- Decision No. 2496/QĐ - BYT dated 18/7/2012 of the Minister of Health promulgating the Regulation on the co-ordination between the National Target Program on HIV AIDS prevention and control, and Tuberculosis prevention and control project under the National health target program.
- Decision No. 2497/QĐ - BYT dated 18/7/2012 of the Minister of Health approving the Co-ordination Framework between National target program on HIV AIDS prevention and control, and Tuberculosis prevention and control Project under the National health target program for the period 2012 - 2015.

In addition, there have been efforts to expand and improve the quality of the HIV prevention services, particularly harm reduction activities. Several policy documents were approved during 2 years; such as:

- The Prime Minister's Directive 16/CT-TTg dated 22/5/2012 on strengthening HIV AIDS prevention and control.
- Decision 3281/QĐ - BYT dated 11/9/2012 of the Minister of Health promulgating " Checklist of Centres for HIV AIDS Prevention and Control".
- Decision No. 4994/QĐ-BYT dated 14/12/2012 of the Minister of Health providing guidance on implementation of HIV AIDS prevention and control at the communal, ward level.
- Joint Circular 25/2013/TTLT-BYT-BTC dated 4/9/2013 stipulating financial management of social marketing activities of contraceptives and products for HIV AIDS and STD prevention and control.
- Joint Circular 29/2013/TTLT-BYT-BVHTTDL-BCA-BLĐTBXH dated 30/9/2013 guiding implementation of harm reduction for HIV prevention with condoms in hospitality establishments.

In addition to the Projects which were submitted to the Government and the Prime Minister, VAAC worked as the focal point to develop and submit important legal documents and technical guidance, including:

- Circular 09/2012/TT-BYT dated 24/5/2012 of the Ministry of Health guiding epidemiological surveillance of HIV AIDS and surveillance of sexual transmission of infections.
- Circular 28/2012/TT-BYT dated 04/2012 stipulating the "List of diseases with which people are infected can not have their tissue, organs transplanted to other patients"
- Circular 29/2012/TT-BYT dated 04/12/2012 on issuance, re-issuance of certification of testing labs which meet the biological safety standards.

- Circular 15/2013/TT-BYT dated 24/5/2013 guiding ensurance of quality of HIV tests.

3. Multi-sectoral collaboration for HIV prevention and control

Under the direction of the National Committee for AIDS, Drugs and Prostitution Prevention and Control, the collaboration among ministries has been strengthened to ensure a stronger multi-sectoral response and consequent improvement in service delivery. Ministries and sectors have been working with each other and with mass organizations, civil society and international organizations to ensure the provision of services. The success of this effort is most notable in the rapid increase in the number of people who have access to HIV prevention, care and support services. Additionally, HIV was mainstreamed into the key policies and decisions of various ministries, and the relevant provisions (including those incorporated into Viet Nam's ten-year Socioeconomic Development Strategy 2011–2020 and Socioeconomic Development Plan 2011–2015) were implemented.

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

MOLISA, MOH, MOPS with support from UN agencies worked together to strengthen HIV prevention for women who sell sex and men who have sex with men, including development of information systems and the generation of evidence at national and sub-national levels and integration of harm reduction approach in national and sub-national program on sex work. In addition, the national response to HIV prevention in sex work has been strengthened through policy dialogue and policy changes i.e. understanding of the actual gaps in current policy on sex work in the light of the new Law on Administrative Sanction. The Law on the Handling of Administrative Violations has been approved, which aims to end the practice of sending sex workers to administrative detention and close these centers, and which guarantees due process rights and legal representation to people who use drugs.

In 2013, the Ministry of Public Security, in collaboration with the Ministry of Health, Global Fund Project, the HIV prevention project in the Asia Pacific region, and UN agencies, carried out IEC/BCC activities; capacity building for staff and prisoners on HIV prevention, care and treatment; and provided ART to 1,080 prisoners and OI and STI treatment to 1,189 prisoners, in 20 prisons. At the same time, the Ministry of Labor - Invalids and Social Affairs ran capacity-building training workshops for staff in 06 Centers, and implemented activities to improve HIV-related knowledge about counseling, HIV testing, care and ART.

The Ministry of Defense, the Committee for Ethnic Minorities Affairs, and the Ministry of Health worked together to reinforce the HIV prevention and control program targeting ethnic minorities via IEC/BCC activities in selected areas. With PEPFAR support, counseling, testing and ART have been provided at military health service facilities, while ART was also provided to people living near these facilities.

The Committee for Culture, Education, Youth, Adolescents and Children (CCEYAC) of the National Assembly, Ministry of Home Affairs (MOHA), Youth Union and other local organizations, with support from UNFPA and UN partners, organized youth policy discussion forums to discuss youth priorities post 2015 (including priorities on SRH and HIV prevention) and how to integrate it into the national socioeconomic development plan. As a result, a national multi-sectoral coordination mechanism on youth related issues has been drafted.

Different ministries/sectors and mass organizations also worked together or side-by-side on HIV-related information, education and communication (IEC) campaigns. The Ministry of Information and Communication took the lead on collaborating with agencies to intensify propaganda on HIV prevention via the mass media, particularly during the action month on HIV prevention and control. The Ministry of Defense enhanced IEC activities on HIV prevention for soldiers, especially new recruits. Meanwhile, the Ministry of Construction and Ministry of Transportation conducted several IEC/BCC activities to raise awareness on HIV prevention among migrants, construction workers, workers in remote areas, and drivers. At the same time, the Committee for Ethnic Minorities Affairs worked together with the Ministry of Health to develop and implement HIV prevention and control programs for ethnic minorities.

The Ministry of Education and Training issued the Decision 5330/QD-BGDDT dated 29/11/2012 to provide guidance to the whole sector to implement the Action Plan on HIV AIDS Prevention and Control of the Education Sector for the period 2012-2020. The Ministry of Education and Training, in collaboration with the Ministry of Health, has implemented the National Strategy on HIV AIDS to 2020 with the vision to 2030, developed the HIV M&E framework for the education sector, and conducted a study on "HIV prevention in public education settings in North West region in 2013". HIV education for students has been integrated into existing school-based training curricula, including life skills-based HIV education for students in grades 5, 8 and 10 in selected schools. MOET developed the Terms of Reference related to MOET inter-departmental and inter-sectoral coordination in monitoring the implementation of the HIV AIDS Law including the elimination of stigma and discrimination. This is well complemented by capacity development both at national and sub-national levels, resulting in strengthened capacity on creating quality and friendly learning environments for children affected by HIV AIDS.

These efforts were supported by those of local government, social political organizations, mass organizations and community. The Central Committee of the Viet Nam Fatherland Front and member organizations jointly implemented the "All people participating in HIV prevention and control in community" initiative and the project "Buddhist leaders participating in HIV prevention and control, provision of counseling and care for HIV infected and affected people in community" which is a part of the campaign "All people unite to build cultural life in residential areas". The Viet Nam Women's Union continued to promote behavior change communication activities through their existing network and routine activities. These included direct communication sessions to improve knowledge about HIV and the prevention of HIV-related stigma and discrimination through the expanding "Sympathy" club network. The Youth Union conducted training workshops on HIV prevention and control for nearly 200 local Youth Union staff. Every year, the General Confederation of Labor Viet Nam has issued guidance and instructions to their members to conduct HIV education among workers. The Viet Nam General Confederation of Labor improved the HIV knowledge of trade union staff in provinces; directed the implementation of HIV-prevention communication activities for 14,000 workers; produced leaflets and manuals for enterprises; supplied HIV-related communication materials such as CDs, handbooks, leaflets and brochures at the local level; and ran training workshops for private-sector workers on HIV prevention and control activities. In particular, in the National Action Month for HIV AIDS in 2013, the General Confederation of Labor has directed the Viet Nam Trade Union launching ceremony held in response to the action month for workers of enterprises that employs 02 workers who are living with HIV to eliminate stigma, discrimination against PLHIV. The Farmer's Union worked in collaboration with Preventive Medicine Centers and Family Planning programs to carry out IEC/BCC activities for farmers through the union network. The Family Planning Association conducted communication activities on HIV prevention and provided condoms to students and people in communities.

4. Prevention

Information, education and Communication (IEC) and Behavior Change Communication (BCC)

Information, Education and Communication (IEC) and Behavior Change Communication (BCC) activities have been implemented in collaboration with multi-sectoral organizations and in various forms at all levels throughout the country. Magazines, television programs, newspapers, bulletins, posters, banners leaflets and campaigns featuring HIV campaign messages have been delivered to key populations at

higher risk as well as the general population. IEC/BCC activities included training, peer education among key populations at higher risk, counseling, establishing hotlines, running competitions, 'edutainment' shows, stories and photo exhibitions.

The Ministry of Public Security, Ministry of Defense, Ministry of Labor – Invalid – Social Affair, Ministry of Construction, Ministry of Education and Training, Ministry of Transportation, Ministry of Culture, Sport and Tourism, Ministry of Agriculture and Rural Development, Ministry of Justice, the Central Committee of the Fatherland Front and mass organizations conducted IEC/BCC sessions to reach mobile populations, ethnic minorities, migrants, youths and teenagers, and prisoners with HIV prevention messages and services.

Adolescent and young people's participation and capacities were strengthened through participation in the design and implementation of the six month healthy sexuality exhibition with the Ministry of Education and Training (MOET) and Ho Chi Minh Communist Youth Union (HCYU) as supportive partners. MOET has taken strong leadership in all the activities, including the research and the dissemination workshop in 2012, and the mapping and development of the exhibition content, the launching and the interactive sessions in 2013. While sexuality education is still a new and sensitive topic in Viet Nam, support from and leadership of MOET is pertinent for the institutionalization and sustainability of the program. It also helps to involve the support and participation of various stakeholders from education, health, youth and parents and the community at large.

Harm reduction programs

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

According to the 2013 HIV Estimates and Projections, by the end of 2013 there would be almost 271,000 people nationwide using drugs (around 85% of whom inject opiates), 72,000 women engaging in sex work, and 382,000 MSM.[16]

A further geographic expansion of the NSP, 100% CUP and HIV prevention for MSM programs took place during the reporting period. In 2013, 57 of 63 provinces carried out community outreach activities for PWID, MSM and FSW, 60 implemented some level of NSP and all provinces distributed condoms free of charge.

The Ministry of Health and the departments of health at the provincial and district levels have worked with peer educators, PLHIV support groups, local officials and police to provide harm-reduction services to PWID, FSW and MSM. According to VAAC, by the end of 2013, there were 2,654 PWID peer educators (former and current drug users), 1,643 FSW peer educators (former and current sex workers and entertainment establishment owners), 368 MSM peer educators (men who currently have sex with men) and 9,484 district collaborators (mostly health-service staff) participating in the HIV prevention programs. As a result of the funding reduction, the number of peer educators has been reduced compared to 2011 figure (3,875 PWID peer educators, 2,278 FSW peer educators, and 11,782 district collaborators) except in the case of the MSM peer educator group (145).[17]

The response to HIV prevention, diagnosis and treatment service needs in prisons, pre-trial detention and 06 Centres remain a serious challenge. Most of these closed settings still lack basic HIV services, even though HIV prevalence within them is estimated to be high. Through initiatives of HAARP in 3 provinces and Global Fund Rounds 8 and 9, basic HIV education, diagnosis and treatment services are being

[16] Preliminary Viet Nam HIV AIDS Estimates and Projections 2013. National Technical Working Group on HIV Estimates and Projections, Ministry of Health, 2013.

[17] D28 Routine Program Report. VAAC, MoH 2013

established in prisons and other closed settings in more than 31 provinces, with additional piloting of some prevention initiatives, including condom provision, in 06 Centers.

Condom promotion programs

The implementation of the National Comprehensive Condom Program for 2011–2020 particularly targets people at high risk of HIV infection and establishes a framework for more effective coordination, expanded market-based approaches and stronger linkages with HIV and sexual and reproductive health programs. This program is critical because of the decline in donor resources for condoms in Viet Nam. In 2012, the program was expanded from 57 to all 63 provinces, the program was also expanded at commune and district levels and at the end of 2013 there were 439 districts with a condom promotion program. As of 2013, almost 14 million condoms had been distributed, mostly through peer educator channels. In addition to that, the condom social marketing program has showed its success. As of the 2012 report, 32 million condoms had been sold through the program.

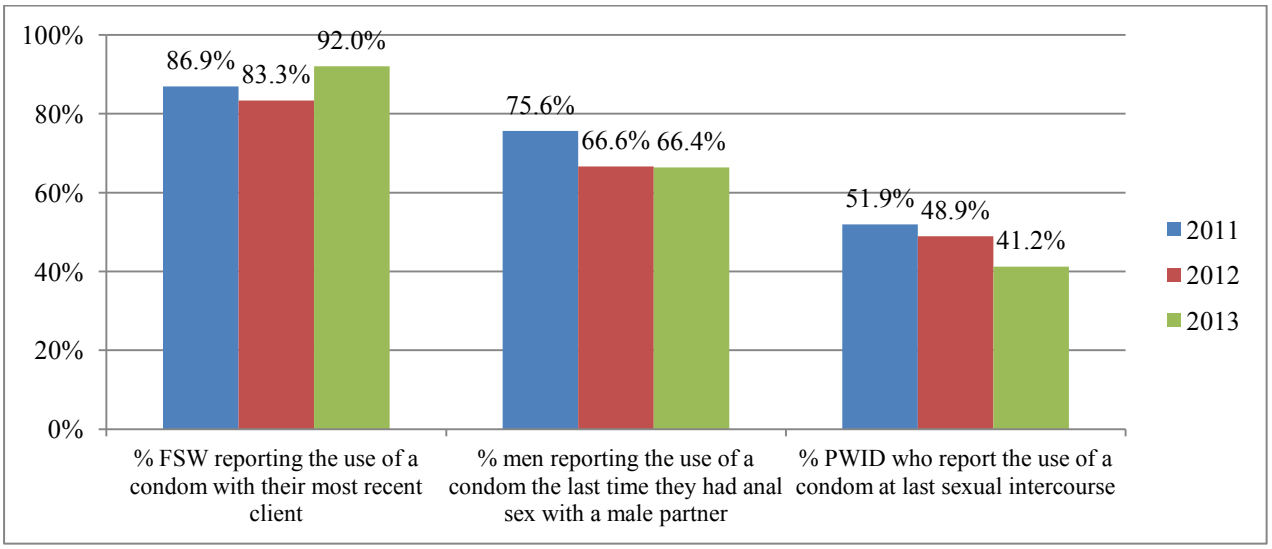
The Ministry of Culture, Sport and Tourism developed an action plan for the period 2010 - 2012 to implement the Condom Program for HIV and STI Prevention in tourism establishments and hotels. The Ministry collaborated with related organizations to develop the Circular 29/2013/TTLT-BYT- BVHTTDL-BCA-BLĐTBXH dated 30/9/2013 on condom provision in entertainment establishments and hotels.

In addition, together with development partners and UN agencies, the National CCP Steering Committee has met and reviewed the National Comprehensive Condom Programming (CCP) Action Plan to address the unmet needs for male condoms for family planning and HIV prevention. Particularly, in 2013, the National CCP Steering Committee reviewed evidence of poor quality of male condoms in the free market and approved follow up actions in 2014-2015 aiming at immediately improving the national mechanism for quality assurance for imported condoms and their distribution in the market, to ensure effectiveness of family planning and HIV prevention programs.

HSS+ and IBBS 2013 data from 26 provinces indicates that 72.9% of SWs reported having received free condoms in the last month. According to the HSS+ and IBBS 2013 data, 92% of sex workers used a condom with their most recent client.

However, condom use among MSM and PWID remained relatively low. According to the HSS+ and IBBS 2013, only 66.4% of men reporting the use of a condom the last time they had anal sex with a male partner, and 41.2% of people who inject drugs who report the use of a condom at last sexual intercourse (Figure 10).

Figure 10: Condom use at high risk behaviors (Source: HSS+ and IBBS)



The close of 05 centers has suspended sending FSW to compulsory reformatory centers. However, there has been no intervention program on health care for FSW at the community.

Needles and Syringes programs

The coverage of the Needle and Syringe Program (NSP) has increased over the years. The average number of needles and syringes provided to PWID increased from 140 NS/PWID in 2011 to 180 in 2012, however this figure reduce to 98 NS/PWID in 2013.[17] The distribution of free needles and syringes was slightly decreased from around 30 million in 2012 to 26.7 million in 2013. There are plans to expand the NSP, with new needles and syringes being distributed for free through peer educators, VCT and OPC sites, and fixed site boxes and at subsidized rates through pharmacies participating in pilot social marketing initiatives. Additionally, the NSP has been extended to additional districts as an effort of the GF project (31 districts within 2013).

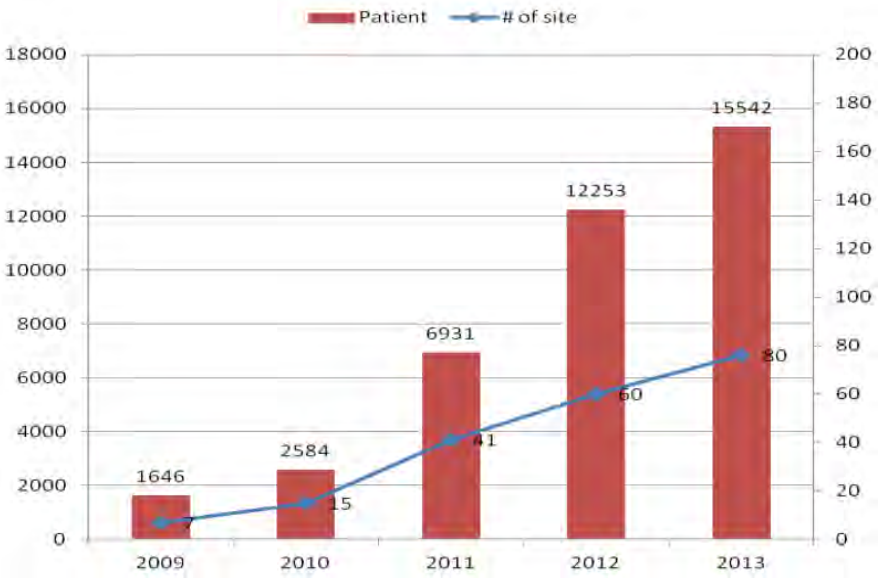
The percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected has slightly increased, from 95.3% in 2011, to 96.4% in 2012, and 97.3% in 2013.

Methadone Maintenance Therapy

The drug detoxification treatment program with methadone has been piloted in Viet Nam since 2008 and has gained positive results. The Government of Viet Nam has given directions to maintain, sustain, and expand the MMT program after the successful pilot. This is an important measure in harm reduction interventions for drug users, especially in preventing HIV infection from drug users to the community.

The Decree 96/2012/NĐ-CP on Substitution Treatment for Opioid Dependents was approved to simplify the administration procedure and increase accessibility to MMT services. As a result, the MMT services were expanded from 41 sites (6,931 patients) in 2011 to 60 sites (12,253 patients) in 2012, and to 80 sites (15,542 patients) in a total of 30 provinces in 2013 (Figure 11)[17].

Figure 11: Number of MMT clinics and patients during 2009 – 2013



MMT has shown significant impacts on reduction of reported drug users involved in crime (from 49% to 2%) as well as risk behaviors after 12 months of treatment.[6] The Proportion of MMT patients who reported continuing drug use declined from 16% to 11%; among those who inject drugs none of them reported sharing needles and syringes. Condom use among MMT patients with regular partners and sex workers increased to 44% and 100%, respectively. Depression also declined from 80% to 15% after 12 months of treatment.[6]

In 2013, WHO supported VAAC in providing evidence of the benefit for integration of MMT, HTC and ART. The study conducted in Hanoi and Can Tho showed that male PLHIV receiving MMT are more likely to be enrolled in care and start ART and have higher retention rate than males not on MMT. The

findings supported and promoted VAAC policy in expansion of MMT and integration of MMT and ART service deliveries.

A consultation workshop on the introduction of OST in prisons and detention centers was held in 2013 with support from UNODC. It was a joint activity of MoPS and MoH with the final outcome being an announcement that the pilot will proceed in 2014-15 in the three regions of Viet Nam.

In the previous years, MMT activities depend heavily in international funding. With donor support for HIV programs decreasing, the country is looking for new ways to finance critical prevention activities such as methadone treatment. This model of cost sharing between the local health department and patients will chart a way forward for sustainable, community-led drug treatment options. Socialization of MMT has been piloted in Hai Phong since 7/2011 and Lao Cai province since 10/2013, where treatment costs are shared by drug users and government funding opened. The co-pay model creates an opportunity for opioid drug users to obtain quality treatment services at minimum cost.

Additionally, significant efforts have been made to sustain the MMT program. The MoH has recently granted permission to 5 eligible enterprises to manufacture Methadone in the country. Methadone and guidelines for the use of the drug was included in the Viet Nam Drugs Dictionary. Training on MMT has been approved by the MoH and Five medical schools and national hospitals have been assigned to deliver these trainings. According to the MoH classification, there were three focal points for providing local establishments with technical guidance on substitution treatment of opioid addiction; they are Mental Health Institute of Bach Mai Hospital, the Central Mental Hospital 1, and the Central Mental Hospital 2.

However, the rate of expansion of MMT services has been inadequate to meet the demands of PWID seeking treatment. The coverage of MMT was low, particularly in high burden provinces such as Ha Noi, HCMC, Thanh Hoa and Nghe An. The major challenges are financial and human resources for maintaining and expanding the MMT program.

Blood transfusion safety

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

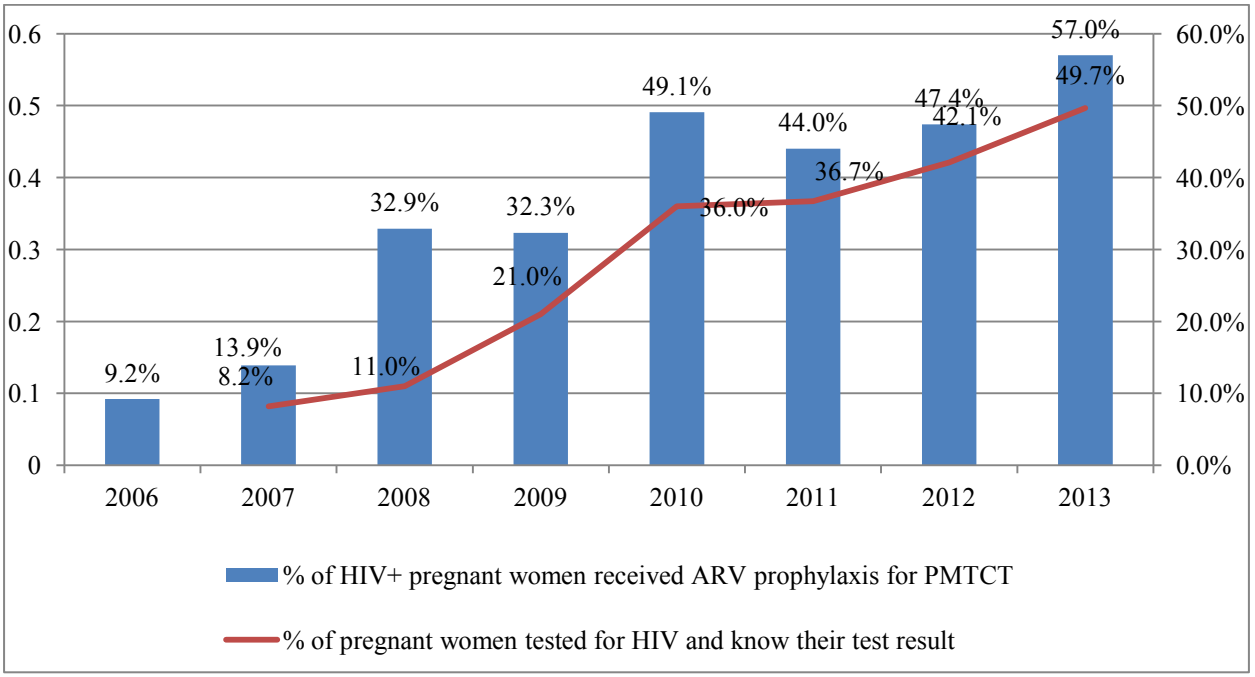
According to 2013 Blood Transfusion Committee reports on the activities of 82 blood centers/blood screening laboratories, there were more than 720,000 blood units collected nationwide, with 390,000 units coming from volunteer blood donors. More than 97% of blood units were screened for HIV, hepatitis B, hepatitis C, syphilis and malaria. Of these, 391 blood units tested positive using an HIV rapid test.[17]

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

Viet Nam has achieved significant results on prevention of mother to child transmission. HIV testing coverage for pregnant women increased from 36.7% in 2011 to 49.7% in 2013. ARVs for prevention of mother to child transmission have also improved. In 2013, out of an estimated 2,981 pregnant women diagnosed as HIV-positive during pregnancy, 1,664 mothers and 1,770 infants received ARV prophylaxis. Early infant diagnosis using virological testing is being expanded and in 2013, 1,985[18] infants received early infant diagnosis and were referred to pediatric care services, indicating a significant increase of the coverage of this service from 26% in 2011 to 68% in 2013 (Figure 12).[17]

[18] Including children born in 2012 who were tested for HIV in 2013

Figure 12: HIV testing and ART coverage for pregnant women by year



PMTCT services have now been integrated into the reproductive health system. HIV testing for pregnant women has been decentralized to commune health station and HIV testing and counseling for pregnant women were conducted at commune health stations during antenatal care visits. In Treatment 2.0 piloting communes, pregnant women were counseled and screened for HIV and received results within 30 minutes if the results were negative. The feasibility of HIV testing at commune health station where pregnant women received ANC services will contribute to improve the coverage of HIV screening for pregnant women. Linkage of HIV positive women to HIV care and treatment services was also strengthened to minimize loss-to-follow-up between the various elements of the PMTCT cascade.

'National Strategy on Population and Reproductive Health 2011-2020' addressed the linkage between SRH and HIV. MoH Viet Nam is planning to fully integrate PMTCT into MCH system by 2015. Moreover, a national action plan on maternal and neonatal health for the period 2011-2015 has strongly addressed the integration of maternal health care and PMTCT services at service delivery points and at different referral levels. Provision of HIV, HBV and syphilis testing to pregnant women was recommended as a part of the ANC package in the national guidelines for reproductive health services (Decision No. 4620/QD-BYT). However, it has not been implemented due to unavailability of necessary resources. A comprehensive model for prevention of mother to child transmission of HIV, HBV and syphilis was piloted in Pho Yen district, Thai Nguyen province, where 98.6% of 3,498 pregnant women were tested for HIV, HBV and syphilis as part of routine ANC. Prevalence of HIV, HBV and syphilis were 0.17%, 8% and 0.03%, respectively and the provision of HIV, HBV and syphilis testing was well accepted by pregnant women. Following WHO consolidated recommendations 2013 on early ART for pregnant women (Options B+), the Ministry of Health has decided to pilot Option B+ in 6 provinces to assess the service delivery model for further expansion.

Despite the improvement of the PMTCT program, Viet Nam is facing many challenges. External funding for HIV has declined significantly while the government budget for the HIV program has also reduced. The funding for HIV tests among pregnant women is facing many significant challenges, with donors reducing their support for these tests and health insurance not yet covering HIV tests of pregnant women. This has been resulting in restrictions to the intervention scale of PMTCT. As the HIV epidemic in Viet Nam has mostly been driven by male injecting drug users, most pregnant women acquired HIV from

husbands/partners who are injecting drug users. Therefore, reduction of new HIV infections in key populations will contribute to the reduction of new infections among pregnant women. In addition, expansion of ART for key populations, especially for people who inject drugs, will optimize the benefit of ART in prevention of HIV transmission and contribute to the reduction of HIV infections among female partners of people who inject drugs. Although, late diagnosis during labor has improved, it is still a major factor for mother to child transmission. Improvement of early diagnosis and early ART for pregnant women are considered as priorities to reduce new infection among newborns in Viet Nam.

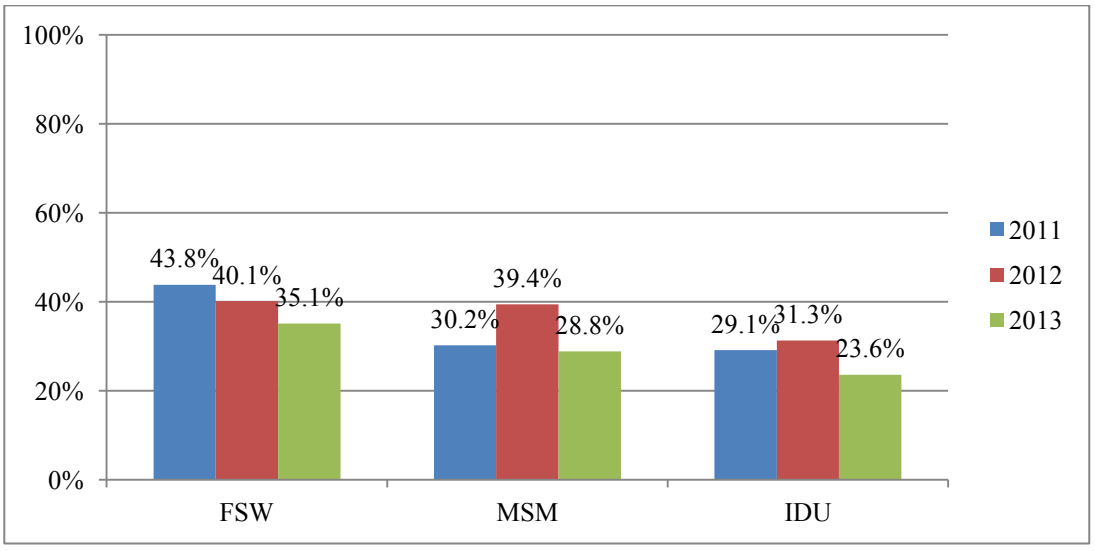
Voluntary HIV Counseling and Testing (VCT)

Viet Nam's VCT program has been scaled up in recent years, with the number of VCT sites and VCT clients increasing from 157 sites in 2005 to 244 sites in 2008, 256 sites in 2009, 317 sites in 2011, and 485 sites in 2013. Low performance VCT sites with a low number of visited clients have been closed.

The number of people who received VCT services during 2013 was 569,061, which indicates a significant decrease in comparison to that in 2011 (851,470 people); among those received VCT services in 2013, 517,329 people tested for HIV. However, there is regional variation in VCT uptake: VCT sites located in Ho Chi Minh City, Ha Noi, Hai Duong and Thanh Hoa attracted large numbers of clients, while those in Binh Dinh and Gia Lai only tested around 10 clients per week.[17]

According to the 2013 HSS+ and IBBS survey, the percentage of key populations at higher risk who received a HIV test in the last 12 months and knew the results was 35.1% among FSW, 23.6% among male PWID and 28.8% among MSM. These results show a slight decrease compared to those of the 2011 HSS+ (Figure 13).

Figure 13: Percentage of FSW, PWID, MSM who have received an HIV test in the past 12 months and know their results (Source: HSS+ and IBBS)



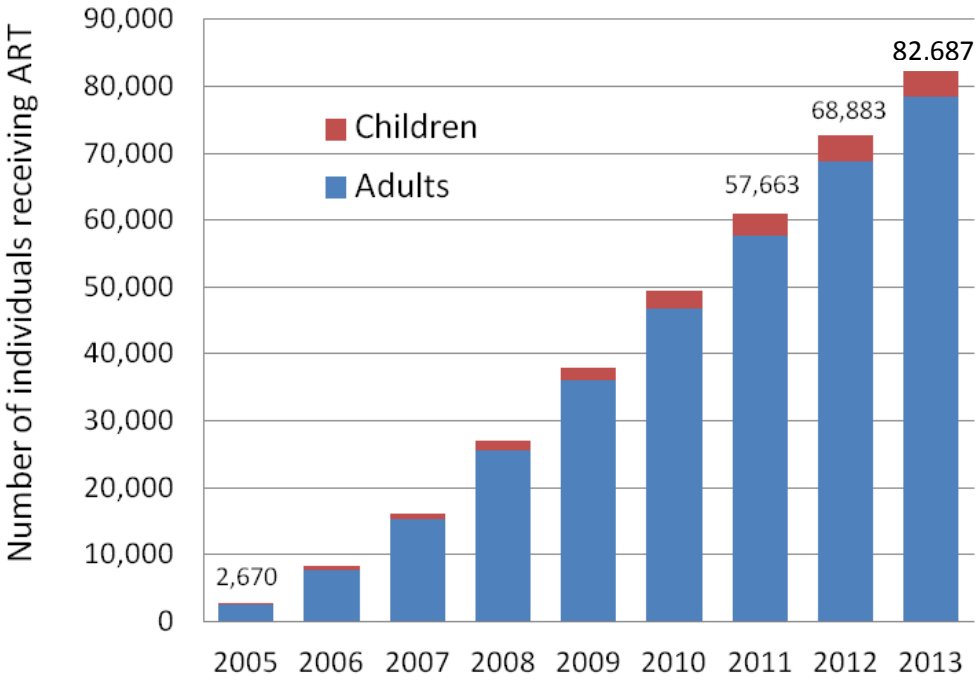
A testing algorithm using three rapid tests was implemented in 21 commune health stations with technical and financial support from WHO. The initial validation process showed the results of negative and positive specimens were consistent with the results of confirmatory lab tests. This confirmed that commune health staff are capable of performing three rapid tests for HIV confirmation which support and advocate for simplification of the HIV testing procedure. VAAC will now develop and validate the national HIV testing algorithm in 2014.

5. Treatment, care and support

Viet Nam continued remarkable scale-up of antiretroviral therapy (ART) in the reporting period. At the end of 2013, a total of 82,687 people (78,438 adults and 4,204 children) were receiving ART in Viet Nam

(Figure 14). This is an increase of 31 times the number of people on treatment in 2005, and 43% increase in the past two years. ART coverage also increased to 67.6% in 2013 (66.0% in adults and 78.1% in children), against current eligibility criteria per national guidelines (CD4<350 cells/ml^3 in adults). ART is delivered at 364 HIV outpatient clinics (OPC) at the end of 2013, among which 56 OPCs provide services to in close settings.[17]

Figure 14: Number of individuals receiving ART in Viet Nam from 2005 to 2013



Viet Nam Authority of HIV AIDS Control (VAAC), Ministry of Health, took strong leadership in planning, managing and coordinating the scale-up of HIV treatment and care programs. Various legal documents were developed or revised, such as the new protocol on managing people receiving ART (Circular 32), guidelines on viral load testing (Decision 1921), and a set of documents to promote TB-HIV collaborative activities (Decision 2594, 2496, 2497 QĐ- BYT dated 18/7/2012). The proportion of retention after 12 months of ARV treatment in 2013 was 84.6% and remained stable over the past years and met the WHO target (over 80%). Assurance of ARV supply has been sustained to ensure no ART interruption due to ARV shortage.

International development partners continued to provide significant financial and technical support for HIV treatment and care scale-up, with major financial support provided by United States (US) Government through the President's Emergency Plan for AIDS Relief (PEPFAR) and Global Fund to Fight AIDS, tuberculosis and malaria (GFATM).

On the other hand, many challenges still remain. The national target is to reach 70% coverage (among those with CD4 <350 cells/mm3) or 105,000 people on ART by the end of 2015, and thus further treatment scale-up is critical. It was found that though patients were accessing treatment earlier than previously (51% with CD4<100 in 2011), late access to treatment remained a significant problem. According to data collected from 68 OPC for adults in 2013, the proportion of patients having CD4<100 at ART initiation was 36.1%, and a further 24% had a CD4 count of 100- 250 cells/mm3, (HIVQUAL 2013 Report). Continued efforts are essential to promote earlier initiation of ART. However, in parallel with this, 94% of people receive ART supported by external donors.[19] As Viet Nam gained middle income country status, the amount of external funds, including those supporting HIV treatment and care began to decrease. Furthermore, the Government of Viet Nam has also made the decision to reduce the funds for

[19] 72611 adults and 4204 children receive ART with support from external donors at the end of 2013.

the national target program on HIV prevention and control for the year 2014, this has increased the burden of financial shortage for HIV AIDS prevention and control in general and ARV treatment expansion in particular. How to further expand access to treatment, in the context of declining funding, without compromising quality of services and health outcomes, has become a critical issue. In addition, HIV treatment and care service delivery has not been fully integrated into the health system, although transition to a more integrated service delivery model has been explored.

In order to address these challenges, VAAC and partners have made considerable efforts and achievements. To promote long-term sustainability, the Prime Minister has approved the project on "Ensuring financial sustainability of the response to HIV in 2013-2020", which aims to diversify financial resources for the HIV response, including through health insurance and public-private partnerships. As part of the efforts to expand the evidence base on the costs and resource needs estimation, VAAC has completed a costing analysis and has disseminated the results.[20] A plan to sustain Viet Nam's access to quality and affordable anti-retroviral medicines beyond 2015 is currently under development.

Since July 2012, VAAC also piloted the UNAIDS/WHO-proposed "Treatment 2.0" approach in 21 communes in Can Tho and Dien Bien provinces. The pilot was aimed at expanding earlier access to ART, while promoting sustainability of HIV treatment by integrating related services into primary health care systems. The results demonstrated clear needs for HIV testing and counseling (HTC) at commune level, and community partners (e.g. peer educators and village health volunteers) have great potential to help key populations to gain knowledge on the benefits of early testing and treatment, to create a demand for testing, and to refer people to testing services. People diagnosed at communes in Dien Bien province had a higher median CD4 count, than those diagnosed at district facilities, when they initiated ART, this is an indication that they accessed the life-saving treatment sooner after infection.

With growing evidence showing that antiretroviral treatment can effectively prevent HIV transmission, various initiatives were introduced, aiming to enhance preventive benefits of ART in addition to its therapeutic benefits. VAAC, WHO and CDC conducted a mathematical modeling study, using data from Can Tho province, to examine the effective strategy to expand ART. The study found that the periodic offering of voluntary HIV testing and counseling (HTC) and immediate ART initiation among key populations will likely lead to significant reduction in new HIV infections and AIDS deaths. VAAC and other stakeholders also started an implementation study to assess the feasibility and acceptability of providing couples with HTC and immediate treatment for positive partners in serodiscordant couples (SDC) in 2 provinces (Dien Bien, Can Tho). By the end of 2013, 126 HIV positive partners started ART irrespective of CD4. Preliminary analysis suggested 78% achieved suppression of virus within the first three months of ART, suggesting the potential of early ART interventions to reduce HIV transmission among serodiscordant couples in Viet Nam.

VAAC and the national tuberculosis program collaborated to develop legal documents to promote the cooperation of the two programs at the provincial level. This includes the adaptation of the WHO 12 point policy package, and the national guidelines on intensified case finding of tuberculosis among PLHIV using four clinical symptoms, and the use of isoniazid preventive therapy; these guidelines were implemented and expanded with support from PEPFAR and GFATM. In 2013, one year after issuance of the Decision 2594, 2496, and 2497/QD-BYT on 18/7/2012 on TB/HIV, the National TB Prevention Project has expanded the PITC for HIV testing among TB patients, which contributed to an increase of 14% of HIV-positive incident TB cases who received treatment for both TB and HIV. However, the reported number has not been updated timely and accurately.

Civil society has made an important contribution in expanding care and support, and the critical role of civil society within a sustainable HIV response is increasingly recognized. PLHIV self-help groups have for many years provided treatment adherence advice and home-based care to their peers. For example, the Sunflowers network of 14 peer support groups is providing services to nearly 2,700 individuals in seven provinces (Hanoi, Quang Ninh, Cao Bang, Thai Nguyen, Ha Giang, Dien Bien and Yen Bai). Each

[20] Duong AT et al. Costing analysis of national HIV treatment and care programme in Viet Nam. J Acquir Immune Defic Syndr 2014;65:e1–e7.

group is supporting the provision of treatment and care and support for HIV-infected mothers, their infants and family within a package of services based on the WHO's four-pronged approach to PMTCT. Treatment-related services include: informing PLHIV about the importance of receiving care; referring them to a range of health services including HIV testing, gynecological check-ups and antiretroviral treatment; and accompanying them to the clinic if they don't want to go alone[21] The achievements of the Sunflowers and other PLHIV groups has inspired the Treatment 2.0 initiative's efforts to mobilize communities of key populations to access HIV testing and treatment services at commune health stations. PLHIV and PWID peer educators and self-help group members are trained alongside hamlet healthcare workers to share with their peers information on the preventative benefits of early diagnosis and treatment; refer key populations to HIV testing at commune level; and then support newly diagnosed PLHIV to enroll into care and initiate treatment.

Efforts have also been made to ensure and improve the quality of HIV treatment and care services. VAAC has introduced and expanded the system for quality improvement, using the HIVQUAL approach, with support from CDC and other partners. By the end of 2013, 68 HIV outpatient clinics (OPCs) in 13 provinces adopted the HIVQUAL, through which the OPC team monitor a set of indicators, and discuss and make actions for quality improvement. It is expected this activity will continue to be expanded to establishments providing HIV treatment for adults and children. It has also been recognized that many people are lost across the continuum of care. VAAC with USAID, FHI360, WHO and other partners has promoted an analysis of the "HIV care cascade" in various provinces, to identify the gaps across the cascade, from HIV diagnosis, linkage to care, ART initiation to long term follow-up, and to guide potential public health action to promote retention across the continuum of care.

Viet Nam has implemented activities to prevent and monitor HIV drug resistance activities since late 2008. These activities included: collecting and analyzing HIV drug resistance early warning indicators; surveys on levels of HIV drug resistance among the community (HIV drug resistance through transmission) and surveys on acquired HIV drug resistance among patients after 12-months and 24-months of treatment. Preliminary results in four OPCs showed that the proportion of HIV drug resistance among patients after 12-months of treatment was at a low level (2.9%). VAAC is now conducting an evaluation of HIV drug resistance among patients after 36 months of ARV treatment. Results from the survey on HIV drug resistance through transmission indicated that the transmission of HIV drug resistance in Viet Nam has remained at a low level, however, for some specific drugs the transmission has been at the medium level.

HIV drug resistance early warning indicators have been monitored at an increasing number of HIV OPCs annually, with 91 clinics monitored in 2013, in order to detect factors at each clinic which may increase the risk of HIV drug resistance emergence. To monitor adverse events of antiretroviral resistance, VAAC in collaboration with national center for drug information and pharmacovigilance, has implemented cohort event monitoring at six OPCs. With support from WHO, an innovative called "targeted spontaneous reporting" has also been piloted in three provinces. The pilot found that the quantity and quality of the reports were significantly improved compared to conventional spontaneous reporting.

However in recent years, funding for HIV AIDS prevention and control has declined significantly. At the same time, the target for ARV treatment has increased from 84,000 to 105,000 patients. The funding reduction will obviously lead to a lack of ARV provision to PLHIV, and poses a risk of further HIV outbreak and an increase in drug resistance; treatment regimens may need to be changed continuously.

6. Civil society involvement

Expansion and strengthening of the CSO network

A significant improvement for civil society involvement in the national response in the period 2012-2013 is the establishment of VNSW (sex workers network) in 2012 and VNMSM-TG network in 2013 as well as the expansion of existing VNP+ and VNPUD networks. The Viet Nam Network of People who Use Drugs

[21] Medical Committee Netherlands-Viet Nam. *Turning towards the Sunlight: An Evaluation of MCNV's HIV Program in Northern Viet Nam*, June 2012.

VNPUD was established in 2012 and it started with 20 group members. In the same year, the Viet Nam Network of Sex Workers (VNSW) was established with 10 member groups. By end of 2013, there were 56 group members of the VNPUD and 12 group members of the VNSW.

In 2013, the Viet Nam Network of MSM & transgender people (VNMSM-TG Network) was launched, immediately having 91 registered groups across the nation. Additionally, faith-based organizations participated in the network of Asia Pacific faith-based organizations working on HIV AIDS.

The number of CSOs with legal entity status has increased, and a small but growing number of local NGOs have demonstrated increased capacity for national advocacy, technical leadership and implementation. These networks have developed linkage and coordination at Central and local level with relevant government agencies, VAAC, MOH project component, PAC, health services, DOLISA, Provincial Union of Science and Technology Associations, the Youth Union and the Women's Union, ...

Increased recognition of the government on the CSO's contribution to the national response to HIV

Government bodies have a greater recognition of the role of CSOs in the HIV response and CSOs have a stronger voice. The Government's representatives participated in CSO workshops and recognized civil society contributions in HIV AIDS prevention and control. For example, in September 2013, the Viet Nam Union of Science and Technology Associations (VUSTA) in collaboration with the National Committee on AIDS prevention and control, and drug abuse, prostitution prevention and control; and the Ministry of Health organized a workshop "Enhancing participation and effective operation of the society organizations in the implementation of the National Strategy on HIV AIDS Prevention and Control". H.E. Nguyen Xuan Phuc, Deputy Prime Minister of the Government of the Socialist Republic of Viet Nam, and leaders of the Party, National Assembly and the Fatherland Front attended the workshop. Addressing the workshop, the Deputy Prime Minister said the Government would pay attention to ensure the removal of the difficulties faced by members of key affected populations and create an enabling environment for the operation of CSO's. Therefore, VUSTA is now in a better position to promote the voice of civil society. Another example is that at the opening ceremony of the VNSW and VNMSM-TG networks, Department of Social Evil Prevention of MOLISA and VAAC representative attended and gave a speech to support the establishment of these networks. CSO representatives were invited by government agencies to participate in the development of legal and policy documents as presented in the paragraph below.

Participation in advocacy and development of legal and policy documents

The presence and representation of CSOs in HIV AIDS prevention and control gave a voice to the community, contributing to advocacy, development and amendment of key legal and policy documents; such as, (i) the Law on sanction of administrative violations, and (ii) documents providing guidance on its implementation, decrees on sending drug addicts to compulsory detoxification establishments which require the court's files and specific enforcement process, (iii) National Strategy on HIVAIDS Prevention and Control till 2020 and the vision to 2030, and four Programs of Action, (iv) Decree 110/2013/ND-CP dated 24/9/2013 which does not cinsider same-sex marriage is not a violation and therefore is not subject for a sanction, (v) Decree 136/2013/ND-CP which took effect on 01/01/2014 in replacement of Decree 67/2007/ND-CP and 13/2010/ND-CP had positive changes with an increase of allowances for the children affected by HIV and their care givers and assure confidentiality for HIV infected children and care takers.

Representatives of CSOs have participated in the Vietnamese delegation that attended the 11th International Congress on AIDS in Asia and the Pacific in 2013. In addition, VUSTA, an umbrella organization for NGOs and CSOs contributing to the HIV response, had an opening speech at the plenary session of the 5th National Scientific Conference on HIV and AIDS in 2013 and as part of this conference, a satellite workshop on CSOs was organized, attracting the wide attention of the community of organizations working in HIV AIDS. The annual 2013 conference on the participation of CSOs in the national AIDS response was organized with participation of more than 100 representatives of community-based groups of people living with HIV and those who have a high risk of infection. In the workshop the

strategic plan for participation of civil society organizations on HIV AIDS prevention was developed using a participatory approach.

VNP+ continues to play a role in policy advocacy, conducting research to provide evidence for improvement of intervention programs, as well as strongly advocating for articles relating to ARV in the Free Trade Agreement, and conducts activities on Pre-Grant Opposition to oppose the patent application for ARV second-line drugs that is produced by Abbott.

VCSPA, a forum of more than 200 networks and CSOs which has contributed to the development of the VNPUD, VNSW and VNMSM-TG, implemented several policy advocacy activities. In 2013, a significant improvement in the participation of the VNMSM-TG network is that several advocacy activities; such as VietPride or the ISEE/ICS's campaign and consultation process, were organized to call for support to same-sex marriage and non-stigma and non-discrimination against this community. However, the draft Law on Marriage does not yet recognize same-sex marriage and it will still take more time for the advocacy efforts to see real results; since 11/2013 there are no longer sanctions against same sex marriage.

Service provision

Linkages within HIV-services and with other health and non-health services have been strengthened to provide comprehensive services to beneficiaries, especially through the participation of CSOs. CSOs play a critical role in implementing prevention interventions at community level, such as; IEC/BCC, peer education, VCT, condoms, needle & syringe distribution, legal counseling and support. For example, the Global Fund project implemented by VUSTA and CSOs reached over 24,000 people in 10 provinces in 2013, provided HIV information and prevention services. CSOs play an important role in referring clients to OPC and supporting treatment adherence, delivering home-based care and providing social, psychological and economic support to PLHIV and their family. CBOs, self-help groups, and networks of PLHIV have contributed greatly to stigma and discrimination reduction by raising their voices in workshops, forums and conferences; the increasing self-motivation, self-reliance and self-confidence of these community groups has contributed to S&D research; anti-S&D monitoring in health care services, in community and on media; and the development and implementation of an anti-S&D model in the community.

Research, Monitoring and Evaluation

CSOs' representative contributed actively in revision of the National M&E Framework in 2012. The new M&E framework has now included civil society in its M&E and reporting system. CSO's representatives have participated actively to contribute to the preparation of the stock taking report, and the UNGASS 2012 and 2013 reports.

CSOs have conducted several research and evaluation studies; such as, the Stigma Index by VNP+, the evaluation of the citizen program by VNP+, Women using drugs by SCDI, the Drug user network by VNP+, Access to Treatment by VNP+, Alcohol abuse – S&D – risk behaviors among MSM by CCRD, etc.

In 2013, the MoH in collaboration with UNAIDS conducted 2 trainings on M&E for members of self-help groups of PLHIV and people who have high risk of HIV infection. VNP+ also conducted several capacity building activities for its members.

Resource mobilization

Despite the limitation in funding from the state budget for CSOs, CSOs and CBOs have implemented successful activities at community level and developed sound proposals which draw attention and funding from donors and INGOs. In 2013, VUSTA and local NGOS and CSOs successfully applied for and received the second round of the Global Fund round 9 grant. Several local NGOs also received funding directly from donors such as AusAID, USAID, Irish AID, etc.

Main challenges

The lengthy and complicated approval procedures for the establishment of CSOs have caused difficulties for CSOs to obtain a legal personality, causing difficulties in implementation of activities and fundraising.

The capacity of CBOs is limited and the organization and human resource structure is often not stable.

There are limited and unstable financial resources available to support the operation of CSOs, and CSOs are only just in their developmental stage now as funding is reducing.

The linkage between the state and CSOs is still limited. There is no clear existing guidance on management between the State and CSOs and there is no mechanism in place to manage the distribution of funds from the State to CSOs. There is also a lack of regulatory mechanisms to enhance participation and contribution of CSOs in socioeconomic development.

IV. BEST PRACTICES

1. Development of the 06 Detention centers renovation plan and closure of 05 centers and policy change on sex work

In the past years, remarkable efforts have been made to review and gradually shift from a punitive approach to a community-based harm reduction approach. One of the key successes is the approval of the Law on the Handling of Administrative Violations in 20 June 2012. The Law puts an end to the compulsory detention of sex workers (came into force in July 2013), and establishes court procedures for sanctioning compulsory treatment to drug dependent people (came into force in January 2013).

An Ordinance and several Decrees guiding the implementation of this new law have been developed to promote community-based detoxification. The Decree 221/2013/ND-CP does not send people to compulsory detoxification centres who are under community-based detoxification programs in accordance with Decree 91/2013/ND-CP, people who are under MMT according to Decree 96/2012/ND-CP etc.

The project on drug treatment reform on the basis of scaling up voluntary, community-based treatment and care was approved on 27/12/2013 (Decision 2596/QD-TTg), according to that provision 80 of the 107 centers will be reformed to provide voluntary and friendly detoxification with possible MMT service provision in 2014. In 2013, the MOLISA has supported 04 centers to be reformed into voluntary treatment centers. The renovation plan will help PUD to have better access to HIV prevention, care and treatment as well as MMT. The MOLISA has developed the Decision of the Prime Minister which supports loan schemes for detoxified PUD, MMT patients, PLHIV and SW. UN agencies, international and local NGOs, civil society organizations and groups of PLHIV, drug users, sex workers and MSM have engaged actively in the review, revision and development of this legislation and policy.

As a result, women who sell sex are no longer being detained on charges of sex work in compulsory centers (05 Centers). A pilot model was implemented by MOLISA, in collaboration with WU, FU, etc to provide community-based support to SW, including harm reduction, economic empowerment, and social and health services. Some provinces such as HCMC, Khanh Hoa, and An Giang have allocated local budgets to fund the loan scheme as well as to support vocational training fees.

With regards to the reformed community-based detoxification initiative, 4 provinces developed and implemented this model. Another 23 provinces, with support from MOLISA, are developing the model "Community-based counseling, care and support site for drug detoxification". In 2013, the number of PUD under community-based and family-based detoxification program accounted to 23% of all detoxified cases. Community-based post-detoxification management was provided to 8,986 people and accounted for 61.4% of all post-detoxified cases. The number of PUDs who received loan and job placement support in 2013 was 5,398, which marks an increase of 30% in comparison to that of 2012.

2. Viet Nam's Treatment 2.0 initiative[22]

Despite the remarkable scale-up of ART in Viet Nam, significant challenges remain to be addressed. HIV diagnosis commonly occurs at a late stage of infection with subsequent late initiation into treatment. These factors contribute to increased mortality among PLHIV and limit the preventive benefits of ART. Ongoing stigma and discrimination, coupled with punitive laws and administrative detention for drug use, impedes access to HIV diagnosis and other services among key populations, such as people who inject drugs. In addition, recent years have seen a decline of overseas development assistance for Viet Nam, including the HIV response.

[22] This contribution story contains excerpts from the final draft of the "*Evaluation Report, Treatment 2.0 Pilot, Dien Bien & Can THo Provinces, Viet Nam*" that was co-produced by the Ministry of Health/VAAC, the Hanoi School of Public Health, UNAIDS and WHO.

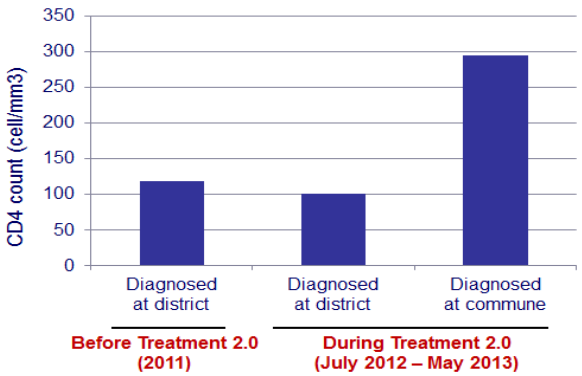
Faced with the above challenges, the Ministry of Health's Viet Nam Authority for HIV AIDS Control (VAAC) has been an early adopter of the WHO-UNAIDS "Treatment 2.0" initiative, which aims to catalyse the next phase of HIV treatment scale up and achieve sustainable universal access to treatment through focused work in five priority areas: 1) optimize drug regimens; 2) provide point of care diagnosis; 3) reduce costs; 4) adapt delivery systems and 5) mobilize communities. Two provinces were selected for a Treatment 2.0 pilot: Dien Bien and Can Tho. The pilot was implemented in 21 communes across the two provinces. HIV testing and counseling was decentralized to commune health stations, where commune health staff performed rapid HIV screening tests. Village healthcare workers and PLHIV self-help group members were mobilized to bring key populations[23] to commune-level HIV testing and district-level treatment initiation. Less toxic, one-pill-a-day antiretroviral medicines were also provided in the pilot areas. After initiating treatment at district level and ensuring their condition was stable, HIV positive patients were transferred to commune health stations for routine follow up. Alongside these activities a costing study was initiated to determine the costs of scaling up the pilot approach.

After one year of implementation, the following results were achieved:

- *Clear demand for commune-level HIV testing:* An average of 20 people per month accessed HIV testing per commune in Dien Bien. In Can Tho it was an average of around 30 per month per commune.
- *Stronger community mobilization:* The number of successful HIV testing referrals by community members increased, from 159 during the baseline period of 2011 to 929 during pilot implementation.
- *Earlier diagnosis and treatment initiation:* People diagnosed at commune level in Dien Bien province had a higher median CD4 count when they were enrolled in care and when they initiated ART, an indication that they were being diagnosed sooner after infection (Figure 15).
- *Quicker linkage to care:* before Treatment 2.0 the median number of days from receiving HIV testing results to determining treatment eligibility and initiating treatment in Dien Bien was more than 150 days. During the pilot, this period was reduced to a median of 28 days for patients diagnosed at commune level. In Can Tho, the reduction was from more than 34 days to 20 days.

There were also challenges experienced during the first year of implementation. HIV-related stigma and discrimination remain powerful barriers to service uptake, and some patients reported that commune healthcare workers do not adequately protect patients' rights of confidentiality. In addition, it is necessary to have greater efforts in providing on-site training to health workers at the communal level. Case monitoring and management from diagnose to treatment should also be developed to avoid losing track and support long-term treatment retention.

Figure 15: Median CD4 count at ART initiation in Treatment 2.0 pilot districts in Dien Bien province



[23] The key populations targeted in the pilot were people who inject drugs and their sexual partners. Pregnant women were also targeted for HIV screening tests.

Despite these challenges, the Treatment 2.0 pilot has successfully decentralized HIV testing and treatment services to commune level, and this is leading to improved health outcomes, especially for people who live far away from district-level HIV clinics. Interviews with patients suggested that HIV testing at commune health stations was convenient and saved time, and they reported that commune health care workers had a friendly attitude. Similarly, patients reported that managing their treatment at commune level resulted in lower transport costs and lower opportunity costs, such as the cost of taking a day off work to get a check-up and receive a new batch of medication.

The Government of Viet Nam will expand the initiative in 2014, with greater focus on remote and mountainous areas with middle to high HIV burden, as well as other adjustments to respond to the above challenges. WHO and UNAIDS will continue to provide financial and technical support to the initiative.

3. Strengthening of the linkages between HIV services and Maternal and Child Health and Sexual and Reproductive Health.

Given the declining international funding for HIV programs in Viet Nam since the country attained middle income country status in 2010, it has been crucial for the country to strengthen the linkages between HIV AIDS intervention programs, including VCT and PMTCT, and other related health care programs such as maternal and child health (MCH), family planning (FP), and RTI/STI settings, to sustain the provision of HIV AIDS commodities and services. However, the public healthcare system of Viet Nam comprises of vertical organizational structures, including healthcare networks for MCH, HIV AIDS, STD/STIs and FP. The interactions and exchanges among those networks, including provision of services, referral systems, and follow-ups are therefore limited. The private health sector has not been yet officially recognized as part of the healthcare system.

Following the introduction of the regional guidelines "*the Asia-Pacific Operational Framework for Linking HIV/STIs Services with Reproductive, Adolescent, Maternal, New-born and Child Health Services"* in 2008*,* a great effort has been made to promote strengthening of linkages between HIV and SRH. By 2012, pilot models on HIV/SRH linkage have been conducted in low HIV contexts such as Tien Giang and Ninh Thuan. Linkages between SRH/HIV policies, programs and services have been strengthened in these provinces. Lessons learned from these pilot models have provided inputs for MCH departments and VAAC to draft National Guidelines for Strengthening SRH/HIV within the existing health care systems.

In 2012, with support from UNFPA, the MCH department has expanded the pilot SRH/HHIV linkage models in the high HIV prevalence context of Quang Ninh and Dien Bien provinces. A needs assessment for strengthening HIV/SRH in Quang Ninh and Dien Bien provinces was conducted in 2012. Based on the findings, intervention models have been designed to fit with the local needs of SRH/HIV, including human resources, staff capacity and local infrastructure. In 2013, MCH and other concerned departments of the MOH continued to implement the designed HIV/SRH linkage models in these two provinces.

4. Developing and strengthening CSOs and CBOs through the VUSTA Global Fund Project

Effective participation and contributions of CSOs and CBOs were recognized in the *Viet Nam 's Global AIDS Response Progress Report 2012, reporting period 1/2010 – 12/2011*"

In this round of reporting, "the increasingly active and extensive participation of CSOs in the national response" has been evidenced to be among the best practices of the previous two years. The development and strengthening of CSOs and CBOs has greatly contributed to the implementation of the national response:

In governance and leadership, VUSTA and several NGOs made monitoring visits on HIV AIDS activities in 10 provinces and cities, conducted many activities in the National Month for HIV AIDS Prevention and Control, and participated in the 5th National Scientific Conference on HIV AIDS. Notably, Deputy Prime Minister Nguyen Xuan Phuc and members of the National Committee on HIV AIDS, Prostitution and Drug Prevention and Control attended the Workshop "Strengthening effective

participation and activities of CSOs in the implementation of the National Strategy on HIV AIDS Prevention and Control" organized by VUSTA in 9/2013.

In the policy and legislative environment, VUSTA collected opinions of CSOs regarding the approval of the Law on Handling Administrative Violations which puts an end to the practice of sending sex workers to administrative detention centers and closes these centers. In addition, it ensures that drug users are subject to legal due process and have the right to legal representation.

In multi-sectoral collaboration for HIV AIDS prevention and control, VUSTA linked CSOs and CBOs with relevant state agencies from the central to the local levels, and improved the quality of service delivery of home-based prevention, harm reduction, care and livelihood support to PLHIV and high-risk groups by CSOs and CBOs

In prevention for HIV transmission, CSOs implemented prevention activities, peer education, behavior change communication, voluntary counseling and testing, livelihood support, and organized exhibitions and photo contests. Notably, CSOs and CBOs played a key role in harm reduction with 4,665 peer educators providing support. These organizations were indispensable in the communication activities promoting condom use, clean S&N use, and communication for methadone treatment for opioid addiction.

In treatment, care and support, the ARV treatment can only have actual results with community groups communicating on ARV treatment adherence and providing home-based care, last-stage care and funeral support.

In organization strengthening and development: In 2013, an additional 76 self-help groups were established and trained, which improved the lives of hundreds of PLHIV, OVC and HIV-affected families in terms of both spiritual and physical aspects. VUSTA and CSOs collaborated effectively to provide services for prevention, care, treatment and livelihood support with the objective of building the capacity for the implementation of the above services. Thus, the role of the community has been improved; HIV AIDS prevention and control has been made more effective with the increased knowledge of the community, and improved levels of discussion and evaluation amongst community members. The reflections from the community perspective have been conveyed to leaders and policy makers and the linkages between the CSOs themselves and between the CSOs and their partners have been made more effective.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

1. Efforts and achievements in resolving the challenges and difficulties mentioned in the 2014 GARP Report (January 2014 reporting for the period of 2012 and 2013)

Over the past two years, the Communist Party, elected bodies and local authorities have further strengthened their commitment to HIV and enhanced the implementation of the National Strategy on HIV AIDS Prevention and Control to 2020 with a vision to 2030 through: (1) improved collaboration between ministries, which has ensured a stronger multi-sectoral response; (2) Closure of 05 centers and policy change on sex work and development of the 06 Detention centers renovation plan; (3) an ongoing focus on prevention, resulting in the expansion of harm-reduction programs, particularly the Methadone Maintenance Therapy (MMT) Program for drug users and interventions for men who have sex with men; (4) Improvement of HIV treatment availability and quality, particularly the successful piloted of the Treatment 2.0 initiative; (5) Strengthening of the linkages between HIV services and Maternal and Child Health and Sexual and Reproductive Health.

2. Main challenges encountered during the period 2012-2013 in implementing the National Strategy and UNGASS commitments

The review process enabled the identification of key challenges that hinder the implementation of HIV interventions.

Insignificant and unstable reduction of the HIV epidemic: although the numbers of PLHIV, new HIV infections and HIV AIDS related deaths have decreased, the reduction has been insignificant, unstable and the level of current HIV incidence remains at a high level. HIV remains a leading cause of death and increase burden of diseases. In 2013, there were 11,567 new infections, on average nearly 1,200 PLHIV were detected each month.[24] The HIV AIDS epidemic has spread widely to all areas; HIV positive people have been identified in 100% of provinces, 98% of districts and 78% of communes/ wards. There are some communes and villages reporting a HIV AIDS prevalence over 10 times higher than the average prevalence of the country, especially areas in mountainous, remote and ethnic minority locations where people still have limited knowledge and services still do not yet address the needs. In some areas, the HIV AIDS prevalence has reached generalized epidemic levels. HIV epidemic and risk behaviors have become complicated and difficult to manage in some areas. HIV sexual transmission is increasing amongst some groups, which is an early warning of the epidemic spreading into the general population, including amongst people who are not thought to be engaged in high-risk behaviors. In addition, it remains very difficult to manage and carry out interventions among high-risk populations including FSW, IDU and MSM.

Policy and legal framework: There are delays in implementation of law and policies. Education on laws and policies is not yet adequate. Knowledge of relevant laws and mechanisms for the implementation of these laws is insufficient and issues relating to legal sanctions have not been properly addressed. Approval of the Law on the Handling of Administrative Violations, which aims to end the practice of sending sex workers to administrative detention and close these centers, and which guarantees due process rights and legal representation to people who use drugs, has been a key success. However, thus far, there has been limited implementation of this law and the actual effects of these legislative changes have yet to be ascertained. There is also limited knowledge about Decree 173/2013/ND-CP (on administrative sanctions for discrimination against PLHIV) among people at the commune level, and in health facilities and enterprises, and thus it is not currently being effectively implemented.

[24] HIV case reporting in 2013. VAAC, MoH 2013

Program coverage is limited and does not yet address the needs, despite a great effort: The uptake and accessibility of HIV services is low among high-risk population groups. The NSP and 100% CUP's coverage has been significantly declining leading to the possibility of renewed HIV outbreak among high risk groups. The rate of expansion of MMT services has been inadequate to meet the demands of PWID seeking treatment. The plan to expand the MMT services to provide treatment for 80,000 people is very difficult to reach; Viet Nam has currently only achieved 20% of the target. Treatment coverage of HIV patients infected with TB remains low owing to their limited understanding of TB detection and treatment. Furthermore, there is a lack of social and economic support for PLHIV and other high-risk population groups who continue to suffer from stigma, discrimination and exploitation and there is currently no dedicated legal service to provide protection for the rights of PLHIV and KAPs. Thus far, the problem of intimate partner transmission (IPT) has also not received adequate attention.

Stigma and discrimination: Stigma and discrimination remains a key barrier for HIV service uptake by key affected populations and with an increasing proportion of new infections being amongst women and girls, special attention needs to be paid to their particular experiences and needs. People who use drugs are among those most vulnerable to HIV infection, drug use is illegal in Viet Nam, creating barriers to accessing vital services and links HIV infection with 'social evils', increasing stigma and discrimination against PLHIV. The 2012-2013 reporting period continued to see incidents of children being denied entry to school; workers living with HIV removed from their positions; the stigmatization of MSM; and drug users being incarcerated in closed settings without access to proper treatment and care services.

Health-system constraints: The national HIV response still relies heavily on international aid and vital programs such as ART and MMT have not yet been fully integrated into the general health system, causing difficulties in implementing the health insurance scheme. Other pertinent issues include a lack of personnel, health facilities, equipment and laboratories. The limited programmatic and management capacity of local institutions can be linked to a lack of staff at all levels within the HIV prevention and control system, and in particular limits the expansion of treatment and harm-reduction programs. It is not only difficult to recruit experienced staff, but existing staff routinely ask to be moved to other areas due to the stresses of the job and unattractive incentives. Capacity with regard to logistics/supply chain management at the commune/health-station level is still limited. While, community organizations have been supported and strengthened, and are now playing a more active role in policy development and program implementation, they continue to face a lack of human and financial resources, hindering them from realizing their full potential.

Limited resources for sustainable programs: Annual funding for HIV AIDS prevention and control was has been falling in recent years. Many donors have already ceased their funding support to Viet Nam 's HIV AIDS activities. Other donors also have revealed plans to withdraw in the coming years. For example, the Global Fund will continue their funding aid until the end of 2015 and PEPFAR until 2018 but the scale of the aid will sharply decrease There is a clear lack of funding for harm reduction, community outreach and VCT since the WB project closed and the HAARP project cut its budget earlier than planned. The funding sources from the National Target Program for HIV AIDS prevention and control will also be significantly cut down by 2/3, from 245 billion in 2013 to 83 billion in 2014. Meanwhile, there are increasingly high targets set for HIV AIDS prevention and control (number of patients receiving ARV treatment increases from 84,000 people to 105,000 people, Methadone treatment, from 16,000 to 80,000 people). Funding reduction will lead to lack of services and ART for PLHIV, possibly causing an increase in HIV incidence in the future. Additionally the risk of HIV drug resistance will increase and the treatment regimen may become less effective and may need to be revised.

VAAC has estimated that to achieve the targets set out by the National Strategy for HIV AIDS Prevention and Control, an additional USD 800 million (or an average of USD 100 million per year) will be needed for bridging the total resource gap estimated for the period 2013–2020.

3. Concrete remedial actions

In a shrinking resource environment, judicious utilization of funding is required to achieve the maximum impact on the epidemic and remain cost effective. This report makes recommendations on the key programmatic and policy changes that need to be introduced for achieving each target.

In the area of policy reform and revision, attention is drawn to the need for sensitizing police, service personnel, and the general population with regards to the vulnerable population groups to ensure adherence to the law and the implementation of related policies and create a more enabling environment. Appropriate implementation guidelines need to be developed for the implementation of the Law on the Handling of Administrative Violations to ensure access to appropriate legal procedures and on the integration and mainstreaming of HIV services into medical services. Supportive regulations and policies must be developed to fill the lacunae in the area of social protection, support and care for PLHIV and children living with and affected by HIV.

There is a need to continue to promote the information, education and communication to raise awareness and responsibility to respond to the HIV epidemic; analyze the consequences of a future outbreak of HIV AIDS; improve the effectiveness of investment programs for HIV AIDS; and ensure social security, poverty reduction and national development strategies are prioritised. Attention must also be focused on the development and implementation of communication models and interventions suitable for mountainous areas, border communities, ethnic minorities and some special groups and hotspots.

In terms of programming for high-risk population groups and their intimate partners, there is a need to develop new approaches for needle, syringe and condom distribution. Moreover, renovation plans on detoxification should be implemented in a large scale to expand voluntary and community-based care and treatment and efforts must be made to scale up voluntary, community-based and comprehensive drug dependence treatment and care. HIV testing should be simplified, expanded and diversified to help people having better access to the services and receive test result in a shortest time. For HIV-positive mothers and their children, expansion and improvement in HIV testing and postpartum services, and integration of prevention of mother-to-child transmission (PMTCT) into Mother and Child Health (MCH) programs is a must. Delivery of antiretroviral therapy (ART) needs to be scaled up and modernized to ensure provision of viable, continued and accessible treatment. The National response must continue to carry out interventions that promote early access to ART to minimize AIDS deaths and HIV transmission and expand ART in close settings. Community mobilization to enhance treatment literacy, support early diagnosis and treatment initiation, and to support retention, is essential. Legal and social support services must be instituted to ensure the elimination of inequality, stigma and discrimination on the grounds of gender, positive status or membership of high-risk population groups. There also needs to be further efforts to mobilize participation of community and CSOs in the national response.

Priority should also be given to reforming the HIV prevention and control system and integrating it into the general health system to promote efficiency, sustainability and decentralization of HIV AIDS prevention and control activities. Developed additional terms of reference for provincial PAC to diversify their roles which include both management, coordination role and provision of HIV-related clinical services. Terms of reference for district health centers should be revised to add a role in provision of HIV-related clinical services so that people's health care fee can be covered by health insurance. Continue implementing the human-resource strategy to retain qualified staff and provide capacity building opportunities for staff at all levels, most especially in the provision, management and coordination of provincial-level HIV efforts.

To address financial challenges, there is also a need to: redefine priorities and coordination to enhance effective HIV investment. Sources of funding will for HIV AIDS will also have to diversify with a move towards reliance on state budget, payment of treatment through health insurance, mobilising contributions from businesses and introducing co-pay mechanisms where people partly pay a small amount for the services they receive. Attention should be paid to enhancing domestic funding; capitalizing on allocative and implementation efficiency gains; integrating health services and improving geographic and thematic prioritization; using efficient alternate models of service delivery; designing and implementing cost effective packages of continuum of prevention, care and treatment services;

harmonizing allocation and management of ODA; and smooth transitioning to alternative funding sources, avoiding disruption of services.

Besides the programmatic recommendations discussed above, Viet Nam must ensure greater political commitment to HIV; strengthen CSO participation in policy development, planning, provision of services, and monitoring and evaluating interventions; and develop closer linkages between HIV and other health, economic and social systems to ensure a viable, holistic and inclusive response to the epidemic and to achieve its targets.

VI. SUPPORT FROM COUNTRY DEVELOPMENT PARTNERS

Due to Viet Nam's economic progress, the country has achieved middle-income country status. As a result, donors have begun to withdraw their funding and are increasingly focusing on ensuring country ownership and the transition of programs to national management. Development partners providing technical assistance and funding for the national HIV response in Viet Nam include:

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

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

The Joint United Nations Team on HIV (hereafter the Joint Team) leads a coordinated UN approach to support the national HIV response, ensuring that each agency provides targeted and effective support on behalf of the Joint Team. The Joint Team organizes joint program and annual review meetings with national implementing partners and civil society to ensure that participation and collaboration are aligned with country needs. Technical support and policy advocacy were provided to influence the development and passage of a new law on administrative violations that puts an end to the compulsory detention of sex workers, establishes court procedure for sanctioning compulsory treatment to drug dependent people and introduces positive reforms to the juvenile justice system. Follow-up support was provided to the development of an Ordinance and several Decrees guiding the implementation of this new law. The UN has also supported the process of drug treatment reform on the basis of scaling up voluntary, community-based treatment and care. Civil society organizations and groups of PLHIV, drug users, sex workers and MSM were supported to engage more actively in the review, revision and development of legislation and policies that have impacts on their lives.

PEPFAR has provided the largest support to HIV programming in Viet Nam. The PEPFAR strategy is to assist Viet Nam in developing the HIV AIDS prevention and control program in a sustainable manner and on a comprehensive nationwide response based on the National Strategy of the Government of Viet Nam, focusing on prevention, care and treatment for HIV patients. The strategy also supports the relevant departments to achieve this goal, including the Viet Nam government (such as the Ministry of Health and other functions and duties related to HIV), the international stakeholders and local non-government organizations and CSOs.

In 2012-13, the World Bank was financing a $35m HIV AIDS Prevention Project in Viet Nam. The specific objective of this project was to support programs designed to halt transmission of HIV AIDS among vulnerable populations (PLHIV, IDUs, CSWs, and their clients and sexual partners) and between these vulnerable populations and the general population. The main concern with respect to the development outcome is sustainability at this high level of performance. The Viet Nam Authority for HIV AIDS Control (VAAC) with the support of the Project has established a transition task force, with representatives from UNAIDS and other key development partners to develop a plan for future HIV AIDS service delivery modalities and activities, in the context of significantly reduced donor funding. Technical

assistance is being provided for developing models of innovative and cost-effective harm reduction interventions. For example, guidelines for commune-level & user-pays methadone treatment, and a draft protocol for rapid HIV testing at the commune level, was completed by December 31st 2013.

In the period 2011-2012, the Global Fund project funded 35.8 million USD to support interventions that have a strong impact and a major influence on high and medium burden provinces/districts. The project enhanced the connectivity of HIV prevention, diagnosis, treatment and care services to increase the effectiveness of programs, and support CSOs to provide community-based HIV prevention, care and support services to PLHIV. This project has been implemented in 53 provinces/cities across the country.

External funding still accounts for the majority of HIV resources supporting the HIV response in Viet Nam. A number of major HIV donors are reducing their funding and/or withdrawing from the country: the WB/DFID program will cease at the end of 2013, PEPFAR has announced a significant reduction in funds for 2012 and warned that funds will continue to decrease in coming years, and the Global Fund has recently cancelled funding for Round 11. With this significant decrease in available international resources, an increase in domestic funding is urgently needed to ensure that recent progress made in the response is not reversed. A sustainable HIV response also requires a focus on transition planning and support for improved multi-sectoral coordination.

VII. MONITORING AND EVALUATION

1. Overview of the current Monitoring and evaluation (M&E) system

Organizational structure

The M&E system is one component of the "Three Ones", and a crucial tool for an effective, efficient, and accountable response to the HIV epidemic. The goal of the M&E system is to provide timely and relevant support for an effective response at national, regional and provincial levels.

Since the new National Strategy on HIV was launched in May 2012 the Ministry of Health has made great efforts to update the M&E system in Viet Nam. This system aims to harmonize the various existing M&E programs in Viet Nam into one National M&E system, with a focus on measuring impact, coverage and program quality. The National M&E system consists of four levels and is based on the existing four-level HIV system in Viet Nam.

- ***At the central level,*** the M&E unit is located at VAAC (Department of HIV AIDS/STI Surveillance).
- ***At regional level,*** there are four M&E units belong to the four regional HIV steering boards, locate at four regional epidemiology institutes:

  The regional M&E unit in the North is located at NIHE, they are responsible for M&E activities in 28 Northern provinces.

  The regional M&E unit in the central provinces is located at the Pasteur Nha Trang Institute, they are responsible for 11 central provinces.

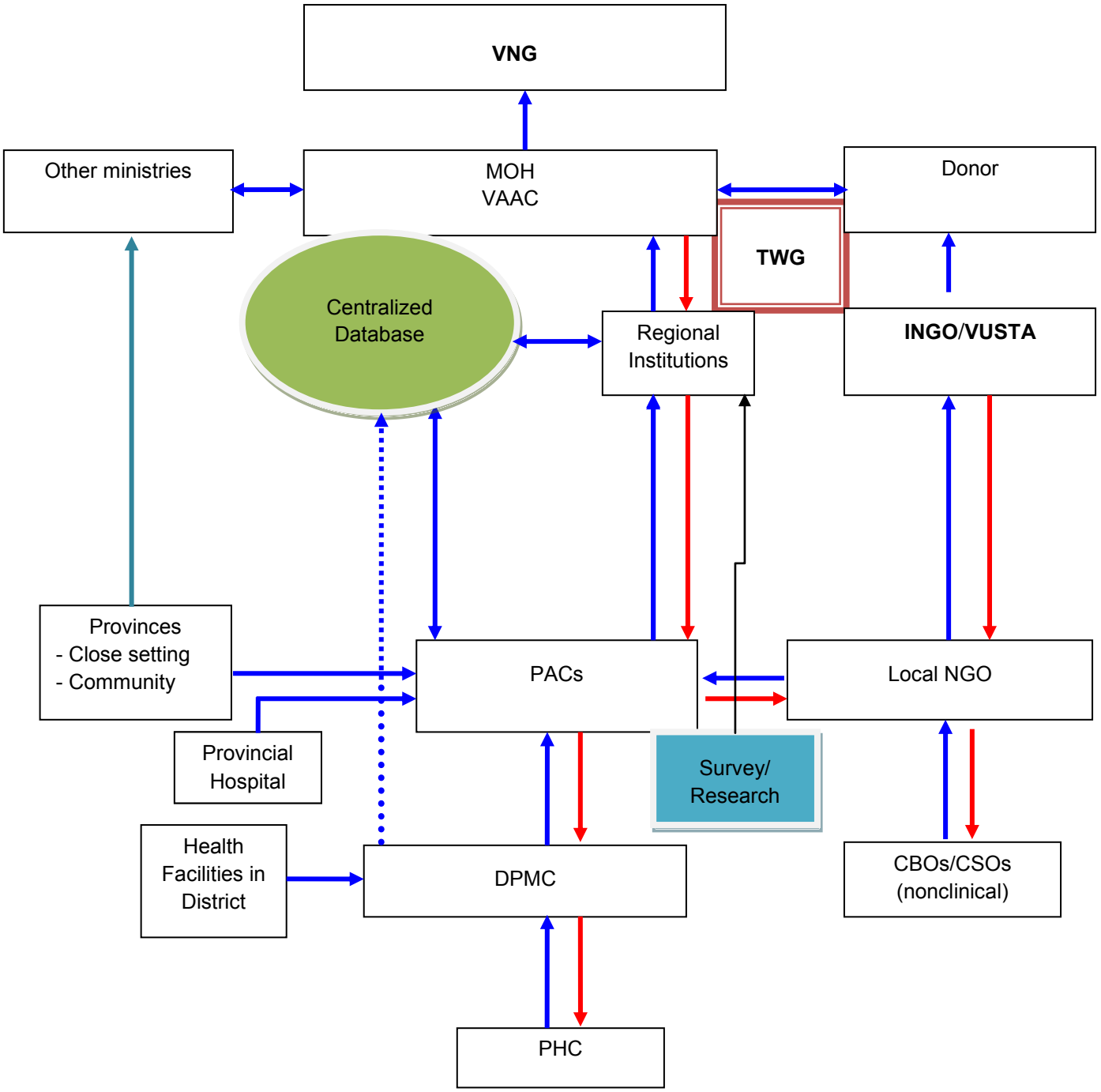
  The regional M&E unit in the South is located at Pasteur Ho Chi Minh City Institute, they are responsible for 20 Southern provinces.

  The regional M&E unit in the central highland is located at Tay Nguyen Institute, they are responsible for 4 Central Highland provinces.
- ***At provincial level*****,** the provincial M&E unit is a sub-unit in HIV AIDS/STI surveillance unit, located at AIDS Center.
- ***At district level*****,** District Preventive Medicine Centers will assign at least one or two full-time and part-time staff.

Additionally, there is a national M&E working group established and coordinated by the VAAC. The staff of regional M&E units, universities and experts from international organizations (UNAIDS, WHO, CDC, USAID, FHI) provide technical assistance on M&E issues.

VAAC and the National SI/M&E TWG conducted an assessment of the National M&E Framework and its alignment with the new national strategy and international updated strategies and standards and have developed the new National M&E plan to 2020. This National M&E Plan is still awaiting final signature and once it is endorsed it will be printed and disseminated.

For an overview of the information flow in Viet Nam, see figure 1.


VNG
Other ministries
MOH
VAAC
Donor
TWG
Centralized
Database
Regional
Institutions
INGO/VUSTA
Provinces
- Close setting
- Community
PACs
Local NGO
Provincial
Hospital
Survey/
Research
Health
Facilities in
District
DPMC
CBOs/CSOs
(nonclinical)
PHC

Human capacity for HIV M&E

In 2012 and 2013, Additional M&E and IT staff were recruited. Refresher training for provincial staff on routine reporting, data management, the use of HIV Info 3.0 in case reporting, and the use of Epi Info in HSS+ was conducted by VAAC and the Regional Institutes. Capacity of the VAAC, Provincial AIDS Committees (PACs) and CBOs has been improved in the generation and use of strategic information and strengthening of the surveillance systems in the country, in particular concerning the use of the Estimates and Projections Package and generation of financial data. In addition, development partners continued efforts to build capacity in this area. In collaboration with UNAIDS, VAAC conducted two training courses on basic M&E for members of CSOs.

In many provinces supported by donors, project-oriented workplans are usually developed for the donor-funded component. Comprehensive, provincial HIV plans that encompass all (i.e. both nationally and internationally funded) prevention, treatment and care activities are not common at the provincial level.

Surveillance system

In 2012, the Circular 09/2012/TT-BYT was issued to guide the implementation of the HIV epidemiologic surveillance and STD surveillance. The surveillance system consists of five components: HIV case reporting, HSS/HSS (+), STD surveillance, size estimates for key populations, and integrated biological and behavioral surveillance.

HIV AIDS case reporting has been in place in all 63 provinces of the country for almost 20 years. The system has grown and expanded over time as the number of VTC (voluntary testing and counseling) sites has expanded, and provider initiated testing has increased at health facilities, including TB and ANC sites. PEPFAR and World Bank have recently provided financial and technical support to improve the case reporting system, including HMIS development of the “HIVInfo” database and staff training. Plans are in place to conduct a systematic evaluation of the HIV AIDS Case Reporting system, and the need to improve the quality and utilization of HIV AIDS case report data is a recognized priority.

HIV sentinel surveillance in Viet Nam has been in place since 1994 providing routine sentinel surveillance data among people who inject drugs (PWID), commercial sex workers (CSW), urban and rural pregnant women, males with sexually transmitted diseases (STD), tuberculosis patients (TB) and military recruits in 41 provinces. HSS (+) began in 7 provinces in 2010, and expanded to 12 provinces in 2011 and 22 provinces in 2013. HSS (+) is similar to HSS, but with the addition of a limited number of behavioral questions. The results of the HSS (+) pilot indicated that the approach can be used to monitor behavioral trends and to estimate incidence (by looking at prevalence in those who recently initiated risk behavior).

Since 2012, efforts have been made to integrate HIV and sexually transmitted infection (STI) surveillance in some provinces to improve the technical efficiency of HIV/STI surveillance and the use of STI surveillance data. In 2013, STI surveillance is dovetailed with HSS in ten provinces.

The fourth component is size estimation for key populations. National level estimates come largely from indirect methods employing such techniques as “population-based proportions” combined with “managed numbers” of sex workers and PWID. At the province level, most use a combination of mapping data from HSS sampling frame development, and data from Department of Labor, Invalids, and Social Affairs, and the Department of Public Security, to estimate numbers of FSWs and PWIDs. Direct size estimation exercises using survey based methods (e.g. capture-recapture and/or multiplier methods) have taken place in selected provinces for selected key populations which is useful for those provinces, but has not yet translated to national level.

The fifth component is the integrated biological and behavioral surveillance. There have been three rounds of IBBS surveys (2006, 2009, 2013) in provinces with PEPFAR funding and also several IBBS surveys (sometimes just a single round) in provinces with WB and GFATM funds.

In 2012 the M&E technical working group played a more active role in trying to coordinate decisions about which data to collect where. As of the result, NIHE & VAAC will lead in setting priorities about which data to collect where; a rapid situation assessment approach should be used to help characterize risk intensity, assess epidemic potential, and determine whether surveillance is needed. An assessment of the surveillance system was conducted in September 2013 and provided recommendations for improvement of the surveillance system.

HIV information management system

In 2012, VAAC conducted an assessment of the implementation of the Decision 28/2008/QD-BYT on the single reporting form and database for routine monitoring and encouraging donors to mainstream their data collection activities in 7 provinces. Based on the results of the assessment and the newly developed National Strategy on HIV prevention and control, VAAC has revised the routine reporting form. The reporting form includes data on:

- Human resources for HIV programs;
- Implementation of IEC/BCC, harm reduction, care and treatment, VCT, PMTCT, safe blood transfusion programs;
- Capacity building;
- Challenges and recommendations from local level.

Additionally, the HIV Info 2.1 software was updated to HIV Info 3.0 which allows M&E staff to more accurately report on HIV cases identified in their location.

Estimates and projections

In 2012 and 2013, the technical working group on EPP has completed the 2013 EPP round, which provides data for the 2013 GARP report. The full EPP narrative report is currently under development.

2. Challenges faced in the implementation of a comprehensive M&E system

- Multiple M&E systems continue to exist in the HIV AIDS prevention and control response, to service separate and specific needs of each donor, and there is lack of coordination between units in collecting and sharing data.
- The quality of data from the D28 report is still limited, due to limited skills of those who collect and compile the data at district and provincial levels. The report has been delayed due to high workload and lack of personnel.
- The current HSS and HSS+ has several concerns, including non-clarity of the protocol, lack of flexibility in the system, lack of justification for choice of geographic location and populations, and concerns about the frequency of data collection, staff overload, diminishing funding from the national government and the donors, difficulties with advocating for resources from provincial and district level governments, inadequate support for training and supervision, and increasing bias and refusal related to such factors as a) insufficient resources for mapping and incentives for PEs, b) low compensation for respondents, and c) increasing number of people being referred to VTCs, who know their status and are therefore less likely to participate in surveillance.
- Although there is periodic mapping (and sometimes rapid assessments), population size estimation is not yet a routine part of the surveillance system, and no standardized methodology for size estimation is in place.

- Meanwhile sufficient personnel and equipment from the central to the provincial level are lacking and the majority of staff has not been trained in this specialized field. Moreover, due to frequent turnover of staff who oversee the M&E activities at provincial level, many trained staff have been reallocated to other departments, leaving untrained and new staff carrying out M&E work.
- The country's budget is decreasing due to its transition to middle income country status and the development of a sustainable service delivery model is severely limited by disparate donor cost and program norms.
- Lack of attention and support from leaders across levels. Misconceptions exist about the relevance and importance of M&E, which is seen only as a reporting and not also a planning tool.

3. Remedial actions planned to overcome the challenges

- Strengthen capacity for the M&E system. Provide technical and financial support for the M&E system at provincial and district levels.
- Harmonization and unification of a set of indicators and data collection tools among different donors, moving toward one M&E system for national programs and all donors-funded projects.
- Re-design the HSS/HSS+ system to be maintained for FSWs, PWID, MSM, and other specific populations, but in a reduced number of sites and with reduced frequency. Use a criterion based approach to select core provinces that are sufficient for informing the national level program about the overall direction of the epidemic.

VIII. ANNEXES

Annex 1. Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV and AIDS

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

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

2. With input from:

Ministries:

Ministry of Education and Training	Yes
Ministry of Health	Yes
Ministry of Labour, War Invalids and Social Affairs	Yes
Ministry of Foreign Affairs	Yes
Ministry of Public Security	Yes
Ministry of Justice	Yes
Ministry of National Defence	Yes
Ministry of Planning and Investment	Yes
Ministry of Finance	Yes
Ministry of Transportation	Yes

Other institutions:

VUSTA	Yes
Women's Union	Yes
Youth Union	Yes
Labour Union	Yes
Viet Nam Red Cross Society	Yes
The Party's Central Commission of Ideology	Yes
National Assembly – Social Affairs	Yes
Civil Society Organizations	Yes
People Living with HIV	Yes
Private Sector	Yes
UN Agencies	Yes
Bilateral and multilateral donors	Yes
International NGOs	Yes

3. Was the report discussed in large fora? Yes

4. Are the surveys stored centrally? Yes

5. Is the data available for public consultation? Yes

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

Name: Dr Nguyen Hoang Long

Title: Director, Viet Nam Administration of AIDS Control, Ministry of Health

Date: 31/03/2014

Signature:

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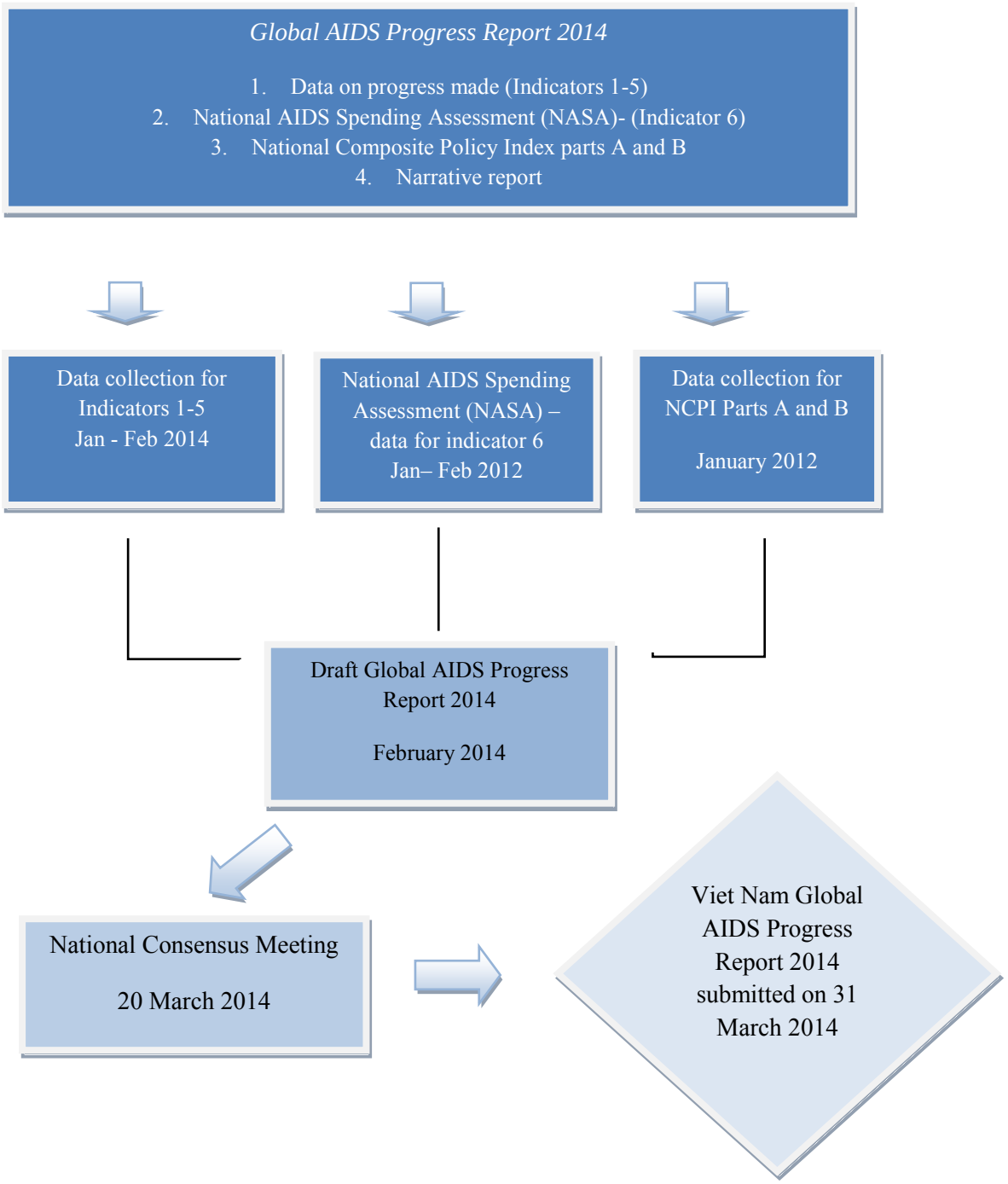
Preparation Process

This report was prepared with broad participation from Government, development partners and civil society. Planning for the report began in January 2014 with the development of a road map for an extensive consultation process. A total of 17 Government agencies, over 40 civil society organizations (self-help groups, faith-based organizations, nongovernmental organizations and international non-governmental organizations), bilateral, multilateral and United Nations (UN) agencies were involved in the preparation of this report. Figure 2 describes the main components of the overall report preparation process.

Figure 2: Viet Nam GARP 2014 reporting process outline



A number of consultants were engaged to support the CPR writing team, which was led by the Viet Nam Administration of AIDS Control (VAAC) and UNAIDS Viet Nam. Local consultants facilitated the collection of data for Indicators 1.1-7.2 and the National Composite Policy Index (NCPI). With regard to Indicator 6(6.1. Domestic and international AIDS spending by categories and financing sources), a national consultant was recruited to collect and process data according to NASA methodology. The results include a database of national HIV and AIDS expenditure detailed by NASA dimensions (financing sources (FS), financing agents (FA), providers of services (PS), beneficiary population (BP) and AIDS spending category (ASC)). The data collection began in January 2014 and finished by end of February 2014. Although incomplete, the data collected and presented in this report is the most comprehensive available to date.

In February 2014 the NCPI Part A questionnaire was sent to members of the National Committee for AIDS, Drugs and Prostitution Prevention and Control. Fourteen Government agencies responded.

Of particular note is the consultation and data-collection process for the NCPI Part B questionnaire. UNAIDS coordinated and organized the participation of civil society organizations (CSOs) in the overall process. UNAIDS held two consultation meetings, one in Ha Noi and one in Ho Chi Minh City, in January 2014 to gather CSO inputs and to discuss and unify the NCPI Part B questionnaire. Representatives from self-help groups, faith-based organizations, and local NGOs contributed actively to the NCPI Part B. Participants at each consultation meeting selected a three-member civil-society task force, made up of people living with HIV, people who inject drugs, men who have sex with men, sex workers and representatives of faith-based organizations to represent them at the national consensus meeting. This extensive involvement of CSOs is testament to the ongoing strengthening of the role of civil society in the national response.

The Joint UN Team on HIV and bilateral agencies attended separate NCPI Part B consultation meetings. At the meeting, participants provided input and reached consensus and completed the NCPI Part B questionnaire.

The NCPI Part B inputs, then, were compiled into one document, 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.

The last step in the development of the progress report was the National Consensus Meeting for the Country Progress Report, hosted by VAAC in Ha Noi on 14 March 2014. The goal of this meeting was to present the findings and give participants an opportunity to review and validate the draft report. A total of 52 participants from 34 organizations representing the Government, development partners and civil society were present. Civil-society participants were drawn from the task forces, which selected five individuals to represent them. Participants provided inputs to the narrative and reviewed the overall report. The amended report, based on the comments received, was then submitted through the Ministry of Health to the National Committee on AIDS, Drugs and Prostitution Prevention and Control for approval.

A full list of participants is below.

Name		Organization
Government organization		
1	Nguyen Hoang Long	VAAC
2	Phan Thu Huong	VAAC
3	Hoang Dinh Canh	VAAC
4	Vo Hai Son	VAAC
5	Do Thi Nhan	VAAC
6	Nguyen Thi Minh Tam	VAAC
7	Do Huu Thuy	VAAC
8	Bui Hoang Duc	VAAC
9	Nguyen Viet Nga	VAAC
10	Pham Tuan Dung	VAAC
11	Quach Van Luong	VAAC
12	Ha Thi Minh Nguyet	VAAC
13	Nguyen Khac Hai	VAAC
14	Tran Van Thang	VAAC
15	Pham Hong Thuy	VAAC
16	Doan Thuy Linh	VAAC
17	Vu Van Chieu	VAAC
18	Pham Tuan Dung	VAAC
19	Nguyen Hoang Mai	National Assembly – Social Affairs
20	Pham Thanh Lam	Department of Health, Ministry of Transportation
21	Vu Manh Tien	Labour Union
22	Pham Thi Lan Anh	Department of Health, Ministry of Public Security
23	Nguyen Dinh Van	Department of Health, Ministry of Public Security
24	Dang Anh Tuan	Ministry of Finance
25	Bui Xuan Long	Ministry of Public Security
26	Le Van Tuan	Ministry of Education and Training
27	Nguyen Thanh Hang	Ministry of Justice
28	Nguyen Thanh Hao	Youth Union
29	Nguyen Thi Tuyet Mai	Women's Union
30	Le Thu Ha	Committee for Ethnic Minorities
31	Ha Truong Giang	Department of Legislation, Ministry of Health
32	Trinh Ngoc Linh	Department of International Relation, MoH
33	Nguyen Thi Hong Lua	National Health Promotion Center
International organization		
34	Alanka Malviya	UNAIDS
35	Nguyen Minh Loc	UNAIDS
36	Patrick Nadol	CDC
37	Ngo Kieu Lan	UNODC
38	Frederique Bourque	UN Women
39	Nguyen Cuong Quoc	FHI 360
40	Nguyen Thi Minh Thu	Clinton
41	Nguyen Minh Nghia	VAAC - US.CDC
42	Estefanvia Guallar	UN Women
43	Nguyen Thi Thuy Van	WHO
44	Masaya Kato	WHO
CSO		
45	Do Thi Van	VUSTA
46	Trinh Thi Le Tram	CCLPHH
47	Dang Van Khoat	CREAES
48	Pham Hoai Thanh	SCDI
49	Nguyen Anh Phong	VNP+
50	Thich Dong Nguyen	Phap Bao Counseling Clinic
51	Hoang Thi Thu Huong	VNSW
52	Nguyen Hoang Liem	VN Glink Vinh Long

Annex 2: NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI) 2014

COUNTRY: VIET NAM

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

Prof. Nguyen Thanh Long MD., PhD.

Vice Minister of Health

Signature:

Address: Ministry of Health

138A, Giang Vo, Ba Dinh, Ha Noi, Viet Nam

Tel: +84 - 4 - 38465731

Date of submission: 31.03.2014

NCPI Respondents

NCPI PART A

Organization	Names/positions	Respondents to Part A					
		A.I	A.II	A.III	A.IV	A.V	A.VI
VAAC	Nguyen Hoang Long	x	x	x	x	x	x
VAAC	Phan Thu Huong	x	x	x	x	x	x
VAAC	Hoang Dinh Canh	x	x	x	x	x	x
VAAC	Vo Hai Son	x	x	x	x	x	x
VAAC	Do Thi Nhan	x	x	x	x	x	x
VAAC	Nguyen Thi Minh Tam	x	x	x	x	x	x
VAAC	Do Huu Thuy	x	x	x	x	x	x
VAAC	Bui Hoang Duc	x	x	x	x	x	x
VAAC	Nguyen Viet Nga	x	x	x	x	x	x
VAAC	Pham Tuan Dung	x	x	x	x	x	x
VAAC	Quach Van Luong	x	x	x	x	x	x
VAAC	Ha Thi Minh Nguyet	x	x	x	x	x	x
VAAC	Nguyen Khac Hai	x	x	x	x	x	x
VAAC	Tran Van Thang	x	x	x	x	x	x
VAAC	Pham Hong Thuy	x	x	x	x	x	x
VAAC	Doan Thuy Linh	x	x	x	x	x	x
VAAC	Vu Van Chieu	x	x	x	x	x	x
VAAC	Pham Tuan Dung	x	x	x	x	x	x
National Assembly – Social Affairs	Nguyen Hoang Mai	x	x	x	x	x	x
Department of Health, Ministry of Transportation	Pham Thanh Lam	x	x	x	x	x	x
Labour Union	Vu Manh Tien	x	x	x	x	x	x
Department of Health, Ministry of Public Security	Pham Thi Lan Anh	x	x	x	x	x	x
Department of Health, Ministry of Public Security	Nguyen Dinh Van	x	x	x	x	x	x
Ministry of Finance	Dang Anh Tuan	x	x	x	x	x	x
Ministry of Public Security	Bui Xuan Long	x	x	x	x	x	x
Ministry of Education and Training	Le Van Tuan	x	x	x	x	x	x
Ministry of Justice	Nguyen Thanh Hang						
Youth Union	Nguyen Thanh Hao						
Women's Union	Nguyen Thi Tuyet Mai						
Committee for Ethnic Minorities	Le Thu Ha						
Department of Legislation, Ministry of Health	Ha Truong Giang						
Department of International Relation, MoH	Trinh Ngoc Linh						
National Health Promotion Center	Nguyen Thi Hong Lua						
VAAC	Nguyen Van Hung						
VAAC	Nguyen Duc Long						

NCPI PART B

Organization	Names/positions	Respondents to Part B				
		B.I	B.II	B.III	B.IV	B.V
CREAES	Dang Van Khoat	x	x	x	x	x
Hai Duong MSM Working group	Nguyen Cong Duong	x	x	x	x	x
Tinh Bien Hai Phong Group	Quach Thi Mai	x	x	x	x	x
Kid's Sun Group	Nguyen Thi Thanh Thao	x	x	x	x	x
SCDI	Khuat Thi Hai Oanh	x	x	x	x	x
VNSW	Hoang Thi Thu Huong	x	x	x	x	x
VNPUD	Pham Thi Minh	x	x	x	x	x
Bright Future Network	Trieu Thi Thu Hien	x	x	x	x	x
Sunflower Network	Vu Thi Phuong Lan	x	x	x	x	x
MSM-TG VN	Vu Bao Huy	x	x	x	x	x
CCRD	Pham Thai Hang	x	x	x	x	x
CCRD	Tran Mai Ha	x	x	x	x	x
CCLPHH	Trinh Thi Le Tram	x	x	x	x	x
ACP+	Nguyen Van Cuong	x	x	x	x	x
Cat Trang Group	Nguyen Thi Van Ha	x	x	x	x	x
Hy Vong An Giang	Tran Thi Thanh Van	x	x	x	x	x
Phap Bao Counseling Clinic	Thich Dong Nguyen	x	x	x	x	x
Phap Bao Counseling Clinic	Le Hong Hao	x	x	x	x	x
G-Link Vinh Long	Nguyen Hoang Liem	x	x	x	x	x
Alo Ban Me	Nguyen Thi Duyen	x	x	x	x	x
VNP+	Nguyen Anh Phong	x	x	x	x	x
VNP+	Lam Ngoc Thuy	x	x	x	x	x
VNP+	Ha Thuy Xuan Hoang	x	x	x	x	x
CARMAH	Le Quoc Bao	x	x	x	x	x
CRCRH	Nguyen Thi Truong Xuan	x	x	x	x	x
UNICEF	Jargalmaa Radnaabazar	x	x	x	x	x
UNWOMEN	Frederique Bourque	x	x	x	x	x
UNAIDS	Alankar Malviya	x	x	x	x	x
UNAIDS	Christopher Fontaine	x	x	x	x	x

NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

PART A

[to be administered to government officials]

I. STRATEGIC PLAN

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

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as MARD, MOF, MHA, MOJ, MPI, MOT, Tourism, Social Works, Minerals and Energy)

☑ Yes	No

IF YES, what was the period covered *[write in]*:

2011 - 2020

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

IF NO or NOT APPLICABLE, briefly explain why.

The National Strategy on HIV AIDS Prevention and Control for the period 2011-2020 with a vision to 2030 was developed in appropriate with the "Getting to zero" commitment of the UNAIDS

The objectives were clearer, more feasible, and based on evidences.

The National Strategy recognized the role of the civil society in HIV AIDS prevention and control and VUSTA was appointed to be the agency which coordinates CSO activities.

The MSM group was paid more attention. The National Strategy indicated them as one of the vulnerable groups that need to be prioritized. There was a plan to scale up the MSM program.

Treatment program: The new strategy demonstrated a more comprehensive treatment, care and support program.

Action plan: Combined action plans into 4 main components: HIV prevention; Comprehensive treatment, care and support; program M&E; and HSS to ensure the sustainability of the program.

Implementation: Assignment of more specific tasks and responsibilities to functional ministries, departments, social organizations in more details.

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

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

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

MOH, Ministry of Police, MOLISA, MOET, MOF, MPI, Ministry of Culture, Ministry of Sport and Tourism, MIC, MOJ, Ministry of Defense, mass organizations, committees of government officials, Fatherland Front, social organizations.

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

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

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?

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

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

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
HIV discordant couples	☑ Yes	No
Elderly	Yes	☑ No
Men who have sex with men	☑ Yes	No
Migrants/mobile populations	☑ Yes	No
Orphans and other vulnerable children	☑ Yes	No
People with disabilities	Yes	☑ No
People who inject drugs	☑ Yes	No
Sex workers	☑ Yes	No
Transgendered people	Yes	☑ No
Women and girls	☑ Yes	No
Young women/young men	☑ Yes	No
Other specific vulnerable subpopulations[25]	☑ Yes	No
SETTINGS		
Prisons	☑ Yes	No
Schools	☑ Yes	No
Workplace	☑ Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	☑ Yes	No
Gender empowerment and/or gender equality	☑ Yes	No
HIV and poverty	☑ Yes	No
Human rights protection	☑ Yes	No

[25] Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees).

Involvement of people living with HIV	☑ Yes	No

IF NO, explain how key populations were identified?

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

PLHIV	☑ Yes	No
Men who have sex with men	☑ Yes	No
Migrants/mobile populations	Yes	☑ No
Orphans and other vulnerable children	☑ Yes	No
People with disabilities	Yes	☑ No
People who inject drugs	☑ Yes	No
Prisoners	Yes	☑ No
Sex workers	☑ Yes	No
Transgendered people	Yes	☑ No
Women and girls	☑ Yes	No
Young women/young men	Yes	☑ No
Other specific vulnerable subpopulations[26]	Yes	☑ No

1.5. 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

1.6 Does the multisectoral strategy include an operational plan?

☑ Yes	No

1.7. Does the multisectoral strategy or operational plan include:

[26] Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

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

1.8. 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 organised:
Draft versions of the National Strategy on HIV AIDS Prevention and Control for the period 2011- 2020 with a vision to 2030 have been posted on the website of VAAC, MOH, and the Government web portal for comments. In addition to general technical group meeting, two separate meetings were held for civil society organizations to provide feedbacks: The first consultation meeting proposed the idea and content of the social organizations in order to develop the strategy. The second meeting contributed to the draft of the strategy by the Viet Nam Union of Science and Technology (VUSTA). The civil society organizations actively involved in the process of building multi-sectoral strategies by providing comments on the draft strategy both in writing and directly in the meetings. The comments then were studied by the Drafting Committee to include into the strategy. VUSTA mobilized the civil society, groups of PLHIV and high risk to provide comments through its network.

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

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

☑ Yes	No	N/A

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

☑ Yes, all partners	Yes, some partners	No	N/A

IF SOME PARTNERS 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: (b) Poverty Reduction Strategy; and (d) sector-wide?

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

☑ Yes	No	N/A

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	☑ Yes	No	N/A
National Development Plan	☑ Yes	No	N/A
Poverty Reduction Strategy	☑ Yes	No	N/A
Sector-wide approach	☑ Yes	No	N/A
Others (write in): The National Strategy on drug and prostitution prevention and control; the Child Protection Program 2011-15; The National Program on Gender equality 2011-20, the National Health Program	☑ Yes	No	N/A

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

HIV-RELATED AREA INCLUDED IN PLAN(S)			
Remove legal regulations aiming for punishment	☑ Yes	No	N/A
HIV impact mitigation	☑ Yes	No	N/A
Reduction of gender inequity as they relate to HIV prevention/treatment, care and/or support	☑ Yes	No	N/A

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

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

Yes	☑ No	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	☑ 4	5

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

☑ Yes	No

If yes, please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
The Government promulgated Decision No. 1107/QĐ-TTg dated 28/7/2009 approving the proposal to improve capacity of the HIV AIDS prevention and control system at provincial level during the period 2010-2015. The Government annually allocates funding for the construction of HIV AIDS prevention centers and equipment purchase for HIV AIDS prevention and control activities.

5. Are the HIV service delivery establishments integrated with other health services?

AREA	Much integration	Moderate integration	No integration
HIV testing and counseling and reproductive/		☑	

sexual health			
HIV testing and counseling and TB	☑		
HIV testing and counseling and outpatient care	☑		
HIV testing and counseling and non-communicable chronic diseases		☑	
ART and TB	☑		
ART and outpatient care		☑	
ART and non-communicable chronic diseases			☑
PMTCT and maternity and child care	☑		
Other comments on integration: HIV testing is widely available but standard counseling is not a common practice in non-HIV services.			

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	☑ 9	10

Since 2011, what have been key achievements in this area:
Control the HIV prevalence rate to under 0.3% - Control the HIV prevalence in the community at below 0.3% - The National Strategy on HIV AIDS Prevention and Control for the period of 2011-2020 is under the progress of completion. The plan was evidence-based in more details and with clearer objectives; and was developed with involvement from many government agencies of multi sectors, various departments, unions, UN agencies, international NGOs and the civil society. It was made according to a common form, and with the involvement of various departments, unions, and civil society. - The Government approved the National Program on HIV AIDS Prevention and Control for the period of 2011-2015 with the specifically-allocated central and local budgets for the implementation of the program. This has helped to reduce financial deficits of the program. Annual workplans of the ministries and departments at different local levels were sent to the VAAC in accordance with regulations. Funding for the activities was disbursed in accordance with the plan. - The HIV AIDS M&E log-frame was re-developed in accordance with the new National Strategy.

Since 2012, the HIV AIDS sentinel survey has included the MSM into its target populations.

- The Ministry of Finance approved a new regulation on cost norms of the HIV/ADS program including the cost norms for peer education activities by peer educators.
- The rate of out-of-date ARV drug was low due to effective planning, coordination and use
- Approved Decree on substitution treatment for opioid addiction which gave opportunities for treatment with medicines other than Methadone, simplified administrative processes, and regulated the expansion of the treatment program
- The Law on sanctions of administrative violation which was approved in 2012 and took effect in 7/2003 stopped sending female sex workers to the education, labor and social centres. The law created a legal framework for the transition from punitive approaches to community-based harm reduction interventions.
- The MoH, Ministry of Culture, Sport and Tourism, The Fatherland Front issued a circular to enhance the HIV prevention program for the whole population.
- The MoH and the Ministry of Defense issued a circular on HIV AIDS prevention and control in bordering areas in the period of 2012-15 with a priority given to the ethnic minorities.
- Improved capacity of functional staffs in most of provinces
- Strengthened human and material resources for the activities

What challenges remain in this area:

- Hardly to estimate the funding committed for HIV AIDS prevention and control in the next period. Funding for the 2014 HIV AIDS program was reduced sharply. A lack of resources caused unable to expand the intervention programs
- Limited planning and management capacity of provincial HIV AIDS prevention and control staffs due to a lack of responsible staff, or new and junior staffs.
- Limited awareness of local people and authorities at several levels
- Limited data quality and insufficient data

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

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

1.1. Government ministers	☑ Yes	No
1.2. Other high officials at sub-national level	☑ Yes	No

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

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

☑ Yes	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
For the past two years, chairman of the National Committee for AIDS, Drug, and Prostitution Prevention and Control and other member ministries/sectors have issued a variety of instructions and conclusions. Especially, during the review conferences on HIV prevention and control, ministries and sectors were requested to develop their HIV prevention plans matching with the new situation, appropriate funds to complete the program, finalize relevant legal documents and push up the inter-sectoral collaboration to implement the comprehensive intervention and international co-operation enhancement. At the meeting with international donors, Mr. Nguyen Xuan Phuc, chairman of the National Committee affirmed the commitments to continue to strengthen the organization and system of HIV prevention and control and creating favorable conditions for the implementation of the HIV AIDS program. In June 2011, the Viet Nam's high ranking leaders have attended the UN High Level Meeting on HIV AIDS prevention and control and committed to materialized the Political Declaration: "Strengthening common efforts to eliminate HIV AIDS" in which committing countries shall elevate national endeavours and strengthen international co-operation in order to successfully implement MDG, thereby reduce and gradually advance to stop HIV AIDS infection by 2015, with an aim to enhance national commitment to have a comprehensive response at the community, local, national, regional and international levels to cease and reverse the HIV epidemic and mitigate its impact. At the National Conference on HIV AIDS prevention and control, the Prime Minister confirmed the commitment of the Party and the State to pay special attention to HIV AIDS prevention and control. The Deputy Prime Minister highlighted that leaders of the Party and Government from the central to local levels and social organizations should continue to raise their own awareness on HIV AIDS prevention and control, provide instructions to development and implementation of local action programs basing on the National Strategy on HIV AIDS Prevention and Control for the Period 2011-2020 with a vision to 2030. The provinces should promote mobilization and investment of resources for HIV AIDS prevention and control, especially in the coming years when international resources are reduced and the central budget is limited; continue to improve people's knowledge on HIV AIDS prevention and control, reduce stigma and discrimination against PLHIV. The health sector together with departments, sectors and unions from the central to local levels should continue to enhance service delivery to meet urgent needs to ensure their rights to access HIV AIDS care, support, prevention and treatment services.

2. Does the country have an officially recognized national multisectoral HIV coordination body

(i.e., a National HIV Council or equivalent)?

☑ Yes	No

2.1. IF NO, briefly explain why not and how HIV programmes are being managed:

2.2. ***IF YES***:

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

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

☑ Yes	No	N/A

IF YES, briefly describe the main achievements:

- The Government promulgated many regulations to instruct and establish the inter-sectoral collaboration in HIV AIDS prevention and control, encourage the organizations, individuals to involve in HIV AIDS prevention and control; allocate funds for this activity. The provinces had their own mechanism of inter-sectoral collaboration.
- There is increasing and efficient involvement of the civil society organizations in HIV AIDS prevention and control. These organizations are invited by the Government to take part in the development of policies and strategies for HIV prevention and control in a new period and provide technical assistance to the projects.
- Some HIV AIDS prevention and control activities are now under the responsibility of local NGOs such as care, support and treatment for HIV-infected patients.
- Social organizations, under the co-ordination of VUSTA, actively involved in the Project of Global Fund which was financed since the 2nd phase of the 9th round
- PLHIV receive better care and treatment services,
- Enterprises and individuals are mobilized to actively involved in HIV AIDS prevention and control activities
- The National Co-ordination Committee of Global Fund in Viet Nam (CCM) consists of members who are the representatives of the civil society and the private sector.

What challenges remain in this area:

- Many social organisations engage in HIV AIDS prevention and control in a spontaneous way without a support, guidance and coordination to involve these organizations in a systematic manner in order to promote and maximize the potential of community resources.
- Currently there is no regular and systematic coordinating mechanism for the activities of social organisations to integrate them into the available health programs and social security programs of the country. At the central level, the VAAC organized quarterly meetings with social organisations. However this activity only focused on sharing information, providing strategic directions and updating activities of the organization. It has not been connected to the key issues of national strategies such as community resources, capacity building, creating a favorable environment for social organisations and high-risk groups.
- The exchange of information in policy framework development is only formality, feedbacks from management agencies are not very regularly and sufficiently provided.
- Lack of operational budget
- Many social organizations such as community-based groups (self-help groups of PLHIV) have not been aware of the importance of legal registration, therefore they have had limited opportunities to participate in policy forums and access to resources of the State and international organizations.
- Limited capacity of civil society

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

% no data available

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

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

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?	☑ Yes	No
6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?	☑ Yes	No

IF YES, name and describe how the policies / laws were amended
- The National Program for HIV AIDS Prevention and Control in the period of 2011-15 with an attached budget was passed by the National Assembly. This has helped the country to have better coordination of HIV AIDS prevention and control activities between ministries, sectors and stakeholders as well as clearly identify the ensured budget, until 2015 at the latest. - The Law on Sanctions of Administrative Violations which was approved in 2012 and took effect in 7/2003 stopped sending female sex workers to the social, education, labor and centres. The law regulated sending drug users to compulsory detoxification centres must be judged and decided by the People's Court at the district level. - People who are applied by this article have the right to know about evidences against them and to invite a legal representative; the judge has the final decision. The law created a legal framework for the transition from punitive approaches to community-based harm reduction interventions. - Decree 96/2012ND-CP on substitution treatment for opioid addiction with methadone (MMT) which was approved in 11/2012 simplified administrative procedures to increase accessibility to methadone treatment services. - Decision issued by the MoH late 2012 on gradual transition of the management of the PMTCT program from the VAAC to the Department of Mother and Child Health. This transition will help pregnant women to have easier access to HIV services which are integrated with available obstetrical services in the community. The implementation of this decision will help to ensure the

sustainability of the program.
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
- The Project to redevelop compulsory detoxification establishment into community-based and evidence-based voluntary and friendly treatment establishments should be approved and implemented soon in order to help IDUs choosing better treatment methods. - Develop legal documents to create a legal framework for the implementation of the Law on sanctions of administrative violations, including an Ordinance on juridical procedures to send injecting drug users to compulsory detoxification establishments.

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

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	☑ 9	10

Since 2011, what have been key achievements in this area:
- Revised and issued some legal documents which are aligned with Law of AIDS prevention and control, facilitate the HIV AIDS prevention practices - Ministries and sectors closely worked with the Ministry of Health to develop legal documents and policies for HIV AIDS prevention and control - Enhanced the monitoring of the National Committee for AIDS, drugs and prostitution prevention and control to HIV prevention activities being done by provinces - Strong commitment and strict instructions of the Party and State were made; - Facilitated and had active engagement of civil society organizations to HIV prevention and control
What challenges remain in this area:
- Funds for HIV AIDS prevention and control are not sufficiently allocated to expanding and scaling up prevention, care and treatment services. - Some legal documents are still under the progress of development or revision, not yet been finalized. - The discrimination against HIV-infected people still exists.

III. HUMAN RIGHTS

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

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

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non- discrimination?	☑ Yes	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
Constitution of the Social Republic of Viet Nam shall provide all citizens economic, politic, social equality, and no discrimination and division.

Briefly explain what mechanisms are in place to ensure these laws are implemented:
The Constitution is elaborated by different legislation.

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

Moderate results

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?	☑ Yes	No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	☑ Yes	No
Elderly people	Yes	☑ No
Men who have sex with men	☑ Yes	No
Migrants/mobile populations	☑ Yes	No
Orphans and other vulnerable children	Yes	☑ No
People with disabilities	Yes	☑ No
People who inject drugs	☑ Yes	No
Prison inmates	☑ Yes	No
Sex workers	Yes	☑ No
Transgendered people	☑ Yes	No
Women and girls	Yes	☑ No
Young women/young men	Yes	☑ No
Other specific vulnerable populations[27] [write in below]:	Yes	☑ No

Briefly describe the content of these laws, regulations or policies:
There has not yet been regulations that facilitate access to health services for transgender groups and mobile populations. The Law on Sanctions of Administrative Violations which was approved in 2012 and took effect in 7/2003 stopped sending female sex workers to the social education and labor and centres and regulated that sending drug users to compulsory detoxification centres must be judged and decided by the People's

[27] Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Court at the district level, nevertheless, decrees providing guidance for the implementation of the law are still under development and have not come into effects yet. Decree 67 required information disclosure to the social security sector and people cannot access to social services and assert their rights unless they disclose their HIV status. Stigma and discrimination prevented PLHIV from disclosing their HIV status, therefore they cannot access to social security. There remain many challenges in implementation of Decree 13/2010/ND-CP due to administrative procedures and changes in the definition of "being poor"
Briefly comment on how they pose barriers:
As stated above

IV. PREVENTION

1. ***Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?***	☑ Yes	No

IF YES, what key messages are explicitly promoted?		
Delay sexual debut	☑ Yes	No
Engage in safe(r) sex	☑ Yes	No
Fight against violence against women	☑ Yes	No
Greater acceptance and involvement of people living with HIV	☑ Yes	No
Greater involvement of men in reproductive health programmes	☑ Yes	No
Know your HIV status	☑ Yes	No
Males to get circumcised under medical supervision	Yes	☑ No
Prevent mother-to-child transmission of HIV	☑ Yes	No
Promote greater equality between men and women	☑ Yes	No
Reduce the number of sexual partners	☑ Yes	No
Use clean needles and syringes	☑ Yes	No
Use condoms consistently	☑ Yes	No
Other [write in below]:	☑ Yes	No
No stigma and discrimination against PLHIV		

Avoid to expose blood and body fluid

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?	☑ Yes	No
2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?	☑ Yes	No

2.1. Is HIV education part of the curriculum in:

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

2.2. Does the strategy include: ***a. age-appropriate sexual and reproductive health elements?***	☑ Yes	No
b. gender-sensitive sexual and reproductive health elements?	**☑ 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 key or other vulnerable sub-populations?	☑ Yes	No

Briefly describe the content of this policy or strategy:
- The Law of HIV AIDS Prevention and Control includes one chapter mentioning IEC for behavioral change and harm reduction as technical contribution to HIV AIDS prevention and control. - Decree No. 108/2007/NĐ-CP provides details of the implementation of harm reduction for HIV prevention - The national action plan on IEC for behavioral change was included in the national strategy on HIV AIDS prevention and control for the period of 2011 – 2020 with a vision to 2030. - Regulations of multisectoral coordination assigning tasks to different ministries and departments in the implementation of the national action plan on IEC for behavioral change. - The National Strategy also includes a plan to strengthen direction of the Party, departments and organizations at different levels as well as promote community participation in

implementation of the national action plan on IEC for behavioral change.

- Development of the Action Plan on HIV Prevention and Control for Education Sector reflects a national commitment on HIV prevention and control, in the context of complicated HIV epidemic and reduction on international aid.

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

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

	IDU[28]	MSM[29]	Sex worker	Customers of Sex Workers	Prison inmates	Other populations[30] PLHIV, people of mobile groups, sex partners of members of the above groups, STI patients, pregnant women, young people
Condom promotion	☑	☑	☑	☑		☑
Drug substitution therapy	☑					
HIV testing and counseling	☑	☑	☑	☑	☑	☑
Needle & syringe exchange	☑					
Reproductive health, including sexually transmitted infections prevention and treatment	☑	☑	☑	☑		☑
Stigma and discrimination reduction	☑	☑	☑	☑	☑	☑
Targeted information on risk reduction and HIV education	☑	☑	☑	☑	☑	☑
Vulnerability reduction (e.g. income generation)	☑		☑			☑

28 IDU = Injecting drug user

29 MSM=Man having sex with man

30 Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

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

Very Poor										Excellent
0	1	2	3	4	5	6	7	☑ 8	9	10

Since 2011, what have been key achievements in this area:
- More instructions from the Party and State, increased financial fund and inter-sectoral collaboration - Highly agreement of the society and in the implementation of inter-sectoral prevention activities - HIV prevention and control is integrated in the general development plan of the nation - The Law on Sanctions of Administrative Violations which was approved in 2012 and took effect in 7/2003 created a legal framework for the transition from punitive approaches to community-based harm reduction interventions. - Decree 96/2012ND-CP on substitution treatment for opioid addiction with methadone (MMT) which was approved in 11/2012 simplified administrative procedures to increase accessibility to methadone treatment services. The MMT program was socialized and scaled up. - HIV prevention and control has been included in the training curriculum in education setting.
What challenges remain in this area:
- Some provinces have not yet paid due attention to the prevention activities; limited budget holds back the expansion in the scope of intervention. - The discrimination against PLHIV and MSM is still a matter to be addressed. The awareness of managers and policy-makers towards some sensitive matters such as MSM should be improved so that the proper policies and interventions would be made to reduce harms caused to this group - The Decree on juridical procedures to send injecting drug users to compulsory detoxification establishments have not been completed yet. The Project to redevelop compulsory detoxification establishment into community-based voluntary and friendly treatment establishments is still under construction and waiting for approval. Therefore, the newly promulgated Law on sanctions of administrative violations have not been implemented yet. A fear of stigma and application for sanctions remain barriers for IDUs from accessing HIV prevention, diagnosis and care services. -

4. Has the country indentured specific needs for HIV prevention programmes?	☑ Yes	No

IF YES, **how were these specific needs determined?**
Needs are determined based on: - Identifying the program target groups and number of beneficiaries of the prevention activities - Results of the HIV AIDS epidemic surveillance, HSS, HSS+, IBBS - Need assessment surveys - Program routine reports - The capacity of financial budget and human resource in meeting the demands - The feasibility of prevention activities. - Development of goals basing on evidences relating to knowledge, attitudes and the practices of HIV prevention.

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

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	☑ 4	N/A
Condom promotion	1	2	3	☑ 4	N/A
Economic support, e.g.: cash support	1	☑ 2	3	4	N/A
Harm reduction for IDU	1	2	3	☑ 4	N/A
HIV prevention for out-of-school young people	1	2	☑ 3	4	N/A
HIV prevention in the workplace	1	2	☑ 3	4	N/A
HIV testing and counseling	1	2	3	☑ 4	N/A
IEC on risk reduction[31]	1	2	3	☑ 4	N/A
IEC on stigma and discrimination reduction	1	2	3	☑ 4	N/A

[31] IEC: information, education and communication

Prevention of mother-to-child transmission of HIV	1	2	3	☑ 4	N/A
Prevention for people living with HIV	1	2	3	☑ 4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	☑ 3	4	N/A
Risk reduction for intimate partners of key populations	1	2	☑ 3	4	N/A
Risk reduction for men who have sex with men	1	2	☑ 3	4	N/A
Risk reduction for sex workers	1	2	☑ 3	4	N/A
School-based HIV education for young people	1	2	3	☑ 4	N/A
Prevention as treatment	1	2	3	☑ 4	N/A
Universal prevention in health care settings	1	2	☑ 3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

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

Very Poor									Excellent
0	1	2	3	4	5	6	7	☑ 8	9	10

Since 2011, what have been key achievements in this area:

- Increased communication activities with the involvement of Ministries, Sectors and other political and social agencies
- Successfully controlled HIV incidences, kept it not increase as fast as in the previous years. The HIV-prevalence in the general population was kept under 0,3%
- Promoted HIV prevention for couples through behavioral change communication and pilots of "Prevention for Treatment" for HIV discordant couples
- The HSS included the MSM group in the study populations to monitor the HIV prevalence
- Implemented the National Condom Program in the period of 2011-2020, with a special focus on high risk groups and development of a more effective coordination framework, creating a closer link between the programs on HIV AIDS prevention and control, sexual health and reproductive health while expanding social marketing of condoms. All of these solutions are critical as the funding for condoms in Viet Nam is being cut down.

- The Ministry of Culture, Sport and Information implemented the action plan of the Condom Program for prevention of HIV and STI infection in hospitality establishments in the period of 2010 – 2020. After this period, the ministry will collaborate with relevant agencies to develop a Joint Circular regulating provision of condoms in entertainment and hospitality establishments.
- Prevention services are continuously expanded, especially the MMT programs, education on reproductive health and sexual health in relations to HIV for young persons
- Reduce stigma and discrimination

What challenges remain in this area:

- The coverage of HIV testing and counseling services among FSW, IDU, and MSM remained limited, especially among women who are long-time sexual partners of men who are at higher risk of HIV infection (male IDUs and bisexual men)
- Though the MMT programme has been scaled up, it has not yet met demands of the IDU. It will be difficult to reach the target of having 80,000 IDU to receive MMT by the end of 2015.
- People's knowledge and practices relating to HIV AIDS prevention are still limited.
- Lack of budget and intensive staff.
- The coverage of the prevention services has not yet met the demand
- The financial funds for prevention projects mostly rely on international sources of aids

V. TREATMENT, CARE, AND SUPPORT

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

☑ Yes	No

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

Elements:

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

Prioritized elements:

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

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

- Expand and implement HIV AIDS care and treatment services at all levels, from the local to the central ones.
  o OPCs under national hospitals at the central level
  o OPCs under provincial general hospitals at the provincial level
  o OPCs under district general hospitals, preventive health care centers, and preventive HIV AIDS centers at district level
  o Communal health centers and village health systems manage the number of PLHIV who are under care and treatment. Some locations have organized home-based care groups at this level.
  o Expand the pilot of the Treatment 2.0 Initiative to provide better determination and diagnosis to PLHIV and provide them with the earliest treatment. The initiative result in better treatment effectiveness with involvement of social organisations.
  o Start the pilot of synthetic ARV drugs (1 tablet/ day) at the district level to enhance treatment adherence. This is a part of the Treatment 2.0 Initiative. The number of patients under treatment d4t has been gradually reduced.

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

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	☑ 3	4	N/A
ART for TB patients	1	2	☑ 3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	☑ 4	N/A
Early infant diagnosis	1	2	☑ 3	4	N/A
Economic support	1	☑ 2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangement)	1	☑ 2	3	4	N/A
HIV testing and counseling for people with	1	2	3	☑ 4	N/A

TB					
HIV treatment services in the workplace or treatment referral systems through the workplace	1	☑ 2	3	4	N/A
Nutritional care	1	2	☑ 3	4	N/A
Pediatric AIDS treatment	1	2	☑ 3	4	N/A
Provision of ARV to pregnant women after labor	1	2	☑ 3	4	N/A
Post-exposure prophylaxis for non-occupational exposures to HIV (e.g. a case of sexual rape)	1	☑ 2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	☑ 3	4	N/A
Psychosocial support for people living with HIV and their families	1	☑ 2	3	4	N/A
Sexually transmitted infection management	1	2	3	☑ 4	N/A
TB infection control in HIV treatment and care facilities	1	2	☑ 3	4	N/A
TB preventive therapy for people living with HIV	1	2	☑ 3	4	N/A
TB screening for people living with HIV	1	☑ 2	3	4	N/A
Treatment of common HIV-related infections	1	☑ 2	3	4	N/A
Other*[write in]*:	1	2	3	☑ 4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	☑ 3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?	☑ Yes	No

Please clarify which social and economic support is provided:

- HIV-infected children from poor households, HIV-infected persons without working ability and from poor households, families or individuals who adopt HIV-infected children, persons who bring up the HIV-infected persons aged under 18 years old receive the monthly social allowances, health insurance, exemption of tuition fee when attending any training program/vocational training, and expense for funeral
- Besides that, PLHIV at the social security facilities also receive financial support to buy the outfits, medicines for normal diseases, treatment for opportunistic infection, monthly hygienic activities for women at the child-bearing age.
- The Aid Fund for PLHIV also provide the financial support and loan offered and job created for disadvantage people

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

☑ Yes	No	N/A

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

☑ Yes	No	N/A

IF YES, for which commodities?

- ARV : by SCMS and VPP
- Methadone: by SCMS

For ARV in specific: currently 5% of ARV supply is purchased in the country, 95% is imported through foreign-funded programs/projects, such as PEPFAR (purchase through SCMS system), Global Fund (purchase through VPP). These projects and programs follow international procurement mechanism.

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

Very bad										Very good
0	1	2	3	4	5	6	7	☑ 8	9	10

Since 2011, what have been key achievements in this area:

- Rapidly expanded the access to ARV treatment, 318 OPC were established (of which 289 facilities for the adult, 118 facilities for children, 89 integrated facilities, 4 OPC at the central level, 155 OPC at the provincial level and 195 at the district level), 82,687 patients have received ARV treatment (including 78,483 adults and 4,204 children). Treatment service in close settings was expanded to 18 prisons providing service to 1,080 PLHIV.
- Managed and coordinated the ARV distribution to ensure uninterrupted provision of ARV drugs to the patients
- Managed and coordinated the test, medical equipment in HIV AIDS treatment including the virus measuring test, EID
- Results from the pilot Treatment 2.0 Initiative launched by WHO and UNAIDS showed that the HIV counseling and testing services, management and supervision of ARV provision for HIV treatment had been implemented communal and ward healthcare centres in the two provinces of Dien Bien and Can Tho. The results also showed that decentralization and integration of the HIV counseling and testing services, management and supervision of ARV provision for HIV treatment are feasible and appropriate with mountainous and remote areas. The counseling and testing services for sexual partners and provision of early treatment for PLHIV who have HIV-uninfected sexual partners are feasible.
- PMTCT: among 1,045,005 pregnant women took HIV tests and 0.14% of them had positive HIV test results, 57% of pregnant women received prophylaxis for PMTCT, 1,770 of children born by HIV-infected women have been treated for prevention of HIV transmission, nearly 40% of children have been treated with Cotrimoxazole for opportunistic infection prevention.
- Pediatric care and treatment services: the OPC system has been established in 54 provinces, 4,204 children had access to ARV.
- Develop Guidance on diagnosing active TB and TB prophylaxis with INH for PLHIV and Decision of the MoH on regulations and a plan of cooperation between the National Target Program on HIV AIDS prevention and control and the TB Program.

What challenges remain in this area:

- The coverage and quality of ARV treatment remained limited. The Initiatives “Treatment 2.0” and “Treatment as Prevention” are still at the pilot period, therefore, only a limited number of patients can be benefited from them. There is a lack of connect and referral between the ARV treatment systems in the community, detention establishments, and detoxification establishments to ensure uninterrupted treatment when sending patients from these establishments to other ones.
- There is a matter of ARV provision in the context of aid reduction. The country has a limited capacity in procurement of ARV drugs at high quality.
- The e-reporting and management system have not yet been developed. The improvement has been delayed due to a small budget, difficult traffic situation in mountainous areas, unavailability of health services, stigma and discrimination against HIV AIDS. The delay to go for HIV tests remained common among pregnant women, therefore, HIV-positive pregnant women had limited accessibility to optimal regimes for PMTCT. This has led to a high rate of HIV transmission from mother to child.
- The rate of new-born babies of women who received tests within two months after giving births to diagnose the HIV status remained limited, only at 25%.
- The capacity of the staff at district level is limited

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

☑ Yes	No	N/A

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

☑ Yes	No

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

☑ Yes	No

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

Very Poor										Excellent
0	1	2	3	4	5	6	7	☑ 8	9	10

Since 2011, what have been key achievements in this area:
- Treatment and care services are continuously expanded. Number of OVC children receiving treatment and taking-care services increases - An increasing number of children who were born by HIV-infected women receiving treatment for HIV prevention.
What challenges remain in this area:
- The coverage of care and supporting services to children is remain limited. - Fund to maintain the ARV treatment when the international resources are cut down is a significant challenge. - There remains discrimination against the HIV-infected and HIV-affected children, some children are not be able to go to schools when reaching the schooling age,

VI. MONITORING AND EVALUATION

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

☑ Yes	No	N/A

Briefly describe any challenges in development or implementation:
Many difficulties in reaching a consensus on measuring indicators, M&E tools and a commitment on sharing and unifying data between ministries, organisations and projects

1.1. IF YES, years covered [write in]: 5 years

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

☑ Yes, all partners	Yes, some partners	No	N/A

Briefly describe what the issues are:
Requirements of the Government and donors, definitions of each indicator are very different and change always.

2. *Does the national Monitoring and Evaluation plan include?*

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

3. Is there a budget for implementation of the M&E plan?	☑ Yes	In Progress	No

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?	No data available %

4. Is there a functional national M&E Unit?	☑ Yes	In Progress	No

Briefly describe any obstacles:
A lack of staff, current staff lacks of capacity.

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

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

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

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

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

☑ Yes	No

Briefly describe the data-sharing mechanisms:
The data-sharing mechanism operates through: - The National HIV Prevention system submits reports following the routine reporting system - Foreign-funded programs submit reports to PACs. PACs then report to VAAC. - Sharing information is through the national M&E technical working group, in order to update M&E activities implemented by various organizations and donors.
What are the major challenges in this area:
- The National M&E unit has not been able to harmonize the M&E systems of funded projects with the national M&E system - Some data have not been collected sufficiently as requested - The reports were not submitted in time, the data duplication in the reports among different projects still existed. There was a lack of M&E staff, and the capacity of current M&E staff in some organization was still limited, - Limited budget for M&E.

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

☑ Yes	No

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

☑ Yes	No

IF YES, briefly describe the national database and who manages it.
- The results of HSS and case reporting surveillance are archived and managed by HIV info software - Reports on HIV AIDS prevention and control are periodically updated through the online-reporting software - The VCT data is reported using the specialized VCT management software - Viet Nam Administration of AIDS control is currently managing the databases of the above mentioned data sets

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

☑ Yes, all of the above	Yes	but only some of the above

IF YES, but only some of the above, which aspects does it include?

6.2 Is there a functional Health Information System[40]?

At national level	☑ Yes	No
At subnational level	☑ Yes	No
IF YES, at what level(s)? *[write in]*		

7.1 Does the country have reliable estimated data on needs on ARV treatment of adults and children for current time and in the future?

☑ Estimated needs for current time and in the future	Estimated needs for current time only	No

7.2 Monitoring the coverage of the HIV program?

☑ Yes	No

a. If yes, is the coverage divided by genders ?

☑ Yes	No

b. If yes, is the coverage divided by population groups?

☑ Yes	No

IF YES, by which population groups?
- IDU - FSW - Pregnant women - AIDS patients

- PLHIV - MSM
Briefly explain how the information is used
- The information entry was made with estimation and projection software, then the information was analyzed by a group of local and international experts and used for policy development, intervention planning. - The information has also been used for evaluating effectiveness, identifying barriers in the process of implementing intervention activities as well as identifying intervention priorities. - The information has been used to develop targets of the National Program on HIV AIDS prevention and control. - The information has been used to provide evidences to policy development and resource coordination.

c. Is the program coverage monitored by geographical areas?

☑ Yes	No

IF YES, by which level (province, district, other) ?
- The provincial level - The district level - The communal level
Briefly explain how the information is used
- The information has been used for policy development, planning, and resource coordination with a focus given to localities with a high number of PLHIV, for estimation and projection of future needs.

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

☑ Yes	No

8.1 How are M&E data used?

For programme improvement?	☑ Yes	No

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

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
Develop annual plans, provide recommendations for the improvement of intervention program Recommendations to the Government on financial increase and be integrated in the instructions of the Government. Provincial AIDS Control Centre (PAC) has not paid adequate attention to data, moreover, due to limited financial budget these agencies cannot use the data to improve the program's quality.

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

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

9.1. Were other M&E capacity-building activities conducted other than training?	☑ Yes	No

IF YES, describe what types of activities
More supervision and support were provided to provinces and assisted in evaluating data quality

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

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	☑ 9	10

Since 2011, what have been key achievements in this area:
- Development of an overview on the HIV epidemic of the country and evaluate the efficiency of the policies and strategies - Development of comments on the situation of HIV-infection, analyzed by ecological areas and high groups. - Successful organization of the National AIDS Conference to collect and share lessons learnt in HIV AIDS prevention and control.
What challenges remain in this area:
- The ability of M&E staff in some organizations is still limited. Personnel arrangement which regularly changes has led to the increase of demand on re-training. - A lack of budget and resources for M&E activities

National Commitments and Policy Instrument (NCPI)

Part B

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

I. CIVIL SOCIETY[32] INVOLVEMENT

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

LOW					HIGH
0	1	2	☑ 3	4	5

Comments and examples
Areas of improvement: A significant improvement in the area of civil society involvement in the HIV response is the establishment of SW and VNMSM-TG networks as well as the expanding of existing VNP+ and VNPUD networks. At the opening ceremony of the networks, MOLISA representative attended and gave a speech to support the establishment. In September 2013, the Viet Nam Union of Science and Technology Associations (VUSTA) in collaboration with the National Committee on AIDS prevention and control, and drug abuse, prostitution prevention and control; and the Ministry of Health organized a workshop "Enhancing participation and effective operation of the society organizations in the implementation of the National Strategy on HIV AIDS Prevention and Control". H.E. Nguyen Xuan Phuc, Deputy Prime Minister of the Government of the Socialist Republic of Viet Nam, and leaders of the Party, National Assembly and the Fatherland Front attended the workshop. There were participation of more than 100 representatives of community-based group of people living with HIV and those who have a high risk of infection. Addressing the workshop, the Deputy Prime Minister said the Government would pay attention to remove the difficulties, create enabling environment for CSO's operation; and that the Government considers CSO as an important partners in the fight against HIV AIDS. CSOs have contributed their opinions and positions to the draft revised Constitution. Representatives of CSOs have participated in the Vietnamese delegation that attended the 11th International Congress on AIDS in Asia and the Pacific in 2013. In addition, a CSO representative had an opening speech at the plenary session of the 5th National Scientific Conference on HIV and AIDS in 2013 and as part of this conference, a satellite workshop on CSOs was organised, attracting the wide attention of the community of organizations working in HIV AIDS.

[32] *Civil society* includes networks and organizations of PLHIV, women, major affected groups (MSM, transgendered people, sex workers, injecting drug users, mobile population, refugees/ resettles, prisoners), faith-based organizations, AIDS-relating service providers, community-based organizations, workers' organizations, human rights organizations etc. Note: the private sector is considered separately.

VNP+ continues to play a role in policy advocacy, conducting research to provide evidence for improvement of intervention programs, as well as strongly advocating for articles relating to ARV in the Free Trade Agreement.

VUSTA which represents CSOs has become a member of the National Advisory Group on HIV AIDS prevention and control. VUSTA has raised the voice of CSOs to government organizations. Particularly the GF project implemented by VUSTA has not only established but also expanded the essential service package on HIV prevention and harm reduction, contributed to reduction of HIV prevalence among vulnerable groups. This also help enabling environment in regards for CSO's participation, and strengthening CSO's capacity in 10 project provinces.

Challenges:

As noted in the 2012 GARPR, many CSOs continue to not yet meet criteria to obtain legal entity. They have limited capacity and a lack of government funding remain the biggest challenges for CSOs in Viet Nam, and the CSOs that do operate are dependent for financing and protection on the international donor community.

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

LOW					HIGH
0	1	☑ 2	3	4	5

Comments and examples

Planning:

There was a consultation process with civil society in the planning and development of the HIV AIDS Prevention and Control program at national level. VUSTA has a chance to participate in planning and be allocated funds from the national budget.

There was good participation of civil society in planning at the provincial level, but only in some provinces. As the provincial plans feed into the national plans, there is thus also a (very limited) civil society involvement in national planning.

Budgeting:

As reported in the previous GARPR, civil society has not yet had real involvement in the budgeting process at the national and provincial level. However, the participation of CSOs in the development of the Global Fund Round 9 budget plan has been more effective than in the previous year.

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

a. The national HIV strategy?

LOW					HIGH
0	1	2	☑ 3	4	5

b. The national HIV budget?

LOW					HIGH
0	☑ 1	2	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	2	☑ 3	4	5

Comments and examples
Despite the increase in Government dialogue with civil society, the extent to which civil society has been involved in the strategy, budgeting and reports has not changed much. ***Strategy:*** The *National Strategy on HIV AIDS Prevention and Control for the period 2011-2020, with a vision to 2030* was developed in 2011 and approved in May 2012. As reported in the previous GARPR, this national strategy includes a role for civil society in providing services, albeit in very general terms, e.g. "community-based treatment and care". Some mass organizations, such as the Women's Union, and VUSTA were identified as implementing partners. The term CSO has been specifically mentioned. ***Budget:*** During the period 2012-2013, the State budget for the HIV programme has increased significantly; however, there is only small budget allocated directly to CSOs. A majority of CSO activities remains funded by international organizations. While the government recognizes civil society, there is still no mechanism to direct budgets to CSO. ***Reports:*** The Government's reports have mentioned CSO activities. Notably, this year the National Scientific Conference on HIV AIDS had a satellite workshop on CSOs to discuss about achievements, challenges as well as solutions for empowerment of CSOs the coming period.

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

a. Developing the national M&E plan?

LOW		HIGH

0	1	☑ 2	3	4	5

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

LOW					HIGH
0	1	2	☑ 3	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	☑ 2	3	4	5

Comments and examples
In the reporting period, VUSTA could participate as a member of the national advisory group, representing CSOs working on M&E elements of the national HIV AIDS program. During 2013-2013, the MoH in collaboration with UNAIDS conducted 2 trainings on M&E for members of self-help groups of PLHIV and people who have high risk of HIV infection. The M&E framework has included civil society, however the application of this document remains limited. However, whilst INGOs are very involved in national- and local-level monitoring and evaluation, local NGO participation in M&E activities is largely limited to the community level, local NGOs are playing an especially active role in some provinces. HCMC and Hai Phong city, for example, involve various groups in their M&E processes. In general, however, participation in M&E is limited to the role of CSOs in monitoring their own project work, they often undertake M&E activities in order to protect themselves and to adhere to donor requirements. M&E project-based activities carried out by CSOs are not fed into the national M&E system. In addition, project data obtained from M&E activities conducted by CSOs have not always been used for planning or decision-making. Whilst PACs have working relationships with peer networks and are exposed to their opinions, their participation in data use for decision making is passive and unclear. CSO involvement in the national M&E TWG has been limited. Whilst the TWG welcomes local CSO participation, their lack of technical M&E capacity makes it difficult for them to participate. There is therefore a need to strengthen this capacity, and to ensure that CSOs are aware of the roles they can have in, and contributions they can make to, national M&E activities. International NGOs play a crucial role in M&E in Viet Nam, but more effort is needed to improve the capacity of local civil society on monitoring and evaluation.

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

LOW		HIGH

0	1	2	3	☑ 4	5

Comments and examples
The presence and representation of the networks in HIV AIDS prevention and control gave a voice to the community, contributing to the Government's amendment of the following policy documents: - The Law on sanction of administrative violations and documents providing guidance on its implementation, decrees on sending drug addicts to compulsory detoxification establishments which require the court's files and specific enforcement process. - Decree 110/2013/ND-CP dated 24/9/2013 with an amendment that does not regulate a sanction on same-sex marriage. - The role of civil society is critically important in advocating for sexual rights and rights to healthcare. The representation of PLHIV has been improving steadily. The national network VNP+ and VNPUD are increasingly vocal and influential. The VNMSM-TG and VNSW networks were newly established during these years and participated actively in HIV response. In 2012-13, the LGBT/MSM groups organised events and ceremonies to call for support to same-sex marriage and non-stigma and non-discrimination against this community. However, the draft Law on Marriage does not yet recognize same-sex marriage and it will still take more time for the advocacy efforts to see real results. The voice of this group is still considered to be very limited. The level of CSO representation has increased and there are a number of capacity-building activities supported by PEPFAR and the Global Fund. There has also been an increase in the number of CSOs, particularly in HCMC, Binh Duong, Vung Tau, Vinh Long, Can Tho, Vinh Phuc, and in the participation of faith-based organizations (faiths include: Buddhism, Hoa Hao, Cao Da, Catholicism and Islam). In the next 2 years, there is a need to expand and improve capacity for VNPUD, VNSW, VNMSM-TG for their greater contribution to the Three Zero.

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

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2	☑ 3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	☑ 3	4	5

Comments and examples

Financial support:

The majority of funding comes from donors, predominantly PEPFAR and the Global Fund. International donor funding, however, is significantly decreasing, making it much more difficult for civil society to access funds. There were some self-help groups in the community which ceased operations during the reporting period and there is not yet local funding to continue using these community resources which have been trained by international funded projects.

As noted in the previous GARPR, there is still no budget allocation for CSOs from the government as the budget law does not allow government funds to be allocated to civil society.

There is also only minor participation by the private sector, and more efforts to engage the private sector in providing funding and other resources are needed.

Technical support:

Technical support for organizational capacity strengthening is very limited due to the reduction of funding to these activities.

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

Prevention for key-populations				
People living with HIV	<25%	25-50%	☑ 51–75%	>75%
Men who have sex with men	<25%	25-50%	☑ 51–75%	>75%
People who inject drugs	<25%	25-50%	☑ 51–75%	>75%
Sex workers	<25%	25-50%	☑ 51–75%	>75%
Transgendered people	<25%	☑ 25-50%	51–75%	>75%
Palliative care	<25%	25-50%	☑ 51–75%	>75%
Testing and Counselling	☑ <25%	25-50%	51–75%	>75%
Know their rights/ legal support	<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%
Programmes for OVC**	<25%	25-50%	☑ 51–75%	>75%

**ART = Antiretroviral Therapy; OI = Opportunistic infections*

***OVC = Orphans and other vulnerable children*

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?

Very Poor		Excellent

0	1	2	3	4	5	6	7	☑ 8	9	10

Since 2011, what have been key achievements in this area:
- Government bodies have a greater recognition of the role of CSOs in the HIV response and CSOs have a stronger voice. The Government's representatives participated in some CSO workshops and recognized civil society contribution in HIV AIDS prevention and control. - As of the increase in participation of CSO, some policies on support to OVC (Decree 136/2013/ND-CP which took effect on 01/01/2014 in replacement of Decree 67/2007/ND-CP and 13/2010/ND-CP) had positive changes with an increase of allowances for the children affected by HIV and an addition to allowances to care givers of these children. There was a change from requiring wide publication of HIV-infected children who receive allowances to keeping the information confidential within the Approval Council without publishing it. - There was an expansion of the networks and their coverage, in particular the networks of VNMSM-TG and sex workers. VNP+ and VNPUD were strengthened and improved. The capacity and organisation of these groups have been improved. - The GF project implemented by VUSTA has contributed to improve capacity and position of CSOs, particularly when the 2nd stage of the project has started to be implemented. - The number of CSOs with legal entity status has increased, and a small number of local NGOs have demonstrated increased capacity for national advocacy, technical leadership and implementation. - Increased recognition of and/or resource allocation to self-help groups by local AIDS administrations and authorities in some provinces - Great efforts to increase participation by civil society and INGOs. - CSO representatives attended the 11th International Congress on AIDS in Asia and the Pacific and the 4th National Scientific Conference on HIV and AIDS in 2013. - Faith-based organisations participated in the network of Asia Pacific faith-based organisations working on HIV AIDS.
What challenges remain in this area:
Whilst there has been some progress, there is no significant change from the previous reporting period, and challenges and limitations remain, with civil society still unable to participate meaningfully: - Civil society can only participate partly in providing services such as: counselling and referring clients of VCT and counselling on ART adherence. - There is still no government budget allocation for CSOs, and the Government still does not recognize CSOs as partners in planning, budgeting or implementing activities in the HIV response. - The existing legal framework has not yet been appropriate for legal registration of civil society organizations. - The capacity of CSOs in organizational development, financial management, programme management and monitoring and evaluation needs to be strengthened.

- The majority of financial and technical support to civil society comes from international donors, while this source of funding is reducing.

II. POLITICAL SUPPORT AND LEADERSHIP

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

☑Yes	No

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

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

- Amendment of the Law on Sanction of Administrative violations, the changes mean that now to send drug users to compulsory detoxification centres, their case must be assessed and decided on by the People's Court at the district level. People who are detained under this article have the right to know about the evidence against them and to invite a legal representative; the judge still has the final decision. The law no longer provides for the sending of female sex workers to the social education, and labour centres. The law has also created a legal framework for the transition from punitive approaches to community-based harm reduction interventions.
- Decree 96/2012ND-CP on methadone substitution treatment for opiate addicts, which was approved in 11/2012, simplified administrative procedures to increase accessibility to methadone treatment services.
- The National Strategy on HIV AIDS prevention and control until 2020 with a vision to 2030 provides that the Government will promote MMT, include ARV drugs on the list of medicines covered by the national health insurance and mobilize and improve the capacity of community-based organisations.
- Decree 136/ND-CP on social protection
- Draft Law on Marriage and Family
- The National M&E Framework for the HIV AIDS program.

However, there is still not many opportunities for dialogue with the relevant government bodies, and authorities still not yet paid adequate attention and give opportunities for CSO to frequently giving their comments. There is some limited engagement of PLHIV in consultation processes to develop strategies and policies, and mostly at the provincial and district levels.

III. HUMAN RIGHTS

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

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

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

☑Yes	No

If Yes to question 1.1 or 1.2, briefly describe the contents of these laws:
Since 2013, the National Assembly has approved the Constitution which will be effect by 01 Jan 2014, to replace the Constitution of the Socialist Republic of Viet Nam in 1992. The Constitution has a chapter on the rights and obligations of citizens and has a provision that all citizens have equal rights without discrimination. Non-discrimination has also been included in the following policy documents and laws: - Decree 108/2008/ND-CP: endorses harm-reduction interventions, including the provision of needles and syringes, condoms and opiate substitution treatment. The following subpopulations are entitled to harm-reduction interventions under the Decree: sex workers and their clients, people who use drugs, PLHIV, homosexual people, migrant and mobile populations and sexual partners of all these subpopulations. - The Law on disability 51/2010/QH12 Article 14 prohibits a number of activities including the stigmatization of and discrimination against people with a disability. - Under the National Labour law 10/2012/QH13, all people have the right to work, and to choose a job, career and vocational training, without being discriminated against on the grounds of gender, ethnicity, social class, religion or belief. - National Laws on domestic violence 02/2007/QH12 forbid domestic violence of all kinds and

protect and provide support to victims.

- Under Article 4 of the Law on child protection, care and education (25/2004/QH11), children are protected, provided with care and education and enjoy the rights prescribed by law, irrespective of sex, legitimacy, adoptive status, race, creed, religion, social class, or the opinions of their parents or guardians.
- Decree 176/2013/ND-CP on administrative sanctions in health sector regulates the administrative sanctions against those who discriminate against PLHIV or people affected by HIV in the fields of education, employment and health care.
- Law on Gender Equity (dated 29/11/2006 of the 10th National Assembly meeting 73/2006/QH11) - under Article 10, forbidden activities include gender-related discrimination in all types of situations.
- Under the Law on the care and protection of people's health dated 11/7/1989, people shall enjoy the right to health care when they are sick. In emergencies, people have the right to seek health care at any health facility, which has to receive patients and provide medical treatment in all cases.
- Decree 96/2007/QD-Tag of the Prime Minister includes provisions on the rights of prisoners to access to HIV treatment.

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

Briefly explain what mechanisms are in place to ensure that these laws are implemented:

According to regulations, a law will be effective six month after the promulgation. There should be detailed guidance for implementation of some articles of the law which will be promulgated by the level and agency as regulated in the law. Therefore, agencies assigned to develop legal documents guiding the implementation of the law's articles have to implement the work after the promulgation of the law and the development process have to be in accordance with the Law on the Promulgation of Legal Documents approved by the National Assembly on 03/06/2004. In addition, the Law on the Promulgation of Legal Documents also regulates the application of legal documents in Article 83 as following:

1. Legal documents shall be applied since their effective dates.

Legal documents shall be applied to behaviors taking place at the point of time such legal documents are being valid. In the event of legal documents taking retrospective effect, such rulings shall be applied.

2. In the event of legal documents having different rulings on the same issue or problem, those legal documents taking superior legal effect shall be applied.

3. In the event of legal documents promulgated by the same State agency but having different rulings on the same issue or problem, the rulings of the legal documents promulgated later shall be applied.

4. In the event of new legal documents imposing no liability or imposing lesser liability on those behaviors taking place prior to their effective dates, the new legal documents shall be applied.

However, during the development of sub-law documents, there have been often delays in the promulgation of decrees, circulars which often takes from six months to one year. In addition, it is

very difficult to implement a number of provisions, for example Decree 176/2013/ND-CP on handling administrative violations regulated that people who discriminate against PLHIV shall be fined, however the feasibility of its implementation is not firm.

Laws are implemented after the Government issues a Decree and the relevant Ministry issues instructions. However, the Government often delays the promulgation of laws and decrees generally from 6 months to 1 year.

For example, while Decree 108/2008/ND-CP mentions interventions for MSM and harm reduction for PWID, such as needle and syringe distribution, the implementation of the Decree has been limited in some provinces and some sectors, and also differs from province to province depending on funding levels. There is also limited knowledge about Decree 176/2013/ND-CP (on administrative sanctions for discrimination against PLHIV) among people at the commune level, or in health facilities and enterprises etc., and thus it is not effectively implemented.

It has also been found that mechanisms to ensure the implementation of laws vary from group to group. In general, PLHIV enjoy the full benefits of the law, as do women and children, especially orphans. However, prisoners cannot always access their entitlements (e.g. timely and appropriate treatment), and anyone who falls into the "social evils" category (e.g. sex workers and people who use drugs) are often discriminated against.

There are also no mechanisms for CSOs to monitor or give feedback to help ensure that laws are enforced.

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

In general, basically the terms of the law are enforced by state agencies, all citizens must abide by and comply with the constitution and the law. However, there are delays in promulgating decrees and in disseminating the law to law-enforcement agencies and the public. Law-enforcement agencies generally have insufficient knowledge of relevant laws and mechanisms of implementation of these laws and issues relating to legal sanctions have not been respected.

The general mechanisms of law enforcement are very weak, with the vast majority of issues related to legal sanctions not taken seriously; overall mechanisms for law-enforcement monitoring are also weak.

2. Does the country have laws, regulations or policies that present obstacle[33]s to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

☑Yes	No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	☑ No

[33] The policies or laws do not necessarily to mention specifically about HIV. They can be policies, codes of law, or regulations can prevent or make it difficult for people who want to access prevention, treatment, care and support services. Examples from previous national reports showed that these law can be: "the law criminalizing homosexual relations", "the law criminalizing carrying condoms or addictive drugs", "the law prohibiting import of gen-related drugs", "policies banning distribution or possession of condoms in prisons", "policies prohibiting people who are ~~deprived of his citizenship to access~~ ART" "criminalization of transmission of and exposure to HIV"; "the law/rights of women to inherit"; "the law prohibiting delivery of information and service on sexual health and reproductive health for young people" etc.

Men who have sex with men	Yes	☑ No
Migrants/mobile populations	☑ Yes	No
Orphans and other vulnerable children	Yes	☑ No
People with disabilities	Yes	☑ No
People who inject drugs	☑ Yes	No
Prison inmates	☑ Yes	No
Sex workers	☑ Yes	No
Transgendered people	Yes	☑ No
Women and girls	Yes	☑ No
Young women/young men	Yes	☑ No
Other septic vulnerable populations[34] *[write in]*: PWID in detention centers have limited access to HIV treatment services.	Yes	☑ No

Briefly describe the content of these laws, regulations or policies:
- Additionally as residency in the specific district of the treatment centre is one of the eligibility criteria for the current national pilot methadone maintenance therapy (MMT) programme, migrants without official residency are not able to access these services.

Briefly comment on how they pose barriers:
- Under the Law on Social Evils, sex work and drug use are classified as social evils. The associated stigma and discrimination prevent or delay drug users and sex workers from accessing drug-treatment, harm-reduction and other social services. The fear of being detained also poses a barrier. - Access to HIV prevention, treatment and care services (particularly harm-reduction interventions such as condoms, needles/syringes and opiate substitution therapy) is still limited in detention centres. - 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.

3. Does the country have a policy, law or regulation to reduce violence against women,

[34] Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

including for example, victims of sexual assault or women living with HIV?

☑Yes	No

Briefly describe the content of the policy, law or regulation and the populations included:
In 2013, the Decree 167/2013/ND-CP regulated the administration sanction in regards to domestic violence. As reported previously: The laws on domestic violence and gender equality have general provisions on domestic violence and sexual violence. The anti-trafficking law 66/2011/QH12 and the regulations on the prevention of cross-border trafficking mention the protection of women with HIV. On 11/12/2013, Decree 167/2013/ND-CP promulgated regulations on administrative sanction, including the article 49, 50, 51 and 52 for infringement health, tortured, abused, insulted the honor and dignity; isolation, shunning or put pressure on family members.

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

☑Yes	No

If YES, briefly describe how human rights are mentioned in the HIV policy or strategy:
As reported in the previous round, the newly developed *National Strategy on HIV AIDS Prevention and Control for the period 2011-2020, with a vision to 2030* states clearly that respect for human rights needs to be ensured; stigma and discrimination countered; the responsibility of families and society for taking care of PLHIV increased; equity in treatment and care for PLHIV ensured; gender equity ensured; and care for children and vulnerable groups, as well as ethnic minorities and people living in remote areas provided. Under Article 4 of the Law on HIV, PLHIV have the right to live within the community and society; to receive medical treatment, care, education and employment; to keep private their HIV status; to refuse medical examination and treatment for full-blown AIDS [sic] and other rights as stipulated in the Law on HIV and other related laws.

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

☑Yes	No

If YES, briefly describe this mechanism:
As reported previously: Decree 07/2007/ND-CP provides guidance on legal aid legislation, and article 3 states that PLHIV are eligible to free legal aid. Under the Decree 176/2013/ND-CP on administrative sanctions for violations in the health sector, fines can be issued if provisions in the Law on HIV are violated. The Centres for Legal Support under the Department of Justice also provides legal support to PLHIV for free of charge.

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

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment	Yes	No	☑Yes	No	Yes	No
HIV prevention[35] services[44]	Yes	No	☑Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	☑Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?
The Law on HIV stipulates that the State should provide ART free of charge to the following groups of PLHIV: 'people who have been exposed to or infected with HIV due to occupation, people who have been infected with HIV due to risks of medical techniques, HIV-infected pregnant women and HIV-infected under-six children'. It also stipulates that government- and donor-funded ART should be provided to these groups as a priority, with other PLHIV receiving ART once these populations have been treated. This means that some PLHIV do still pay for treatment where donor funding is not available. Most of the funding for ARV medicines comes from international sources. As international organizations gradually withdraw their aid, there is a concern that access to medicines and other services will no longer be free.

[35] Such as safe blood infusion, condom advertisement, harm reduction from PWID, HIV prevention for out-of-school young people, HIV prevention at workplace, HIV counseling and testing, IEC on risk reduction and stigma and discrimination reduction, PMTCT, prevention for PLHIV, reproductive health services including STI prophylaxis and treatment , risk reduction for sexual partners of people belong to the three high-risk groups as listed above, risk reduction for MSM, FSW, school-based HIV education for students, normal rules in health facilities.

At present, there are discussions on domestic production of ARV and payment mechanism through health insurance to deal with the future shortage of funding.

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

☑Yes	No

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

☑Yes	No

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

☑Yes	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:
The Law on HIV mandates the equitable access to prevention, treatment and care to all populations in need of these services, regardless of their socio-economic status. National Strategy reflects the government's viewpoints on ensuring equity in the HIV prevention and control.

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

☑Yes	No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
Under the Law on HIV, key populations at higher risk are given priority with regards to access to IEC on HIV prevention and control (Article 11); and harm reduction interventions (Article 21). However, the Law on HIV does not specify targeted approaches for the following key populations at higher risk:

MSM, female PWIDs, prisoners, people in administrative detention, and migrant and mobile populations.

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

Decision 96/2007/CP dated 28/6/2007 on management, counseling, care and support to PLHIV and HIV prevention in prisons and administrative detention centres provides for the provision of HIV prevention, treatment and care in these settings. However, access to HIV prevention, treatment and care services (particularly harm-reduction interventions such as condoms, needles/syringes and opiate substitution therapy) is basically non-existent in prisons. ART services in closed setting are improving slightly.

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

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

☑Yes	No

IF YES briefly describe the content of the policy or law:

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

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

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

Yes	☑ No

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

Yes	☑ No

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

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

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[36]?

☑ Yes	No

b. Programmes for members of the judiciary[37] and law enforcement on HIV and human rights issues that may come up in the context of their work?

☑ Yes	No

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

a. Legal aid systems for HIV casework

☑ Yes	No

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

☑ Yes	No

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

☑ Yes	No

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

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would

[36] For example they include the campaign "Understand your rights" – a campaign to improve capacity of PLHIV so that they understand about your rights and HIV relevant legal regulations (see the UNAIDS guidance: mentioning the HIV relevant legal regulations at the central level, working document, 30/4/2008)

[37] They include, for example, judges, magistrates, prosecutors, police, human rights commission member and labor court judges or members of the labor committee

you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	☑8	9	10

Since 2011, what have been key achievements in this area:
There are several newly passed laws and policies on human rights issues related to HIV and existing laws were updated and revised in the reporting period, including: Law on sanctions for administrative violations, Decree 96/2012/ND-CP on substitution treatment with methadone to addiction of opiate substances (MMT), the National Strategy on HIV AIDS Prevention and Control until 2020 with a vision to 2030, the National Target Program on HIV AIDS, Decree 136/2013/ND-CP on social protection and the National M&E Framework for the HIV AIDS program, decree 110/2013/ND-CP dated 24/9/2013. There is also an increased recognition of drug users as patients who require medical assistance, and a small reduction in drug users in 06 Centres.

What challenges remain in this area:
While there has been progress, with new laws promulgated and existing laws amended, and their effective implementation remains a challenge. All key populations at higher risk remain highly stigmatized despite legal documents. - There also continues to be a basic lack of human rights, including HIV treatment, care and prevention services, for people in closed settings. - Compliance with regulations is low among law-enforcement agencies and monitoring mechanisms and sanctions are very weak. - Decree 45/2010/ND-CP dated 21/4/2010 guides the development of social associations but creates a barrier to the establishment of associations of vulnerable groups, as a group cannot register with a name or terms of reference which overlap with those of an existing organization. As the Viet Nam HIV AIDS Association has been formally established, no PLHIV self-help group is able to register.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?

Very Poor										Excellent
0	1	2	3	4	5	☑6	7	8	9	10

Since 2011, what have been key achievements in this area:
As of the Law on sanctions for administrative violations, sex workers have not been allocated into detention centers. MMT patients have better access to MMT services, as the result of the implementation of the Decree 96/2012/ND-CP. There is increased knowledge within civil society about the law in general and human rights in particular, compared with the previous reporting period. Efforts to reduce stigma and discrimination in schools and health care systems have also improved.
What challenges remain in this area:
The implementation of laws remains weak due to the late introduction of developed policies to commune authorities and the community. The remaining inconsistencies between public security measures to control drug use and sex work and public health measures to reach the populations engaged in these activities. Understanding among FSW about regulations on sanctions for administrative violations remains limited. Stigma of and discrimination against key populations at higher risk and PLHIV continues. A lack of remedies and penalties for violations of the law.

IV. PREVENTION

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

☑ Yes	No

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

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	☑4	N/A
Condom promotion	1	2	3	☑4	N/A
Harm reduction for people who inject drugs	1	2	☑3	4	N/A
HIV prevention for out-of-school young people	1	☑2	3	4	N/A
HIV prevention in the workplace	☑1	2	3	4	N/A
HIV testing and counselling	1	2	☑3	4	N/A
IEC[38] on risk reduction	1	2	☑3	4	N/A
IEC on stigma and discrimination reduction	1	2	☑3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	☑3	4	N/A

[38] IEC: information, education, communication

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Prevention for people living with HIV	1	2	☑3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	☑2	3	4	N/A
Risk reduction for intimate partners of key populations	1	☑2	3	4	N/A
Risk reduction for men who have sex with men	1	2	☑3	4	N/A
Risk reduction for sex workers	1	2	☑3	4	N/A
School-based HIV education for young people	1	2	☑3	4	N/A
Universal precautions in health care settings	1	☑2	3	4	N/A
Other*[write in]*: Prevention services for mobile groups	1	☑2	3	4	N/A

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	☑8	9	10

Since 2011, what have been the key achievements in this area:
There have been a number of notable achievements in the reporting period: - Prevention programmes for key populations at higher risk, particularly MSM, have been included in the *National Strategy on HIV AIDS Prevention and Control for the period 2011-2020, with a vision to 2030*. - The Ministry of Public Security, Ministry of Defense, Ministry of Labor – Invalid – Social Affair, Ministry of Construction, Ministry of Education and Training, Ministry of Transportation, Ministry of Culture, Sport and Tourism, Ministry of Agriculture and Rural Development, Ministry of Justice, the Central Committee of the Fatherland Front and mass organizations conducted IEC/BCC sessions to reach people with risk behaviours, mobile populations, ethnic minorities, migrants,

youths and teenagers, prisoners with HIV prevention messages and services.

- A further geographic expansion of the NSP, 100% CUP and HIV prevention for MSM programmes took place during the reporting period. In 2013, 49 of 63 provinces carried out community outreach activities for PWID and FSW, 60 implemented some level of NSP and all provinces distributed condoms free of charge.
- Circular 29/2013/TTLT-BYT-BVHTTDL-BCA-BLĐTBXH guides the implementation of harm reduction for HIV prevention by condom promotion at tourism establishments and hotels.
- The Ministry of Culture, Sport and Tourism developed an action plan for the period 2010 - 2012 to implement the Condom Program for HIV and STI Prevention in tourism establishments and hotels. The Ministry is now going to collaborate with related organizations to develop a circular on condom provision in entertainment establishments and hotels.
- The methadone maintenance therapy programme has been expanded to 30 provinces/ cities with 80 sites providing services to 15,542 patients. The MoH has recently granted a permission to 5 eligible enterprises to manufacture Methadone in the country.
- In the past two years, the GF project had more interventions for intimate partners of PWID and HIV discordant couples and sexual partners of MSM.
- Networks of PLHIV, PWID, SW and MSM have been recognized and mobilized to be more active in the HIV response.
- The incidence of new cases among PWIDs has been declining steadily and incidence/prevalence among SWs has remained low. This indicates a degree of success of the prevention programmes.
- Access to condoms have become easier, clients now buy condoms proactively. However, the condoms available for free distribution are decreasing and gradually replaced by condom social marketing program.

What are remaining challenges in this area:

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

- Though the pilot models have been expanded (prevention for the three key populations, PMTCT...), their quality has been decreased due to the reduction in funding. Post-test counseling quality remains week.
- Whilst there has been a scale up of harm reduction and there is a greater recognition that people who use drugs need medical care, services are still limited and PWID do not access services due to fear of being detained in compulsory 06 Centres. Many MMT establishments are overloaded due to a higher demand for treatment. It is unlikely that the target of 80,000 PWID on MMT will be achieved by the end of 2015. There is a new trend among the PWID of using synthetic drugs and engaging in group sex that lead to a higher risk of HIV sexual transmission.
- Quality of sexual and reproductive health services has decreased significantly due to the impact of the funding cut. Stigma still exists in health facilitates that provide these kind of services. FSW are not aware of how to protect themselves from STIs.
- Whilst there has been progress in the response for MSM, rising incidence among MSM remains a concern. Challenges remain in accessing prevention services, in particular for MSM located in rural areas.
- Testing and counselling services differ in availability and quality from province to province,

and with little availability in rural areas. In general, counselling services are of low quality.

- A lack of proper attention is paid to out-of-school young people who are considered a high risk population group.
- PMTCT among ethnic women remained limited due to their limited knowledge of its importance and the availability of services.
- A failure to manage and follow up prevention activities among the mobile group
- IEC for risk reduction is mostly project oriented, targeting just some key populations at higher risk and not necessarily reaching all people in need.
- There is a lack of integration of reproductive health/STI and HIV services.
- There are significant differences throughout the country in terms of HIV prevention programmes; provinces with greater donor support have a better quality of services.

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

V. TREATMENT, CARE AND SUPPORT

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

☑Yes	No

If YES how were these specific needs determined?
Existing support for PLHIV includes: psychological support; legal and social support; support for OPC registration; stigma- and discrimination-reduction activities; economic development: loans, job creation; group meetings for capacity building; nutrition support, particularly for children; home-based care; education support; OVC programmes; palliative care; sexual and reproductive health; TB treatment; OI prophylaxis; treatment for STIs and other infections. There are also national guidelines for the early treatment of hepatitis B and for PMTCT.
If NO, how are HIV treatment, care and support services being scaled up

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

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	☑3	4	N/A
ART for TB patients	1	2	☑3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	☑2	3	4	N/A
Early infant diagnosis	1	2	☑3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	☑2	3	4	N/A
HIV testing and counselling for people with TB	1	2	☑3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	☑2	3	4	N/A
Nutritional care	1	☑2	3	4	N/A
Paediatric AIDS treatment	1	2	☑3	4	N/A
Post-delivery ART provision to women	1	2	☑3	4	N/A

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	☑2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	☑3	4	N/A
Psychosocial support for people living with HIV and their families	1	☑2	3	4	N/A
Sexually transmitted infection management	1	☑2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	☑3	4	N/A
TB preventive therapy for people living with HIV	1	2	☑3	4	N/A
TB screening for people living with HIV	1	2	☑3	4	N/A
Treatment of common HIV-related infections	1	☑2	3	4	N/A
Other*[write in]*: Home based care	☑1	2	3 3	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	☑7	8	9	10

Since 2009, what have been key achievements in this area:
The coverage of services (such as ART, PMTCT, livelihoods support and STI treatment) has expanded, especially the Early Infant Diagnosis. The services provided are now more comprehensive than in the past. Treatment is provided at 06 center and prison. Health insurance now provides coverage for PLHIV. Guidance on PMTCT has included the treatment regime starting from the 14th week and Care and support services have been expanded, with an increased number of CSO support group. ; The capacity and knowledge of CSOs to provide these services has also increased with steps also being taken to work across government ministries and departments to ensure cooperation and a coordinated response.

Treatment 2.0 has been piloted in two provinces in Viet Nam, helping to increase the number of people able to access treatment and care services. TB screening and prophylaxis for PLHIV is also now available in almost all provinces.

What challenges remain in this area:

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

- Donors are phasing out. The HIV AIDS program is facing a severe shortage of resources and this is a great challenge. Due to the reduced funding, PLHIV find it difficult to access treatment and STI prophylaxis treatment. PLHIV also no longer receive nutritional care which used to be supported by the donor-funded projects.
- Many women cannot access to continuous ARV treatment after delivery. In remote areas, HIV-infected pregnant women find it difficult to access prevention programs and their awareness remains low.
- In regards to the pilot of the Treatment 2.0 strategy, some PLHIV expressed their concern on the confidentiality of the HIV test result; this will be a barrier for the expansion of the pilot. Many patients are afraid of discrimination and disclosure and as a result will not attend treatment services in their own locality. This illustrates the importance of confidentiality provisions.
- Guidance for treatment of Hepatitis C has been promulgated, however the drug has not been included in the health insurance list of included medicines.
- The coverage of livelihood supporting services remains limited.
- Stigma and discrimination still exist, with health service staff particularly identified as being responsible. Stigma and discrimination are challenges for ART access as many patients refuse treatment because of the risks of unintended disclosure. In addition, some PLHIV do not want to start ART because of associated financial costs and the perceived complication of ART.
- TB treatment services for PLHIV are still not adequate and in most provinces, ART regimens are not changed when patients undertake TB treatment; in addition, many TB patients are unable to access ART early enough. In some provinces, 2-line regimen ARV medicines or medications for HepB/C treatment are unavailable.
- Post-exposure prophylaxis is only available to some professionals (such as military and health staff) and in the case of rape no treatment is provided. While early testing for infants is provided in some provinces, in others only some infants get tested, while others do not know their results.
- Treatment inside 05/06 Centres and prisons remains very limited. PLHIV often have to transfer medicine from outside, which costs a considerable amount, or interrupt their treatment, which increases the risk of drug resistance.
- The role of CSOs in treatment, care and support has not been fully recognized. The obstacles faced by CSOs, such as difficulties in legal registration, make it difficult for them to provide services.
- Sustainability is an issue in light of reductions in international funding. In addition, when Viet Nam signs the Asia-Pacific Trade Agreement, which will mean that generic ARV medications are no longer available due to rules on intellectual property rights, patients will face more difficulties in accessing treatment because of increased prices of ART.

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

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

☑Yes	No

2.1. IF YES, is there an operational dentition 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

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	☑8	9	10

Since 2011, what have been key achievement in this area:
- The number of HIV-positive infants born to HIV-positive mothers has reduced significantly due to the expansion of PMTCT, and early testing for infants born to mothers with HIV has been expanded. - Nutritional support to infants born to HIV-positive mothers is on-going and effective. Many HIV-related OVC receive allowances in accordance with Decree 67. - The accessibility and coverage of ART for HIV+ OVC is high. - Better collaboration between the Government and CSOs in the provision of treatment, care and support for OVC and the expansion of CSOs providing these services. There is continued commitment to the National Plan of Action on Children affected by HIV (NPA), despite a rapid decline in international donor funding for HIV-related OVC.
What are remaining challenges in this area:
- There is still stigma and discrimination, which poses a barrier to school attendance for many children.

- Data on HIV-related OVC has not been revealed, which makes planning and evaluation of HIV-related OVC programmes difficult.
- Foster care is still limited to HIV infected and affected children who are abandoned, therefore these children are often sent to public social protection centers.
- The NPA remains unfunded by international donors.
- Some families prevent children from accessing treatment due to poor knowledge.

Annex 3. Calculation methods for the HSS+/IBBS combined indicators

Data source

1. HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Viet Nam 2013
2. Behavioural surveillance integrated into Sentinel Surveillance (HSS+) in Viet Nam, 2013

Study sites and sample size

Study	Number of provinces	Sample size
IBBS		
- PWID	8	3550
- FSW	6	3097
- MSM	3	1241
HSS+		
- PWID	22	4846
- FSW	20	4284
- MSM	8	1249

Calculation method

- Calculating indicators for each province, by age group, and according to the indicator definition of GARP (Reference: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2014/GARPR_2014_guidelines_en.pdf)
- Calculating median of all provincial data points of provinces that participated in IBBS and HSS+. For example, indicator of PWID population is the median of 30 provincial data points of 30 provinces. Indicator of FSW population is the median of 26 provincial data points of 26 provinces. Indicator of MSM population is the median of 11 provincial data points of 11 provinces.
- The median is use for reporting to GARP.

Results

Indicator	GARP indicator (median)	Indicator from HSS+ sourse	Indicator from IBBS source
1.7 Percentage of sex workers reached with HIV prevention programmes	51.0%	54.5%	50.1%
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	92.0%	87.0%	93.9%
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	35.1%	36.5%	35.9%
1.11 Percentage of men who have sex with men reached with HIV prevention	42.3%	52.4%	36.2%
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	66.4%	64.0%	66.4%
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	28.8%	29.9%	26.5%
2.2. Percentage of people who inject drugs who	41.2%	48.2%	37.2%

report the use of a condom at last sexual intercourse			
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	97.3%	97.4%	93.7%
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	23.6%	26.4%	24.8%

Limitations

- The data are not representative of the national population because they were only collected at 'hot spots' in some provinces/cities (PWID: 30 provinces, FSW: 26 provinces, MSM: 11 provinces) among a total of 63 provinces/cities nationwide.
- Data on male sex workers and female injecting drug are not available.
- Data were not adjusted for population size
- Data were not adjusted for RDS sampling method
- HSS+ 2013 expands to cover some provinces which have limited investment and low coverage of intervention. This could explains the reason for an observed decline of the indicators in comparison to previous years.

Annex 4. National Funding Matrix – 2014

Cover Sheet

Please provide the following information when submitting the completed National Funding Matrix.

Country: **Viet Nam**

Contact Person at the National AIDS Authority/Committee (or equivalent):

Name: Dr Nguyen Hoang Long ___ Title: Director, Viet Nam Administration of AIDS Control, Ministry of Health

Contact Information for the National AIDS Authority/Committee (or equivalent):

Address: 135/3 Nui Truc,Ba Dinh, Ha Noi, Viet Nam Email: longmoh@yahoo.com

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Reporting Cycle 2011: calendar year __X_____ or fiscal year _____

Reporting Cycle 2012: calendar year __X____ or fiscal year _____

Reporting Cycle 2013: calendar year _____ or fiscal year _____

For a fiscal year reporting cycle, please provide the start and end month/year: ___ / ___ to ___ / ___

Local Currency:

Average exchange rate with US dollars during the reporting cycle: 2011: 20,353 / 2012: 20,827

Methodology: National AIDS Spending Assessments – with full report submitted as an attachment

Unaccounted Expenditures:

+ Household expenditure were not estimated (about US$ 16 million in 2010)

+ Public expenditure of the labor sector (in orphanages, social houses and closed centers) were not estimated (about US$ 1.5 million in 2010)

Countries that have submitted data for 2011 and/or 2012 already in their last report (GARPR 2013) do not need to fill in data for these years again, unless data in the last report were missing, incomplete or there have been changes to the data as more information has become available since. In this case, we will replace the data in our database reported for these years in the last submission (GARPR 2013) with the newer data reported in the 2014 submission.

2011: US$ 130,934,204

2012: US$ 136,113,097

2013: NA

Budget Support: Is budget support from an international source (e.g. a bilateral donor) included under the Central/National and/or Subnational sub-categories under Public Sources of financing?

2011: No / 2012: No

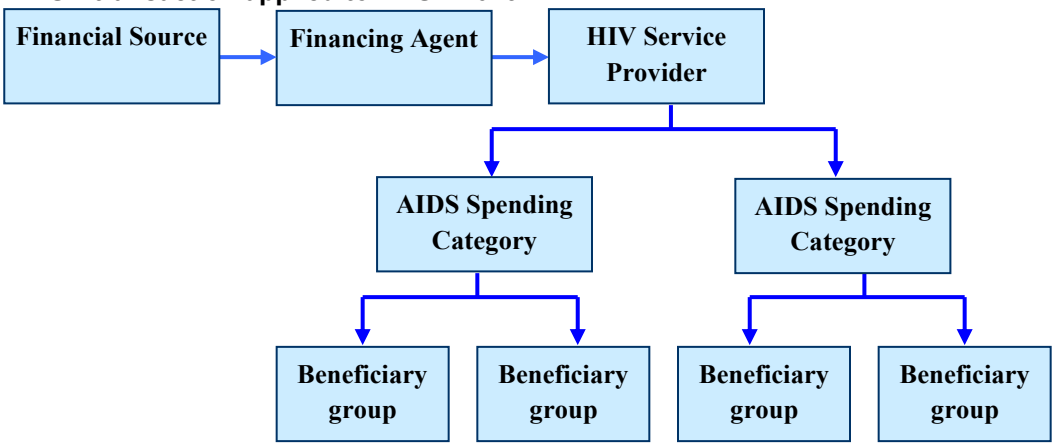
Indicator 6.1. Domestic and international AIDS spending by category and financing source for the period 2011-12

This report is based on data collected by the National AIDS Spending Assessment (NASA) in 2013. While NASA resulted in a big database, a subset of verifiable data was extracted under the guidance of VAAC and analysis was conducted in order to report against indicator 6.1: Domestic and international AIDS spending by category and financing source for the period 2011-2012.

NASA uses a comprehensive and systematic methodology provided by UNAIDS to determine the flow of resources intended to combat HIV and AIDS. The tool tracks actual expenditure (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV and AIDS[39].

Financial flows and expenditures related to the National Response to HIV are captured from their origin (financial source) via financial intermediaries (financing agent) to various service providers, and classified according to HIV-related interventions and activities (AIDS spending categories) and beneficiaries. Figure 1 illustrates the elements of a financial flow recorded by NASA 2013.

Figure 1. NASA transaction applied to NASA 2013



Costing techniques can be used to estimate actual expenditure based on internationally accepted costing methods and standards used to retrogressively measure past actual expenditure. In NASA 2013 costing was employed to estimate the costs of staff responsible for HIV in the government health system.

Data Collection Form

A Data Collection Form was prepared based on the NASA Manual and the concrete requirements for NASA 2013. The Form was adapted and simplified to ensure that respondents could complete it on their own, identifying financial source, financing agent, service provider, AIDS spending category and beneficiary. In addition, a specific Data Collection Form for Public Sources was developed to guide PAC, VAAC and other Vietnamese partners on reporting public expenditures.

The Data Collection Form was circulated to all financing sources and agents, and provincial AIDS centres (PAC) which were the key program implementers in 63 provinces. Exceptions were PEPFAR primary partners including USAID, CDC, US Department of Defence (DoD), Family Health International (FHI), Abt Associates, SCMS and HAIVN. PEPFAR reported on behalf of these partners.

The number of organizations who responded to the data collection request in 2013 increased significantly compared to the previous NASA due to better response rate among the public organizations. Particularly,

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

100% of provincial AIDS centres (PACs) responsible for implementation of the National Target Program on HIV AIDS reported their data for NASA. Table 1 below summarises the organizations contributing in this report.

Table 1. Respondents of National AIDS Spending Assessment 2013

Type of respondent organisations	Number of respondent organisations
Public organisations	72
Bilateral organisations	6
Multilateral organisations	8
International NGO and foundations	8
Total	**94**

Validation process

After sending the Data Collection Form, telephone, email and post were used as the main communication channels to guide on technical issues, verify respondent classification and expenditures. Visits were conducted to the major project offices managed by the MOH.

NASA 2013 incorporated the feedback from two provincial validation workshops organized in Dien Bien and Can Tho provinces.

Data processing and analysis

Responses from partners were entered to an excel worksheet, and processed with Stata software.

Assumptions and limitation of NASA 2013

NASA 2013 has a large amount of unclassified expenditures reported by PEPFAR. This year the PEPFAR Coordination Office decided to report on PEPFAR expenditures on behalf of all PEPFAR partners using the results of the PEPFAR internal Expenditures Assessment (EA). However, the EA results were very far from meeting requirements of NASA, since they contain just two dimensions (out of six) of NASA classification system – the financial source (the US government) and the AIDS spending category (ASC). Moreover, the ASCs reported by PEPFAR were general and did not cover the series of activities reported by public organizations and NGOs that implemented PEPFAR-funded programs. The NASA team, using information collected from PEPFAR service providers and bottom-up estimation, reconstructed a series of the PEPFAR-originated transactions, however, they could not resolve completely the issue of unidentified financing agents and service providers. As part of the PEPFAR reported expenditures were neither verified at financing agent nor service provider levels, VAAC decided to exclude these expenditures from the national AIDS spending reported to GAPR.

NASA 2013 omitted household expenditures on HIV which were estimated to a total of US$ 16 million per year in 2008-2010 period. Expenditures of the labour sector on HIV AIDS (estimated to US$1.5 million) were also not counted.

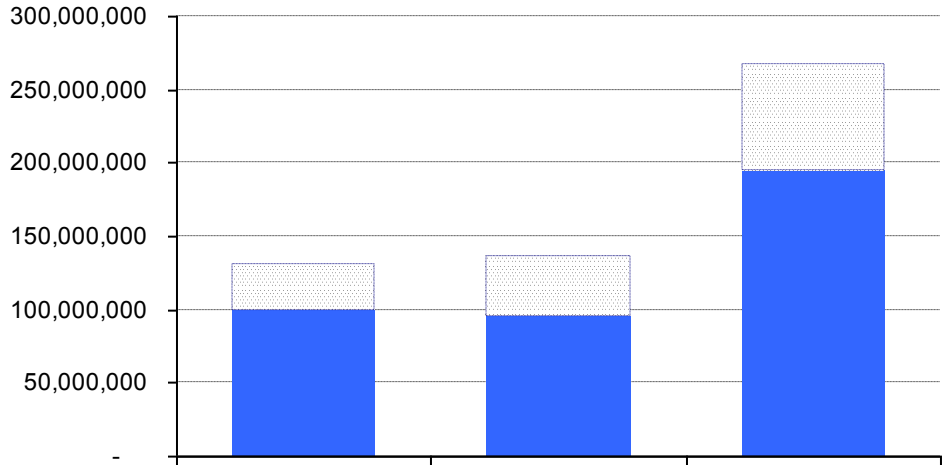
All respondents used the calendar year as their financial year, except PEPFAR. PEPFAR partners reported expenditures in the PEPFAR financial year, starting 1st October of the previous year and ending 30 September of the year of report.

Overview of AIDS expenditures in 2011-12

In 2011-2012 period, US$ 195.3 million from the public and international sources were spent on the AIDS response. AIDS expenditure accounted for 0.07% of GDP while per capita AIDS expenditure was US$1.1.

Figure 2 illustrates total national AIDS spending in 2011-12. This figure includes a dotted part which represents unverified expenditures of PEPFAR.

Figure 2. Total national AIDS expenditures, 2011-12



	2011	2012	2011-2012
PEPFAR unverifiable expenditure	31,089,286	40,666,607	71,755,893
Total actual spending	99,844,918	95,446,491	195,291,409

AIDS expenditures by financial source

NASA 2013 captured public and international financial resources and omited spending of households on AIDS. Total expenditure, and the propotional share of each major financial source in 2011-12 are illustrated in Table 2 and Figure 3

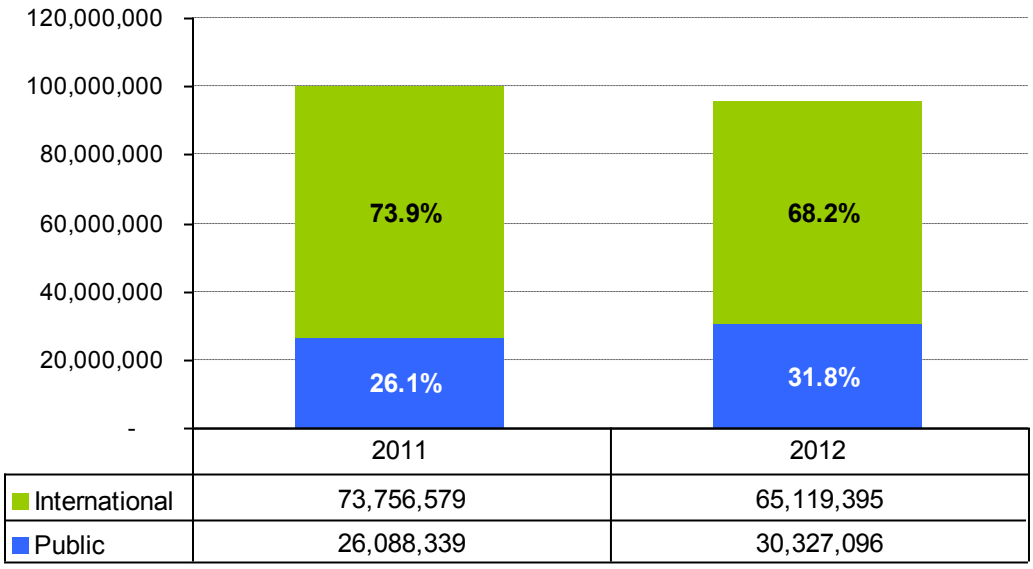
Table 2. Summary of AIDS expenditures in Viet Nam by financing source, 2011-12 (US$)

Source	2011	2012	2011-12	%
Public sources	**26,088,339**	**30,327,096**	**56,415,435**	**28.9%**
Central government	16,974,002	19,140,627	36,114,629	18.5%
Provincial government	9,114,337	11,186,469	20,300,806	10.4%
International sources	**73,756,579**	**65,119,395**	**138,875,974**	**71.1%**
Bilateral organizations	**51,186,232**	**42,821,545**	**94,007,777**	**48.1%**
Government of Australia	3,019,655	3,022,209	6,041,864	3.1%
Government of France	394,294	399,195	793,489	0.4%
Government of Ireland	143,205	137,496	280,701	0.1%
Government of Japan	223,715		223,715	0.1%
Government of Luxembourg	162,561		162,561	0.1%
Government of Netherlands	984,412	443,531	1,427,943	0.7%
Government of Norway	323,553	111,739	435,292	0.2%
Government of Sweden	45,001	109,040	154,041	0.1%
Government of United Kingdom	12,461,936	9,644,785	22,106,721	11.3%
Government of United States[40]	33,261,727	28,917,091	62,178,817	31.8%
Other governments (Canada, Colombia, Germany)	166,173	36,459	202,632	0.1%

[40] PEPFAR Coordination Office reported spending of US$ 64.4 million in 2011 and US$ 69.6 million in 2012. However, only verifiable expenditures have been included in Viet Nam national spending.

Multilateral organizations	**21,913,769**	**21,580,840**	**43,494,609**	**22.3%**
Asian Development Bank (ADB)	3,672,407	183,926	3,856,333	2.0%
Global Fund for AIDS, Tuberculosis and Malaria (GFATM)	16,346,834	19,495,015	35,841,849	18.4%
UN agencies	1,894,528	1,901,899	3,796,427	1.9%
International not-for-profit organisation	**576,578**	**667,010**	**1,243,588**	**0.6%**
Bill and Melinda Gates Foundation	16,279	86,668	102,947	0.1%
Caritas Internationalis/Catholic Relief Services	50,000	50,000	100,000	0.1%
The Clinton Foundation	50,245	217,889	268,134	0.1%
Other international non-profit-making organizations and foundations n.e.c. (Norwegian Church Aid, UNITAD)	460,053	312,453	772,507	0.4%
International not-for-profit organisation	**80,000**	**50,000**	**130,000**	**0.1%**
Johnson & Johnson	80,000	50,000	130,000	0.1%
Total	**99,844,918**	**95,446,491**	**195,291,409**	**100.0%**

Figure 3. National AIDS spending by public and international sources, 2011-12[41]



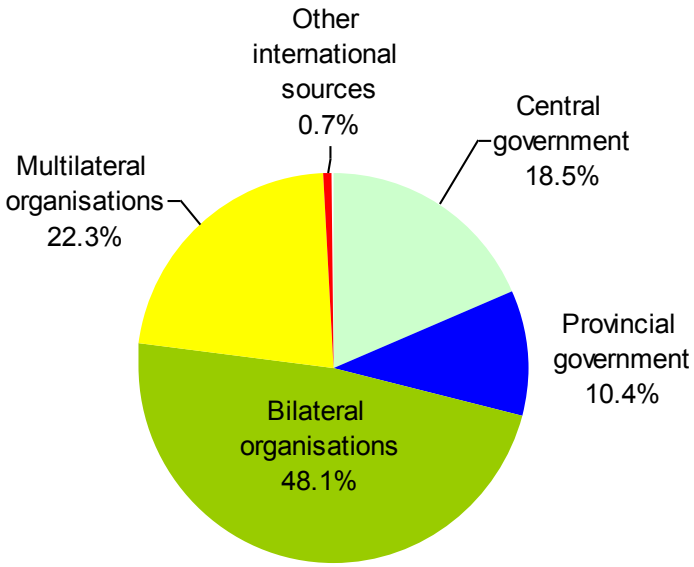
International sources provided US$138.9 million in the 2011-12 period, accounting for 71.1% of national expenditure. Of that total, 67.7% came from bilateral organizations and 31.3% from multilateral sources.

PEPFAR alone contributed US$ 62.2 million, accounting for 31.8% of national expenditure and 65% of total bilateral contribution in the 2011-12 period. International not-for-profit organizations provided 0.7% of national expenditures in this period.

Public sources, consisting of the central and provincial government budgets, provided US$ 56.4 million in 2011-12 period. Figure 4 illustrates relative share of each financial source in national expenditures.

[41] The total international spending includes only verifiable expenditure

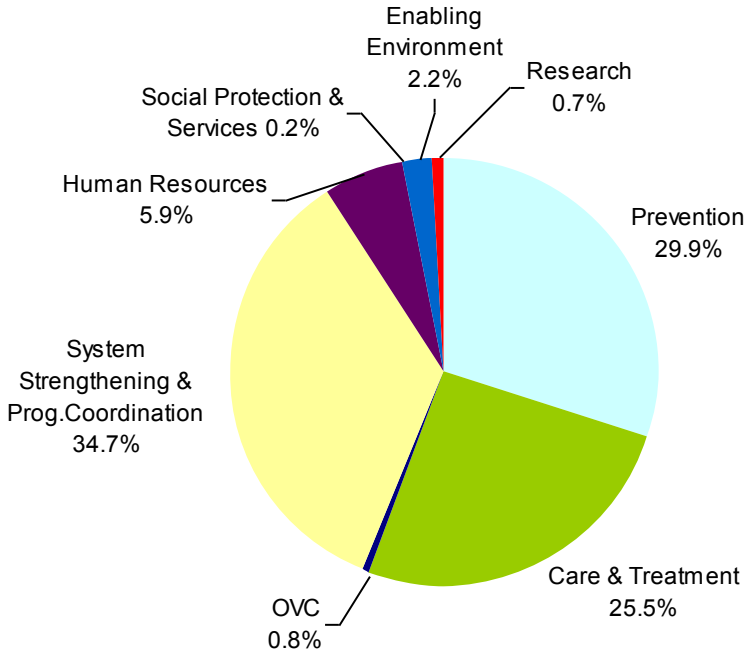
Figure 4 Share of major sources in total national AIDS expenditure, 2011-12



AIDS expenditures by spending category

The NASA classified expenditures into 8 key programatic areas (AIDS Spending Category). Distribution of national AIDS expenditure by these areas are summarised in Figure 5.

Figure 5 Share of major ASC in total expenditure, 2011-12

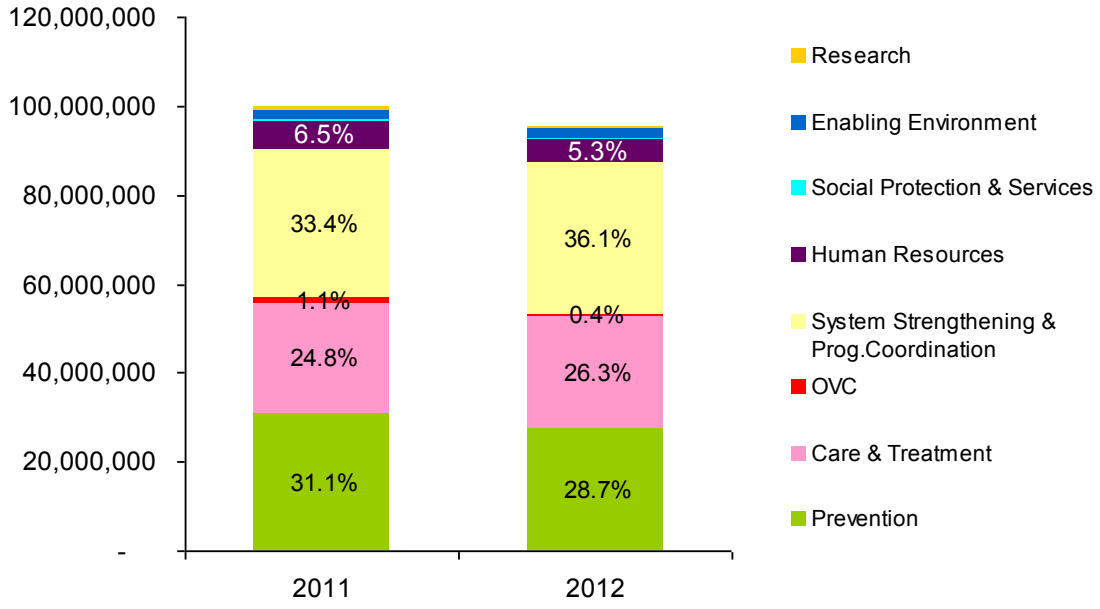


The three programmatic areas receiving the majority of resources are : system strengthening and program coordination (34.7%); prevention (29.9%); and care and treatment (25.5%). Human resources shared 5.9% of national expenditure, enabling environment 2.2%, OVC 0.8%, research 0.7% and social protection and social services – only 0.2%.

The volume of resources spent on system strengthening and program coordination increased from US$ 33.3 million in 2011 to US$ 34.5 million in 2012, leading to an increase in relative share of this programmatic area from 33.4% to 36.1%. Spending on care and treatment also increased slightly both in absolute value and proportionally – from US$ 24.7 million (24.8%) in 2011 to US$ 25.1 million (26.3%) in 2012. However, prevention expenditure reduced from US$ 31 million (31.1%) to US$ 27.4 million (28.7%) during the same years.

Spending on the enabling environment remained stable (around US$ 2.1 million), while all other programmatic areas experienced an expenditure reduction, visible both in absolute value and proportionally. Figure 6 summarises distribution of annual spending over 8 key programmatic areas.

Figure 6: Distribution of annual national expenditure by ASC, 2011-12



AIDS expenditure by beneficiary population

The NASA methodology classifies beneficiaries into six main groups: people living with HIV (PLHIV); most-at-risk populations; key populations; specific "accessible" populations; the general population; and non-targeted interventions. Figure 7 and Table 3 below detail distribution of expenditure by beneficiary in 2011-12.

29% of AIDS expenditure in the 2011-12 period benefited PLHIV. Activities targeting most-at-risk populations (including people who inject drug, female sex workers and men who have sex with men) received 17% of total AIDS expenditure. Other key population groups including OVC, children born or to be born of women living with HIV, ethnic minorities and institutionalized people, received 5% of all resources. Activities for specific "accessible" populations, including mainly health care workers, received 6% of total expenditure. 9% of total expenditure in 2011-12 benefited the general population, while 34% of expenditure supported non-targeted activities, including program management and administration, transaction costs, monitoring and evaluation, investment in infrastructure and equipment.

Figure 6 Disaggregation of AIDS expenditure by six beneficiary population groups, 2011-12

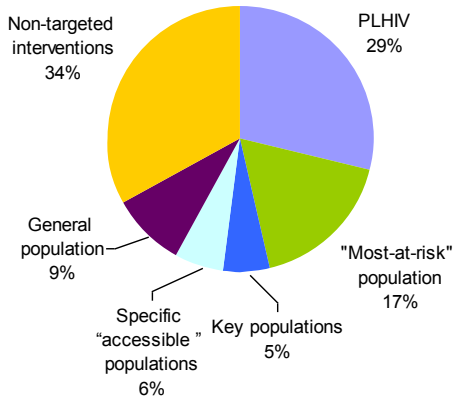


Table 3 Disaggregation of AIDS expenditure by six beneficiary population groups, 2011-12

Beneficiary population group	2011	2012	Total 2011-12	%
PLHIV	27,870,936	28,610,946	56,481,882	29%
"Most-at-risk" population	18,645,215	15,429,352	34,074,567	17%
Key populations	6,398,634	4,250,108	10,648,742	5%
Specific "accessible "	6,393,906	5,371,055	11,764,961	6%
General population	8,823,710	8,958,025	17,781,735	9%
Non-targeted interventions	31,712,518	32,827,003	64,539,521	33%
Total	**99,844,918**	**95,446,490**	**195,291,408**	100%

AIDS expenditure in 2011

In 2011, a total of US$99.8 million were spent to support the national HIV response. AIDS expenditure accounted for 0.07% of GDP; US$1.14 was spent per capita.

Public sources, including both central and local Government budgets, contributed US$26 million to the HIV response. Of this, US$17 million (65%) came from the central budget, though the National Targeted Programme on HIV (US$10.2 million) and PAC Office Construction Program (US$ 6.8 million), while US$9.1 million (35%) came from local (provincial) budgets, which mainly supported the operational costs of PAC activities. In 2011, the total Government spending on HIV accounted for 1.2% of total Government expenditure on health.

International sources provided funds for 73.9% of total AIDS spending, while domestic sources covered the remaining 26.1%. Of all recorded AIDS expenditure, 51.3% was financed through bilateral grants and 21.9% from multilateral sources.

PEPFAR was the largest bilateral donor, providing 33.3% of resources for national AIDS expenditure, or US$33.3 million. The Government of the United Kingdom shared 12.5% of total expenditures, contributing US$ 12.5 million. The Global Fund to Fight AIDS, Tuberculosis and Malaria provided the funds for 16.4% of national AIDS expenditure. The detailed breakdown of AIDS expenditure by source is summarised in Figure 8.

Figure 7 Summary of AIDS expenditure in Viet Nam by financing source, 2011

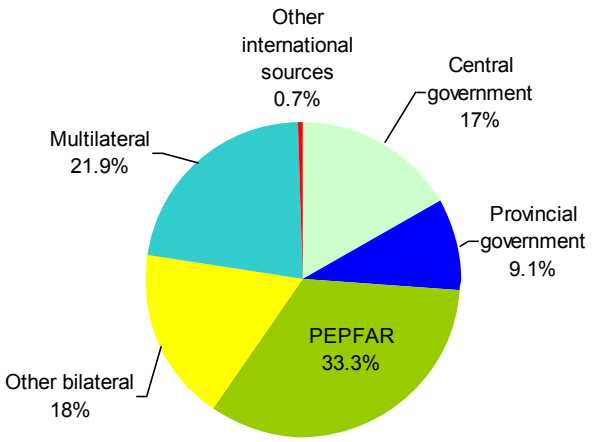
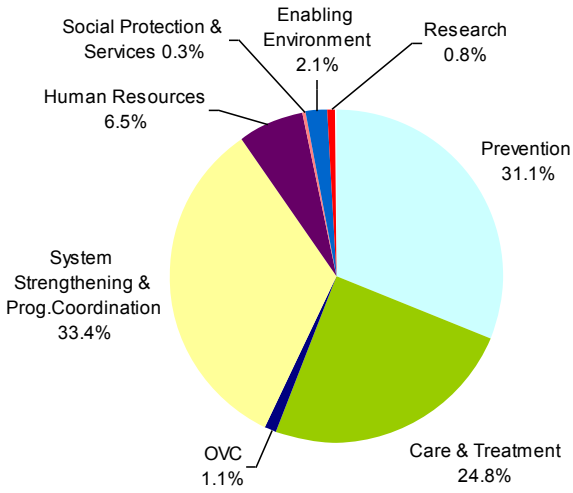


Figure 9 describes AIDS expenditure under the eight major AIDS spending categories (ASC) in 2011. The majority of resources are allocated to system strengthening and program coordination (33.4% of all resources), prevention (31.1%), and care and treatment (24.8%).

In 2011, US$31 million were spent on prevention and US$24.7 million on treatment and care. System strengthening and program coordination received US$ 33.3 million.

A total of 6.5% of all funds were spent on human resources and 2.1% on the enabling environment. Activities to support OVC received 1.1% of funds in 2011, whiles research and social protection and social services shared less than 1% each (0.8% and 0.3% respectively).

Figure 8 Total AIDS spending by ASC, 2011



The detailed breakdown of expenditure by financial source and ASC (Figure 10) shows that Government expenditure was concentrated on system strengthening and program coordination (62%). 35% of public sources were used to support prevention and care and treatment. PEPFAR[42] spent more on care and treatment (48%) and prevention (26%). Other bilateral sources focused on prevention (48%), while also

[42] Analysis is conducted only to those expenditures that have been verified at service provider level

investing in system strengthening and program coordination (28%). Multilateral spending was balanced between prevention (33%), system strengthening and program coordination (29%), care and treatment (21%), and human resources (11%). Other international sources (mainly not-for-profit organizations and foundations) spent their funds on care and treatment (61%), prevention (9%), OVC (8%), and program coordination (17%).

Figure 9 Distribution of expenditure by source and ASC, 2011

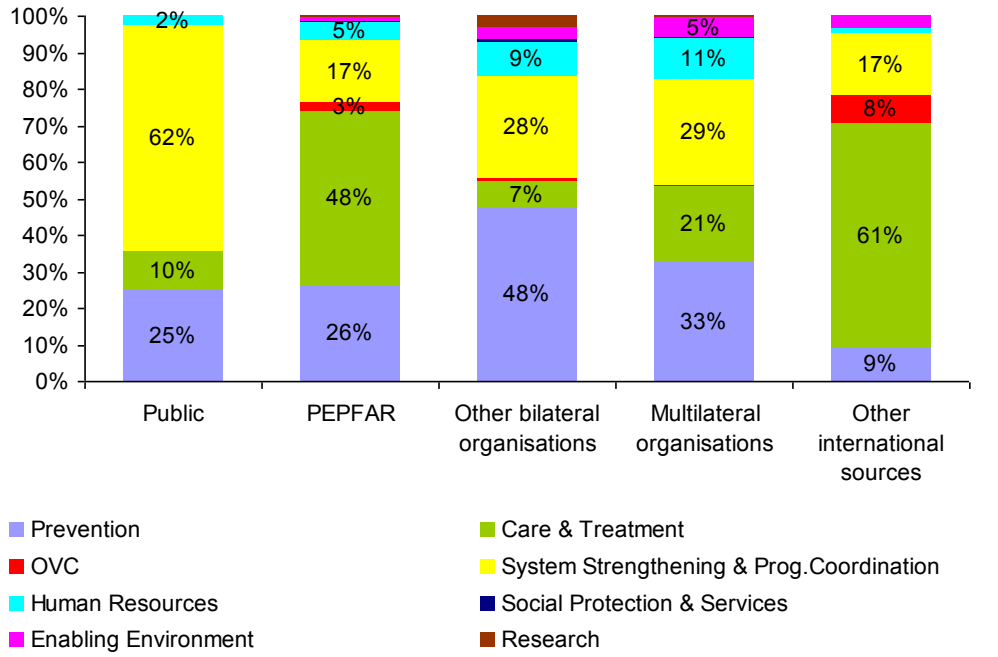
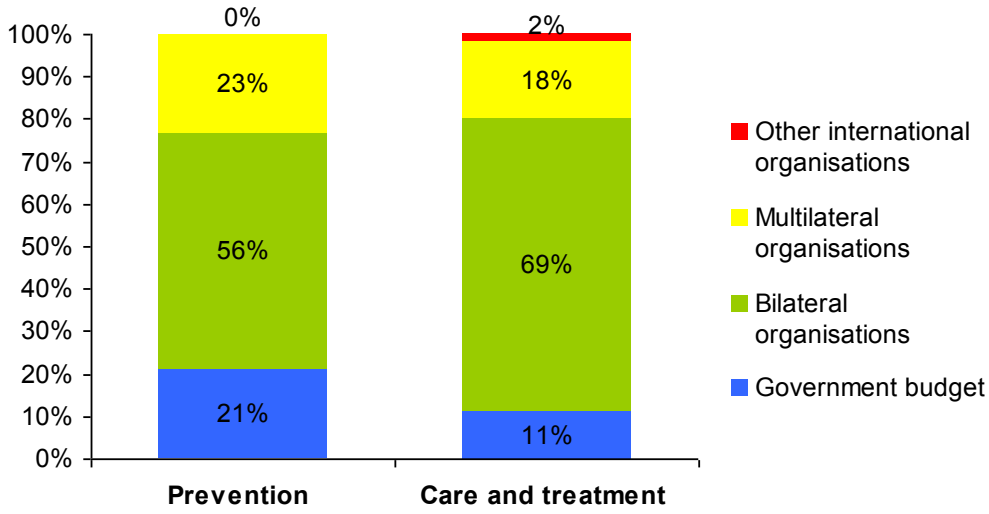


Figure 11 illustrates the contribution of various financial sources to the prevention and treatment and care spending categories. Both prevention and treatment and care were heavily financed by international sources, which provided 79% of total prevention resources and 89% of total treatment and care resources. The Government budget paid for 21% of prevention costs and 11% of treatment and care costs.

Figure 10 Spending on prevention, treatment and care by different financial sources, 2011



AIDS expenditures in 2012

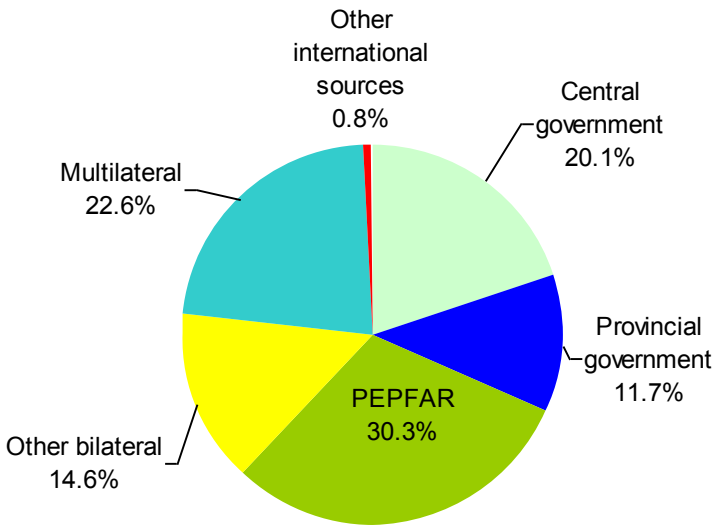
AIDS expenditure in 2012 fell below the level of 2011. A total of US$ 95.4 million were spent on the AIDS response in 2012, 4.4% less than 2011 spending. AIDS expenditure accounted for 0.06% of GDP (down from 0.07% in 2011). Per capita AIDS expenditure in 2012 stayed at US$ 1.08.

In 2012, the government spent US$ 30.3 million on the AIDS response, an increase of 16.2% compared to 2011. Of the total government expenditure, US$19.1 million (63% of government spending) came from the central budget, while US$11.2 million (37%) came from local (provincial) budgets. The central government expenditure was channelled through the National Targeted Programme on HIV (US$ 12.4 million, or 41% of total government spending) and PAC Office Construction Program (US$ 6.7 million, or 22% of total government spending)

International aid remained the main source of funding for the AIDS response, sharing 68.2% of total national spending, while the government budget paid the remaining 31.8%. Of all recorded AIDS expenditure, bilateral contribution accounted for 44.9% and multilateral funds for 22.6%.

PEPFAR provided US$ 28.9 million, accounting for 30.3% of national AIDS spending. The Government of the United Kingdom shared 10.1% of total expenditures, contributing US$ 9.6 million. Funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria increased both in volume and proportionally, to reach US$ 19.5 million in 2012 (from US$ 16.3 million in 2011) or 20.4% of national AIDS expenditure (from 16.4% in 2011). Figure 12 illustrates relative share of major sources in national AIDS expenditure.

Figure 11 Summary of AIDS expenditure in Viet Nam by financing source, 2012



Distribution of AIDS expenditure by AIDS spending categories in 2012 is summarised in Figure 13. System strengthening and program coordination remained the largest programmatic areas, absorbing 36.1% of all resources. Two other major ASC were prevention with 28.7% and care and treatment with 26.3% of total spending.

In absolute value, system strengthening and program coordination received US$ 34.5 million, an increase of 3.4% compared to 2011. US$27.4 million were spent on prevention and US$25.1 million on treatment and care. As compared to 2011 expenditure, spending on prevention was down by 12% while it was up by 2% for care and treatment.

In 2012, a total of 5.3% of all funds were spent on human resources and 2.3% on the enabling environment. Research activities received 0.6% of funds, whiles OVC shared only 0.4% (down from 1.1% in 2011). Only 0.2% of AIDS expenditures were allocated to social protection and social services.

Figure 12 Total AIDS spending by ASC, 2012

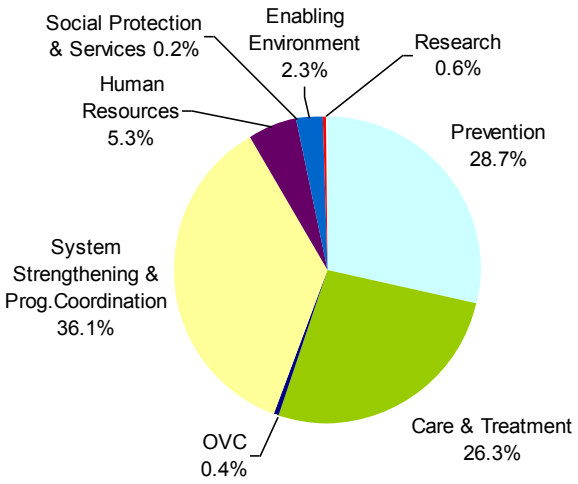


Figure 14 provides the breakdown of 2012 expenditure by financial source and ASC. The expenditure pattern for government, PEPFAR and multilateral sources remained as they were in 2011, while there were remarkable changes in expenditure structures of other bilateral organizations and other international sources.

Like in 2011, a majority of government expenditure in 2012 was concentrated on system strengthening and program coordination (61%). 36% of public sources were used to support prevention and care and treatment. PEPFAR[43] spent 56% of all resources on care and treatment, and 25% on prevention. Multilateral spending remained balanced between prevention (35%), system strengthening and program coordination (29%), and care and treatment (20%).

In 2012, other bilateral organizations provided much more resources for system strengthening and program coordination (43% of all resources, compared to 28% in 2011) while they altered spending on prevention (36%, down from 48% in 2011). Other international sources (mainly not-for-profit organizations and foundations) also expanded spending on system strengthening and program coordination to 45% (from 17% in 2011) while cutting spending on care and treatment to 29% (from 61% in 2011).

[43] Analysis is conducted only to those expenditures that have been verified at service provider level

Figure 13 Distribution of expenditure by source and ASC, 2012

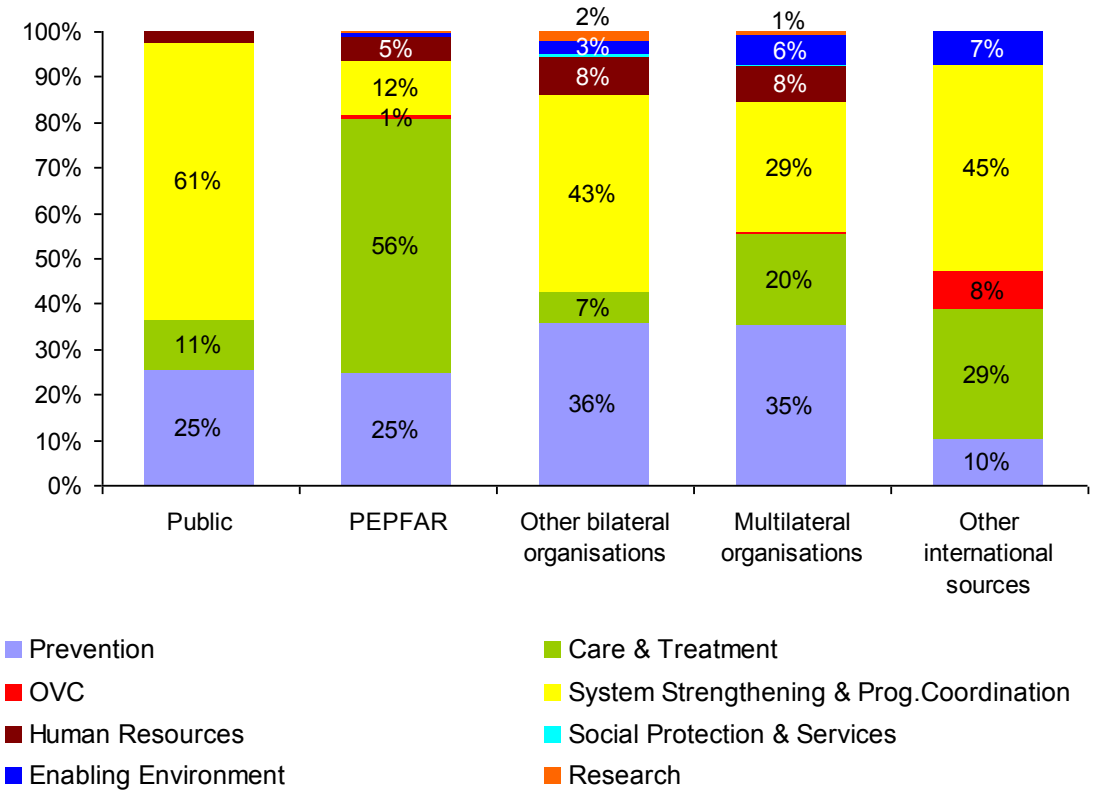
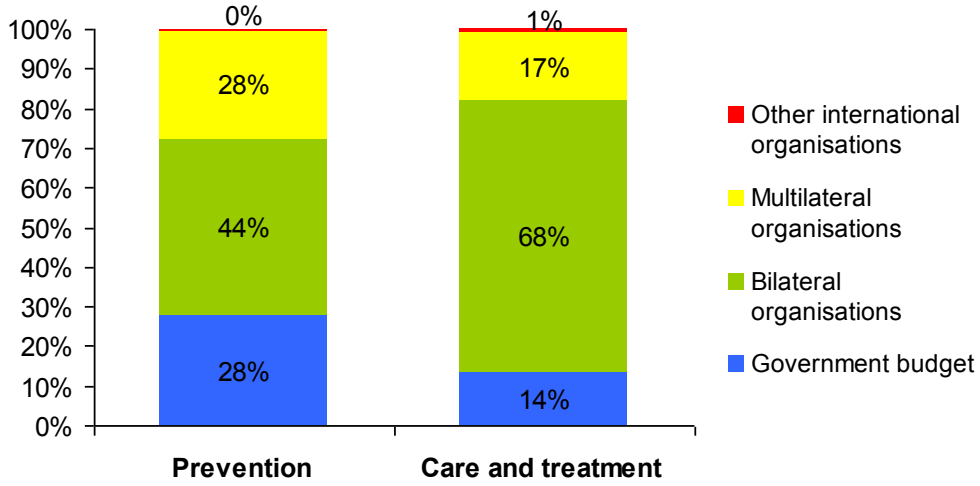


Figure 15 details relative share of various financial sources in the prevention and treatment and care spending. International aid remained the main financial source for both prevention and treatment and care, but their relative share reduced slightly as compared to 2011. International organizations provided 72% of total prevention resources (down from 79% in 2011) and 86% of total treatment and care resources (down from 89% in 2011). The Government budget paid for 28% of prevention costs and 14% of treatment and care costs.

Figure 14 Spending on prevention, treatment and care by different financial sources, 2012



LIST OF PARTNERS CONTRIBUTING DATA TO THIS SURVEY

Bilateral organisations

1. Australian Agency for International Development (AusAid)
2. Canadian International Development Agency (CIDA)
3. Network for Therapeutic Solidarity in Hospitals (Esther)
4. Irish Aid
5. President's Emergency Plan for AIDS Relief (PEPFAR)
6. Swedish International Development Cooperation Agency (Sida)

Multilateral organisations

1. Asian Development Bank (ADB)
2. United Nations Development Fund for Women (UN Women)
3. United Nations Educational, Scientific and Cultural Organization (UNESCO)
4. United Nations Population Fund (UNFPA)
5. United Nations Children's Fund (UNICEF)
6. United Nations Office on Drugs and Crimes (UNODC)
7. Joint United Nations Programme on HIV (UNAIDS)
8. World Health Organization (WHO)

International non-profit making organisations and foundations

1. Care International
2. Clinton Health Access Initiative (CHAI)
3. Catholic Relief Services (CRS)
4. Medical Committee Netherlands-Viet Nam (MCNV)
5. Nordic Assistance to Viet Nam (NAV)
6. Pact
7. Pathfinder
8. Population Service International (PSI)

Public organisations

1. Central Program Management Unit (CPMU) of ADB-funded Project on HIV Prevention for Youth, Ministry of Health
2. Central Program Management Unit (CPMU) of Life-Gap Project, Ministry of Health
3. Central Program Management Unit (CPMU) of Global Fund Project on HIV AIDS, Ministry of Health
4. Central Program Management Unit (CPMU) of WB/DFID Project on HIV AIDS, Ministry of Health
5. Central Program Management Unit (CPMU) of HIV AIDS Asia Regional Program (HAARP), Ministry of Health

6. General Department on Social Evils Prevention, Ministry of Labour, Invalids and Social Affairs
7. Ho Chi Minh City AIDS Committee
8. Hanoi School of Puclic Health, MOH
9. Nha Trang Pasteur Institute, MOH
10. Viet Nam Authority for AIDS Control (VAAC)
11. An Giang PAC
12. Ba Ria – Vung Tau PAC
13. Bac Kan PAC
14. Bac Giang PAC
15. Bac Lieu PAC
16. Bac Ninh PAC
17. Ben Tre PAC
18. Binh Dinh PAC
19. Binh Duong PAC
20. Binh Phuoc PAC
21. Binh Thuan PAC
22. Ca Mau PAC
23. Can Tho PAC
24. Cao Bang PAC
25. Da Nang PAC
26. Dak Lak PAC
27. Dak Nong PAC
28. Dien Bien PAC
29. Dong Nai PAC
30. Dong Thap PAC
31. Gia Lai PAC
32. Ha Giang PAC
33. Ha Nam PAC
34. Ha Noi PAC
35. Ha Tinh PAC
36. Hai Duong PAC
37. Hai Phong PAC
38. Hau Giang PAC
39. Hoa Binh PAC

40. Hung Yen PAC
41. Khanh Hoa PAC
42. Kien Giang PAC
43. Kon Tum PAC
44. Lai Chau PAC
45. Lam Dong PAC
46. Lang Son PAC
47. Lao Cai PAC
48. Long An PAC
49. Nam Dinh PAC
50. Nghe An PAC
51. Ninh Binh PAC
52. Ninh Thuan PAC
53. Phu Tho PAC
54. Phu Yen PAC
55. Quang Binh PAC
56. Quang Nam PAC
57. Quang Ngai PAC
58. Quang Ninh PAC
59. Quang Tri PAC
60. Soc Trang PAC
61. Son La PAC
62. Tay Ninh PAC
63. Thai Binh PAC
64. Thai Nguyen PAC
65. Thanh Hoa PAC
66. Thua Thien Hue PAC
67. Tien Giang PAC
68. Tra Vinh PAC
69. Tuyen Quang PAC
70. Vinh Long PAC
71. Vinh Phuc PAC
72. Yen Bai PAC

Ha Noi, March 2014