



# Commitment for Action:

*Assessing Leadership for Confronting  
the HIV/AIDS Epidemic Across Asia*

## Focus on Viet Nam

January 2005



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**By**

**Le Bach Duong**



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# ● CONTENTS

Acknowledgments.....	iv
Abbreviations.....	v
Executive Summary.....	vii
<hr/>	
INTRODUCTION.....	1
Background.....	2
Purpose and Methodology.....	2
Characteristics of Political Commitment.....	3
<hr/>	
SALIENT FINDINGS.....	7
Understanding of Political Commitment.....	8
Top Leadership.....	10
Government Response.....	12
<i>Policy Formulation, National Legislature, and Regulatory Environment</i> .....	12
<i>Resources</i> .....	15
<i>Organizational Structure</i> .....	16
<i>Multiministry Involvement</i> .....	18
<i>Foreign Technical Assistance and Foreign Experience</i> .....	18
<i>Public Information and Education</i> .....	19
Role of NGOs and Civil Society.....	21
Research, Monitoring, and Evaluation.....	23
Stigma and Discrimination.....	24
<hr/>	
RECOMMENDATIONS AND CONCLUSIONS.....	25
Top Leadership.....	27
Government Response.....	27
Role of NGOs and Civil Society.....	28
Research, Monitoring, and Evaluation.....	28
Stigma and Discrimination.....	28
<hr/>	
APPENDICES.....	29
A: Questionnaire.....	30
B: References.....	34

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# ● ABBREVIATIONS

<b>ABC</b>	Abstinence, be faithful, and use condoms
<b>AIDS</b>	acquired immune deficiency syndrome
<b>ANE</b>	Asia and the Near East
<b>API</b>	AIDS Program Effort Index
<b>ARV</b>	antiretroviral
<b>CCM</b>	Country Coordinating Mechanism
<b>CEPHED</b>	Center for Public Health and Development
<b>COHED</b>	Center for Public Health Research and Development
<b>CSDS</b>	Center for Social Development Studies
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>GIPA</b>	Greater Involvement of People Living with HIV/AIDS
<b>HAART</b>	highly active antiretroviral treatment
<b>HIV</b>	human immunodeficiency virus
<b>IDU</b>	injection drug user
<b>IEC</b>	information, education, and communication
<b>ISDS</b>	Institute for Social Development Studies
<b>MOCI</b>	Ministry of Culture and Information
<b>MOET</b>	Ministry of Education and Training
<b>MOF</b>	Ministry of Finance
<b>MOH</b>	Ministry of Health
<b>MOLISA</b>	Ministry of Labor, Invalids, and Social Affairs
<b>MPI</b>	Ministry of Planning and Investment
<b>MPS</b>	Ministry of Public Security
<b>MSM</b>	men who have sex with men
<b>NAC</b>	National AIDS Committee
<b>NACP</b>	National AIDS Control Program
<b>NAP</b>	National AIDS Program
<b>NASB</b>	National AIDS Standing Bureau
<b>NCADP</b>	National Committee for Prevention and Control of AIDS, Drugs, and Prostitution
<b>NGO</b>	nongovernmental organization
<b>NSP</b>	national strategic plan
<b>PASB</b>	Provincial AIDS Standing Bureau
<b>PCADP</b>	Provincial Committee for the Prevention and Control of AIDS, Drugs, and Prostitution
<b>PLHA</b>	person living with HIV or AIDS
<b>PMTCT</b>	prevention of mother-to-child transmission
<b>PPC</b>	Provincial People's Committee

<b>SHAP</b>	STI/HIV/AIDS Prevention Center
<b>STI</b>	sexually transmitted infection
<b>SUCECON</b>	Supporting Center for HIV/AIDS/STI Control
<b>UNAIDS</b>	Joint United Nations Program on HIV/AIDS
<b>UNDP</b>	United Nations Development Program
<b>UNGASS</b>	United Nations General Assembly Special Session on HIV/AIDS
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	voluntary counseling and testing
<b>VICOMC</b>	Vietnamese Community Mobilization Center for HIV/AIDS
<b>VND</b>	Vietnamese dong
<b>WHO</b>	World Health Organization

## ● EXECUTIVE SUMMARY

To prevent the further spread of HIV among vulnerable groups and the general population as well as to provide care, support, and treatment for those already affected, Viet Nam must enact a comprehensive response to the epidemic. Many of the key features of a strong response—including multisectoral engagement, protection of human rights, civil society participation, meaningful involvement of people living with HIV or AIDS (PLHAs), well-financed programs and well-trained staff, and monitoring and evaluation systems that allow for developing lessons learned—are directly and indirectly influenced by an enabling policy environment and strong national political commitment. However, few attempts have been made to identify key characteristics of or ways to measure strong political commitment for addressing HIV/AIDS, particularly in the context of low HIV prevalence countries. Against such a backdrop, this assessment of national political commitment for confronting the HIV/AIDS epidemic in Viet Nam not only provides a mechanism for improving in-country responses but also contributes to the international community’s understanding of political commitment and leadership and their impact on strategies to address HIV/AIDS worldwide.

The study involved a literature review of relevant materials and in-depth interviews with 16 key stakeholders representing various sectors of Vietnamese society, including government, mass organizations, PLHA groups, international donor organizations, international nongovernmental organizations (NGOs), faith-based groups, academia, and the media. The interviews were structured around a qualitative assessment guide developed by the POLICY Project that covers 13 aspects of national political commitment, including policy environment, resources, organizational structure, and stigma and discrimination.

In terms of defining political commitment, respondents reported that national leaders can demonstrate their commitment by delivering speeches and public statements; formulating and adopting policies, strategic plans, and legislation; and allocating human and financial resources to HIV/AIDS programs. However, respondents stressed that political commitment must go beyond mere statements of support and instead directly support the implementation of policies and programs. To date, while Viet Nam has yet to enact laws on HIV/AIDS, it has issued ordinances, decrees, and instructions that form the legal framework for the country’s HIV/AIDS response. Respondents’ general impression was that national political commitment for addressing HIV/AIDS is strong among top leaders and is evident throughout the Communist Party structure and state-organized mass organizations.

Nonetheless, respondents noted several areas where Viet Nam’s national leaders could demonstrate greater political commitment. For example, even though legal documents have been amended in accord with international human rights guidelines, they remain insufficient. Current policies do not guarantee the full rights of PLHAs (e.g., confidentiality, working rights, rights to medical support, and so forth). Respondents concluded that the government’s budgeted funds were inadequate to meet the country’s needs for HIV/AIDS prevention and care, particularly given its population of 80 million. The budget focuses heavily on HIV prevention, with significantly less funding devoted to care and treatment. In addition, the government has traditionally linked HIV/AIDS prevention activities with activities designed to prevent and control so-called “social evils,” such as sex work and injection drug use. This approach, according to respondents, has added to the stigma and discrimination surrounding HIV/AIDS and hinders the success of prevention and care programs.

The study also asked respondents to comment on the role of NGOs and civil society in relation to the country's response to HIV/AIDS. Respondents reported that NGOs have made significant contributions to the country's response, particularly at the local level, but few have been involved in national policymaking processes; moreover, the government could do more to encourage NGOs' participation. Vulnerable groups—such as women, injection drug users (IDUs), sex workers, men who have sex with men (MSM), and other affected communities—have begun to organize into advocacy, support, and peer-education groups. Commitment to addressing HIV/AIDS is considered strong among mass organizations, particularly women's groups, and is growing in other sectors, such as faith-based communities and the business sector.

In terms of strengthening political commitment and thereby improving the country's national response, stakeholders from across Vietnamese government and society must work to:

- Foster an enabling policy environment by, for example, promoting the view that HIV/AIDS is a public health and development issue and not a “social evil”;
- Establish mechanisms that will help translate policies and public statements into action (e.g., resources, human capacity development) and monitor implementation to build on lessons learned;
- Increase resource allocation and efficiency and ensure that the allocation of both human and financial resources responds to emerging needs;
- Encourage and support meaningful civil society and PLHA participation in national policymaking and program implementation;
- Facilitate the collection, analysis, and dissemination of high-quality, accurate information regarding trends in the epidemic as well as its social and economic impacts; and
- Conduct advocacy to help national and local leaders understand their role as opinion leaders who can help confront the HIV/AIDS-related stigma and discrimination faced by PLHAs and affected communities.

# INTRODUCTION

# ● INTRODUCTION

## ● Background

The Socialist Republic of Viet Nam is located in a region that is home to some of the world's fastest-growing HIV/AIDS epidemics. While not yet experiencing the HIV prevalence levels found in Thailand, Cambodia, and parts of China, Viet Nam has witnessed a dramatic increase in prevalence among groups that practice high-risk behaviors, including injection drug users (IDUs) and sex workers. Viet Nam's first case of HIV infection was identified in 1990. According to UNAIDS, by the end of 2003, 220,000 Vietnamese adults and children were living with HIV/AIDS, and the country had a national adult (age 15 to 49) HIV prevalence level of 0.4 percent (UNAIDS, 2004). The epidemic in Viet Nam is still in its early stages, and a large share of reported HIV cases is limited to men (85 percent), though new infections are increasingly affecting women. As for vulnerable populations, IDUs account for 60 percent of all reported HIV/AIDS cases. However, HIV prevalence is increasing in all subgroups included in the country's sentinel surveillance system (Socialist Republic of Viet Nam, 2003).

To prevent the further spread of HIV among vulnerable groups and the general population as well as to provide care, support, and treatment for those already affected, Viet Nam must enact a comprehensive response to the epidemic. Many of the key features of a strong response—including multisectoral engagement, protection of human rights, civil society participation, meaningful involvement of PLHAs, well-financed programs and well-trained staff, and monitoring and evaluation systems that allow for developing lessons learned—are directly and indirectly influenced by an enabling policy environment and strong national political commitment. Until now, however, few attempts have been made to identify clearly key characteristics of or ways to measure strong political commitment for addressing HIV/AIDS, particularly in the context of low HIV prevalence countries. Against such a backdrop, this assessment of national political commitment for confronting the HIV/AIDS epidemic in Viet Nam not only provides a mechanism for improving in-country responses but also contributes to the international community's understanding of political commitment and leadership and their impact on strategies to address HIV/AIDS worldwide.

## ● Purpose and Methodology

This case study of Viet Nam is part of a multicountry assessment designed to analyze national political commitment and leadership for confronting HIV/AIDS in low HIV prevalence countries in Asia as well as to develop indicators to measure national political commitment. It is based on the assumption that while experience shows that political commitment can help catalyze a strong response before an epidemic

### HIV/AIDS in Viet Nam: At-A-Glance

- 59,000 cumulative reported HIV cases by December 2002; of which 8,793 cases had progressed to the development of AIDS
- A majority of the reported people living with HIV/AIDS in Viet Nam are men (85 percent)
- IDUs account for 60 percent of reported HIV/AIDS cases
- HIV/AIDS affects younger populations, with people under 30 accounting for 63 percent of reported cases

*Source: Socialist Republic of Viet Nam (2003)*

spreads to the general population, political commitment is a term often used without a clear sense of what it means, how it affects programs, and how it can be strengthened by advocates and policymakers.

The study was conducted in four countries with low seroprevalence in Asia during mid-2003 by the POLICY Project for the Asia and Near East Bureau of the U.S. Agency for International Development (USAID).<sup>1</sup> The study expands and builds on POLICY's past efforts in the development of methodologies to measure political commitment for confronting the HIV/AIDS epidemic.<sup>2</sup> The study's methodology involved two phases:

- **Literature review and assessment guide development.** POLICY Project researchers conducted a review of the literature on political commitment for addressing HIV/AIDS and other relevant health issues, such as reproductive health. The review, coupled with the project's own experience in assessing and building political commitment, informed the development of a qualitative research tool for measuring 13 aspects of national political commitment (see Appendix A). Local consultants and counterparts also reviewed relevant country-specific materials relating to the country's national response and political commitment. The materials included national HIV/AIDS plans; UNAIDS reports; applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); and other relevant documents.
- **Identification of key stakeholders and in-depth interviews.** Key HIV/AIDS stakeholders from the public sector and civil society were identified as interview subjects who would discuss their views on current levels of national political commitment for confronting HIV/AIDS in Viet Nam. In-depth interviews were carried out with 16 persons. The respondents represent various sectors of Vietnamese society, including government, mass organizations, PLHAs, international donor organizations, international nongovernmental organizations (NGOs), faith-based groups, academia, and the media.

## ● Characteristics of Political Commitment

Strong political commitment for confronting the epidemic is an essential component of a comprehensive and effective strategy for addressing HIV/AIDS at the local, regional, national, and international levels (UNAIDS, 2000; USAID, 2000). The POLICY Project defines political commitment as:

*[T]he decision of leaders to use their power, influence, and personal involvement to ensure that HIV/AIDS programs receive the visibility, leadership, resources, and ongoing political support that is required to support effective action to limit the spread of HIV and mitigate the impacts of the epidemic (POLICY Project, 2000).*

A sizeable body of literature exists on political commitment in general and on political commitment for HIV/AIDS in particular (e.g., Patterson, 2000; POLICY Project, 2000). The review of the literature suggests several concrete actions and events that characterize political commitment. Examples include:

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<sup>1</sup> The four countries in the study are Bangladesh, India, Nepal, and Viet Nam.

<sup>2</sup> See *HIV/AIDS Toolkit: Building Political Commitment for Effective HIV/AIDS Policies and Programs* (POLICY Project, 2000), available at <http://www.policyproject.com/pubs/toolkit.cfm>. Also see "Measuring the Level of Effort in the National and International Response to HIV/AIDS: The AIDS Programme Effort Index (API)" (UNAIDS, USAID, and POLICY Project, 2001), available at <http://www.policyproject.com/pubs/Monographs/APIreport.pdf>.

- **Formulating a national HIV/AIDS plan.** The Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), for example, sets as a goal that all countries should have national strategic plans in place by 2003.
- **Strengthening the public health infrastructure.** Scaling up an HIV/AIDS response requires the development of and investment in necessary infrastructure, including health facilities, related systems, and human capacity. For example, the ability of a country, such as Thailand, to conduct vaccine trials serves as an important indicator of political commitment because clinical trials cannot be conducted without first developing basic utilities and laboratory facilities, training staff, ensuring supply lines and transportation, and so on.
- **Passing public health legislation.** Legislation can take many forms. One example is legislation that identifies HIV/AIDS as a communicable disease and outlines the role of the state in prevention, care, and mitigation. Another example is legislation that makes HIV/AIDS a national priority, such as the Philippines AIDS Law of 1998, which mandated education about HIV-related risks and safer practices and behaviors as well as screening, counseling, and the provision of health services (Stephenson, 2001). A third example is laws that prohibit discrimination against PLHAs.
- **Mobilizing and allocating resources.** Sufficient and cost-effective budget allocations are necessary for the successful implementation of prevention, treatment, and care programs.
- **Encouraging civil society participation.** NGOs should be encouraged to act locally to reduce risk behaviors and slow the spread of the epidemic and to participate broadly in a country's planning and policymaking processes (Parkhurst, 2000).
- **Promoting human rights.** Commitment to international conventions and compliance with international standards, such as the "International Guidelines on HIV/AIDS and Human Rights" (Watchirs, 2000), is essential for creating an enabling policy environment for HIV/AIDS programs and for reducing stigma and discrimination.
- **Serving as an "AIDS policy champion."** Some top-level political leaders have used their status and personal dedication to keep HIV/AIDS high on the agenda in their own countries. Examples include President Yoweri Museveni of Uganda, former President Kenneth Kaunda of Zambia, former President Nelson Mandela of South Africa, and Senator Mechai Viravaidya of Thailand.

*Political commitment is the decision of leaders to use their power, influence, and personal involvement to ensure that HIV/AIDS programs receive the visibility, leadership, resources, and ongoing political support that is required to support effective action to limit the spread of HIV and mitigate the impacts of the epidemic (POLICY Project, 2000).*

Patterson (2000) identifies a number of indicators of political commitment drawn from successful national programs, including:

- Key ministries with their own HIV/AIDS plans and budgets, as in the case of Thailand (Sittitrai, 2001);
- Provincial governors playing a lead role in the HIV/AIDS program of their respective provinces, as in the case of Thailand (Sittitrai, 2001);

- Encouraging multisectoral engagement and including businesses, PLHAs, faith-based organizations, and other community leaders in policy dialogue and resource mobilization, as in the case of Thailand (Sittitrai, 2001);
- Government publicly acknowledging the HIV/AIDS epidemic as a national priority and creating a highly placed national HIV/AIDS commission early on, as in the case of Uganda;
- Enabling and promoting NGO involvement in HIV/AIDS activities, as in the case of Senegal;
- Including HIV/AIDS-related topics in health and sex education for school-aged children, as in the case of Senegal;
- Integrating detection of and treatment for sexually transmitted infections (STIs) into primary health services, as in the case of Senegal; and
- Providing antiretroviral (ARV) drugs and/or adopting a government policy of universal access, as in the case of Brazil.

The next chapter explores the extent to which Viet Nam's national response to HIV/AIDS has demonstrated strong political commitment for confronting the epidemic.



# SALIENT FINDINGS

*This section presents the key findings from the in-depth interviews regarding respondents' attitudes and opinions toward several aspects of national political commitment. The major topics covered are:*

- *Understanding of Political Commitment*
- *Top Leadership*
- *Government Response*
- *Role of NGOs and Civil Society*
- *Research, Monitoring, and Evaluation*
- *Stigma and Discrimination*

*Where appropriate, and primarily for providing additional background information, respondents' views are supplemented with information from the literature review of relevant policies, budgets, and strategic plans.*

## ● UNDERSTANDING OF POLITICAL COMMITMENT

Respondents agreed that the formulation and implementation of laws and policies are the most important signs of political commitment to addressing the HIV/AIDS epidemic. Such laws and policies form the legal framework for the mobilization of resources, for institutional arrangements, and for policy implementation. To a lesser degree, political commitment is represented in statements proclaimed by leaders during meetings at the international, national, and local levels. The signing of international conventions and agreements reflects Viet Nam's determination to join the collective efforts of the international community.

Due to the structure of the country's government, respondents noted that an important indicator of the degree of political commitment toward HIV/AIDS prevention lies in the issuance of the Party Instruction, which is the highest level of commitment. In Viet Nam, the political formula is as follows: "The Party provides leadership, the government manages, and the people have ownership." Commitment through Party Instructions facilitates consensus throughout the system and supports collective efforts undertaken through the vertical and horizontal structure of the state apparatus, including the mass organizations—which are considered the "third pillar" of society, along with the Party and the government. Mass organizations, all joined under the umbrella of the Viet Nam Fatherland Front, involve individuals from a wide spectrum of social groups. The state organizes the mass organizations with a clear mandate of, among other activities, mobilizing people to achieve nationally defined goals.

While political commitment can be demonstrated through public statements and the adoption of policies and laws, respondents explained that it also involves support for implementation. Respondents from mass organizations, government, and academia stated that political commitment means providing mechanisms for the implementation of HIV/AIDS programs, accompanied by an institutional structure at the national and all subnational levels to ensure program implementation. Resource allocations from the state budget and the development and use of human capacity are critical. Sectoral and local contributions to programs should also be encouraged. The relevant government agencies at all levels should direct and monitor the programs.

Respondents mentioned the above points again as indicators for measuring changes in a country's political commitment: the issuance of relevant laws, policies, and Party Instructions; the establishment of intervention programs; the allocation of sufficient budgetary and human resources; the development of an institutional framework at the national and subnational levels; and the leadership and statements of the Party and government officials at all levels. One government respondent suggested that measuring political commitment involves both quantitative and qualitative measures. A representative from a mass organization stated that it involves measuring changes in knowledge, attitudes, and practices among target groups and the country's leaders. Two respondents from mass organizations suggested that political commitment is best evidenced when programs reach and have an impact on society.

## KEY POINTS: UNDERSTANDING OF POLITICAL COMMITMENT IN VIET NAM

- National leaders can demonstrate their political commitment by delivering speeches and public statements; formulating and adopting policies, strategic plans, and legislation; and allocating human and financial resources to HIV/AIDS programs.
- A key concern is to ensure that political commitment goes beyond mere statements of support and is translated into direct support for the implementation of policies and programs.
- Respondents felt that the country's Party system helps ensure broad-based consensus on the need to address HIV/AIDS and can help mobilize the country through a variety of mechanisms, such as the mass organizations.

## ● TOP LEADERSHIP

Respondents from government, mass organizations, a donor organization, and academia reported that Viet Nam's top leaders have shown increasing political commitment for addressing HIV/AIDS. In particular, they noted that the Prime Minister, Deputy Prime Minister (who chairs the National Committee for Prevention and Control of AIDS, Drugs, and Prostitution [NCADP]), and the Party General Secretary and President have all demonstrated support. However, respondents also generally agreed that commitment in Viet Nam is based on collective leadership and broad-based support across government and Party entities.

Concrete actions of the top leaders include the following:

- Issuance of key legal documents that form the legal framework and provide guidelines for national HIV/AIDS activities;
- Establishment of the National AIDS Program (NAP);
- Formulation of broad-based institutional frameworks at the national level—for example, NCADP, chaired by a Deputy Prime Minister—and at the subnational level to lead NAP;
- Allocation of funds from the national budget for NAP activities; and
- Issuance of occasionally strong statements by top leaders, who sometimes participate in publicized events for awareness-raising purposes.

Over time, the following types of changes have occurred:

- Policy revisions;
- Restructuring of NAP and the institutional framework to suit the epidemic's changing status; and
- Increased budget allocations.

Government and society have also shifted their perception of and approaches to HIV prevention. For example, anti-stigmatization has emerged as an issue such that some high-ranking government officials have engaged in widespread information, education, and communication (IEC) activities. The government is also becoming more receptive to international experiences, with more communication and joint activities carried out with international organizations.

When asked about Viet Nam's greatest success in the country's battle against HIV/AIDS, respondents mentioned the ordinance that establishes the legal framework for HIV/AIDS interventions; awareness-raising and public education efforts; and the establishment of associations for PLHAs and other community-based activities. Respondents also pointed to a change in the top leadership's perception of and approach to HIV prevention. More specifically, actions have shifted away from a medical focus to broader, more comprehensive activities that take into consideration societal factors, including more participation and mobilization of society and more attention to prevention rather than reaction to the epidemic.

According to respondents, the major strength of Viet Nam's top leadership with respect to HIV/AIDS prevention and care is the strong consensus regarding the seriousness of the epidemic and the need for the collective action of both government and society. That consensus is strengthened by the highly centralized structure of the leadership, with power resting in the Party and the central government. Thus,

once top leaders arrive at consensus, actions will unfold through the government's vertical and horizontal structures as resources (e.g., financial, human, and infrastructure) are mobilized.

However, the major weakness of the top leadership's response, respondents noted, is reflected in the somewhat conflicting views regarding the approach adopted in NAP. Despite the change in top leaders' perception of the epidemic, the leaders are still inclined to consider HIV/AIDS as closely linked with a "social evil"—and not a public health issue; thus, HIV prevention efforts are overtly merged with actions designed to control sex work and illicit drug use. The problem of associating HIV/AIDS with certain populations whose behavior is considered "deviant" or a "social evil," namely, IDUs and sex workers, is that it exacerbates the already severe discrimination against individuals in these populations—creating "double discrimination." The link between HIV/AIDS and "social evils" in Viet Nam drives the epidemic underground, making it even more difficult for already stigmatized groups to gain access to services or to attend school, seek employment, or secure housing. It also reinforces the mistaken assumption that others are exempt from possible infection. The latter belief is especially dangerous for women, who in fact are biologically, socially, and economically more vulnerable to HIV infection than men.

## KEY POINTS: TOP LEADERSHIP IN VIET NAM

- Respondents reported that Viet Nam has demonstrated increasing political commitment for addressing HIV/AIDS and individual leaders have played a key role in fostering that commitment. A broad-based consensus throughout the government and the Party underscores the need to respond to HIV/AIDS.
- Viet Nam's greatest successes in responding to the epidemic lie in the ordinance that outlines the legal framework for HIV/AIDS interventions, awareness-raising programs, and the establishment of associations for PLHAs and other community-based activities.
- One concern noted by respondents was that, while perceptions are changing, the government's approach too closely associates HIV/AIDS with so-called "social evil" programs that target sex work and injection drug use, thereby increasing stigma and discrimination among vulnerable groups.

## ● GOVERNMENT RESPONSE

This section explores respondents' assessment of specific aspects of the government's response, including policy formulation, national legislature, and regulatory environment; resources; organizational structure; multiminsty involvement; foreign technical assistance; and public information and education.

### ● Policy Formulation, National Assembly, and Regulatory Environment

**Policy Formulation.** Although Viet Nam has enacted no law specifically dealing with HIV/AIDS, several key documents establish the legal and institutional framework for and provide guidelines on national collective efforts to respond to the HIV/AIDS epidemic. The primary documents are Party Instruction No. 52 CT/TW of the Communist Party Central Committee; National Assembly Ordinance on HIV/AIDS Prevention and Control; and Government Decree No. 34 on HIV/AIDS Prevention and Control.

Party Instruction No. 52, issued on March 11, 1995, directs party organs at all levels to take charge of leading HIV/AIDS prevention programs through political and IEC actions with the aim of upholding healthy lifestyles, controlling illicit drug use, and eliminating sex work. It also requests party organs to play the central role in coordinating activities aimed at prevention and control of HIV/AIDS by people's committees at all levels.

The Ordinance on HIV/AIDS Prevention and Control, dated May 31, 1995, specifies the following:

- Delineates responsibilities and tasks of ministries, sectors, mass organizations, the armed forces, and citizens in the implementation of HIV/AIDS prevention and control according to existing laws;
- Contains a declaration against discrimination against PLHAs;
- Includes preventive medical and social measures;
- Defines state management of the prevention and control of HIV/AIDS; and
- Provides an execution guide to the ordinance.

By the end of 2004, the HIV/AIDS Prevention and Control Ordinance had been reviewed, and a new draft, which incorporates a human rights-based approach, was being finalized. The draft will be submitted to the government for endorsement and then to the National Assembly for approval and promulgation. Various stakeholders, including government representatives, NGOs, PLHAs, international organizations, and others, were involved in drafting and reviewing the ordinance.

Government Decree No. 34, released on June 1, 1996, details implementation of the ordinance. Key areas concerning the prevention and control of HIV/AIDS follow:

- Promotion of safe behavior;
- Prohibition of drug use and sex work;

- Prohibition of intentional and criminal HIV infection;
- Introduction of school-based education on HIV/AIDS;
- Obligation of HIV-positive individuals to inform their partners about their cases and obligation of HIV-positive immigrants to inform the quarantine on entry to Viet Nam;
- Community support of PLHAs;
- Rights of PLHAs to be treated in various health facilities and the responsibility of these facilities to provide care without discrimination;
- Security and incentives for health workers in their contact with HIV/AIDS cases;
- Responsibilities of the National AIDS Committee (NAC), Ministry of Health (MOH), Ministry of Culture and Information (MOCI), Ministry of Labor, Invalids, and Social Affairs (MOLISA), and Ministry of Finance (MOF); and
- Roles and responsibilities of various state agencies and organizations in implementing IEC for HIV/AIDS prevention and control.

In addition to the above government documents, other policies on HIV/AIDS focus on six priority areas: IEC, epidemiological surveillance, risk prevention, national management actions, multisectoral collaboration, and social support:

- The MOH-MOCI-Ministry of Education and Training (MOET) Joint Circular No. 02/TT-LB, dated March 17, 1993, defines responsibilities of the ministries as follows: MOH for HIV/AIDS and STI education for staff in the health sector, medical facilities, and schools and for coordination of IEC activities; MOCI for HIV/AIDS education for staff within the sector and for mobilization of mass media to provide information on HIV/AIDS; and MOET for education on HIV/AIDS in schools.
- For IEC programs, the MOCI-NAC Joint Circular No. 112/NQLT, issued on July 22, 1999, defines objectives, responsibilities, and activities; outlines collaborative implementing mechanisms and mobilization of resources; and establishes a common IEC network for HIV/AIDS prevention and control.
- Decree No. 1418/2000/QĐ-BYT, dated May 4, 2000, pertains to epidemiological surveillance on factors related to the distribution of and trends in HIV infections among the population for the purpose of planning, prevention, control, and evaluation of interventions, with annual samples drawn from seven groups: IDUs, sex workers, STI patients, pregnant women, newly recruited soldiers, tuberculosis patients, and blood donors.
- Government Decrees No. 5/CP and 6/CP, issued on January 29, 1993, prohibit illicit drug use and sex work.
- Responsibility for national management of the prevention and control of HIV/AIDS rests with the National Committee for HIV/AIDS Prevention and Control and its subnational subsidiaries per Decree 358-CT issued on October 5, 1997, and later with NCADP and its subsidiaries per Decree 61/2000/QĐ-TTĐ issued on June 5, 2000.
- Policies such as Decree No. 34 mention social support for HIV/AIDS cases without discrimination. In addition, Joint Circular No. 29/2000/ TTLB-BLĐTBXH-BYT, dated on December 28, 2000, prohibits areas of employment for HIV-positive people (e.g., health services and orthopedic surgery involving direct contact with human blood and bodily fluids) to prevent transmission.

Early in 2003, the Prime Minister issued Directive 02-2003/CT-TTg to strengthen the organization for and to intensify HIV prevention activities throughout the country. To improve Viet Nam's HIV/AIDS response, the directive establishes guidelines for each ministry regarding its specific functions and responsibilities. It also clearly states that ministries should coordinate with agencies and other political and social organizations to implement the directive and report to the Prime Minister.

On March 17, 2004, the government promulgated the National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a Vision for 2020. The strategy is intended to ensure and intensify participation and multisectoral coordination in HIV/AIDS prevention and control. The strategy's four priority action areas are behavior change communication and prevention; harm reduction; counseling, care, and treatment; and program management, monitoring, and evaluation.

As asserted by respondents, Viet Nam's current policies show strong commitment at the highest level of leadership. The government has also created a favorable environment for the implementation of intervention programs at all levels. The Party Instruction sets forth general guidelines for all activities regarding HIV/AIDS prevention and control and raises societal awareness of the collective actions required to combat HIV/AIDS. The Ordinance of the National Assembly officially provides the legal framework for the interventions. The Government Decree sets out specific functions and tasks for ministries and organizations at all levels.

A key feature of Viet Nam's current HIV/AIDS policies is that they all require a multisectoral response to the epidemic. Policymaking in Viet Nam is almost always a cross-sectoral exercise. One ministry cannot unilaterally formulate policy; however, one ministry should take the lead. In the case of HIV/AIDS policies, it is the MOH that takes the lead role, with the participation of the other ministries. For example, development of the HIV/AIDS strategy involved a steering committee headed by the MOH and including Vice Ministers of seven ministries: Ministry of Planning and Investment (MPI), MOF, MOET, MOLISA, MPS, Ministry of Defense, and MOCI. The team that drafts the strategy consists of key experts from the MOH and other ministries. In addition, the steering committee takes into account the inputs from various workshops. As such, the legal documents guide interventions that go beyond the health sector to address other related social concerns and thus move from reactive to preventive measures that incorporate organizations at all levels. Most crucially, as emphasized by many respondents, the government budget makes financial commitments to HIV/AIDS priorities.

HIV/AIDS prevention is integrated into other socioeconomic policies as well. In 2002, the government approved a series of national development plans that included HIV/AIDS issues as priority targets. For example, the Socioeconomic Development Strategy for 2001–2010 and the Socioeconomic Development Action Plan for 2001–2005 are broken down into the following specific action plans:

- The Comprehensive Poverty Reduction and Growth Strategy up to 2010: with the goals of reducing HIV prevalence among persons age 15 to 49 and among children by 2010;
- The Millennium Development Goals: with the goals of slowing the increase in the spread of HIV/AIDS by 2005 and halving the rate of increase by 2010;
- The HIV/AIDS program, as is included in the National Target Health Program (for prevention of dangerous epidemics, social diseases, and HIV/AIDS).

Policy weaknesses and gaps remain, however—including, most notably, the lack of clear and detailed instructions on how to collaborate with and coordinate among various ministries and agencies. Another problem concerns how to ensure uniform knowledge and approaches among stakeholders. With the

coordinating body under the MOH, it is likely that only vertical links are enforced such that the tendency to a “medicalized” prevention approach persists.

In addition, Viet Nam’s policies do not clearly define roles for NGOs, the private sector, and multisectoral action. Another concern is the lack of commitment to the GIPA principle (Greater Involvement of People Living with HIV/AIDS). The issue has been raised in awareness-raising and advocacy activities, but no legislation makes the commitment clear. Policies address high-risk groups such as IDUs and sex workers, but not other vulnerable groups such as prison inmates and truck drivers.

***National Assembly and Regulatory Environment.*** Viet Nam has systematically created and perfected a set of legal documents on HIV/AIDS prevention and control, starting with the ordinance, the Party Instruction, and the Government Decree. A respondent from the government explained that Viet Nam has drafted over 30 legal documents that cover almost all key areas of prevention and intervention. However, many issues still need to be addressed—for example, insurance and other social policies for health workers and prison staff—and implementation remain inadequate. Recent changes reported by one respondent include standardized legal documents and guidelines covering the operations of institutions in the health sector. As a result, institutions devoted to preventing HIV—from the central to the local levels—now enjoy a higher level of coordination and a clear division of labor. Antidiscrimination and stigmatization are on the public agenda but still need to attain greater prominence as well as a clear legal framework for resolving these issues.

In general, Viet Nam’s legal documents have been amended, to some extent, in accord with international human rights guidelines, albeit still insufficient. For example, current policies do not guarantee all rights of PLHAs (e.g., confidentiality, working rights, rights to medical support, and so forth). A respondent from an international donor organization noted that stigma permeates Vietnamese society, which does not consider HIV/AIDS as a broad social issue. Instead, Vietnamese society tends to link epidemics with sex workers and IDUs, thus hindering effective prevention. Attention has now been paid to safeguarding medical workers as well as IDUs and sex workers—groups that have a right to be treated at medical facilities.

The issue of requirements regarding businesses’ policies and services for employees living with HIV/AIDS has not been highlighted, and no legal framework has been developed. One respondent reported that common practice calls for laying off employees found to be HIV positive. Some recently launched pilot projects (funded by international organizations) are working to improve the employment status of PLHAs.

## ● Resources

By 2003, the national budget for Viet Nam’s HIV/AIDS program had steadily increased to reach 60 billion VND (or approximately 4 million US\$). While respondents acknowledged the increase in the budget, they argued that funding was still insufficient for a population of nearly 80 million. The central government’s per capita budget totaled about 800 VND in 2003, or only 0.05 US\$, which was much lower than that of Thailand (1.6 US\$), for example. In 2004, the national budget was increased to 80 billion VND (approximately 5 million US\$).

The allocation of the budget for NAP is inefficient, according to respondents. The budget for infrastructure and capital equipment represents the largest share (46 percent) of the total budget, at the expense of other activities. Central spending accounts for about 44.8 percent and the authorized budget for the provinces is 55.2 percent. As for types of activities, 60 to 65 percent of the total budget is spent on

medical activities and 35 to 40 percent on nonmedical activities (Market and Development Research Center, 2002).

In addition to the central government budget, there are contributions from local authorities and from ministries. However, only large ministries and the large cities of Hai Phong, Hanoi, and Ho Chi Minh City are authorized to develop their own budgets for HIV prevention activities. The local contribution is estimated to be about 7 billion VND, or about one-tenth of the government budget.

The budget for the HIV/AIDS program is transparent and released to the public. National Assembly meetings provide opportunities for discussing budgeting mechanisms and processes. The budgeting process is centralized, although decentralization takes place at the beginning of the process. Every year, the provinces and ministries prepare their own budgets for submission to the central government. The MOH reviews all the HIV/AIDS budget proposals and formulates an overall budget, identifying objectives in consultation with NCADP. The MOH next works with the MPI, which reviews the budget, makes an overall inventory, suggestions, and changes, and then collaborates with the MOF to balance and finalize the budget. Allocation of funds to the provinces is based on considerations of state priorities and local situations. The national budget is then submitted to the National Assembly for approval (with considerations made from various departments). Finally, the MOH allocates the approved budgets to the provinces and organizations.

To increase the budget for HIV prevention, Viet Nam has been active in seeking international support. Every three months, the government holds a policy forum with international donors and, every year, conducts a separate meeting with donors on HIV/AIDS. As a result, in the past years, foreign assistance has increased significantly. The country also submitted an application to GFATM and received about 12 million USD. In July 2004, Viet Nam was named the 15th focus country of the U.S. President's Emergency Plan for AIDS Relief and received an additional 10 million US\$.

While government and international donor respondents considered the current budget insufficient, Viet Nam is still a poor country, with large increases in the budget unlikely. Suggestions have been made to encourage the government to integrate NAP more effectively with externally funded programs.

According to respondents, at the time of the study, funding was spread over the population rather than targeted to vulnerable groups most affected by the epidemic. Other problems concern the use of funds. Ministries, organizations, and localities sometimes apply their budget allocations from the central government and international donor funds to activities with high delivery rates rather than to well-designed activities with high impact. At issue is inadequate institutional structure and mechanisms—e.g., poor capacity, bureaucracy, complicated administrative procedures, overlapping and confusing functions—that make NAP implementation fall short as a result of ineffective use of national budget and international funds.

## ● Organizational Structure

The National Committee for Prevention and Control of AIDS, Drugs, and Prostitution is the national organizational structure that manages NAP. NAP was translated into the Medium Term Plan with four main objectives: to prevent and limit the transmission of HIV; to limit and decrease HIV incidence and AIDS-related deaths; to reduce socioeconomic harms caused by HIV/AIDS; and to mobilize society to implement policies and promote international collaboration.

NAP is considered a National Target Program with six major components, namely:

1. IEC activities
2. Exposure prevention and control activities in the medical sector
3. Monitoring, care, counseling, and treatment for PLHAs
4. Scientific research
5. International collaboration
6. Community mobilization for participation in HIV/AIDS prevention and control

A Deputy Prime Minister chairs NCADP. The three Vice Chairpersons are the Minister of Health, Minister of Public Security, and Minister of Labor, Invalids, and Social Affairs. In addition, representatives from 13 other ministries, government agencies, and mass organizations sit on the committee. Each ministry, agency, and mass organization has its own focal point and a Vice Minister or an equivalent in charge.

Four offices assist the work of the committee. The first office functions in the Government Office to assist the chairperson. The three other offices are the Standing Office for the Prevention and Control of Prostitution in MOLISA, the Standing Office for the Prevention and Control of Drugs in MPS, and the Standing Office for the Prevention and Control of HIV/AIDS in the MOH.

The provincial level operates with a similar structure; the Provincial People's Committees (PPCs) set up Provincial Committees for Prevention and Control of HIV/AIDS, Drugs, and Prostitution (PCADPs). Either the PPC's Chairperson or Vice Chairperson chairs the PCADPs. District and Commune People's Committees have established similar committees. However, the establishment of the Provincial AIDS Standing Bureaus (PASBs) is not uniformly institutionalized. The bureaus are either independent offices or sections of offices or are located within the Provincial Center for Preventive Medicine, depending on local authorities' perception of their role. At the time of this study, 43 out of 61 provinces had established PASBs.

According to respondents, several problems plague the NAP organizational structure. At the national level, responsibility for program management rests with two bodies: the NASB (National AIDS Standing Bureau) under the MOH and the MOH's AIDS Division. In principle, NASB assists both NCADP and the MOH in planning and coordinating various HIV prevention activities under NAP (including promotion of cooperative activities among government agencies, the private sector, and mass organizations). In particular, the MOH's AIDS Division assists the MOH in coordinating HIV prevention efforts in the health sector throughout the country. However, the existence of two management bodies has created overlapping areas of authority and resulted in many misunderstandings. While a Deputy Prime Minister is responsible for overseeing NAP, he is too busy with other responsibilities to perform the needed oversight. At the same time, no one Vice Chairperson of NCADP is able to devote full time to NAP. In addition, conflicting views within NCADP about the relationship between HIV/AIDS and sex work and drug use hamper the committee's efforts to address the epidemic.

The vertical structure from NCADP downward to the PCADPs is also weak, largely because of inadequate staff resources. Most NCADP and PCADP staff carry a heavy workload and cannot attend to all their responsibilities. While many received training, they are still deficient in program design, planning, and coordination skills. In addition, the problem of poor communication between NCADP and the PCADPs hinders timely and effective coordination and management.

Similarly, horizontal coordination among ministries, government agencies, and mass organizations is limited at both the central and local levels. Staff cannot participate full time in NCADP and the PCADPs because of other job responsibilities. While the MOH is mandated as the focal point for the HIV/AIDS program, it faces difficulties in securing collaboration from other ministries, agencies, and organizations. Supervision and monitoring are carried out regularly, but in superficial and bureaucratic ways.

As part of the National Strategy on HIV/AIDS Prevention and Control in Viet Nam, announced in March 2004, the government has outlined nine action programs. Details of the programs, as well as provincial implementation plans, are to be developed and submitted for approval by December 2004.

## ● **Multiministry Involvement**

The activities under NAP represent a multisectoral strategy for preventing HIV. In addition to the MOH, MOLISA, and MPS, the strategy involves other ministries, state agencies, and mass organizations, including those with representatives on NCADP, namely, the MOCI, MOF, Ministry of Justice, MOET, MPI, Ministry of Agriculture and Rural Development, Government Office, Custom Office, Youth Union, Women's Union, Trade Union, Border Defense, and Committee for Ethnic Minorities and Mountainous Areas, as well as other organizations and the local governments of Viet Nam's 61 provinces. The Government Decree announcing the new national strategy in March 2004 assigned tasks to relevant ministries in order to implement the multisectoral approach.

Ministries, state agencies, local government, and mass organizations represented on NCADP are asked to participate in the development of Medium-Term Plans formulated for a five-year period. Every year, NASB works with each ministry/sector member of NCADP to develop a specific action plan and to evaluate plan implementation at year's end. The participation and roles of the ministries and organizations vary with their areas of expertise; for example, MOLISA is responsible for the care and support of affected people, including groups targeted as "social evils." MPS is in charge of drug control, and the National Committee for Population, Family, and Children is responsible for policies relating to family and children. Other participating mass organizations include the Fatherland Front, Vietnamese Women's Union, Youth Union, Peasant Association, and Viet Nam General Federation of Laborers, which work on awareness-raising and advocacy activities. MPI and MOF are involved in overall planning. In terms of budget, depending on the assigned tasks, some ministries have a supplementary budget added to their allocation from the state budget.

## ● **Foreign Technical Assistance and Foreign Experience**

The most important type of international cooperation takes the form of technology transfer and experience learning. Viet Nam has sent several delegations at different levels, including the ministerial level, to visit countries within the region. For example, more than 20 study tours visited Thailand. Delegations also traveled to other countries, including Australia, Holland, Switzerland, and the United States. These visits have led to increasing consensus on approaches and measures to address the HIV/AIDS epidemic. In addition, the government has invited several experts to provide training and guidance and share their experiences. Foreign assistance has also helped underwrite a number of training courses. Key government officials have participated in almost all major international efforts (e.g., conferences and large forums), and the government regularly exchanges information and materials with neighboring countries.

In 2004, Viet Nam became one of the 15 focus countries in the U.S. President's Emergency Plan for AIDS Relief—an effort that will increase the country's resources for HIV/AIDS. According to respondents, specific programs that need increased technical assistance include the following:

- *Prevention of mother-to-child transmission (PMTCT).* To date, international assistance has focused only on the treatment phase (4 US\$ per mother), not on assistance for safe infant feeding and nutritional support.
- *Access to highly active antiretroviral treatment (HAART).* Given HAART's expense and the government's limited funds, the poor cannot get access to treatment. With funding from the Emergency Plan, Viet Nam expects to be able to support treatment for 13,000 people.
- *Public information and education.* International support is essential for reaching remote areas. Specific needs include vehicles and IEC materials. Germany has provided audio/visual equipment and IEC materials for distribution to communes in 15 provinces. International assistance can also be used for behavior change communication.
- *Monitoring and evaluation.* Standard laboratories and modern equipment are needed.
- *Vulnerable populations.* International assistance is needed for addressing issues associated with IDUs, sex workers, and MSM.

In general, technical assistance to date has been limited to model and pilot projects rather than directed to scale-up or wide application. The government has no money to continue these projects and thus faces a sustainability problem—as well as the problem of harmonizing donor aid with lessons learned.

## ● Public Information and Education

One of NAP's main tasks calls for carrying out IEC programs for HIV/AIDS. The government has taken steps to design laws, policies, and specific action plans that support and strengthen activities to raise the general population's awareness of HIV/AIDS. Communication policies have been regularly revised and amended to address the general population's misconceptions about HIV/AIDS and to reduce stigma and discrimination against PLHAs and their families. The lessons learned in various localities from communication and education programs for behavioral change have been updated regularly and shared with other localities, sectoral agencies, and mass organizations to ensure delivery of a common message on HIV/AIDS.

In 2002, the government approved the National Strategy on Strengthening Reproductive Health. Reproductive health and sexual health education programs have been regarded as one of the national priority programs. Most HIV/AIDS communication activities targeting Vietnamese youth have been integrated into the reproductive/sexual health programs such that HIV/AIDS and reproductive health issues are not separated. The programs, which are revised and updated annually, have succeeded in mobilizing the participation of mass media and mass organizations.

Alongside national strategies aimed at increasing IEC, Viet Nam has set forth additional laws, instructions, and guidance to increase awareness among vulnerable groups and those who practice high-risk behaviors, such as IDUs, sex workers, young people, migrants, and prison inmates. However, the government has not yet issued any separate instructions or regulatory documents targeting MSM.

The HIV prevention program has mobilized all mass media institutions, including television and radio—both national and local—and has implemented an extensive range of IEC activities. For example, about 2,000 programs air annually on HIV/AIDS-related subjects, and NASB organizes four press conferences every year. Training sessions on HIV/AIDS are held for journalists every year.

In general, the information delivered through various IEC efforts is accurate and current, providing people with basic knowledge about the epidemic and ways to prevent infection. However, with messages delivered through one-way communication channels, audiences have little opportunity for offering feedback on needed programming improvements. In addition, messages still reflect some bias, focusing mainly on risks and threats—creating fear of PLHAs within the community or linking the causes of HIV/AIDS to immoral lifestyles and thus failing to address discrimination and stigmatization, despite some progress.

With respect to information on HIV prevention, it has tended to threaten people and generate fear. Now, the government has capacitated cadres of the mass media institutions so that they can disseminate more appropriate messages that deliver practical information (e.g., where to go for services and so forth). Some initial efforts are underway to engage PLHAs in television and radio broadcasts to help reduce the fear associated with HIV/AIDS. The media have already presented pictures and scenes of activities supporting PLHAs.

NAP has succeeded in making HIV testing available. However, most tests are mandatory; voluntary testing has yet to take root. In any event, testing capability is far short of demand due to limited resources and technology. In fact, public information and the mass media rarely mention testing and encourage only those considered at risk to be tested. In addition, test results need to be better managed to ensure confidentiality. Counseling is also available but is of poor quality and not particularly accessible. Owing to lack of training, many counselors are ill-equipped to deliver needed counseling services. The newspapers and television have mentioned counseling, but those in need do not know where to go for such services. Telephone hotlines are available, but only a few people have access to them.

Education on HIV/AIDS in the schools is linked to civil education and moral education through extra-curricula. Education focuses on drug control and the risk of HIV infection as well as on basic knowledge and facts about the epidemic. Nevertheless, education on HIV/AIDS issues is poor and materials are outdated.

## **KEY POINTS: GOVERNMENT RESPONSE IN VIET NAM**

- Although Viet Nam has no law on HIV/AIDS, it has developed several key documents (e.g., decrees, ordinances, and Party Instructions) that establish the legal and institutional framework for addressing the epidemic and provide guidelines on national collective efforts for responding to HIV/AIDS. In terms of policy gaps, NGOs, the private sector, and multisectoral actors lack clearly defined roles. In addition, Viet Nam has evidenced no commitment to the GIPA principle and does not guarantee some rights of PLHAs. Voluntary testing has not taken root—many tests are mandatory—and pre- and post-counseling needs to be improved.
- Overall, respondents felt that the budget is insufficient to meet current needs and that existing resources are used inefficiently. For example, programs may try to focus on wide coverage rather than on achieving high impact, often targeting the general population as opposed to groups most in need of prevention, care, and support.
- Viet Nam has developed an organizational structure that seeks to promote multiministry involvement at the national level and that establishes provincial and local mechanisms for implementing HIV/AIDS programs. However, more needs to be done to foster collaboration and build capacity.

## ● ROLE OF NGOs AND CIVIL SOCIETY

In general, Vietnamese NGOs exhibit limited capacity, although they are most active in HIV/AIDS prevention. While local NGOs have played a minor role at the national level, for example, in the planning of NAP, they are particularly active at the local level, working on their own initiatives in HIV prevention, implementing activities under NAP, and providing technical support to communities. Every three months, a task force of Vietnamese and international NGOs meets to discuss coordination and collaboration, including activities in HIV/AIDS prevention. The major NGOs involved in HIV/AIDS prevention are the Vietnamese Community Mobilization Center for HIV/AIDS Control (VICOMC); STI/HIV/AIDS Prevention Centre (SHAP); Supporting Center for HIV/AIDS/STI Control (SUCECON); Institute for Social Development Studies (ISDS); Center for Public Health Research and Development (COHED); and the Center for Public Health and Development (CEPHED). Some are particularly helpful in reducing stigma and discrimination. For example, COHED is now working on the links between communities and the 05 and 06 rehabilitation centers (for sex workers and drug users). Thus, it facilitates dialogue and humanizes HIV/AIDS, helping to reduce stigma. The Center for Social Development Studies (CSDS) is another center involved in operational research on the stigma issue.

According to respondents, in terms of faith-based organizations, which are limited in number, some are involved in HIV/AIDS prevention. Some Buddhist temples provide care for PLHAs. A few Catholic and other Christian churches now talk with their followers about HIV/AIDS.

PLHAs are starting to become more engaged in HIV/AIDS program efforts, notably through the formation of peer self-support groups working in community care and family care; participating in meetings and conferences to share their views and experiences; and taking part in IEC campaigns.

The participation of academia is relatively new but important. Members of academia undertake research, assessments, and training and serve as technical advisors on various projects under NAP and international organizations.

As for the healthcare profession, some health centers are reluctant to serve PLHAs, even though policies mandate otherwise. In other cases, some professionals discriminate against PLHAs, not treating them as they would other patients.

Women's groups are especially active in HIV/AIDS awareness-raising activities and social support, with a strong commitment from mass organizations and NGOs. The government has asked the Vietnamese Women's Union, the state-organized mass organization, to work at both the national and community levels, mainly in community development and IEC, including HIV prevention.

Until recently, business was not involved at all in HIV/AIDS programs. The common practice is to fire employees found to be HIV positive. Some initiatives are underway to raise employers' and employees' awareness about HIV/AIDS.

Advocacy organizations made up of individuals from target groups, particularly sex workers and IDUs, have organized into self-support and peer education groups. They focus mainly on IEC activities organized either by the government or local and international NGOs.

Local celebrities and other prominent figures have not systematically supported the HIV/AIDS program. Occasionally, singers and actors perform in shows with awareness-raising objectives. The government encourages such participation in entertainment activities but has not outlined a comprehensive plan.

With respect to HIV/AIDS prevention and care, NGOs and civil society are increasing in number, size, and quality. Therefore, it is incumbent upon the government to work more closely with such groups, creating an appropriate legal framework and necessary support.

## **KEY POINTS: ROLE OF NGOs AND CIVIL SOCIETY IN VIET NAM**

- Viet Nam's NGOs and civil society are still emerging; however, HIV/AIDS has been one area where NGOs have been active—particularly at the local level. Their role in national policymaking has been more limited.
- Vulnerable groups and those already affected by the disease have begun to organize themselves into advocacy, support, and peer-education groups.
- Commitment to addressing HIV/AIDS is limited, though growing, in faith-based communities and among businesses. To date, women's groups have been active in awareness-raising activities and social support.

## ● RESEARCH, MONITORING, AND EVALUATION

Two programs—sentinel surveillance and behavior surveillance— provide information on trends in HIV transmission, along with behavior indicators for some target populations.

- ***HIV sentinel surveillance*** began in 1994 in eight provinces and has expanded to 40 provinces (out of 61). Using WHO guidelines, surveillance focuses on six target populations: IDUs, female sex workers, STI patients, tuberculosis patients, pregnant women, and army conscripts or army candidates. Horizontal surveillance is repeated annually (during the June–August period), with a sample of 400 persons for the high-risk population and 800 persons for the low-risk population. The HIV/AIDS reporting system operates as follows: The AIDS Divisions in provincial health departments are responsible for collecting and compiling a monthly report on test results and for detecting and monitoring HIV/AIDS patients in their own provinces in accordance with a national report format and report system. The AIDS Divisions then send data and information to the local Pasteur Institute and Institute of Epidemiology and Hygiene as well as to the National Institute of Epidemiology and Hygiene and AIDS Division of the MOH. The results of the HIV sentinel surveillance are reported by the end of the year.
- ***Behavioral surveillance surveys*** were initiated in Viet Nam in 2000 with the technical and financial assistance of the U.S.-based Family Health International. Viet Nam conducted two rounds of behavior surveillance surveys in 2000 and 2001 in five provinces: Can Tho, Da Nang, Hai Phong, Hanoi, and Ho Chi Minh City. Target populations were street-based female sex workers, female sex workers in karaoke bars, IDUs, and migrant workers (e.g., male construction workers, long-distance truck drivers, and seafarers/fishermen).

In terms of monitoring and evaluation, the current system is unable to provide information for calculating all significant indicators for evaluating NAP's effectiveness. According to respondents, the surveillance system did not meet all the criteria of the WHO guidelines. Coordination at all levels is weak, and current data focus mainly on program activities.

### KEY POINTS: RESEARCH, MONITORING, AND EVALUATION IN VIET NAM

- Viet Nam has instituted the use of both HIV sentinel surveillance surveys and behavioral surveillance surveys to provide some information on both the general population and groups at high risk for HIV infection.
- Respondents noted gaps in the measurement of key indicators and expressed the need for improved data collection methods, dissemination, and use.

## ● STIGMA AND DISCRIMINATION

In terms of legal protection of human rights, Vietnamese law provides for and secures equity between men and women. In addition, the Protection of the People's Health Code rules that "all Vietnamese citizens are entitled to have access to health care services regardless of any population groups they belong to." With respect to the epidemic, the Ordinance on HIV/AIDS Prevention passed by the Standing Committee of the National Assembly already stipulates that "[p]eople infected with HIV/AIDS shall not be discriminated" against. The MOH's regulation on professional handling of HIV/AIDS cases (issued according to Decision No. 2557/QD-BYT on December 26, 1996) also states that "[s]tipulations in this document completely secure the principle of non-discrimination, non-prejudices and confidentiality for people infected with HIV and AIDS patients."

Still, respondents stated that, owing to fear of HIV/AIDS, the level of stigma remains high in Viet Nam's urban and rural areas, although the situation in the large cities has improved considerably as compared with earlier years. People working in the private and informal sector face greater stigmatization due to the fact that IEC activities do not reach them. Worse, stigmatization has forced HIV/AIDS to go underground. PLHAs are likely to be unemployed and frequently lack access to care and treatment. They are abandoned and stigmatized and are considered to live a "bad lifestyle."

Several facts come together to explain the level of stigmatization, most notably society's lack of adequate information about HIV/AIDS, shortcomings in IEC activities, and the association of HIV/AIDS with "social evils," which is prevalent in the mass media.

Respondents felt that the government generally lacks a concrete plan for addressing stigma and discrimination. Increasingly, however, the government is disseminating more progressive messages to reduce stigmatization. Some top leaders now participate in publicized events, such as visiting with PLHAs. For example, one respondent noted that the Vice Minister of the MOH shook hands with a person living with HIV/AIDS and that the Chairwoman of the National Committee for Population, Family, and Children has requested the delinking of social evils and HIV/AIDS.

### KEY POINTS: STIGMA AND DISCRIMINATION IN VIET NAM

- While Vietnamese laws guarantee equality for all citizens and protect their right to access to health care services, levels of stigma and discrimination remain high.
- The prevailing perception in Viet Nam seems to be that HIV/AIDS is linked to "social evils" or "bad lifestyles"—which contributes to stigma and discrimination against PLHAs and affected communities.
- To date, respondents felt that the government does not have an action plan for combating stigma and discrimination. However, respondents were able to identify some examples of steps taken by top leaders to help reduce stigma—though these seem to be sporadic.

# RECOMMENDATIONS AND CONCLUSIONS

## ● RECOMMENDATIONS AND CONCLUSIONS

In its 2000 update on the global HIV/AIDS epidemic, UNAIDS identified nine common features of effective national responses (see box). “Political will and leadership” was the first item on the list. What attests to the importance of national political commitment is the fact that it plays a critical role in promoting all of the other eight common features of effective responses. For example, strong political commitment from a country’s top leaders can help mobilize resources, facilitate buy-in across sectors, encourage community-based involvement, ensure the wherewithal to support a sustained response, and promote openness in terms of addressing HIV/AIDS and caring for those affected by the disease. Understanding and strengthening national political commitment is therefore essential for confronting the HIV/AIDS epidemic—particularly in low-prevalence countries where there is still time to act before the epidemic spreads. These are the countries where political commitment early on can make a difference—but the time to act is now.

### UNAIDS: Common Features of Effective National Responses

1. Political will and leadership
2. Societal openness and determination to fight against stigma
3. A strategic response
4. Multisectoral and multilevel action
5. Community-based responses
6. Social policy reform to reduce vulnerability
7. Longer-term and sustained response
8. Learning from experience
9. Adequate resources

*Source: UNAIDS (2000)*

This study considered various aspects of national political commitment in Viet Nam. The last decade has witnessed a rapid increase in the Vietnamese government’s political commitment to HIV/AIDS prevention and control. The government established and now regularly revises its legal framework and institutional arrangements for the national efforts crystallized in the National AIDS Program. Policies and interventions have become increasingly multisectoral in nature and reflect a long-term perspective. In addition, the government encourages the participation of civil society in both NAP and other related activities. The country’s top leadership is also becoming more receptive to international expertise and experience.

Still, many challenges lay ahead, notably the perfection of policies, greater engagement of top leaders, building the capacity of the institutional infrastructure, and greater involvement of civic organizations (including PLHA groups) and the private sector in HIV/AIDS activities. IEC and advocacy efforts remain deficient, particularly with respect to reducing stigma and discrimination within the government and communities. Other problems center on resource mobilization and efficient and more effective use of international assistance.

In light of the study’s findings and respondents’ views, the report proposes the following sector-specific recommendations for strengthening Viet Nam’s political commitment and the national response to HIV/AIDS:

## ● Top Leadership

- Consensus building on the issues, particularly approaches and measures to address the impact of HIV/AIDS.
- More direct involvement of leaders at all levels in NAP and other related activities.
- A vice chairperson of NCADP working full time for NAP.
- Closer links between policymakers, service providers, and the scientific community.
- Better communication between leaders and society.
- More advocacy aimed at leadership at all levels, including improved understanding of the epidemic's socioeconomic impacts.
- Government more receptive to international experiences and expertise.

## ● Government Response

### *Policy Formulation*

- Detailed instructions for policy implementation.
- Commitment to the GIPA Principle and protection of human rights of PLHAs.

### *Legal/Regulatory/Environment*

- Gaps to be filled.
- Mechanism for better implementation of policies.
- Clear instruction and guidelines.
- Policies for business regarding their policies and services for employees living with HIV/AIDS.

### *Resources*

- Increased government budget allocation.
- Greater mobilization of resources from localities.
- Improved resource efficiency and use.

### *Organizational Structure/Multiministry Involvement*

- Encourage and create favorable conditions for participation of civil society in NAP.
- Build capacity for NAP organizations, including employment of full-time staff.
- Improve coordination and collaboration structure and mechanisms through ownership building and participation.
- Build consensus on approaches and measures for tackling HIV/AIDS.
- Involve lower levels more directly in planning processes.

### *Foreign Technical Assistance and Foreign Experience*

- Build capacity of Vietnamese institutions to internalize international expertise, experience, and skills.
- Budget for sustainability and scale-up of pilot programs.

### *Public Information/Education/Use of Media*

- Improve quality and content of IEC materials.
- Promote meaningful involvement of PLHAs.
- Eliminate messages that add to stigmatization and delink HIV/AIDS from “social evils.”

## ● Role of NGOs and Civil Society

- Adoption of a legal framework for better operation of NGOs and civil society.
- Capacity building for NGOs.
- Collaboration mechanism.
- Promotion of inclusion (e.g., participation in all areas of NAP).

## ● Research, Monitoring, and Evaluation

- Improve data quality.
- Encourage local authorities to use the data.
- Facilitate wide dissemination of data.

## ● Stigma and Discrimination

- Better incorporation of stigma and discrimination reduction efforts into policies.
- Delinking HIV/AIDS with “social evils” legislation and approaches.
- Improved IEC activities to reduce and eliminate stigma.
- More involvement of civil society in NAP to reduce stigma.
- Greater participation of PLHAs in NAP.

# APPENDICES

# ● APPENDIX A: QUESTIONNAIRE

## 1. What Do You Understand Political Commitment to Mean?

- How would you measure it?
- How would you know it when you see it?

## 2. Top Leadership

- Does the president or prime minister regularly make strong statements in support of HIV/AIDS programs?
- Is the president or prime minister seen as leading the effort against HIV/AIDS? Why or why not?
- In what ways, if any, does the president or prime minister indicate concern or commitment?
- How has this changed over time, if at all?
- Are there any personal connections to the HIV/AIDS epidemic by top leadership? E.g., a family member is affected by the disease. If so, is this openly disclosed or discussed?
- Does the top leadership contribute toward reduction of stigma? If so, in what ways?
- What has been the biggest success in the battle against HIV/AIDS? Who would you credit for this success?
- What has been a failure or shortcoming in the leadership's actions (now or before)?
- Is there broad-based leadership for political commitment or is it largely driven by one or two individuals?

## 3. Policy Formulation

- Is there a national HIV/AIDS policy? Please describe. What are its strengths/weaknesses? Was it developed in a participatory manner? If so, how? Who participated?
- Is there a national HIV/AIDS law? Please describe. What are its strengths/weaknesses? Was it developed in a participatory manner? If so, how? Who participated?
- Is there a national HIV/AIDS strategic plan (NSP)? What are its strengths/weaknesses? Was it developed in a participatory manner? If so how? Who participated?
- Is there commitment to the GIPA (greater involvement of people living with HIV/AIDS) principle? E.g., People living with HIV or AIDS (PLHAs) are included in a meaningful way in the policy formulation processes of the country. Has this commitment been codified into national policies or law?
- Has the NSP been fully implemented?
- Has the NSP been costed?
- Are there policies/laws that focus upon human rights? Of PLHAs? Are these HIV specific or included in other laws/policies?
- Are there specific policies to address stigma and discrimination related to HIV/AIDS?

## 4. Resources

- Does the country commit a significant amount of its own budget to the national HIV/AIDS program? How about ministries other than the Ministry of Health? If so, which?
- Is the national HIV/AIDS budget transparent? Is it published and/or available for public review?

- If budget process is centralized, are funds allocated to the provincial budgets for HIV/AIDS?
- If budget process is decentralized, do provincial budgets allocate funds for HIV/AIDS activities?
- Do resources get from the national to the local level?
- Has there been a recent increase in government funding for HIV/AIDS?
- Has the country submitted an application to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM)?
- Is the Country Coordinating Mechanism (CCM) multisectoral in nature? Does it include PLHAs and other affected populations?
- How do you think international donors view the adequacy of funding by the government for the HIV/AIDS program?
- Is the country pursuing donor support for HIV/AIDS? To what extent?
- Is the available funding actually spent?
- Is available funding used efficiently?
- Is AIDS a priority for debt relief funds?
- How would you characterize resource availability? Lots? Not enough? Okay?
- Is funding targeted to vulnerable groups most affected by the epidemic or to general population and/or low-risk populations?
- How are resources allocated according to prevention, treatment and care, and mitigation—is the allocation level balanced?

#### **5. Organizational Structure/National AIDS Control Program**

- Is there a central command structure or Steering Committee for the National AIDS Control Program (NACP)? If so:
  - How significant is it? Strengths? Weaknesses? Actions needed?
  - Is the head of the NACP highly placed within the government structure? Is he/she seen as having access to the top leadership of the country?
  - Are there sufficient personnel resources in the NACP?
  - Is the NACP multisectoral in focus? In its planning/prioritizing function or in program implementation?
  - Who are its members?
  - Are the members adequately trained and knowledgeable of the issues?
  - Does the HIV/AIDS program have a set of specific goals and targets?
  - Is there a specific mechanism to monitor the implementation of the NACP?

#### **6. Multi-Ministry Involvement**

- Which ministries, besides health, are significantly involved in the HIV/AIDS program? In what ways?
- Are implementation activities strongly supported by these ministries?
- Do ministries have their own dedicated HIV/AIDS budgets? Personnel?

#### **7. Role of NGOs and Civil Society in Implementation**

- To what extent are local NGOs involved in addressing the HIV/AIDS epidemic?
- Name the major NGOs that have HIV/AIDS programs.
- How are NGOs involved in the planning and implementation of the NACP?
- Do any organizations actively pursue issues related to stigma and discrimination? If so, which? How are they doing this?
- How supportive is each political party in addressing HIV/AIDS issues? What specific actions have they taken?

- Comment on the commitment of the following:
  - Faith-based groups?
  - PLHA groups?
  - Academia?
  - Health care professionals?
  - Women’s groups and other human rights groups?
  - Business?
- Are there advocacy organizations made up of individuals from target groups? E.g., sex workers? Men who have sex with men (MSM)? Injection drug users (IDUs)?
- Are local celebrities and/or sports figures involved in open support of AIDS programs? Does the government encourage this?
- Has there been an increase in the number, size, and quality of roles played by civil society?

**8. Foreign Technical Assistance and Foreign Experience**

- Does the government analyze and study the experience of neighboring countries? E.g., Mekong region drawing on the experience of Thailand.
- Does the government send delegations to visit countries with effective HIV/AIDS programs?
- What specific programs/populations are of concern requiring increased technical assistance?

Programs	Populations
Voluntary counseling and testing (VCT)	IDUs
Prevention of mother-to-child transmission (PMTCT)	Sex workers
Access to highly active antiretroviral treatment (HAART)	MSM
Public information and education	Youth
Monitoring and evaluation	Women
Condom distribution	Heterosexual men
Other	Other

- Is available foreign technical assistance used to its maximum capacity?

**9. Public Information/Education/Use of Media**

- Does the government use the media to address the HIV/AIDS problem? In what ways? If not, what other mechanisms are used to address the HIV/AIDS problem and reach the public with information?
- Does the government give accurate information to the public about:
  - Preventing HIV?
  - ABC (Abstinence, Be Faithful, Use Condoms) campaign? Correct and consistent use of condoms?
  - VCT?
- How is this information distributed/disseminated? Is there a national social marketing campaign addressing these issues?
- Is life skills education incorporated into the school curricula? What does it include? At what school levels?

**10. Legal/Regulatory Environment**

- Is there a special HIV/AIDS committee in the legislature?

- Is anti-discrimination legislation in place and enforced? Describe (e.g., employment testing, access to insurance).
- Has there been an effort to improve laws pertaining to HIV? If so, how? If not, why not?
- Have any HIV/AIDS-related constitutional amendments been passed or considered?
- Are the country's HIV/AIDS laws in accordance with international human rights guidelines?
- Are there laws safeguarding the human rights of vulnerable populations?
- Do businesses have clear and mandatory requirements regarding their policies and services for employees living with HIV/AIDS?

### **11. Monitoring and Evaluation**

- Is there an effective HIV surveillance system? Describe.
- Does information reach local-level policymakers or remain only among the highest-level policymakers?
- Are priorities established systematically and based on the best available information?
- Are there specific benchmarks/goals for each of the main components of the NACP?

### **12. Program Components as Indicators of Political Commitment**

- Does the NACP program implementation include components on:
  - VCT
  - PMTCT
  - HAART
- If not, is the program working to include each one?
- Are there specific prevention and care programs focused on vulnerable populations (e.g., sex workers, truck drivers, migrant workers, MSM, IDUs, orphans)? Describe.
- Are these programs reviewed and evaluated regularly by independent experts?

### **13. Stigma and Discrimination**

- Is there a high level of stigma? For example, are people afraid to get tested? Are people afraid to disclose their HIV status because of violence, job loss, and ostracism?
- In your opinion, what are the root causes of stigma in this country?
- Are policymakers doing anything to address stigma? If yes, please describe what specific actions are being taken.

## ● APPENDIX B: REFERENCES

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