Report
Evaluation of the National AIDS Program
(for VIE/98/006 Project – HIV/AIDS Capacity Development)

Independent evaluator:
Market and Development Research Center

With technical support:
Research Triangle Institute

Hanoi, May 2002
Report
Evaluation of the National AIDS Program
(for VIE/98/006 Project – HIV/AIDS Capacity Development)

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Opinions and judgments in this report are of the authors only and do not necessarily reflect the view of the Project Management Unit.

Hanoi, May 2002
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<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>BSS</td>
<td>Behavioral Surveillance Surveys</td>
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<tr>
<td>CEMA</td>
<td>Committee for Ethnic Minorities and Mountainous Areas</td>
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<td>CHC</td>
<td>Commune health center</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FP</td>
<td>Family planning</td>
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<td>GSO</td>
<td>General Statistic Office</td>
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<td>GTZ</td>
<td>German Technical Cooperation</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immuno-deficiency virus &amp; Acquired Immuno-deficiency Syndrome</td>
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<td>IDU</td>
<td>Injecting drug user</td>
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<td>IEC</td>
<td>Information – Education – Communication</td>
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<tr>
<td>IPMN</td>
<td>Institute for Protection of Mothers and Newborns</td>
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<tr>
<td>KABP</td>
<td>Knowledge, Attitudes, Behavior and Practice</td>
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<tr>
<td>NIHBT</td>
<td>National Institute for Hematology and Blood Transfusion</td>
</tr>
<tr>
<td>NIHE</td>
<td>National Institute of Hygiene and Epidemiology</td>
</tr>
<tr>
<td>MARD</td>
<td>Ministry of Agriculture and Rural Development</td>
</tr>
<tr>
<td>MCH-FP</td>
<td>Maternal and Child Health – Family Planning</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring &amp; Evaluation</td>
</tr>
<tr>
<td>MOCI</td>
<td>Ministry of Culture and Information</td>
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<tr>
<td>MOET</td>
<td>Ministry of Education and Training</td>
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<tr>
<td>MOF</td>
<td>Ministry of Finance</td>
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<tr>
<td>MOFA</td>
<td>Ministry of Foreign Affairs</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOPS</td>
<td>Ministry of Public Security</td>
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<tr>
<td>MOJ</td>
<td>Ministry of Justice</td>
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<tr>
<td>MOLISA</td>
<td>Ministry of Labour, Invalid and Social Affairs</td>
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<td>MPI</td>
<td>Ministry of Planning and Investment</td>
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<td>MTP</td>
<td>Medium Term Plan</td>
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<td>NAC</td>
<td>National AIDS Committee</td>
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<td>NAB</td>
<td>National AIDS Bureau</td>
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<td>NAP</td>
<td>National AIDS Program</td>
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<td>NCADP</td>
<td>National Committee for Prevention and Control of AIDS, Drug and Prostitution</td>
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<td>NASB</td>
<td>National AIDS Standing Bureau</td>
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<td>NCPFP</td>
<td>National Committee for Population and Family Planning</td>
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<tr>
<td>Ob-Gyn</td>
<td>Obstetric and Gynecology</td>
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<td>PAC</td>
<td>Provincial AIDS Committee</td>
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<tr>
<td>PASB</td>
<td>Provincial AIDS Standing Bureau</td>
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<tr>
<td>PHD</td>
<td>Provincial Health Department</td>
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<tr>
<td>PCPM</td>
<td>Provincial Center for Preventive Medicine</td>
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<tr>
<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
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<td>PMCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>PPC</td>
<td>Provincial People’s Committee</td>
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<tr>
<td>PFP</td>
<td>Population and Family Planning</td>
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<tr>
<td>RTI</td>
<td>Research Triangle Institute</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>STD</td>
<td>Sexually Transmitted Diseases</td>
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<tr>
<td>Acronym</td>
<td>Term</td>
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<td>--------------------------------</td>
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<tr>
<td>SW</td>
<td>Sex worker</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDCP</td>
<td>United Nations Drug Control Programme</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<tr>
<td>USD</td>
<td>US Dollars</td>
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<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
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<tr>
<td>VNA</td>
<td>Vietnam News Agency</td>
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<td>VWU</td>
<td>Vietnam Women's Union</td>
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<td>VYU</td>
<td>Vietnam Youth Union</td>
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<td>WHO</td>
<td>World Health Organization</td>
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The Evaluation of the National AIDS Program (NAP) in the period January 1996 to June 2001 undertaken by the Market and Development Research Center (MDRC) comes under the Project VIE/98/006 “Strengthening Capacity in Management, Policy Formulation and Coordination of HIV/AIDS Activities in Vietnam.” The Project is implemented by the National AIDS Standing Bureau (NASB), and is administrated by the United Nations Development Programme (UNDP) with financial support from the Australian Agency for International Development (AusAID).

The evaluation of the NAP was implemented from June to September 2001. The information and data collected from this evaluation demonstrate the considerable commitment of Vietnamese Government officials in coping with the HIV/AIDS epidemic. The evaluation found that there is a wide range of activities carried out daily throughout the country, in all levels of social structure, in order to combat the epidemic. The evaluation also revealed many difficulties faced by people who cope in silence with HIV. This report is in recognition of all these people.

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Finally, this is the first-ever independent evaluation of the NAP. Also it was the first evaluation of a national program carried out by a local NGO. Both facts show the openness of the VIE/98/006 project, whose support agencies are from NASB, UNDP and UNAIDS. We thank NASB, UNDP and UNAIDS for giving us this valuable chance to contribute to efforts against this global disease and to demonstrate the capacity of a local NGO.

On behalf of the authors:

Prof. Pham Bich San, PhD
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EXECUTIVE SUMMARY

Epidemic

During period January 1996 – 2001, reported HIV infected cases increased almost 10 times - from nearly 4,000 at the end of 1995 to nearly 40,000 by October 26, 2001. In the same period, reported AIDS cases increased almost 15 times - from more than 400 to nearly 6,000. Surveillance data showed an increased infection rate in all groups of the population - both those at risk and general population. By 2000, the infection rate among new military recruits was 0.95% - close to the rate that is considered to be a generalized epidemic.

At the same time, surveillance data and reported cases also revealed the changing face of the epidemic. The percentage of Injecting Drug Users (IDUs) among reported cases had been decreasing in contrast to the increase of sexual transmission. The infection rate among pregnant women increased 10 times from 1994 to 2000. HIV infections were occurring at a younger age. Percentages of infected people under 30 years old increased almost 3 times from 1995 to 2000. Young infected people, who were more likely to be sexually active, contributed to the spread of HIV in the general population.

The period from 1996-2001 could be viewed as transitional, from a concentrated level to a generalized level of epidemic. There were more people infected, people living with HIV/AIDS (PLWHA) belonged to different social groups, there were more AIDS patients, and the NAP had to move to a new strategy, where infection prevention is in tandem with care and treatment for PLWHA.

Policy environment

In the period 1996-2001 the NAP translated strong political wills into action. The document triad - Party Instruction No 52, National Assembly Ordinance and Government Decree No 34 which were issued in 1995 and early 1996 set the legal frame and provided guidance for development of policy and program on HIV/AIDS in the country. A series of legal and policy documents were produced afterwards to regulate and instruct on different aspects of HIV/AIDS prevention and control activities. It is fair to say that the policy environment was quite favorable for the NAP.

Organization of National AIDS Program and capacity of executive system

National AIDS Program (NAP) had been developed as a government program with important support from UN and international communities. The period 1996-2001 witnessed two major changes in organization of the NAP.

The first change occurred in 1997 when the NAP went beyond the health sector to become a multi-sectoral program with an official government system at all levels as result of the government Decision No 1122 on HIV/AIDS program organizational structure. Three years later, in mid-2000, the government decided to merge the National AIDS Committee (NAC) with committees concerned with the prevention and control of illicit drugs and prostitution to become National Committee for Prevention and Control of AIDS, Drugs and Prostitution (NCADP). This change caused some turbulence in the organization of the NAP execution system, which took some time to reorganize in all localities. However, as the NAP was still led by a government multi-sectoral committee with 17 members, it could maintain multi-sectoral approach within the government system. The NGO and private sector had never been included in NAP official structure.
The execution of the NAP at central level had been the National AIDS Bureau under the supervision of the Vice-Prime Minister. It was recently renamed the National AIDS Standing Bureau (NASB) under supervision of Minister of Health. The MOH, since mid-2000, had taken the lead in the NAP. Related Ministries/Unions all had AIDS Divisions as partners of NASB to implement HIV/AIDS activities within the Ministry/Union system. However, the existence of MOH’s AIDS Division, in parallel with NASB, caused confusion sometimes, especially when it came to medical aspects of the NAP.

NASB had 25 staff whose backgrounds were mostly medicine. Given the multi-sectoral approach of the NAP, and planning and coordination function of NASB, its staff were seen as lacking in public health knowledge, administration, management and communication skills.

At local levels, before the change in mid-2000, a committee with similar a composition to the NAC was replicated in almost all provinces, districts and communes and the AIDS Bureau had been acting in almost all provinces. However, after that change, by mid-2001, only two thirds of provinces had their AIDS Bureau re-established. Those bureaus shared staff with provincial health authorities and almost all staff were employed part-time and were not specialized in HIV/AIDS. At district level, the Preventive Medicine Team of the District Health Center is responsible for implementation of the NAP. At commune level, the NAP was one of the national health programs implemented by the Commune Health Center. Recently, communes with an infected resident could assign a health staff member to be responsible for HIV/AIDS activity. This staff member received a monthly financial incentive. With the lack of specialized staff and executive body in many provinces, the NAP system at local levels was in great need of strengthening.

**Objectives and contents of NAP**

The Medium-Term Plan (MTP) 1994-1995 and 1996-2000 was the guiding document for the implementation of NAP in the evaluation period. This MTP defined 3 main objectives:

1. To prevent and limit the transmission of HIV/AIDS among people living in communities in Vietnam;
2. To strive to limit and decrease HIV incidence and AIDS-related death, and to reduce socio-economic harms caused by HIV/AIDS;
3. To mobilize society as a whole, to implement policies and measures, and to promote international collaboration in order to achieve two above goals.

To achieve those objectives, from 1996 onward, NAP had been implemented as a National Target Program. Seven main components of the program included:

1. Information, Education and Communication (IEC) activities;
2. Exposure prevention and control activities in medical sector;
3. Monitoring, care, counseling and treatment for HIV/AIDS infected people;
4. Program management and coordination;
5. Scientific research;
6. International collaboration; and

Funding for the NAP had come from the government, the international community and local sources. During 1996-2001, the government budget for the NAP ranged from 50 to 60 billion VND that was estimated as 60% of total the budget. The UN and other international agencies
contributed around 25% and local sources accounted for 15%. Of the government budget, about 60% was dedicated to activities in the health sector.

Program interventions

The NAP interventions had been moving forward to UNAIDS-recommended programs that were based on international experience and practice. Program interventions were classified as medical and social interventions. NASB was responsible for implementation of non-medical interventions while MOH's AIDS Division was responsible for the medical area.

Information, Education and Communication (IEC):

IEC was one of the biggest NAP interventions. The IEC program had been successful in mobilizing the active participation of mass media and mass organizations. This intervention was seen as effective, with 70% of the population of reproductive age demonstrating basic knowledge of HIV/AIDS modes of transmission and prevention measures. However, IEC had not fully reached the whole population. The IEC programs targeting high-risk groups such as youths, men who have sex with men, HIV infected people, SWs and IDUs had not been developed on a national-scale. Also, IEC activities had not been sufficient for behavior changes. It is recommended that IEC program should be further invested and developed; the Behavior Change Communication (BCC) approach should be adopted.

Voluntary counseling and testing:

The NAP has successfully made HIV testing widely available. However, voluntary testing has not really been practiced. The vast majority of tests had been mandatory. The availability had not made testing voluntary. Health staff, although it had been introduced nationwide, poorly conducted pre- and post-test counseling. It is recommended that the counseling and testing component of the NAP be revised to follow internationally defined voluntary counseling and testing.

Male condom promotion:

Considerable progress has been demonstrated by the social marketing of male condoms in Vietnam in the areas of manufacturing, distribution and pricing. However, even though the condom was accepted as a contraceptive device, it has not been widely accepted as a method to prevent HIV transmission in high-risk groups. The 2000 Behavioral Sentinel Surveillance (BSS) revealed that less than 50% of IDUs used condom with SWs. A national agency should be assigned to carry out a condom promotion program. A more accessible distribution system, together with IEC messages that emphasize the males’ role in practicing safe sex and encouragement of women to be actively involved in the condom use decision, may contribute to increased condom use.

Sexual health and life skills education for young people:

Sexual health and life-skills education for young people had been introduced to most schools. Efforts had been made to improve effectiveness of the school-based program. In general, youth received information from the general IEC program. A number of innovations had been piloted in the main urban centers but not in rural or mountainous areas. The lack of data on youth sexual health and life skills created great difficulty in tailoring a specific program. It was impossible to evaluate the impact of the intervention to this group. It is recommended that a national database
on youth sexuality and life style be built-up. Intervention for youth should target both in- and out-of-school youths in all areas of the country.

Prevention of HIV transmission and treatment for drug users:

Prevention of HIV transmission and treatment for IDUs, including an IEC component such as compiling leaflets on HIV/AIDS for IDU group, organizing IEC activities for the families of drug users, rehabilitation centers 05, 06 and supplying clean injection equipment and condoms through peer educators, as well as ensuring that sterile syringes/hypodermics are always available for sale in state and private pharmacies and shops. However, though the HIV/AIDS prevention program for IDUs obtained some achievements, there still remain constraints. The number of syringes provided has been insufficient to encourage and sustain behavioral change. Interventions seem to limit themselves mainly at IEC activities. There were still no appropriate policies or mechanisms to encourage peer education activities. The counseling and care services for IDUs, who are HIV/AIDS infected are far from adequate. Therefore, the proportion of HIV/AIDS infection in the IDU group has not been reduced, rather the trend has increased in the last five years. It is recommended that methods of prevention of HIV/AIDS transmission and treatment for IDUs should be strengthened in terms of financial, legal and technical investment.

Abolishing stigma and discrimination:

One of the objectives of the IEC program of the NAP was to improve people's understanding of HIV/AIDS in order to reduce fears and discrimination toward HIV/AIDS infected people. However, specific activities were not designed in a holistic program but were addressed in counseling and caring activities for AIDS patients. These activities can not be considered sufficient since they only target AIDS patients and their closely related persons, but have little impact on the larger community and the wider society. The Ordinance stipulates that HIV/AIDS infected people are to be protected against discrimination and stigma. However, in reality, the Ordinance is not always sufficiently and strictly observed with consistency. There was evidence that showed stigma and discrimination against people infected with HIV/AIDS was still common, not only in the community but also among leaders and health providers. In the next NAP, elimination of stigma and discrimination should be put forward as an independent component of the program. A better-designed IEC program aimed at elimination of stigma and discrimination should focus not only on family and friends of HIV/AIDS infected persons but should also target leaders and communities as well as health providers. To do so, more quality research on this topic should be conducted to help design appropriate intervention activities.

Prevention of transmission in medical services:

Prevention of HIV transmission in medical services had gained a lot of attention. Infection prevention had been improved in medical services. Supplies were available in the market. However, the focus had been given to prevention of transmission from determined HIV infected clients rather than Universal Precautions. Improvement of infection prevention facilities and supplies put a burden on hospital budgets, which had not been equivalently increased. Health insurance did not cover infection prevention supplies. Health workers and clients safety depended on clients' payment ability. It is strongly recommended that MOH considers Universal Precautions as a leading approach for prevention of transmission in medical services and put it into regular practice in all medical services – both public and private.
Prevention of transmission by blood safety:

Safe blood transfusion had been one of the priorities for the NAP from the beginning and was initially successful. The Regulation for Blood Transfusion issued in 1992 established standards and guidelines for blood safety. By 2000, the blood safety program had reached its objective of 100% blood units screened for HIV. The proportion of voluntary donors had been increasing almost double during 1996-2000. However, it was still half way in achieving the objective of having 50% of blood units voluntarily supplied. Voluntary donors still received some “feeding up” money. Strategy for blood collection was recently shifted from collecting at district health facilities to provincial or regional facilities. Blood units transfused increased by 60% from 1996 to 2000, demonstrating the need for transfusion indicators to be reviewed and standardized. It is also recommended that investment for voluntary blood donation should move from paying donors “feeding up” money to increase IEC and advocacy activities. The cold chain for transportation and storage of blood once collected at provincial or regional centers needs to be in place to ensure the quality and availability.

Prevention of mother to child transmission:

Prevention of mother to child transmission was at the very early stage of implementation with a very small budget. A national program had not been in practice. PMCT activities so far included IEC, testing, counseling and prophylactic treatment for infected mothers and their newborns. IEC relied on the general IEC program. Other activities had been carried out only in large, specialized hospitals. Between 1996-2000, about 180,000 pregnant women were tested. Counselors were reluctant to counsel infected women. In a clinical trial with UNAIDS support, a small number of women found to be infected and their newborns were given prophylactic treatment, but it was reported that the drug supply was insufficient. The national program for PMCT needs to be redesigned to reach more pregnant women and those of reproductive age. More investment should be given to implement PMCT’s components.

Prevention and treatment of sexually transmitted diseases:

It is fair to say that the program for prevention and treatment of STDs was at the early stage of development. The program had widely disseminated a syndrome-based diagnosis and treatment approach. This approach, together with development of private clinics and pharmacists made treatment for STDs available. However, IEC, counseling, partner notification and treatment, and case management were the weak points of the program. Moreover, data on STD cases was seriously unreliable. In order to manage STDs and monitor the program, a system for data collection such as STD surveillance system is needed. Counseling and partner notification and treatment, should be institutionalized. Efficacy of treatment should be reviewed and treatment alternatives should be recommended in different settings.

Treatment of HIV-infected and AIDS patients:

With the increasing number of people living with HIV/AIDS (PLWHA), care and treatment became a more pressing component of the NAP. A system to treat PLWHA had been set up at provincial level with the objective of preparing the medical system to cope with the new and threatening disease. However, the lack of infrastructure, equipment for diagnosis of opportunistic diseases and follow-up treatment, medicine for specific treatment, and staff training, the medical system was facing serious challenges. Community and home-based care – models to share the burden with the hospital system- had been initiated but not yet systematically piloted and developed. It is strongly recommended that care and treatment for PLWHA is a priority of the
Investment should be put into preparing infrastructure, purchasing equipment and medicine, training staff and developing, and putting into practice a home-based care system. However, in the mean time, a minimal care package should be initiated to include physical and mental care, and treatment using locally available regimens - possibly including traditional medicine.

Surveillance:

Sero-surveillance was one of the first components of the NAP. A system of sentinel surveillance had been established in 31 out of 61 provinces in the country. Vietnam sero-surveillance system was evaluated and reported as fully developed. Surveillance provided the most reliable HIV/AIDS data. Molecular epidemiology had been approaching the most updated technique and contributed to the development of intervention strategies. The first round of behavioral surveillance was conducted in 2000. However, Sero-surveillance was facing challenges, as surveyed groups had become more and more complicated. The use of surveillance data was not fully exploited. Local authorities had not been active in using surveillance data. It is recommended that more consideration need to be made for selection of surveillance sample and its data should be more widely disseminated; local authorities should be trained to use surveillance data as a tool for advocacy and development of local AIDS Programs.

The evaluation of NAP has come up with the following conclusion and recommendations:

**Conclusion**

**Achievements and strengths of NAP during 1996-2000**

1. NAP has been developed as a government program with the participation of a large number of government bodies.
2. NAP has succeeded in maintaining strong political support and has translated a number of documents issued by the Party, National Assembly and the Government into legal and policy documents as well as program interventions.
3. NAP has built up a rather comprehensive official system for HIV/AIDS control and prevention activities for the whole country. This system is able to mobilize government and international resources to deliver important interventions to slow the spread of the epidemic.
4. NAP has been developing in to a comprehensive response, aiming for the best international practices. All UNAIDS-recommended interventions have been practiced in Vietnam although at different degrees of intensity.
5. Although the infection rate had been increasing in all groups, the epidemic was still held at the concentrated state.
6. The majority of the population is aware of HIV/AIDS and demonstrates basic knowledge of HIV/AIDS, its modes of transmission and methods of prevention.
7. HIV test have been made available in all provinces, accessible to majority of population. Blood screening for HIV is widely practiced throughout the country.
8. A fully-developed sero-surveillance system has been in place and is moving forward to the second generation surveillance.

**Shortcomings**

1. The NGO and private sectors have not been officially included in the NAP. The organizational structure of the NAP was fully government-based.
2. The merging of the National AIDS Committee and other national committees for drug and prostitution control to become National Committee for Prevention and Control of AIDS, Drug and Prostitution seems to be an opportunity to strengthen inter-sectoral collaboration.
However, this collaboration is still very loose, showing a lack of synchrony in policies relating to HIV/AIDS, such as those on harm reduction among groups with risk behaviors.

3. The ability to evaluate the NAP in general and some interventions in particular is limited due to the lack of monitoring/evaluation indicators and a weak monitoring system.

4. Coordination between NASB and MOH's AIDS Division has not been well set-up, causing confusion for implementation of the program.

5. NAP has almost no full-time specialized staff at local levels that limits both the development of technical expertise in this important area and intensive implementation of the program.

6. Planning of the program is top-down from the provincial level to the commune.

7. Available information from surveillance and research on HIV/AIDS has not been fully utilized to develop relevant policies.

8. Counseling components on VCT, quality assurance of blood transfusion, stigma and discrimination, PMCT, prevention of nosocomial transmission, treatment for HIV/AIDS patients, sexual health and life skills education for adolescents have been lacking or are poorly practiced.

9. Effectiveness of harm reduction activities among IDUs has been limited.

10. There is a lack of communication between policy makers, program managers, researchers, PLWHA, donors, NGO and media on legal and policy issues, updated information and data as well as orientation and priorities of the program.

11. The budget for the NAP was on one hand limited, on the other hand distributed based on egalitarianism, which made investment for NAP intervention too scattered and insufficient to be effective.

**Recommendations**

**Priorities for the coming years**

It is recommended that in coming years, priorities should be given to the following areas:

1. Strengthening the synchronous collaboration between key organizations of the National Committee for Prevention and Control of AIDS, Drugs and Prostitution.

2. Financial resources for NAP need to be supplemented, secure sufficient investment to enforce priorities and maintain regular activities.

3. Maintaining political commitment and support at a high level by improving policy communication. NASB should take the lead in communicating with policy makers and media. A unit at NASB, such as public relations or policy communication should be established or developed from an existing department to be responsible for such a task. Staff responsible for policy communication should be trained to have adequate and relevant skills.

4. NGOs, the private sector and PLWHA should be officially involved in the NAP, in terms of policy development, planning and implementation.

5. Harm reduction programs should be developed countrywide, targeting groups with high-risk behaviors – including IDU, SW, STD clients and PLWHA. Condoms and clean needles should be available to those groups. NASB should work closely with related agencies to develop relevant policies for the support of such programs. International assistance should be invested in this program to ensure adequate supplies.

6. Medical curriculum should be reviewed to ensure adequate attention to address issues relating to HIV/AIDS, including Universal Precautions and HIV/AIDS management. Moreover, health staff should receive retraining on HIV/AIDS as soon as possible.

7. Universal Precautions should be prioritized in medical activities toward HIV/AIDS prevention. MOH should organize training and education programs for health workers and clients on Universal Precautions and institutionalize this in all medical services, including both public and private sectors.
8. Care and treatment for PLWHA should be prioritized when it comes to national strategy and budgeting. In the coming year, a comprehensive care and treatment model should be developed to reach all PLWHA either in the hospital, at home or on the streets. This holistic model should include a hospital system for treatment, a home-based system for care, hospice for those who are homeless and a cross-cutting BCC component to provide proper knowledge and encourage responsible and healthy behaviors. Treatment sub-divisions of MOH should work together with NASB and mass organizations, as well as local authorities, to develop this model. International donors should consider assisting in the development and implementation of such a model. Parallel to the development of the comprehensive model, NAP should encourage localities to initiate and put into practice minimal care packages, comprising of physical and mental support and locally available treatment.

9. Sexual health and life-skills education, together with service provision for adolescents should be developed into a national program in the soonest. Such programs should be able to reach adolescents in and out of school, in all areas of the country.

10. Capacity of the NAP should be strengthening by:
   i. Considering merging MOH’s AIDS Division and NASB or setting up a clear working mechanism for those two bodies.
   ii. Assigning key personnel as full-time staff at provincial and district levels.
   iii. Developing a training curriculum specialized on HIV/AIDS management and providing training to those who are working on HIV/AIDS at all levels.
   iv. Strengthening M&E systems by developing a set of indicators and setting up M&E mechanisms for NAP and its components.

Policy and legal issues

1. Policies on condoms and clean needles for groups with high-risk behavior should be reviewed and adjusted for harm reduction purposes.
2. HIV/AIDS related policy should be gender-sensitive, with adequate and equal care for boys and girls, men and women.
3. Policies on HIV/AIDS and related issues should be well disseminated.
4. Some legal issues should be concretized into instructions or regulations. Those include:
   i. Prevention of nosocomial transmission, both in medical and social services.
   ii. IEC and services for HIV/AIDS prevention among young and unmarried people.
   iii. Stigma and discrimination toward HIV infected and affected people.
5. Some legal issues should be enforced. Those include:
   i. Intentional and unintentional transmission of HIV to others.
   ii. Insurance and compensation to health workers who are at risk of HIV infection.

NAP capacity, management, coordination and planning

1. Investment should be made in the development of a comprehensive M&E system for the NAP, which covers all program interventions. The system should use UNAIDS indicators with necessary adaptations/modifications to fit the situation in Vietnam.
2. NAP personnel should be strengthened by staffing the program with full-time HIV/AIDS professionals. While the organizations structure can be integrated into the health sector, personnel should be specialized. A training program then should be developed to provide essential knowledge and skills on technical, communication, planning and management issues of HIV/AIDS program.
3. Planning of the program should be two-ways, bottom-up and top-down. Program managers at all levels should be able to develop their own annual plans, reviews and comment on those of a lower or a higher level. While the budget was not sufficient for all activities, giving budget
ceilings can be considered, however all levels should be made most active in planning their activities by developing their own annual plan.

4. NASB should be able to make coalitions of all organizations/programs working on HIV/AIDS and related issues in Vietnam by informing policy issues, helping with prioritizing, providing guidance, sharing experience, making linkages and so on. At the same time, NASB should play the key role in coordinating/advising for coordination of resources and ensuring sufficient investment for the program's priorities.

5. Communication between policy makers, program managers, researchers, PLWHA, donors, NGOs and media should be improved. NASB should have a communications unit, responsible for developing any NAP communication strategies and plans as well as coordinating with other departments/sections for wider communication that benefits NAP.

6. MOH should review the coordination between NASB and MOH’s AIDS Division to have clearly defined functions and responsibilities of each body.

7. Evaluation of the NAP should be conducted on a regular basis. Those evaluations should be sufficiently invested to be well-designed and implemented. In order to make the evaluation feasible, it is important to define clearly NAP’s objectives in a quantifiable way and to set up a system for regular collection of information.

8. A cost-effectiveness and/or cost-benefit evaluation should be conducted to give evidence and knowledge base for further investment. However, such an evaluation can be made possible only if information on resources used for NAP is relatively sufficient. NASB should improve the system for collection and restore information on resources for NAP.

Program intervention

1. Harm reduction for IDUs should be strongly improved. Interventions in rehabilitation centers, on clean needle supply should be considered and carefully designed, aiming at reducing the infection rate in this group.

2. A BCC program on PLWHA should be developed to increase healthy and responsible perceptions and behavior toward and from PLWHA. This program should be designed to raise awareness and encourage healthy and responsible behaviors of PLWHA as well as of the whole community toward those PLWHA.

3. Investment should be made to put in practice the following interventions and intervention components:
   i. Counseling component on VCT,
   ii. PMCT,
   iii. Treatment for HIV/AIDS patients,
   iv. Sexual health and life skills education for adolescents,
   v. Prevention of nosocomial transmission,
   vi. Care of children infected and affected by HIV/AIDS.

Gender aspects of the program

1. Raising gender awareness and improving skills of gender analysis for policymakers and program managers as well as implementers in HIV/AIDS prevention systems.

2. Strengthening research capacity on gender.

3. Improving skills of advocacy for researchers and community activists, to ensure that gender is adequately addressed in the process of designing and implementing HIV/AIDS policies and programs.

Based on the different achievements and limitations of the NAP, the above conclusions and recommendations were produced for related agencies and institutions to review and take action, with the hope that the NAP will become more effective.
1. BACKGROUND AND RATIONALE OF THE EVALUATION

1.1 HIV/AIDS in Vietnam

1.1.1 Socio-economic context

By the time the first HIV positive case was reported in Vietnam in 1990, the society had begun to experience a profound change that continues today. The consequences of this change still have not been fully documented. The catalyst for this change was the Doi Moi (“renovation”) policy, adopted at the end of 1986 and brought into fully play between 1989 and 1990. The impact could first be seen in changes of economic policy, which began the gradual shift from the centrally planned economy to a more market-based economy based on socialist orientations. With a slogan of “untied and bursting” private economic activities were gradually allowed to develop to meet the variety of increasing demands of the people. At the same time, Vietnam established an “open door” policy that promoted the establishment of diplomatic and economic trade relations with the outside world. Under these new policies, momentous changes in Vietnamese society have occurred.

Firstly, there has been a substantial shift in Vietnamese attitudes, from one pole characterized by a communal closeness and conformity to one characterized by a readiness to accept many new things, for example “Western-style” that would not be conceivable by the more traditional Vietnamese of society only a few years ago. This shift peaked in the period 1993-1995 and gradually moderated by the end of 2000. This change of values allowed for the appearance and tacit acceptance of many behaviors that would before have been considered inappropriate, and biased. The young generation has been strongly influenced by these new trends and youth are asserting themselves by adopting these lifestyles and behaviors.

Secondly, there has been an increase in overall income levels as well as social stratification. During the ten years of Doi Moi, average per capita income has more than doubled, from USD 180 in the late 1980’s to approximately USD 400 in the beginning of 2001. However, the disparity in income levels between social strata and between urban and rural areas has also greatly increased. Income disparity was 6.04 times higher between the highest income group and the lowest. This was 2.95 times higher in urban areas as compared with rural areas. Income levels are especially low in the Northern mountainous areas. This caused difficulties in changing crop structure, especially the change in planting opium poppies in some areas. As a consequence of low-income levels, health care, education and other social services have become difficult to access by the poor.

“Doi Moi” also substantially improved the country’s transportation infrastructure, allowing for higher mobility of the population and acceleration of the urbanization process. Urban areas have developed rapidly. Significant numbers of rural residents migrated to cities but they mostly reside in the urban peripheries. They are, by their mobility, spatial movement and life styles becoming a population segment facilitating the spread of diseases. Moreover, there are large highly mobilized groups who are at high risk to HIV/AIDS infection. Social controls, largely based on community affiliation, are gradually losing their effect on these groups.

Despite the positive impacts of higher incomes and improved transportation, these factors have also allowed for an increase in certain “social evils”. There has been a rapid increase in the number of drug addicts and with this there is a marked increase in the smuggling and sale of heroin both in and out of the country. It is estimated that currently Vietnam has about 120,000 Injecting Drug Users (IDUs). Prostitution has also increased. The number of sex workers varies
from 40,000 according to estimates by MOLISA to 300,000 according to some expert estimates (WHO, 2001). Some border areas in the country are developing rapidly in terms of both economic activity and in conjunction there is also seen an increase of prostitution and drug abuse.

1.1.2 Epidemiology

Since 1994 the epidemiological surveillance system has provided regular data on HIV/AIDS in Vietnam. By the end of 2000, the HIV epidemic in Vietnam was at a concentrated state with the prevalence among at least one high-risk group higher than 5% and below 1% for the general adult population (age 15-49) in urban areas (Walker, 1999).

As of October 26, 2001, Vietnam has 41,220 HIV cases, 6,165 AIDS cases and 3,338 AIDS deaths (Vietnam News, 2001). This is the 10-year impact since the first HIV case was found in December 1990 in Ho Chi Minh (HCM) City. The other early cases were mainly among foreign fishermen who were apprehended due to illegal fishing in Vietnamese waters. No cases were found in 1991 after testing 2,000 IDUs, 4,500 Sexually Transmitted Disease (STD) patients, 2,600 sex workers (SWs) and 38,500 blood donors.

In 1992, among approximately 47,000 tests, 11 cases of HIV infection were found. Among the 11,023 STD patients tested eight cases were detected and among 1,915 IDUs tested only one case was found. In 1994 1,100 cases of HIV infection were reported in several Central and Southern provinces, mainly among IDUs. 1994 is considered the starting point of the HIV/AIDS epidemic in Vietnam.

From 1994, the epidemic spread quickly. The number of HIV and AIDS cases steadily increased (Figure 1 and Figure 2). Of these, around 90% were among IDUs, and the remaining cases were among high-risk groups such as SW, STD patients and Tuberculosis (TB) patients, with some among the general population.

![Figure 1 Reported cases of HIV infected, 1990 - 2000](image)
During the past five years, there has been a steady shift in age structure of HIV infected cases from the older age groups to the younger ones. In the year 2000, detected cases in people under 40 years of age was 84.1% and 9.7% for those under 20 years of age (Table 1).

Regarding sex, more HIV infected males are being reported (85%) compared to females (15%) (MOH, April 2001). These proportions have remained steady over the past 5 years. However, proportion of HIV infected pregnant women has increased from 0.02% in 1994 to 0.2% in 2000.

Surveillance data revealed that the epidemic has been changing in terms of social groups. The percent of IDUs among reported cases decreased from 87% in 1993 to 51.5% in 1996. There was an increase of infection rates among SWs, STD patients, TB patients, pregnant women and new military recruits being detected as shown in Table 2. This trend has caused concern that HIV transmission is not just concentrated in high-risk groups but has started to spread amongst the general population, although only at very low levels.

Table 1 Distribution of HIV infected cases by age range (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>&lt;20 years old</th>
<th>20-29 years old</th>
<th>30-39 years old</th>
<th>40-49 years old</th>
<th>&gt;49 years old</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>2.8</td>
<td>19.1</td>
<td>45.2</td>
<td>25.6</td>
<td>2.3</td>
<td>5.0</td>
</tr>
<tr>
<td>1996</td>
<td>3.4</td>
<td>22.2</td>
<td>41.4</td>
<td>26.4</td>
<td>2.2</td>
<td>4.4</td>
</tr>
<tr>
<td>1997</td>
<td>10.9</td>
<td>48.4</td>
<td>21.0</td>
<td>15.4</td>
<td>1.6</td>
<td>2.7</td>
</tr>
<tr>
<td>1998</td>
<td>7.0</td>
<td>37.8</td>
<td>30.3</td>
<td>19.7</td>
<td>1.7</td>
<td>3.5</td>
</tr>
<tr>
<td>1999</td>
<td>10.1</td>
<td>61.1</td>
<td>18.6</td>
<td>6.9</td>
<td>1.2</td>
<td>2.1</td>
</tr>
<tr>
<td>2000</td>
<td>9.7</td>
<td>50.4</td>
<td>24.0</td>
<td>12.0</td>
<td>1.3</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: NASB/MOH statistics, April 2001

According to reports for the year 2000, there were 20,831 newly infected cases. Therefore cumulative cases are 118,749 among those there are 4,123 AIDS cases and 3,521 deaths. According to the year 2005’s projection, the cumulative number will be 197,581 HIV infected with 51,286 cases developing into AIDS and 46,202 deaths due to AIDS.

Figure 2 Reported cases of AIDS, 1993 - 2000
Table 2 Trend of HIV infected cases by target groups (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>IDUs</th>
<th>SWs</th>
<th>STD patients</th>
<th>TB patients</th>
<th>Pregnant women</th>
<th>New recruits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>14.89</td>
<td>0.85</td>
<td>0.45</td>
<td>0.54</td>
<td>0.07</td>
<td>0.01</td>
</tr>
<tr>
<td>1996</td>
<td>10.89</td>
<td>0.73</td>
<td>0.48</td>
<td>0.45</td>
<td>0.03</td>
<td>0.04</td>
</tr>
<tr>
<td>1997</td>
<td>12.87</td>
<td>1.46</td>
<td>0.58</td>
<td>0.75</td>
<td>0.12</td>
<td>0.13</td>
</tr>
<tr>
<td>1998</td>
<td>15.50</td>
<td>2.44</td>
<td>0.94</td>
<td>0.98</td>
<td>0.08</td>
<td>0.15</td>
</tr>
<tr>
<td>1999</td>
<td>18.88</td>
<td>3.77</td>
<td>1.64</td>
<td>1.19</td>
<td>0.08</td>
<td>0.41</td>
</tr>
<tr>
<td>2000</td>
<td>23.90</td>
<td>4.33</td>
<td>1.36</td>
<td>1.71</td>
<td>0.2</td>
<td>0.95</td>
</tr>
</tbody>
</table>

Source: NASB/MOH statistics, April 2001

It is worth noting that compared to projections made previously for Vietnam the actual numbers of cases seems much lower. In 1999, the UNDP projection for Vietnam for the year 2000 estimated 570,000 HIV/AIDS infected cases. In 1993, WHO estimated that there were 350,000 infected persons. Then, in 1998, the National AIDS Bureau (recently National AIDS Standing Bureau), with assistance from WHO, estimated the number of HIV infections in 2000 to be about 135,000 HIV infections.

1.1.3 Evaluation of the National AIDS Program

In response to the spreading HIV epidemic in Vietnam, UNDP, World Bank as well as other UN agencies and NGOs have been supporting the government of Vietnam to strengthen the NAP. Among many projects with external support, since 1995 UNDP has been working to strengthen management capacity of the program through project VIE/93/009 that was implemented from January 1995 to January 1998. This is the first project assisted by UNDP to strengthen capacity on coordination and planning for HIV/AIDS activities in Vietnam. The project VIE/98/006 was developed based on experiences learnt from the project VIE/93/009 with financial support from AusAID. This evaluation is one component of the project.

Project VIE/98/006, aims at strengthening the NAP in terms of management capacity, and therefore requires a broad picture of the NAP. In addition, the Medium-Term Plan (MTP) for AIDS prevention and control 1994-1995 and 1996-2000 has been completed. According to the MTP, there should be an evaluation conducted in early 2001 to "evaluate the achievements of the MTP" (NAC, 1994).

An evaluation of the program will also provide information for further development of the NAP. Therefore, Ministry of Health (MOH) and UNDP - in project VIE/98/006, “Strengthening capacity in management, policy formulation and coordination of HIV/AIDS activities in Vietnam,” with the coordination of NASB, have conducted a NAP evaluation for the period 1/1996 - 6/2001.

The evaluation had two general objectives:

1. Assess impact of the National AIDS Program from 1996 to 2001 (referred to as the Impact Evaluation), and:
2. Identify needs and opportunities for strengthening the planning, management, monitoring, and coordination capacity of the National AIDS Program (referred to as the Organizational Capacity Assessment).
2. METHODOLOGY

2.1 Scope of the evaluation

The evaluation focused on two domains within the National AIDS Program:

- Policy and program activities implemented by the central government at the national level, including selecting member organizations of the National Committee for Prevention and Control of AIDS, Drugs and Prostitution (NCADP), and:
- Policy, program management and activities implemented within the three provinces and two cities of Lang Son, Hai Duong, Da Nang, Hanoi and HCM City.

The three provinces were selected based on the Government’s plans to further develop programs in these locations under Project VIE/98/006 beginning in 2001. Hanoi and HCM City were selected because of their higher prevalence of HIV/AIDS, of the existence of a broad range of HIV/AIDS programs and activities, and to capture both the urban and rural dimensions of HIV/AIDS in Vietnam. Those locations are not necessarily nationally representative study sites of the full range of issues and programs over the period January 1996 to June 2001. The main description and conclusion of the NAP will be mostly based on reviewed documents and interviews with key informants at central level. Information collected from provinces and cities is used for clarification and illustration of different aspects of the NAP, including management at local levels and perception of beneficiaries towards the NAP.

2.1.1 Impact evaluation

The MTP for prevention and control of HIV/AIDS in Vietnam (NAC, 1994) provides the rationale for conducting this impact evaluation. The plan stipulates detailed intermediate objectives for the period 1994-1995 and several long-term objectives for the period 1994-2000. It also calls for a comprehensive evaluation of the program at the end of 2000 “in order to evaluate the MTP achievements”. This evaluation will assess the achievement of the MTP 1996-2000 objectives.

The impact evaluation focused on three broad components of the NAP: 1. Legal and policy environment; 2. Key HIV/AIDS programs, and 3. Management issues. The following eleven HIV/AIDS program activities were evaluated and are presented in the report in no particular order:

1. Information, Education and Communication.
2. Voluntary counseling and testing.
3. Male condom promotion.
4. Sexual health and life skills education for adolescents.
6. Abolishing stigma and discrimination.
7. Prevention of transmission through medical services.
8. Prevention of transmission through blood transfusion.
11. Treatment of HIV-infected and AIDS patients.
These interventions were selected based on both the key NAP activities conducted during 1994–2000 and identified for 2001 – 2005, as well as UNAIDS recommendations concerning the essential components of a NAP.

The impact evaluation had three components. The first was to define the National AIDS Program. This entailed describing and documenting various aspects of the national program including the legal framework, policy environment, projects and interventions, and implementing organizations, and their various roles and resources that were allocated and expended. This component of the impact evaluation was designed to answer the following questions:

- What HIV/AIDS activities have taken place during the period January 1996 to June 2001?
- Are there (or were there) policies and plans in place to guide implementation of these activities? How were decisions made regarding the introduction, discontinuation or direction of activities?
- What organizations have managed and implemented these activities? What were the organizations’ roles and responsibilities? What has been the nature of various stakeholders’ participation? What has been the nature of interactions across organizations?
- What resources have been allocated and used by each of the activities – how much and for how long? Who funded the activity?
- How has the program evolved over time? (For example, what are the trends in funding for the various activities? Have new activities been introduced, or others discontinued?)
- How have gender issues been addressed in the National AIDS Program?

The second component was to assess the performance and impact of the NAP in order to measure past progress and improve future activities. Specific questions for this component of the evaluation included:

- Is the program reaching the population it was intended to reach? Is it reaching those with the greatest need?
- How well has the program (and projects) achieved its objectives/targets (if they exist)?
- What are the strengths of the interventions? What should be continued? Why?
- What are the weaknesses? How can the program be improved (or what should be discontinued?) Why?
- Has (how has) the HIV/AIDS program taken into consideration gender-related constraints and opportunities? How can gender-sensitivity be strengthened to improve performance of the HIV/AIDS program?
- Has/How has the program performance changed over the five-year period?
- What are the unintended outcomes (positive and negative) of the program?
- What external factors have influenced program implementation and performance?

The third component looked at the evaluation ability of the program; that is, what systems are in place to monitor and evaluate the performance and impact of the NAP? This component focused primarily on the current program and requirements to bring evaluation systems in line with international practices. It aimed to answer the following questions:

- Who uses (and should use) program performance data? What are their data needs?
- What data are available now (and during the period January 1996 to June 2001) to measure program performance? What is the quality of those data?
• What data are currently available for the indicators recommended by UNAIDS for the monitoring and evaluation of national AIDS programs (see Guide to Monitoring and Evaluation, UNAIDS 2000)?

• Which of the UNAIDS indicators are applicable for measuring the performance of the national program in Vietnam over the next 5 years? What other indicators are required in order to meet the information needs of data users?

• How can gender issues related to the NAP be monitored and evaluated?

• What is recommended to strengthen the national monitoring and evaluation system?

2.1.2 Organizational capacity assessment

Since 1994, the National AIDS Bureau (recently NASB) has been designated as the primary agency for planning, management and coordination of the NAP (Prime Minister, 1997, 2000). One of the objectives of Project VIE/98/006 is “to strengthen the capacity of the NASB, the Provincial People’s Committees (PPCs) of Hai Duong, Lang Son and Da Nang, and AIDS divisions of selected member organizations of the NCADP in planning, management, monitoring, and coordination of the activities under the NAP” (VIE/98/006 Project document, 1998). To improve the design and implementation of this component of the project, the organizational assessment looked at the current planning, management, monitoring and coordination capacity of the NASB of MOH, and the People’s AIDS Committees (PAC) (or their equivalent) in the three provinces. The corresponding city level committees in Hanoi and HCM City were included in the assessment to make the assessment more nationally representative. In doing so, both internal and external functions of these organizations were studied to include relationships with the NCADP and other organizations.

The organizational assessment sought to answer the following questions:

• What is the current composition of the organizations?

• How long has this organizational configuration been in place? Is this expected to change in the near future?

• What organizations do these organizations report to?

• What organizations do they coordinate (including Vietnamese and international organizations)?

• What are the current activities of the organizations?

• What is their annual budget? What is the source of their funds?

• Which management areas are weakest? Which are most amenable to improvement through training?

In assessing the management capacity of these organizations, the following areas were studied:

• Organizational structure, functions, responsibilities, and coordination

• Human resources

• Organizational management

• Financial management

• Research, monitoring and evaluation.

2.2 Evaluation planning

MDRC, with guidance from RTI, developed a detailed evaluation plan prior to the start of data collection to clarify expected outcomes and guide the evaluation process. The evaluation plan
included the key evaluation questions that would be addressed (given above in Section 2.1), roles and responsibilities in carrying out the evaluation, data collection and analysis methods to be used, key data sources including documents and types of key informants, a report outline, evaluation codes of behavior for the conduct of the evaluation, a dissemination plan, and an activity schedule.

NASB and Project VIE/98/006 managers reviewed and approved the evaluation plan prior to the start of data collection.

2.3 Evaluation subjects

Subjects of the evaluation exercise included:

- Available documents, reports, guidance, speeches relating to the formulation, implementation and management of any aspects of NAP as well as interventions. In total, more than 100 documents have been reviewed. A selected list of those documents is presented in Annex A.
- Managers and professionals who are involved in management and implementation of the programs at different levels, institutions and localities. In total, 132 managers and professionals were interviewed. Positions and institutions of the interviewed managers and professionals are listed in Annex B.
- Program beneficiaries. Those include: IDUs, SWs, HIV/AIDS patients and their family members, patients in the hospital, pregnant women, unmarried and married men and women. In total, more than 250 beneficiaries were interviewed or participated in FGDs. A tabulation of program beneficiary interviews and FGDs is provided in Annex C.

2.4 Data collection method

Data collection and fieldwork was conducted from 18 June to 16 September 2001. Data collection consisted of:

- Review of secondary data, including official Party and government policy documents, program reports, research studies, and other documents,
- Collection of primary qualitative data through in-depth interviews with key informants and program beneficiaries, and focus group discussions (FGDs) with members of the general population.
- For the assessment of the legal frame and policy environment, the Delphi method (for assessing the strengths and weaknesses) and meta-analysis workshops (for identifying priority issues for the future policy agenda) were implemented. Eight experts (four from the medical sector and four from social sector) were invited to participate.

Secondary data and information served as important sources of information for analysis of the legal framework and policy environment. They also provided quantitative data, including data on the epidemic and program budget allocation. Two documents in particular provided key information: the NASB 10-year Summation Report (1990-2000) and the MOH 10-year Summation Report (1990-2000) of HIV/AIDS prevention and control activities (NASB, 2001; and MOH, 2001). The evaluation team identified documents through a 2-stage process:

1. Requests from key HIV/AIDS program organizations in Vietnam (e.g., NASB, MOH, NGOs and international organizations) for materials that they felt would provide relevant information for this evaluation; and:
2. Using these collected materials to identify additional organizations and materials.
For the in-depth interviews, the evaluation team attempted to consult representatives from all key central level units. However, it was not possible to include some units due to scheduling difficulties. One hundred and thirty two key informant interviews were conducted with Party and government policy makers, program managers and other officials; international and non-governmental organization program managers; and technical experts at central, provincial, city and lower levels.

Key informants were selected for interviews, based on their expert knowledge of and involvement in HIV/AIDS-related activities. The evaluation team identified the first round of informants based on their personal knowledge and introduction of the local AIDS division. A second round of informants was then identified using a “snowball” approach whereby first round informants were asked for their recommendations on additional informants to interview.

Program beneficiary interviews and FGDs were held to clarify or collect additional information concerning specific issues that arose during key informant interviews. About 60 interviews were held with program beneficiaries, including HIV/AIDS patients and their relatives, STD patients, SWs, IDUs, blood transfusion patients, antenatal clinic patients, and peer educators in the three provinces and two cities. Over twenty FGDs were conducted with unmarried youths, aged 30 years and under, and married people under 50 years of age in the same areas, with a total 201 individuals participating in the focus groups.

Provincial and city AIDS offices provided lists of districts and communes where program beneficiaries or potential beneficiaries resided. Individual program beneficiaries (SW, IDU) were selected from urban sites, and then a snowball approach was used to identify other potential participants. To identify SWs and IDUs, Provincial AIDS Standing Bureaus (PASB) assisted in identifying peer educators who in turn introduced program beneficiaries for possible participation. These beneficiaries in turn provided introduction to other SWs or IDUs for participation. Other program beneficiaries – HIV/AIDS, STD, blood transfusion and antenatal clinic patients – were identified through health providers and interviewed at visited provincial centers for preventive medicine, hospitals, and clinics.

FGD participants were also selected from the districts and communes where beneficiaries resided. From these lists, one district and one commune were randomly selected from each of the five sites. Similarly one urban ward of the town/city was selected. Therefore, two sites were selected (one rural commune and one urban ward). In each selected commune and ward two FGDs and in-depth interviews with commune/ward authorities were held. In the commune/ or ward, one household was randomly selected from the household list, and then the “door-to-door” technique was used to identify other households until ten households were selected. A person living in each selected household who met evaluation criteria was invited to participate in the FGD.

Informed consent, including assurance of confidentiality, was obtained from all potential interview and focus group participants at the outset of the interview and FGD selection process.

For each of the groups that provided data (e.g., target beneficiaries, FGD, program implementers, policy makers, and health service providers), a separate interview guideline was developed. The questions in the guidelines were developed based on the overall evaluation questions presented in Section 2.1. Due to time constraints for data collection, guidelines were first developed and used in Da Nang, where the evaluation was initiated. During the interview process in Da Nang, many guidelines were revised (i.e., some questions have been rephrased and amended and some
other questions were added). The revised guidelines were then used in the subsequent evaluation sites in Lang Son, Hai Duong, Hanoi and HCM City. Before going to the field, evaluation team members have been trained carefully on each of question guidelines.

Four teams of 3-4 members each collected the data. Teams were assigned to the different geographic locations. All team members were researchers experienced in qualitative research methods.

An in-depth interview was on average 1–1.5 hours in length with some exceptions being 2 hours long or another meeting scheduled. The length of FGDs also was on average 1-1.5 hours. All interviews and FGDs were audiotaped during the discussions and conversations.

2.5 Data analysis

After the fieldwork, tapes were transcribed and typed. All transcribed interviews and FGDs have been photocopied and distributed to key researchers who are involved in the report-writing group.

A content analysis was conducted of the transcripts of the in-depth interviews and FGDs in the Vietnamese language. Data analysis was made based on evaluation questions that were asked in the Evaluation framework. Information extracted from the interviews and FGDs was arranged based on the two types of assessments: impact of the program over the last 5 years (information related to legal framework, policy environment, and 12 program interventions), and the organizational assessment (information related to structures, human resources, management, finance, and monitoring and evaluation).

2.6 Limitations of the evaluation

When considering the findings and recommendations of this evaluation, it is important to keep in mind a number of limitations in the evaluation design and implementation. While this is an evaluation of the NAP, it may not cover the full range of HIV/AIDS issues and activities across the country and among all stakeholders.

In identifying the effectiveness, impacts, and constraints in existing policies and strategies, management and implementation of the NAP, the evaluation focused on the activities conducted at the central, provincial, and sub-provincial levels of the government. Though the evaluation attempted to consult representatives from all key central level units, it was not possible to include some people due to scheduling difficulties. Likewise, it was not possible to include all 61 provinces and central cities of the country in the evaluation. Instead, the evaluation reviewed central-level and national program documents, consulted key stakeholders having experience with and insight into the national program, and conducted in-depth studies of three provinces and two central cities. Of these five sites, three were in the North (Hai Duong, Lang Son and Hanoi), one central (Da Nang), and one in the South (HCM City). Based on these data sources, the findings and recommendations presented are assumed to be applicable or relevant nationally unless otherwise noted. Findings that were unique to a particular region, activity or group are presented as such.

It also was not possible to include all HIV/AIDS projects, activities or stakeholders in the evaluation. Many HIV/AIDS interventions and activities are being implemented in various parts of the country through local non-governmental organizations (NGOs) and private voluntary organizations (PVOs) with support from international donor agencies. This evaluation...
concentrated on covering those activities and groups operating in the five focus provinces and cities. However, it is possible that some activities or organizations have been omitted.

Another challenge faced in conducting this evaluation concerns changes that have occurred in the government organizational structure for management and coordination of the program during the period. These changes in the structure and roles of organizational units, and the extent to which these changes have been implemented from the central level to provincial and lower levels, complicated the analysis and presentation of findings and recommendations.

Lastly, it was difficult to measure the impact of the NAP as it lacked clear goals, objectives and indicators of success. To the extent possible, existing program goals, objectives and indicators were used to guide the evaluation and measure performance. Looking to the future, international standards, specifically the UNAIDS indicators, were used to frame recommendations on how to strengthen the monitoring and evaluation of the program. However, because of the lack of clear indicators of success, there often was a lack of data that could be used to measure performance or to make recommendations concerning the future application or development of performance indicators.
3. IMPACT EVALUATION RESULTS

This section presents key findings from the impact evaluation. It begins with a description of the NAP (Section 3.1), an analysis of the policy environment (Section 3.2) and overall legal framework (Section 3.3), the key findings for program interventions (Section 3.4), and then sentinel sero-surveillance and behavioral sentinel surveillance.

3.1 Description of the National AIDS Program

3.1.1 Planning for the period 1991-2000

The National HIV/AIDS Prevention and Control Program (NAP) in Vietnam officially began as the Program for the Prevention and Control of Infectious Diseases in the last years of the 1980-decade. The fundamental guiding principle of the program was to consider prevention as the crucial measure and propaganda as the key method. This is in line with the development orientation of the health branch in Vietnam (MOH, 1999). However, it soon became a social program rather than a sole health sector program.

The first MTP for HIV/AIDS control and prevention for the period 1991-1993 was developed with the assistance of WHO and implemented in 9 target provinces and cities of total 53 provinces. In the first two years, the HIV/AIDS prevention and control program did not receive government funding for its implementing activities. In 1993, after a large number of HIV cases were detected in HCM City, Khanh Hoa and some other Southern provinces, the government invested 10 billion Vietnam Dong (VND) for safe blood transfusion equipment in order to strengthen blood safety efforts.

At the end of 1993, the UN/WHO Global AIDS Program assisted Vietnam in developing the MTP “Strategy for AIDS Prevention and Control for 1994-2000”. Also, since 1994, the government has provided annual budgets for the HIV/AIDS control and prevention activities in the whole country.

The MTP for HIV/AIDS Prevention and Control in Vietnam identified several long-term goals for the period from 1994 to 2000 as follows:

1. To prevent and limit the transmission of HIV/AIDS among people living in communities in Vietnam;
2. To strive to limit and decrease HIV incidence and AIDS-related death, and to reduce socio-economic harm caused by HIV/AIDS;
3. To mobilize the all levels of society to implement policies and measures, and to promote international collaboration in order to achieve the above two goals (NAC, 1994).

The immediate objectives of the MTP for the period 1994-1995 targeted 15 specific tasks, including Information Education and Communication (IEC) activities, HIV/AIDS education in schools, epidemiological surveillance, safe blood transfusion, and management system development in different sectors and administrative levels. The Plan specified funding levels for some activities, but not for others. The NAP budget for this two-year period was 17,900,000 USD. Of this, government funding accounted for 9,000,000 USD, with the balance from international sources.
Through these immediate objectives, the program identified key activities to implement in addressing HIV/AIDS in the country. During the period of 1994-1995, the following accomplishments were recognized:

- A system of relatively complete documents was developed which created a legal framework for HIV/AIDS prevention and control activities;
- An organizational structure was established at the national level for HIV/AIDS prevention and control to include both medical and social science oriented activities;
- Safe blood transfusion was strengthened;
- A system of HIV/AIDS sentinel surveillance was set up;
- Research activities were started including knowledge, attitudes, beliefs and practices (KABP) studies and medical research were initiated.

The period 1994-1995 could be considered as the initial national program. A national program with its true meaning probably operated in later period. However, the national response to the HIV/AIDS epidemic undoubtedly was very positive which posed the formulation of basic guidelines to cope with the epidemic.

### 3.1.2 National Target Program, 1996-2001

From 1996 forward, HIV/AIDS prevention and control in Vietnam had been implemented according to the National Target. This was implemented with specific yearly action plans in order to achieve annual goals. The Program has been implemented in 7 main areas:

1. Information, Education and Communication (IEC) activities;
2. Exposure prevention and control activities in medical sector;
3. Monitoring, care, counseling and treatment for HIV/AIDS infected people;
4. Program management and coordination;
5. Scientific research;
6. International collaboration; and
7. Community mobilization for participation in HIV/AIDS prevention and control activities.

**IEC activities:** are implemented around basic themes identified by NCADP. For example, in 2001 the theme was “men make the change of the HIV/AIDS epidemic.” Top-ranking activities are carried out through mass media such as television, press, and other types of information provision including commune/ward information dissemination using public address systems or news releases and other art performances to target the general public. Furthermore, information is disseminated directly to individuals of target groups identified through the network of propagandists and collaborators of the HIV/AIDS program and other mass organizations. Other forms of propaganda are direct propaganda by disseminating information materials and campaigns. Lastly, harm reduction intervention activities targeted high-risk groups. These IEC activities have been conducted both independently as well as integrated with programs such as population and family planning (FP) programs, and the Fatherland Front of Vietnam’s promotion program to “Unify the whole population to build a new life in residential areas”, etc.

**HIV/AIDS prevention and control activities in the medical sector:** covers a range of activities: prevention of health service exposure; guarantee of safe blood transfusion; improvement of laboratory examination; HIV/AIDS and STD surveillance and in future to monitor the STD treatment service conducted by private healthcare providers; treatment activities for HIV/AIDS patients; prevention of HIV/AIDS infection in obstetric and pediatric systems; and strengthening
the management and monitoring system for equipment, devices, and lab kits for HIV/AIDS prevention and control.

Monitoring, care, counseling and treatment activities for HIV/AIDS infected people: aim to assist those infected to improve and maintain their health in order to prolong their lives, and to provide counseling to families and communities of HIV infected people about HIV/AIDS prevention. This area includes many activities, ranging from the establishment of care and counseling networks to promoting the involvement of religious organizations, charity groups and entrepreneurs in prevention activities. These activities involve staff working in health facilities, prisons, and re-education centers, as well as people living within general communities. Accordingly, the monitoring of care extends from the formal state health care system to informal peer group activities.

Program management and coordination activities: are geared toward capacity building necessary to establish and maintain an effective HIV/AIDS prevention and control program, which can work, effectively in the Vietnamese conditions. This includes strengthening the HIV/AIDS prevention network, improving management skills of HIV/AIDS program staff, and improving coordination with other sectors to develop specific policies, directions, and guidelines for planning. These activities are implemented through conducting training courses, supervisions, evaluation and development of indicators for evaluating HIV/AIDS prevention and control activities.

Scientific research: is conducted based on guidance provided by the Scientific Committee of NASB on prioritized research topics. Through the review and approval of this Committee, appropriate implementing agencies are selected for conducting this research. This research is primarily operational in focus, which serves primarily for policy making, and planning of HIV/AIDS program. Up to the present time there are some research projects focusing mainly on blood transmission and infection, and KABP studies on specific target groups and in specific localities. The behavioral surveillance of 2nd generation also includes activities of international scientific exchanges with other countries in the world as well as in the region.

International collaboration: has been extensively pursued to raise foreign aid for HIV/AIDS prevention activities. This includes a series of international cooperative activities carried out with in the NASB as well as in other organizations. These collaborative efforts also include sharing experiences with other countries in the region, as well as coordinating activities with neighbor countries to prevent the cross-border and regional spread of HIV/AIDS.

Community mobilization aims at making full use of political commitment, Party and government administration leadership at various levels, community participation, and HIV/AIDS infected people and their families. Among those, the NAP defines the most important element in the success of the program as the collaboration and support by Party and government leaders and administrators at all levels.

Between 1996-2001, specific budgets were allocated for specific priorities. For example, in the annual plan of 2001 there were four areas of spending:

- Intervention activities in 3000 target communes/wards;
- Ensuring 5000 surveillance sample in 30 target provinces and 1000 in other provinces;
- One hundred percent of blood units screened;
- Following up 70% of HIV infected people with an identifying address or 60% of HIV infected cases found.
In the year 2000, there were 5 areas of spending:

- To adequately conduct the HIV prevention in 3000 target communes;
- Surveillance in 21 provinces;
- One hundred percent of blood units scanned;
- Preventive activities in 100% of 05 and 06 Centers and in 100% of reformatories;
- Preventive treatment from mother to child transmission for 100% of monitored HIV infected pregnant women.

However, indicators used for assessing the fulfillment of the planned activities were still very sparse and changed from year to year. The main measure was whether an activity was implemented or not.

3.1.3 Resource allocation and budgets

The annual budget plan was developed based on three main components:

1. Government spending as legally stipulated for the NAP;
2. Spending for national target programs as defined by NASB;
3. Spending for regular activities including IEC activities of the Steering Committee for Prevention and Control for HIV/AIDS, Drugs and Prostitution at provincial level and sectors; professional health care activities; AIDS prevention activities at district level; management, monitoring and evaluation, training, meeting, summation, and rewards by the Steering Committee at provincial/city level.

The Government budget for the NAP was rather modest until 1993 but since 1994 it has increased considerably and now comprises half of the total budget for the program including support from international organizations such as the UN, bilateral donors as well as NGOs (UN, 2000). The budget from the central Government for the AIDS program increased on average 5 billion VND every year (45 billion VND in 1995; 50 billion VND in 1996; 55 billion VND in 1997; 49.4 billion VND in 1998; 50 billion VND in 2000; and 60VND in 2001). In addition to the budget from the central government, there were contributions from local (provincial, district and commune) authorities for activities related to HIV/AIDS. The Ministry of Finance (MOF) estimated that for the period 1996-2000, the HIV/AIDS program had 60% funding from the central Government budget, 15% from the contribution of local authorities and 25% from foreign aid. During 1997-1999, UN funded USD 4,571,949; international NGOs and other donors funded USD 7,422,189.

At provincial level local funding accounted for 70-80% and central level contributed 30% for the period 1997-2000 (MOH, 2001). Currently, each district receives annually about 4.5-5 million VND, and each target commune/ward receives about 3 million VND for HIV/AIDS prevention activities. Of the total budget allocated to the HIV/AIDS prevention program, 60-65% is spent on medical activities and 35-40% on non-medical activities.

Depending on local requirements, local governments can complement central-provided funding with their own resources. This is especially common in economically developed provinces in the South, such as HCM City. Based on the approved working plan, activities are then implemented by relevant sectors and organizations as well as at local levels through administrative systems. However, as allocated funding is often delayed, it is hard to appoint the exact time for the commencement of many activities at the local level.
3.2 Policy environment

3.2.1 Brief history of policy development for NAP

Before 1990, there was a general perception that HIV/AIDS was the responsibility of the health sector because it is a disease. As a result, the Committee for HIV/AIDS Prevention and Control was within the administration of the MOH. The development and formulation of HIV/AIDS-related policies was implemented by various agencies of the MOH to be coordinated by the Department of Hygiene and Preventive Medicine. A Vice Minister of Health who responsible for preventive medicine, Director of the Department of Hygiene and Preventive Medicine, Director of the Institute of Hygiene and Epidemiology, Director of the Institute of Hematology, Director of the Institute of Dermatology and Head of Department of Infectious Diseases of Bach Mai General Hospital were the people at the highest level of policy development for HIV/AIDS prevention and control. The Committee was rarely active even thus far, there had been no case detected in Vietnam until 1991. As early as April 5, 1988, MOH issued a Circular, signed by a Vice-Minister, to be sent to various province health offices and institutions. This circular reviewed five activities and provided guidelines for further action in terms of HIV/AIDS prevention under MOH policies. This could be seen as one of the very first policy documents on HIV/AIDS in Vietnam.

Before long, the health sector realized that HIV/AIDS prevention was linked with behaviors (sexual behavior, addiction to intravenous drugs, prostitution) that were generally considered outside the purview of the health sector. Therefore, some HIV/AIDS policy issues were within the realm of the health sector while some were not. Stakeholders for the development and the formulation of policies for HIV/AIDS prevention and control, hence, should include not only health representatives but also from other sectors.

The National AIDS Committee (NAC) was created by the involvement of related sectors in 1990, chaired by a Vice Prime Minister. The executive body for the NAC is the National AIDS Bureau (NAB). On December 22, 1990, NAC issued the instruction 26/BYT-CT calling for immediate action to prevent HIV transmission in the country. The document was developed based on global experience. The document had two parts, one part for the identification of five immediate activities and one part for the definition of responsibilities of six other involved sectors. The five immediate activities were:

- Detection of HIV positive cases (case detection done by leading health institutions, high-risk groups invited for voluntary testing, but obligatory examination will be applied in case of necessity; counseling must be provided while keeping confidentiality for PLWHA.)
- Care for HIV positive cases (develop a network for counseling so PLWHA are not isolated).
- Strengthening of the HIV/AIDS care system.
- Supplementary professional procedures dealing with HIV/AIDS.
- IEC for the health sector in particular and for the wider society in general.

The inter-sector action involved:

- MOCI in IEC activities and in HIV control for tourists;
- MOPS in HIV control for prisoners and control of prostitution and drug abuse;
- MOET in teaching of HIV/AIDS prevention in schools;
- MOJ in the issuing of legal documents related to HIV/AIDS; and

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• VYU in the promotion of healthy lifestyle.

The development of the HIV/AIDS prevention and control body from a committee under the administration of MOH to a national committee, together with the above mentioned documents showed the sound awareness towards HIV/AIDS as well as strong political will of the Government in the battle against the global epidemic. Thus, it is fair to say, from the beginning, the NAP of Vietnam has had a supportive policy environment in which to develop.

3.2.2 Key policy documents

After the establishment of the NAC in 1990, policies on HIV/AIDS have been developed to gather national and international experience, to show political will and to be suitable within Vietnamese culture as well as existing administration systems in the country. Six policy elements were reflected in key documents as the followings: IEC, epidemiological surveillance, risk prevention, national management and inter-sectoral action, and social support (e.g., abolition of discrimination).

Information – Education - Communication:

The NAP's executive body, MOCI and MOET are the most active players in policy on IEC. This policy element expressed best in two documents:

1. Joint Circular (No. 02/TT-LB issued on March 17, 1993) between MOCI, MOET, and MOH indicated responsibility of each Ministry in HIV/AIDS prevention as the following:

**MOH:**

- HIV/AIDS and STD education for staff in the health sector,
- Teaching of HIV/AIDS in medical faculties and schools,
- Teaching of HIV/AIDS in various refreshing courses,
- Coordination of IEC activities conducted by the Youth Federation, the VWU, and member ministries of the National Committee for the prevention and control of HIV/AIDS.

**MOCI:**

- Education of HIV/AIDS for staff within the sector,
- Mobilization of various TV and radio channels, various newspapers and journals for providing regular information on HIV/AIDS,
- Promotion of various artist groups to perform works related to a healthy lifestyle,
- Administration and management of entertainment places by province offices of culture and information.

**MOET:**

- Teaching of HIV/AIDS in schools according to Vietnamese culture,
- Training of trainers for the teaching of HIV/AIDS in schools,
- Teaching of HIV/AIDS for students in universities and colleges,
- Province Offices of Education and Training have to collaborate with Province Offices of Health in the prevention and the control of HIV/AIDS at province level,
• The circular also called on other sectors including the Trade Union, MOLISA, the General Office of Tourism to be involved in IEC for HIV/AIDS prevention and control.

2. Joint Circular (No 112/NQLT issued on July 22, 1999) between the MOCI and the NAC for IEC in the prevention and the control of HIV/AIDS, defined objectives, activities, responsibilities and collaborative implementing structures. The collaboration aimed at mobilizing all possible resources from the two sectors for a common goal, to establish a common IEC network for HIV/AIDS prevention and control. The content of the collaboration included:

• Integration of HIV/AIDS control in the promotion of cultural families,
• Training for IEC personnel,
• Introduction of AIDS control information in activities of the cultural and information sector,
• Implementation of campaigns for AIDS control,
• Organization of seminars, workshops, entertainment, etc. related to HIV/AIDS control,
• Production of materials for HIV/AIDS control.

Responsibilities of each body include:

**NAC:**

• Provide up-to-date information on HIV/AIDS to the cultural and information sector,
• Elaborate the annual IEC plan for HIV/AIDS and active collaboration with the cultural sector for the production of appropriate IEC materials accordingly,
• Provide updated knowledge on HIV/AIDS through refresher courses,
• Finance the implementation of annual IEC plan for HIV/AIDS control.

**MOCI:**

• Active collaboration with various levels of HIV/AIDS control structure for the elaboration of annual action plan,
• Assignment of professional IEC staff to assist in the prevention and the control of HIV/AIDS at various levels, mainly in the rural, mountainous and remote areas,
• Use of existing materials and equipment in the cultural sector for IEC for HIV/AIDS control,
• Guide for mass media to implement regularly IEC for HIV/AIDS control.

Structures for IEC implementation at central level were the National AIDS Bureau and the AIDS committee of the MOCI. At province and district levels, province/district AIDS bureaus and province/district AIDS committees were the implementing structures.

NAC and MOCI also jointly developed an Action Plan for 1999-2000 to improve awareness of various sectors, various levels, various mass organizations and of the people for their knowledge of HIV/AIDS as well as to develop potential capabilities of individuals, families and communities in the prevention of HIV/AIDS transmission, thereby contributing to the building of culturally well-behaved households. There were 13 activities in this Action Plan to meet those objectives.
Epidemiological surveillance:

Epidemiological surveillance of HIV/AIDS was mentioned in various legal documents issued by the MOH. The policy for HIV/AIDS surveillance was expressed comprehensively in the decree No 1418/2000/QD-BYT issued on May 4, 2000.

HIV/AIDS epidemiological surveillance is defined as the continuous and systematic collection of data on factors related to the distribution and the trend of HIV/AIDS development in population with various levels of risks (high risk groups) in selected areas in order to provide update information for the planning, the prevention, the control and the evaluation of intervention measures. Annual samples were collected from 7 groups: IDU (in rehabilitation centers and in communities), SWs (in concentration sites), STD patients (in public health facilities and in private clinics), pregnant women (in maternity houses), newly recruited soldiers, TB patients and blood donors. Samples were collected from May to August, and for newly recruited soldiers from November to December. The epidemiological surveillance is based on case detection and includes screening of blood for transfusion. Case detection has to be done with appropriate counseling. Blood screening for transfusion was stated in Circular No 3278/YT-DP issued on May 19, 1998. According to this Circular, 100% of blood donations are to be tested.

Risk prevention:

As the high concentration of HIV/AIDS prevalence was in those groups with high-risk behaviors, the policy for “targeting interventions at high risk groups” was considered as an important control measure. This policy allowed for the distribution of condoms to SWs and the distribution of sterile syringes to IDUs. However, drug use and therefore addiction, and prostitution are forbidden in Vietnam by the decree No 5/CP and 6/CP of the Government issued on January 29, 1993, which lists both acts as social evils. So, conflicts have risen during implementing these policies.

Administrative management and inter-sectoral action:

The program for HIV/AIDS prevention and control was managed at national level. The Government decree establishes the National Committee for HIV/AIDS prevention and control (Decree 358-CT) on October 5, 1997 and the establishment the NCADP (Decree 61/2000/QD-TTG) on June 5, 2000. These decrees provided guidelines for the establishment of committees for the prevention and the control of HIV/AIDS at various levels that made inter-sectoral action more effective. It can be said that administrative management and inter-sector action are complementary for the implementation of the HIV/AIDS control program

Social support:

The program for prevention and control of HIV/AIDS was based on humanitarian concepts toward HIV/AIDS cases. There was a policy for social support to HIV/AIDS cases without discrimination. This policy for no discrimination was also expressed by the new outlook “living together with AIDS”. The social support to HIV/AIDS cases went together with measures to prevent transmission by them. The temporary Joint Circular No 25/1999/TTLB-BLDBXH-BYT was issued on October 14, 1999 restricting 7 areas of employment for professionals that are detected as HIV positive. The revised Join Circular No 29/2000/TTLB-BLDBXH-BYT issued on December 28, 2000 reduced the areas of employment barred for HIV infected people to 2 areas: 1. Health services involve direct contact with human blood and body fluid; and 2. Orthopedic surgery and cosmetic services that involve direct contact with human blood and body
fluid. That move showed the progress in reducing discrimination as well as the improvement in general understanding about HIV/AIDS.

### 3.2.3 Strengths

This review of key policy documents indicates that the policy environment for HIV/AIDS was created in a timely fashion. Policy development began before the first HIV positive case was detected in the country. Most of the interviewed managers and professionals acknowledged that authorities at all levels of the administrative systems were clearly aware of the seriousness of HIV/AIDS and showed great desire to control its transmission.

From the beginning, HIV/AIDS was conceived as a health problem (a communicable disease) and the focus lay on the medical sector. It quickly became apparent the disease was a social concern and responsibility. Medical administrators thought that the prevention of a disease linked with behavior required the involvement of the whole society, the participation of all communities with the emphasis on the prevention of disease. Interviews with key informants and review of documents demonstrated that the inter-sectoral approach had gained a strong consensus among policy makers and program managers.

### 3.2.4 Challenges and opportunities for improvement

One or more informants identified the following policy gaps or need for clarification or elaboration:

- There was no clearly defined inter-relationship between the six elements of the combined intervention strategy.
- There was a clear policy for IEC but there were not yet policies regarding “messages”, “channels” and “target audiences”
- There was a clear message about HIV transmission but no clear message for safe behavior (use of condoms and sterile needles)
- There was a clear strategy of inter-sectoral action but a policy for the involvement of NGOs were not clearly defined
- There were policies for some high-risk groups (IDU and SW), but not for other specific groups such as HIV positive prisoners, truck drivers, etc.
- There were policies for the national/governmental management of HIV/AIDS, but there were no policies to improve the management capacity accordingly.
- There are needs for policies in several issues, including:
  - Counseling policy especially for HIV/AIDS and linked with services.
  - Policies for tailoring specific measures (requiring specific study to determine appropriate measures for specific conditions)
  - Condom policy (linkage with the Vietnamese culture for more acceptability)
  - Sterile needle policy (linkage with policy for peer education)
  - Non-discrimination policy (linkage with policy for social support)
  - Policies for care for AIDS cases (community/ family, humanitarian/ Government-social/ medical/ non medical care, treatment of opportunistic infections, etc.)
  - Policies for the involvement of NGOs (in country NGOs and international NGOs, Red Cross, etc.)
  - Policies for management (e.g., more coordination and leadership).

Additionally, a review of policy documents revealed that several policies promulgated in the period 1996-2001 conflict and required adjustment. These are as follows:
Policies for high-risk groups (IDUs and SWs): conflicts and trends

The policy for high-risk groups (IDU and SW) intends to recognize these high-risk groups and then to educate them in prevention methods for HIV/AIDS. The policy for IDUs and SWs, rather than assist in education and awareness, forbids them and obliges them to give up injection or prostitution. The HIV/AIDS program in 1996-2000 decided to adopt the policy of “condoms for SWs” and “sterile needles for IDUs” – both have in international experience proven as effective measures. However, as prostitution and addiction were forbidden, the program could not be implemented on a large scale but only in a small scale, using peer educators. However, discussions with peer educators revealed that policies implemented by police and anti-social evils institutions are somehow obstacles for clean needles and condom programs as needles or condoms found in the possession of IDUs or SWs can be used as evidence against them. This is one of the biggest hurdles for harm reduction programs. It also reflects the inconsistency among leading agencies of NCADP.

Efficiency of policies: resource allocation conflicts

During the period 1996-2000 there was a general consensus on the combination of IEC and epidemiological surveillance for HIV/AIDS prevention and control. However, at the operational level, there were some problems regarding resource allocation to IEC and to epidemiological surveillance: who will take how much from the limited resources? And the problem here is not only the competition for more allocation between the medical sector and the social sector. The problem here could derive from the difference in concepts. The majority of stakeholders agreed that there was a need to combine medical measures with IEC (social and anthropological measures) but there was still debate on whether it be medically or socially focused.

Administrative management and inter-sectoral action:

The involvement of various sectors for the prevention and the control of HIV/AIDS are necessary because the disease is linked to many social and behavioral factors. The medical sector itself could not solve all problems. In practice, each sector works vertically within the sector according to its assigned responsibilities. The coordination of various sectors working toward a common goal is always necessary to make the inter-sectoral action effective. But, there are conflicting interests between sectors. Administrative management of the HIV/AIDS control program cut across these vertical operations of various involved sectors. In practice, administrative management has not effectively developed links with and between sectors. The linkage between the administrative management of the NAP and inter-sector action should be improved.

Social support and discrimination:

In the view of the common people, HIV/AIDS carries similar social stigma to leprosy at the beginning of last century. While legal documents call for no discrimination toward HIV/AIDS patients, communities and families continue to fear the infection. Results of the FGDs revealed that most people consider the disease as a declaration of death. The point here is not only calling for an end to discrimination, but also calling for social support. There is another aspect of the problem. Some HIV positive cases used the disease as an advantage to menace others. Many HIV infected prisoners were not made aware of their HIV status. If they were, they may have committed more crimes. Some hospitals complained that IDUs who were HIV positive behaved badly. There were legal documents forbidding criminal actions involving intentional infection.
However, there are no policies to differentiate those who have criminal intentions. The conflict here is between the humanitarian concept for HIV/AIDS cases on one side and the administrative/legislative concept for their possible criminal actions on other side.

In summary, although there were some issues that needed further attention, a supportive policy environment has been created for the development of NAP since the beginning of the program. This reflects a sound awareness as well as strong political will of the country’s leadership in confronting this global epidemic. Such an environment is an important base for the development of a legal framework towards the national response to HIV/AIDS.

3.3 Legal framework

3.3.1 Key documents

Three important legal documents define the legal frame supporting the HIV/AIDS prevention and control program for the period 1995-2001.\(^1\) These are:

1. Instructions of the Party (Instruction No 52CT/TW of the Communist Party Central Committee, issued on March 11, 1995;
2. Ordinance on HIV/AIDS prevention and control of the National Assembly, dated May 31, 1995 and
3. Decree of the Government (Decree Number 34) on HIV/AIDS prevention and control, issued June 1, 1996.

The triad of important legal documents for HIV/AIDS prevention and control started with the Instructions of the Party. It was issued when there were 2280 detected HIV positive cases (February 11, 1995) and showed the strong willingness of the Party to control this worldwide epidemic. Evaluating that the AIDS control program was not strong enough to keep the infection under control and that authorities at various levels had not yet taken adequate action to limit the disease, the Central Committee of the Communist Party requested Party organs at various levels to strengthen their leadership in the AIDS program. Suggested measures included:

- Promotion of healthy lifestyle as well as the control of drugs and prostitution,
- Use of IEC intervention as well as the keeping of safe blood transfusion and other sterile conditions, and
- Coordination of all efforts by people’s committees at various levels.

Following the instruction of the Party was the Ordinance of the National Assembly issued on May 31, 1995. It has 5 chapters with 30 provisions as follows:

- Defines responsibilities of State offices, the Fatherland Front and its member organizations, economic and social organizations, units of people’s armed forces and all citizens, foreign organizations and individuals in Vietnam in the implementation of HIV/AIDS prevention and control according to regulations by the law (Chapter 1).
- Regulates claims against discrimination regarding HIV/AIDS cases but clearly expresses the support for the prevention of disease transmission (Chapter 2).

\(^1\) Prior to the “Instructions of the Party,” there were several legal documents issued by the Ministry of Health and the National committee for the prevention and the control of HIV/AIDS, which contributed greatly to the creation of the legal frame of the program for the period 1995-2000, providing necessary background for issuing of the triad of important legal documents.
• Defines preventive measures. Prevention should be based on IEC measures to be implemented by various social sectors, what would raise people’s awareness on safe behavior for disease prevention. Prevention should be also based on medical measures such as epidemiological surveillance (to include laboratory examinations for screening and for diagnosis) as well other activities to be implemented by the medical sector. This chapter of the Ordinance also defines the combination of social measures and medical measures for the control and the prevention of HIV/AIDS. In this chapter, there is an article (article 21) for the regulation of insurance regarding professional risk and an article (article 24) for the prohibition of intentional transmission (Chapter 3).

• Defines State management of the prevention and the control of HIV/AIDS (Chapter 4).

• Chapter 5: Execution of the Ordinance

On June 1, 1996, the Government then issued Decree No 34 to implement the Ordinance. This Decree has 20 articles, covering almost all areas concerning the prevention and the control of HIV/AIDS that had been mentioned in the Ordinance. The content of the Decree includes:

• Promotion of healthy lifestyle (safe behavior) and the prohibition of drugs and prostitution (risks) and the assigning of various organizations to implement IEC for HIV/AIDS prevention and control for various target groups (mass media; State agencies; mass/community organizations; socio-economic organizations and the army).
• Introduction of health education on issues of HIV/AIDS in secondary and high schools.
• Prohibition of intentional and criminal infections of HIV.
• Obligation of HIV positive individuals to inform their partners about their cases and the obligation of HIV positive immigrants to inform the quarantine on entry to Vietnam
• Authorization for hospital directors and health authorities from district level upward to inform partners of HIV positive individuals about their cases and the prohibition of mass media to provide information about names, age, addresses and photos of HIV positive cases without their consent; the authorization for district health authorities upward and users of labor forces to request HIV examinations of those who are judged to be at risk
• Support of communities to HIV/AIDS cases without discrimination
• Right of HIV/AIDS cases to be treated in various health facilities as well as the responsibilities of these health facilities to take care of HIV/AIDS cases
• Security and incentives for health workers in their contact with HIV/AIDS cases
• Definition of responsibilities for the NAC, the MOH, the MOCI, MOLISA and the MOF.

3.3.2 Strengths

Key informants at provincial and central levels reported that the legal frame created good environment in general for the implementation of the program for the control and the prevention of HIV/AIDS at all levels in the country. There was a structure from the central government to the commune authority supporting this legal frame. A network of volunteers and peer educators was added to this structure. From the authorities’ aspect, the implementation of the legal frame is highly effective.

Specific strengths that were identified in the meta-analysis workshop include:

1. Vietnam had established organizational structures for the prevention and control of HIV/AIDS prior to its occurrence in 1990.
2. Organizational structures for HIV/AIDS prevention and control in Vietnam extended from the health sector to other related sectors.
3. Structures for the prevention and control of HIV/AIDS moved up from ministerial level to national level.
5. AIDS committees at various levels were established for the promotion of inter-sectoral action while AIDS offices (bureaus) at various levels were created for the administration and the coordination of activities to prevent and to control HIV/AIDS.
6. Legal framework and requirements for HIV/AIDS prevention and control was developed gradually.
7. Change of structures for HIV/AIDS prevention and control in 2000 had positive effects for more coordination between the control of HIV/AIDS, the control of Drugs and the control of prostitution and more collaboration between the medical sector and the social sector for the prevention of HIV/AIDS. Although displacement of the National AIDS Bureau from the Government office to the NASB of MOH created some difficulties and confusion for the operation at both central and provincial levels, the health sector was always the key actor of the program. Therefore, the adaptation to the new structure through lower levels was swift.
8. The NASB had an important role for the coordination and the implementation of the program.

The prompt promulgation of the triad of the above mentioned documents was evidence of the high level of commitment from country’s leadership. It seldom happens in Vietnam that such a triad of legal documents is approved quickly and synchronously as the HIV/AIDS program. The Party’s Instruction has provided general guidelines for all HIV/AIDS prevention and control activities and raised the wider society’s awareness of the need to cope with HIV/AIDS epidemic. The Ordinance officially provided the legal frame for the program. It also placed emphasis on the inter-sectoral approach of the legal frame as well as on commitment of authorities at highest level. Lastly, the Government’s Decree sets specific functions and tasks to get ministries and branches, organizations at all levels to participate in HIV/AIDS prevention and control’s related activities. The most crucial point here is that for these priorities, there is a financial commitment provided from the government budget.

3.3.3 Challenges and opportunities for improvement

Most key informants commented that the legal documents reflect Government awareness, but their implementation requires more commitment from related authorities. Commitment should be judged on the level of investment and financing for the program. Almost all interviewees agreed that authorities at all levels were aware of the HIV/AIDS problem and were willing to control the possible disaster caused by this disease. All interviewees expressed that the control of HIV/AIDS could not be done without the involvement of the whole society. The legal frame showed the willingness of the authorities to control HIV/AIDS. But, there is a great divide between willingness and commitment.

Experts in the meta-analysis workshop noted the following areas for improvement:

- Coordination across implementing structures is weak. Few legal documents exist to define the coordination between offices for HIV/AIDS control, Drugs control and prostitution control, which are located in three different ministries (MPS, MOH and MOLISA). In particular, the collaboration between the social sector and the medical sector was sometimes inadequate.
- Few legal documents were issued for the involvement of NGOs, resulting in low community participation.
Experts noted several opportunities exist to address these shortcomings:

- The IX Party Congress has provided guidelines for the prevention and the control of HIV/AIDS.
- The Five-year plan included activities related to the prevention and the control of HIV/AIDS.

A Delphi study was conducted with the participation of 8 experts to score 3 factors:

- Awareness that HIV/AIDS could be kept under control.
- Belief that HIV/AIDS could be kept under control in Vietnam.

“If the legal frame was strong enough to make TV have similar advertisement for HIV/AIDS as it had done for Tiger beer, people would keep in mind what should be done to prevent the disease.” A health educationist, HCM City.

“There should be appropriate measures to mobilize the society in this work, without social mobilization, nothing happens. But, there is a need to have a stronger legal frame in order to mobilize the society as expected.” A sociologist, Hanoi.

Results showed that the belief that HIV/AIDS could be controlled in Vietnam was low while awareness was high and willingness was very high. Therefore, there is a need to provide more evidence on the possible decrease of HIV incidence in Vietnam. The consolidation of belief could be transformed into higher commitment and more financing for HIV/AIDS prevention and control.

In summary, the triad of legal documents issued by the three leading bodies - The Party, the National Assembly and the Government showed strong political wills and high commitment of country leadership to NAP. These documents, in turn, supported the development of policy elements and provided legislative foundation for the program implementation. However, there is still a need for the kind of legal documents that support the strengthening of coordination between social and medical sectors in a common effort to halt the epidemic.

3.4 Program interventions

UNAIDS have recommended different interventions for a National AIDS Program. Although not clearly defined, Vietnam’s NAP in last 5 years had been fully or partly implementing those interventions. In order to review the NAP based on the global experience and practice, this process evaluates program interventions suggested by UNAIDS. They include:

1. Information, Education and Communication.
2. Voluntary counseling and testing.
3. Male condom promotion.
4. Sexual health and life skills education for young people.
6. Abolishing stigma and discrimination.
7. Prevention of transmission in medical services.

Interventions of NAP came under 3 main areas of National Target Program (see also section 3.1.2) which included: 1. IEC; 2. Exposure prevention and control activities in medical sector; and 3. Monitoring, care, counseling and treatment for HIV/AIDS infected people.
11. Treatment of HIV-infected and AIDS patients.

The evaluation results of the program interventions are presented below in the order above. They have been grouped into medical and non-medical interventions, without any particular order.

3.4.1 Information, Education and Communication

a) Background

Information Education and Communication (IEC) activities to improve knowledge of HIV/AIDS for behavior change have been defined in the MTP of 1994-1995 and 1996-2000. The MTP states specific activities to achieve these objectives. These were:

- IEC program on HIV/AIDS,
- Education program on AIDS and STDs in schools,
- Education program on HIV/AIDS/STD for people practicing high-risk behaviors and target groups\(^3\), and
- Intervention programs to reduce high-risk behaviors.

The programs’ objectives were:

- Improving people’s knowledge so that the wider society can protect itself and actively participate in HIV/AIDS prevention,
- Changing high-risk behaviors,
- Promoting positive attitude towards HIV/AIDS infected persons, and
- Minimizing discrimination and stigmatization.

b) Legal framework

Various legal documents (e.g., the Instruction Ref: 52-CT/TW dated 11 March 1995 issued by the Central Executive Committee of the Communist Party, “Guidance of the prevention and control of AIDS”; the Ordinance on the Prevention and Control of HIV/AIDS issued by the National Assembly on 31 May 1995; and the Government Decree 34 CP “Guidance to Execute Ordinance on the Prevention and Control of HIV/AIDS issued on 1 June 1996) have created a positive legal environment for IEC activities\(^4\). Article 7 of the Ordinance on the prevention and control of HIV/AIDS affirms that IEC is one of main measures against HIV/AIDS transmission. Articles 5, 7, 8, and 9 of this Ordinance clearly define that state offices, socio-economic organizations as well as community and family are responsible for education and communication on HIV/AIDS prevention for their members.

The 1st Article of the Decree 34/CP of the Government dated June 1, 1996 clearly defines the content of IEC on HIV/AIDS prevention. IEC activities should include information on HIV/AIDS and legal issues relating to prevention of HIV/AIDS, and prevention of drug abuse and prostitution leading to transmission of HIV/AIDS. IEC messages should also promote healthy life styles, a sense of responsibility of individuals, family, and community in HIV/AIDS prevention. The IEC programs should introduce measures to reduce the risks of infection,

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\(^3\) This area will be addressed in subsequent sections of this report in the context of the specific target groups.

\(^4\) Other legal documents include Circular No 02/TTLBB; March 17, 1993 between MOH, MOCI and the MOET on implementation of IEC activities in HIV/AIDS prevention; and Decision 112/NQLT, July 22, 1999 by the MOCI and the NAC on collaboration in promoting IEC activities on HIV/AIDS prevention nationwide.
encourage communities to take responsibility for infected persons and educate the latter to be responsible in prevention of infection.

Creating a positive legal environment reflects strong commitment of the leaders of highest level on IEC activities for HIV/AIDS prevention. This can be considered as a strong point of the NAP in Vietnam. Here, a great contribution of the program managers should be recognized and appreciated when they could mobilize top leaders to get strong commitment and support for IEC activities through specific documents and policies.

However, from the field assessment awareness of HIV/AIDS legal issues is low. For example, the Ordinance on the prevention and control of HIV/AIDS was issued in 1995, but until the present time, few people interviewed knew about it. Many people from the general population interviewed have a poor knowledge of legal issues in regards to HIV/AIDS prevention and care of infected persons. They don’t know that a HIV positive person who intentionally transmits the disease to other people is considered a criminal or a HIV positive person is protected by laws and must be cared for by the family and community.

c) Implementing Agencies

IEC activities for HIV/AIDS prevention have been assigned to the NAC and its related ministries including MOH, MPI, MOF, MOLISA, MOET, MOJ, MOCI; and the mass organizations like the Fatherland Front, VYU, VWU, Red Cross, etc. Also IEC activities for HIV/AIDS prevention have mobilized a large number of media professionals including journalists, TV and radio editors and speakers, as well as social workers (NCADP, 2001).

d) Budget

During the period 1997-1999, IEC activities received approximately 28% of the total NAP budget (about USD 2,250,000 per year). The Government budget for NAP has increased remarkably since 1994 and accounted for about half of total program budget while the other half came from UN agencies, bilateral programs and INGO (UN, 2001). This is the second largest NAP budget allocation after medical treatment (NAC, 2000). In 2001, additional funds of 3 million VND had been allocated to each of 3000 target communes/wards nationwide mainly for IEC activities. However, of the NAP budget still only 8.1% reached provincial level (see table 5). IEC activities received 10% of the total UN funding (of USD 4,571,949) during 1997-1999 and international NGOs and other donors also contributed 10% (of USD 7,422,189) (UN, 2001).

Thus, the funding allocated for IEC activities from both national budget and contribution of the international organizations for NAP during 1997-1999 was approximately USD 8 million. The Review of Ten Years of Implementing the HIV/AIDS program stated that due to the lack of funds, there was a serious shortage of materials and equipment for IEC activities causing unmet need, especially at the grassroots level (NCADP, 2001). Key informants interviewed for this evaluation expressed similar concerns over the level of funding.

| “The program of HIV/AIDS prevention seems to incline to medical service. Regarding the IEC, so far it’s mainly propaganda for the program. How it does impact on the beneficiaries, it is difficult to say because the fund is too small and divided into many portions. The numerator is small while the denominator is large, not much intervention could be carried out.” (MPI official) | “We pursue the view that prevention is a key component focusing on education for the young generation. However, the budget is too limited... Planners and financiers said that our country is very poor and it is impossible to find additional resources. From that limited amount we have to invest up to 60% for medical services... MOET has got 200 million dong per year, this is too small for education of an generation.” (NASB official). |

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e) Assessment of Program Activities

According to the Ten Year Review, 70% of people aged 15-49 have basic knowledge of HIV/AIDS prevention. The level was considered high compared to other countries (NCADP, 2001).

An important success of the NAP was achieving the IEC objective, “improving people’s knowledge on HIV/AIDS, on the modes of transmission and preventive measures.” Most people interviewed believe that the IEC program was effective and other independent evaluations support this finding. KABP surveys conducted in the last few years indicate a high percentage of people are aware of HIV/AIDS. The studies on behaviors of people aged 15-49 in twelve provinces and cities in 1997 showed that 75% knew two main methods for preventing HIV/AIDS transmission such as using a condom and clean syringes (NAC, 1997). Studies with high-risk groups like IDU and SW also showed a high level of awareness. From 70% to more than 90% of interviewees were aware of HIV/AIDS, and most of them knew two measures preventing HIV/AIDS transmission (Le Truong Giang et al, 1998; Khuat Thu Hong et al, 1997; Nguyen Chi Phi et al, 1999).

The Ten Year Review concluded that although IEC activities have greatly improved the public’s knowledge it was not sufficient for behavioral change (NCADP, 2001). According to many interviewed experts, the second objective of the NAP, aiming at behavioral change, has not achieved expected levels. The results of FGDs with people aged 15-49 in the sites under this evaluation showed that many people still did not have in-depth knowledge, such as results from blood tests could be negative in the “window” period, or that the percentage of infants infected from HIV positive mothers is not 100%, or that newborns should not be breastfed by HIV infected mothers. Inadequate knowledge of HIV/AIDS has created two situations. One, a part of the population believe that HIV/AIDS is the disease of bad people only, and believe it will not happen to them and they do not need to take preventive action for themselves and their family members. Or two, people are too frightened of AIDS and therefore avoid or even discriminate infected people including their relatives or friends.

Some program activities are described in more detail below:

IEC program on HIV/AIDS:

The IEC program mobilized the mass media to produce large volumes and diverse IEC activities and products. Hundreds of thousands of magazines, newspapers, bulletins, posters, banners, and leaflets on HIV/AIDS infection and methods of prevention have been delivered to millions of people. Different educational activities have been carried out including peer education among people living with HIV/AIDS, counseling, hot lines, competitions, variety shows, exhibitions of pictures, photos, short stories, etc. The TV and radio system in all 61 provinces of the country delivered news or reports on HIV/AIDS on a monthly basis. Annually, on average, there are about 4,000 news/reports on HIV/AIDS broadcasted on provincial television (in 1998 alone, there were 7,275). All popular central and local newspapers have news or articles on HIV/AIDS. During 1999, messages on HIV/AIDS have been delivered almost 10,000 times by provincial newspapers and journals (NASB 2001).

However, according to experts, the content of

“In general, people keep in their mind that AIDS is very dangerous, however they have not fully understood it. Therefore, they discriminate against AIDS infected persons, regarding AIDS as a social evil rather than an epidemic.” (Hai Duong, PASB official).
IEC messages delivered on mass media was too general. The IEC activities still focus on information dissemination to the public for “knowing” rather than providing skills for “practicing”. There are still few insightful and high quality articles or IEC products. Dr. Do Hong Ngoc, the IEC expert in HCM City said that some journalists do not have a full understanding of HIV/AIDS and have inadequate skills to disseminate HIV/AIDS information. So certain articles have puzzled the public, even lead to misunderstanding, and created negative attitudes towards PLWHA. According to Dr. Do Hong Ngoc, the impact of the IEC activities could be higher if media professionals involving in the program have better knowledge on HIV/AIDS and IEC skills on HIV/AIDS.

Regarding the content of IEC messages, there were some threatening messages that partly lead to discrimination against PLWHA. An official of Hai Duong believes that because the IEC activities on caring for PLWHA is not sufficient the latter are still discriminated against or overlooked by other people.

The Ten Year Review realized that IEC activities have not yet covered all regions and have not reached all groups of people, e.g. IDUs, SWs and seasonal migrants. IEC activities have not responded well to the changes and complexity of the epidemic. The IEC network for direct counseling at community levels has a shortage of both quantity and quality of human resources and was unable to meet the increasing needs of the program (NCADP, 2001).

During the field assessment, officials in different agencies involved in the NAP commented that information on HIV/AIDS has not reached remote areas. Many people in these communes do not know how HIV is transmitted. As an explanation for that situation, the Report on Ten years Implementing HIV/AIDS Prevention Program by the Committee of Ethnic Minorities and Mountainous Areas had noted that carrying out IEC activities in mountainous areas was very difficult, particularly for ethnic minorities. Access to information is limited due to the lack of mass media, low education and the language barrier (NCADP, 2001).

The head of a Commune Health Center (CHC) of Da Nang said that only 20% of the commune populations have access to HIV/AIDS information. The majority of these people belong to the two target groups, women and adolescents, who account for only one fourth of total population.

The study on “Sexual Perception and Behavior of Vietnam Ethnic Minority Groups” with Hmong, Dao, Thai, and Khmer in Lao Cai, Lai Chau and Kien Giang provinces conducted by Development Research Center (DRCC) with support from UNICEF and UNAIDS showed that knowledge of these groups on HIV/AIDS and STDs was poor. They know about sexual-related issues, or HIV/AIDS by word of mouth rather than through official channels. Education constraints, language barriers and social communication abilities are obstacles preventing these groups from having a full understanding of sexual behavior to prevent HIV/AIDS and STDs (UNAIDS, 2001).

**Education program on AIDS and STDs in schools:**

In the school system, education on HIV/AIDS prevention is included in the population and reproductive health education program. Since 1980s, the MOET with funds from UNFPA had
developed a pilot population education program that then expanded to all schools over the

country in the 1990s. From 1998 the population education program was further strengthened by a

new UNFPA supported project and eventually moved its focus to adolescent reproductive health

(MOET, 2001)(See section 3.4.4. for more details).

Since 1996, the education program on HIV/AIDS prevention has been introduced to schools at

all levels, from primary school to universities, colleges and professional schools under VWU and

VYU (NCADP, 2001).

Commenting on IEC program in school, an international expert on HIV/AIDS in Vietnam said

that the education on HIV/AIDS in schools has not been as successful as expected. Teachers

have not been trained well in regards to skills and methods for teaching HIV/AIDS, sexual and

reproductive health. They have not been trained to overcome the cultural and psychological

barriers relating to sensitive issues like sexuality or condoms. Therefore young people have not

been provided sufficient knowledge and skills on how to practice safe behavior. This would put

them at risk once they enter sexual relations.

In the school curriculum information on HIV/AIDS in particular and on reproductive health in

general, especially in general schools, was simple and non-specific. The education program is

mainly focused on information provision to youth but not aimed at skills development. This

would limit the formulation of positive behavior of adolescents (NASB, 2001).

The education program for HIV/AIDS prevention in schools was introduced in grades 5, 9 and

11 only. Therefore those children who dropped out of school before 5th grade do not have access

to this information.

Interventions to reduce high-risk behaviors:

According to many interviewed experts, the second objective of the NAP aiming at behavior

change is still far from being achieved. The experts think that the IEC activities have only

scratched the surface and have not yet achieved in-depth knowledge. The Ten Year Review

concluded that although IEC activities have greatly improved the public’s knowledge, it was not

sufficient for behavior change. For instance, one indicator of safe sexual behavior is the condom

use rate, which has increased considerably during recent years, but is still far from expected. This

issue will be discussed further in the sections on male condom promotion, sexual education and

life skills for adolescents.

In its first stage, the program has tried to widen the coverage of IEC activities i.e. to disseminate

information to the general population. In recent years, the program has gone in depth, specific

IEC activities have been designed and implemented for different groups such as pregnant

women, adolescents, and married women who have husbands working in the cities.

Besides, if the content of IEC in the past implies that only persons of special groups like SWs,

IDUs, or bad men can be infected with HIV/AIDS, IEC material has to change to emphasize that

every person can be infected if he or she is not aware of the risk and does not practice safe

behavior.

Gender aspects:

Gender issues have not been sufficiently integrated into the content of IEC program for

HIV/AIDS prevention. Although information on the higher risk of acquiring infection for women
than men is available in a number of messages, the causes that are deeply rooted in gender relations have not been touched. Cultural, moral norms on patriarchy, on women’s virtue and gender stereotypes leading to gender inequality, for instance, women’s passive role in sexual relationship and therefore in negotiations for safe sex, have never been addressed in the content of the IEC program.

Men’s roles in practicing safe sex recently have been promoted. However, the message still has not been given much public attention because it has been integrated only in several IEC campaigns but not to the content of frequent national IEC activities. The most popular message available so far is “Men could change the epidemic”. Men’s responsibilities for practicing safe sex, and in taking care of family member who is infected with HIV/AIDS, have not been sufficiently emphasized. The available messages are not enough to change men’s behavior. In HIV education programs for schools, the section on men’s responsibility is almost absent.

In short, IEC activities have greatly contributed to increased knowledge of people on transmission routes of the disease and prevention measures. However, much more needs to be done in response to the changes and complexity of the epidemic.

f) Evaluability of the program

Data on IEC activities nationally, provincially and at ministerial levels, are available and accessible, i.e., the number of leaflets distributed or the number of people receiving IEC messages, etc. However, because of lack of coordination the information from national and provincial level, and between the central organizations were not comparable. It is difficult for instance, to get accurate number of leaflets distributed nationwide or number of campaigns carried out in all 61 provinces of the country. As there was no consistency of data collection it was difficult to have a clear overview of the country or to compare between provinces or agencies. Therefore it is not possible at present to monitor and evaluate the specific IEC activities and the entire program.

KABP studies can be used for evaluation of quality or effectiveness of the program. However these studies were limited for monitoring and evaluation purposes due to inconsistency in the quality of the studies. The sample of many studies was small and non-representative of the country.

The MTP had objectives but no indicators for IEC activities. Quantitative indicators for this area of the program may include: the number of activities carried out, the number of IEC products developed and distributed, number of people covered by IEC campaigns, the number of peer education groups, the number of mass media involved in delivery messages on HIV/AIDS, etc. The most important qualitative indicators may include: content of IEC message delivered, the level of awareness or attitudes of people toward PLWHA, etc. There are no specific indicators suggested by UNAIDS for IEC so far.

g) Recommendations

1. There should be a program tailored for PLWHA to improve their knowledge and support their healthy behaviors.
2. The content of IEC messages should be improved considerably to meet the increasing needs of the public that requires deeper and more sufficient information and knowledge (e.g. to cover legal issues).
3. IEC should focus on behavior change, legal aspects and gender issues.
4. The IEC activities should not be one-way propaganda placing the public in a passive position but should change to two-way communication and encourage the active participation of the people.
5. The BCC approach should be studied and applied in the NAP.
6. Improve coverage to remote/underserved areas.
7. Indicators for the IEC program need to be developed and applied nation-wide for monitoring and evaluation purposes.
8. Gender issues should be fully integrated in the IEC activities from the very beginning. The focus should be made on gender-power relations, empowerment for women, men’s role and responsibilities in practicing safe behavior and caring for PLWHA.

3.4.2 Voluntary counseling and testing

a) Background

International experiences show that counseling on HIV/AIDS and voluntary HIV testing is one of the more substantial parts of an HIV/AIDS program. Voluntary Counseling and Testing (VCT) is part of the prevention/care continuum i.e. a referral tool for care and support services. Theoretically, the more people that seek testing and learn of their status in a setting where their confidentiality is assured, the better informed people become, and the more client-friendly services available for referral, the less stigmatized people will be regarding the disease. VTC can be seen as a “cross-cutting” issue in HIV/AIDS interventions as it relates to all target groups and interventions of NAP.

When the MTP was mapped out in 1994, VCT was not set as an independent component of the NAP. At the time that VCT as internationally defined, it was not available in Vietnam. The MTP did not mention pre- or post-test counseling but has set targets to establish and strengthen the testing laboratory system at central and local levels, to make testing convenient, available and of a higher quality. Until now, testing was mainly mandatory and closely connected to epidemiological surveillance but the service has been made available in all provincial centers and many districts. Currently efforts have been made to introduce international-standardized VCT to the NAP of Vietnam.

In 1999, NASB carried out an assessment of counseling services in Vietnam. According to this assessment, policy makers, leaders of hospitals or health facilities were not aware of the importance of counseling in HIV/AIDS prevention. Many provinces have not paid attention to developing counseling services. Also there was a shortage of experiences to organize HIV/AIDS counseling networks and activities (NASB, 2000).

In 2000, NASB started the program “Strengthening counseling services in 20 provinces and cities.” Its purpose was to develop a pilot model on counseling for the development of the national guidelines for a counseling network and services. The guidelines were published December 2000 (Medical Publishing House) stating two purposes: 1) provide psychological support to HIV/AIDS infected person and those who are affected by HIV/AIDS; and 2) prevent HIV transmission. In the same year, the AIDS Division, MOH also published a guiding notebook for counseling for HIV/AIDS. That notebook was distributed to all PASBs. VCT has been included in the MTP 2001–2005 recently.

This section mainly discusses counseling and testing services which were available in Vietnam. However the voluntary services are not discussed as specific data was not available.
b) Legal environment

Although it was not mentioned as a component in the MTP, VCT was highlighted in the Ordinance for Prevention and Control HIV/AIDS. Article 16 stipulates that health facilities are responsible for the provision of HIV tests to those persons who want to detect infection. Article 18 defines that health staff involved in testing are responsible for upholding the confidentiality of the name, age and address of the test subjects. Article 1 of the Decision 1122 QD-TTg of the Prime Minister, dated 24th December 1997 instructed the NAC to be responsible for setting up the network on HIV/AIDS counseling services. These documents have provided a positive environment for implementing voluntary counseling and testing services.

c) Budget

Budget allocation for counseling and testing cannot be determined. In most cases, counseling is combined with medical treatment costs while testing is included in surveillance costs. The shared budget for medical treatment and counseling from national and international sources for 1997-1999 was 37% of NAP or USD 9 million, and the budget for surveillances was 7% or USD 1.7 million (NAB, 2000). However, it was not clear how much was actually spent on counseling and testing.

According to the NAB’s evaluation report on counseling service, a shortage in the budget for counseling was one important factor effecting quality and coverage of counseling services. A lack of space for counseling, and the low number of training sessions conducted resulted from an insufficient budget.

While the budget for HIV testing in general accounted for a considerable percentage of the NAP’s budget, the budget allocated for counseling was still limited.

Counseling in HCM city received better investment than that in other cities/provinces. Dr. Do Hong Ngoc, the Director of the city Health Education and Information Center reported that his center had provided pre- and post-test counseling for many clients. By mid-2001, more than 600 workers at grassroots level had been trained on counseling. However, according to Dr. Ngoc, it is very difficult to sustain counseling service with such a small budget.

"We are poor and our budget is small. We cannot feed this network. They work for sometime then they change to another job. Therefore we are lacked of a professional network." Dr. Do Hong Ngoc, HCMC city.

d) Implementing agencies

Counseling skills were provided to health staff in testing facilities. Lately other organizations have been mobilized into the counseling network. In the guidelines for counseling activities in 2001 the following agencies were mobilized in each province:

- Center for preventive medicine
- Dermatological Center
- MCH-FP Center
- Department of hematology of the provincial hospital
- Department for Infectious diseases
- Rehabilitation centers 05, 06 under MOLISA
- Prisons
• 2 counseling facilities of WU or YU or Red Cross
• The local Hotline 1080
• Counseling facilities of those districts with large number of HIV positive people
• Peer educators.

According to UNAIDS Vietnam, there had been some progress in setting up pre- and post-test counseling in some health facilities. Some health workers in provinces were trained and guided on pre- and post-test counseling. However, as counseling was a new concept and the budget was small, the program lacked counselors and the available counselors lacked skills.

Interviews with counselors and managers revealed that not only a lack of personnel and skills was evident, but also counselors faced psychological pressure when defined solutions and support for infected clients were not available, in addition to the stigma and discrimination of the community.

e) Assessment of Program Activities

Testing:

Testing services become more and more available during 1996 to 2001. However, so far, few voluntary tests have been done. According to the MOH report on HIV/AIDS prevention activities in 1996-2000, the testing system to detect HIV/AIDS has been implemented throughout the entire country (MOH, 2001). At the district level, 200 of 500 districts nationwide can provide tests. Quick testing methods have been introduced to a number of districts where facilities and equipment for testing were not formerly available. So far, the number of voluntary testing facilities is still very small.

For the period 1996 – 2000, up to 1,296,865 blood samples had been tested and 25,473 samples were found positive (MOH, 2001). Figure 3 presents sources of samples tested during these years. It is easy to recognize from the figure that most of the tests were mandatory or for surveillance purposes. Those for blood donors, IDU, SW, STD clients, new military recruits, and even pregnant women in some of the larger obstetric and gynecological hospitals are required to undergo mandatory testing. The “other” group consists of prisoners, restaurant/bar/hotel workers, returned refugees, and patients who are suspected as having HIV. Too many of those tests were mandatory. The most voluntary tests were probably those of the “unknown” group, which accounted for 9% of total samples or more than 114,000 samples in 5 years. Interviews with testing professionals highlighted that almost all clients who came to be tested of their own accord wanted to remain anonymous.

In a national survey on women’s health by the General Statistics Office in the year 2000, among 10,000 women aged 15-49, although 52.4% knew the address of an HIV testing facility, only 5.6% of them went for testing. Women living in the North West, Central High Lands, and Mekong river delta had the lowest percentage of those who knew the facilities addresses in comparison with women in other regions (GSO, 2000).
Among the high-risk groups, BSS determined about half of SWs and IDUs studied had HIV tests. However only 5% of drivers from Hanoi, 13.3% HCM City, 3.9% Can Tho and 4.9% Da Nang have been tested for HIV (MOH – FHI. 2001).

However, the reliability of the test is questioned because of the lack of quality assurance of the HIV test kits. Test kits are imported from different companies without laboratories in Vietnam evaluating them. The average percentage of discrepancy results per laboratory detected by Quality Assessment Program of WHO has been 1.9% in Australia and 3.6% in South East Asia and Western Pacific region. The highest discrepancy rates obtained have been 6.0% and 16.3% respectively (Gust A, Walker S, Chappel R J and Dax EM, 2001). WHO Hanoi had strongly recommended establishing a quality assurance scheme to evaluate HIV test kits to be used in Vietnam to minimize false test results. Experience from WHO global program called EQAS (External Quality Assessment Schemes) can be useful for Vietnam.

Counseling:

According the NASB, by 1999, pre- and post- test counseling had been conducted in all provinces/cities of the country (NASB, 2000). However, there was a shortage of counseling facilities. There are no counseling rooms that meet standard requirements. The existing counseling facilities do not make clients feel comfortable. Patient privacy and confidentiality are not always guaranteed. The access for those who are in need of counseling is still limited, especially in rural areas. There are few activities in terms of counseling services available to family members of HIV/AIDS infected persons or to their partners and friends.

Therefore, the Ten Year Review found, most people appointed for HIV tests including voluntary and compulsory tests, as well as regular check ups have not received pre-test counseling. Post-test counseling services were provided only to those who tested positive (NCADP, 2001).

By the year 2000, in the 42 provinces that reported to NASB there were 3109 counselors. Among them 73% are those who participated in the pilot program “Strengthening counseling work in 20 provinces/cities”.

Thus, counseling services have been set up in all provinces. However, the Ten Year Review noted that the counseling services have not been well implemented. There is insufficient training and a serious shortage of professional counselors. Counseling services have not been paid adequate attention (NCADP, 2001).

At the end of the year 2000, the guidelines for setting up the counseling network and conducting counseling services was developed and disseminated nationwide. Still many health staff do not realise that counseling should help clients to be aware of their situation and help the client make decisions for their future. Most health staff believe that counseling means giving advice or guiding decisions that the client should make. Some of the health staff believe that counseling does not play an important role in HIV/AIDS prevention activities; or they can provide counseling without being trained. There is still a belief amongst health staff that counseling is unnecessary and ineffective (NASB, 2000).

According to the assessment of the NCADP in the year 2000, most HIV tested cases including those who underwent voluntary or mandatory routine testing, were not counseled before testing but were counseled only after being tested positive (NCADP, 2001).
The MOH Review on HIV/AIDS prevention activities carried out by the health sector during 1996-2000 has provided information on counseling services in different parts of the country including counseling rooms, counseling in the community and telephone counseling. The information showed that the number of counseling sessions provided has increased remarkably (Table 3). However, there is no separate information on voluntary counseling and pre- and post-test counseling. The information also did not indicate who received counseling at these places.

Table 3 Total number of people who received counseling during 1996-2000

<table>
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<tr>
<td>At counseling facility</td>
<td>11,062</td>
<td>25,872</td>
<td>40,171</td>
<td>51,873</td>
<td>65,327</td>
<td>194,305</td>
</tr>
<tr>
<td>At community</td>
<td>39,134</td>
<td>61,736</td>
<td>93,079</td>
<td>98,580</td>
<td>177,913</td>
<td>470,442</td>
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<tr>
<td>By telephone</td>
<td>4,228</td>
<td>6,743</td>
<td>13,387</td>
<td>23,842</td>
<td>29,461</td>
<td>77,661</td>
</tr>
<tr>
<td>Total</td>
<td>54,424</td>
<td>94,351</td>
<td>146,637</td>
<td>174,295</td>
<td>272,701</td>
<td>742,408</td>
</tr>
</tbody>
</table>


According to this Review, for 2000 alone, there were 68,058 counseling sessions in the 13 provinces/cities that participated in the pilot program. This is an increase of 17% compared to 1999. It is worthy of note that, the year 2000 made up 40% of total counseling sessions during the last 10 years (NASB, 2000).

The interviews with staff in the AIDS prevention system from central to grass roots levels and experts also confirmed that the counseling service has not performed well, especially in pre-test counseling. If counseling services are not well managed it is difficult to control the infection and it is impossible to eliminate stigmatization and discrimination against HIV/AIDS infected people. AIDS patients may not get adequate support from their family and community. Health staff working in HIV/AIDS prevention and those who provide HIV tests may not feel comfortable when in contact with infected persons. Moreover, interviews with counselors revealed that most of the counselors found it difficult to do post-test counseling for those infected as there is no way to cure them from the foreseen death.

The quoted statement of an official in Lang Son Center of Social Diseases reflects the current situation of counseling services in his province but the issues he addressed are common to many other provinces.

Health facilities are responsible for insufficient counseling. I have been working in HIV/AIDS prevention for several years; I have never received any training for counseling. When providing counseling for clients I used my experience instead of knowledge and skill I should get from training. Therefore, when it is required, a grassroots worker like myself does not know how to counsel. Regarding HIV/AIDS patients, they feel uncomfortable with their family members and relatives because they are not counseled properly. They lack knowledge but do not know where they have to go to get it.

f) Evaluability of the program

Currently it is very difficult to evaluate the VCT intervention, as there was no constructive indicator system. Lacking a clear distinction between general counseling and testing and VCT, it is not possible to evaluate how VCT is organized and implemented. Counseling and testing
activities have been carried out and improved upon, however, it is unclear how many cases are from voluntary testing.

Indicators were not stated in the MTP. The UNAIDS-suggested indicators include a number of VCT facilities, a number of provinces and districts having VCT facilities, a number of qualified counselors, and a number of counseling sessions per year, etc. The qualitative indicators may consist of the degree of satisfaction of counseled clients, and the willingness of people in the locality to attend counseling.

g) Recommendation

1. VCT as internationally defined should be introduced again into the NAP.
2. There should be a national reference laboratory or an equivalent mechanism to evaluate HIV test kits to be used in Vietnam as well as to assure quality of HIV testing throughout the country.
3. The Ministry of Health should institutionalize pre- and post-test counseling in every facility that provides testing. On one hand, pre- and post-test counseling should be made mandatory. On the other hand, MOH should have plan for staff assignment and training.
4. An M&E system for VCT should include a definition of indicators and setting up a system for collecting and sharing information.

3.4.3 Male condom promotion

a) Background

The condom is used for both family planning and prevention of STDs including HIV/AIDS. In Vietnam, both Population and Family Planning (PFP) and HIV/AIDS prevention carry out male condom promotion. As the programs effect cannot be separated, the evaluation reports on both programs.

The male condom was introduced into Vietnam as a contraceptive method in 1960 when the family planning program began. However, until the end of 1980s, the use of condoms for birth control purposes was low. The prevention effect of condoms against STDs was emphasized only when the HIV/AIDS epidemic became widespread in Vietnam. Currently, male condom promotion is carried out by the joint efforts of both PFP and HIV/AIDS programs. As of 1993, social marketing has expanded resources for condom promotion and to widen condom distribution (NCPFP, 2000).

In the MTP, condom promotion was not defined as an independent objective of NAP but was considered as an intervention activity focusing on groups with high-risk behavior and those who were infected with STDs. However, the promotion of condom use is increasingly becoming more important component of the NAP.

b) Legal environment

Although condom promotion was not considered a primary target of the NAP, but a part of Population and Family Planning program, the activities of condom promotion in general and the

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6 Up to present time, in Vietnam only the male condom is popular. The female condom has been introduced but is still not popular.
social marketing of condoms developed a favorable legal environment. This is reflected by permission allowing messages on condoms in the mass media, i.e. television (NCPFP, 2000).

According to the results of the field assessment, most interviewed people indicated that there are legal issues that proved unfavourable for condom promotion when used for HIV/AIDS and STD prevention. For example, condoms are not widely available, and are not always available when required. At restaurants and hotels where condoms were made available to guests, proprietors were considered to be engaging in the sex business. For people suspected by police to be SWs, a condom found in their pocket can be considered as evidence of involvement in selling sex services. This creates obstacles for condom promotion activities, especially to the groups with high-risk behaviour and to people who have to travel frequently.

The DKT project of condom social marketing in four provinces, Can Tho, Tay Ninh, Quang Tri and Quang Ninh since 1996 has faced a lot of obstacles when expanding their condom retail network not just inside but also outside pharmacies. Selling condoms outside pharmacies can be regarded as illegal. Owners of groceries shops, restaurants, karaoke and bars refuse to sell condoms, as they are afraid of being accused of engaging in social evils. Other commercial businesses, which are not related to “social evils”, also refuse to sell condoms (Duncan O. Earle and Trinh Thi Lien, 2000).

c) Budget

In the family planning (FP) program, 4.36% of the national budget is used for buying condoms. There is only a small amount allocated from provincial budgets. In the period 1996-1999, the total budget for buying condoms for social marketing was VND 74,643,000,000 and for free distribution was VND 16,284,000,000. According to an evaluation of the National Committee for Population and Family Planning (NCPFP), the budget for social marketing, was insufficient (NCPFP, 2000).

Condoms for HIV/AIDS and STI prevention come mainly from social marketing programs and markets. The total number of condoms for the NAP from the government budget and foreign aide for the period of 1993-1999 was about 3.9 millions pieces (NCPFP, 2000). According to NCPFP, the budget for condom purchase was insufficient (NCPFP, 2000).

Condom distribution, up to the time of the evaluation, was mainly initiated and implemented by population and family planning programs. There was no allocation of budget from the NAP for condom promotion.

d) Implementing agencies

Before 1993, condoms were mainly distributed by public health facilities free of charge. Few condoms were available in the free market. Since 1993, condoms have also been distributed through the network of FP motivators. Social organizations such as VYU, VWU, and the Trade Union also participate in condom distribution schemes to their members (NCPFP, 2000).

The condom-marketing program was introduced in Vietnam in July 1993 through the pilot project conducted by DKT international for 11 cities and provinces. As of 1999, 54 out of 61 provinces and cities carried out condom marketing through a network of two sole agents and 18,000 retail outlets. According to NCPFP, DKT has occupied a large market-share. However, it is still limited to urban areas (NCPFP, 2000).
So far there is no national agency undertaking condom social marketing. Since 1998, the NCPFP has implemented the pilot project aimed at developing an appropriate operation and management mechanism in order to expand condom social marketing nationwide and fully cover the needs of 13 cities and provinces. This pilot project also looked for national organizations to which DKT can hand over the condom social marketing program.

e) Assessment of Program Activities

Availability and Accessibility:

At present, in both urban and rural areas, FP program condoms were easily accessed. The distribution system comprises of 61 provincial sole agents and a retail network that relies mainly on the FP motivators at community level. The program includes two government-approved factories for condom manufacturing with production capacity of 90 million and 70 million pieces a year, respectively. In 1999, these two factories produced 104 million condoms that met international standards of quality.

Regarding condom provision, according to the NCPFP, in 1993 a total of 17,793,000 condoms were distributed, of which 3,565,000 (5%) were for social marketing. In 1999, 106,083,000 condoms were distributed nationwide; 81% (84,000,000 condoms) were from social marketing of which 22,000,000 pieces were produced in Vietnam.

Results of the field assessment in Lang Son, Hai Duong and Da Nang shows that a condom can easily be bought in the market with 200 VND. The main retail outlets are pharmacies, grocers, supermarkets and tobacco shops. In addition, NCPFP (2000) estimated 25-30 million condoms were illegally imported into Vietnam’s market annually. The price of these condoms in 1998 ranged from VND200 to VND 25,000 per condom.

Most women interviewed said that they were reluctant to buy condoms. Unmarried people said that many unmarried youth want to use condoms but they do not dare to buy condoms, as they are afraid of falling into disrepute. One expert from an international NGO said that when she bought 50 condoms for a training course, the seller thought she might be a hotel owner buying condoms for her clients. Also, for many rural areas, especially remote and mountainous regions, the choice of condoms outside the FP channel is limited.

Quality and Effectiveness:

The FP program assessment in the period 1993-2000 found staff of the program and clients said that the condoms provided free of charge are less preferred than those brands sold in the free market. They complained that the condoms provided for free were thick and did not have enough lubricant (NCPFP, 2000). Many people were willing to buy condoms in the market rather than receiving free of charge brands. This is consistent with the field assessment which found, people preferred condoms imported from Japan or Thailand to those from China or domestic products due to their high quality, thin feel, nice smell and some other physical advantages despite their higher price.

“It would be good if people have the right to choose the service they want. A high rank leader of the government should support this. Currently, for instance, a proposal for promotion and distribution of nice-smelling condoms may not be approved as it is believed that condoms are used for prevention of infection not for sexual pleasure.” International NGO expert.
The rate of condom use in Vietnam remains very low. Among 70% of couples that use birth control methods, 6% use condoms (NCPFP, 2000). The rate of condom use among groups with high-risk behavior was also very low. Thirty percent of SWs in Hanoi and HCM City reported regular use of condoms when having sex with new clients over a 12-month period (MOH-FHI, 2001). SWs in Hai phong, Da Nang and Can Tho reported a higher rate, 70%. The rate of condom use with regular clients was much lower and extremely low with regular partners. In HCM City and Can Tho, the rate was as low as 0.4% and 6.9%, respectively (MOH-FHI, 2001).

Truck drivers, mobile laborers and IDUs reported a low rate of regular condom use when having sex with regular or irregular partners or with SWs over a 12-month period. IDUs had the lowest rate of regular condom use with SWs, being 28% in Hanoi, 38.1% in Can Tho and about 50% in Da Nang, HCM City and Hai Phong (MOH-FHI, 2001).

According to the NAC, one of the reasons of low use is the rarity of condoms in Vietnam. According to the NCPFP estimation, the quantity of condoms from all sources together could meet 30%-35% of actual needs (NCPFP, 2000). The NCADP (2001) thought if condom promotion was defined as an objective of the NAP, efforts could have avoided the shortage of condoms and the low rate of condom use.

However it is difficult to measure the direct relation between the rate of condom use and the rate of HIV infection. Therefore it is impossible to quantify how much promotion of condoms in Vietnam effects the reduction of HIV/AIDS infection. As a result, impacts of condom promotion and supply were usually assessed through intermediate variables such as percentages of condom use, popularity of condoms in market and other distribution channels.

Gender aspects:

Condom use is a gender issue, especially in Vietnamese culture, where sexuality is not easily discussed between couples. Women’s innocence in sexual matters is highly valued and the control of negative consequences of sexual contact is considered women’s responsibility. In IEC messages for HIV/AIDS prevention gender issues in general and the role of men in safe sex almost has not been touched. Until recently, activities encouraging men to share responsibilities in family planning have just been initiated in some projects. Regarding HIV/AIDS prevention, in the year 2000, the NAP introduced the slogan “Men can change the epidemic” for the first time.

Female condoms have not been yet officially introduced in Vietnam. In 2000, under the support of UNAIDS and WHO, a pilot study with 600 women in two districts of Hanoi was conducted. More than half of the respondents said that female condoms are acceptable. Two hundred thirty people said that they would continue using female condoms if they could be purchased at a reasonable price. These women added that they felt more confident and safer when using female condoms. Among 100 SWs participating in this study, 84 wanted to continue using female condoms (UNAIDS, 2001).

f) Evaluability of the program

According to the UNAIDS guide to monitoring and evaluation of the NAP (UNAIDS, 2000) the following issues should be considered when evaluating condom promotion activities: national policies on condom social marketing, availability, price and quality of condoms.

Of these indicators, in Vietnam, so far there has been no data on quality of condoms. Data on the number of condoms distributed is available, perhaps because of commercial aspect of the social.
marketing of condoms. However it is difficult to use this data for evaluating the NAP as in some cases, data from one source contradicts that from other sources and the separation of condom use for FP or STI prevention is not possible. The field assessment proved it was impossible to quantify the total number of condoms available at all sources. Therefore for assessment for the NAP intermediate variables such as the rate of condom use, and the availability of condoms in the market and other distribution channels in high-risk groups can be used.

As available condom data is mainly provided by social marking implementing agencies, more independent studies on condom promotion need to be conducted. Therefore, increasing objectivity of the data and possibly answering a wider range of research questions such as what are the determinants of condom use in Vietnam.

g) Recommendations

1. Intervention to develop condom use behavior should be taken as an important activity of the NAP.
2. Methods of condom distribution should be improved for easier access by clients, especially unmarried youth and persons with high-risk behavior.
3. One national agency should be assigned to carry out the condom promotion program and be responsible for collecting data on condom use as well as provision.
4. IEC messages should emphasize the role of men in practicing safe sex by using condoms and encourage women to negotiate and decide for condom use.
5. More independent studies on different aspects of condom use should be conducted.
6. More pilot programs with a larger scale on female condoms should be conducted in different regions of the country.
7. Independent assessment of condom promotion activities should be conducted in a regular basis.
8. Improve monitoring and evaluation.

3.4.4 Sexual health and life-skills education for young people

a) Background

International experience shows that sexual health and life skills of young people are closely related to promotion of their safe and sustainable behavior for improvement of reproductive health including HIV/AIDS prevention. Having sufficient knowledge of HIV/AIDS may reduce high-risk behavior, but knowledge alone is not enough to change the behavior to the level that could prevent infection. In-depth and life-skills education on HIV/AIDS are further steps of IEC program as it is more effective for behavior change (World Bank, 1997).

When the MTP was formulated, sexual health and life skills education for young people was not included in the NAP as an independent and specific objective. In annual plans, from 1996 to 2000, this intervention was also not clearly identified. However, the IEC Program for adolescents in schools and activities of the VYU was defined in the Plan. This served as background for sexual health and life skills education activities to be carried out in some localities.

In the plan of action for the period 1994-2000, the VYU intended to change the direction of IEC activities from raising awareness of HIV/AIDS (during 1990-1994) to educating and promoting skills for behavior change among youth (VYU, 2001).
Since 2000, NASB has been assigned to develop guidelines for provinces and cities to implement “The IEC Program on HIV/AIDS for Adolescent”. The set of manuals used at the provincial level has been issued with the technical and financial support from GTZ, SF/UK, UNAIDS, UNICEF and UNDCP. The guideline addresses not only provision of information for young people, but also emphasizes the importance of education of skills for reproductive health and HIV/AIDS prevention. This reflects that program managers are fully aware of the importance of life skills education of the young generation to protect themselves against HIV/AIDS infection. However, it is too soon to assess the effectiveness of the program. This report, then, only mentions activities implemented in the past.

b) Legal environment

Article 7 of the Ordinance for prevention and control of HIV/AIDS and the Decree 34/CP issued in June 1, 1996 emphasized that IEC activities were basic measures to raise people’s awareness of HIV/AIDS prevention. Article 8 of the Ordinance defined that education on HIV/AIDS prevention should be introduced into schools with appropriate contents to take into account the differences in types of schools, levels of education, ages, gender and culture of different ethnic groups. These documents have created a favorable legal environment for development and implementation of IEC activities on HIV/AIDS prevention for youth in general and youth in schools in particular.

c) Budget

Annually, MOET receives an amount of VND 200-300 million from the government budget for IEC on HIV/AIDS prevention in schools. According to a high rank official of the NASB, this fund is too small for the education of an entire generation. A MOET official said there is a shortage of IEC materials on HIV/AIDS to distribute to students. Also MOET has insufficient resources for training teachers and for extra IEC classes. Some assistance is provided by a limited number of internationally supported projects or provincial funding.

d) Implementing agencies

MOET and the VYU are major agencies responsible for IEC activities for young people. These two agencies also implement projects on sexual health and life skills education for youth. However, for many people in these agencies, implementing the projects is considered an additional job rather than their daily political tasks. Therefore for national implementation a larger number of qualified staff in both agencies is required.

e) Assessment of Program Activities

Few activities in sexual health and life-skills education for young people have been carried out by MOET and YU. The Ten Year Review (NCADP, 2001), and the report of the MOET have discussed IEC activities for youth, mainly students, but not mentioned sexual health and life skills education for young people, including out of school youth.

Political commitment:

The results of analyzing materials, reports and interviews show that education of sexual health and life skills for adolescents was not a specific objective of the NAP. Developments of IEC for HIV/AIDS prevention for youth are still at the formal level. There exists an opinion that education of sexual health and life skills for young people does not suit the national identity and
is considered “showing the way to the deer”. An expert of an international organization comments that schools are not ready to carry out such work due to obstacles of culture, and because teachers do not have adequate teaching skills.

The legal environment is perhaps in favor of implementing sexual health and life skills programs, but it appears that program efforts depend on initiative and the ability of policy exercise as well as capacity of design and implementation of people who are directly in-charge of taking care of and educating the young generation. This activity is not adequately invested by government bodies, and still depends much on initiative and support of international organizations.

Knowledge on youth and their sexual behaviors:

There has been so far no national data on sexual behavior or life style of youth. Without a knowledge base on youth, it is very difficult to develop intervention target this group.

Pilot programs in schools:

MOET and the VYU have piloted activities on education of sexual health and life skills for young people within the frame of the population and reproductive health program and the HIV/AIDS prevention program. A considerable part of these activities has received technical and financial support from international organizations such as UNFPA, UNICEF, Population Council, the Ford Foundation, Path Canada and others. For example, the project entitled “Adolescent health, development and HIV/AIDS prevention” for young people aged 10-18, funded by UNICEF has been carried out by MOET and Vietnam Red Cross.

MOET, with the assistance from UNFPA has developed a self-learning manual for teachers on “Adolescent Reproductive Health Education” (2001). The manual has 10 modules. Each module has two parts: one for self-learning for teachers and the other for teaching students. The 10 modules are as follows:

1. Friendship, Love, Marriage and Parenthood
2. Sexuality and Reproduction
3. Early Pregnancy and Contraceptives
4. Adolescent Health
5. Gender Equality
6. Adolescents and Children's Rights
7. Parents and the Family
8. Population and Development
10. From Family Planning to Reproductive Health

Nonetheless, these projects are pilot activities in some localities. The majority of young people in Vietnam still passively receive information on HIV/AIDS through mass media, education program at school, reproductive health books and peers, especially out-of-school youth. The young
people who do not go to school have less chance of accessing and strengthening their knowledge and life skills, thus their understanding of HIV/AIDS was ambiguous, increasing HIV vulnerability.

**Innovative projects:**

Several innovative projects for adolescents have been developed in certain localities, such as clubs and moveable propaganda teams where young people can discuss and consult on issues of friendship, love, sexuality and reproductive health, as well as HIV/AIDS and STDs.

Some useful activities in mass communication also have been launched, e.g., the Program ‘The Window of Love’ on Vietnamese Radio and ‘From Eyeing to the Heart’ of VTV3, Vietnam television. Some other creative forums like ‘Hope Coffee’, ‘Condom Coffee’ in HCM City, ‘Counseling Coffee’ in Hanoi, ‘Ever-Green’ in other cities and provinces became the places where young people can explore more information, exchange and learn from each other about topics of love, sexuality, and safe behaviors (such as safe sexual behavior). The telephone hot lines are also set up for young people to exchange and explore information on love, sexuality, HIV/AIDS and reproductive health.

In accordance with the UNAIDS’ assessment, a few models of HIV/AIDS prevention for youth in Vietnam were able to encourage and maintain sustainable changes in behavior (UNAIDS, 2001). However, these new interventions and other forms of IEC activities like counseling cafes, counseling centers, and hot lines as mentioned above are available in urban areas only, especially in big cities. The majority of youth who live in rural areas have no access to these services.

**Knowledge among adolescents:**

The research results of knowledge, attitude, action and practice (KAP) of adolescents in 1999-2001 showed that they had good knowledge of HIV/AIDS and other STDs. Nevertheless, many of them still misunderstood HIV/AIDS infection and protection. Among them unsafe activities of sexuality and injection still persist (UNAIDS, 2001; Nguyen Xuan Anh and colleagues, 1999; Ngo Thanh Thuy, 1999; Vu Minh Phuc, 1999).

In a focus group discussion of adolescents, many young people said that they heard talks on HIV/AIDS, and used condoms to protect themselves. However all communication messages, including meetings and discussions in the locality do not give adequate instruction on the use of condoms.

**Gender aspects:**

Activities of the educational projects of sexual health and life skills for adolescents that are funded by international organizations referred to gender issues. Typically, some basic concepts of gender are introduced and a few particular gender aspects of Vietnamese culture were also discussed in the forums and exchange meetings. Nonetheless, gender issues of HIV/AIDS were not adequately referred to. For example, higher acceptability of infection of women is noted, but the role and responsibility of men is not addressed. Also, female teenagers and women are often portrayed in IEC messages as feeble and pitiable, and in need of protection - not as persons who have rights equal to men in terms of protecting the interests of themselves.
f) Evaluability of the program

National data on youth sexual health and life-skills is lacking. The MTP did not specify any indicator to be used for this area of the program therefore there is no program data. No study on a national scale has been conducted so far. Educational activities of sexual health and life skills have been implemented as pilot activities in some localities, evaluating their effectiveness or impact on the portion of HIV/AIDS infected reduction is neither routinely done nor nationally applicable.

UNAIDS recommended a number of indicators to be used for the monitoring and evaluation of this program area. Those include: medium age of first sex, young people having premarital sex, condom use at last premarital sex, young people with multiple partners, condom use at last higher risk sex or at first sex, and age-mixing in sexual relationships.

g) Recommendations

1. A national program on adolescent sexual health and life skills should be developed as a priority of the NAP. This program should have in-school and out-of-school sub-programs, and education and service provision components.
2. A data base on youth sexuality and life-styles as a knowledge base for development of interventions should be collected. A national-scale study could provide primary inputs for this database.
3. Political commitment and social acceptability for adolescent sexual health education and service provision should be strengthened.
4. A monitoring and evaluation system for this program should be developed as well.

3.4.5 Prevention of HIV transmission and treatment for drug users

a) Background

Injecting drug users (IDUs), one among the highest risk groups of HIV infection in Vietnam, accounting for the highest proportion of HIV/AIDS infected cases. Over 60% of total HIV infected cases detected, and the majority of AIDS patients and AIDS deaths belong to this group. Additionally, the proportion of identified IDUs with HIV has risen from 10.9% in 1996 to 12.9% in 1997, 16.6% in 1998, and 21.4% in 1999 (NAC, 2000).

The HIV/AIDS education intervention program aiming at reduction of high-risk behaviors among IDUs is one of four IEC programs, included in the MTP 1996-2000. The objectives of those target programs are to educate individuals and high-risk groups such as IDUs, SWs and others to practice safe behavior in order to avoid HIV/AIDS transmission to themselves and community.

Annual plans from 1996 to 2000 also pay attention to intervention activities of HIV/AIDS prevention for IDUs in communities and rehabilitation centers and re-education Center 05 and Center 06 of MOLISA. Several harm-reduction projects are also implemented in the scale of these objectives.

In 2000, NCADP under support of GTZ, SCF/UK, UNAIDS, UNICEF, UNDCP and international experts compiled a set of guidelines on peer education for the provincial level, entitled “Planning and implementing the peer education Program for IDUs”. This is the first detailed guidance for peer education, which is designed and disseminated at the national level.
This reflects awareness of the importance and commitment of the program leaders towards peer education in particular, and intervention program for group of IDUs in general.

b) Legal environment

Activities aimed at encouraging and educating high-risk groups to implement HIV/AIDS prevention measures are defined at Article 9 of the Ordinances of HIV/AIDS prevention and control promulgated by the National Assembly and enacted 31/5/1995. This creates a favorable legal base for the implementation of IEC activities aiming to improve awareness and change behaviors of IDUs. Models of “friend helps friend”, and peer education are also put in activities of many provinces and cities.

However, people who are working in this area face difficulties when implementing harm-reduction activities. Supply of clean syringes and condoms sometimes is misunderstood as “giving a hand” or encouraging drug injection. Many pharmacy owners refuse to sell clean syringes to customers who are thought to be drug addicts, because they are afraid of being implicated as an accessory to drug use.

The legal framework related to drug control, the ability of controlling drug trafficking, changes in lifestyle values systems, and the wider society’s awareness of social evils, are factors that have created an environment that is not favorable for HIV/AIDS prevention activities and treatment for IDUs.

c) Budget

According to financial statistics of UNAIDS, in three years, 1997-1999, the Program of HIV/AIDS prevention and treatment for IDUs accounted 2% of total budget spending for HIV/AIDS prevention and control activities, including state budget and international fund (NAC, 2000). Within those 3 years, 335,000 USD had been spent for this program. Amount of 335,000 USD was spent on this activity in these years.

According to the Circular No128/1999/TT-BTC enacted 26/10/1999 by MOF, which provides guidance on expenditure norms for the NAP, each provincial peer education team (one team only in each province) is allocated a quota of VND 80,000/per month.

During interviews, many local staff in the study sites said that this amount was too small to stimulate enthusiasm of collaborators. There is an effort to provide additional support from local budgets or from other sources, but these sources are generally small and unsustainable. Some localities have financial resources from projects. However, once projects are completed, resources also end and the activity stalls. Therefore, it is difficult for the peer education team to sustain their activities. Consequently, if this could not be overcome, it in turn affects effectiveness of the work and sustainability of the program.

Therefore, harm-reduction projects depend largely on international funds. Therefore severely limiting the success of IDU prevention activities.

7 At this point in time, sex workers and drug users are considered “high-risk individuals”. In later time, this term was changed to “individuals having high-risk behaviors”.
8 Total of national budget for NAP in 3 years, 1997,1998,1999, were 12,200,000 VND only.
9 Total international funding for those 3 years was 4,571,949 USD. There is no budget from international NGOs and other donors for this activity.
d) Implementing agencies

The implementation of HIV/AIDS prevention Program for IDUs is assigned to MOLISA, MPS, MOH, Youth Union, and the Vietnam Red Cross Association. Besides, local authorities, branches, and organizations, other associations are also mobilized to participate in this program.

In rehabilitation centers, social support centers and prisons, MOLISA, MPS and MOH jointly organize classes for their inhabitant members and prisoners on HIV/AIDS prevention measures, guiding on effective condom use and sterile syringe usage. At the community level, mass organizations integrate with local authorities to provide information, propaganda, and education to every family, which has an IDU member.

e) Assessment of program activities

Two types of program interventions are included in HIV/AIDS prevention and treatment for IDUs IEC and harm-reduction interventions. IEC activities for IDUs have been carried out in the whole country while the harm reduction intervention programs have been carried out only in half of the total provinces and cities of the country.

IEC and harm reduction activities include:

- Leaflets on HIV/AIDS for IDUs,
- IEC activities to every family of targeted individuals,
- Propaganda and education in Rehabilitation Centers and the Center 05 of MOLISA,
- Advice to targeted individuals on how to properly use a condom and sterile syringes and needles,
- Ensure availability of sterile syringes for single use through conducting provision services of sterile syringes in the state and private pharmacies and shops with payment.

Results of recent program evaluations:

According to a UNAIDS’ assessment, the HIV/AIDS Prevention Program for IDUs obtained considerable achievements, although many constraints remain. For example:

- The number of syringes provided has been not enough to support behavior change.
- Interventions seem to stay at IEC activities.
- There are still not sufficient policies or mechanisms to stimulate peer education activities.
- The counseling and care for IDUs who are HIV/AIDS infected is still limited. (UNAIDS, 2001).

An evaluation report of GTZ on the effectiveness of the IEC Program on harm-reduction shows that the Program using peer education approach is successful in strengthening awareness with visible results, but it is not enough to change behavior. Provision services are often lacking. Social environment and individuals greatly affect decisions to implement safe behavior. There are some support policies of the government but they are not always effective. Moreover, there is a lack of awareness of the policies by some health staff, community leaders, and in part of the general population (Cao Lan Anh, GTZ, 1999).
The Summation report MOLISA 2000 on the achievement of HIV/AIDS prevention activities since its participation in the Program shows that in-depth propaganda and education for SWs and IDUs still face difficulties. There remains about 50% of the target population who are not adequately aware of HIV/AIDS and lack skills on practicing safe behaviors for HIV/AIDS prevention. Almost 100% of HIV infected persons released from the centers back home continue drug injection and commercial sex work. Forty two percent of them still share syringes with others (NCADP, 2001).

According to a report of MOLISA, rehabilitation centers (05, 06 centers) received every year about 25,000 IDUs and SWs. Infection rates among them has been increasing rapidly from 7.8% among IDUs and 1.8% in 1996 to 25.5% and 14.1% in 2000. Therefore, HIV/AIDS activities in those centers are not limited only to prevention, but cover care and treatment for PLWHA. The lack of IEC materials, the lack of infection prevention facilities and supplies, lack of equipment for diagnosis STD and lack of medicine and even basic toiletry as razor or sanitary napkin were listed in report of MOLISA as some difficulties for HIV/AIDS prevention. NAP supported only 35% of the centers with some equipment and supplies for infection prevention. 42% of those centers received an annual budget from NAP with a fixed amount of 5 millions VND per center per year which is seen as far from sufficient for needs of HIV/AIDS prevention and care for PLWHA in those centers.

A study by Nguyen Anh Tuan and his colleagues in 1999 on the impact of communication education on perception, knowledge, and practice of 520 drug addicts in Hai Phong found: Despite a very good understanding of the danger of HIV/AIDS infection through sharing needles many of them still keep on sharing syringes. The proportion of users sharing syringes is very high, up to 69% of interviewed drug addicts. The proportion of respondents who do not use condoms in sexual relations in the last six months before the study is also rather high, which occurs in about 46% of unmarried respondents and 70% of married ones. The fact that undergoing treatment to stop drug use and mandatory testing for HIV did not contribute to change in IDUs’ behaviors (Nguyen Anh Tuan and colleagues, 1999).

A study by Nguyen Tran Hien and his colleagues on 1,519 IDUs in HCM city in the 3 year-period 1995-1998 revealed that IDUs who practice drug injection for 5 to 9 years are more likely to be HIV infected than those who inject drugs for over ten years. The high and increasing proportion of HIV infections among IDUs in HCM city suggests that the number of newly infected cases is high. This fact proves that the prevention measures are not appropriate and effective. The research also found that IDUs who inject in common gathering places are exposed to a higher risk of HIV infection, compared to those who inject at home since in these places they commonly share syringes and drug bottles, sharing the same water to clean syringes. Due to seizing campaigns many addicts do not dare to carry syringes with them. Besides, IDUs and owners of drug injection equipment have no time to sterilize syringes and needles between uses. Among people who have sexual relations, the proportion of condom users is low, especially in sexual relation with SWs (Nguyen Tran Hien and colleagues, 1999).

The conclusion of the Summation Report of the 10 Year working of HIV/AIDS prevention recognized, HIV/AIDS prevention activities for the community of IDUs, especially harm-reduction activities are still not so effective as expected (NCADP, 2001).
Access to sterile syringes:

Sterile syringes are not lacking in the market. Syringes are available for sale at most of pharmacies. The price of a syringe in the market fluctuates from 800 to 1,000 VND.

However IDUs do not always have access to sterile syringes when needed. According to a study of the Market and Development Research Center under requirement of WHO and UNDCP in 2001, many pharmacies do not want to sell syringes to people who are recognized or thought to be IDUs because they are afraid of being seen to be ‘giving a hand’ to social evils.

In localities where there are harm-reduction programs and/or intervention projects, sterile syringes and condoms are provided free of charge through channel of peer educators. However, according to assessment of staff of local AIDS divisions, the number of syringes available through the peer educator distribution is not enough to meet the demand. Trang Vu, in her report gave an example of a city distribution of 300 needles for about 200 IDUs per month. In addition, delivering syringes through peer educators does not receive the support of the wider community all the time. There are still many people who think that this activity enables growth or maintains drug injection. This perception contributes to the creation of obstacles, which prevent IDUs access to sterile syringe sources. In addition, current drug laws make needle exchange difficult, for both IDUs and peer educators because the possession of contaminated needles and syringes can be regarded as evidence of drug use and can result in arrest (Trang Vu, 2001).

Drug use is not accepted in rehabilitation centers. However drugs are still used and as it is not acceptable to provide sterile syringes, needle sharing is common. An IDU in Da Nang said that he has injected drugs for more than 30 years but it was not until 1994 after a year living in the rehabilitation center he was HIV infected because of the sharing of needles in the center. This is not the only case.

Gender aspects:

Currently, the majority of IDUs in Vietnam are men. The consequences of drug injection are imposed on themselves and their families, especially in sexual relationships with their wives, have been exposed without control over their own situation. Nonetheless, perhaps there is almost no study on this topic. The communication messages delivered to IDUs rarely raise this issue in a wider socio-economic perspective including gender issues involved in drug injection. The content of communication education primarily focuses only on HIV infection as one of drug injection’s consequences but not from gender aspect. This somewhat limits behavior change and sustainability of safe behavior. At the same time it does not encourage women in the families, particularly of IDUs’ mothers and wives, instead of resignation, to have stronger actions and decisions to help changing behaviors of their drug injecting relatives.

A study conducted by Nguyen Tran Hien and his colleagues in HCM city found that female IDUs tend to share syringes more than their male counterparts (Nguyen Tran Hien and colleagues, 1999). The access of these women to HIV/AIDS information and assistance for behavior change may be more difficult due to disadvantages of economic, educational, and other social conditions, notwithstanding the strong social discrimination towards female IDUs.
j) Evaluability of the program

There was no indicator for this program stated in MTP. However, the recent BSS done in 2000 using all UNAIDS recommended indicators, which include: IDUs sharing needles, and IDUs using condoms in their last sexual intercourse. With the progress of BSS, there is a hope that those indicators will be continuously collected in coming years. Beside those indicators, HIV infection rate in IDUs, which is collected through sero-surveillance, should be used as a core indicator to evaluate impact of the program. The consistent increasing of infection rate among IDUs in recent years shows the weakness of this intervention.

g) Recommendations

1. Revise current policies to support prevention and treatment for IDUs. A national program on harm reduction should be one of the NAP components in coming years.
2. Design and implement intervention in rehabilitation center to prevent transmission in those centers.
3. Strengthen harm reduction interventions.
4. Improve quality of IEC interventions to IDUs to focus on skills development and behavior change.
5. Strengthen IEC interventions to communities and local authorities to build support for harm reduction programs.
6. Improve monitoring and evaluation.

3.4.6 Abolishing stigma and discrimination

a) Background

Stigma and discrimination make life of HIV/AIDS infected people more difficult and obstructs efforts to provide care for infected persons as well as efforts to prevent HIV transmission. E.g., if they are already infected, they may continue to transmit HIV to others because they are afraid of accessing health services to determine their HIV status. The discrimination and stigma to HIV/AIDS infected people indicates poor knowledge and low understanding of HIV/AIDS (UNAIDS, 2000).

One MTP objective of the IEC program is to increase understanding of HIV/AIDS in order to reduce fears and discrimination to HIV/AIDS infected people. However, specific activities were not designed independently but were integrated into counseling and caring activities for AIDS persons.

In annual plans from 1997 to 2000, the contents of IEC messages changed from threatening messages to messages that invoke compassion, charity, and open-hearts. In order to avoid cold-treatment, stigma, and discrimination to HIV infected people. However, this activity was not mentioned either in the Ten Year Review of NCADP (2001) or in reports of other ministries, branches and social organizations. In these latter reports, they only target AIDS patients and their closely related persons but it has not yet been extended to larger communities and the whole society.
b) Legal environment

The Ordinance for the HIV/AIDS Prevention and Control promulgated by the National Assembly in 31st May 1995 sets up a favorable legal environment for activities aiming at reducing discrimination and stigma to the HIV/AIDS infected people. Specifically:

- Article 4 of the Ordinance stipulates that HIV/AIDS infected people are to be protected against discrimination and stigma.
- Article 9, part C emphasizes that government organizations, mass organizations, socio-economic agencies as well as armed-force units are responsible for conducting and providing health services and spiritual supports to HIV/AIDS infected people.
- Article 11, part 2 stipulates responsibilities of family members of HIV/AIDS infected people in providing health care and spiritual supports to HIV/AIDS patients in order to help them integrate into a normal life in their family and community.
- Article 20 assigns responsibilities of health providers in providing care for AIDS patients and prevention of HIV/AIDS transmission to their family members. AIDS patients with acquired opportunistic infections should be provided treatment at relevant specialized health facilities. The refusal of examination and treatment of HIV/AIDS infected people is strictly prohibited.

However, those promulgated regulations of the Ordinance are not always followed.

On October 14, 1999, MOLISA and MOH issued the temporary Joint Circular No 25/1999/TTLB-BLDTBXH-BYT which prohibits HIV-infected people from working in 7 occupations/jobs related to work in the health sector, production of vaccines, orthopedic surgery, and daily services including hair cutting, nail cutting, massages, ear-piercing, etc., sterilization of health equipment, direct services in the hotels, dancing halls, childcare in kindergartens and other service agencies. This Circular soon was replaced by the revised Joint Circular No 29/2000/TTLB-BLDTBXH-BYT issued on December 28, 2000. The newly issued Circular, prohibited areas of employment for HIV infected people reduced from 7 to 2 areas: 1. Health services involving direct contact with human blood and body fluid; and 2. Orthopedic surgery and cosmetic services that involve direct contact with human blood and body fluid. The new Circular sounds much more reasonable and shows the increase in general knowledge on HIV/AIDS.

c) Budget

There is no separate budget for activities that aim at reducing discrimination and stigma as those activities are included as a part of the IEC program for HIV/AIDS prevention.

d) Implementing agencies

The NCADP is responsible for guiding and coordinating IEC activities including the objective to reduce discriminations and stigma. Other organizations such as MOET, MOLISA, MOCI, and other social organizations have take responsibility to implement these activities.

e) Assessment of program activities

Information – Education – Communication:

In recent years there have been more articles/shows, which delivered messages about eliminating HIV/AIDS discrimination and stigma. These messages have been reaching a large numbers of
people living in urban and delta areas. The slogan “Living together with AIDS” was initiated in 1996. Some publications, with support from international organizations have high quality. Stories told by HIV/AIDS infected people themselves bring strong personal impressions and have high educational contents. However, those publications have not been widely disseminated (Nguyen Tran Hien, 1999).

Still, some materials on removing discrimination and stigma are vague, have general contents and their appearances were not attractive and they are generally considered monotonous.

A health worker in Da Nang made the suggestion that the IEC messages should substantially change to make people not fear HIV/AIDS, otherwise, it would be very difficult to carry out the care for AIDS patients in communities.

Beside IEC activities, the Ten Year Review (NCADP, 2001) mentioned, activities such as pre- and post-test counseling, care at community level, “friend helps friend”, and peer education gradually contribute to the changing of people’s awareness and help to reduce discrimination and stigma.

Continuing challenges:

The existing challenges require further efforts from the NAP in terms of IEC activities. Some people committed suicide not only because they are infected with HIV, but also they could not stand the social discrimination that would occur if people knew. For instance, a man left his two-year-old child to die when he was informed that his wife was infected with HIV. However it turned out later on that it was a false result (AFP, April 7, 2001). The quoted woman in Da Nang who was HIV-infected through her drug injecting husband has taken their three children to her parents’ home to avoid transmission to them. She was shunned by her own children as a result.

Interview results indicated that people know that they should not discriminate and stigmatize HIV/AID infected persons. However, many of them, even health workers, could not overcome their feelings of fear when talking to or coming into contact with HIV/AIDS infected persons. Even communes meet and discuss how to expel HIV patients from their community.

Gender aspects:

Discrimination and stigma is a gender issue. However, in Vietnam there has not yet been any study/research that mentions gender issues, stigma and discrimination. In practice, double standards still exist. An unfaithful woman to her husband will be condemned more seriously than an unfaithful man. Two mistaken HIV tests as mentioned above provide clear evidence for illustration. Similarly, a woman who had premarital sexual relations or was involved in commercial sex work would also be criticized more severely than a man in similar situations. Being labeled as HIV infected or being confirmed to be HIV/AIDS infected due to extramarital relations, premarital sexual relations or prostitution drives women to desperation, not only because they have the disease but also because of strong social discrimination and stigmas.
f) Evaluability of the program

There was no indicator indicated in MTP for this program and no data has been collected so far. Therefore, it is difficult to evaluate the effectiveness of the activities for removing discrimination and stigma.

UNAIDS recommended accepting attitudes toward HIV positive people and employers not discriminating as core indicators for this program.

g) Recommendations

1. Ensure that existing anti-discriminatory laws are enforced
2. Develop and foster a BCC program to change perception and behaviors of the general population towards PLWHA.
3. Work to reduce stigma and discrimination toward high-risk groups in general (e.g., SWs and IDUs) and women
4. More studies need to be done on this issue.
5. A monitoring and evaluation system needs to be established for this program.

3.4.7 Prevention of transmission in medical services

a) Background

Every year a large proportion of the population utilize medical services. In the year 1999, according to Ministry of Health Statistics Yearbook, there were more than 135 million instances of people seeking medical examinations. The average number of medical examinations then was 1.77 per capita. In the same year, there were 5.2 million in-patient consultations. Those figures were from the public sector only. Meanwhile, the private sector also receives a considerable number of clients. In HCM City alone, there are about 11 million consultations with the private sector in comparison to 11.7 millions in the public sector.

The number of patients undergoing surgical operations, birth deliveries, and abortions, was estimated at least 3.5 million in 2000. In total, millions could be exposed to nosocomial diseases each year through medical services.

b) Legal environment

The MOH has released a number of Decisions and Instructions related to HIV/AIDS prevention in the health sector. However the search for policies within the time period January 1996 to June 2001 did not find any documents that covered prevention procedures of HIV within the health setting. For example:

- Regulation on Blood Transfusion promulgated by MOH's Decision No. 937, September 4, 1992, provides technical and legal foundations for technical procedures related to blood transfusion, however there are no equivalent regulations for other medical procedures.
- Technical procedures on dealing with HIV/AIDS promulgated by MOH's Decision No. 2557, December 26, 1998 focuses on procedures for medical professionals in contact with HIV/AIDS patients. The Decision also states "because medical history and clinical examination are not sufficient to determine whether or not a patient has HIV, all blood and body fluids of the patient must be considered as potentially HIV infected" however this falls short in providing procedures for universal precautions.
• Some articles of Ordinance on Private Medical and Pharmaceutical Practice Government's Decree No. 06/CP, January 29, 1994 mention responsibility of private medical facilities in AIDS prevention and control. Article 16 of the Ordinance states "Private medical and pharmaceutical facilities have responsibilities to collaborate with local health authorities in control of STDs, drug addiction, AIDS and some other communicable diseases which can be dangerous for the society”. However, this Ordinance does not state concrete actions those facilities should take regarding prevention of communicable diseases.

It can be stated that every health worker who has direct contact with patients are bearing some risk of infection. Existing legal documents also do not give clear and concrete regulations to cases infected due to medical services. Decree 46/CP, August 6, 1996 regulates fines from 500,000 to 2,000,000 VND for cases of violation of procedures on sterilization, blood transfusion and other technical procedures related to HIV/AIDS. Accidental transfusion of HIV-infected blood is referred to article 242 of Criminal Code for "Violating regulations on examination, treatment, producing and processing medicine, dispensary and selling of medicine which results in serious loss of a patient's health" (MOJ, 2001).

While legal documents are insufficient, dissemination of the existing documents is also limited. For example, many medical professionals, or even health managers and members of PAC during interviews were not aware of their professional risk insurance. Decree No. 34, June 1, 1996 of the Government states that the government pays for professional risk insurance of medical professionals who are infected by contacting with HIV infected patients.

Supervision and enforcement of issued legal documents needs full implementation. Decree 46/CP, August 6, 1996 on administrative punishments to state management on medical practice has regulations on punishment to administrative violations on HIV/AIDS infection prevention. According to the Report of Summary Meeting for AIDS prevention in the health sector, period 1995 - 2000, since the Ordinance on HIV/AIDS prevention in May 1995 to the time of the Meeting (April 2001), there had been no special inspection mission on implementation and therefore no punishment so far.

In summary, there are many legal documents addressing HIV/AIDS transmission prevention in medical services but many of the existing regulations were not concrete enough or were unsatisfactory. In addition, the dissemination was limited and supervision of regulations enforcement is loose.

c) Budget

Usage of disposable instruments and supplies, together with improvement of decontamination and sterilization has been an increasing expense of medical services. Da Nang General Hospital only purchases every month 40-44,000 disposal syringes at an additional of 24 - 32 million VND. Hospital budgets are covering a limited amount of cost for preventing transmission of disease in the medical setting.

As state budget for the health sector is low, disposal supplies, such as needles, catheters and gloves are often covered by the collection of fees from patients. Even health insurance does not cover these costs. Therefore national prevention of transmission of disease in the medical setting can be dependent on the patient's ability to pay and/or hospitals ability to utilize available resources. Such practices are placing poor patients and medical staff at higher risk of infection.
Since 2000, there has been a budget line "transmission prevention in medical services" with a budget approximately 3.5% or 2.58 billion VND for 2000 (MOH, 2001). It reflects the attention of the NAP to this issue. However, this amount was apparently insufficient.

d) Implementing agencies

MOH is the management body that has oversight of health services for the whole country. Nearly 13,000 public and about 20,000 private facilities with about 220,000 medical staff directly implement medical activities.

e) Assessment of program activities

All medical facilities and staff were aware of the importance of HIV/AIDS transmission prevention. Leaders of the health sector at different levels all pay special attention to this area. Transmission prevention was targeted as one priority of many medical facilities. Effectiveness of transmission prevention in medical services in the last few years was reflected in the following changes:

- Special attention to instrument processing: In recent years, major hospitals were establishing infection prevention departments to collectively process instruments, and ensure the safety of instruments. However, at lower levels such as district and commune, investment for transmission prevention was still limited (MOH, 2001).
- Gradually formulate models for medical wastes processing: Processing of medical wastes was gaining considerable attention from medical facilities and health managers. Interviews with private practitioners in HCM City revealed that the City could manage to collect medical wastes from private clinics (interview of private practitioners).
- Usage of disposable instrument and supplies: Prevention instruments and supplies - from disposable needles to decontamination chemicals or disposable surgeon gowns - were increasingly becoming available.
- Common usage of decontamination chemicals: In recent years, decontamination has become a standard step for instrument processing at all levels of health services, including private clinics.
- HIV testing of patients: HIV tests have become more widely available. All provincial hospitals, many nationals and specialized hospitals can provide HIV tests. However, there are still issues in these activities. Many medical staff in evaluated hospitals prefer mandatory HIV testing of patients. This may be a result of poor knowledge and experience, and inappropriate attitudes when in contact with HIV infected patients. Also this was preferred if medical staff were not following strictly universal precautions. The major change in this area was offering voluntary testing. However, patients still have to pay for 50% cost of the test, which varies from 30 - 50,000 VND. There were a remarkable percentage of health workers who did not follow universal precautions (only 32.7% of abortion providers wash hands before performing procedure (Population Council, 2000).

There is a high concern over safety at private facilities. Private practitioners themselves admit that transmission prevention in private clinics is limited due to insufficient instruments and supplies, infrequent supervision and instructions; and a lack of knowledge among those who are either formally trained or not, such as traditional practitioners or traditional dentists. Given the fact that the patient load in the private sector has been increasing, stricter controls than what currently exist will be necessary.
In summary leaders of health sector, medical professionals and the public all have good awareness of HIV transmission prevention. However, they need in-depth knowledge and detailed legal procedures. Also adequate resources need to be invested into transmission prevention at grassroots levels –such as instruments, supplies and training.

f) Evaluability of the program

MOH has developed infection prevention (IP) protocol for health facilities. Infection Prevention is one of the many procedures closely monitored by the health system in both public and private health facilities. However, there is no regular system for collecting sufficient data on universal precautions - the guiding principles of IP.

Among UNAIDS indicators for HIV/AIDS, apart from the percentage of health facilities which practice correct Universal Precautions, there was only one additional indicator: the proportion of accidental transmission among clients who receive the same kind of services. The method for information collection needs to be assessed.

g) Recommendations

1. The legal base for prevention of transmission in medical services should be reviewed and further developed to support Universal Precautions practice, protect health workers and clients.
2. MOH and Vietnam Health Insurance should consider reimbursing essential supplies for infection prevention, such as disposable syringes, transfusion kits, gloves and so on.
3. Health sector should organize a holistic education program, which targets health workers and clients to raise awareness and knowledge of both.
4. MOH should put into practice Universal Precaution principles in all medical services - both in public and private sectors and Medical Schools.
5. MOH should integrate HIV infection prevention into the regular monitoring and reporting of the health system.
6. Indicators to evaluate the transmission prevention in medical services may include: the percentage of health facilities that practice correctly Universal Precautions and proportion of accidental transmission among clients.

3.4.8 Prevention of transmission through blood transfusion

a) Background

According to National Institute of Hematology and Blood Transfusion (NIHBT), from 1996 to 2000 a total number of 741,000 blood units had been transfused. Blood transfusion gained special attention because HIV transmission probability is extremely high in contaminated blood. Safe blood transfusion, since the beginning of the NAP, has been set up as an important component of the program. This was also one of the four main components of MTP.

b) Legal frame

Article 14 of the Ordinance for HIV/AIDS prevention states: "Health facilities have to test for HIV of all blood donors" and it "Strictly forbids transfusion of blood containing HIV to other people". The Regulations of Blood Transfusion, promulgated by MOH Decision No. 937, September 4, 1992, establishes technical standards and guidelines for blood transfusion, from the selection of donors to collecting blood, restoring, dispensing and transfusion.
c) Budget

The budget for safe blood transfusion was mobilized from different sources. According to the NIHBT, the NAP contributes the biggest portion for blood transfusion, 30-70% of the total budget or 2.2 to 11.5 billion VND. This was 4-9% of the NAP budget (MOH, 2001).

Other sources of financial assistance include WHO, Luxemburg government, MOH and loans from the WB. Some local budgets contribute significant amounts to safe blood transfusion. The cost for a blood unit was as much as 550,000 VND, however the fee that patients pay is limited to 250,000 VND. To ensure the safest blood supply HCM City pays the difference. With about 40,000 blood units collected per year, it is billions of dong (the interview with leader of the city Hematology and Blood Transfusion Center).

d) Implementing agencies

The NIHBT was the leading institution, taking overall responsibility for technology, professional skills as well as organization of the whole system. At provincial level, there was a provincial center for blood transfusion or department of hematology of provincial general hospital. At the district hospital there was a hematology section in the laboratory department. In the AIDS Division as well as AIDS divisions at provincial level, there was a safe blood transfusion sub-committee who oversee blood safety program within the province. The blood transfusion system was well organized.

e) Assessment of program activities

Blood screening:

The percentage of screened blood increased from 98.7% in 1996 to 100% in 2000. Blood screening was estimated to have detected from 1994 to the end of 2000, 841 HIV cases, approximately 32,000 HBV cases and 8,860 HCV cases and malaria (MOH, 2001).

Blood screening is organized down to district level. By the end of 2000, there are 81 institutions at provincial level and 430 institutions at district level established to screen blood. The blood transfusion system had reached the target: where there is blood taken, there is blood screening (Interview with leader of the NIHBT).

However, the strategy to provide screening equipment down to district level in the last few years has not been so cost-effective as expected due to many reasons. According to the Report on Equipment and supplies in HIV/AIDS prevention of the NAP, a number of serodia equipment and test kits had not been effectively used (NAC, 2000). Since 2000, the blood transfusion system shifted to a new strategy of collecting blood in provincial level blood transfusion institutions, then the blood would be supplied to the health facilities that were eligible for blood transfusion. This model, in opinions of specialists in blood safety was more cost-effective but apparently, it was dependent on a good cold chain.

Although all blood for transfusion is screened, HIV infection is still possible because of the “window period” where a newly infected person cannot be detected. New testing techniques have shortened the “window period”. However, quick tests were still widely used. A boy of 13 years old was infected by blood from a donor in the “window period” of infection (leader of NIHBT). Also using family blood during an emergency could be infectious but cannot be detected if the family member was in the “window period” of infection.
Another strategy to enhance blood transfusion safety is transfusion of blood elements. However, only around 10 institutions can apply this technique in different degrees. Therefore, according to the NIHBT, the proportion of whole blood transfusion was still at the level of 90%.

Sources of blood – blood donation:

There are currently three main sources of blood donation: paid donor, voluntary donors and family members. One objective of the national blood transfusion system is to reduce the percentage of paid blood donors and increase voluntary blood donors up to 50%. Voluntary blood donations have increased from 13% in 1996 to 23% in 2000. In some localities where the voluntary blood donation movement is well organized, such as HCM City and Da Nang, voluntary blood accounts for up to 70% and 50% of total blood transfused, respectively. HCM City can manage to organize a regular movement for voluntary donors, to meet the city’s blood demand.

However, an interview with a blood transfusion specialist revealed that several issues with voluntary blood donations exist. As a “voluntary donor”, they receive about 100,000 VND for “feeding up” which is 2/3 the amount given to paid donors. Therefore it cannot be considered voluntary. More seriously, a WHO specialist in blood transfusion believes that money attracts those who have high-risk behavior such as IDUs to donate blood to pay for their drug habits.

Some local managers were concerned that the budget for communication, organizing, and mobilizing donors was too small, which limits the development of the movement. They don’t dare use “feeding up” money for such activities, as it does not follow the guidance. In HCM City, however the “feeding up” money was given to the Red Cross to mobilize donors and organize the donation.

WHO was working with Vietnam Health Insurance to pilot the model in which the poor donate blood to receive health insurance for the family, rather than receiving money in the hand. Insurance is a more positive and encouraging form of compensation than money.

NIHBTs objective was to reduce blood donation from family members, as they were paid donors. However this was not implemented. Nationwide, between 1996 and 2000, blood donations from family members’ were almost unchanged, between 13.5% and 14%. This was partly explained by many district hospitals in mountainous areas performing surgery using family blood due to a lack of a cold chain to store blood units.

Blood transfusion indications – volume of blood transfused:

The number of blood units transfused has increased from 112,000 in 1996 to more than 184,000 in 2000 (MOH, 2001). One objective of Vietnam Safe Blood Transfusion (which was a UNAIDS indicator) was to minimize the number of blood units transfused. There are different comments from different sources on the achievement of this objective. Some local staff believe that blood utilization has been decreasing in the last few years. However, the indicators for blood transfusion have been changed to exclude many surgical operations that were classified as requiring blood transfusion. However, according to the judgment of managers at central level, indications of blood transfusion are still too wide and inappropriate.

The annual figures on numbers of blood units transfused tends to support this latter opinion, i.e., compared to 1996, number of blood units transfused in the year 2000 increased by 72,000 units.
or 60% (MOH, 2001). This suggests that the safe blood transfusion program should not only be implemented by the Hematology and Blood Transfusion system. Developing national standards on indications on transfusion of blood and blood replacement products could be a solution to involve other professionals to the safe blood transfusion program. One objective of Vietnam Safe Blood Transfusion (which is also a UNAIDS indicator) is to minimize the number of blood units transfused. Indications for blood transfusions, in observation of some informants have been changed recently. However, in the opinion of managers at the central level of the safe blood transfusion program, indication practices are still too broad and inappropriate.

Monitoring and supervision:

According to leaders of the Safe Blood Transfusion program as well as staff at the provincial level, monitoring and supervision at central and provincial level were seen as regular, serious and effective. However, monitoring and supervision at district level were not carried out regularly in most provinces.

f) Evaluability of the program

In general, it is fair to say blood transfusion safety program can be evaluated. There is information available on percentages of transfused blood units screened for HIV, which was a core indicator recommended by UNAIDS. With 100% of transfused units screened by the year 2001, the safe blood transfusion program has reached their first important achievement. The next target was reducing percentages of paid donors and donations among relatives. This fits with another UNAIDS indicator on donor recruitment. Data shows progress on reducing paid donors but not in donations from relatives. The additional UNAIDS indicator on the reduction of blood transfusion, however, has not received enough attention. Evidence suggested there was a substantial increase of blood transfused units year after year and this indicator requires further development.

g) Recommendations

1. The policies and guidance on voluntary blood donations should be revised to not pay the voluntary blood donors but instead allocate greater budget for advocacy, mobilizing and organizing blood donations. Forms of compensation other than money - such as insurance cards or free blood transfusions in the case needed - can be considered. Explore adoption to other areas of HCMC practice of contributing “feeding up” payment to volunteers at Red Cross.

2. The shift from collecting blood at the district level to provincial or regional level can help to improve the quality of the screening. However, it should be very well organized to ensure blood availability. The cold-chain needs to be well-equipped and monitored for quality and also availability of the blood.

3. Safe blood transfusion program should pay more attention to reduction of relative blood donor.

4. MOH should work out a standard/guidance on blood transfusion indicators to avoid unnecessary transfusion.

5. Monitoring systems, especially to the district level should be strengthened by having assigned staff, developed forms and indicators.
3.4.9 Prevention of mother to child transmission

a) Background

In Vietnam, the detection of HIV among pregnant women increased from 0.04% in 1996 to 0.2% in 2000. From 1996 to 2000, there have been 217 pregnant women found with HIV, among 187,860 tested (MOH, 2001). In MOH’s AIDS Division as well as local AIDS Divisions, there are sub-committees for prevention of mother to child transmission (PMCT).

b) Legal frame

So far, the only legal document directly addressing PMCT is the “Guideline on diagnosis and treatment of HIV/AIDS” issued by MOH’s Decision 1452, May 8, 2000. In the guideline, there was a chapter on prophylactic treatment for Mother to Child Transmission (MCT) that provides guidance on pre- and peri-natal prophylactic treatment, procedures for birth attendance, post-natal treatment to mother and child, and indications for pregnancy termination.

c) Budget

The budget of the NAP for PMCT is very small, ranging from 120 to 810 million VND. In 2000, the budget was 500 million VND. This budget is mostly allocated for training and IEC. Most pregnant women who were HIV tested had to pay for the test. The NAP aims at providing prophylactic treatment for all infected pregnant women. However, not all pregnant women were tested. This budget would need to increase to achieve this objective.

d) Implementing agencies

The Institute for the Protection of Mother and Newborn, the leading institution on obstetric and gynecology, was in charge of MOH’s PMCT sub-committee and is responsible for this area nationally. Provincial MCH/FP centers were in charge of such committees in the provinces. Health facilities, especially those, which specialize in obstetrics and gynecology, are implementing PMCT.

e) Assessment of program activities

Activities of PMCT include IEC, testing, counseling, and prophylactic treatment. There is no central or national legislation directing the PMCT program. Medical facilities were self-mobilizing and self-organizing within their professional and financial capacity.

Information – Education – Communication:

IEC activity on PMCT was mostly carried out by the general IEC program on HIV/AIDS, which provides limited information on PMTC as one of the three modes of HIV transmission. In-depth interviews, and focus group discussions done in the evaluation showed that a majority of the population, including a relatively high number of local authorities, leaders and program managers do not know that only certain percentages of children born to infected mothers acquire HIV. The IEC messages in this issue were still too vague and did not provide correct information.
In the last few years, obstetric and gynecology (Ob-Gyn) hospitals have been receiving IEC materials on this area from the NAP. Some institutions such as Tu Du hospital produce brochures and IEC materials on PMCT.

**Testing:**

HIV testing for pregnant women was the first essential step for a PMCT program. HIV testing is performed on 100% of pregnant women in large Ob-Gyn hospitals. Despite the gradual increase in the number of HIV tested pregnant women from 27,000 in 1996 to 54,000 in 2000, this is still a very modest percentage among the more than 1.5 million babies born every year. For 2000, there were 108 HIV positive mothers identified of the estimated 3,000 (MOH, 2001).

There has been so far no regulation on HIV testing for pregnant women. The two most important obstacles for the PMTC program were availability of HIV laboratory tests and test expenses. Only major Ob-Gyn hospitals have HIV tests available. Most hospitals charge for the HIV test - currently costs range from 30 to 50,000 VND. Some big hospitals such as Tu Du who can actively coordinate their budget and provide free tests to the very poor. However, the percentage of people who cannot afford HIV testing in this hospital was small and only accounts for a small percentage. HIV tests for pregnant women were still the unanswered question to the PMCT program as, without testing and low HIV prevalence, there was no base for prophylactic treatment.

**Counseling:**

HIV counseling rooms and trained counselors are available in some major Ob-Gyn hospitals such as Tu Du, Hung Vuong, IPMN, and Phu San Hanoi. Tu Du and Hanoi Ob-Gyn provide regular talks or group counseling to pregnant women. However, knowledge on PMCT among pregnant women in general was still limited. According to specialists at IPMN and Tu Du, all HIV positive pregnant women receive counseling (51 cases in 2000 at Tu Du hospital). However, counselors often find it difficult to give counseling to those women as they noted “we cannot offer them a solution to treat the condition (HIV positive)”.

Providers argued whether to counsel HIV positive mothers to terminate their pregnancies. The current draft of national standard/guideline on safe motherhood mentions that: “When the women are (found to be HIV positive) in the first trimester of pregnancy, they should be counseled to terminate the pregnancy.”

**Prophylactic treatment:**

Prophylactic treatment has been introduced recently into the NAP through the project "Approach HIV infection treatment". Prophylactic treatment in Vietnam up to now has only been under clinical trials with few clients and little experience. However, hospitals that participated in the above clinical trials found medicine supply as complicated, slow and insufficient (interview PMCT program staff).

HCM City, Ob-Gyn hospital Tu Du, according to national and international experts, was seen as a standard model for PMCT for Vietnam. The hospital tests for HIV in all pregnant women who make ante-natal care visits to the hospital, undergo group counseling, produce IEC materials for pregnant women, provide individual counseling to those who were infected, and take care of abandoned children whose mothers are infected. The neonatal care department has strong experience and is well organized to receive and care for infected and abandoned children.
f) Evaluability of the program

Available data on the program over the past five years appeared to be collected by chance rather than on purpose as there were no plans or objectives for PMCT in recent years. Data on one of the two UNAIDS core indicators, and one of the two additional indicators was available. Numbers or percentages of pregnant women tested and numbers or percentages of pregnant women who were found HIV positive and treated with Anti-Retroviral Drugs were recorded. The data reflects the small scale of the program (and the lack of its programmatic organization).

For the future, the national action plan on HIV/AIDS prevention and control for 2001 - 2005 states the objective that by the year 2005, 100% of pregnant women who are HIV positive will receive appropriate counseling, treatment and care. This objective needs clarification because it appears to be either unclear or unrealistic e.g., if the program really hopes to reach 100% of pregnant women nationwide who are HIV positive, it is unrealistic when HIV testing services are available only in big cities and provincial centers. If the program concerns only those who were found with HIV positive, it is unclear how many pregnant women will receive HIV testing or at which extent this indicator applied.

g) Recommendations

1. The PMCT program should be redesigned, not only to target pregnant women but all women who can become mothers.
2. HIV testing systems should be organized with the spirit of being “women friendly” to encourage pregnant women to come for voluntary HIV testing.
3. Gradually include VTC as one component of the prenatal care but the voluntary testing should be respected.
4. Pro-abortion counseling to HIV infected pregnant women should be reconsidered.
5. A system for receiving, care and treatment for HIV positive women and newborns should be established to ensure the availability and quality of the services. Ob-Gyn facilities should be ready to receive HIV positive mothers and their children. There should be a mechanism to make available prophylactic drugs, care and proper counseling.

3.4.10 Prevention and treatment of Sexually Transmitted Diseases

a) Background

Researchers have shown that STD infected people have a higher probability for HIV infection. It was estimated that there were approximately 1 million people with STDs in Vietnam by the year 2000 (WHO-MOH, 2000). The most common STDs in Vietnam are Chlamydia with about 500,000 cases, and Gonorrhea and Syphilis with 150,000 cases each. The HIV projection for STD patients with the national infection rate of 1.36% was only 13,000 cases.

b) Legal frame

Three decrees or ordinances govern the legal frame for HIV and STDs:

- Ordinance on HIV/AIDS prevention, Article 16 states "when requested, public health facilities have a responsibility to undertake HIV testing for people at risk. The "Common Law on HIV/AIDS Prevention and Control" published by MOJ explains that people at risk for HIV/AIDS include those who were injecting drugs, SWs and STD patients. This book
also states that HIV testing was required for those people and if they do not obligate with the indication, they may be forced to have a test.

- Ordinance on private health practice requests the participation of private health facilities in STD prevention, but there was no specific instruction on how they should collaborate.
- Decree 46/CP, Article 10, stipulates administrative fines of 1 to 2 million VND for not reporting STI cases to health authorities.

Although promulgated, many stipulations in the above-mentioned documents were not concrete or practical. In addition, dissemination and enforcement have not received enough attention. Some interviewed private practitioners, even those who specialized in STD treatment were not aware of the regulations on reporting such cases. Moreover, the under-reporting of STI cases is a method of tax evasion.

c) Budget

Total NAP budget for STD prevention and treatment annually ranges from 300 million to 1 billion VND. The 2000 budget was 860 million (MOH, 2001). This budget, in comparison to the magnitude of the issue with 1 million STI cases in a population of about 78 million, was too small and insufficient for organizing a national program, even with few activities.

d) Implementing agencies

Aware of the importance of the issue, a sub-committee for STI prevention and treatment was established at central as well as local levels. All AIDS Divisions at different levels have a sub-committee for STD prevention. The National Institute for Dermatology and Venereology and their provincial institutions were in charge of this sub-committee. Currently, Dermatology and Venereology Institutions (DVI) were implementing STD prevention activities by integrating into other institutional programs.

However, the organizational structure of the DVI themselves was confusing. At the provincial level there exist four different organizational models: center, station, hospital and teams within the preventive medicine center or Social-Diseases Control Center. The last model appears troublesome due to lack of consistent supervision and guidance from the DVI who supervise and support all the other models.

In addition, the role of Ob-Gyn facilities in examination and treatment of female STD patients was very important. In this assessment we observed that while most male STD clients come to dermatology facilities, female clients seek services in Ob-Gyn facilities - as with any other reproductive tract conditions. Coordination between those two systems was not clear and both were going their own way.

e) Assessment of program activities

According to interviewed experts, two major achievements of the STD prevention program in particular and the NAP in general were:

1. Provision of correct knowledge on the role of condoms in prevention of STI/HIV, and
2. Wide dissemination of the strategy on syndrome-base diagnosis and treatment, the determining factor for availability and accessibility of the services.
Prevention and treatment of STDs include IEC, counseling, diagnosis and treatment, and HIV testing.

Information – Education – Communication:

IEC activities were mostly organized within the general IEC activities of the NAP, whereas the rest of the STD program was under the responsibility of DVIs.

A vast majority of the reproductive age population in rural and urban areas know that using condoms for sexual intercourse will prevent STDs. Condom use among SW’s clients has been increasing (Khuat Thu Hong, 1999; BSS, 2000). Interviewed STD patients in this evaluation were aware of the risk of having unprotected sex and the role of condoms. However, according to interviewed STD private practitioners and experts on sexuality, many people were not using condoms due to lifestyle or having sex while drunk or were drawn along, not able to act consciously. Most interviewed people believed that nowadays their non-use of condoms was not due to a lack of knowledge. In other words, almost everybody is aware of condoms and their role in protection. This achievement should be attributed to IEC component of the NAP other than STI prevention program itself.

Counseling:

Counseling for clients and their sexual partners was very important in the prevention of STI transmission. This activity, although having been organized, has been almost inactive so far. Professionals on STD prevention admitted that lack of professional staff and lack of counseling skills makes a counseling room a symbolic act rather than a reality. Based on evaluators’ observation and interviews with STD clients, partner notification and treatment was poorly practiced.

STI management:

WHO’s strategy on syndrome-based diagnosis and treatment, which has been disseminated nationwide, makes the service more available and easier to access. Among physicians who were trained, all were able to diagnose and treat most of the STDs without modern laboratory tests. Leaders of STD control sub-committee were very proud of this wide dissemination. The development of the private sector with convenient and private clinics was another factor increasing accessibility to the services. Besides, pharmacists, where a considerable proportion of STD clients come to buy drugs for self-treatment, more or less contribute to the availability of the services (WHO, MOH, 2000). It was usually not difficult for STD clients to seek treatment.

As the syndromic-approach seems to be abused without acknowledging its limitation, the quality of the services was raised. Based on international experience, inappropriate use of specific antibiotics following the syndromic-approach has lead to bacterial resistance to drugs, which makes treatment more difficult. Specialists on STDs also have acknowledged this fact in Vietnam. This was reflected in the new national standard/guideline on STDs that recommends treatment of STDs with new antibiotics.

HIV testing:

As STD patients take compulsorily HIV tests, most of DVI, hospitals, and centers were capable for HIV testing. HIV testing, therefore, was available to those who visit these facilities. An obstacle, however, was that most STD clients seek services at private clinics where no HIV
testing is available. Private practitioners reported that referring clients to public facilities for HIV testing was not always possible due to clients' embarrassment and also due to the fear of "losing clients" from the provider's point of view.

Private sector facilities:

In most of the private clinics, treatment results cannot be controlled; there were almost no IEC materials; counseling was limited to question and answer sessions, which varies according to availability and openness of providers; and HIV testing was impossible. As a result, while WHO estimates 1 million cases of STDs in Vietnam for 2000, the total number of STD patients tested for HIV was only 81,000 - less than 10% of total STD patients. Cooperation between public and private facilities is seriously lacking.

f) Evaluability of the program

It was difficult to evaluate STI prevention program as available statistics were seen as unreliable while other necessary data, such as number of cases, was not available. Statistics in public facilities show an increase of STDs with 50,000 cases in 1996 to 127,000 cases in 2000. Reported numbers from the private sector also show a similar trend with 1,300 cases in 1996, increased to nearly 9,000 cases in 2000. This statistic is one important weakness of the program. All experts believe that the percentage of clients who seek STD services in public facilities accounts for about only 10-20% of all clients. In the mean time, private clinics, for many reasons including tax aversion, only report a symbolic number.

Data was either not available or unreliable. The program in recent years focused on quantifying STD cases by recording reported cases, but failed as the number was seriously under-reported. In fact, while data for all four UNAIDS indicators: appropriate diagnosis and treatment of STDs; advice on prevention and HIV testing; drug supply at STD care services and treatment seeking for STI could be collected through monitoring or survey, there was no attention to gather or use them as indicators to evaluate the program.

The MTP for the next five years will develop a STD surveillance system, which may help understand the magnitude of the problem. However, an STD surveillance system does not provide information about the quality of services that UNAIDS-recommended indicators can really help. Therefore, it will be necessary for the STD program to have information regarding both the target groups and the quality of existing services.

With unreliable data, no STD surveillance, the STD picture looks vague. Even professionals and policy makers cannot be sure about magnitude of the problem and targets for interventions. In that context, technical services were the only activities that the system can measure. However, there was no data to evaluate technical performance. Without data, it was hard to say whether or not technical performance has reached standard or not.

In short, as information is lacking and biased, the STI prevention program in the NAP has been acting by sense of touch.

g) Recommendations

1. The national program for STD prevention should be reviewed and reorganized to meet the scope of the problem as percentage of HIV positive cases among STD clients is increasing.
There should be a link between the Dermatology and Venereology system with Ob-Gyn system to have a common strategy.

2. A quality STD surveillance system should be developed to have more detailed information about the problem. However, while resources for this activity are not available, reviewing and reorganizing monitoring and reporting systems as well as tax policy to private clinics can be an alternative.

3. UNAIDS indicators should be used for monitoring.

4. Efficacy of the current treatment protocols should be reviewed and a national guidance for STI management should be developed accordingly. The guidance should combine syndrome-based and case-management approach to have proper treatment effect.

5. Counseling during STI consultation, partner notification and treatment should become important components of the STI prevention program.

3.4.11 Treatment of HIV-infected and AIDS patients

a) Background

With an estimated 40 million infected with HIV worldwide and 26 million accumulated deaths, HIV now stands as the worst infectious disease pandemic in recorded history (UNAIDS, 2001). The threat imposed by HIV is reflected not only in the tragedy of each individual case and his/her affected loved ones but on the global scale of human health and the potential for demographic, economic and political destabilization in many countries.

Thus, globally, treatment of HIV and AIDS is a pressing issue in most of the forum on HIV/AIDS. "Provide care and treatment for all those infected" is one of the five objectives of the UN General Secretary's call for action Kofi Annan, 2001. The recent UN General Assembly Special Session on AIDS also declared "Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right to everyone to the enjoyment of the highest attainable standard of physical and mental health". Care, support and treatment for those infected and affected by HIV/AIDS is one of the focus of UNGASS as one important approach to combat the epidemic.

In Vietnam, as of Oct 26, 2001, 41,220 HIV cases, 6,165 AIDS cases, 3,338 AIDS deaths were recorded. With an estimate of more than 100,000 HIV infected people, the number of people who will live with AIDS will obviously increase in years to come. Program managers were aware of the importance of this issue. A major objective of the MTP 1994 - 2000 was "To strive to limit and to decrease the morbidity and mortality rates of HIV/AIDS cases". Therefore, the treatment of HIV infected and AIDS patients has been raised as one important component of the NAP.

b) Legal frame

There were an HIV/AIDS Ordinance, a number of Decrees, Instructions, Decisions, and Regulations of the government, MOH, NAC and related government bodies on HIV infected and AIDS patients. These documents were comprehensive and covered diagnosis, treatment, announcement of test result, subsidy for drugs and financial support, even burial rates for death due to AIDS. However, the urgent matter in those regulations was the government's

"There has been no instruction for implementation so far. And that regulation - sounds very generous but actually it (the compensation) is paid for only one doctor, one nurse, one care-taker for 7 - 800 patients a year." Doctor at Clinical Institute of Tropical Diseases
subsidy for treatment.

MOF’s Circular 128, December 16, 1999 regulates items and rates of government subsidy for the NAP. The Circular set the rate for medications for poor HIV/AIDS patients and health workers who become infected due to direct care of infected patients who were treated in a public facility as 100,000 VND/patient/year. Subsidies for health examinations and the treatment of opportunistic infections every six months, was 30,000 VND/patient/exam. As medicine to use for HIV/AIDS treatment was expensive, the above rate was only symbolic. There was almost no regular specific treatment to HIV/AIDS patients.

The pressing point in the legal framework for AIDS prevention in health facilities was the lack of satisfaction and details in policy and regulations to health workers who have direct contact with HIV infected and AIDS patients and their specimens. The Ordinance on HIV/AIDS, which addresses professional risk insurance for health workers who have direct contact and care for HIV/AIDS patients, has not been implemented. The compensation rate was 5,000 VND/patient/day. The most recent regulation of the MOH to increase salaries of health workers who directly care for HIV patients by 40% has neither been implemented nor satisfactory.

c) Budget

The NAP budget spent on HIV/AIDS treatment ranges from 1.31 to 4.2 billion VND per year or 2 - 6% for 1996 - 2000. This source of budget was allocated to localities based on the rate regulated by MOF in Circular 128 (MOH, 2001).

While many countries in the world were focusing on specific treatment to patients and developing countries, with UN support, were negotiating with pharmaceutical companies to buy discounted drugs, Vietnam does not seem to be involved in these issues.

d) Implementing agencies

A system for the treatment of AIDS patients has been established and put into practice. Clinical Institute of Tropical Diseases was assigned to provide professional guidance to the whole health sector on treatment. In localities, organizational structures for HIV/AIDS treatment were different. In some provinces, the AIDS section was placed in the provincial preventive medicine center. In some other provinces, patients were received in the department for transmitted diseases. Some other provinces assign Dermatology hospital to receive patients.

In all AIDS Divisions, there was a sub-committee on treatment of HIV/AIDS patients. In charge of this sub-committee in the central level was the Clinical Institute for Tropical Diseases. In the province, the institution that was assigned to receive patients also is in-charge of the sub-committee.

e) Assessment of program activities

In recent years, the number of HIV/AIDS patients cared for and treated has been used to assess program performance. The increasing number shows that more courses of services were being delivered e.g., in 1996, there were 195 service courses (patient/time for examination and/or

"Last year we had 2.7 billion (VND) for drugs while treatment for one patient costs about 80 million a year on average. Last year, 1 billion was spent (to buy drugs) for health workers who were exposed, then 1.7 billion left. 1.7 billion could treat 30 patients in the whole country, given to 5 or 7 patients in HCM City, 5 or 7 patients in here..., including PMCT and all the different kinds." Leader, Treatment Sub-committee.
treatment), which gradually increased to 4,313 in 2000. This data, however, does not reflect coverage of the treatment or quality of the service.

**Availability of treatment services:**

HIV/AIDS patients’ medical services were only available in major cities and some provinces where the number of infected people was relatively high. In many provinces, the health sector was not set up to manage HIV/AIDS patients. Beside the difficulties in organizing a professional institution to receive patients, the other problem was whether HIV infected patients get treated together with non-infected in the same facility. This issue was somehow resolved in some large hospitals with separated wards for HIV infected patients. However, in most of the medical facilities, this has not been addressed appropriately.

Effectiveness of treatment for HIV infected people and AIDS patients so far has been very low. There was almost no specific treatment and care for treating HIV/AIDS patients. The current protocol focused on treating opportunistic infections only.

Harm reduction should also be addressed in facilities that provide treatment for HIV/AIDS clients because those clients are sources of transmission and health facilities are ideal places for contacting with infected people. However, harm reduction, including distribution of clean needles and condoms have not been introduced in those facilities.

**Training of health care workers:**

Health workers were not prepared to cope with working with HIV/AIDS patients. Medical school only paid attention to HIV/AIDS education in recent years. Therefore, amongst health workers in general and those who were directly involved in care and treatment of HIV/AIDS patients, professional knowledge was limited. The Clinical Institute for Tropical Diseases was assigned to organize training for health workers in localities but due to a lack of budget and personnel, training has been given only in some provinces (interview with the Institute leader). Managers who were responsible for care and treatment of HIV/AIDS patients in provinces believed that professional training of health workers is very important.

**Community and home-based care:**

Community and home-based care could be an alternative to reduce the burden for the hospital system when it comes to care for PLWHA. People working on HIV/AIDS had been trying to initiate other models for caring of PLWHA, especially AIDS patients.

Home-based care has been recently initiated in some provinces, such as the social nurses model where HIV infected people are trained to care for themselves or instructions for their family to provide care for AIDS patients. This model had been put in practice in Ho Chi Minh City among “Friends help friends” club members.

In some other provinces such as Da Nang, peer educators played the role of instructors to families of AIDS patients.

"Currently, the most serious problem to the Treatment Sub-committee (of the MOH’s AIDS Division) is medication for patients, there is almost no medication for patients." Leader, Treatment Sub-Committee.

"The drug that had been given before - the one to inhibit HIV development, I have not had that for more than I year." AIDS patient.
Investment for main-point-communes (those with infected residents) is an effort of the NAP to bring care for PLWHA to community level, where assigned staff take responsibility for the care of PLWHA.

All of the above-mentioned models can only be really effective once stigma and discrimination is eliminated and infected people can be public about their HIV status.

**Hospice:**

The first and the-only-so-far hospice for PWLHA was recently established in Ho Chi Minh City with a modest capacity of 15 beds. With about half of PLWHA in Ho Chi Minh city not living with family currently, hospices could be an option for care.

**Minimal care package:**

Globally, the concept of the “Minimal care package” has been introducing. The minimal care model is based on locally available experience and resources to provide care for PLWHA both mentally and physically. This model could be the combination between community- and home-based care and locally available treatment, including appropriate traditional prescriptions. The minimal care package appears as the only feasible solution for the short term.

**Care and treatment for infected and affected children:**

There are more than 1,000 children infected with HIV so far. The number will definitely increase in the coming year. And the large number of children whose parents will die from AIDS is increasing as well.

Care for infected children and the orphans of infected people, is still a difficult issue for care providers. The interview with a children hospital's leader revealed that most of obstetric and gynecology hospitals would feel relieved if they could transfer children born to infected mothers to the children’s hospital as soon as they have an excuse. The fact is, with the exception of Tu Du hospital, most of the other obstetric and gynecology hospitals where children are born to infected mothers don't have the necessary facilities and are not ready to care for those children.

Very seldom are infected children abandoned by their parents, but when they are sick from the disease with their sick parents, or when their parents die of AIDS, it is very difficult to find a place for them to be cared for, regardless if they are infected or not. Currently children’s hospitals are the places to care for many infected children, just because they have nowhere to go and they are physically vulnerable. But children need more than medicine. The first centers for care of infected and affected children were established in Ho Chi Minh City. Due to limitation of time and scope of the evaluation, the team could not give concrete comment about this model but it seems to be the only solution exists for those children right now.

**f) Evaluability of the program**

Available data consisted of numbers of service courses and percentages of AIDS clients who receive some care and treatment. There was no indicator for monitoring or evaluation of this program stated in MTP.
The MTP 2001-2005, in the section related to treatment of HIV/AIDS, reflects the intention to set up a treatment network that will make services available at district level. However, there is no quantifiable indicator mentioned. UNAIDS indicators for this program include: medical personal trained in AIDS, health facilities with capacity to deliver care, health facilities with drugs in stock and households helped to care for young adults and orphans. However, UNAIDS indicators focus on evaluating availability rather than quality of care. Indicators to evaluate quality of care should also be developed and applied.

**g) Recommendations**

1. The NAP should consider introducing and encouraging localities to develop their own minimal care packages based on local situations. On the other hand, the NAP should also evaluate existing models for care and treatment in the country, make local experience become NAP experience to share throughout the country.

2. It is necessary to strengthen the system to receive, care and treat HIV/AIDS patients. Besides the special centers, all health facilities should be prepared to receive HIV/AIDS patients.

3. HIV/AIDS should be comprehensively covered in all medical schools with sufficient time and an appropriate curriculum.

4. Health workers who were trained before need to have refresher training on HIV/AIDS, especially those who are working regularly with HIV/AIDS patients.

5. All compensation to those who are working with patients needs to be respected. In the meantime, review the policy taking into consideration the fact that HIV/AIDS cases will increase any way.

6. Harm reduction, including distribution of clean needles and condoms should be included as a component, integrated to treatment and counseling for HIV/AIDS patients.

**3.5 Surveillance**

Surveillance was one of the major components of the NAP and was considered by program managers as among the most successful components. Vietnam was one of the six countries in Asia, except China and India, or forty-seventh amongst countries in the world that have a well-developed surveillance system (Walker, 2001). Strengthening the surveillance system will provide more live and accurate views of the situation in the country that in turn will contribute to developing more appropriate intervention programs.

The Sub-committee for Surveillance of MOH was established in the very first days of the NAP. The sub-committee is coordinated by NIHE at central level and PCPM at local levels.

After the development of the sero-surveillance system, behavioral surveillance was introduced in Vietnam. The first Behavioral Sentinel Surveillance (BSS) was conducted in 2000.

Surveillance was the responsibility of the MOH’s AIDS Division Surveillance sub-committee.

Three major activities within the surveillance component include sentinel sero-surveillance, molecular epidemiology and behavioral surveillance.

**3.5.1 Sentinel sero-surveillance**

Sentinel sero-surveillance system in Vietnam has been developed rapidly. Starting in 1994 in ten provinces, sero-surveillance then extended to twenty provinces in 1996 and recently, in early 2001, to thirty-one of sixty-one provinces in the whole country.
Sero-surveillance data collection was done once a year instead of twice as in the past. Data was collected from high-risk groups i.e. IDUs, SWs, TB patients, and STD clients as well as the general population i.e. pregnant women and military recruits. Despite the variation in quality of data between provinces, sero-surveillance result was considered as the most reliable official data on HIV/AIDS.

The collective results of the sero-surveillance show the trend of increasing infection in all groups and population, either at risk or general. Those results also provide justifications for program planning and direction. For example, the increasing prevalence among the IDU group shows the need for harm reduction intervention activity.

Sentinel sero-surveillance was designed at NIHE and currently implemented at provincial preventive medicine center. However, not every center was active in the surveillance exercise and their responsibility was to estimate the magnitude and characteristics of the epidemic in its own locality. How this data was used in each center shows a passive attitude in surveillance. Rather than analyzing the data, they transfer it to NIHE and wait for feedback about epidemic characteristics as well as the estimation for the number of infected cases.

Another challenge to surveillance includes the trend for surveyed groups to become less and less homogenous. Results of BSS showed that more female SWs were injecting drugs. Experts on surveillance reported that more IDUs were recruited into the military. This somehow explains the rapid increase of HIV among new military recruits – from 0.15 in 1998 to 0.41% in 1999 and 0.95% in 2000. The point to be made here is that this group is considered as of “general population” while according to UNAIDS definition, the epidemic is at generalized state when HIV prevalence is from 1% in general adult population (Walker, 2001). The prevalence of 0.95% in the newly military recruits in 2000 is very close to 1%.

Sample size was another challenge, as according to provincial managers some provinces have difficulty in recruiting the required sample size of 400 SWs or IDUs as both groups were considered involved in illegal activities.

3.5.2 Molecular epidemiology

Molecular epidemiology of HIV in Vietnam has shown the progress in approaching the most up-to-date techniques in HIV/AIDS and was considered the first stepping stone in studying for an HIV vaccine in Vietnam (MOH, 2001).

The first significant contribution of the molecular epidemiology was the recognition of HIV subtypes in different high-risk groups at different localities. Different HIV subtypes found in the North and the South have confirmed the hypothesis about cross-border transmission. This finding was important for intervention strategies. The newly developed ADB-funded project targets the mobile population with a focus on cross-border mobilization partly based on the findings of molecular epidemiology.

It was too early to assess the quality of work on HIV molecular epidemiology in Vietnam. However, its implications can be used in programs straight away.
3.5.3 Behavioral sentinel surveillance

Vietnam was approaching second generation of surveillance in the reporting period. BSS recently (early 2001) joined epidemiological surveillance to give more in-depth views of the picture of HIV/AIDS in Vietnam.

BSS has just finished the first year survey in five provinces. Despite many discussions about the reliability of the results, the first BSS has highlighted some important issues in behaviors of high-risk groups. Although condom use in the last sexual intercourse can be as high as 99% with new customers, condom use with frequent customers can be as low as 10.8%. Injecting drug use was another risky behavior that was believed to be increasing among SWs. BSS results revealed percentages ranged from 9% to 43%. Sharing needles in some localities was at alarming levels e.g., as many as 44% of IDUs in HCM city had always shared. That was to say behavioral surveillance could greatly contribute to interventions if the results are disseminated widely and to the appropriate audience.

BSS has collected a large dataset on behavior of groups with high-risk behaviors. However, most of the results presented in the BSS report were frequencies. More specific recommendations could be produced if more cross-tabulation analysis could be done.

Recommendations for surveillance

1. Given the increasing complexity of population groups, sampling procedures for sero surveillance should be seriously taken into consideration in order to assure the appropriateness as well as accurate representative of the surveyed groups.
2. BSS should be regularly conducted and expanded to more provinces in order to have a better picture for the whole country.
3. Surveillance data can be used as on advocacy tool and scientific evidence for intervention activities. Dissemination of that data therefore is very important. Local authorities should be more actively involved in planning, implementing and utilize surveillance data.
4. Establishment of the surveillance system in every province with the contribution from local budget should be considered.
4. ORGANIZATIONAL CAPACITY ASSESSMENT

4.1. Organizational structure of the National AIDS Program

4.1.1 Organizational overview

At the outset, the NAP was the concern of MOH. Soon after that, even before the first detected HIV case, the NAP organization was placed high in the government structure. The change in structure is present in Diagram 3.

The first legal document to define an organizational structure for HIV/AIDS prevention and control was issued by MOH (in the decree 528/BYT-QD) on June 24, 1987. In this Decree MOH created a sub-committee within the structure of the MOH committee for the prevention and the control of infectious diseases. This sub-committee had the participation of representatives from the Department of Hygiene and Disease prevention, the Institute of Hygiene and Epidemiology, the Institute of Hematology, the Institute of Dermatology, the Institute for the Protection of Mothers and Newborn babies and the Department of Infectious Diseases in Bach Mai General Hospital. The sub-committee was required to conduct research and epidemiological surveillance, implement laboratory examination, implement IEC activities, suggest measures for prevention and seek international collaboration.

In 1990, the National Committee for the Prevention and the Control of HIV/AIDS (National AIDS Committee NAC) was established by Decision 358-CT to be issued on October 6, 1990. According to this decision, there was one chairperson and four vice chairpersons (from the MOH). Also there were seven other members. These were the VYU; VWU; MOCI; MOET; MOI; MOFA; and MOJ. The Committee was responsible for planning and implementing of action plans as well as for mobilizing resources for HIV/AIDS prevention and control.

Since 1990, the NAC has operated actively. There were some further changes but the institutional frame remained the same e.g. in 1994, the Prime Minister made a Vice Prime Minister the chairperson of the committee (23/11/1994) and further, (25/11/1994) an independent working bureau was established for the NAC. Its staff were recruited from MOH but worked independently.

In the Decision of the government in 1997 (Decision 1122/1997/QD-TTg) a NAC with full ministry status was established. The decision also established Provincial AIDS Committees (PACs) within the People Committee frame and a Province AIDS Bureaus (PAB) to work as an office with specialized staff members from province health offices or from other offices, who were members of PACs. At district level, there were District AIDS Committees and at commune level, head of commune is responsible for AIDS prevention activities with the assistance of the commune CHC. As resulted, a full HIV/AIDS network was created.

Recently, on June 5, 2000, the Government issued the decision No. 61.2000/QD-TTg for establishing the NCADP on the basis of merging three Government institutions which share overlapping concerns: (1) The Government’s Steering committee for the prevention and the control of social evils (MOLISA); (2) The National Committee for the prevention and the control of AIDS, Drug and Prostitution (NCADP); and (3) The NAC. This committee replaced the NAC, Decree No 358-CT as well as other national committees for drug and prostitution control. The NAC ministerial members become part of the NCADP. Additional
members have been added and in 2001, there were forty-one different sectors and organizations on the NCADP.

4.1.2 NCADP

The organizational structure of NCADP is presented in Diagram 1 and its functional structure Diagram 2.

The NCADP was composed of a chairperson who is a Deputy Prime Minister; three vice-chairpersons who were the Minister of Public Security, the Minister of MOLISA, and the Minister of Health; and 13 members who were representatives of various ministries, government agencies and mass organizations. Specific responsibilities were assigned to the sixteen member agencies.

At the implementation level, there were four offices: (1) an unit located in the Government Office, to assist the chairperson leadership of the committee; (2) the Standing Office for Prevention and Control of Prostitution in MOLISA; (3) the Standing Office for the Prevention and Control of Drugs located in the MPS; and (4) the Standing Office for Prevention and Control of HIV/AIDS located in the MOH (staff and materials of the NAC were transferred to the MOH).

At provincial level, a similar structure was established. Provincial People Committees (PPCs) set up Provincial Committees for prevention and control of HIV/AIDS, Drugs and Prostitution (PCADP) to be chaired by PPC’s chairperson or vice-chairperson. District and Commune People Committees were also able to establish their own similar committee.

4.1.3 Central level

In 1997, an executive body or working bureau for the NAP, NAB was defined by Decision No 1122/1997/QD-TTg of the Prime Minister dated 24/12/1997 which assigned NAC’s tasks. NAC had ministerial status and NAB was the executive agency for the NAC that managed all activities for HIV/AIDS prevention and control. According to this Decree, NAB’s primary functions were to:

- Develop strategy, policy and planning;
- Prepare annual financial plan and allocate approved budget;
- Provide guidance, monitoring and supervising and speed up the implementation of HIV/AIDS activities;
- Coordinate and manage international cooperation at national and local levels;
- Coordinate with ministries and branches to solve letters of complaint and denouncement and to deal with violation of laws; and
- Prepare preliminary summation and evaluation of effectiveness of the HIV/AIDS prevention and control activities every year and over period of time.

Since June 2000, after integrating the NAC into the NCADP, management at central level became the responsibility of two bodies: NASB and MOH’s AIDS Division. Changes to the executive bodies for the NAP from NAB to NASB and AIDS Division are presented in Diagram 3.
NASB was established according to the Decision No 61/2000/QD/Ttg by the Prime Minister. Decisions No 10/2001/QD-BYT dated 12/1/2001 and No 338/2001/QD-BYT dated 08/02/2001 signed by the Minister of Health describes NASB’s functions, responsibility, charters on organization and activities as:

- Develop long term and annual programs and plans to submit to the Minister of Health and the Vice-chairperson of NCADP for approval. Provide guidance and monitoring of the implementation of these plans and programs;
- Organize and extend international cooperation;
- Conduct the implementation and coordination among ministries and branches, mass organizations and the PPCs;
- Promote for the integration of IEC activities;
- Collaborate with ministries and branches to construct related documents;
- Implement tasks and activities assigned by the Vice-chairperson of NCADP and MOH’s leadership; and
- Manage its related agencies.

Diagram 1. National Committee for Prevention and Control of AIDS, Drugs and Prostitution
Diagram 3 Changes of executive body for NAP 1990 - 2000

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<tr>
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<td>MOH</td>
<td>NCADP</td>
</tr>
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<td>Ministry</td>
<td>AIDS Division</td>
<td>NAC</td>
<td>MOH</td>
</tr>
<tr>
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<td>MOH</td>
<td>NAC</td>
<td>Department/ Section</td>
<td>NAC</td>
<td>NAC</td>
</tr>
<tr>
<td>Department/ Section</td>
<td>Admin. Office</td>
<td>Ministry Office</td>
<td></td>
<td>PAC</td>
<td>NASB</td>
</tr>
</tbody>
</table>

Notes: Bold lines show direct impact. The dotted lines show indirect impact.
Therefore it can be seen that the change in functions and responsibilities from 1997 to 2000 were small. However, since June 2000 NASB’s administration has changed as all budget planning, coordination with branches and provinces, and with international organizations came under MOH’s management.

The current organizational structure of NASB consists of six departments:

1. Administrative - Personnel and Training Department;
2. Planning and Compiling Department;
3. Financing and Accounting Department;
4. International Cooperation Department;
5. Department for IEC and Community Mobilization; and

Another change was the Department for Monitoring of Health activities of former NAC was merged into the AIDS Division. The AIDS Division coordinates medical related activities within the health sector through its apparatus, the Secretary Board of the MOH’s Steering Committee for HIV/AIDS Prevention and Control. The Secretary Board is located within the Department of Preventive Medicine.

Responsibilities for implementing HIV/AIDS prevention and control activities in the health sector lie with seven sub-committees. Each of those sub-committees was headed by one of the MOH’s institution i.e. PMCT is lead by the Institute for Protection of Mother and Newborns; Care and Treatment by Clinical Institute of Tropical Diseases; STD prevention and control by NIDV; Surveillance by NIHE; Blood safety by NIHBT; Pediatrics by Institute for Child Health Protection.

In principal, up to present time, the NASB takes responsibility for planning and coordination of the NAP and MOH’s AIDS Division was responsible for activities in the health sector. However, since HIV/AIDS was originally approached as a medical issue and the NAP has a large medical and health component, overlap occurs when it comes to the medical areas of the NAP. Results from the key informant interviews conducted for this evaluation show that this parallel existence has created many misunderstandings and this situation should be improved.

This confusing situation is also reflected in some official reports.

The existence of two management bodies at central level requires a high level of coordination from MOH and both agencies so that each other’s activities will be complementary, not contradictory.
4.1.4 Provincial-level

At provincial level, since 1997, the PACs have been established in order to implement HIV/AIDS prevention and control’s activities at local level. The PAC has functions and responsibilities, which were similar to the one at central level (NAC).

Interviews with key informants at the central level and annual reports of the NAC revealed that: by December 1998, 60/61 provinces had replicated the NAC at provincial level called PAC’s bureaus with uniform structure nationwide. Of these, thirteen have their own stamp and bank account. PAC’s main functions were to provide guidance, coordination and monitoring rather than carrying out specific prevention and control activities. PAC’s bureaus were staffed by personnel of the Provincial Health Department (PHD) or its related branches, i.e., PAC activities were implemented by staff of the health sector. By June 2000, PACs were in the process of independently building up both inside and outside the health sector with its gradually concretized functions and responsibilities.

The change at central level in June 2000 resulted in big changes in the organization of provincial AIDS program. While a reproduction of NCADP called PCADP was established in every province, replicating NASB required shifting the PACs to form PASBs, which took more consideration of local authorities and more time. Although all 61 provinces have AIDS Division within the PHD, the Bureau can be established as an independent office or a section of an office, or located within the provincial center for preventive medicine (PCPM) depending on the perception of local authorities towards its role. Key leaders of NASB reported that by July 19, 2001, a year after re-organization of NAP, 43 provinces had a PASB established, among them, 13 PASB had their own stamp and bank account. Those bureaus located in PCPM could stand separately or integrated with Center's AIDS Clinic.

In short, there is no defined organizational structure for NAP at provincial level. There are three different structures in three VIE/98-006 provinces. In Da Nang, PASB was located within the PCPM, headed by the Director of the Center and share staff with AIDS Clinic. In Hai Duong, PASB was also located in PCPM, headed by the Center's Director and shared staff with the Center, but separate from the AIDS Clinic. Lang Son was quite different where the Technical Division of the PHD implemented the provincial AIDS program. There was no uniform organizational structure for the provincial AIDS program nationwide.

There exist major obstacles, which could restrain the PAC in fulfilling its social mobilization tasks in HIV/AIDS prevention activities. There are many related branches-members of provincial HIV/AIDS program who do not adequately understand what they should do and what investment they can receive from the government. Besides general orientation, functions and specific tasks of the PASB, there is a need to adequately institutionalize as soon as possible because in practice most of HIV/AIDS prevention and controls are mainly realized at provincial level. Due to the lack of adequate regulation, at present activities of many PASB are mainly based on individual knowledge and experiences as well as individual relations of insiders. In provinces, which have already set up their PASB, the instructional relationship between NASB and its provincial offices is relatively close. The inconsistencies in organizational structure at the provincial level could restrain the improvement of management, and it could be hard to find a common way to improve the PASB to become a professional working office. A leader of NASB affirmed that HIV incidence increased more rapidly during the transition of the NAC system to the new system.
4.1.5 Provincial inferiors

Below the provincial level, at district and commune level, the establishment of the Steering Committee for prevention and control of HIV/AIDS, Drugs and Prostitution lies on decisions of local authorities. A network for the NAP has been created with staff from the Preventative Medicine Team of District Health Center to be in charge of HIV/AIDS activities on a part-time basis. At communal level, HIV/AIDS was managed as one of about ten national health programs. Recently, in communes with infected residents, a member of CHC was assigned as a specialized staff member, with additional financial incentives. This staff member, although called “full-time” works on HIV/AIDS on a part-time basis only.

Local authorities officially supported this health-based network when activities were beyond the health sector. Vice-Chairperson of People Committee in charge of social-cultural affairs at district or communal level usually was the sponsor for HIV/AIDS activities in localities. The recent organizational changes at central and provincial levels doesn’t seem to seriously effect lower levels, as they do not have an institutional body for HIV/AIDS activities.

In summary, the current NAP was placed quite high in the government structure. Overall responsibility for the NAP lay with the Minister of Health who reports to a Vice-Prime Minister. However, the NAP in Vietnam was mainly government-based. Non-governmental organizations and the private health sector have not been formally included in the NAP. There has been no formal mechanism for coordination between activities of government, NGOs and the private sector.

Existing NASB and MOH’s AIDS Division were two management bodies at central level. The loose coordination between those two bodies has sometimes caused overlap and confusion.

Horizontal structures of the NAP show clearly a multi-sectoral approach with the involvement of forty-one different ministries and mass organizations. The vertical structure of the NAP from central to communal level, nonetheless, after the NAP organizational change in 2000, has not been fully developed at provincial level.

Recommendations for NAP organizational structure

1. Organizational structure of the NAP should be revised to formally include NGOs and the private sector.
2. A mechanism for coordination between government and non-government activities needs to be developed and institutionalized.
3. Working mechanisms between NASB and MOH’s AIDS Division should be improved for closer coordination.
4. PASB should be established and institutionalized in all provinces.

4.2 Human resource

4.2.1 National AIDS Standing Bureau (NASB)

At present, NASB has 25 regular staff and other staff working on short-term contracts to fulfill different projects. Most of the staff have university degrees, and three of them have PhD degrees. Regarding professional background, most of staff are medical doctors. Compared to other organizations in Vietnam, qualification levels for staff of the NASB is high because partly, it was established rather late and in the context that Vietnam already has sufficient conditions for
providing university graduates, and partly it has young staff, and it has sufficient conditions to receive international training and exchange on a large scales.

Their strength with medical qualification is that they received study time longer (six years of study in medical university compared to four years in other universities). With medical qualification staff have better understanding and experiences in medical aspects of HIV/AIDS prevention activities. However, as dealing with HIV/AIDS requires a multi-sectoral approach and other new knowledge, staffs, besides their professional background, need to supplement and improve their knowledge, especially concerning social aspects such as communication, understanding of behavior changes, and program management.

Due to temporary instability in organizational structure there is not an adequate list of primary tasks with corresponding required expert titles with high qualification level. Staffs are still in the situation of learning while working. With such personnel, basically NASB has equipped sufficient staff to deal with assigned tasks. However, to adequately and successfully fulfill these tasks, staff should have high technical qualification in their related areas according to job description. NASB is aware of the need to build staff qualification levels for HIV/AIDS prevention and control and it considers this as an important orientation.

In particular, staffs need to have technical skills that allow them to work adequately and professionally with other organizations and they should also have high management skills to deal with coordination and management works. These two types of technical and management skills are still insufficient and there are only a few staff members that can meet requirements. There is few staff that is capable of managing programs independently. Numbers of staff that can work on international cooperation are even fewer.

Regarding management knowledge, staffs gain management skills mainly through their working experiences. Training courses on management in Vietnam mainly focus on theoretical background rather than practical skills. Therefore the training in management skills is still insufficient although they are regularly conducted according to the national program. There are needs for additional training from outside sources.

Additionally, basic administrative skills should be improved. This has been reflected in letters and documents developed by NASB. NASB lacks skilled intermediate-level staff who can assist in NASB in solving administrative problems so to release high-ranking cadres from doing these jobs, therefore saving their valuable time. The working system of recruiting permanent staff does not allow for recruiting appropriate personnel to work for them.

There is approximately one third of NASB staff who can fulfill their tasks capably, another third of the staff need supplementary training to improve their working capacity and the remained third needs basic re-training if it is possible.

Moreover, there is the fact that qualified staff may transfer to another organization since in the current context, qualified experts are lacking in Vietnam.

4.2.2 Provincial AIDS Standing Bureaus (PASB)

PASB was responsible for the implementation of the AIDS program in the province. It was the lower level of both NASB and MOH’s AIDS Division. Therefore, PASB staff should have knowledge on both medical and social aspects of HIV/AIDS. Administration, program coordination, policy communication and advocacy were skills required for PASB staff.
A key leader of NASB believes that a fully functioning PASB needs a minimum of five well-qualified staff. In reality, each PASB has only two or maximum three staff to work on HIV/AIDS who has at the same time other work responsibilities separately from the PASB, e.g. Da Nang. Lang Son only has one part-time AIDS specialist. Leaders at NASB reported a similar variation in other provinces.

With such a small number of staff, PASB’s responsibilities require its staff to be multi-functioning. However, qualification of provincial staff in studied provinces was very diverse. According to the NASB estimation, approximately 80% of the newly established PASB staff worked previous in PAC, the other 20% were newly recruited. Provincial authorities undertake recruitment or appointments of staff. There were no standard criteria for the recruitment of staff. Provincial authorities may have different views on personnel issues. Therefore, in some provinces, PASB staffs were very experienced and capable while others were not.

However, the general situation was that a small number of provincial staff has not been formally and adequately trained in different aspects of HIV/AIDS and skills required by their work.

Worthy of note is that it was difficult to have staffs who were really committed to working long-term for the HIV/AIDS program because opportunities for promotion were uncertain.

"The mechanism and system are not stable. Salary, and future prospects are not clear. I work on AIDS and I cannot be promoted. I won’t be promoted to Chairman of AIDS Committee, will I? But if I am a doctor in other specialty, I have a chance to be promoted to Vice Director of Provincial Health Department. Those who have progressive willingness can be up to Director, Vice Minister, to Vice Chairman or Chairman of PPC. Working on AIDS, getting to the Chief of the Bureau is the highest."

(Administrator, AIDS Bureau).

Recommendations for Human Resources

1. NASB should review its tasks and develop a list of required positions together with job descriptions. Staff recruitment should base on job description of each position.
2. Provide management, public health, and communication training to NASB key staff.
3. Establish full time HIV/AIDS staff at Provincial level.

4.3 Organizational management

4.3.1 National strategy development

With the contribution of leading experts from different professional branches, NASB (previously known as NAB) had guided orientation for the development of the NAP which was in-line with international trends and applicable to Vietnam’s context. Aware of risks during the period 1985-1992, NASB commenced the process of developing the basic legal frame for the HIV/AIDS prevention and control (1993-1995). Basically it ensured epidemiological surveillances, safe blood transfusion and brought out social issues based on a strong organizational frame (1996-2000). It continuously promotes the prevention program by focusing on societal action for behavior change as well as focusing increasingly on treatment activities and prevention of HIV/AIDS transmission through hospitals (2001-2005).

The management of NAP is based upon specific strategies with defined steps and timeframe. The main strategy was the MTP that spans five years. However, annual plans define the steps and timeframe. The analysis of the annual plans identified that activities were based upon reaction to the HIV/AIDS epidemic. Also, annual plans may not match the objectives of the MTP and there
were gaps in the annual plan from year to year. Therefore, improvement with ensuring consistency between the MTP and annual plans can be made.

4.3.2 Process of submitting work plans and approving budgets

The approval of proposed budget could be considered as a solid part of the work plan. Annually, implementing agencies submit their proposed annual work plans with a budget to the responsible organizations in their sector and locality, e.g. districts to provinces, provinces to central. They were compiled locally into a general annual work plan and submitted to the NASB. Then NASB reports this general work plan to government functional management organizations, MPI and MOF.

There was a high level of centralization from the top-down. Therefore approved work plans will have high-level support. However depending on the orientation at central level annually, local initiatives may or may not proceed. First, submitted working plans will undergo a revision then budget cut down. These revisions and budget cut downs were sometimes very substantial with moderate arguments, especially provincial level submitting budgets to central level. This is known as the “asking- giving” mechanism (cơ chế xin cho).

The following issues were raised:

- Implementing agencies submit budgets higher than previous years.
- Implementing agencies are uncertain which activities will be implemented and what will the accompanying budget be.
- Implementing agencies do not know exactly whether their proposed plans were approved and with how much budget.
- The time range from the approval of the plans to getting the budget for activities’ varied considerably. Advance funding was available for implementing agencies related directly to people’s lives such as hospitals. However it was common that activities were implemented at the end of the planning time due to delayed budget allocation.
- There were sub-divisions from provincial to lower levels that did not know the availability of some spending categories.
- Districts and communes find the planning process symbolic, rather than of any value as the higher level will provide them a fixed work plan and budget.
- District and communes feel they do not have enough technical expertise on HIV/AIDS to be creative and professional in planning.
- With limited provincial budgets, initiatives from district and commune level cannot be supported.

Table 4 presents an example of a district budget plan in the provincial annual plan. This reflects the top-down approach of the planning, the rigid budget and vertically organized activities.
Table 4 Example of a budget plan for a district from provincial annual plan

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<th>Activities</th>
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<th>3rd quarter</th>
<th>4th quarter</th>
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<tr>
<td>Propaganda for AIDS in IEC campaign phase I and II/2001 and World AIDS Day</td>
<td>111</td>
<td>2,800</td>
<td>1,200</td>
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<tr>
<td>Regular meetings of district AIDS committee and training for commune and other sectors</td>
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<td>2,000</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IEC activities</td>
<td>111</td>
<td>8,000</td>
<td>1,200</td>
<td>1,200</td>
<td>1,200</td>
</tr>
<tr>
<td>Regular meeting of commune AIDS committee and training for village cadres</td>
<td>119</td>
<td>3,200</td>
<td>800</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>Seminar, discussion on AIDS at villages</td>
<td>119</td>
<td>3,200</td>
<td>800</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>Monthly incentive for specialized worker</td>
<td>119</td>
<td>7,680</td>
<td>1,920</td>
<td>1,920</td>
<td>1,920</td>
</tr>
<tr>
<td>Total</td>
<td>134,520</td>
<td>26,330</td>
<td>37,880</td>
<td>26,330</td>
<td>43,980</td>
</tr>
</tbody>
</table>

Unit: 1,000 VND

Similar to district or commune level, most of the studied government organizations (including VWU and VYU) related to HIV/AIDS prevention and control activities, except organizations with international support, little attention was given to developing work plans. This was because the existence of the organization itself naturally makes it included in the plan developed at higher level with some funding. However, budgets allocated for such organization was somehow more flexible as their activities were not necessarily vertically driven as those of local AIDS authorities.

The process of submitting work plans and receiving budget approval requires centrally a high level of professional skill for compiling and analyzing information. Due to the above stated reasons creative program coordinators at central level need to work with provincial levels, to ensure initiatives for control and prevention of HIV/AIDS was supported and put into practice.

4.3.3. Program supervision of work plans and work-styles

At central level, supervision was a main activity, however it does not gain its expected effect due to the lack of qualified experts. The supervision at present does not provide detailed guidance of assignment or readjustment of work plans. Also considerable amount of time of those responsible for supervision was allocated to administration. To improve the situation the supervisor should have the skills to provide an adequate situational analysis and then provide necessary guidance.

Each of NASB’s departments has clear assigned tasks and has its own plan of development. The weakest point here was the lack of clear stipulation of responsibility and authority of each
individual to carry out the plan or task. Authorization characteristics were low but there was a high level of encouragement and persuasion. Consequently, according to interviews with program managers, this lead to a longer process of decision making as it requires a high level of consensus.

At provincial level supervision, guidance and working style varies. Provincial cadres were the ones who initiated, supervised and monitored the general implementation of HIV/AIDS activities. However, the cadres own competence in organizing provincial staff ranged from insufficient to very strict. There were staffs who knew how to make plans for their activities and how to monitor their work based on their work plan. They have the ability to be financial distributors to stakeholders and maintain communication and planning. Meanwhile, in some provinces, it was difficult for some staff to grasp the concept of a HIV/AIDS network and they relied on implementing agencies to implement annual plans.

Styles also vary between local government and mass organizations within one province. Most HIV/AIDS activities rely on the health care network for implementation. Outside the health sectors at grassroots level, they operate by the “call-up” (phong trao) or “command conforming” system. Central level would provide work plans. Provincial level may be called up to do IEC, but not engage in activities targeting harm reduction for high-risk groups. Some exceptions exist when there were pilot projects being implemented. It would be important to provide guidance for local government and mass organizations to ensure overlap of functions does not occur.

There were significant differences in working styles between Northern and Southern PASBs. Northern cadres rely on the central level guidance; Southern cadres take more initiatives. This could be due to the difference in impact of the HIV epidemic and market lead environment. The Central region has a balance of the two extremes with strong centralized management with high initiatives of their working staff.

There was also diversity in the quality of work of different PASBs. According to assessments of a NASB leader, currently one third of PASBs work efficiently, other third are satisfactory, and the remaining third unsatisfactory. However, there were some provinces without PASBs that have good work assessments. These activities in those provinces were effective due to specific programs and assistance of other networks i.e. international. However, there was still no independent and objective evaluation on this issue.

As HIV/AIDS activities were carried out at provincial level, central level guidance and supervision was important. Training to central and provincial staff in planning, monitoring and skills to carry out HIV/AIDS activities would have positive effects to the implementation of the NAP at localities.

4.3.4 Coordination

Coordination was an important activity for the NAP due to its inter-sectoral characteristics. The inter-sectoral response to HIV/AIDS was significant and recognized as strength of the NAP. However, coordination activities of this response in Vietnam have not been well developed. This was possibly due to the organizational structure being organized vertically so horizontal coordination was neglected and less developed. Inter-sectoral coordination was seen as an area needing improvement.
NASB's coordination with MOH’s AIDS Division:

Since June 2000 when the NASB was shifted under the umbrella of the Ministry of Health, new working relationships had to be formed. However, the working mechanism between NASB and the AIDS Secretariat of the MOH’s AIDS Division (operated by the Department of Preventive Medicine), was not clear and limited the communication and coordination between them was inhibited.

NASB’s coordination with Sub-divisions of the AIDS Division, and the collaboration between stakeholders was useful and good. In general, interviews with in charge persons of sub-divisions showed that they gave good assessment to HIV/AIDS prevention and control activities of NASB. Many activities, which have been implemented under contracts signed by NASB to sub-divisions, were developed effectively. The contract mechanism proved to be efficient in mobilizing the participation of sub-divisions into the NAP.

Coordination across ministries and unions:

The NCADP has sixteen member Ministries and mass organizations (Diagram 1), which were established in June 2000 to improve coordination and response to “social evils”. Those ministries have responsibility to implementing HIV/AIDS activities. Also, other ministries can participate in the NAP. As reported by a NASB leader, so far, the NAP could mobilize up to forty-one ministries and mass organizations to participate in activities. In general, the coordination between branches in the NAP still stays at a simple level with occasional meetings. After discussions at meetings, each branch continues its activities on their own view of the issues. It was difficult to say if member institutions of the NCADP have consensus towards common objectives through quarterly meetings. However, the participation and coordination of HIV/AIDS activities was very necessary, but experience has shown it has been difficult to coordinate the inter-sectoral response.

Even the coordination between three key ministries of NCADP is still very loose. A concrete example is the lack of consensus in policy on condoms and clean needles for groups with risky behavior patterns. This is one of the key points for the three ministries to work together but up to the time of this evaluation, there had been no collaborative project to make the policy more appropriate.

Ministry of Education and Training (MOET). The involvement of MOET into the program was significant and the staffs of MOET have appropriate backgrounds. HIV/AIDS activities organized by MOET system were highly effective though textbooks and in-school IEC activities. However, coordination can be strengthened with NASB providing technical assistance for HIV/AIDS activities in schools so that messages would be more specific and more appropriate for school children and students. In their turn, MOET can integrate more HIV/AIDS activities into the school program and mobilize schools participate in different NAP programs.

Ministry of Culture and Information (MOCI). MOCI play a critical role in IEC activities of the NAP as it manages the whole mass media system including TV, radio, newspaper and every type of publication. NAP provides contents for mass media. MOCI encourage their system to be actively involved in the NAP’s activities. Training for journalists should be organized regularly by NASB to provide sufficient and updated knowledge to the media. The NAP should build up coalitions with media in policy communication as well.
**Ministry of Justice.** Activities also were implemented actively both in the development and propaganda of laws. Interviews with key informants and in FGDs revealed that documents were prepared at appropriate times, but were not disseminated among the general population. This requires a greater investment and assistance from NASB.

**Vietnam Youth Union.** The VYU has been involved all administrative levels in HIV/AIDS activities but contents of the activities should be renewed more often, especially to approach high-risk groups. On the other hand, the characteristic of the VUY system, e.g. the regular renewal of Union leadership makes HIV/AIDS prevention activities neither professional nor consistent (YU, 2001).

**Vietnam Women’s Union.** The Women’s Union was the most effective mass organization in Vietnam in terms of their propaganda and promotion activities for the government new policy and lines at the grassroots level. Their HIV/AIDS activities were practical. Their activities were quite independent. The system can work more effectively if the women’s union's leaders at different levels - especially those at the grassroots-level were equipped with adequate knowledge and skills (Women’s Union, 2001). Coordination with NASB to acquire these skills would over come this problem.

**NASB’s coordination with international organizations:**

NASB has responsibility and functions to “organize and extend the international cooperation in the field of HIV/AIDS prevention and control” (Article 5, Item 2, Regulation of organization and activities), and “…is allowed to invite experts, scientific researchers in and outside the country to be its collaborators” (Item 8)\(^{10}\). These regulations permit NASB to take initiatives in carrying out their international cooperation. International cooperation was one of NASB’s successful activities. NASB was involved in many internationally supported activities, such as UN, Australian, German and American projects.

However, under item 4 of the Decision No 1122/1997/QD-TTg, NASB was more a “core unit for international cooperation, coordination and management of bilateral and multilateral cooperation on HIV/AIDS prevention and control implemented by the government, branches and localities”. At central level, coordination of bilateral and multilateral cooperation is the responsibility of the MPI. At lower levels, international organizations can work with provincial levels. The participation of NASB in coordination of international cooperation is equivocal.

It is recommended that NASB – as the plan-making institution for the NAP consult with the MPI and work closely with the MPI in coordination of international cooperation.

**Coordination at provincial and lower levels:**

At provincial level, coordination between branches was simpler because of the broad powers of the PPC. In some instances when the PPC was concerned, they can coordinate between branches and organization even in the absence of a PASB. The relationship at lower levels was dependent on the interests of the PPC in HIV/AIDS activities. The former NAB had more power in coordination at provincial level as PAB at that time was in their direct management line (see Diagram 3). The newly established NASB was facing difficulties in coordination at provincial

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\(^{10}\) Organizational Regulations enclosed with the Decision No 338/2001/QD-BYT dated 08/02/2001 signed by the Minister of Health.
level as the provincial executive body for HIV/AIDS was no longer their direct subordinate and most of the budget allocated for provinces now was authorized to PPC. The position of NASB as a subordinate of the MOH makes it difficult sometimes in negotiations with PPC in HIV/AIDS issues. However, the coordination of NASB to provincial level was very important as it was responsible for making and monitoring of annual and long-term programs and plans. MOH should give NASB enough authority to work with provinces, especially in terms of organization of local HIV/AIDS systems as well as programs and planning issues.

Coordination of non-government organization11:

The non-government sector has been developing in Vietnam since the country opened to the world in 1986. Although many NGOs have been established, their role in society has not been well recognized. There have been few NGOs listed as focusing in the HIV/AIDS area. A recently established charity group under International Security Newspaper, which initiated a movement to support some children orphaned due to AIDS. The readers replied positively. As in other countries the private/NGO response has been a large and successful response to HIV/AIDS prevention and control, Vietnam needs to encourage development of this sector.

However concern was raised that there has been very little coordination or information collected about these agencies by the government. With encouragement there should be more appropriate guidance, particularly to equip the non-government sector with essential and adequate knowledge and skills for implementation of HIV/AIDS prevention and control activities. There was also a pressing need to coordinate between organizations to ensure effectiveness, avoid overlaps and losing track of common policies.

Private health services have been growing quickly but so far there is no independent organization representing private practitioners. The ADB through the Population and Family Project has been supporting a model of Association of Private Health Practitioner. The pilot was still ongoing.

The non-government response will be particularly important as the number of HIV infected people rise and the government system will be unable to cope with the impact of the epidemic.

**Recommendations of organizational management**

1. MOH should review functions and tasks of NASB and the AIDS Division to have clear assignments for each and regulations on coordination between the two bodies when it comes to medical activities. Disseminate regulations to institutions, organizations and local authorities for their information.

2. Annual plans should be developed in consistency with the MTP. Monitoring and evaluation systems should be strengthened to provide updated information for annual planning development, in line with the MTP.

3. Annual plans should be two-way developed - top-down based on available funds and bottom-up based on need and ability of local level in mobilizing other resources.

4. Program coordinators at higher levels need to work with lower levels in reviewing their annual plan, to ensure work plan initiatives for control and prevention of HIV/AIDS are not lost and to improve the capacity of lower levels.

5. Provide supervisors with necessary skills to provide an adequate situational analysis and then provide necessary guidance to all levels.

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11 Non-government in this section refers to local non-government sector only.
6. NASB should improve coordination with them by keeping them informed about policies, strategies and priorities as well as providing technical assistance for their program.

7. The contract mechanism, together with other working mechanism should be built up to increase the NAP impact.

4.4 Financial management

4.4.1 Allocation of state budget

Annual state budget for NAP ranges from 50 - 60 billion VND for a population of nearly 80 million (Table 5). Per capita budget for HIV/AIDS prevention and control was about 800 VND per person–(about 0.05 US dollars). This was small in comparison to 0.6 to 1.6 USD in Thailand or the total expenditure for global HIV/AIDS prevention and control activities of 10 billion USD for a population of more than 6 billion.

State budget expenditure on infrastructure and capital equipment accounted for the largest share with insufficient allocation for other activities. 46% of the NAP budget was on equipment, test kits and drugs. The expenditure on training, maintenance and operating these modern equipments, according to specialists in this evaluation, was inappropriate and unplanned. 60% was spent on the health care system. In the 2001 budget, there was no specific budget line item for training. This financial allocation seems inappropriate when compared to the objectives of the NAP.

<table>
<thead>
<tr>
<th>#</th>
<th>Items</th>
<th>Budget allocated</th>
<th>% in NAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Managed by MOH to dispense to provinces: Test kit</td>
<td>6426</td>
<td>10.7</td>
</tr>
<tr>
<td>II</td>
<td>Authorized budget (to provinces)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Province monitoring</td>
<td>1782</td>
<td>3.0</td>
</tr>
<tr>
<td>2</td>
<td>District monitoring</td>
<td>2712</td>
<td>4.5</td>
</tr>
<tr>
<td>3</td>
<td>Intervention at 05/06 centers</td>
<td>976</td>
<td>1.6</td>
</tr>
<tr>
<td>4</td>
<td>Main-point communes</td>
<td>9000</td>
<td>15.0</td>
</tr>
<tr>
<td>5</td>
<td>Sero-surveillance tests</td>
<td>905</td>
<td>1.5</td>
</tr>
<tr>
<td>6</td>
<td>Blood screening tests</td>
<td>419</td>
<td>0.7</td>
</tr>
<tr>
<td>7</td>
<td>STI surveillance tests</td>
<td>160</td>
<td>0.3</td>
</tr>
<tr>
<td>8</td>
<td>Activities of health sector's sub-committees at provinces</td>
<td>3530</td>
<td>5.9</td>
</tr>
<tr>
<td>9</td>
<td>IEC</td>
<td>4872</td>
<td>8.1</td>
</tr>
<tr>
<td>10</td>
<td>Supervision and care (for HIV positive)</td>
<td>2019</td>
<td>3.4</td>
</tr>
<tr>
<td>11</td>
<td>Harm reduction</td>
<td>1050</td>
<td>1.8</td>
</tr>
<tr>
<td>12</td>
<td>Counseling</td>
<td>500</td>
<td>0.8</td>
</tr>
<tr>
<td>13</td>
<td>BSS</td>
<td>300</td>
<td>0.5</td>
</tr>
<tr>
<td>14</td>
<td>Prevention of cross-border epidemic</td>
<td>200</td>
<td>0.3</td>
</tr>
<tr>
<td>15</td>
<td>Sentinel surveillance</td>
<td>200</td>
<td>0.3</td>
</tr>
<tr>
<td>16</td>
<td>STI surveillance</td>
<td>200</td>
<td>0.3</td>
</tr>
<tr>
<td>17</td>
<td>Equipments for health sectors</td>
<td>4000</td>
<td>6.7</td>
</tr>
<tr>
<td>18</td>
<td>Flood assistance</td>
<td>270</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Sub-total for authorized budget</td>
<td>33095</td>
<td>55.2</td>
</tr>
</tbody>
</table>
### III Budget allocated to other ministries organizations at central level

<table>
<thead>
<tr>
<th>No.</th>
<th>Ministry or Organization</th>
<th>Budget (VND)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ministry of Defense</td>
<td>300</td>
<td>0.5</td>
</tr>
<tr>
<td>2</td>
<td>MOLISA</td>
<td>180</td>
<td>0.3</td>
</tr>
<tr>
<td>3</td>
<td>MOPS</td>
<td>1,024</td>
<td>1.7</td>
</tr>
<tr>
<td>4</td>
<td>Ministry of Communication and Transportation</td>
<td>80</td>
<td>0.1</td>
</tr>
<tr>
<td>5</td>
<td>MARD</td>
<td>70</td>
<td>0.1</td>
</tr>
<tr>
<td>6</td>
<td>Ministry of Justice</td>
<td>50</td>
<td>0.1</td>
</tr>
<tr>
<td>7</td>
<td>Trade union</td>
<td>160</td>
<td>0.3</td>
</tr>
<tr>
<td>8</td>
<td>Fatherland Fronts</td>
<td>100</td>
<td>0.2</td>
</tr>
<tr>
<td>9</td>
<td>CPCC</td>
<td>60</td>
<td>0.1</td>
</tr>
<tr>
<td>10</td>
<td>Red Cross</td>
<td>50</td>
<td>0.1</td>
</tr>
<tr>
<td>11</td>
<td>Vietnam Voice</td>
<td>114</td>
<td>0.2</td>
</tr>
<tr>
<td>12</td>
<td>Vietnam TV</td>
<td>70</td>
<td>0.1</td>
</tr>
<tr>
<td>13</td>
<td>Ho Chi Minh Political Institute</td>
<td>40</td>
<td>0.1</td>
</tr>
<tr>
<td>14</td>
<td>People Newspaper</td>
<td>40</td>
<td>0.1</td>
</tr>
<tr>
<td>15</td>
<td>CEMA</td>
<td>50</td>
<td>0.1</td>
</tr>
<tr>
<td>16</td>
<td>War Veterans Association</td>
<td>30</td>
<td>0.1</td>
</tr>
<tr>
<td>17</td>
<td>Supreme Investigation</td>
<td>30</td>
<td>0.1</td>
</tr>
<tr>
<td>18</td>
<td>Vietnam News Agency</td>
<td>30</td>
<td>0.1</td>
</tr>
<tr>
<td>19</td>
<td>MOET</td>
<td>380</td>
<td>0.6</td>
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<tr>
<td>20</td>
<td>WU</td>
<td>240</td>
<td>0.4</td>
</tr>
<tr>
<td>21</td>
<td>MOCI</td>
<td>180</td>
<td>0.3</td>
</tr>
<tr>
<td>22</td>
<td>YU</td>
<td>220</td>
<td>0.4</td>
</tr>
<tr>
<td>23</td>
<td>Farmer Association</td>
<td>78</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td><strong>Total budget allocated for other ministries</strong></td>
<td><strong>3,576</strong></td>
<td><strong>6.0</strong></td>
</tr>
</tbody>
</table>

### IV Central Management Unit for buying kits, equipments, drugs...

<table>
<thead>
<tr>
<th></th>
<th>Budget (VND)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Management Unit</strong></td>
<td><strong>16,903</strong></td>
<td><strong>28.2</strong></td>
</tr>
<tr>
<td><strong>TOTAL BUDGET</strong></td>
<td><strong>60,000</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Source: National AIDS Standing Bureau (NASB), 2001

#### 4.4.2 Financial management

The current financial management system originated from the long period of centralized planning. The system of financial norms and criteria for expenditure were more appropriate for remote and mountainous areas, while it was less appropriate for the rural delta areas, inappropriate for urban areas and very difficult to apply for major cities, i.e. the official categories as defined by the MOF do not fit the planning needs of current programs. Therefore, except those activities that have accurate standards like blood testing, the financial norms and criteria vary widely in order of usefulness.

Financial sources managed by NASB were from the state budget, foreign funding, and other revenue sources permitted by the government. However, poor financial systems exist. Therefore, there was a lack of access and assessment of the funds spent on HIV/AIDS activities in the last...
five years. NASB requires adequate accounting systems to manage the funding from different sources.

As the budget was authorized (by NASB, MOF and the PPC) for PASB to manage, the PASB has authorization to manage the funding. The common way of allocating the budget was by local managers allocating equally portions to each commune. A commune with HIV infected people received a fixed budget of 3 million VND a year from the state budget. Those communes can also obtain some additional funding from local authorities. Other communes do not have a specific budget. Table 4 presents the financial plan for the year 2001 of a province. Districts have to strictly follow budget line items in what is called "spend according to the ordinance" or fixed budget line items. This makes it easier for provincial managers to manage financial resources, however it limits creativity and flexibility in the lower level.

At central level the financial system was decentralized. However at Provincial level it was centralized. This has caused a series financial management problems. On one side, this decentralized process allows provinces to take more initiatives in its local activities which allows for the concentration of budget to meet local demands and this would give more room for better coordination. At the same time the centralized management at provincial level can reduce the responsibility of the central level in monitoring and supervision of financial expenditure. However, even with decentralized provincial level, central level guidance was still necessary for implementation of the NAP.

In addition to the state budget, there was also a huge resource mobilization from different social sectors, different organizations and institutions for HIV/AIDS activities throughout the whole country. These contributions have not been calculated, however it would be many times more than state budget. It can be seen as one success of the government's multi-sectorial response.

The financial management styles of International programs and projects also vary, depending on the country of origin and how the project was administered. However record keeping and transparency appear higher. However, utilization of international funding sources needs to be improved. The following criteria are provided. First, it should correspond to the specific needs of Vietnam, and secondly, it should avoid overlapping at the local level.

Also the NAP has not conducted cost-effectiveness analysis of HIV/AIDS prevention and control activities.

**Recommendations of financial management**

1. Increase state expenditure on the NAP, and allocate funding according to objectives.
2. Make better use of international financial assistance by regular reviewing of the NAP and determine priorities of the program to allocate funding. Large-scale international assistance should be included in the annual plan.
3. The NAP should conduct cost-effectiveness analysis of HIV/AIDS prevention and control activities to make better use of resources by investing in more cost-effective activities.

**4.5 Research, monitoring and evaluation**

**4.5.1. Research**

The Department of Scientific Research Management on HIV/AIDS, NASB manages researches of NASB or those in collaboration with NASB. Sometimes this department conducted social
science research. The Scientific Committee also provides advice to NASB as it consists of leading professors and researchers in different disciplines, including medical and social sciences. This committee comments on NASB’s research plan as well as reviews or comments on research proposals and reports.

Investment in scientific research activities was insufficient and ineffective due to many existing problems, which were currently lying in the management mechanism of the scientific activities. The research so far has been restricted and has not been able to provide information on the National HIV/AIDS situation, except using data collected through reporting systems or national surveillance. In depth research and new findings were mainly obtained through international sources. Therefore the information reported by NASB is not keeping pace with the changes in the epidemic.

Also, communication between researchers and policy makers was still poor. Dissemination workshops were the main efforts of researchers to inform other researchers, program managers and policy makers. Scientific conferences on HIV/AIDS are organized annually, however this method has not been very successful in influencing the direction of the NAP. NASB also published HIV/AIDS research collections. A few channels for dissemination of research results exist, however more concerted action to inform policy and programs needs to happen.

It is necessary to enhance the work of NASB’s Department of Scientific Research Management. Particularly, higher qualified staff are needed, e.g. at least one senior researcher, in order to develop a necessary and appropriate research program on management activities in Vietnam. Investment in research on HIV/AIDS should be focused on some large scale, high quality researches, to provide information on certain aspects of the program that can be translated into policy or programs. Communication between researchers and policy makers needs to be improved by providing researchers with communication skills or Department of Scientific Research Management having staff with policy communication skills so the research has policy impact.

4.5.2 Monitoring

Monitoring of the NAP had been conducted in 3 forms. The first and official is health inspection since the NAP was under the responsibility of MOH. The second is monitoring of local authorities. And the third is monitoring for programs, particularly for each activity and project within the NAP.

The role of Health Inspection was clear once there were some complaints or denouncements, or issues relating to legal aspects. In the mean time, local authorities paid more attention to financial aspects of the program as state budgets to be spent at localities had been authorized to provinces. Technical aspects of the NAP were monitored by NASB, PASB and MOH's technical sub-committees. In this report, this form of monitoring is called "program monitoring".

In general, monitoring and evaluation activities conform to MTP and an annual work plan. However, since the system of indicators was not synchronous or not available and tools are lacking, it is hard to monitor the designed work plan. The main indicator was whether certain activities were implemented or not, without adequate comments on the process of implementation or results of each activity.

Besides, as there was no clear mechanism for feeding and information exchange, monitoring was not so meaningful to the monitored institution/project and to the whole NAP as it should be. In
addition, except some programs with heavy technical components, such as testing or blood screening, most of the monitoring activities stopped at inspection other than assistance. Medical interventions mostly were monitored by MOH's sub-committees. Assistance from experts in sub-committees greatly contributed to the improvement of technical performance. However, the lack of experts in other aspects of HIV/AIDS, non-medical components of those programs hardly improved.

In parallel with field monitoring was the regular report system and data input for preparation or summation of projects. The NAP's data largely relied on this system. However, due to many reasons, many experts believed that most data was not really reliable.

Monitoring of the NAP is currently organized vertically rather than horizontally or inter-sectorally. NASB at central level monitored PASB at provincial level. PASB monitored HIV/AIDS activities implemented by Preventive Medicine Team at district level. This team, in their turn, monitored implementation of the NAP by commune health center.

Program monitoring, although it was a program activity, was seldom carried out on activities implemented by other agencies, which left the monitoring on their activities to the vertical system of those agencies which in turn are not professional agencies on HIV/AIDS.

4.5.3 Evaluation

Evaluation and evaluability of the NAP in Vietnam was the major weakness of a successful program. There were various evaluations of HIV/AIDS activities but they were mainly carried out with assistance from international organizations. Government budgets for evaluation activities were not sufficient. Therefore, it was unlikely that management of the NAP will be sufficiently evaluated. At the same time, there were not many independent evaluation organizations, especially in social and management fields, even though the Prime Minister has instructed recruitment of scientific research organizations that are independent of the government. Both the lack of finance and a complex mechanism makes evaluations difficult.

The NAP evaluated performance was based on reported and estimated numbers of HIV/AIDS cases. Results of sero-surveillance and currently joined behavioral surveillance served primarily a monitoring purpose. However, prevalence of infection among different groups of population in the sero-surveillance was used for estimating HIV/AIDS numbers throughout the country. The NAP, in the opinion of many program managers, was considered successful when the estimated number of HIV/AIDS cases was lower than projection. However, without a clearly stated objective, even this indicator does not show what the program has achieved. In addition, the accuracy of the estimation was always in question. Some managers of the local AIDS Program even wrongly cited the difference between the reported number and projected number as a success of the program.

UNAIDS guidelines for monitoring and evaluating the National AIDS Program recommends a set of indicators for monitoring and evaluating NAPs. Many of these indicators are appropriate for the Vietnam situation and effort should be initiated to review these indicators, adapt them (as appropriate) and select a set of indicators that will be used to manage the NAP. Data collection and reporting systems should then be established.

Evaluability of program components and suggestions for selection of indicators (based on UN guidelines) has been described above in Section 3 in the context of each program component. In the past, there was no general approach for evaluability of the program components. Each
intervention program based on its own capacity to develop a comprehensive plan and within that plan, there was some or none quantifiable indicator.

Evaluations of the NAP will continue to have difficulty as long as all goals and objectives are only stated generally. None of the long-term or immediate objectives written in the MTP was spelt out clearly with a quantifiable indicator. Therefore measuring the impact and achievement of the NAP is not possible. In comparison to the MTP of 1996-2000, the action plan of 2001-2005 has made progress on quantifying specific objectives of the program. However, only a few component programs have stated clear quantifiable objectives and more development of goals are needed.

**Recommendations for Research, Monitoring and Evaluation**

1. Make clear supervision and monitoring mechanisms of NASB in different branches and local levels.
2. Develop horizontal agency information exchange so experiences can be shared within NASB.
3. Investment to scientific research activities needs to be focused to understand some important aspects of the program that will then be able to be translated into policies or programs.
4. A set of indicators for NAP activities should be developed based on international practices and UNAIDS guidelines for the monitoring and evaluation of the national AIDS program.
5. MTP as well as annual plans should have clearly stated goals, and measurable objectives.

Overall, management activities of the NAP have followed the changing conditions of Vietnam in the last five years. Achievement of the NAP in terms of management was reflected in the following aspects:

- Timely orientation and appropriate approach to meet Vietnamese conditions;
- Existence of many networks which can respond to HIV/AIDS prevention and control, which can be delivered down and directly to the people, and
- “Open door” and integration processes are closely controlled and managed by the centralized political system.

However, with increasing economic development in the coming years, functions and responsibilities of the management system should be made clear, staff should be specialized, together with a sufficient financial investment to cope with new developments of the epidemic.
5. CONCLUSION AND RECOMMENDATIONS

5.1. Conclusion

The HIV/AIDS epidemic in Vietnam was detected a decade ago. Since 1994, the year when sero-surveillance system was able to estimate infection prevalence in different population groups until now, the epidemic remains concentrated but high prevalent in groups with high risk behaviors, especially IDUs.

Vietnams national response to the epidemic was fairly appropriate with a long-term perspective. Country leadership as well as the people were soon aware of the potential threat of HIV and showed a strong will to stop the transmission of the disease. The NAP was organized in a large-scale from the beginning of the epidemic.

The period from 1996 to the time this evaluation was completed (September 2001) witnessed determined efforts of the whole country to combat this global epidemic.

5.1.1 Achievements and strengths of NAP during 1996-2000

1. The NAP has been developed as a government program with the participation of a large number of government bodies.
2. The NAP has succeeded in maintaining strong political support and translated a number of documents issued by the Party, National Assembly and the Government into legal and policy documents as well as program interventions.
3. The NAP has built up a rather comprehensive official system for HIV/AIDS control and prevention activities for the whole country. This system is able to mobilize government and international resources to deliver important interventions to slow the spread of the epidemic.
4. The NAP has been developing to be comprehensive, aiming for the best international practices. All UNAIDS-recommended interventions have been practicing in Vietnam although at different degrees of intensity.
5. Although the infection rate had been increasing in all groups, the epidemic remains at the concentrated level.
6. The majority of the population is aware of HIV/AIDS and demonstrates basic knowledge of HIV/AIDS, its modes of transmission and methods of prevention.
7. HIV tests have been made available in all provinces, accessible to majority of population.
8. A fully-developed sero-surveillance system has been in place and is moving forward to the second generation surveillance.

5.1.2 Shortcomings

1. The NGOs and the private sector have not been officially included in the NAP. The organizational structure of the NAP was fully government-based.
2. The merging of the National AIDS Committee and other national committees for drugs and prostitution control to become National Committee for Prevention and Control of AIDS, Drug and Prostitution seems to be an opportunity to strengthen inter-sectoral collaboration. However, this collaboration is still very loose, showing in the lacking of synchrony in policies relating to HIV/AIDS such as those on harm reduction among groups with risk behaviors.
3. The ability to evaluate the NAP in general and some interventions in particular is limited due to the lack of monitoring/evaluation indicators and a weak monitoring system.

4. Coordination between NASB and MOH's AIDS Division has not been well set-up, causing confusion in the implementation of the program.

5. The NAP has almost no full-time specialized staff at local levels that limits both the development of technical expertise in this important area and intensive implementation of the program.

6. Planning of the program is top-down from the provincial level to the commune.

7. The available information from surveillance and researches on HIV/AIDS has not been fully utilized to bringing up relevant policies.

8. Counseling components on VCT, quality assurance of blood transfusion, stigma and discrimination, PMCT, prevention of nosocomial transmission, treatment for HIV/AIDS patients, sexual health and life skills education for adolescents have been lacking or are poorly practiced.

9. Effectiveness of harm reduction activities among IDUs has been limited.

10. There has been a lack of communication between policy makers, program managers, researchers, PLWHA, donors, NGO and media on legal and policy issues, updated information and data as well as orientation and priorities of the program.

11. The budgets for the NAP were on one hand limited, on the other hand distributed based on egalitarianism which made investment for NAP intervention too scattered and insufficient to be effective.

5.2. Recommendations

5.2.1 Priorities for the coming years

It is recommended that in coming years, priorities should be given to the following areas:

1. Strengthening the synchronous collaboration between key organizations of the National Committees for Prevention and Control of AIDS, Drugs and Prostitution.

2. Financial resources for NAP need to be supplemented, secure sufficient investment to enforce priorities and maintain regular activities.

3. Maintaining political commitment and support at a high level by improving policy communication. NASB should take the lead in communicating with policy makers and media. A unit at NASB, such as public relations or policy communication should be established or to developed from an existing department to be responsible for such tasks. Staff responsible for policy communication should be trained to have adequate and relevant skills.

4. NGOs, the private sector and PLWHA should be officially involved in the NAP, in terms of policy development, planning and implementation.

5. Harm reduction programs should be developed countrywide and targeting groups with high-risk behaviors – including IDU, SW, STD clients and PLWHA. Condoms and clean needles should be available to those groups. NASB should work closely with related agencies to develop relevant policies for the support of such programs. International assistance should be invested in this program to ensure adequate supplies.

6. Medical curriculum should be reviewed to ensure adequately addressing issues relating to HIV/AIDS, including Universal Precautions and HIV/AIDS management. Moreover, health staff should receive retraining on HIV/AIDS as soon as possible.

7. Universal Precautions should be prioritized in medical activities toward HIV/AIDS prevention. MOH should organize training and education programs for health workers and clients on Universal Precautions and institutionalize this in all medical services, including both public and private sectors.
8. Care and treatment for PLWHA should be prioritized when it comes to national strategy and budgeting. In the coming year, a comprehensive care and treatment model should be developed to reach all PLWHA either in the hospital, at home or on the streets. This holistic model should include a hospital system for treatment, a home-based system for care, hospice for those who are homeless and a cross-cutting BCC component to provide proper knowledge and encourage responsible and healthy behaviors. Treatment sub-division of MOH should work together with NASB and mass organizations, as well as local authorities, to develop this model. International donors should consider assisting in the development and implementation of such a model. Parallel to the development of the comprehensive model, the NAP should encourage localities to initiate and put in to practice minimal care packages, comprising of physical and mental support and locally available treatment.

9. Sexual health and life-skills education, together with service provision for adolescents should be developed into a national program in the soonest. Such programs should be able to reach adolescents in and out of school, in all areas of the country.

10. The capacity of the NAP should be strengthened by
   i. Considering merging MOH’s AIDS Division and NASB or setting up a clear working mechanism for those two bodies.
   ii. Assigning key personnel as full-time staff at provincial and district levels.
   iii. Developing a training curriculum specialized on HIV/AIDS management and providing training to those who are working on HIV/AIDS at all levels.
   iv. Strengthening M&E systems by developing a set of indicators and setting up M&E mechanisms for the NAP and its components.

5.2.2 Policy and legal issues

1. Policies on condoms and clean needles for groups with high-risk behaviors should be reviewed and adjusted for harm reduction purposes.
2. HIV/AIDS related policy should be gender-sensitive, with adequate and equal care for boys and girls, men and women.
3. Policies on HIV/AIDS and related issues should be well disseminated.
4. Some legal issues should be concretized into instructions or regulations. Those include:
   i. Prevention of nosocomial transmission, both in medical and social services.
   ii. IEC and services for HIV/AIDS prevention among young and unmarried people.
   iii. Stigma and discrimination toward HIV infected and affected people.
5. Some legal issues should be enforced. Those include:
   i. Intentional and unintentional transmission of HIV to others.
   ii. Insurance and compensation to health workers who are at risk of HIV infection.

5.2.3 NAP capacity, management, coordination and planning

1. Investment should be made in the development of a comprehensive M&E system for the NAP, which covers all program interventions. The system should use UNAIDS indicators with necessary adaptations/modifications to fit the situation in Vietnam.
2. NAP personnel should be strengthened by staffing the program with full-time HIV/AIDS professionals. While the organizations structure can be integrated in health sector, personnel should be specialized. A training program then should be developed to provide essential knowledge and skills on technical, communication, planning and management issues of HIV/AIDS program.
3. Planning of the program should be two-ways, bottom-up and top-down. Program managers at all levels should be able to develop their own annual plans, reviews and comment on those of
a lower or a higher level. While budget is not sufficient for all activities, giving budget ceilings can be considered, however all levels should be made most active in planning their activities by developing their own annual plan.

4. NASB should be able to make coalition of all organizations/programs working on HIV/AIDS and related issues in Vietnam by informing on policy issues, helping prioritizing, providing guidance, sharing experience, making linkage. At the same time, NASB should play the key role in coordinating/advising for coordination of resources and ensure sufficient investment for the program's priorities.

5. Communication between policy makers, program managers, researchers, PLWHA, donors, NGO and media should be improved. NASB should have a communication unit, responsible for developing any NAP communication strategies and plans as well as coordinating with other departments/sections for wider communication that benefits the NAP.

6. MOH should review the coordination between NASB and MOH's AIDS Division to have clear defined functions and responsibilities of each body.

7. Evaluation of the NAP should be conducted on a regular basis. Those evaluations should be sufficiently invested to be well-designed and implemented. In order to make the evaluation feasible, it is important to define clearly the NAP’s objectives in a quantifiable way and to set up a system for regular collection of information.

8. A cost-effectiveness and/or cost-benefit evaluation should be conducted to give evidence and knowledge base for further investment. However, such an evaluation can be made possible only if information on resources used for NAP is relatively sufficient. NASB should improve the system for collection and restore information on resources for NAP.

5.2.4 Program intervention

1. Harm reduction for IDUs should be strongly improved. Interventions in rehabilitation centers, on clean needle supply should be considered and carefully designed, aiming at reducing the infection rate in this group.

2. A BCC program on PLWHA should be developed to increase healthy and responsible perceptions and behaviors toward and from PLWHA. This program should be designed to raise awareness and encourage healthy and responsible behaviors of PLWHA as well as of the whole community toward those PLWHA.

3. Investment should be made to put in practice the following interventions and intervention components:
   i. Counseling component on VCT.
   ii. PMCT.
   iii. Treatment for HIV/AIDS patients.
   iv. Sexual health and life skills education for adolescents.
   v. Prevention of nosocomial transmission.
   vi. Care and treatment for children infected and affected by HIV/AIDS.

5.2.5 Gender aspects of the program

1. Raising gender awareness and improving skills of gender analysis for policymakers and program managers as well as implementers in HIV/AIDS prevention systems.

2. Strengthening research capacity on gender.

3. Improving skills of advocacy for researchers and community activists to ensure that gender is adequately addressed in the process of designing and implementing HIV/AIDS policies and programs.
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TvT Associates. Inc. under The Synergy Project. Vietnam and HIV/AIDS. 1999


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ANNEX B: MANAGERS AND PROFESSIONALS INTERVIEWED

A. Ho Chi Minh City
1. Standing AIDS Bureau of Ho Chi Minh City
2. Center for Counseling in HCM City
3. Center for Tropical Diseases HCM City
4. Tu Du Hospital
5. Center for Blood Transfusion HCM City
6. Center for Preventive Medicines HCM City
7. Faculty of Dentology. HCM City University of Medicine & Pharmacology
8. Youth’s Union of HCM City
9. Center for Fostering and Support of Children of Go Vap District
10. Club “Friends help Friends”
11. Cafe “Belief”
12. Private STD Clinic
13. Private Dentist Clinic
14. Private Clinic for Throat - Nose - Ear (ENT) and Pediatric

B. Hanoi
2. AIDS Standing Bureau in Hanoi
3. MOLISA – Department for Prevention and Control of Social Evils
4. Ministry of Public Affairs – Dept. of Health
5. MOF – Dept. of Socio - Cultural Issues
6. Ministry of Justice
7. MPI
8. WU
9. MOET – Dept. for Physical Education
10. MOCI
11. Central Dept. of Science and Education
12. YU - Center for Population – Health and Environment
13. MOH
   - Curative Dept.
   - Sub - Committee for Safe Blood Transfusion – Institute of Hematology and Blood Transfusion
   - Sub - Committee for MCH – Institute for Mother and Newborn Protection
   - Sub - Committee for STDs Protection and Control – Institute of Dermatology
   - Sub - Committee for Treatment – Institute for Tropical Diseases
   - Sub - Committee for Epidemiological Surveillance – Central Institute of Hygiene and Epidemiology
   - Sub - Committee for Pediatric
   - Dept. for MCH/FP
14. Dong Da Hospital. Hanoi
16. Experts:
   - Prof. Le Dien Hong, Prof. Nguyen Thi Hoai Duc (RHAF), Dr. Jamie Uhrig,
   - Dr. Le Bach Duong, sociologist, Institute of Sociology
17. Mr Pham Tien Khang, Viec chairman, Dong Ngac commune People Committee.
C. Lang Son Province

1. Steering Committee of Prevention and Control for AIDS - Drugs – Prostitution:
   - Chairlady of SC, Vice-Chairlady of the provincial People’s Committee of Lang Son
   - Vice Chairlady of the SC– Vice - Director of the Provincial Health Department of Lang son Province
   - Standing AIDS Bureau of Lang son province - Person - in charge. coordinator of the Project VIE/98/006

2. Women’s Union of Lang Son Province
3. Dept. of Public Affair of Lang Son Province.
4. Dept. of Education and Training Lang Son Province
5. DOLISA of Lang Son Province
6. Dept. of Justice Lang Son Province
7. Dept. of Culture and Information Lang Son Province
8. Lang Son Provincial Hospital
   - Director of the Hospital
   - Dept. of Hematology
9. Center for Prevention and Control of social evils of Lang Son Province
10. Center for Preventive Medicines of Lang Son Province
11. Center for communication and health education of Lang Son Town
12. Division for Prevention and Control of AIDS - Drugs - Prostitution of Lang Son Town
13. Health Center of Lang son town
14. Health Center of Hoang Van Thu Ward
15. Division for Prevention and Control of AIDS - Drugs - Prostitution of Cao Loc District

D. Hai Duong Province:

1. Steering committee of Prevention and Control for AIDS - Drugs – Prostitution of Hai Duong province: Chairman of the SC– Vice - Chairman of the provincial People’s Committee of Hai Duong Province, Vice Chairman of the SC. Chairman of the AIDS Standing Bureau of Hai Duong province– Director of the Center for Preventive Medicine of Hai Duong Province, Person in charge of Provincial AIDS Standing Bureau
2. Provincial Polyclinic
3. Provincial Health Dept.
4. Women’s Union of Hai Duong province
5. Provincial Youth Union
6. Provincial Dept. of Police
7. Provincial Dept. of Education and Training
8. Provincial Dept. of Justice
9. Provincial Center for Venereal Diseases
10. Provincial Dept. for Preventive and Control of Social Evils
11. Provincial Center for Blood Transfusion
12. Division for Prevention and Control of AIDS - Drugs - Prostitution of Kinh Mon District:
   - Chairman of the Division – Vice - chairman of the District People’s Committee
   - Vice - chairman of the Division – Director of the District Health Center
13. Division for Prevention and Control of AIDS - Drugs - Prostitution of Hai Duong City
- Chairman of the Division – Vice - chairman of the People’s Committee of the Hai Duong City
- Person in - charge of AIDS prevention and control of Hai Duong City
14. Center for Health Education
15. An Luu Commune - Person in - charge of AIDS prevention and control
16. Pham Ngu Lao Ward, Hai Duong City - Person in - charge of AIDS prevention and control

E. Da Nang:
1. Steering committee of Prevention and Control for AIDS - Drugs – Prostitution of Da Nang
   Chairman of the SC– Vice - Chairman of the provincial People’s Committee of Da Nang
2. Provincial Health Dept.
3. Center for Preventive Medicine of Da Nang
4. Provincial Polyclinic:
   - Dept. of Hematology
   - Laboratory
5. Hospital for Dermatology of Da Nang
6. Center for Health education
7. Provincial Dept. of Justice
8. Women’s Union of Da Nang
9. Provincial Dept. for Preventive and Control of Social Evils
10. Provincial Dept. of Police
11. Division for Prevention and Control of AIDS - Drugs - Prostitution of Hai Chau District, Da Nang City:
   - Chairman of the Division – Vice - chairman of the District People’s Committee
   - Person in - charge of AIDS prevention and control of Hai Chau District
11. Division for Prevention and Control of AIDS - Drugs - Prostitution of Hoa Vang District:
   - Chairman of the Division – Vice - chairman of the District People’s Committee
   - Head of the Hygiene and Preventive Team of Hoa Vang District
12. Hoa Minh commune - Commune heath center
14. Hoa Nhan commune - Commune heath center
ANNEX C: PROGRAM BENEFICIARIES INTERVIEW AND FGD

A. Ho Chi Minh city
1. IDU
2. Sex workers HIV infected
3. General population in District 4:
   - FGD of female unmarried youth
   - FGD of married people
4. General population in Thu Duc, HCM:
   - FGD of unmarried youth
   - FGD of married people

B. Hanoi
1. General population in Quynh Mai Ward, District Hai Ba Trung, Hanoi
   - FGD of unmarried youth 1
   - FGD of married people 1

2. General population in Dong ngac commune, Tuliem district, Hanoi
   - Mr. Pham Tien Khang, vice-chairman of the commune
   - FGD of unmarried youth 1
   - FGD of married people 1

C. Lang son
1. Pregnant woman 3
2. Patients having blood transfusion 1
3. Patients of the Enterology 1
4. HIV/AIDS patients 4
5. Relatives of HIV/AIDS patients 2
6. IDUs 3
7. Sex workers 3
8. General population of Lang Son Town
   - FGD of unmarried youth 1
   - FGD of married people 1

9. Hop Thanh, Cao Loc District
   - FGD of unmarried youth 1
   - FGD of married people 1

D. Hai Duong
1. Pregnant women 2
2. Patients having blood transfusion 2
3. AIDS patients 2
4. HIV infected persons 2
5. Family members of HIV/AIDS+ 2
6. Patients of the Enterology 1
7. IDUs 3
8. Sex workers 1
9. Pham Ngoc Lao ward
   - FGD of unmarried youth 1
   - FGD of married people 1
10. An Luu commune:
    - FGD of unmarried youth 1
    - FGD of married people 1
E. Da nang

1. Pregnant women 1
2. STDs 2
3. HIV/AIDS patients 2
4. Hospital patients 1
5. Relatives of HIV/AIDS patients 1
6. IDUs 2
7. Sex workers WHO Vietnam HIV infected 2
8. Hoa Tien commune:
   - FGD of unmarried youth 1
   - FGD of married people 1
9. Binh Hien ward:
   - FGD of unmarried youth 1
   - FGD of married people 1
### ANNEX D: PARTICIPANTS OF DISSEMINATION WORKSHOP, APRIL 2 – 3, 2002

<table>
<thead>
<tr>
<th>No.</th>
<th>Full names</th>
<th>Positions</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Prof. Chung A</td>
<td>Director</td>
<td>NASB</td>
</tr>
<tr>
<td>2.</td>
<td>Dr. Nguyen Quang Hai</td>
<td>Vice Director</td>
<td>NASB</td>
</tr>
<tr>
<td>3.</td>
<td>Dr. Chu Quoc An</td>
<td>Vice Director</td>
<td>NASB</td>
</tr>
<tr>
<td>4.</td>
<td>Dr. Le To Uyen</td>
<td>Vice Head, Admin - Training-HR Section, PMU</td>
<td>NASB</td>
</tr>
<tr>
<td>5.</td>
<td>Dr Nguyen Van Thang</td>
<td>Communication and Community Mobilization Section, PMU</td>
<td>NASB</td>
</tr>
<tr>
<td>6.</td>
<td>Dr Doan Ngu</td>
<td>Vice Head - International Cooperation Section</td>
<td>NASB</td>
</tr>
<tr>
<td>7.</td>
<td>Dr Vuong Thuy Lan</td>
<td>Vice Head - International Cooperation Section</td>
<td>NASB</td>
</tr>
<tr>
<td>8.</td>
<td>Dr Le Ngoc Yen</td>
<td>Vice Head - Scientific Research Section</td>
<td>NASB</td>
</tr>
<tr>
<td>9.</td>
<td>Mr Le Anh Tuan</td>
<td>Vice Head - Finance Section</td>
<td>NASB</td>
</tr>
<tr>
<td>10.</td>
<td>Dr Nguyen Dac Vinh</td>
<td>Vice Head - Planning Section</td>
<td>NASB</td>
</tr>
<tr>
<td>11.</td>
<td>Dr Sabine Flessenkamper</td>
<td>Program Officer</td>
<td>NASB</td>
</tr>
<tr>
<td>12.</td>
<td>Dr Dao Quang Vinh</td>
<td>Project Manager</td>
<td>VIE/98/006</td>
</tr>
<tr>
<td>13.</td>
<td>Dr Richard Pooley</td>
<td>Project Officer</td>
<td>VIE/98/006</td>
</tr>
<tr>
<td>14.</td>
<td>Ms Nguyen Thu Lien</td>
<td>Interpreter/Secretary</td>
<td>VIE/98/006</td>
</tr>
<tr>
<td>15.</td>
<td>Ms Tran Thu Huong</td>
<td>Accountant/Admin. Assistant</td>
<td>VIE/98/006</td>
</tr>
<tr>
<td>16.</td>
<td>Dr. Pham Xuan Da</td>
<td>Secretary to Vice Minister</td>
<td>MOH</td>
</tr>
<tr>
<td>17.</td>
<td>Dr. Hoang Thi Hiep</td>
<td>Vice Head</td>
<td>Projects management Board, MOH</td>
</tr>
<tr>
<td>18.</td>
<td>Dr. Tran Thu Thuy</td>
<td>Director</td>
<td>Dept. of Treatment</td>
</tr>
<tr>
<td>19.</td>
<td>Nguyen Thi Minh Chau</td>
<td>Officer</td>
<td>Dept. Intl Cooperation</td>
</tr>
<tr>
<td>20.</td>
<td>Nguyen Chi Dung</td>
<td>Aid Section</td>
<td>Dept. Finance</td>
</tr>
<tr>
<td>21.</td>
<td>Nguyen The Hung</td>
<td>Deputy Director</td>
<td>Dept. Human Resources</td>
</tr>
<tr>
<td>22.</td>
<td>Vu Thi Bich Dung</td>
<td>Senior official</td>
<td>Dept. Human Resources</td>
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#### Members of NCADP

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<th>Organization</th>
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<tbody>
<tr>
<td>23.</td>
<td>Dang Thi Khao Trang</td>
<td>Vice-Director VIE/01/009 Project Manager</td>
<td>Population-Health-Environment Centre, Youth Union</td>
</tr>
<tr>
<td>24.</td>
<td>Patrick Griffith</td>
<td>Assistant to VIE/01/009 Project Manager</td>
<td>Population-Health-Environment Centre, YU</td>
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<tr>
<td>25.</td>
<td>Do Thi Thanh Nhan</td>
<td>Officer</td>
<td>Education-Life Section, WU</td>
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<tr>
<td>26.</td>
<td>Nguyen Thanh Lam</td>
<td>Officer</td>
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**Local NGO**

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