THE SOCIALIST REPUBLIC OF VIET NAM

THE THIRD COUNTRY REPORT ON FOLLOWING UP THE IMPLEMENTATION TO THE DECLARATION OF COMMITMENT ON HIV AND AIDS

REPORTING PERIOD: JANUARY 2006 – DECEMBER 2007

HANOI, JANUARY 2008

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ADB	Asian Development Bank
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Therapy
ARV	Anti Retrovirus
ASEAN	Association of South East Asian Nations
AusAID	Australian Agency for International Development
BCC	Behavioural Change Communication
CCM	Country Coordination Mechanism
CDC	Centres for Disease Control, USA
CS	Civil Society
CSO	Civil Society Organisations
DfID	Department for International Development, UK
FHI	Family Health International
FSW	Female Sex Workers
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of people living with HIV
GTZ	German Technical Cooperation Agency
HCMC	Ho Chi Minh City
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiatives
IBBS	Integrated Behavioural and Biological Survey
IDUs	Injecting Drug Users
IEC	Information – Education – Communication
ILO	International Labour Organisation
IOM	International Organisation for Migration
JICA	Japan International Cooperation Agency
KfW	German Reconstruction Bank
M&E	Monitoring and Evaluation
MARD	Ministry of Agriculture and Rural Development
MDGs	Millennium Development Goals
MDM	Medicines du Monde
MOET	Ministry of Education and Training
MOH	Ministry of Health

MOLISA	Ministry of Labour, War-Invalids and Social Affairs
MOPS	Ministry of Public Security
MPI	Ministry of Planning and Investment
MSM	Men have sex with men
MTCT	Mother to Child Transmission
NCPI	National Composite Policy Index
NIHE	National Institute of Hygiene and Epidemiology
NORAD	Norwegian Agency for Development
NVP	Nevirapine
OVC	Orphaned and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
POA	Programme of Action
PSI	Population Services International
RH	Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex Workers
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Funds for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Organisation for Drugs and Crime
UNV	United Nations Volunteers
USAID	United States Agency for International Development
VAAC	Viet Nam Administration of AIDS Control
VCT	Voluntary Counselling and Testing
VPAIS	Viet Nam Population AIDS Indicators Survey
VWU	Viet Nam Women's Union
WB	The World Bank
WHO	The World Health Organisation

I. STATUS AT A GLANCE

The Third Country Report on Following up the Declaration of Commitment on HIV/AIDS[1] (UNGASS) was prepared by Ministry of Health of Viet Nam with support from UNAIDS in the period October – December 2007. The Report recognizes significant achievements and efforts made by Viet Nam, as well as the country's commitment to scale up towards Universal Access to prevention, treatment, care and support for all in need.

This report has been prepared with broad participation of Governmental and International partners, as well as national and international non-governmental organisations. In November and December 2007, the National Composite Policy Index (NCPI) form was sent to fifty five (55) organizations, agencies, individuals and civil society groups/networks. Their responses are included in the report. Two consultation workshops (one in Hanoi and one in Ho Chi Minh City) were conducted with civil society organizations and PLHIV. At these, more than 116 participants from all over the country discussed the achievements made and challenges ahead. The National Consensus Meeting was organized on January 9, 2008; seventy three (73) participants from fifty five (55) Governmental and international partners, as well as civil society delegates, national and international non-governmental organizations attended the presentation of findings and were given an opportunity to contribute to the draft report *(See Annex 5 for list of participants).*

Viet Nam's HIV epidemic remains largely concentrated among key populations at higher risk, with high HIV prevalence among injecting drug users, female sex workers and their partners, and men having sex with men. Significant interaction between the risk behaviours of sharing injecting equipment and unprotected sex, particularly among young men, continues to drive the HIV epidemic in Viet Nam

The outstanding achievements that reflect Viet Nam's efforts and commitment in the reporting period 2006-2007 include: (1) Finalization of the system of legal documents related to HIV prevention and control; (2) Consolidation and improvement of human resources for HIV response in 90% of cities/provinces; (3) Establishment of the National Monitoring and Evaluation framework as part of the "Three Ones" ; (4) Expanded coverage of HIV prevention interventions among most at risk populations; (5) Increased accessibility to ARV treatment for people living with HIV ; (6) Facilitation and support for civil society organizations to participate in HIV prevention, treatment, care and support ; and (7) Increased national funding for HIV prevention and care, which has been accompanied by increasing support from the international community[2].

The Central Government budget allocation for the AIDS programme was US$ 5 million in 2006 and has been increased to US$ 9.4 million in 2007. Besides the budget provided by the central government to the provinces, local authorities are responsible for mobilisation of additional resources for implementation of HIV programmes. However data for funds raised at the local level are not available for the reporting period.

International donors contributed significantly to total AIDS spending in Vietnam. It is estimated that the total budget for HIV prevention, treatment, care and support in Viet Nam in 2006 was around US$ 56.8 million, including US$ 5 million from the domestic budget and US$ 51.8

[1] Declaration of Commitment was approved at the United Nations General Assembly, Twenty-sixth Special Session on HIV/AIDS, June 2001 (UNGASS)
[2] See Part III and IV for more details.

million from the international community. Overall, while many government policies, strategies and guidelines are in place, the majority of funding for HIV programmes still comes from international donors.

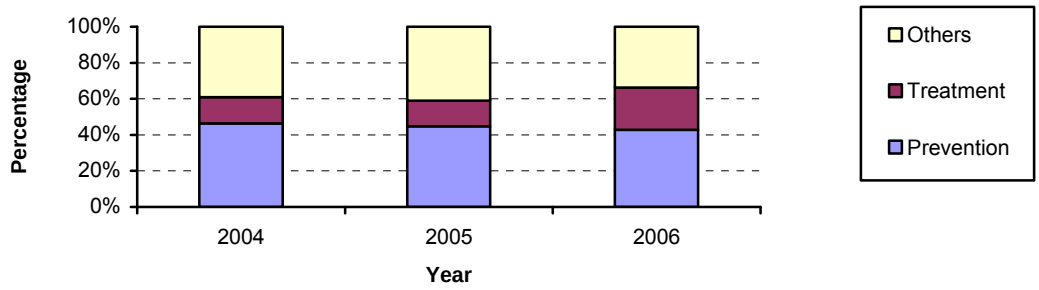


Figure 1: Central Government HIV spending by categories 2004 to 2006

The national response relating to the policies and programmes of prevention, treatment, care and support are analysed in parts III and IV of the report. The key reported indicators are presented in Annex 4, and summarized in the table below.

UNGASS indicators summary

Indicators	Main Data Source	Status: 2006- 2007
National Commitment and Action – EXPENDITURES		
1. Domestic and international AIDS spending by categories and financing sources	VAAC Reports from International organizations; MPI/ UNDP	Amount of national funds disbursed by government: 2005: 19.42 millions USD 2006:12.75 millions USD (reported) 47.15 millions USD (estimated) 2007: 9.4 millions USD from Government of Viet Nam
National Commitment and Action - Policy Development and Implementation Status		
2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	NCPI Results	See annex 3
National Programmes		
3. Percentage of donated blood units screened for HIV in a quality assured manner		*No data available*
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	National Programme report, VAAC	Adults 2006: 18.1% 2007: 30% Children 2006: N/A 2007: 789

5. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	PEPFAR PMTCT Programme Report, 2006 - 2007	2006: 9.2% 2007: 13.9%
6. *Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV*		*No data available*
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Viet Nam Population and AIDS Indicator Survey 2005 (VPAIS). General Statistical Office, National Institute of Hygiene and Epidemiology, and ORC Macro (2006).	Male: 2.1.% Female: 2.6% Total: 2.3%
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	HIV/STI integrated biological and behavioural surveillance (IBBS) in Viet Nam2005/ 06. Viet Nam Ministry of Health (2006)	FSW: 15.1% MSM: 16.3% Male IDUs: 11.4%
9. Percentage of most-at-risk populations reached with HIV prevention programmes	MSM: IBBS 2005/06 FSW and IDUs: WB and DfID project report 2007	FSW 65.2% MSM: 25.6% Male IDUs: 43.2%
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child		*Not relevant to the country epidemic.*
11. Percentage of schools that provided life skills-based HIV education within the last academic year		*No data available* *Data are being collected and will be available in 2008*
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14		*No data available*

13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	VPAIS, 2005	Male: 50.3% Female: 42.3% Total: 46.2 %
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	IBBS, 2005/06	FSW: 35.4% MSM: 54.9% Male IDUs: 37.6%
15. Percentage of young women and men who have had sexual intercourse before the age of 15	VPAIS, 2005	Male: 0.5% Female: 0.3% Total: 0.4%
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	VPAIS, 2005	Male: 0.7% Female: 0 % Total: 0.3%
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse		*No data available*
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	IBBS, 2005/2006	FSW: 97.1%
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	IBBS 2005/2006	61.3%
20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	IBBS 2005/2006	36.4%
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	IBBS 2005/ 2006	88.8%
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected	VPAIS, 2005	0.3%

23. Percentage of most-at-risk populations who are HIV infected	IBBS 2005/ 2006	FSW: 4.2% MSM: 9% Male IDU: 23.1%
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Special study - ART cohort data collection (Viet Nam Administration for HIV/AIDS Control)	Adults: 81% Children: 93.1%
25. Percentage of infants born to HIV-infected mothers who are infected	Modelled c/o UNAIDS Geneva	

Data sources for the above mentioned indicators come from: different programme reports; HIV/AIDS estimates and projections 2005 – 2010; the HIV/STI integrated biological and behavioural surveillance (IBBS) conducted in 2005 – 2006 and the Viet Nam Population and AIDS Indicator Survey 2005 (VPAIS). In most cases, data disaggregated by gender and age group is not available, and due to the sampling methodology (only selected provinces were included in the studies) the results do not always reflect the nationwide situation.

There is no available national data for the following six UNGASS indicators: 3, 6, 10, 11, 12 and 17. Due to the change of the definition for indicator number 3, and a focus on the quality of laboratory procedures, there is no available data for this reporting period. Efforts were made to collect data on HIV/TB co–infection, however due to the different definitions used for numerator and denominator than those suggested in the UNGASS guidelines, the available data is presented in the narrative report, but not recorded in CRIS. Indicators number 11 and 17 have been included as indicators in the national M&E framework and will be available for the next reporting period. Indicator number 10 is applicable only for the countries that have HIV prevalence among the general population of higher than 5%. This is therefore not applicable for Viet Nam. Indicator number 12 is not a national indicator and will not be reported against.

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC IN VIET NAM

Status of the epidemic

Vietnam's HIV epidemic is still in a concentrated phase, with the highest sero-prevalence among key populations at higher risks. These include injecting drug users (IDUs), female sex workers (FSWs) and men who have sex with men (MSM). Prevalence in the general population is estimated at 0.53%. According to the 2005 Estimation and Projection Report, there were an estimated 293,000 people living with HIV in 2007.

Cumulative reported data as of 31 August 2007 are 132,628 HIV infected case; 26,828 cases of AIDS, and 15,007 deaths due to AIDS. HIV cases were reported nationwide in all 64 in provinces/cities, 96% of 659 districts and more than 66% of 10,732 wards/communes. Of all reported HIV cases, 78.9% are in the age group 20 – 39, with males accounting for 85.2% of total reported HIV cases. People living with HIV are getting younger and heterosexual transmission is becoming more significant.

There is great variability within Viet Nam in the timing of local HIV epidemics. The epidemics in HCMC and the north-east coast initiated earlier, while epidemics in other parts of the country are more recent. This variability has resulted in a geographic concentration of HIV cases in big cities and provinces where the local HIV epidemic in groups of IDUs, FSWs and MSM is substantial. The Quang Ninh province has the highest HIV prevalence, while Ho Chi Minh City has the highest number of reported HIV cases (as of 31/7/2006 a total of 23,321 HIV cases, accounting for 17.32% of HIV cases reported nationwide).

Treatment and Education Centres for drugs users and sex workers (Government-managed closed settings for IDUs and FSWs) have become increasingly important for the status of the epidemic. It is estimated that by the end of 2006, there were 42,000 drug users (one quarter of all reported drug users), and 3,234 FSWs (14 per cent of all reported FSWs) residing in 84 centres across Viet Nam[3]. HIV prevalence among residents (mostly IDUs) ranges between 40 and 50 per cent, with some 18,000 – 22,600 PLHIV residing in these centres, equivalent to 16-19 per cent of reported HIV cases in Viet Nam in 2006. As of June 2007, MOLISA estimates that the number of IDUs in Treatment and Education Centres has increased to approximately 60,000.

Characteristics and trends of the HIV Epidemic in Viet Nam

Table 1: HIV Prevalence – Findings of 2001 – 2006 Sentinel Surveillance

Targeted Populations	HIV Prevalence by Year (%)					
	2001	2002	2003	2004	2005	2006
IDUs	29.4	29.4	26.8	28.6	25.5	23.2
FSWs	4.7	5.9	4.3	4.4	3.5	4.0
Antenatal Women	0.30	0.34	0.24	0.35	0.35	0.37
Male Military Recruits	0.93	0.65	0.45	0.44	0.31	0.16

[3] Ministry of Labour, Invalids & Social Affairs, Viet Nam (2006): Statistical Year Book

Due to the limitations of available data, reported figures do not reflect the overall status and trends of the epidemic. Based on the results from the sentinel surveillance and integrated biological-behavioural study (IBBS) conducted in 2006, the following conclusions on the key features of the epidemic in Viet Nam can be made:

1. Viet Nam's HIV epidemic is still in a concentrated phase, with the highest sero-prevalence among key populations at higher risk, including injecting drug users (IDUs), female sex workers (FSWs) and men who have sex with men (MSM)

The HIV prevalence rate is very high among injecting drug users. The average prevalence nationwide among this group is 28.6% but the rate differs between cities/provinces. In provinces such as Quang Ninh, Ho Chi Minh City (HCMC), Hai Phong, Can Tho, Thai Nguyen and Dien Bien, the prevalence rate has reached 54.5%, 47.61%, 46.25%, 45%, 40.75% and 36.83% respectively.

The average prevalence rate among FSWs nationwide is 4.4%, and differs across the country (e.g. in city of Can Tho, the prevalence rate was 33.86% in 2006, while in the capital Ha Noi was 14.25%)

According to the IBBS, the HIV prevalence among a small sample (790) of MSM in Ha Noi and Ho Chi Minh City was reported 9 and 5 percent respectively.

There is a lack of data to accurately estimate the overall size of IDU, SW and MSM populations as well as the HIV prevalence among these key populations at higher risk (including mobile populations).

HIV prevalence among the antenatal women group and military recruits group is continuously observed at a low level, 0.37% and 0.16% respectively, as per the sentinel surveillance studies.

2. **Significant interaction between the risk behaviours of sharing injecting equipment and unprotected sex.**

According to the IBBS, the rate of sharing needles and syringes among IDUs 6 months prior the interviews was very high, especially in Ho Chi Minh City, An Giang, and Da Nang with 36.8%, 33%, and 29.3% respectively.

Significant amounts of IDUs were also involved in high-risk sexual behaviour with different partners, including FSWs (e.g. in some provinces like An Giang, Can Tho, Hanoi the reported percentage of IDUs having sex with FSWs was 43%, 28.7%, and 20.5% respectively) . The rate of sexual behaviours without condom use between injecting drug users and female sex workers is quite high: 55% in An Giang and 54.8% in Ho Chi Minh City.

Female sex workers do not consistently use condoms with their clients and other sexual partners: the rate of frequent use of condom with clients (including frequent/random clients) among street female sex workers in the last month was low 37% – 62%; there is a high rate of female sex workers injecting drugs: 18.52% in Can Tho and 24.36% in Hanoi. This rate is projected to increase.

Men having sex with men (MSM) also do not consistently use condoms during anal sex with their partners, and they also have sex with male sex workers and with females. HIV prevalence rate among MSM in 2006 was 9.4% in Ha Noi and 5.3% in Ho Chi Minh City.

III. NATIONAL RESPONSE

The government of Viet Nam acknowledges HIV as an important development issue which requires the mobilisation of different stakeholders outside the health sector. The Viet Nam Administration for HIV/AIDS Control (VAAC) under the Ministry of Health (MOH) reports on national HIV issues and progress to a multi-sectoral committee, the National Committee for HIV/AIDS, Drugs and Prostitution Prevention and Control, which is chaired by the Deputy Prime Minister.

Viet Nam has made major advances in the response to HIV since the 2004 launch of the *National Strategy on HIV/AIDS Prevention and Control in Viet Nam until 2010 with a vision to 2020* (hereafter referred to as the 'National HIV Strategy') and the establishment of the VAAC. Under the National HIV Strategy and coordinated by VAAC, nine Programmes of Action (POAs) were called for to provide detailed guidance for the implementation of HIV programmes. The National Strategy also calls for members of the National Committee for HIV/AIDS, Drugs and Prostitution Prevention and Control to develop their own programmes of action to support the national AIDS response. This policy framework has enabled Viet Nam to begin implementing the 'Three Ones' (One national AIDS coordinating authority, One national agreed upon HIV action framework and One Monitoring and Evaluation(M&E) system) and take steps towards its commitment to Universal Access to prevention, treatment, care and support.

In addition, Provincial AIDS Centres are increasing the number of full time staff working on the delivery of HIV related services at the provincial and district levels. Integration of national and donor-supported programmes at the provincial level is now emphasised as a mechanism for promotion of more active multi-sectoral involvement and improved service delivery.

In this report, the AIDS response in Viet Nam is categorized in four major areas: (1) Governance; (2) Policy and Legislative Framework; (3) Prevention; and (4) Treatment, Care and Support.

1. Governance:

Leadership

Through the period 2006 – 2007, HIV has been at the centre of the political agenda with active participation of leaders from the State, Party and Government.

The highlighted events are:

- Leadership and HIV Workshop chaired by Mr Truong Vinh Trong, Deputy Prime Minister; Madam Tong Thi Phong, Vice Chairwoman of the National Assembly and Mr. To Huy Rua, Director for the Party Commission for Education and Communication. The workshop emphasised the role of leaders and leadership, especially of the Party and PLHIV in the National AIDS response.
- Annual review meeting of the party and National Assembly projects on HIV.
- Indochina Parliamentary Workshop on HIV/AIDS Laws and Policies
- First National HIV Monitoring and Evaluation Conference that brought together leaders, health workers, M&E practitioners, PLHIV and other partners from central level and all provinces, to discuss the newly approved National M&E Framework and strategic use of data.

- National Conference on Harm Reduction, chaired by Mr Truong Vinh Trong, Deputy Prime Minister. This conference brought together leaders, colleagues and PLHIV from all provinces and levels of Government and the Party, to discuss and really understand *how* to move forward the Harm Reduction agenda in Viet Nam. This resulted in the approval of the National Harm Reduction Programme of Action
- National Workshop on Greater Involvement of PLHIV (GIPA) with participations of representatives from the Party, various sectors of the Government of Viet Nam, VWU, civil society and international partners. This workshop resulted in the GIPA Call to Action which urges all part of the society to accept and support the implementation to improve the lives of PLHIV, as part of the national response to HIV.
- Central Party Commission on Communication and Education has taken the lead in promoting harm reduction interventions and reducing stigma and discrimination towards PLHIV

In most of the above mentioned events, PLHIV were invited to participate and address the audience. This emphasises the recognition of the role of PLHIV by leaders of the State, Party and the Government.

The People's Committees and Party Committees at all levels have integrated the AIDS response into their development plans, especially in their poverty reduction strategies. With the establishment of the information management system for implementation of Directive 54, the Party has shown its commitment and leadership in the National Response.

Finance:

- The Government of Viet Nam supports activities and services in each of the POA areas. The budget allocation for 2007 was US$ 9.4 million, an increase of 4 million USD from 2006. Compared to the previous reporting period 2004 – 2005, the national budget allocation for HIV activities has increased by 58%. Because this budget is for programme implementation by 18 ministries and sectors whose sub-departments extend across 64 provinces and cities, the resulting budget for individual programmes and services is still fairly limited. Provinces and local authorities are also requested to provide further resources for the implementation of HIV related activities and services.
- In terms of total funding for the National HIV programme there has been a significant increase in the international donors' financial contributions. Support from international donors for HIV programmes increased from US$ 13 million in 2005 to US$ 47.15 million in 2006. Of total budget, about 45% is allocated to prevention. The actual expenditure of these funds was not fully available at the time of this report (see annex 3 for more details).
- A considerable source of funding (60%) for the National AIDS response comes from international development aid. The major donors are the President's Emergency Plan for AIDS Response (PEPFAR), the Global Fund to fight AIDS, TB and Malaria (GFATM); the UK Department for International Development (DFID), the Asian Development Bank (ADB) and the World Bank. Their contribution has assisted Viet Nam greatly in scaling up and improving prevention, treatment, care and support activities in the country.

Strengthening health infrastructure and human resources:

Following the creation of VAAC in 2005, Provincial AIDS Centres were established during 2006 and 2007. Up to now, fifty eight out of sixty four (58/64) provinces have an established

Provincial AIDS Centre. The Provincial AIDS centres are under the Provincial Department of Health, with an allocated number of full and part time staff. In total, there was 943 full-time staff working in these Provincial AIDS Centres at the end of 2007. In addition, VAAC has assigned 4 Regional Institutes of Hygiene and Epidemiology as regional supporting structures. These promote a decentralised management approach in the overall national response.

The provincial AIDS centres assist in the implementation of the national response at local level, bringing HIV to the attention of provincial and local Government.

However, having been newly established, with very limited number of staff and technical capacity, this structure, especially at provincial level still needs great investment to strengthen its capacity if it is to successfully carry out the newly approved programmes of actions, comply with other legal documents and coordinate HIV efforts at the provincial level. Capacity building is needed both in terms of human resource management and physical capacity.

Multi-sectoral Collaboration:

The Government of Viet Nam considers the national response the work of all sectors of Government and society. The National Strategy assigns duties and responsibilities to ministries and other sectors. These include six ministries[4], several provincial and municipal People's Committees and the state-run media. The Viet Nam Fatherland Front, a major organization of the Viet Nam Communist Party Commission on Popular Mobilisation, and its related mass organizations are requested to lead the mass mobilisation of society in the national response. All these actors should integrate HIV activities into their plans and strategies with budget allocations for the implementation of these activities. At ministerial level, most of the ministries have included HIV in their work plans.

Highlighted below are some key actions taken by various sectors in Viet Nam:

- The Labour Union has gradually implemented the programme on HIV at work places, raising awareness of both employers and employees on HIV issue.
- The Viet Nam Women's Union (VWU) supports the establishment of Empathy Clubs, and implements a Greater Involvement of People living with AIDS (GIPA) project, in order to enhance involvement and participation of PLHIV. The VWU also encourages the elderly to become involved in HIV prevention activities. In addition, various forms of activities have been organised by Union members all over the country.
- The Fatherland Front, actively works with people at the community level, launched a campaign to promote positive living which is named "cultured family and community". In this campaign, families and communities will be certified if they meet the criteria given by the organisation. One of the criteria is for non-stigmatising of and non-discrimination towards PLHIV.

However budget allocations and implementation of the ministerial action plans are still in need of further improvement. Though HIV related activities are integrated in the work plans, most of the funds for their implementation come solely from the National AIDS Programme. Very few sectors and local Government actually allocate sufficient budget for the planned activities (e.g. The Ministry of Education and Training (MOET) has developed a national action programme for

[4] Ministry of Health, Ministry of Culture and Information, Ministry of Education and Training, Ministry of Labour, War Invalids and Social Affairs, Ministry of Planning and Investment and the Ministry of Finance.

secondary education, the most extensive plan for the education sector until now, which is still not funded)

Though there is a multi-sectoral coordinating body, there is a need to further strengthen both inter- and intra-ministerial collaboration in order to achieve integration of different HIV interventions. The linkages between the HIV services and other services - e.g. Sexual and Reproductive Health, Population Services - needs to be further strengthened.

In the period of 2006-2007, there have been some major successes in the Government efforts to harmonise collaboration with international partners:

- The completion and approval of the Programme of Action 9 on International Cooperation and Capacity Building, and;
- The completion and approval of the National Coordination Action Plan, a synchronised effort by VAAC and international partners in response to the Hanoi Call for Action on donor coordination .

These promising plans have only recently been approved and the implementation ahead will require further efforts from all stakeholders.

At provincial level, multi-sectoral coordination varies with more attention being paid to this matter in provinces with higher HIV prevalence. Ho Chi Minh City is an excellent example of effective coordination; the Provincial AIDS Committee coordinates the implementation of the National Programme within the province, and brings together all partners and donors involved in the implementation using the 'Three Ones" model.

Civil Society Involvement

Compared to the previous reporting period, there has been increased contribution from Civil Society Organisations to the overall National AIDS response. The years 2006 – 2007 have seen a strong improvement in involvement and participation of civil society in all aspects, from prevention, treatment, care and support, behavioural change communication, counselling and testing, harm reduction and, to a lesser extent, policy development processes. Compared to the previous reporting period, the participation and contribution of civil society has also been better recognised and accepted.

The establishment of the National Partnership Platform on HIV/AIDS at the end of 2007 signifies the close cooperation in HIV activities amongst civil society organisations. In the last 2 years, civil society has contributed significantly to the national response:

- There has been an increasing number of *self-help groups* (60 groups with more than 4,000 members in total) established in the whole country. Self-help groups have organized themselves in informal networks. Members of these groups have been actively involved in policy development processes; raising awareness of updated legislation; supporting ART services in health facilities; referring between and within health and social services; and last but not least, they have been a key factor in fighting against stigma and discrimination towards people and children living with HIV.
- Religious groups from different faiths including Buddhist, Catholic, Protestant, Cao Dai, have been actively participating in the national response, especially in the area of stigma and discrimination reduction, treatment and care (both in health facilities and home). Some of these groups provide shelter support and care for children living with HIV. Some religious organisations provide palliative care and burial support to PLHIV and their families. The

Council of Catholic Bishops of Viet Nam has provided life skills and sex education for young people.

- Community based establishments have expanded throughout the country with an increasing number of the families of PLHIV taking part in the active work of the groups. Group members provide care and support, including job creation for PLHIV, and have participated in raising awareness of HIV prevention, treatment, care and support.
- Key populations at higher risk (IDU, FSW, and MSM) have been involved in: peer education, BCC and harm reduction activities; referral services; research; counselling and providing moral support for those at risk of HIV infection.
- Local NGOs have conducted: research and surveys; carried out community based projects; pilot model for reducing stigma and discrimination; promoted harm reduction; community based care; counselling; and social and economic support to PLHIV. These organisations have also provided technical support and have shared resources with self-help groups. Advocacy is also an important part of the work conducted by Local NGOs. Furthermore, they provide a bridge with international organisations.
- Representatives of CSOs have participated in a number of nationally important events, e.g. national meetings, conferences, delegations to international meetings (e.g. the High Level Meeting 2006, M&E National Conference in 2007) and forums.

CSOs have actively sought more resources to improve their capacity and become equal partners in the National AIDS response. There is a need for further capacity building in the area of management as well as in improving the understanding of HIV programme design, implementation and monitoring in order to scale up more effective work in prevention, treatment, care and support.

With earlier involvement of CSOs in this preparation process, compared to last round of the reporting process, CSOs have been able to contribute to the content of this report in a more comprehensive and participatory manner. The CSOs have acknowledged the openness and acceptance of the Government, a sign of the recognition of the work contributed by CSOs in the overall national response.

The HIV technical working group, with UNAIDS Viet Nam as its secretariat, has regular meetings and seminars. So far, there have been 20 meetings organised in the last 2 years. A total of 700 members from 54 Government Agencies, NGOs and international organisations have attended these meetings. They serve as a collaboration platform for concerned organisations/agencies to share lessons learnt from theirs areas of work, experiences, plans and information related to the national response in Viet Nam.

2. Policy and Legislative Framework:

Viet Nam has made strong progress in policy and legislative for HIV prevention and control. The number of milestone documents developed and issued in the last two years signifies the commitment and the efforts of the Government in HIV response:

- The Law on HIV/AIDS was passed by the National Assembly of the Socialist Republic of Viet Nam on June 29, 2006. This is the most important document regarding legislation for HIV prevention and control. The law protects the rights of people living with HIV against

stigma and discrimination and stipulates the responsibility of the Government and other parts of society to be involved in the national response to HIV.

- The Decree 108/2007 ND-CP issued on June 26, 2007 provides detailed instructions for the implementation of the Law. It creates a crucial legal corridor for the implementation of HIV prevention, treatment, care and support for PL HIV.

  The people elected National Assembly, through its Social Affair Committee at Central level, and its network of Provincial People's Councils, has taken on the responsibility to oversee the implementation of the Law on HIV/AIDS and the Decree 108.

- The Inter- Ministerial Circular 147/2007/TTLB-BTC-BYT between the Ministry of Health and the Ministry of Finance was issued on December 12, 2007. This Circular includes key adjustments and favourable conditions, and cost norms for the implementation of the National Strategy on HIV and AIDS prevention and control; and the implementation of the National Programmes on Prevention and Control of Social Diseases, Dangerous Diseases and HIV and AIDS, period 2006 - 2010.

- Decision 29/2007/QD-TTg on Management, Care and Support, Treatment and Counselling for PLHIV in closed settings (including educational, rehabilitation centres, detentions, prisons and social care centres).

- Decision 60/2007/QD-TTg; Decision 96/2007/QD-TTg; Decision 67/2007/QD-TTg on support for people and children living with HIV

- Seven out of eight National Programmes of Action have been developed and approved in 2006 and 2007, with assistance from international partners. These documents lay out specific objectives and directions for the National response to HIV. The completion of these documents in the last two years reflects the efforts and commitment of the Government of Viet Nam to enhance the implementation of HIV prevention and control. The approved programmes of action are :

Prevention:

1. *HIV Prevention through Information, Education and Communication (IEC) and Behavioural Change Communication (BCC) – Approved 2006*
2. *Harm Reduction Prevention targeting high risk populations - Approved 2007*
6. *Prevention of Mother to Child Transmission (PMTCT). – Approved 2006*
7. *STI Management and Treatment. – Approved 2006*

HIV treatment, care and support:

3. *Care and Support for PLHIV & (merged with Programme 5) Access to HIV Treatment including ARVs – Approved 2006*

HIV governance:

4. *HIV Surveillance and Monitoring and Evaluation (M&E) - Approved 2007*
9. *Capacity Building and International Cooperation Enhancement – Approved 2007*

The remained Programme of Action to be developed is on Blood Safety.

- Viet Nam has also committed to a number of national and international agreements, initiatives and declarations: Millennium Development Goals (MGDs); the Declaration of

Commitment on HIV (UNGASS); Universal Access; the Three Ones Principles; the Ha Noi Core Statement on effective use of foreign aid; the Asia Pacific Ministerial Declaration on HIV/AIDS Leadership and Development; the Hanoi Call to Action on Children and AIDS; the GMS Regional Strategy on Mobility and HIV Vulnerability Reduction; and the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers.

The Government has also endorsed and supported other movements and efforts such as the "Viet Nam Call to Action for the Greater Involvement of People Living with HIV" in 2007 – a joint initiative between the Party, the Government, PLHIV and International partners working on HIV in Viet Nam.

- The Decision on pre-departure training for Vietnamese migrant workers including HIV; Government Decision on Cross-Border HIV/AIDS Prevention and Control both developed and approved in the last two years.
- Directive 54 issued by the Central Communist Party Secretariat in 2005 has been an effective legal basis for mobilising support and involvement of Party members, most of them Government officials, local authorities in the national response . With support from UNDP, a system to monitor the implementation of this directive has been set up through out the country, under supervision of the Central Party Commission for Science and Education.

The period 2006 – 2007 has set many benchmarks in policy and legislative development. The newly approved and issued legal documents will form the foundation for a more active, enhanced AIDS response in Viet Nam. At the same time, to have successful and effective implementation of these documents, the Government of Viet Nam will need to overcome many challenges in the future.

3. Prevention

In the past two years, the HIV prevention programme has been scaled up with major support from PEPFAR, GFATM, the World Bank, DFID, ADB, and the UN.

3.1. Behavioural Change Communication programmes (BCC)

BCC activities have been carried out with the participation and coordination of many sectors and civil society. The programme mobilises the mass media to produce large volume and diverse BCC activities and products. Magazines, newspapers, bulletins, posters, banners, and leaflets on HIV and methods of prevention have been delivered not only to key populations at higher risk but also to the general population. Different educational activities have been carried out including peer education among key populations at higher risk and people living with HIV, counselling, hot lines, competitions, edutainment shows, exhibitions of pictures, photos, short stories, etc... Youth (aged 15–24) are a priority target group within the BCC programme. Almost half of them (46%) correctly identified ways of HIV transmission, and were able to correctly reject three misconceptions on HIV transmission. [5] Especially in HCMC and Thai Binh, provinces with a high HIV prevalence, 78% of youth had comprehensive knowledge on HIV prevention.[6]

[5] VPAIS

[6] Household survey on HIV prevalence and AIDS indicators in HCMC and Thai Binh province. MOH and NIHE, 2005.

In 2004, 24% of female sex workers (FSW) and 34% of male injecting drug users (IDU) correctly identified ways of preventing sexual transmission of HIV and rejected two major misconceptions about HIV transmission. Almost two years later, in mid 2006, 45% of female sex workers and 45% of male injecting drug users could do so.[7] Although there is a slight increase in knowledge within key populations at higher risk, the increase still remains relatively low. Accesses to BCC services has been limited, which is shown by a low rate of FSW have accessed to preventive services (1.6 times/1.5 years[8]).

The IBBS 2005/06 found that over 50% of MSM in Hanoi and Ho Chi Minh City receive some form of HIV education. However, as the interviewed MSM participating in the IBBS are mainly recruited in drop-in centres of on-going intervention projects, this figure may not represent the real level of knowledge of MSM across the country. The largest number of MSM is hidden and it is still hard for many projects to reach and provide information to. Furthermore, there is still lack of MSM-specific information, education and communication (IEC) materials.

Positive change in the awareness of people has resulted in the reduction of stigma and discrimination towards PLHIV. However, to some extent, they still experience the limited access, particularly, to prevention, care and treatment, and education for children. Double stigma and discrimination has been reported among people living with HIV that also belong to a key population at higher risk (IDU, SW or MSM).

HIV education in schools has stepped up with reproductive health (RH) and HIV education included in school textbooks and taught from primary school. However, one of the findings in the 2006 RH and HIV curriculum review (MOET & Save the Children) is that “Information regarding RH and HIV in school textbooks is selective, and some important topics are missing”. And that additional interventions for most at risk adolescents need to be developed.

3.2. Harm Reduction Intervention programmes

The Law on HIV/AIDS and the Decree 108/2007 ND-CP have set up a solid foundation for harm reduction activities in Viet Nam. The harm reduction[9] programme has been strongly supported by international partners.

The programme has mainly focused on providing information, condoms and needles/syringes, and referral to VCT services targeting injecting drug users, female sex workers, and mobile populations. However, interventions targeting mobile populations and interventions in closed settings are still limited.

Despite the IBBS 2006 showing high HIV prevalence among MSM, HIV interventions for MSM are still limited. Only very recently have they been included in national surveillance activities and are not included in either the on-going operational research agenda nor as one of the key populations for the sentinel surveillance. There have been no MSM population size estimation exercises conducted in Viet Nam and behavioural studies have covered only small samples of the population. This lack of national data on MSM has further contributed to difficulties in planning and implementing evidence-based programmes and strategies. Thus far, MSM-targeted projects are implemented only in 5 out of 64 provinces. There is a need to develop an

[7] IBBS
[8] HR
[9] Harm reduction is a term that defines policies, programmes, services and actions that work to reduce the: health, social and economic harms to key populations at higher risk in Viet Nam. These key populations include: IDUs, FSW, MSM, mobile populations.

operational plan for MSM and HIV interventions based on the promulgated Programmes of Action.

Migrants and mobile populations are included in both the National Strategy and Law; however there is no specified strategy or programme to ensure their access to prevention, treatment and care and support services as yet.

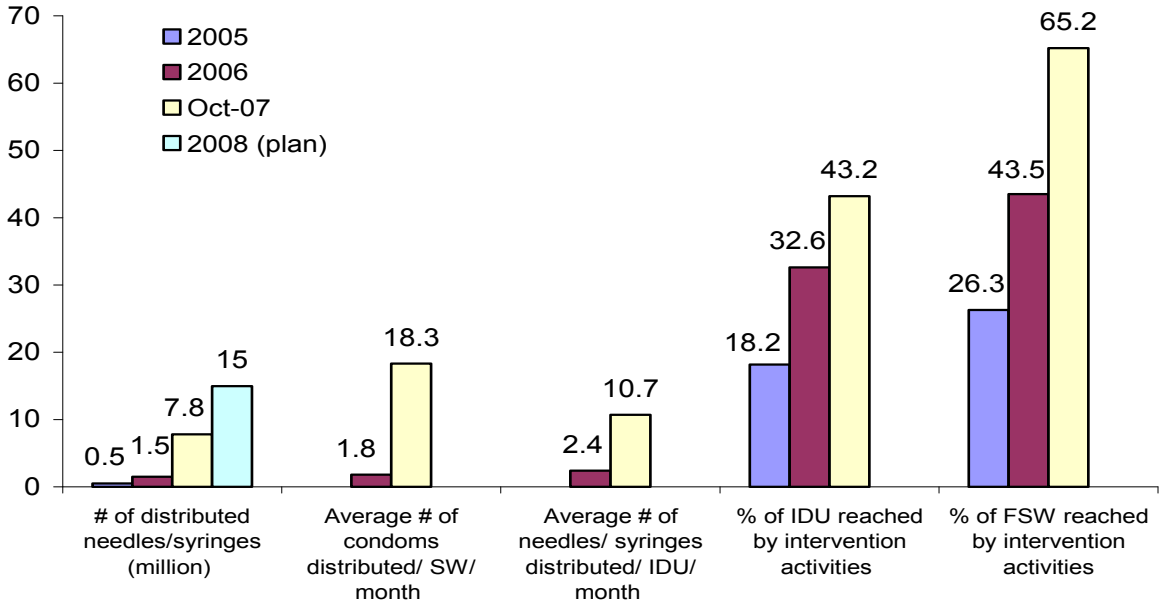


Figure 2: Results of harm reduction activities in 33 provinces under DfID and WB project[10]

Condom promotion programme

Condom promotion programme have been implemented in 314 out of 639 districts, in 58 provinces/cities and in Centres for Treatment, Education and Social Support for IDUs and SWs in 12 provinces. In 33 provinces covered by the DFID and WB projects, which are currently the biggest projects working on harm reduction in Viet Nam, 13.7 million condoms were distributed in the first 10 months of the year 2007. Condoms are mostly distributed through peer educator networks, with these accounting for 50% of total distributed condoms. In this project area, coverage of harm reduction activities among female sex workers has increased from 26.3% in 2005 to 65% in 2007 [11].

Studies on sexual behaviours of female sex workers revealed that the proportion of those who used a condom in the last sex with their casual client has increased from 90% in 2004[12] to 97% in 2006. However, FSW consistent condom use with clients over the last months was variable, ranging from 24% in one province to 95% in another in 2006. These data demonstrate the HIV risk for clients of sex workers, their wives and sexual partners, as well as the need for specific interventions targeting these groups.

[10] **DFID and WB programme report by 10/2007**
[11] **DFID and WB report**
[12] **UNGASS round 2**

As low as two-thirds of MSM reported using condoms in the last anal sex act with their consensual partner, and one-third of IDUs reported the use of a condom in the last sex with their lover/wife.[13]

Needle/syringe provision

The needle/syringe provision programme has expanded from 21 provinces/cities in 2005[14] to 42 provinces/cities by the end of June 2007.[15] There is a rapid increase in the number of needle/syringes distributed in the 33 provinces of the DFID and WB projects. Forty-three per cent (43%) of IDU in the project sites were reached by the HIV prevention programme. The average number of needles/syringes distributed per IDU per month has increased from 2.4 in 2006 to 10.7 in 2007. Positive results were seen in the high proportion of IDU using sterilized injecting equipments - 88.8% in 2006.[16]

However, in some provinces with high HIV prevalence, the number of communes implementing the programme remains low, accounting for less than 10%. Distributed needle/syringe could also address only 10–15% of the need of approached IDUs.

Methadone substitution treatment

Methadone substitution treatment was approved by the Government to be one of the key harm reduction interventions among IDU populations in late 2007. In the coming period, the programme is going to be piloted for around 1500 IDUs in two cities with severe drug abuse epidemics. Lesson learned from this pilot programme will be implemented when scaling up to other provinces/cities.

Other issues

Responding to HIV prevention, treatment, care and support service needs in closed settings remains a serious challenge. There are 84 mandatory drug treatment centres in the country with an annual total detention population ranging from 60,000 – 70,000 people.[17] An estimated 80% of these individuals have a history of injecting drug use, and HIV sero-prevalence rates are reported to range between 30–60% in many of these facilities.[18] A further 35,000 reported drug users are under detention in the prison system.[19] Therefore prisons and drug treatment centres alone contain approximately 100,000 of the total number of all reported drug users. Currently these facilities lack basic HIV prevention, treatment, care and support service provision.

It is important to note also that there are large numbers of drug users due to be released back into the community in the coming two years. With recorded drug use relapse rates of 80–90% common across the country[20] and an absence of effective HIV prevention programming inside these close setting facilities, a situation whereby re-initiation of HIV high risk behaviours is likely. This may correspond to an increase in HIV transmission within these returning populations which may then spread in to the wider community.

[13] **IBBS**
[14] UA report
[15] HR conference/page 8
[16] IBBS
[17] Viet Nam Country Coordinating Mechanism, (2007) Application proposal to Global Fund Round 7.
[18] UNODC, MOLISA, WHO, and UNAIDS, (2007) Project I66 monitoring and evaluation mission report, Hanoi.
[19] MOLISA, (2007) Report to the National Committee on Drugs, Prostitution, and AIDS, Hanoi.
[20] MOLISA, (2007) Report to the National Committee on Drugs, Prostitution, and AIDS, Hanoi**.**

In addition, because of this high relapse rate among returning drug users, there is a subsequent risk of being re-detained. Closed setting is often marked by the absence of both facility-based services and any continuum-of-care which would link them to community-based HIV treatment, care and support services. All these factors will combine to result in numerous interruptions in ARV treatment regimens among these returning detainees, which in turn will lead to increases in ARV drug resistance.

3.3 Prevention of HIV mother to child transmission (PMTCT)

HIV testing for pregnant women is an effective measure for the PMTCT. In Viet Nam, the percentage of pregnant women reported to have an HIV test at ANC visits remains low and has slightly decreased: in 2004, 22.4% of pregnant women had an HIV test in the last year;[21] in 2006, 16.5% had the test in the last 2 years.[22]

In 2006, of 506 facilities providing ANC services, 107 facilities (21%) provided the basic minimum package of PMTCT services. This package includes a single-dose NVP (Nevirapine) regimen provided in the national programme, and recently, the three-combination ARV prophylaxis (PEPFAR supported) for HIV positive pregnant women. In addition to ARV prophylaxis, HIV-infected women are encouraged to bottle-feed and are provided with formula free of charge. In 2007, national PMTCT procedures were developed and approved with consultation from various organisations working on PMTCT.

In 2006, 492 HIV positive pregnant women received three-combination ARV prophylaxis for PMTCT. One year later, this number has increased by more than 50% (to 744 cases).[23] A study in HCMC revealed that effective PMTCT programme in the city could reduce the MTCT rate to 5%.[24]

The National Programme of action for PMTCT was approved in 2006 and the Guidelines for its implementation are currently under development. With these still unfinished, implementation of the plan is affected and harmonious effort on PMTCT in the country is limited.

3.4 Voluntary HIV counselling and testing (VCT)

The VCT programme has been scaled up over the last two years, with support from CDC, Global Fund, World Bank, and FHI, covering all provinces nationwide. The number of VCT sites and VCT clients has notably increased from 157 sites in 2005 to 228 sites in 2006. The percentage of key populations at higher risk who ever received an HIV test has also increased from 12% among FSW in 2004 to 20% in 2006, and from 10.6% among IDU in 2004 to 16.5% in 2006.

[21] Ministry of Health (2005). Baseline survey on the realities of care, counseling, support to HIV infected cases and community-based HIV interventions in Vietnam (Survey in 20 provinces).
[22] MICS (survey in 64 provinces)
[23] Report of PEPFAR programme
[24] Report by PAC on PMTCT

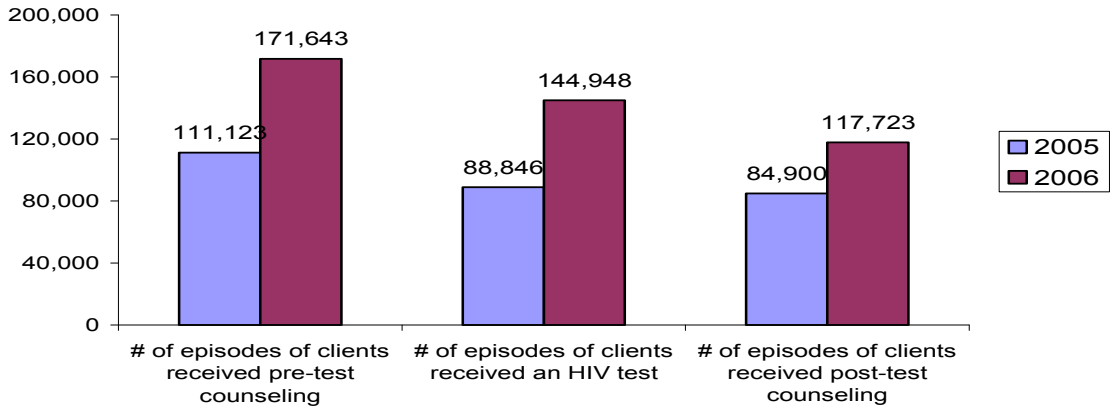


Figure 3: Increase of the number of clients receiving services in VCT sites nationwide

As can be seen the VCT programme has improved significantly, however the amount of key populations at higher risk who receive an HIV test and know their results has still remained low in the last 12 months: [25] 15% of FSW, 11.4% of IDU, and 16.3% of MSM.[26]

Moreover, it seems that people at a high-risk of HIV infection often do not want to know their HIV status because they believe that effective treatment is not available to them. While access to VCT is increasing, it appears to be mostly used by people who are not living with HIV. For instance, 75-85% of female sex workers in An Giang, 84% of IDU in Can Tho, and 90% of MSM in Hanoi who were living with HIV were unaware of their status.[27]

3.5 Blood transfusion safety

The blood transfusion safety programme has performed well in Vietnam, resulting in 100% of blood units and blood products being screened for HIV, Hepatitis B, Hepatitis C, Syphilis and Malaria. Since 2006, out of the 108 blood centres/blood screening laboratories, 26 (24%) facilities have participated in the external quality assurance programme. In late 2007, new guidelines on Blood safety were issued by the Ministry of Health. These assure high standards for blood safety and blood transfusion and currently all blood screening laboratories are receiving technical assistance from NIHE to fulfil the National Standards for Quality Assurance as per MOH Guidelines.

Despite the continued country's efforts to assure the best possible high standards in this area Viet Nam cannot report data for indicator 3 due to the change of indicator's definition in the UNGASS 2008 Guidelines.

3.6 STI management programme

According to a report by the National Dermatology and Venereology Institute, there are 130,000 STI cases annually. However, the estimated incidence is around 1 million cases per year. Various activities have been implemented to reduce STI prevalence such as: conducting IEC activities around STI prevention for both the general population as well as key populations at higher risk; building capacity for health staff working with STI management systems; strengthening STI sentinel surveillance and expanding it to 20 provinces; as well as provision of equipment, test kits and STI drugs.

[25] VPAIS
[26] IBBS
[27] IBBS

However, the STI management programme still faces challenges. The majority of people diagnosed with an STI visit private clinics for treatment. There is a lack of drugs provided for patients at public health facilities and there is a need to further invest in building the capacity of health staff.

The IBBS 2006 revealed a high STI prevalence among FSW and MSM in some provinces/cities. For instance, 17% of SSW in Ha Noi and 14% of KSW in HCMC were infected with Chlamydia, 9% of SSW in HCMC was infected with syphilis, and 11% of MSM in Ha Noi had rectal gonorrhoea.[28]

4. HIV treatment, care and support (POA 3 & 5)

The government is committed to scaling up treatment, care and support interventions. A National Action Plan on HIV/AIDS Care and Treatment was approved in 2006. A series of national normative guidelines have been developed which should serve as a foundation for coordination of different initiatives, and for effective scale-up of treatment, care and support.

MOH estimates the number of PLHIV in need of ARV treatment will increase from 42,480 in 2006 to 72,970 in 2010[29]. The National Action Plan states that 70% of adults and 100% of children who are eligible will receive ARV by the year 2010.

To achieve this objective, MOH with support from International donors (e.g. PEPFAR and GFATM), has made considerable efforts in the past two years. As a result and as Figure 4, below demonstrates, significant progress in ARV coverage has been made in the last two years. By the year 2007, ARV was available in all 64 provinces. At the end of quarter 3 of 2007, a total of 14,969 people were receiving ARV. This marks a 5.7 fold increase compared to the end of 2005, and is made up of 14,180 adults and 789 children. It is estimated that 18.1% and 30% of people in need of treatment were receiving ARV at the end of 2006 and Quarter 3 2007, respectively (Indicator 4).

[28] IBBS
[29] National Action Plans on HIV/AIDS Care and Treatment to the year 2010, Ministry of Health (Hanoi 2006).

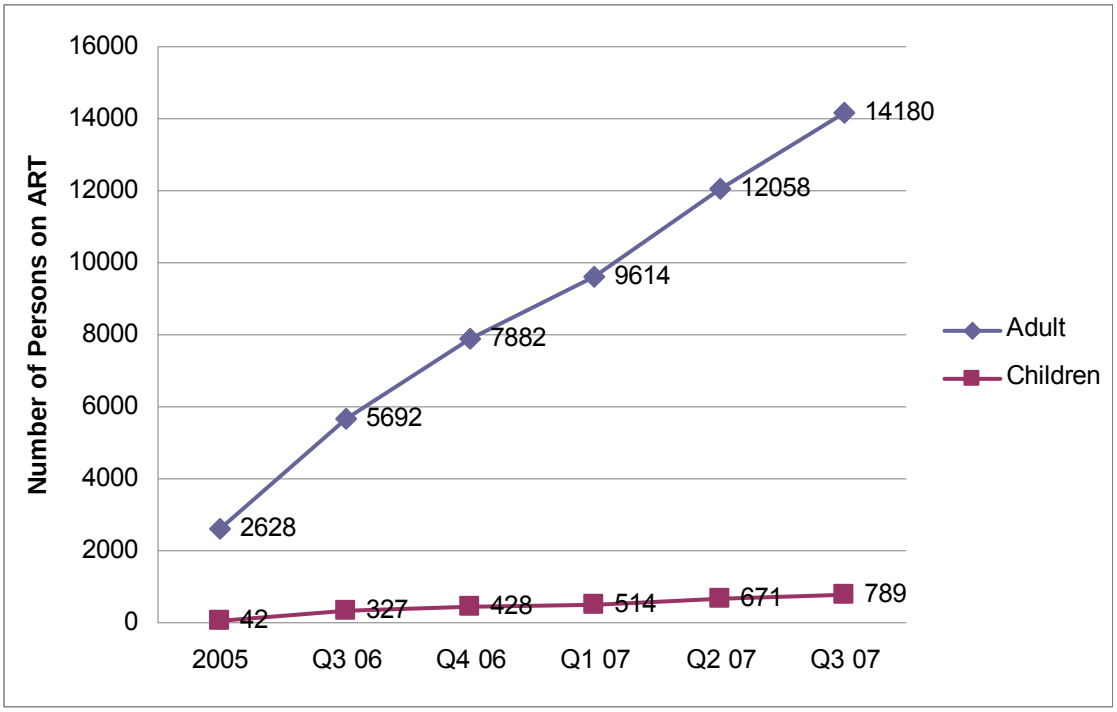


Figure 4: The number of adults and children on ARV in Viet Nam from 2005 to Quarter 3 2007

A recent study demonstrated the ARV treatment programme in Viet Nam has also been very effective: 81% of adults and 93.1% of children who were still alive and on ARV 12 months after the initiation of the treatment.

Since Viet Nam is one of the high TB burden countries, close collaboration between HIV and TB programmes is important. In 2007, VAAC and the National TB Programme have jointly worked to develop national operational procedures for collaborative activities. According to the ARV cohort study conducted in eight ARV treatment sites in 2007, estimated percentage of PLHIV newly infected with TB who receives treatment for both HIV and TB is 25%. However, if calculating the percentage of those who received both ARV and TB treatment from the eight ARV treatment study sites among the total number of people who co-infected with both HIV and TB nation-wide, the percentage of PLHIV who receive treatment for both HIV and TB is 15%. Due to the different calculation methods, the above mentioned data is not reported in CRIS for indicator number 6.

Based on the considerable achievements made in the past years, Viet Nam plans to further scale-up care, treatment and support services. To realise this plan, the following challenges need to be addressed:

- First of all, further mobilisation of internal and external resources and their appropriate allocation are crucial to achieve the National Action Plan on Care and Treatment. Coverage to be expanded to rural areas where currently, there is no donor support.
- Secondly, further efforts are needed to promote an enabling environment for key populations at higher risk so that they will access and continue to access HIV care and treatment. Many IDUs and FSWs are in treatment and education centres, prisons and other social sponsored centres under the management of MOPS and MOLISA. Capacity to provide care, treatment and support in those closed settings needs to be developed rapidly

and the linkage between the Centres and communities should be strengthened in order to continue treatment without interruption. Close coordination among MOH, MOPS and MOLISA and further efforts to address stigma and discrimination is vital to enhance utilisation of the services by key populations at higher risk. Opioid substitution therapy (e.g. Methadone Maintenance Treatment) is to be introduced in 2008. This is expected to enhance IDUs' ARV adherence rates. Integration with HIV prevention is necessary to maximize the synergy.

- Thirdly, quality improvement efforts will become increasingly important. Continued capacity building of health care workers and district coordinators for comprehensive care, treatment and support is essential. Patient monitoring and HIV drug resistance surveillance should be implemented in accordance with national protocols to address the different channels through which people obtain ARV treatment, including the PLHIV that are obtaining ARV drugs from government pharmacies or private practitioners at their own expense, or buy low-cost ARVs through self-help groups. Measures are needed to ensure the quality of ARV treatment provided outside of public services. The procurement and supply management of ARV drugs, currently supported by different donors through parallel systems, is another area that needs greater harmonisation.
- Fourthly, despite the efforts made in support of strengthening the civil society (CS) involvement in all areas of national AIDS response, at the moment, there is no legal framework for CS organisations (CSO) to officially register their activities. This limits financial supports to CSOs for provision of care services on a broad scale. However, the new HIV Law supports community mobilisation in the HIV response, this opens a new door to potential opportunities for CSOs to enhance care and support services.

IV. BEST PRACTICE

There are many noticeable examples of what could be considered as best practice for the reporting period 2006-2007. Those that Viet Nam wants to highlight are:

1. The leadership provided by the Party, National Assembly, Government and local authorities at all levels of the country AIDS response.
2. The promotion of the "Three Ones" principle and establishment of the National monitoring and evaluation framework.
3. A rapid expansion of harm reduction programmes for most-at-risk populations and ARV treatment coverage and access to treatment for people living with HIV.

1. The leadership provided by the Party, National Assembly, Government and local authorities at all levels of the AIDS response has included**:**

- The Party sector (Party Commission for Education and Communication, Party Commission for People Mobilization, The Ho Chi Minh Political Academy, and City/Provincial Party Organizations) has often directed both the overall system and local authorities at all levels to carry out Party Directive 54 of the Central Communist Party Secretariat. A series of

workshops, trainings, seminars and forums on HIV Law implementation have been conducted and followed by the regular monitoring and supervisions to the lower levels.

- The people elected bodies and the Party agencies (Social Affairs Committee of the National Assembly, Party Commission for Education and Communication, City/Provincial People's Councils) have had a strong involvement in the national AIDS response. The regular monitoring and supervision to oversee the participation of these organizations in the HIV response has been organized.
- A strong participation of the high profile state leadership, such as the President, Vice-President, the Chairperson of Social Affairs Committee of the National Assembly, the Deputy Prime Minister and the Health Minister.
- The People's Committees at all levels. These have regularly directed the organization and implementation of the AIDS response and considered it as one of its priority tasks for local socio-economic development. The People's Committee leaders at all levels have often appeared in important local events related to HIV activities.

2. Promotion of the "Three Ones" principle as the optimal architecture to ensure inclusive, participatory and effective national AIDS response.

- Being established under the Government Decision 432/QĐ-TTg, the Viet Nam Administration of HIV/AIDS Control (VAAC) has undertaken the role of a State management on HIV/AIDS and acts as a standing committee on HIV/AIDS for the National Committee for AIDS, Drugs and Prostitution Prevention and Control. The joint circular 11/TTLT-BNV-BYT between the Ministry of Home Affairs and the Ministry of Health and the Decision of the Health Minister 25/2005/QĐ-BYT provides detailed instructions on authority, tasks and functions that are mandatory for the system of AIDS response at provincial level to exist successfully.
- The National Strategy on HIV and AIDS response was approved by the Prime Minister in 2004 and the Programmes of Actions to implement the National Strategy were consequently developed and approved by the Ministry of Health in 2006 and 2007.
- As a result of broad a consultative process with inclusion of national and international partners, the National Monitoring and Evaluation Framework, using UNGASS indicators as the basis, and the Programme of Action on HIV Monitoring and Evaluation was developed and officially promoted in January 2007.

3. A rapid expansion of harm reduction programmes for most-at-risk populations and ARV treatment coverage and access to treatment for people living with HIV.

- One of the programmes prioritised by the Government in the overall national AIDS response is the Harm Reduction Programme for most-at-risk populations. To enhance its implementation, provinces and cities have differed in their initiatives and approaches. The changes in awareness and attitudes of local government leaders have been evident in increased efforts to expand harm reduction programme coverage. Many provinces and

cities have established inter-sectoral commitments which created favourable legal corridors for programme implementation.

- In accordance with the Law on HIV and AIDS prevention and control, and with the Decree 108, favourable conditions were assured for the implementation of harm reduction programmes. At the National Conference on Harm Reduction, chaired by the Deputy Prime Minister, Mr. Truong Vinh Trong, representatives from MOPS, MOLISA, MOH and other local leaders discussed efforts made in this area. The Deputy Prime Minister explained the roadmap for implementation the National Programme of Action on Harm Reduction
- With technical and financial support from international organisations, provision of clean needles and syringes, and condoms has expanded rapidly. In the first ten months of 2007, in the thirty three (33) provinces participating in a project funded by DFID and WB, 65% FSW and 43% IDU had access to harm reduction programmes; and 15 millions condoms and 7.5 millions needles and syringes have been distributed.
- The government commitment for scaling up treatment was translated into the National Action Plan on HIV/AIDS Care and Treatment, approved in 2006. A series of national normative guidelines have been developed since, and serve as foundation for coordination of different initiatives, and for effective scale-up of treatment, for all in need.
- Coverage of the ARV treatment programme has been considerably scaled up, increasing the accessibility of ARV treatment for AIDS patients. By the end of 2007, there were approximately 14180 people on ARV treatment in all cities/provinces, which is a 5.7 fold increase compared to the end of 2005.

V. SUPPORT FROM COUNTRY DEVELOPMENT PARTNERS

The last few years have seen a significant expansion of bilateral and multilateral support to the National HIV response. Overall, international support has increased from about US$7– 8 million a year in 2002-04, to around US$50 million per year in 2006.

The international organizations that have supported technical assistance and funding for the national HIV response in Viet Nam are:

- Bilateral : The United States of America (USAID, CDC/PEPFAR), the United Kingdom Government (DFID), Norway (NORAD); Australia (AusAid); Germany (GTZ, KfW); France; Canada; Sweden (SIDA), Denmark (DANIDA) and Japan (JICA)
- United Nations Organisations: UNAIDS, UNDP, WHO, UNICEF, UNFPA, UNESCO, UNODC, ILO, IOM and UNV.
- Multilateral Organizations: The World Bank (WB), Asian Bank for Development (ADB) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).
- International Non-Government Organizations: Family Health International (FHI); the Ford Foundation; DKT; Population Service International (PSI); CARE, Future Group/HPI, Pact, MDM, World Vision and Save the Children Fund UK.

In line with the Ha Noi Core Statement, international development partners have committed to align with the government's strategies and to strengthen national systems. Under the lead of the Ministry of Planning and Investment (MPI) and MOH, and in order to further enhance management, UN agencies, donors and INGOs have developed a joint government of Viet Nam-Donor Coordination Action Plan (CAP) for the coordination and utilisation of resources on HIV. This is set within the framework of the 'Three Ones', and aligned with the principles of the Ha Noi Core Statement.

During the reporting period of 2006–2007, Viet Nam has continuously received strong support from the international community in the areas of prevention, treatment, care and support, as well as in the areas of: developing the National Programme of Actions to implement the National Strategy, promulgating legal documents and the Law on HIV , providing training and capacity building for staff working on HIV at different levels, and project staff working in international funded projects at the both central and local levels.

Viet Nam highly appreciates and respects all the support and contributions from the international community which has reinforced the national AIDS response and would encourage international partners to continue to implement the objectives of the "Hanoi Core Statement" on Aid Effectiveness, under the framework of the "Three Ones".

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

1. Efforts and Achievements to Resolve the Challenges and Difficulties Mentioned in the 2nd Country UNGASS Report (January 2006 reporting for the period of 2004 and 2005):

- The commitment of the Party sector, people elected bodies and local authorities at all levels to a better HIV response, has been strengthened since the previous reporting period covered in the 2nd Country UNGASS Report.
  This is demonstrated by promulgation of the Law on HIV and AIDS and other related legal documents; formalization of a more adequate policy framework on AIDS response and the strong leadership of the Party agencies, people elected bodies and local authorities at all levels.

- An expansion of harm reduction programme coverage targeting high risk populations (IDU, FSW) in 33 sentinel provinces supported by WB, DFID and PEPFAR.

- An expansion of coverage and access to quality HIV care and support and AIDS treatment, including quality referral services, has been considerably improved in those cities and provinces with a high HIV prevalence. AIDS response funding from the Government has been significantly increased, along with the support from the international community.

2. The Main Challenges Encountered for the 2 year Period of 2006-2007 in Implementing the National Strategy and UNGASS Commitments.

- Despite availability of an adequate policy framework in support of the national response, the legal regulations related to HIV prevention have not been harmonized nor sufficiently implemented by the other sectors and local authorities at all levels. In particular HIV harm reduction interventions and the 100% condom promotion programme have not yet been widely implemented. Methadone substitution treatment has been piloted on a small scale only since the end of 2007.

  The IBBS 2006 reports a limited coverage of the harm reduction programme with 88% to 97% of the IDUs not receiving free of charge needles and syringes for the last 6 months in Can Tho (88%), Quang Ninh (88%), Da Nang (97%), and Hanoi (97%). There are only 20% to 30% of the IDUs receiving HIV voluntary counselling and testing (VCT) services.

- Providing prevention, treatment, care and support interventions in closed settings remains a challenge. Closed settings include education centres, re-education centres, detention centres, prisons or other social sponsored centres under the management of Ministry of Public Security (MOPS) and Ministry of Labour, War-Invalids and Social Affairs (MOLISA). In such settings services for PLHIV are still under limited largely as a result of poor facilities and a lack of the trained staff to meet the requirements of the large number of people living with HIV in these centres.

- Human resource constraints are a major challenge. In all provinces, there is a need to build the capacity of existing staff working on HIV and increase the overall number of staff supporting the response. Due to the fact that all Provincial AIDS Centres are newly established, their programmatic and management capacity is still limited, which in turn affects HIV programme management and implementation as well as delivery of quality prevention, treatment and care services for those in need. Many HIV services are seriously fragmented and uncoordinated largely due to a project oriented approach.

- Despite the fact that harm reduction programmes and safer sex promotion are made available for key populations at higher risk, still Viet Nam has not finalized a specific AIDS response strategy nor a plan of action for targeting subgroups of the young population (e.g. most at risk adolescents, street children)
- Compared to the previous reporting period, there has been some improvement in the participation of the Civil Society Organizations in the area of prevention, treatment, care and support. However, additional efforts must be to promote civil society Organisations as equal partners in the national response and to encourage their involvement in all steps of design and implementation of HIV activities.
- Achieving Millennium Development Goal 6 on HIV and meeting Universal Access targets will require far greater investment in HIV prevention, treatment, care and support services. Central Government funding for HIV programming in 2007 has been increased, but there is a need to further increase domestic resources for the national response. Recurrent cost financing and overall technical and managerial sustainability will also become a major issue once Viet Nam becomes a middle-income country and some bilateral donors reduce, limit or phase out official development assistance.

3. The Required Response for Achieving the National Strategy Objectives and UNGASS Indicators

- Strongly and harmoniously enforce the legal documents related to the AIDS response and put them into practice by all sectors and at all levels. Special attention should be paid to implementation of harm reduction interventions; development of legal documents related to health insurance for people living with HIV and further promotion of the initiated activities for the reduction of stigma and discrimination.
- To further increase access to prevention, treatment, care and support for all in need, including the residents of the education centres, detentions, prisons and other social sponsored centres, and finalise the development of the remaining plan of actions.
- To strengthen the National HIV/STI surveillance system and promote better use of available data for policy development and evaluation of achieved results in the national response, particularly at a provincial level.
- To provide sufficient numbers of qualified staff and provide capacity building opportunities for staff at all levels, especially for newly founded provincial AIDS centres, and especially in the areas of development, provision, management and coordination of HIV efforts at local levels.
- To enhance participation of civil society organizations and PLHIV, and make financial support, both from international and national agencies more accessible. Civil society organizations and PLHIV need to be further involved in programme and policy development, implementation, and monitoring and evaluation of the HIV programmes, as well as in decision-making processes. This includes the greater involvement of PLHIV (GIPA) through the creation and strengthening of organizations of people living with HIV.
- To continue increasing HIV funding from the government and mobilize contributions from the local authorities, business companies, the private sector and the community. It is recommended that the Government increase the central Government budget from AIDS programmes to 16.6 million USD in 2008 and 18.8 million USD in 2009 in order to reach the overall objective of National Strategic Plan by the year of 2010.

VII. MONITORING AND EVALUATION ENVIRONMENT

1. Overview of the Current HIV/AIDS Monitoring and Evaluation System in Viet Nam

The national HIV surveillance system was established in 1987. The first HIV case was reported in Viet Nam in 1990. In addition to the established HIV case reporting system, in 1994 annual sentinel HIV surveillance began in 8 provinces, and expanded into 40 provinces by 2002 with samples collected from FSWs, IDUs, ANC attendees and national military recruits. In 2005-2006, with support from international partners, the MOH, through FHI, conducted the first community-based integrated HIV bio-behavioral surveillance (IBBS) in 7 provinces. IBBS will be repeated in 2008 and 2010 to obtain trends in HIV/STI risk behaviors and intervention exposure among IDUs, FSWs, and MSM.

Building on existing efforts, and in line with the adoption of the 'Three Ones" architecture by Viet Nam, in January 2007 the MOH approved the National HIV Monitoring and Evaluation System that aims to:

- Guide programme implementation and monitoring of the HIV epidemic in Viet Nam;
- Strengthen the evidence base for effective HIV policies;
- Promote the effective use of monitoring and evaluation for improving HIV programme development and quality reporting and performance at all levels;
- Ensure accountability for the use of resources;
- Incorporate the collection of data necessary to track progress against the UNGASS targets and MDGs;
- Guide the collection of strategic information from multiple sources;
- Help identify the gaps in currently available information, and take steps to fill them; and
- Encourage the effective use of data for advocacy purposes.

The Organizational structure of the HIV/ AIDS Monitoring and Evaluation System in Viet Nam is based on an existing four level HIV system:

- At Central Level: the National M & E Unit is located in the Ministry of Health (the HIV/AIDS/STI Surveillance Unit, Viet Nam Administration for AIDS Control, VAAC)
- At Regional Level: 4 regional M & E units are located in the Regional HIV and AIDS Steering Committees:
    - The Northern M & E Unit is located at the Northern HIV and AIDS Steering Committee (National Institute for Hygiene and Epidemiology- NIHE) and is responsible for the HIV epidemic monitoring and evaluation in 29 Northern cities/provinces.
    - The Central Regional M & E Unit is located at the Central HIV and AIDS Steering Committee (Pasteur Nha Trang) and is responsible for HIV epidemic monitoring and evaluation in 11 Central cities/provinces.
    - The Southern Regional M & E Unit is located at the Southern HIV and AIDS Steering Committee (Pasteur Ho Chi Minh City) and is responsible for the HIV epidemic monitoring and evaluation in 20 Southern cities/provinces.
    - The Tay Nguyen Central Highland M & E Unit is located at the Tay Nguyen Central Highland HIV and AIDS Steering Committee (Pasteur Tay Nguyen) and is responsible

for the HIV epidemic monitoring and evaluation in 4 Tay Nguyen Central Highland Central cities/provinces.

HIV/AIDS M & E Units are located in the HIV/AIDS/STI Surveillance Department of the Provincial AIDS Centres and report to the central government. Every District Preventive Medicine Centre has at least one to two staff working on HIV M & E.

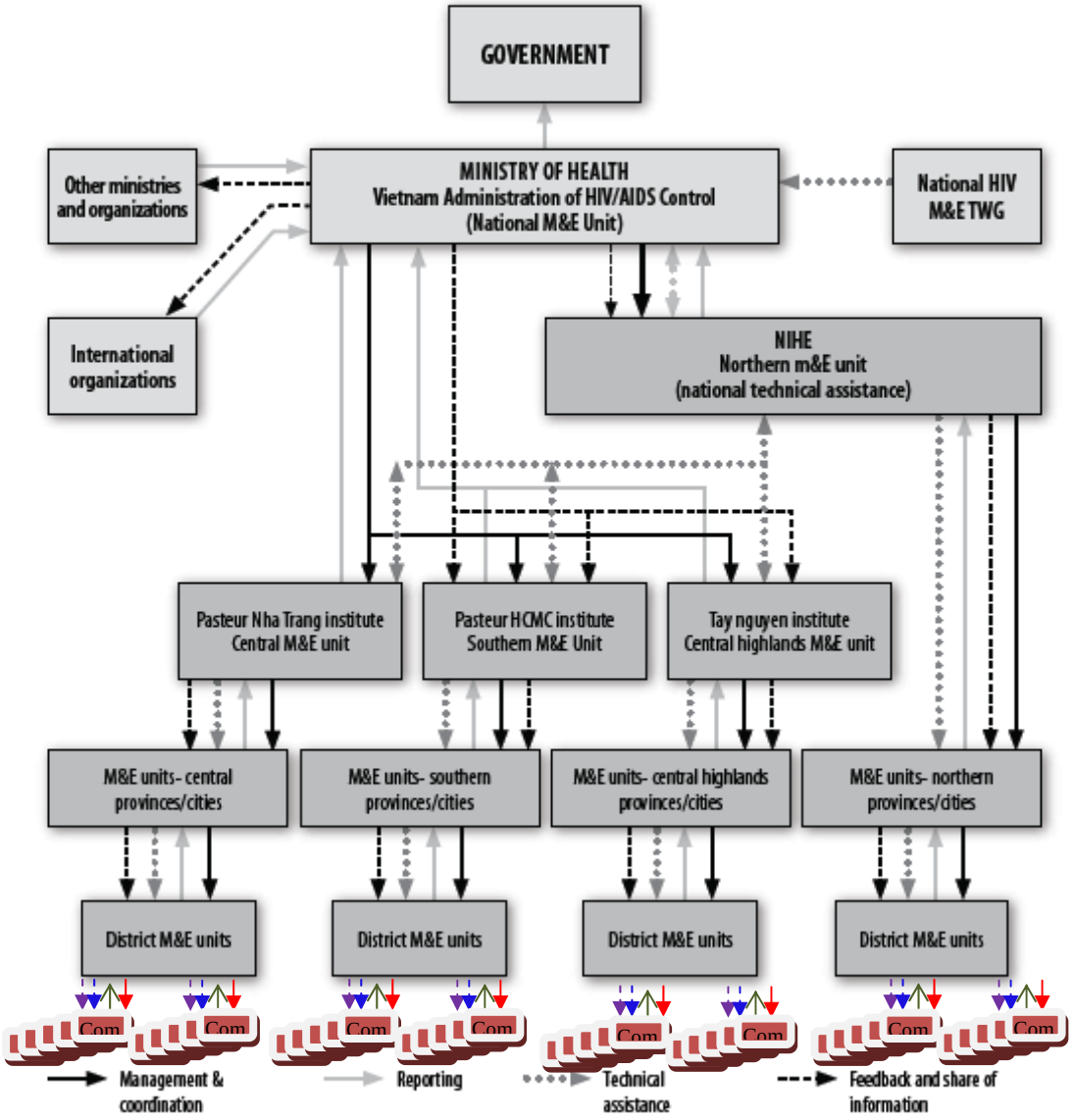
In addition to the M&E Unit in VAAC responsible for the day to day technical assistance for planning and implementation of the national M&E system, a National HIV M&E Technical Working Group consists of members from different national and international partners (representatives of universities, experts from national institutions, UNAIDS, WHO, UNICEF, CDC, USAID, FHI and others) and also provides inputs and advice for better implementation of the M&E Framework.

2. The Main Challenges of the M & E Programme

There are 4 main challenges encountered by the National M&E Programme in Viet Nam:

- The lack of a sufficient number of trained staff at all levels
- The lack of quality assurance systems for collection (especially at the community level) and analysis of data on HIV prevention, treatment, care and support for key populations at higher risk.
- The lack of sufficient and adequate use of M & E, which results in poor programme development, resource coordination and allocation. The data from HIV sentinel surveillance is currently that most often utilised. The IBBS data is mainly used at the Central level and by international organizations.
- The lack of sufficient financial support, especially for M & E activities at the provincial level (Provincial AIDS Centres M&E facilities are not equipped, and 12 cities/provinces out of 64 do not have the necessary laboratory equipments for HIV tests confirmation).

Figure 5: National M&E structure in Viet Nam



3. Remedial Actions

The actions needed to overcome the current challenges are clearly stated in the "National Programme of Action on HIV/AIDS Monitoring and Evaluation" [30]. The priorities are:

- Consolidation of the HIV/AIDS M & E system and development of M & E Units at all levels.
- Development of National Guidelines on Technical Procedures for implementation of HIV/AIDS M & E programme;

[30] It is promulgated by the Health Minister's Decision 08/2007/QĐ-BYT on 19th January 2007

- Finalisation of the system for data collection, reporting and HIV surveillance, management and implementation of the HIV/AIDS M & E programme;
- Improvement of the quality and coverage of the routine reporting systems at district, provincial, regional and national levels and the creation of a national M&E database;
- Development of a system for better use of data and raise awareness among all partners at national and local levels on how to use available data for programme planning, resource mobilisation and allocation;
- Provision of technical capacity building for staff working on M&E at all levels, especially in the areas of data collection, data analysis, data use and production of strategic information;
- Provision of necessary equipment and infrastructure;
- Promotion of international cooperation for improvement of the HIV/AIDS M & E programme; and
- Increase in available resources through allocation of at least 10% of the total budget of the HIV Programmes (including external funds) for M & E activities.

4. The Necessary Technical Support for the M & E Programme

The technical and financial support needed for overcoming the listed above challenges, has been specifically indicated in the "National Programme of Action on HIV/AIDS Monitoring and Evaluation" as follows:

- Provision of technical assistance for the development of National Guidelines on Technical Procedures for implementation of HIV/AIDS M & E programming;
- Technical and financial support for provision of basic equipment and infrastructure;
- Support for comprehensive technical training for staff working on M &E both at national and provincial levels;
- Support for design and organisation of specific HIV studies, including vaccine trails, resistance to ARV; effectiveness of ARV treatment, and national surveys, using the National M&E Indicators' framework by the year of 2010.

ANNEX 1

CONSULTATION/PREPARATION PROCESS FOR THE NATIONAL REPORT ON MONITORING THE FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS

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

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

2. With input from:

Ministries:

Ministry of Education & Training	Yes
Ministry of Health	Yes
MOLISA	Yes
Ministry of Foreign Affair	Yes
Ministry of Public Security	Yes
Ministry of Justice	Yes
Ministry of National Defence	Yes
Ministry of Planning and Investment	Yes

Other institutions

Central Women Union	Yes
Youth Union	Yes
Labor Union	Yes
Vietnam Red Cross	Yes
The Party's Central Commission of Ideology	Yes
Civil Society Organizations	Yes
People living with HIV	Yes
Private Sectors	Yes
UN Agencies	Yes
Bilateral and multilateral donors	Yes
International NGOs	Yes

3.	Was the report discussed in large forum ?	Yes
4.	Are the survey 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 (If yes):

Name: Duong Quoc Trong,
Title: Director General of Administration of HIV/AIDS Control
Date: 31/1/2008

Signature:

Address: 135/3 Nui Truc, Ba Đinh, Hanoi, Vietnam
Email: duongquoctrongbyt@hn.vnn.vn
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ANNEX 2

NATIONAL COMPOSITE POLICY INDEX

Country: The Socialist Republic of Vietnam

Name of the National AIDS Committee Officer in Charge: Nguyen Quoc Trieu

Signature:

Address:

Nguyen Quoc Trieu
Minister
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Date to send report: 31/01/2008

NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

PART A

I. Strategy Plan

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?

Yes ☑	Period covered: 2004-2010	N/A	No

IF NO or N/A, briefly explain:

IF YES, complete questions 1.1 through 1.10; otherwise, go to question 2.

1.1. How long has the country had a multisectoral strategy/action framework?
Number of years: 04

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

Sectors included	Strategy/Action framework		Earmarked budget	
Health	Yes ☑	No	Yes ☑	No
Education	Yes ☑	No	Yes ☑	No
Labour	Yes ☑	No	Yes ☑	No
Transportation	Yes ☑	No	Yes ☑	No
Military	Yes ☑	No	Yes ☑	No
Police	Yes ☑	No	Yes ☑	No
Women	Yes ☑	No	Yes ☑	No
Young people	Yes ☑	No	Yes ☑	No
Other*: *[write in]Justice, Agriculture and Rural development, Vietnam Father Frontland,Labour Union, Red Cross Association, Farmer Association, Functional Departmenst of Communist Party, Social issues Committee of National Assembly…*	Yes ☑	No	Yes ☑	No

IF NO *earmarked budget*, how is the money allocated?

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

Target populations a. Women and girls b. Young women/young men c. Specific vulnerable sub- populations[15] d. Orphans and other vulnerable children	a. Yes ☑ No b. Yes ☑ No c. Yes ☑ No d. Yes ☑ No
Settings e. Workplace f. Schools g. Prisons	e. Yes ☑ No f. Yes ☑ No g. Yes ☑ No
Cross-cutting issues h. HIV, AIDS and poverty i. Human rights protection j. PLHIV involvement k. Addressing stigma and discrimination l. Gender empowerment and/or gender equality	h. Yes ☑ No i. Yes ☑ No j. Yes ☑ No k. Yes ☑ No l. Yes ☑ No

1.4. Were target populations identified through a process of a needs assessment or needs analysis?

Yes ☑	No

IF YES, when was this needs assessment /analysis conducted? Year:
: 2001-2003

IF NO, how were target populations identified?

1.5. What are the target populations in the country? *[write in]*
- Injecting Drug Users (IDU)
- Female Sex Workers (FSW)
- Men who have sex with men (MSM)

- Migrant workers/mobile population
- People living with HIV
- STIs' patients
- Pregnant women
- Young people

1.6. Does the multisectoral strategy/action framework include an operational plan?

Yes ☑	No

1.7. Does the multisectoral strategy/action framework or operational plan include:

a. Formal programme goals?	Yes ☑	No
b. Clear targets and/or milestones?	Yes ☑	No
c. Detailed budget of costs per programmatic area?	Yes ☑	No
d. Indications of funding sources?	Yes ☑	No
e. Monitoring and Evaluation framework?	Yes ☑	No

1.8. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy/action framework?

Active involvement	Moderate involvement ☑	No involvement

IF active involvement, briefly explain how this was done:

IF NO or MODERATE involvement, briefly explain:
Civil Society organisations mainly founded and operate in urban areas, with small scale activites. Hence only in certain areas (harm reduction, M&E) civil society participated, but not through out the process of the framework development.

1.9. Has the multisectoral strategy/action framework been endorsed by most external Development
Partners (bi-laterals; multi-laterals)?

Yes ☑	No

1.10. Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their
HIV and AIDS programmes to the national multisectoral strategy/action framework?

Yes, all partners ☑	Yes, some partners	NO

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?

Yes ☑	NO	N/A

2.1. *IF YES*, in which development plans is policy support for HIV and AIDS integrated?

a) National Development Plan ☑
b) United Nation Development Assistance Framework ☑
c) Poverty Reduction Strategy ☑
d) Sector Wide Approach
e) Other: Drug and Prostitution control and Children Protection ☑

2.2. *IF YES*, which policy areas below are included in these development plans?

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	☑	☑	☑		☑
Treatment for opportunistic infections	☑	☑			
Antiretroviral therapy	☑	☑			
Care and support (including social security or other schemes)	☑	☑	☑		☑
AIDS impact alleviation	☑	☑	☑		☑
Reduction of gender inequalities as they relate To HIV prevention/treatment, care and/or support	☑	☑	☑		☑
Reduction of income inequalities as they relate To HIV prevention/ treatment, care and /or support	☑	☑			☑
Reduction of stigma and discrimination	☑	☑	☑		☑
Women's economic empowerment (e.g. access to credit, access to land, training)		☑	☑		
Other: *[write in]*					

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?

Yes ☑	No	N/A

3.1. *IF YES*, to what extent has it informed resource allocation decisions (from low to high)?

Low					High
0	1	2	3 ☑	4	5

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes ☑	No

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

Behavioural change communication	Yes ☑	No
Condom provision	Yes ☑	No
HIV testing and counselling*	Yes ☑	No
STI services	Yes ☑	No
Treatment	Yes ☑	No
Care and support	Yes ☑	No
Others: *[write in]*	Yes	No

* What is the approach taken to HIV testing and counselling? Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:

- The VCT services help the high risk populations realise the risks and benefits of the HIV tests
- Counselling and testing is voluntary, especially for most- at-risk populations. Moverover, according to the laws on HIV and AIDS prevention and control, there are listed occupations that require HIV testing in its recruitment process, e.g. the police, army

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

Yes ☑	No

5.1. Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

Yes ☑	No

5.2.Have the estimates of the size of the main target population sub-groups been updated?

Yes ☑	No

5.3. Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy

Estimates and projected needs ☑	Estimates only	NO

5.4. Is HIV and AIDS programme coverage being monitored?

Yes ☑	No

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

Yes	No ☑

(b) *IF YES*, is coverage monitored by population sub-groups?

Yes ☑	No

IF YES, which population sub-group?
- Injecting drug Users (IDU)
- Female sex Workers (FSW)

- Men who have sex with men (MSM)
- STIs' patients
- Pregnant women
- Army recruits

(c) *IF YES*, is coverage monitored by geographical area?

Yes ☑	No

IF YES, at which level (provincial, district levels)?

- Province/Cities directly under central level
- Some of district/towns of identified provinces.

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

Yes ☑	NO

Overall, how would you rate *strategy planning efforts* in the HIV and AIDS programmes in 2007 and in 2005 ?

2007	Poor											Good
		0	1	2	3	4	5	6	7	8	9☑	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8☑	9	10

Comments on progress made since 2005:

- AIDS response system has been set up and consolidated from the central to local levels; the health care system has been improved
- An increasing number of people accessing the HIV prevention and ARV treatment services
- An International cooperation has been strengthened

II. Political support

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

1. Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?

President/Prime Minister	Yes ☑	No
Other high officials	Yes ☑	No
Other officias at provincial/district levels	Yes ☑	No

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

Yes ☑	No

IF NO, briefly explain:

2.1.*IF YES*, when was it created? Year:

- 1994: National Committee for HIV/AIDS response
- Năm 2000: National Committee for AIDS control, drug and prostitution control

2.2. *IF YES*, who is the Chair: Deputy Prime Minister

2.3. *IF YES*, does it:

have terms of reference?	Yes ☑	No
have active Government leadership and participation?	Yes ☑	No
have a defined membership?	Yes ☑	No
include civil society representatives?	Yes ☑	No
IF YES, what percentage? *[write in]*	15%	
include people living with HIV?	Yes	No ☑
include the private sector?	Yes	No ☑
have an action plan?	Yes ☑	No
have a functional Secretariat?	Yes ☑	No
meet at least quarterly?	Yes ☑	No
review actions on policy decisions regularly?	Yes ☑	No
actively promote policy decisions?	Yes ☑	No
provide opportunity for civil society to influence decision-making?	Yes ☑	No
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes ☑	No

3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/ programmes?

Yes ☑	No

3.1.If Yes, does it include :

Terms of reference	Yes ☑	No
Defined membership	Yes ☑	No
Action plan	Yes ☑	No
Functional Secretariat	Yes ☑	No
Regular meetings	Yes ☑	No
	Frequency of meetings	

IF YES, what are the main achievements?

- Provision of consultative advice to the related policy development agencies on AIDS response (the HIV Law, the Party Directive 54/CT-TW, and the National Strategy)
- Acting as an advisory agency for the Government to lead and coordinate the national AIDS response.
- An increasingly effective management and coordination of AIDS response
- An improvement of capacities of the organizational structure, human resourse and facilities for AIDS response
- Reduction of stigma and discrimination related to HIV

IF YES,What are the main challenges for the work of this body?

4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year? < 25%

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes ☑	No
Technical guidance/materials	Yes ☑	No
Drugs/supplies procurement and distribution	Yes ☑	No
Coordination with other implementing partners	Yes ☑	No
Capacity-building	Yes ☑	No
Other: *[write in]*		

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

Yes ☑	No

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

Yes ☑	No

6.2. *IF YES*, which policies and legislation were amended and when?

Policy/law	Year
List of careers that PLWHA cannot be worked	2006

Overall, how would you rate *strategy planning efforts* in the HIV and AIDS programmes											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10 ☑
2005	Poor										Good
0		1	2	3	4	5	6	7	8	9☑	10

Comments on progress made since 2005:

- A finalization of the legal documents related to AIDS response
- Consolidation and strengthening of the AIDS response system
- Strengthening of the international cooperation

III. Prevention

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

Yes ☑	NO	N/A

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

Be sexually abstinent	☑
Delay sexual debut	
Be faithful	☑
Reduce the number of sexual partners	☑
Use condoms consistently	☑
Engage in safe(r) sex	☑
Avoid commercial sex	☑
Abstain from injecting drugs	☑
Use clean needles and syringes	☑
Fight against violence against women	☑
Greater acceptance and involvement of people living with HIV	☑
Greater involvement of men in reproductive health programmes	☑
Other: *[write in]*	

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

Yes ☑	No

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

Yes ☑	NO

2.1. Is HIV education part of the curriculum in?

Secondary schools?	Yes ☑	No
Upper-secondary schools?	Yes ☑	No
Teacher training?	Yes ☑	No

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

Yes ☑	No

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

Yes ☑	No

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

Yes ☑	No

IF No, briefly explain:

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

	IDU	MSM	FSW	Clients of Sex workers	Prison inmates	Other sub-population
Targeted information on risk reduction	☑	☑	☑	☑	☑	
Stigma & discrimination reduction	☑	☑	☑			
Condom promotion	☑	☑	☑	☑		
HIV testing & counselling	☑	☑	☑	☑		
Reproductive health, including STI prevention & treatment	☑	☑	☑	☑		
Risk reduction (e.g. income generation)			☑			
Drug substitution therapy	☑					
Needle & syringe exchange	☑					

Overall, how would you rate *policy efforts* in support of HIV prevention in 2007 and in 2005 ?												
2007	Poor											Good
	0	1	2	3	4	5	6	7	8	9☑	10	
2005	Poor											Good
	0	1	2	3	4	5	6	7☑	8	9	10	
Comments on progress made since 2005:												

4. Has the country identified the districts/provinces (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes ☑	No

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

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts/provinces in need?

HIV prevention programmes	The activity is available in		
	all districts/provinces in need	*all* districts/provinces in need	*all* districts/provinces in need
Blood safety	☑		
Universal precautions in health care settings	☑		
Prevention of mother-to-child transmission of HIV		☑	
IEC on risk reduction	☑		
IEC on stigma and discrimination reduction	☑		
Condom promotion		☑	
HIV testing & counselling	☑		
Harm reduction for injecting drug users		☑	
Intervention programmes for other high risk groups		☑	
Reproductive health services including STIs prevention and treatment	☑		
School-based AIDS education for young people		☑	
Programmes for out-of-school young people			☑
HIV prevention in the workplace			☑
Other *[write in]*			

Overall, how would you rate the efforts in the implementation of HIV prevention programmes ?												
2007	Poor											Good
	0	1	2	3	4	5	6	7	8☑	9	10	
2005	Poor											Good
	0	1	2	3	4	5	6	7☑	8	9	10	
Comments on progress made since 2005:												

IV. Treatment, Care and Support

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

Yes ☑	NO

1.1. *IF YES*, does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes ☑	No

2. Has the country identified the districts/provinces (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes ☑	No	N/A

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

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts/provinces in need?

HIV treatment, care and support services	**The service is available in**		
	all districts/provinces in need	*most* districts/provinces in need	*some* districts/provinces in need
Antiretroviral therapy	☑		
Nutritional care			☑
Paediatric AIDS treatment	☑		
Sexually transmitted infection management		☑	
Psychosocial support for people living with HIV and their families		☑	
Home-based care		☑	
Palliative care and treatment of common HIV-related infections		☑	
HIV testing and counselling for TB patients	☑		
TB screening for HIV-infected people		☑	
TB preventive therapy for HIV-infected people		☑	
TB infection control in HIV treatment and care facilities		☑	
Cotrimoxazole prophylaxis in HIV-infected people			☑
Post-exposure prophylaxis (e.g. occupational exposures to HIV,	☑		

rape)			
HIV treatment services in the workplace or treatment referral systems through the workplace			☑
HIV care and support in the workplace (including alternative working arrangements)			☑
Other programmes: *[write in]*			

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

Yes ☑	No

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

Yes ☑	No

4.1. *IF YES*, for which commodities?: *[write in]*

- ARV medicines

5. Does the country have a policy or strategy to address the additional HIV- or AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes ☑	No	N/A

5.1. *IF YES*, is there an operational definition for OVC in the country?

Yes ☑	No

5.2. *IF YES*, does the country have a national action plan specifically for OVC?

Yes ☑	No

5.3. *IF YES*, does the country have an estimate of OVC being reached by existing interventions?

Yes	No ☑

IF YES, what percentage of OVC is being reached?

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9☑	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8☑	9	10
Comments on progress made since 2005:											

V. Monitoring and Evaluation

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

Yes ☑	Year covered:	In progress	No

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

Yes ☑	No

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

Yes ☑	No

1.3. *IF YES*, have key partners aligned and harmonized their M&E requirements (including indica- tors) with the national M&E plan?

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

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes ☑	No
behavioural surveillance	Yes ☑	No
HIV surveillance	Yes ☑	No
a well-defined standardized set of indicators	Yes ☑	No
guidelines on tools for data collection	Yes ☑	No
a strategy for assessing quality and accuracy of data	Yes ☑	No
a data dissemination and use strategy	Yes ☑	No

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

Yes ☑	Year covered: 2007	In progress	No

However the budget doesn't meet the demand

3.1. *IF YES*, has funding been secured?

Yes ☑	No

4. Is there a functional M&E Unit or Department?

Yes ☑	In progress	No

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

4.1. *IF YES*, is the M&E Unit/Department based

In the National AIDS Committee (or equivalent)	Yes	No
In the Ministry of Health	Yes ☑	No
Elsewhere		

4.2. IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff:		
Position: Manager	Full time: 2 Part time:	Since when 2005
Position: Technical	Full time: 3 Part time:	Since when 2005
Position:	Full time: Part time:	Since when?
Position:	Full time: Part time:	Since when?

Number of temporary staff:	3 (full time)

4.3. *IF YES*, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?

Yes ☑	No

IF YES, does this mechanism work? What are the major challenges? The M & E system has been well functioned. However, it remains main challenges in insufficient technical staff, shortage of resources, facilities, equipment and budget as well

4.4. *IF YES*, to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low					High
0	1	2	3	4 ☑	5

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

No	Yes, but meets irregularly	Yes, meets regularly ☑

IF YES, Date last meeting: *[write in]*: Dec 5, 2007

5.1. Does it include representation from civil society, including people living with HIV?

Yes	No ☑

If Yes describe the role of civil society representatives and people living with HIV in the working group:

6. Does the M&E Unit/Department manage a central national database?

Yes ☑	No	N/A

6.1. *IF YES*, what type is it? *[write in]*

- HIV case reporting and sentinel surveillance data are managed by info 2.1 program
- Monitoring are managed by excel and updated on quarterly basis.

6.2. *IF YES*, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

Yes ☑	No

6.3. Is there a functional Health Information System?

National level	Yes ☑	No
Sub-National level IF YES, at what level(s)? (write in)	Yes ☑	No

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

Yes ☑	No

7. To what extent is M&E data used in planning and implementation?

Low					High
0	1	2	3 ☑	4	5

What are examples of data use?

- Mapping data on IDU and FSW are used for condom, needle and syringe supplies and plan for recruiting peer educators.
- The IBBS data is used for planning and implementing the harm reduction program in the PEPFAR supported provinces

What are main challenges of data use?

- Low quality of monitoring data that make application difficult

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

At national level?	Yes ☑	No
IF YES, number of individuals trained (write in): 30		
At sub-national level?	Yes ☑	No
IF YES, number of individuals trained (write in): 515		
Including civil society?	Yes	No ☑
IF YES, number of individuals trained (write in):		

Overall, how would you rate the *M&E efforts* of the AIDS programme?												
2007	Poor											Good
	0	1	2	3	4	5	6	7	8☑	9	10	
2005	Poor											Good
	0	1	2	3	4	5	6	7☑	8	9	10	
Comments on progress made since 2005:												

NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

PART B

I. Human rights

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

Yes ☑	No

1.1. *IF YES*, specify: *[write in]*

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

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations from getting HIV, AIDS?

Yes ☑	No

2.1. *IF YES*, for which sub-populations?

Women	Yes ☑	No
Young people	Yes ☑	No
IDU	Yes ☑	No
MSM	yes ☑	No
Sex Workers	Yes ☑	No
Prison inmates	Yes ☑	No
Migrants/mobile populations	Yes ☑	No
Other(write in): Children ☑		

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

- At national level, the Social Affairs Committee under the National Assembly is responsible for oversight the implementation of the laws.
- At provincial level, this responsibility is under the Social and Cultural Sub-committee, under the Provincial People's Council supervise the implementation of the laws. Legislation system (People's Procuracy and Court) undertakes the role of supervision and enforcement of implementation of the law and other legislation instructions. However, there is not a specific mechanism in place to enforce the implementation of the Laws and other legal regulations related to protection of the most- at- risk populations

IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

- The Government Decree 108/2007/ND-CP regulates a number of articles of the Law on HIV/AIDS Prevention and Control

The Circular 29/2007/QD-TTg issued by Ministry of Labour, War-Invalids and Social Affairs (MOLISA)

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

Yes ☑	NO

3.1. *IF YES*, for which sub-populations?

Women	Yes	No
Young people	Yes	No
IDU	Yes ☑	No
MSM	Yes	No
Sex Workers	Yes ☑	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No
Other (write in)		

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

Although the Law on HIV has been in effect, there are other laws which had been passed before, which contain certain articles that are contradictory with the new law:

- Article 3, 2000 Law on Prevention and Control of Drug abuse: "*instigating, forcing, involving, inducing, hosting, assisting the illegal use of drug", or "storage, trafficking, buying and selling the instruments to be used in the process of production, illegal use of drugs.*
  Activities like distribution of needles and syringes, condoms can be regarded as breaking the laws. This creates difficulties for IDUs to access clean needles and syringes, for fear of being arrested, since the needle and syringe distribution for IDUs appears to be illegal. Some IDUs on ARV treatment also did not disclose their drug use status so the services providers were unable to support for treatment adherences and provide HIV prevention counseling. It might also hinder the use of methadone for treatment of drug addiction.

- The 2003 Ordinance on prevention and control of commercial sex work: "*availing oneself of business service to carry out commercial sex work*" or '*lending a hand to commercial sex work"*
  Carrying condoms can possibly be regarded as evidence of commercial sex work. This creates difficulties in accessing to and providing HIV information and services for commercial sex workers.
- In addition, migrants are often not registered under the household registration system and therefore, have less access to services.
- In addition, access to certain HIV prevention, treatment and care services (including pre and post-test counselling and harm reduction interventions such as condoms, syringes and opiate substitution therapy) is prohibited in some mandatory detention and rehabilitation settings.
- The HIV Law gives priority for receiving ARV treatment to people who are actively participating in the AIDS response. In certain instances this makes it harder for people that are not actively involved to access ARV treatment.

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

Yes ☑	No

- The Law on HIV/AIDS Prevention and Control

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?

Yes ☑	No

IF YES, briefly describe this mechanism

The legal aid offices were established in Ho Chi Minh City and Hai Phong to support legal related needs and PLHIV rights.

6. Has the Government, through political and financial support, involved most- at-risk populations in governmental HIV-policy design and programme implementation?

Yes ☑	No

IF YES, describe some examples

- There is financial support to most-at-risk populations, but only on a limited scale. Examples include Innovation Day during the World AIDS Day campaign, where small funds have been given to projects managed and implemented by PLHIV, or former IDUs.
- In some provinces, the Provincial AIDS Center supported the establishment of ,and provided seed funding to, self-help groups. However, almost all of the self-help groups and other most-at risk groups (i.e. MSM) have not received budget from the National HIV and AIDS Programme.
- Key populations at higher risk have participated in implementing a number of programs and projects, but not fully taken part in designing the programs. The National Strategy and Law on HIV7AIDS Prevention and Control encourages the participation from social organizations, community and people living with HIV .
- At policy design level, there are two PLHIV serving as members of the CCM and the sub-CCM of the GFATM on HIV. The consultations on the Law on HIV-AIDS Prevention and Control and the Programs of Action on Monitoring & Evaluation and Harm Reduction have included PLHIV and key populations at higher risk.

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

HIV prevention services	Yes ☑	No
Anti-retroviral treatment	Yes ☑	No
HIV-related care and support interventions	Yes ☑	No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

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

- In the National Strategy on HIV prevention and control, free services are not mentioned regarding prevention and care and support. However, with the increasing involvement of donor funded activities, free services in all 3 major areas are provided in provinces covered by these projects. Actions are taken to improve services:

  +) Implementation level: Under the umbrella of the Three Ones, Provincial AIDS Committees are strengthening provincial coordination to increase access to prevention, treatment, care and support.

  +) ARV: Scale up access to ARV treatment through PEPFAR, Global Fund and Ester;

  +) Care & Support: Through Viet Nam Women's Union Empathy Club, Self-help groups
- Increase National Budget for HIV and AIDs prevention and control, especially for HIV preventive services, ARV treatment, and HIV related care and supports.
- Mobilise international supports.

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?

Yes ☑	NO

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

Yes ☑	No

9.1. Are there differences in approaches for different most-at-risk populations?

Yes ☑	NO

IF YES, briefly explain the differences:

It is mentioned in the law on HIV that harm reduction interventions carried out among most at risk populations should be suitable to their social-economic conditions.
Different approaches are used for different target groups: IDUs, CSWs, mobile population, MSM. Examples include peer education, drop-in centres, outreach activities, mobile clinics, etc.

- The IDU groups are distributing needles and syringes, and FSWs groups are providing condoms
- As same sex relationships are not considered illegal, outreach services to MSM are, to some extent, easier than reaching IDU and FSW populations. There is no threat of being arrested, therefore, several self help groups of MSM have been established to exchange information and link with the other groups and service providers.

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

Yes ☑	No

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

Yes ☑	No

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

Yes	No ☑

IF YES, describe the effectiveness of this review committee

- The issuance of the Ministry of Health Decision 3353/QĐ-BYT on 13 September 2005 signed by the Health Minister on establishment of ethical review committee in clinical testing in human beings
- The Research Institutes, Universities and some local facilities have Committees on ethical review for medical research.
- However, none of the Committees include People living with HIV.

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

Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watch-dogs, and ombudspersons which consider HIV-related issues within their work	Yes ☑	No
Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment	Yes	No ☑
Performance indicators or benchmarks for a) compliance with human rights standards in the context of HIV efforts	Yes	No ☑
b) reduction of HIV-related stigma and discrimination	Yes ☑	No

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

- The National HIV M & E Framework includes an indicator to measure attitudes to HIV and stigma and discrimination.

- The Human Rights Research Centre of Ho Chi Minh Political Academy often participates in studies, assessments, workshops, seminars and forums on HIV/AIDS

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes ☑	No

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

- Legal aid systems for HIV and AIDS casework	Yes ☑	No
- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV	Yes ☑	No
Programmes to educate, raise awareness among people living with HIV concerning their rights - Legal support offices - Legal counselling hotline	Yes ☑	No

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes ☑	No

IF YES, what types of programmes?

Media	Yes ☑	No
School education	Yes☑	No
Personalities regularly speaking out	YEs ☑	No
Other (write in): HIV programme at workplace ☑		

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005 ?

2007	Poor										Good
	0	1	2	3	4	5	6	7	8☑	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8 ☑	9	10

Comments on progress made since 2005:

Comments on progress made since 2005:

Progress has been made with the promulgation of the new Law on HIV/AIDS (2006) and the accompanying decree 108 (2007). These address stigma and discrimination towards PLHIV and clearly stipulate the rights and responsibilities of PLHIV. It also contains more comprehensive provisions prohibiting specific types of discriminatory behaviour in the health, employment and education sectors. The Law is an important step forward for Viet Nam and the Decree with guidelines for implementing this Law is a critical document. In particular the expanded scope for harm reduction activities is a major improvement.

There is a concern that the following issues are not addressed in the Decree:

1. Issues relating to confidentiality of HIV test results, particularly in closed settings.
2. The protection against discrimination in the employment sector specifically allows for mandatory testing of recruits in certain occupations, hence the protection in this sector is not universal.

Another positive development is the promulgation of Decree 67 on support policies for social protection beneficiaries which provide subsidies to families of children living with HIV (in 2007)

Overall, how would you rate the *effort to enforce* the existing policies, laws and regulations in 2007 and in 2005 ?

2007	Poor										Good
	0	1	2	3	4	5	6	7☑	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6☑	7	8	9	10

Comments on progress made since 2005:

After the issuance of the HIV laws, the dissemination and advocacy for this laws and other related legal documents have been carried on. This leads to changes of awareness among policy makers, law enforcement staff and general population.

Despite improvements in laws and policies, there is a concern that decree 108 does not contain comprehensive guidance on the implementation of the Law. In particular, there is a concern that there are no remedies and penalties that are to flow from a breach of provisions of the Law. Without legal remedies for the violation of rights, and easily accessible avenues through which to pursue these, the Law will not have the desired impact.

II. Civil society participation

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

Low					High
0	1	2	3☑	4	5

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts?)

Low					High
0	1	2	3☑	4	5

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

a. in both the National Strategic plans and national reports?

Low					High
0	1	2☑	3	4	5

b. in the national budget?

Low					High
0	1	2☑	3	4	5

4. Has the country included civil society in National review of the National Strategy Plan?

Yes	No ☑

IF YES, when was the Review conducted? Year: *[write in]*

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

Low					High
0	1	2	3	4 ☑	5

List of the organizations having participation from civil society organizations:

- The self-help groups of people living with HIV (at present there are over 75 groups nationwide)
- The MSM self-help groups (in Hanoi, Hai Phong, Nha Trang, Ho Chi Minh City and Can Tho)
- The Religious based Groups and organizations (Buddhism, and Catholic groups)
- The community voluntary groups (the Empathy Clubs, The Clubs of Mothers and Wives, the Clubs of Young Women, Child Sponsored Association, Parents of Children living with HIV groups…)
- The non-governmental organizations (many of the NGOs working on the AIDS response)
- The Mass-organizations, such as Women Union, Youth Union, , and the Fatherland Front….
- GFATM's CCM
- Research institutions
- Lawyers Association

6. To what extent is civil society able to access?

a. adequate financial support to implement its HIV, AIDS activities?

Low					High
0	1	2	3☑	4	5

b. adequate technical support to implement its HIV, AIDS activities?

Low					High
0	1	2	3 ☑	4	5

Overall, how would you rate the efforts to increase *civil society participation* in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8☑	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7☑	8	9	10

The role of civil society has been recognized by the state in various national strategies and plans, including the National HIV/AIDS Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a vision to 2020 and the Social Economic Development Plan for 2006-2010(SEDP). The new Law on HIV/AIDS Prevention and Control also recognizes and encourages the supportive activities of civil society organizations.

Participation of civil society in policy development and in planning and review of program implementation is still limited. However, there is increasing awareness of the role civil society can play (esp. PLHIV and LNGOs) and subsequent space for their participation in the response to HIV.

The work of national and international NGOs has been widely acknowledged. Some NGOs have collaborated with the Party, the National Assembly and Government agencies/ organisations to work on different interventions and policy advocacy for HIV prevention.

III. Prevention

1. Has the country identified the districts/provinces (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes ☑	No

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

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts/provinces in need?

HIV prevention programmes	Activities are in:		
	All districts/provinces	Most of districts/provinces	Some of districts/provinces
Blood safety	☑		
Universal precautions in health care settings	☑		
Prevention of mother-to-child transmission of HIV		☑	
IEC on risk reduction	☑		
IEC on stigma and discrimination reduction	☑		
Condom promotion	☑		
HIV testing & counselling	☑		
Harm reduction for injecting drug users		☑	
Risk reduction for men who have sex with men			☑
Risk reduction for sex workers		☑	
Programmes for other most-at-risk populations		☑	
Reproductive health services including STI prevention & treatment		☑	
School-based AIDS education for young people	☑		
Programmes for out-of-school young people			☑
HIV prevention in the workplace		☑	
Other Programme: For older people			

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2007 and in 2005 ?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8☑	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7☑	8	9	10

Comments on progress made since 2005:

In comparison with 2005, HIV prevention services have been scaled up and improved in 2007. In particular, the work of community outreach and distributions of needle and syringe among IDU population and condoms for FSWs has gone beyond the piloted scale and started expanding.

With technical and financial assistance, Viet Nam possesses the ability to further scale up comprehensive interventions in a targeted and effective manner. Significant donor funding has been made available to implement effective HIV services (although continued effort is needed to fill the still large gap of funding).

Harm reduction services targeting key populations at higher risk (IDUs, FSWs and MSM) have, until recently, faced legal impediments which resulted in limitations both to delivering services and expanding coverage. The approval of the HIV Law and the associated Decree No.108 in 2007 provides a legal framework for delivering an effective and comprehensive package of harm reduction services for IDUs, FSWs and MSM. As a result, a comprehensive range of HIV services including needle and syringe programs and methadone maintenance therapy can now be implemented and expanded

HIV prevention through IEC and BCC for the general population is carried out on a widespread basis through mass media, IEC materials and BCC interventions, and through individual programmes and projects. National IEC/BCC has resulted in high awareness of HIV but little change in risk behaviours.

The National Programme of Action for Prevention of mother-to-child-transmission of HIV (PMTCT) was approved in 2006. PMTCT operational guidelines and a scaling up plan are being formulated at present.

Voluntary HIV counselling and testing (VCT) is a priority activity in the National HIV Strategy. MOH, in partnership with PEPFAR, Global Fund, MSI and the World Bank, has established some VCT capability in 50 of Viet Nam's 64 provinces, giving priority to high-prevalence regions. National Guidelines on VCT have been developed.

In April 2007, MOET launched the "action programme on reproductive health and HIV prevention education for secondary school students (2007-2010)". This programme builds on a policy framework that addresses gender sensitive HIV education for young people.

However, human resource constraints must be addressed, in addition to issues concerning stigma and discrimination in the health care and community settings. Other challenges include:

- Most of the national programs of action have not been well costed and practical normative guidance are yet to be available in many technical areas
- Many HIV services are fragmented and uncoordinated largely due to project oriented nature of the national program
- Current HIV/STI surveillance system needs to be strengthened and data collected need to be better used for planning and monitoring the results of the response, particularly at provincial level

IV. Treatment, Care and Support

1. Has the country identified the districts/provinces (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes ☑	No

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

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts*/provinces in need?

HIV treatment, care and support services	**The service is available in**		
	all districts* in need	*most* districts* in need	*some* districts* in need
Antiretroviral therapy	☑		
Nutritional care		☑	
Paediatric AIDS treatment			☑
Sexually transmitted infection management		☑	
Psychosocial support for people living with HIV and their families		☑	
Home-based care		☑	
Palliative care and treatment of common HIV-related infections	☑		
HIV testing and counselling for TB patients		☑	
TB screening for HIV-infected people		☑	
TB preventive therapy for HIV-infected people		☑	
TB infection control in HIV treatment and care facilities		☑	
Cotrimoxazole prophylaxis in HIV- infected people		☑	
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	☑		
HIV treatment services in the workplace or treatment referral systems through the workplace		☑	
HIV care and support in the workplace (including alternative working arrangements)		☑	
Other programmes: *[write in]*			

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2007 and in 2005 ?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8☑	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7☑	8	9	10

Comments on progress made since 2005:
There is government commitment for scaling up. A National Programme of Action on treatment, care and support was approved in January 2007, stressing the district as the hub for the continuum of care, including ARV treatment, PMTCT and referral to community services. A series of national normative guidelines have been developed, which should serve as a foundation for coordination of different initiatives, and for effective scale-up of treatment, care and support
There has been strong scale-up in provision of ARV care and treatment services through the country, especially in higher prevalence provinces. Viet Nam is moving towards a national programme approach as opposed to a project approach in the care and treatment area

The 2 year period of 2006-2007 has witnessed a significant progresses in treatment, care and support. Before 2006, the number of people on ARV treatment was very small. In 2007, 14 180 people living with HIV nationwide have been provided ARV treatment. ARV treatment for children has been gradually expanded. The PMTCT program has been implemented at provincial level. Cotrimoxazole used in OI treatment has been scaled up. The integration of TB and HIV treatment is gradually being implemented. The home-based care and socio-psychological support are increasingly undertaken by many self-help groups of PLHIV, community and voluntary based groups and religious based groups. The Government has issued several policy documents to support adults and children living with HIV, e.g. the Decree 108, the Decision 60/2007, Decision 96/2007 and Decision 67/2007.

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

Prevention for youth	<25%	25-50% ☑	50-75%	>75%
Prevention for vulnerable sub-populations				
- IDU	<25%	25-50% ☑	50-75%	>75%
- MSM	<25%	25-50% ☑	50-75%	>75%
- Sex Workers	<25%	25-50% ☑	50-75%	>75%
Counselling and testing	<25% ☑	25-50%	50-75%	>75%
Clinical services (OI/ART)	<25% ☑	25-50%	50-75%	>75%
Home-based care	<25%	25-50%	50-75% ☑	>75%
Programmes for OVC	<25%☑	25-50%	50-75%	>75%

3. Does the country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes	No	N/A NPA on children and AIDS is under development

3.1. *IF YES*, is there an operational definition for OVC in the country?

Yes ☑	No

3.2. *IF YES*, does the country have a national action plan specifically for OVC?

Yes	No☑

3.3. *IF YES*, does the country have an estimate of OVC being reached by existing interventions?

Yes	No☑

IF YES, what percentage of OVC is being reached?:

ANNEX 3

NATIONAL EXPENDITURE

The Vietnam actual expenditure for HIV and AIDS Program in 2006 is USD 12.75 million which include $US 4.95 million from public sources and $US 7.78 million from international sources. This actual expenditure lack of sub-national sources, private sector, consumer/out of pocket and some international sources that could not collected. Among international sources, PEPFAR Vietnam Program contributes significant part to the country expenditures on AIDS. It is estimated that if the PEPFAR Vietnam Program is included, the country expenditures for HIV and AIDS Program in 2006 reach to $US 47.15 million.

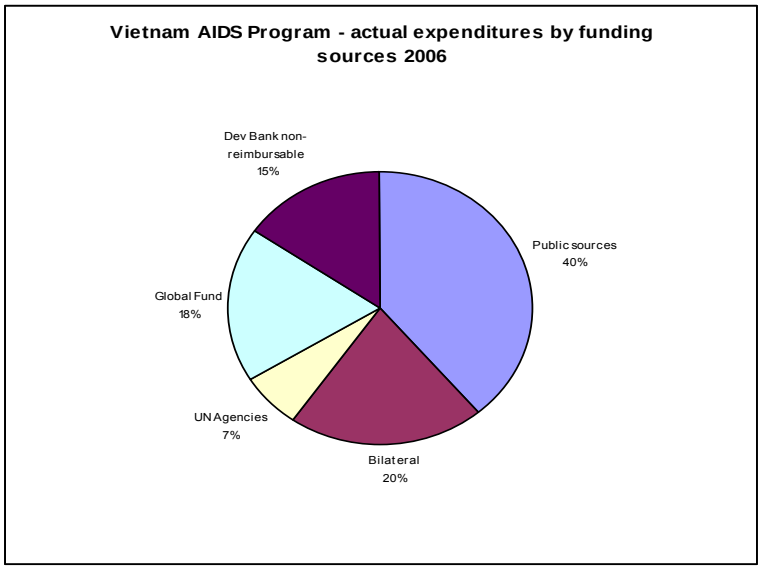
National expenditure in 2006 – summary table

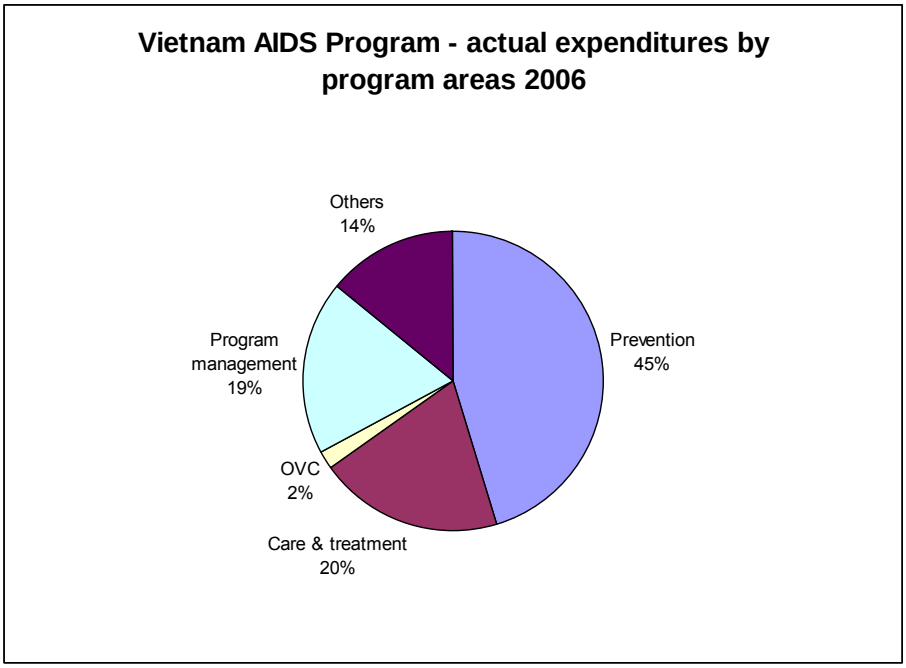
Unit: USD

	Public sources	International sources	Total
Actual expenditure	4.968.302	7.787.456	12.755.758
Estimate	4.968.302	42.187.456	47.155.758

The actual expenditure on AIDS in Vietnam 2006 is about ¼ of the estimate and according to UNGASS report guidelines, it contains:

- International sources contribute 60% and 20% from bilateral source, 7% from UNs,18% from Global Fund and 15% from development Bank (non-reimbursable)
- Investment for Prevention is 45%, 20% for OVC program, 19% for Program management and capacity building and 12% for others




Vietnam AIDS Program - actual expenditures by program areas 2006
Others 14%
Prevention 45%
Program management 19%
OVC 2%
Care & treatment 20%

ANNEX 4

NATIONAL PROGRAMS, KNOWLEDGE, BEHAVIOUR AND IMPACTS

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

1. Method of data collection

- **Data source**:
  - Program report
  - HIV/AIDS estimates and projections 2005 - 2010
- **Target population**: Adults and children with advance HIV infection who are currently receiving ARV
- **Study sites:** Nationwide
- **Study method**:
  - Numerator was taken from program reports
  - Denominator was calculated by taking 15% of the estimates number of people living with HIV in 2006 and 2007

2. Method of measurement

- **Numerator:** Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol at the end of the reporting period (at the end of December for 2006, and at the end of September for 2007)
- **Denominator:** Estimated number of adults and children with advanced HIV infection

3. Results

- In the last few years, the government of Vietnam with support from the PEPFAR and Global Fund to Fight AIDS, Tuberculosis, and Malaria has made big effort to scale up the ART program. In 2007, ART has been made available in 64 provinces.
- In the year 2002, only 1% of adults with advanced HIV infection received ART (UNGASS report 2001 – 2003). In addition, ART for children was not available in the country at that time. However this proportion had increased to 18.1% in 2006 and almost one and a half time to 30% one year later in 2007. The pediatric ART also covered for 789 children by September 2007.

4. Limitation of the data

- Data disaggregated by gender and age group is not available (as for numerator, we do have both adults and children data. The denominator is not available for children at the moment).
- Estimated number of children with advanced HIV infection is not available

- This proportion might exclude people with advanced HIV infection who receive prescriptions from state or private physicians and procured drug by their own. For instance, in 2006, there was 106 people with HIV (cumulative number) participated in the Bright Future self help network organizing their own to receive low-cost ART from STADA, a pharmaceutical company. This might slightly underestimate the percentage receiving treatment, although it should not have a major impact on the percentage.

Indicator 5. Percentage of HIV infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission

1. **Method of data collection**

- **Data source**: Report of the program on prevention of mother-to-child transmission of PEPFAR program
- **Target population**: HIV infected pregnant women
- **Study sites:** Nationwide
- **Study method**: Collect secondary data of program report

2. **Method of measurement**

- **Numerator:** Number of HIV infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission
- **Denominator:** Estimated number of HIV infected pregnant women in the last 12 months (equal to number of women delivered in the last 12 months multiplied by HIV prevalence among pregnant women attending ANC – result of the HIV sentinel surveillance in 40 provinces).

3. **Results**

- In the last few years, the government of Vietnam has made big effort to scale up the PMTCT program. By the year 2006, there are 107 health facilities that provide minimum PMTCT package nationwide.
- In the year 2002, only 2.4% of HIV infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (UNGASS report 2001 – 2003). However, by the year 2006, proportion of HIV infected pregnant women who received the most effective antiretroviral regimen that available in the country to reduce the risk of mother-to-child transmission is 9% and 14% in 2007. But data on HIV infected pregnant women who received SD-NVP for PMTCT is not available. In 2006, there are only 26 ANC facilities sending report (out of 41 facilities that received SD-NVP from national program); provide a figure of 241 HIV infected pregnant women received SD-NVP. Therefore, in reality, number of HIV infected pregnant women who received all kinds of regimen of antiretrovirals to reduce the risk of mother-to-child transmission should be higher.

4. **Limitation of the data**

- Data from the national PMTCT program has not been available yet, thus, this proportion is underestimated.

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

1. Method of data collection

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

2. Method of measurement

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

3. Results

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

4. Limitation of the data

- Data for this indicator for the year 2006 and 2007, which is nationally representative has not been available yet. Therefore, we have to use data of the year 2005.

5. Other surveys with data for the same indicator

- A household survey conducted 2005 among 4,536 persons aged 15-49 in Ho Chi Minh City and Thai Binh province in 2005 showed that there were 0.5% of respondents receiving an HIV test and the test result in the last 12 months (0.7% among men and 0.4% among women).[31]
- A national household survey conducted among 9,470 women aged 15-49 in 64 provinces/cities in 2006 showed that there were 8.3% of respondents reporting ever received an HIV test and being informed about their test results. The proportion was higher among those with higher educational level and income, and living in urban areas.[32]

[31] Ministry of Health (September 2005). Report on household survey on HIV prevalence and AIDS indicators in Ho Chi Minh City and Thai Binh province.
[32] General Statistics Office (2006). Vietnam multiple indicator cluster survey 2006.

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

1. **Method of data collection**

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Female sex workers (Women who were 18 years or older, who reported having sex for money at least once in the month prior the survey, and were working on the street or in establishments).
- **Study sites**: The IBBS was conducted in seven provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Da Nang, Ho Chi Minh City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey (IBBS of FHI). In Ha Noi and Hai Phong, respondents were selected using cluster sampling methods. In the other 5 provinces/cities, all female sex workers were included in the sample for the survey.

2. **Method of measurement**

- **Numerator:** Number of sex workers who have been tested for HIV during the last 12 months and who know the results
- **Denominator:** Number of sex workers included in the sample

3. **Results**

- Result of the survey in 2006 indicates that 15% of female sex workers received an HIV test in the last 12 months and knew their results.
- There is no significant difference of this indicator among sex workers aged less than 25 (14.2%) and aged more than 25 (15.5%).
- In 2004 12% of female sex workers had ever received an HIV test and knew their results (UNGASS report 2003-2005). By the year 2006, one-fifth of female sex workers reported having ever had an HIV test. However, only 8% of respondents have ever had a voluntary HIV test, known the result, and received post-test counseling (IBBS report).
- Moreover, it seems like people at high-risk of HIV infection often do not want to know their HIV status because they believe that effective treatments are not available to them. While access to VCT is increasing, it appears to be most predominantly used by sex workers who are not HIV infected. For instance, 75-85% of HIV infected female sex workers in An Giang were unaware of their status.

4. **Limitation of the data**

- This data does not represent for national population, because it was collected only from hot-spots of sex workers in provinces/cities with high HIV prevalence.
- No data on male sex workers available
- This data is not weighted for population size of sex workers in each of 7 provinces/cities, because data on population size is not available.

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

1. **Method of data collection**

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Men who have sex with men (Men 15 years or older, who had engaged in sex with men at least once in the previous 12months).
- **Study sites**: The IBBS part for MSM was conducted in two cities (Ha Noi and Ho Chi Minh City). In each city, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey (IBBS of FHI). Respondents were selected using respondent driven sampling method (RDS).

2. **Method of measurement**

- **Numerator:** Number of men who have sex with men who have been tested for HIV during the last 12 months and who know the results
- **Denominator:** Number of men who have sex with men included in the sample

3. **Results**

- Result of the survey indicates that only 16.% of men who have sex with men received an HIV test in the last 12 months and know their results.
- There is no significant difference of this indicator among MSM aged less than 25 (16.1%) and aged more than 25 (16.7%).
- Another survey among MSM in Ho Chi Minh city in 2004 showed that 19% of respondents ever had an HIV test.[33] Two years later, in 2006, the proportion had not increased significantly. IBBS result indicates that only 22% of men who have sex with men reported ever had an HIV test. Among them only about 20% received test result and counseling.
- While access to VCT is increasing, it appears to be most predominantly used by MSM who are not HIV infected. For instance, 90% of HIV infected MSM in Hanoi were unaware of their status.

4. **Limitation of the data**

- This data are not representive for the national MSM population, because it was collected only from hot-spots of men who have sex with men in two cities with high HIV prevalence.
- This data is not weighted for population size of men who have sex with men in each city, because data on population size is not available.
- This data is not weighted for sampling method (RDS).

[33] Ministry of Health, World Health Organization (2004). HIV prevalence and risk factors of HIV transmissions among men who have sex with men in Ho Chi Minh City, Vietnam.

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

1. Method of data collection

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Injecting drug users (Men 18 years or older, who reported drug injection in the month prior the survey)
- **Study sites**: The IBBS was conducted in seven provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Da Nang, Ho Chi Minh City, Can Tho, and An Giang. In each city or province, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey (IBBS of FHI). In Hai Phong, respondents were selected using cluster sampling methods. Respondents Driven Sampling (RDS) method was applied to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, and Can Tho. In Quang Ninh and An Giang, all injecting drug users in the sampling frame were included in the survey.

2. Method of measurement

- **Numerator:** Number of injecting drug users who have been tested for HIV during the last 12 months and who know the results
- **Denominator:** Number of injecting drug users included in the sample

3. Results

- Results of the survey indicates that 11% of injecting drug users received an HIV test in the last 12 months and know their results.
- Injecting drug users aged more than 25 years are more likely to have an HIV test in the last 12 months and knew their results (13%) than those aged less than 25 years (8.1%).
- In 2004, only 11% of male injecting drug users have ever received an HIV test and know the result (UNGASS report 2003-2005). By the year 2006, 16% of male IDU reported having ever had an HIV test. However, only 9% of respondents have ever had a voluntary HIV test, known the result, and received post-test counseling (IBBS report).
- While access to VCT is increasing, it appears to be most predominantly used by IDU who are not HIV infected. For instance, 84% of HIV infected IDU in Cantho were unaware of their status.

4. Limitation of the data

- This data are not representive for the national IDU population, because it was collected only from hot-spots of IDUs in provinces/cities with high HIV prevalence.
- No data on female injecting drug users available
- This data is not weighted for population size of injecting drug users in each of 7 provinces/cities, because data on population size is not available.
- This data is not weighted for sampling method (RDS).

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

1. **Method of data collection**

- **Data source**:
  - Central Project Management Unit – Activity report of the first 10 months in 2007 of the Project on HIV prevention in Vietnam funded by the DfiD
  - Central Project Management Unit – Report on project evaluation in 2006 and 2007 and plan for 2008. The Project on HIV/AIDS prevention and control in Vietnam funded by the WB
- **Target population**: Female sex workers
- **Study sites**: Project are in 33 provinces.
- **Study method**: Collect secondary data from program reports.

2. **Method of measurement**

Numerator: Number of sex workers who were reached by intervention program for HIV prevention, including knowing place for an HIV test and receiving condoms in the last 10 months

- **Denominator:** Total number of estimated sex workers in the project areas

3. **Results**

- Results of two projects in 33 provinces revealed that proportion of female sex workers who were reached by HIV prevention program was 65%. A female sex worker was provided on average 18 condoms a month (in 2007), which was 10 times higher than that of the year 2006.
- The IBBS survey indicates that approximately 40% of sex workers know where to get an HIV test, and 60% of them have received condom in the last 6 months. However, only 30% of them know where to get an HIV testing and had received condom. Sex worker aged more than 25 years are more likely to be reached by HIV prevention programs than those aged less than 25 years. Injection is one of the risk factors for sex workers in the IBBS study, but only about one-third or less of injecting sex workers reported receiving needles and syringes in the past 6 months.

4. **Limitation of the data**

- Report of two projects collected only number of female sex workers who were reached by the HIV prevention program in general, but not number of female sex workers who were reached by a single intervention program.
- This data are not representive for the national SW population, because it was collected only from 33 provinces in the DfiD and WB projects.
- No data on male sex workers available
- No data disaggregated by age group available
- This indicator only looks at the the coverage of prevention programs, quality and frequency of the programmes are not measured and is of course also crucial.

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

1. Method of data collection

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Men who have sex with men
- **Study sites**: The IBBS part for MSM was conducted in two cities (Ha Noi and Ho Chi Minh City). In each city, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey (IBBS of FHI). Respondents were selected using respondent driven sampling method (RDS).

2. Method of measurement

- **Numerator:** Number of men who have sex with men who replied "yes" to both questions
  - Question 1: Do you know of a place in the city where you live where people can go to have a confidential test to find out if they are infected with HIV?
  - Question 2: During the last 6 months, have you received free or cheap condoms?
- **Denominator:** Total number of respondents surveyed

3. Results

- The survey indicates that 43% of MSM know where to get an HIV test, and 48% of them have received condom in the last 6 months; lubricant was less common. However, only one-fourth of them knows HIV testing site and receive condom. In addition, this percentage only reflects the coverage of prevention programs, yet represents the quality and frequency of the programs.
- MSM aged more than 25 years (53%) are more likely to be reached by HIV prevention programs than those aged less than 25 years (44%).
- There has been a big effort in the last two years to increase the coverage of condom promotion program. Several self help group for MSM was established and involved in HIV prevention activities. In 2004, only 39% of MSM reported to have ever received a condom,[33] while in 2006, 47% of them received condom in the last 6 months.

4. Limitation of the data

- This survey asked if a MSM had received a condom during the last 6 months, not during the last 12 months as in the international UNGASS guidelines.
- This data are not representive for the national MSM population, because it was collected only from hot-spots of MSM in cities with high HIV prevalence.

- This data is not weighted for population size of men who have sex with men in each city, because data on population size is not available.
- This data is not weighted for sampling method (RDS).
- MSM were interviewed at drop-in centers of on-going intervention projects, thus the figure presented above might be high estimates.
- This indicator only looks at the the coverage of prevention programs, quality and frequency of the programmes are not measured and is of course also crucial.

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

1. Method of data collection

- **Data source**:
  - Central Project Management Unit – Activity report of the first 10 months in 2007 of the Project on HIV prevention in Vietnam funded by the DfiD
  - Central Project Management Unit – Report on project evaluation in 2006 and 2007 and plan for 2008. The Project on HIV/AIDS prevention and control in Vietnam funded by the WB
- **Target population**: Injecting drug users
- **Study sites**: Project are in 33 provinces.
- **Study method**: Collect secondary data from program reports.

2. Method of measurement

Numerator: Number of injecting drug users were reached by intervention program for HIV prevention, including knowing place for an HIV test and receiving condoms and sterile needles and syringes in the last 10 months

- **Denominator:** Total number of estimated injecting drug users in project areas

3. Results

- Results of two projects in 33 provinces revealed that proportion of male IDU who were reached by HIV prevention program was 43%. An IDU was provided on average 11 sterile needles and syringes a month (in 2007), which was 4.5 times higher than that of the year 2006.
- The IBBS survey indicates that approximately 47% of IDU know where to get an HIV test, but only 16% and 21% of them have received condom and syringes/needles in the last 6 months, respectively. Moreover, only 6% of them being reached by all three HIV prevention programs. There is no significant difference of this indicator among IDU aged less than 25 and those aged more than 25.

4. Limitation of the data

- Report of two projects collected only number of IDU who were reached by the HIV prevention program in general, but not number of IDU who were reached by a single intervention program.
- This data does not represent for national IDU population, because it was collected only from 33 provinces in the DfiD and WB projects.
- No data on female injecting drug users available
- No data disaggregated by age group available
- This indicator only looks at the the coverage of prevention programs, quality and frequency of the programmes are not measured and is of course also crucial.

Indicator 13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

1. Method of data collection

- **Data source**: Vietnam Population and AIDS Indicator Survey 2005 (VPAIS). General Statistical Office, National Institute of Hygiene and Epidemiology, and ORC Macro (2006).
- **Target population**: People aged 15-24
- **Study sites**: All 64 provinces of Vietnam
- **Study method**: A cross-sectional household survey was conducted among 4.877 people aged 15-24 from September to December 2005 by using AIDS Indicator Survey (AIS) questionnaires. VPAIS 2005 was a nationally representative sample of the entire adult population of Vietnam.

2. Method of measurement

- **Numerator:** Number of respondents aged 15-24 years who gave the correct answer to all five questions

  1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
  2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
  3. Can a healthy-looking person have HIV?
  4. Can a person get HIV from mosquito bites?
  5. Can a person get HIV by sharing food with someone who is infected?
- **Denominator:** Number of all respondents aged 15–24

3. Results

- The survey shows that 46% of people aged 15-24 who both correctly identify ways of preventing the transmission of HIV through sexual intercourse and reject major misconceptions about HIV transmission.
- There were no difference of this proportion among two age groups (45% among people aged 15-19 and 48% among people aged 20-24) .
- This proportion was found higher among men (50%) than among women (42%).
- This proportion was found higher among people with higher educational level and income and living in urban area (versus rural area).

4. Limitation of the data

- Data for this indicator for the year 2006 and 2007, which is nationally representative has not been available yet. Therefore, we have to use data of the year 2005.

5. Other surveys with data for the same indicator

- A household survey conducted among people aged 15-49 in Ho Chi Minh City and Thai Binh province in the same year showed that among 1,417 respondents aged 15-24, there were 78% who gave correct answer to all 5 questions (79% among men and 77% among women).[31]
- A national household survey conducted among 3,136 women aged 15-24 in 64 provinces/cities in 2006 showed that there were only 44% of respondents who gave correct answer to all 5 questions. The proportion was found higher among those with higher educational level and income, and living in urban area.[32]

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

1. Method of data collection

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Female sex workers
- **Study sites**: The IBBS was conducted in "hot-spots" in seven provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Da Nang, Ho Chi Minh City, Can Tho, and An Giang.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey. In Ha Noi and Hai Phong, respondents were selected using cluster sampling methods. In the other 5 provinces/cities, all female sex workers were included in the survey.

2. Method of measurement

- **Numerator:** Number of sex workers who gave the correct answer to all five questions
  1. Having sex with only one faithful partner reduces the risk of HIV transmission
  2. Using condom every time during vaginal sex prevents HIV transmission
  3. In your opinion, can you tell someone is infected with HIV just by looking at him/her?
  4. Mosquitoes and other insect bites will transmit HIV
  5. One can get HIV if one uses public toilets
- **Denominator:** Number of all respondents

3. Results

- The results shows that 35% of sex workers both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
- There is no significant difference of this indicator among sex workers aged less than 25 and those aged more than 25.
- More than 80% of respondents gave correct answer to the ways of preventing the sexual transmission of HIV. However, only about two-thirds of them correctly rejected major misconception about HIV transmission.
- 82% know that having sex with only one faithful partner reduces the risk of HIV transmission
- 91% know that using condom every time during vaginal sex prevents HIV transmission

- 66% know that we cannot tell someone is infected with HIV just by looking at him/her?
- 58% know that mosquitoes and other insect bites cannot transmit HIV
- 72% know that one cannot get HIV if one uses public toilets

4. Limitation of the data

- This indicator is not exactly the same as in the international UNGASS guidelines, question 1 and question 5 differ.
- This data does not represent for national population, because it was collected only from hot-spots of sex workers in provinces/cities with high HIV prevalence.
- No data on male sex workers available
- This data is not weighted for population size of sex workers in each of 7 provinces/cities, because data on population size is not available.

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

1. Method of data collection

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Men who have sex with men
- **Study sites**: The IBBS for MSM was conducted in "hot-spots" of two cities (Ha Noi and Ho Chi Minh City).
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey. Respondents were selected using respondent driven sampling method (RDS).

2. Method of measurement

- **Numerator:** Number of men who have sex with men who gave the correct answer to all five questions
  1. Having sex with only one faithful partner reduces the risk of HIV transmission
  2. Using condom every time during vaginal sex prevents HIV transmission
  3. In your opinion, can you tell someone is infected with HIV just by looking at him/her?
  4. Mosquitoes and other insect bites will transmit HIV
  5. One can get HIV if one uses public toilets
- **Denominator:** Number of all respondents

3. Results

- The results shows that 55% of MSM both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
- There is no significant difference of this indicator among MSM aged less than 25 and those aged more than 25.
- Only 70% of respondents know that HIV cannot be transmitted by mosquito bites. However, more than 80% of them gave correct answer to the rest four questions.
- 91% know that having sex with only one faithful partner reduces the risk of HIV transmission
- 95% know that using condom every time during vaginal sex prevents HIV transmission
- 82% know that we cannot tell someone is infected with HIV just by looking at him/her?
- 71% know that mosquitoes and other insect bites cannot transmit HIV
- 84% know that one cannot get HIV if one uses public toilets

4. Limitation of the data

- This indicator is not exactly the same as in the international UNGASS guidelines, question 1 and question 5 differ.
- This data does not represent for national population, because it was collected only from hot-spots of men who have sex with men in two cities with high HIV prevalence.
- This data is not weighted for population size of men who have sex with men in each city, because data on population size is not available.
- This data is not weighted for sampling method (RDS).

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

1. Method of data collection

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Injecting drug users
- **Study sites**: The IBBS was conducted in "hot-spots" in seven provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Da Nang, Ho Chi Minh City, Can Tho, and An Giang.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey. In Hai Phong, respondents were selected using cluster sampling methods. Respondents Driven Sampling (RDS) method was applied to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, and Can Tho. In Quang Ninh and An Giang, all injecting drug users in the sampling frame were included in the survey.

2. Method of measurement

- **Numerator:** Number of injecting drug users who gave the correct answer to all five questions
  1. Having sex with only one faithful partner reduces the risk of HIV transmission
  2. Using condom every time during vaginal sex prevents HIV transmission
  3. In your opinion, can you tell someone is infected with HIV just by looking at him/her?
  4. Mosquitoes and other insect bites will transmit HIV
  5. One can get HIV if one uses public toilets
- **Denominator:** Number of all respondents

3. Results

- The results shows that 38% of IDU both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
- IDU aged more than 25 years (42%) tend to have better knowledge on HIV transmission than those aged less than 25 years (29%).
- 77% know that having sex with only one faithful partner reduces the risk of HIV transmission
- 82% know that using condom every time during vaginal sex prevents HIV transmission
- 71% know that we cannot tell someone is infected with HIV just by looking at him/her?
- 65% know that mosquitoes and other insect bites cannot transmit HIV
- 72% know that one cannot get HIV if one uses public toilets

4. Limitation of the data

- This indicator is not exactly the same as in the international UNGASS guidelines; question 1 and question 5 differ.
- This data does not represent for national population, because it was collected only from hot-spots of injecting drug users in provinces/cities with high HIV prevalence.
- No data on female injecting drug users available
- This data is not weighted for population size of injecting drug users in each of 7 provinces/cities, because data on population size is not available.
- This data is not weighted for sampling method (RDS).

Indicator 15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15

1. **Method of data collection**

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

2. **Method of measurement**

- **Numerator:** Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years
- **Denominator:** Number of all respondents aged 15–24 years

3. **Results**

- The survey indicates that only 0.4% of youth aged 15-24 years reported having had sex before the age of 15.
- This proportion is found higher among women (0.5%) than men (0.3%).
- There is no difference of this proportion among two age groups (15-19 and 20-24).

4. **Limitation of the data**

- Data for this indicator for the year 2006 and 2007, which is nationally representative has not been available yet. Therefore, we have to use data of the year 2005.
- As the cultural norms in Vietnam may limit discussion on sexual activity, it may have prevented respondents from truthfully answering sensitive survey questions regarding sexual activity in early age. In addition, VPAIS was conducted in a household setting that limited the respondents' privacy when answering sensitive questions which might have further compounded the likelihood of underreporting of sexual activity.

5. **Other surveys with data for the same indicator**

- A household survey conducted among people aged 15-49 in Ho Chi Minh City and Thai Binh province in the same year showed that there were no respondents among 1,327 persons aged 15-24 reporting having had sex before the age of 15.[31]
- A national household survey conducted among 9,470 women aged 15-49 in 64 provinces/cities in 2006 showed that there were only 0.7% of respondents who was in marriage or union before their 15th birthday. The highest proportion was found among those who were illiterate, poorest, living in rural area, and was ethnic minorities.[32]

Indicator 16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

1. Method of data collection

- **Data source**: Vietnam Population and AIDS Indicator Survey 2005 (VPAIS). General Statistical Office, National Institute of Hygiene and Epidemiology, and ORC Macro (2006).
- **Target population**: People aged 15-49
- **Study sites**: All 64 provinces of Vietnam
- **Study method**: A cross-sectional household survey was conducted from September to December 2005 by using AIDS Indicator Survey (AIS) questionnaires.

2. Method of measurement

- **Numerator:** Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
- **Denominator:** Number of all respondents aged 15–49

3. Results

- Reporting of multiple partners is extremely uncommon. Only 0.3% of respondents aged 15-49 report having had sex with more than one partner in the last 12 months (0.7% among men and 0% among women).
- There were only 13% of never-married men who had sex in the year before the survey report having had more than one partner.
- Women report having had only one sexual partner over their lifetime, while men report a mean of 1.4 sexual partners over their lifetime, with little variability by age or education.
- The only sub-populations to have a mean of more than 2 partners are the never-married, the formerly married, and men living in Ho Chi Minh City.

4. Limitation of the data

- Data for this indicator for the year 2006 and 2007, which is nationally representative has not been available yet. Therefore, we have to use data of the year 2005.
- In this survey, members of the groups whose behaviours put them at highest risk for HIV would be less likely to be found in the home at the time of the survey, potentially influencing the representativeness of the results.
- As the cultural norms in Vietnam may limit discussion on sexual activity, it may have prevented respondents from truthfully answering sensitive survey questions regarding premarital and extramarital sex. In addition, VPAIS was conducted in a household setting that limited the respondents' privacy when answering sensitive questions which might have further compounded the likelihood of underreporting of sexual activity.

5. Other surveys with data for the same indicator

- Another household survey conducted among 4,537 persons aged 15-49 in Ho Chi Minh City and Thai Binh province in the same year showed different results with 5.7% of respondents reporting having had sex with more than one partner in the last 12 months (9.1% among men and 3.2% among women).[31]

Indicator 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client

1. **Method of data collection**

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Female sex workers
- **Study sites**: The IBBS was conducted in "hot-spots" in seven provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Da Nang, Ho Chi Minh City, Can Tho, and An Giang.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey. In Ha Noi and Hai Phong, respondents were selected using cluster sampling methods. In the other 5 provinces/cities, all female sex workers were included in the survey.

2. **Method of measurement**

- **Numerator:** Number of respondents who reported that a condom was used with their last one-time client
- **Denominator:** Number of respondents who reported having commercial sex in the past month

3. **Results**

- The survey shows that 97% of female sex workers reported to use a condom with their most recent one-time client in the past month. The range of this indicator among the 7 provinces/cities was from 93 – 100%.
- In addition, there were 91 % of female sex workers that reported use of a condom with their most recent regular client; but only 39% reported to use a condom with non-commercial sex partner in the last sex.
- However, the proportion of consistent condom use among female sex workers is lower, ranging from 69 – 95%; and even lower in Quang Ninh, where only 40% reported consistent condom.
- In all 7 provinces/cities and in both direct- and indirect-sex workers, the highest proportion of condom use was found when female sex workers have sex with one-time clients, followed by regular client and non-commercial sex partners.
- The proportions of condom use among direct- and indirect-sex workers are almost the same.
- There is no significant difference of this indicator among sex workers aged less than 25 and those aged more than 25.

4. Limitation of the data

- This indicator slightly differs from the international UNGASS guidelines. The question asked in the IBBS was asked "Did you use a condom with your most recent one-time client in the past month?" and not "Did you use a condom with your most recent client?".
- This data are not representive for the national SW population, because it was collected only from hot-spots of sex workers in provinces/cities with high HIV prevalence.
- No data on male sex workers available
- This data is not weighted for population size of sex workers in each of 7 provinces/cities, because data on population size is not available.

Indicator 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

1. **Method of data collection**

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Men who have sex with men
- **Study sites**: The IBBS for MSM was conducted in "hot-spots" of two cities (Ha Noi and Ho Chi Minh City).
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey. Respondents were selected using respondent driven sampling method (RDS).

2. **Method of measurement**

- **Numerator:** Number of respondents who reported that a condom was used the last time they had anal sex with a consensual partner
- **Denominator:** Number of respondents who reported having had anal sex with a male partner in the last six months

3. **Results**

- This study indicates that 63% of respondents reported to use a condom during the last time they had anal sex with consensual partner. This proportion was higher among respondents in Ha Noi (76%) than those in Ho Chi Minh City (54%).
- 65% of respondents reported to use a condom in the last time they sold sex to male partner, and 50% reported using condom during the last sex with male sex worker.
- Only 34% of respondents reported to use condom consistently with consensual male partners in the last one month.
- There is no significant difference of this indicator among MSM aged less than 25 and those aged more than 25.

4. **Limitation of the data**

- This data is not representative for the national MSM population, because it was collected only from hot-spots of men who have sex with men in two cities with high HIV prevalence.
- This data is not weighted for population size of men who have sex with men in each city, because data on population size is not available.
- This data is not weighted for sampling method (RDS).
- This indicator is not appropriate with UNAIDS requirement due to difference of question regarding condom use during the last anal sex. This survey did not include a question "Did you use a condom in the last time you had anal sex in the last 6 months?". Instead, the respondents were asked "Did you use a condom during the last sex with consensual partner?"

Indicator 20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

1. Method of data collection

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Injecting drug users
- **Study sites**: The IBBS was conducted in "hot-spots" in seven provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Da Nang, Ho Chi Minh City, Can Tho, and An Giang.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey. In Hai Phong, respondents were selected using cluster sampling methods. Respondents Driven Sampling (RDS) method was applied to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, and Can Tho. In Quang Ninh and An Giang, all injecting drug users in the sampling frame were included in the survey.

2. Method of measurement

- **Numerator:** Number of respondents who reported that a condom was used the last time they had sex with regular partner
- **Denominator:** Number of respondents who report having had sexual intercourse in the last 12 months

3. Results

- This survey indicates as low as 35% of respondents reported that a condom was used the last time they had sex with a regular partners. This indicator ranges from 32 – 47% in the seven provinces/cities.
- Proportion of injecting drug users who reported to use a condom in the last sex with casual partner is almost the same (34%). However, in Da Nang and Ho Chi Minh City, this proportion was 0%.
- About two-thirds of respondents reported to use a condom in the last sex with female sex worker (ranged from 47 – 91%).
- Proportion of injecting drug users reported to use condom consistently in the last 12 months is very low: 16 – 36% with regular partners, 45 – 81% with female sex workers, and 14 – 62% with casual partners. The lowest proportion is found among respondents in Ha Noi, An Giang, and Can Tho.
- There is no significant difference of this indicator among IDU aged less than 25 and those aged more than 25.

4. Limitation of the data

- This indicator is not exactly the same as the international UNGASS indicator. The definitions for the numerator and denominator differ slightly. This survey did not

include a question "Did you use a condom during the last time you had sex in the last month?". Instead, the respondents were asked "Did you use a condom during the last sex with regular partners in the last 12 months?".

- This data is not representative for the national IDU population, because it was collected only from hot-spots of injecting drug users in provinces/cities with high HIV prevalence.
- No data on female injecting drug users available
- This data is not weighted for population size of injecting drug users in each of 7 provinces/cities, because data on population size is not available.
- This data is not weighted for sampling method (RDS).

Indicator 21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

1. Method of data collection

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Injecting drug users
- **Study sites**: The IBBS was conducted in "hot-spots" in seven provinces/cities; Ha Noi, Hai Phong, Quang Ninh, Da Nang, Ho Chi Minh City, Can Tho, and An Giang.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey. In Hai Phong, respondents were selected using cluster sampling methods. Respondents Driven Sampling (RDS) method was applied to select respondents in Ha Noi, Da Nang, Ho Chi Minh City, and Can Tho. In Quang Ninh and An Giang, all injecting drug users in the sampling frame were included in the survey.

2. Method of measurement

- **Numerator:** Number of respondents who report using sterile injecting equipment the last time they injected drugs
- **Denominator:** Number of respondents who report injecting drugs in the last month

3. Results

- The survey indicates that there is 88.8% of IDU reporting the use of sterile injecting needles/syringes the last time they injected.
- There is no significant difference of this indicator among IDU aged less than 25 and those aged more than 25.
- Based on self-reports, needle sharing appears to have decreased from previous years but is still unacceptable high. Twelve to 33% of IDU reported sharing needles in the past 6 months. The rates were highest in the Central and Southern provinces.

4. Limitation of the data

- This data is not representative for the national IDU population, because it was collected only from hot-spots of injecting drug users in provinces/cities with high HIV prevalence.
- No data on female injecting drug users available
- This data is not weighted for population size of injecting drug users in each of 7 provinces/cities, because data on population size is not available.
- This data is not weighted for sampling method (RDS).

Indicator 22. Percentage of young people aged 15–24 who are HIV infected

1. **Method of data collection**

- **Data source**: Vietnam Population and AIDS Indicator Survey 2005 (VPAIS). General Statistical Office, National Institute of Hygiene and Epidemiology, and ORC Macro (2006).
- **Target population**: People aged 15-49
- **Study sites**: Hai Phong city
- **Study method**: A cross-sectional household survey was conducted from September to December 2005 by using AIDS Indicator Survey (AIS) questionnaires.

2. **Method of measurement**

- **Numerator:** Number of young people (aged 15–24) tested whose HIV test results are positive
- **Denominator:** Number of young people (aged 15–24) tested for their HIV infection status

3. **Results**

- Result from the survey indicates that the HIV prevalence among young people aged 15-24 is 0.3%. There is no case aged 15-19 being found as HIV positive, while the prevalence among people aged 20-24 is 0.8%.
- HIV prevalence among women aged 15-49 is 0.2%, lower than that among men aged 15-49 (0.9%).
- Among women aged 15-49, HIV infected cases were found only among women aged 25-34. The survey found infection occurring among men aged 20-39, a broader age range than was found among women.
- Particularly, the prevalence is found to be 2% among men aged 15-49 living in urban area, and 1.1% among never-married 15-49 year-old men.

4. **Limitation of the data**

- Data is not nationally representative because it comes from only one city (Hai Phong).
- HIV sentinel surveillance data among antenatal clinic attendees disaggregated by age group (15-19, 20-24, and 15-24) is not available.

5. **Other surveys with data for the same indicators**

- Data from HIV sentinel surveillance among antenatal clinic attendees in 40 provinces indicates that the HIV prevalence among this group (of all age) was 0.37% in 2005 and stayed stable in 2006 (0.38%). This prevalence among military recruits was found to be 0.31% in 2005 and decreased by half in 2006 (0.16%).
- A household survey in Ho Chi Minh City and Thai Binh province in 2005 showed that the HIV prevalence among people aged 15-24 was a bit higher - 0.6% (1% in Ho Chi Minh City and 0.4% in Thai Binh province). In addition, the HIV prevalence among men and women aged 15-49 was 0.7% and 0.3%, respectively. [31]

Indicator 23.1 Percentage of most-at-risk populations who are HIV infected – Sex Workers

1. Method of data collection

- **Data source**: HIV sentinel surveillance
- **Target population**: Sex workers from rehabilitation centers and community
- **Study sites**: 40 out of 64 provinces/cities in Vietnam
- **Study method**: Sentinel surveillance is conducted by Ministry of Health once annually from May to August. HIV testing with testing strategy II is performed as the national guideline.

2. Method of measurement

- **Numerator:** Number of sex workers who test positive for HIV
- **Denominator:** Number of sex workers tested for HIV

3. Results

- The HIV prevalence among sex workers in 40 provinces in 2005 was 3.5% and slightly increasd in 2006 to 4.2%.
- Particularly, HIV prevalence of higher than 10% is found among sex workers in Ha Noi, Ho Chi Minh city, Can Tho, Thanh Hoa, and Dong Nai.

4. Limitation of the data

- Results from sentinel surveillance reflect the trend of HIV infection in sentinel sites, but they are not representative for targeted population nationwide. Additionally, most of sentinel sites are in urban settings; therefore, data may not be representative for rural, remote, and mountainous areas.

5. Other surveys with data for the same indicator

The IBBS conducted in 7 provinces/cities in 2005 – 2006 showed that the HIV prevalence is 8.6%. The prevalence is highest in Ha Noi (16.6%), following by that in Can Tho (11.7%), Quang Ninh, Ho Chi Minh City, and An Giang (around 8%), and Hai Phong (6%). Only 0.8% of sex workers in Da Nang is HIV positive.

Indicator 23.2. Percentage of most-at-risk populations who are HIV infected – Men Who Have Sex With Men

1. **Method of data collection**

- **Data source**: Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Vietnam 2005 – 2006. Vietnam Ministry of Health (2006).
- **Target population**: Men who have sex with men
- **Study sites**: The IBBS for MSM was conducted in two cities (Ha Noi and Ho Chi Minh City). In each city, districts considered as "hot-spots" were chosen as study sites.
- **Study method**: A cross-sectional survey was conducted from October 2005 to July 2006 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey (IBBS of FHI). Respondents were selected using respondent driven sampling method (RDS).

2. **Method of measurement**

- **Numerator:** Number of men who have sex with men who test positive for HIV
- **Denominator:** Number of men who have sex with men tested for HIV

3. **Results**

- The HIV prevalence among men who have sex with men in the survey was 9%
- After adjusting for the Respondent Driven Sampling method, the HIV prevalence among MSM in Hanoi was 9.4%, and in Ho Chi Minh city 5.3%.
- Approximately 60% of HIV-positive MSM reported using condom inconsistently with male partners in the previous month. Inconsistent use of condom might increase the possibility of HIV infection among MSM and their male and female sexual partners.
- In addition, drug injection and its high correlation with HIV infection were found among MSM samples where injection risks were not uncommon. The (unadjusted) HIV prevalence among MSM who ever inject drug was 31%, which was 4 time higher than that among non-injecting MSM (7.3%).

4. **Limitation of the data**

- This data does not represent for national population, because it was collected only from hot-spots of men who have sex with men in two cities with high HIV prevalence.
- This data is not weighted for population size of men who have sex with men in each city, because data on population size is not available.
- This data is not weighted for sampling method (RDS).

Indicator 23.3. Percentage of most-at-risk populations who are HIV infected – Injecting Drug Users

1. **Method of data collection**

- **Data source**: HIV sentinel surveillance
- **Target population**: Injecting drug users from rehabilitation centers and community
- **Study sites**: 40 out of 64 provinces/cities in Vietnam
- **Study method**: Sentinel surveillance is conducted by Ministry of Health once annually from May to August. HIV testing with testing strategy II is performed as the national guideline.

2. **Method of measurement**

- **Numerator:** Number of injecting drug users who test positive for HIV
- **Denominator:** Number of injecting drug users tested for HIV

3. **Results**

- The HIV prevalence among injecting drug users in 40 provinces in 2005 is 25.5% and in 2006 is 23.1%.
- Particularly, HIV prevalence of higher than 40% is found among injecting drug users in Ho Chi Minh city, Can Tho, Hai Phong, Thai Nguyen, and Quang Ninh.

4. **Limitation of the data**

- Results from sentinel surveillance reflect the trend of HIV infection in sentinel sites, but they are not representative for targeted population nationwide. Additionally, most of sentinel sites are in urban settings; therefore, data may not be representative for rural, remote, and mountainous areas.

5. **Other surveys with data for the same indicator**

- The IBBS conducted in 7 provinces/cities in 2005 – 2006 showed that the HIV prevalence among injecting drug users was 33.7%. In Hai Phong and Quang Ning, more than half of respondents were infected with HIV (66% and 59%, respectively). The prevalence in Ho Chi Minh city, Can Tho, and Ha Noi were 34%, 37%, and 24%. The lowest prevalence was found among respondents in Da Nang (2%) and An Giang (13%).

Indicator 24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

1. Method of data collection

- **Data source**: Special study - ART cohort data collection (Vietnam Administration for HIV/AIDS Control)
- **Target population**: Adults and children with advance HIV infection who started ART in the 9 month period from January to September 2006.
- **Study sites:** 17 adult ART sites and 4 pediatric ART sites were sampled to obtain the ART cohorts as representative as possible for this study. The sites were selected semi-proportionate to the number of ART patients, in consideration to the geographical area (North/Center/South), the number of ARV doses distributed by donors (60% by PEPFAR, 30% of GF, 10% National), level of health facilities (national/provincial/district), and urban/rural area.
- **Study method**: Data collection team visited selected ART sites, and extracted data from ART register (or from other source, e.g. original database, patient record form), using the ART cohort analysis form (as included in the WHO patient monitoring guidelines).

2. Method of measurement

- **Numerator:** Number of adults and children who are still alive and on ART at 12 months after initiating treatment
- **Denominator:** Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up

3. Results

- Among 17 adult ART sites and 4 pediatric ART sites sampled, the data extraction was possible only at 15 adult sites and 3 pediatric sites, as other sites had not used the standard recording system.
- **Adults**: The net cohort at 12 months after ART was initiated at the 15 adult ART sites (denominator) was 1684, and the number of individuals who are alive and on ART at 12 months (numerator) was 1364. As a result, the survival at 12 months on ART was calculated as 81%.
- **Children**: The net cohort at 12 months after ART was initiated at the 3 pediatric ART sites (denominator) was 175, and the number of individuals who are alive and on ART at 12 months (numerator) was 163. As a result, the survival at 12 months on ART was calculated as 93.1%.

4. Limitation of the data

- Although the sample ART sites were selected to obtain the ART cohorts as representative as possible for this study, by including different types of ART facilities. However, the sampling was not random, and also data extraction was not possible at some selected ART sites. As a result, the data may not be truly representative.
- Data disaggregated by gender is not available

ANNEX 5

List of participants of the National Consensus Workshop

On the UNGASS report 2007 - 9 January 2008

#	Name	Organisation
I	**Ministry of Health**	
1	Tran Quang Hung	Ministry of Health – Department of International Collaboration
2	Nguyen Thu An	Ministry of Health – Department of Planning and Finance
3	Nguyen Van Quang	Ministry of Health – Department of Legislation
4	Do Trung Hung	Ministry of Health – Department of Legislation
5	Tran Thi Xuan Hang	Ministry of Health – Department of Legislation
II	**Administration for HIV/AIDS Control**	
1	Duong Quoc Trong	General Deputy Director
2	Nguyen Thanh Long	Vice Director
3	Nguyen Van Kinh	Vice Director
4	Chu Quoc An	Vice Director
5	Dang Don Tuan	Administrative Office
6	Ha Van Ha	Administrative Office
7	Nguyen Tuan Anh	Administrative Office
8	Le Thanh Hong	Administrative Office
9	Le Anh Tuan	Department of Planning & Finance
10	Duong Thuy Anh	Department of Planning & Finance
11	Tran Thi Thu Thuy	Department of Planning & Finance
12	Vu Van Chieu	Department of Planning & Finance
13	Pham Hong Thuy	Department of Planning & Finance
14	Ta Thi Lien Huong	Department of Planning & Finance
15	Nguyen Phuoc Ha	Department of Planning & Finance
16	Vo Thi Xuan	Department of Planning & Finance
17	Nguyen Duc Long	Department of Planning & Finance
18	Nguyen Dac Vinh	Department of Scientific Research & International collaboration
19	Tran Bich Tra	Department of Information - Education - Communication
20	Mai Xuan Phuong	Department of Information - Education - Communication

21	Nguyen Thi Huynh	Department of Harm Reduction
22	Nguyen Thi Minh Tam	Department of Harm Reduction
23	Nguyen Thi Huong	Department of Care and Treatment
24	Vu Duc Canh	Department of Care and Treatment
25	Pham Duc Manh	Department of M&E
26	Phan Thi Thu Huong	Department of M&E
27	Vo Hai Son	Department of M&E
28	Hoang Dinh Canh	Department of M&E
29	Nguyen Viet Nga	Department of M&E
30	Nguyen Duc Huy	Department of M&E
31	Le Tong Giang	Department of M&E
32	Bui Thu Trang	Department of M&E
33	Phan Thanh Tinh	Life GAP/CDC project
III	**Technical Sub-committees**	
1	Nguyen Anh Tuan	National Institute of Hygiene and Epidemiology
2	Nguyen Quoc Trung	National Institute of Hygiene and Epidemiology
IV	**Other sectors**	
1	Nguyen Thanh Ha	Ministry of Justice, Department of Administration and Criminal Laws
2	Le Van Thanh	MOLISA, Department of Social Evils Prevention
3	Nguyen Thi Hoai Linh	VWU, Centre for Supporting Women to fight AIDS
4	Bui Ngoc Thanh	Youth Union, Center for Education – Population – Environment
5	Dang Hoa Ai	Vietnam Labour Union, Centre for Prevention of AIDS and Social Evils
6	Bui Thi Thanh Phuong	Viet Nam AIDS Association
7	Ninh Thi Binh	Ministry of Foreign Affair, Dept. of International Organisations
8	Phạm Thị Thu Ba	MOET, Department of student's welfares
9	Nguyen Thi Minh Thu	Ministry of Transportation – Department of Health
10	Nguyen Van Loc	Ministry of Public Security – Department of Health
V	**International organisations**	
1	B. Crumpton	DFID, UK
2	Kerry Groves	AUSAID
3	Nguyen Thu Hang	AUSAID
4	Nguyen Duy Tung	FHI

5	Luisa Brumana	UNICEF
6	Jason Eleigh	UNODC
7	Akiko Takai	UNFPA
8	Masami Fujita	WHO
9	Masaya Kato	WHO
10	Eamon Murphy	UNAIDS
11	Vladanka Andreeva	UNAIDS
12	Ludo Bok	UNAIDS
13	Chu Hong Anh	UNAIDS
14	Nguyen Duc Duong	USAID
15	Hoang To Linh	IOM
16	Nguyen Ngoc Oanh	IOM
VI	**Civil society**	
1	Khuat Thi Hai Oanh	ISDS
2	Huynh Thu Thanh Huyen	Representative of the Southern network of PLHIV
3	Nguyen Van Dzung	Green Pine Group
13	Thich Thanh Huan	Viet Nam Buddhist Association
14	Nguyen Thi Bich Huyen	Council of Catholic Bishops of Vietnam