EMBASSY OF THE
UNITED STATES OF AMERICA
HANOI

AMBASSADOR

November 8, 2004

Dear Ambassador Tobias:

It is with great pleasure that I present Vietnam's Five Year Strategy for the Emergency Plan for AIDS Relief. The report is a collaborative effort of the United States Mission in Vietnam. It represents the collective efforts of the United States Departments of State, Defense, Health & Human Services, and Labor as well as the United States Agency for International Development and has been developed in close collaboration with partners from all sectors of Vietnamese society.

Working on the Emergency Plan has helped my Mission Team to forge new partnerships, expand networks and strengthen interagency collaboration. Building on these partnerships, we are confident that we can make a major contribution in helping Vietnam to prevent the threat of a generalized epidemic of HIV/AIDS, and also to strengthen efforts to treat and care for those already affected by the disease.

We appreciate your support and look forward to a long-term successful program.

Sincerely,

Michael W. Marine

Michael W. Marine

The Honorable
Randall Tobias,
Ambassador,
Office of the U.S. Global AIDS Coordinator,
Washington, D.C.

# The President's Emergency Plan for AIDS Relief

# Five-Year Strategic Plan for The Socialist Republic of Vietnam

# 2004 - 2008

**NOVEMBER 12, 2004**

Date approved By Chief of Mission: November 12, 2004
Date submitted to Global Coordinator:
Date approved by Global AIDS Coordinator:

# TABLE OF CONTENTS

# Foreword

I am pleased to share with you the Five-Year Strategy for implementing the President's Emergency Plan for AIDS Relief in the Socialist Republic of Vietnam. This document was developed by the United States Mission Team in Vietnam in close collaboration with many partners including government, local and international organizations.

This Five-Year Strategy, which will guide the use of Emergency Plan funding, is designed to support the efforts of the Government of Vietnam to build a sustainable, comprehensive national HIV/AIDS control program based on the Vietnam National Strategy, with a focus in the areas of HIV/AIDS prevention, care and treatment, targeting those who are most at risk.

This document outlines how the United States Government (USG) will support the achievement of the bold targets set out for Vietnam. Specifically, this strategy summarizes how the USG will support the Government and people of Vietnam to prevent new infections, provide safe and effective antiretroviral treatment to people who need it, and provide care to people who are infected and affected by HIV/AIDS including orphans and vulnerable children.

This strategy will evolve as the United States Mission Team in Vietnam engages new partners and responds to innovations, inputs, experiences and outcomes. Success will be measured by lives saved, families held intact and Vietnam's success in mitigating the harmful effects of the epidemic. I am very encouraged by the successes we have achieved together to date, and the whole Vietnam Mission Team looks forward to making an important difference in the years to come.

**Michael W. Marine**
**United States Ambassador**

# Executive Summary

Vietnam is one of 15 focus countries supported by the Emergency Plan for AIDS Relief, a program of the U.S. State Department under the direction of Global AIDS Coordinator Ambassador Randall Tobias. In the Socialist Republic of Vietnam, the Emergency Plan encompasses all U.S. supported HIV/AIDS programs including those of the U.S. Agency for International Development (USAID), Department of Health and Human Services/Centers for Disease Control and Prevention (DHHS/CDC) and Departments of Labor (DOL) and Defense (DOD). In-country support for the Emergency Plan is provided by a team of representatives from each of these agencies that is under the direction of U.S. Ambassador to Vietnam Michael Marine. The U.S. HIV/AIDS Team in Vietnam works directly with Ambassador Marine and Deputy Chief of Mission John Boardman.

The Five-Year Strategy for use of U.S. Emergency Plan funding for Vietnam proposes to support Vietnam in building a sustainable, comprehensive national HIV/AIDS control program based on the Vietnam National Strategy and with a focus in the areas of HIV prevention, care and treatment. The Strategy includes support to multiple sectors in achieving this goal, including the Government of Vietnam (e.g., Ministry of Health and other ministries involved in HIV/AIDS issues), international and local faith and community-based organizations, mass organizations and the private health sector. Among the themes of the strategy are human capacity development, building sustainable systems and the use of new partners including non-governmental organizations (NGOs), faith-based organizations (FBOs) and public-private partnerships.

The programs and interventions proposed in the Emergency Plan strategy are built on a series of principles consistent with Vietnam's National Strategy, including provision of voluntary services that are centered on clients' needs, reduction of the stigma and discrimination associated with HIV, a focus on comprehensive and high quality services and government ownership of programs and the greater involvement of people living with HIV and AIDS.

Specific targets to be achieved in Vietnam by March 2008 are prevention of 660,000 new HIV infections, provision of safe and effective anti-retroviral treatment to 22,000 HIV-infected patients and provision of care to 110,000 people infected and affected by HIV/AIDS including orphans and vulnerable children (Note: Targets are currently under review and it is anticipated they will be revised). Achieving these numbers will mean that programs must be targeted toward people at high risk for HIV. In Vietnam, these are: injection drug users, sex workers, men who have sex with men, people already identified with HIV and sex partners of these "most at risk" populations in the provinces and urban areas with the highest burden of HIV. Other populations at risk, including orphans and vulnerable children and mobile workers are also of concern and will be included in the overall plan. In the first year of the Emergency Plan (2004), programs will focus on high burden communities including the provinces/urban areas of Quang Ninh, Hai Phong, Hanoi and Ho Chi Minh City. Additional focus provinces will be included in subsequent years based on HIV/AIDS burden, capacity and geography, in collaboration with the Government of Vietnam.

The strategy assumes that existing U.S. Government programs in Vietnam will expand prevention and care activities as well as support initiation of treatment programs. In addition, new activities will occur in the focus provinces through support of new and existing partners. Programs will be expected to integrate with and refer to each other and with other activities (e.g., supported by other donors or sectors) to support a community network model for HIV/AIDS prevention, treatment and care.

In the area of prevention, programs targeted toward "most at risk" populations will include community outreach, behavior change communication and prevention interventions with HIV-infected people. Consistent and correct condom use messages as well as provision of condoms to high-risk populations will be critical components of these programs. In addition, support will be provided for certain general population prevention activities in focus provinces, such as prevention of mother to child HIV transmission programs, blood safety and safe injection programs and messages on abstinence, delay of sexual debut and "being faithful" to one partner aimed at vulnerable youth.

In the area of treatment, support is available for safe and effective anti-retroviral drugs for adults and children, laboratory equipment and tests related to HIV/AIDS treatment, laboratory quality control and monitoring, development of drug procurement, management and drug distribution systems.

HIV/AIDS care refers to a broad spectrum of activities involving HIV-infected persons such as voluntary HIV counseling and testing, palliative care, and provision of drugs to prevent or treat opportunistic infections and certain treatment interventions for injection drug users. HIV/AIDS care also encompasses activities supporting orphans and vulnerable children infected or affected by HIV/AIDS. Areas of focus in the five-year strategy include support for coordination of national guidelines and strengthening access and support for HIV voluntary counseling and testing services; support for diagnosis and treatment of sexually transmitted infections among "most at risk" populations; support for test results disclosure and partner counseling and referral for HIV-infected clients; expanded access to opportunistic infection preventive therapies; expanded diagnosis and treatment of opportunistic infections; access to pain management interventions; promoting integration of tuberculosis (TB) and HIV programs; pilot studies of drug replacement programs; innovative strategies to improve the quality of life of people living with HIV/AIDS; and enhancing referral networks for comprehensive HIV/AIDS prevention, care and treatment services.

Currently, large populations at risk for acquiring or transmitting HIV in Vietnam are those detained in provincial drug treatment rehabilitation centers. One challenge to the existing Emergency Plan strategy is that as yet no policy has been set by the U.S. Government for use of funds supporting activities in these centers.

The strategy provides opportunities to support additional interventions aimed at engendering bold leadership in central and local government and society as a whole, interventions focused on sustainability of programs and human capacity development and the strengthening coordination and collaboration within government and other international donors. The strategy also proposes to coordinate with the Ministries given the responsibility to respond to

the HIV/AIDS epidemic, UN agencies and the international donor community in supporting the National Strategy not only in areas of prevention care and treatment but also in monitoring and evaluation, surveillance, analyzing and synthesizing data.

**Tãm t¾t**

ViÖt Nam lµ mét trong 15 n-íc träng ®iÓm ®-îc tµi trî theo KÕ ho¹ch KhÈn cÈp Phßng chèng AIDS cña Tæng thèng Hoa Kú, mét ch-¬ng tr×nh cña Bé Ngo¹i Giao Hoa Kú ®Æt d-íi sù chØ ®¹o cña Ngµi §¹i sø §iÒu phèi Ch-¬ng tr×nh AIDS Toµn cÇu Randall Tobias. T¹i ViÖt Nam, KÕ ho¹ch KhÈn cÊp nµy bao gåm tÊt c¶ c¸c ch-¬ng tr×nh vÒ HIV do Hoa Kú tµi trî trong ®ã gåm cã c¸c ch-¬ng tr×nh cña C¬ quan Ph¸t triÓn Quèc tÕ Hoa Kú (USAID), Trung t©m KiÓm so¸t vµ Phßng chèng BÖnh tËt Hoa Kú (CDC), Bé Lao ®éng vµ Bé quèc phßng. C¸c hç trî trong n-íc thuéc KÕ ho¹ch KhÈn cÊp sÏ do mét nhãm gåm c¸c ®¹i diÖn cña c¸c c¬ quan nµy thùc hiÖn d-íi sù chØ ®¹o cña Ngµi §¹i sø Hoa Kú t¹i ViÖt Nam Michael Marine. Nhãm c«ng t¸c nµy sÏ lµm viÖc trùc tiÕp víi Ngµi §¹i sø Marine vµ Ngµi Phã §¹i sø John Boardman.

ChiÕn l-îc 5 n¨m thùc hiÖn KÕ ho¹ch KhÈn cÊp cho ViÖt Nam ®Ò xuÊt viÖc hç trî ViÖt Nam x©y dùng mét ch-¬ng tr×nh kiÓm so¸t HIV toµn diÖn vµ bÒn v÷ng cÊp quèc gia trªn c¬ së ChiÕn l-îc Quèc gia cña ViÖt Nam vµ träng t©m lµ c¸c lÜnh vùc dù phßng, ch¨m sãc vµ ®iÒu trÞ HIV. §Ó ®¹t ®-îc môc tiªu nµy, ChiÕn l-îc sÏ bao gåm c¸c hç trî mang tÝnh chÊt ®a ngµnh, trong ®ã gåm cã ChÝnh phñ ViÖt Nam (nh- Bé Y tÕ vµ c¸c bé/ngµnh kh¸c cã liªn quan trong lÜnh vùc HIV/AIDS), c¸c tæ chøc céng ®ång vµ t«n gi¸o quèc tÕ vµ ®Þa ph-¬ng, c¸c tæ chøc quÇn chóng vµ thµnh phÇn y tÕ t- nh©n. Néi dung cña chiÕn l-îc còng ®Ò cËp ®Õn viÖc ph¸t triÓn n¨ng lùc, x©y dùng c¸c hÖ thèng bÒn v÷ng vµ cã sù tham gia cña c¸c ®èi t¸c míi bao gåm c¸c tæ chøc phi chÝnh phñ (NGO), tæ chøc t«n gi¸o (FBO) vµ c¸c h×nh thøc c«ng-t- phèi hîp.

C¸c ch-¬ng tr×nh vµ biÖn ph¸p can thiÖp ®Ò xuÊt trong b¶n ChiÕn luîc thùc hiÖn KÕ ho¹ch KhÈn cÊp nµy ®-îc x©y dùng trªn cë së mét lo¹t c¸c nguyªn t¾c thèng nhÊt víi ChiÕn l-îc Quèc gia cña ViÖt nam, bao gåm viÖc sö dông c¸c dÞch vô tù nguyÖn, chó träng vµo c¸c nhu cÇu cña kh¸ch hµng, gi¶m kú thÞ vµ ph©n biÖt ®èi xö liªn quan ®Õn HIV, tËp trung vµo c¸c dÞch vô chÊt l-îng cao vµ toµn diÖn, ®¶m b¶o an toµn cho cho c¸c nhµ cung cÊp dÞch vô, quyÒn së h÷u nhµ n-íc ®èi víi c¸c ch-¬ng tr×nh vµ sù tham gia ®«ng ®¶o h¬n cña nh÷ng ng-êi nhiÔm HIV/AIDS.

C¸c môc tiªu cô thÓ cÇn ®¹t ®-îc t¹i ViÖt nam tõ nay tíi th¸ng Ba n¨m 2008 lµ: dù phßng cho 660.000 ca nhiÔm HIV míi, ®iÒu trÞ kh¸ng retro-virus an toµn hiÖu qu¶ cho 22.000 bÖnh nh©n nhiÔm HIV, vµ ch¨m sãc 10.000 ng-êi nhiÔm vµ bÞ ¶nh h-ëng bëi HIV/AIDS trong ®ã bao gåm trÎ må c«i vµ trÎ cã nguy c¬. §¹t ®-îc nh÷ng môc tiªu nµy cã nghÜa lµ c¸c ch-¬ng tr×nh cÇn nh»m vµo nh÷ng ®èi t-îng cã nguy c¬ l©y nhiÔm HIV cao. T¹i ViÖt nam nh÷ng ®èi t-îng nµy bao gåm: ng-êi tiªm chÝch ma tuý, nhãm m¹i d©m, ®ång tÝnh nam, nh÷ng ng-êi ®· x¸c ®Þnh lµ bÞ nhiÔm HIV, b¹n t×nh cña c¸c ®èi t-îng “nguy c¬ cao nhÊt”nãi trªn t¹i c¸c tØnh vµ c¸c khu ®« thÞ cã sè ng-êi nhiÔm HIV cao nhÊt. Trong n¨m ®Çu cña KÕ ho¹ch KhÈn cÊp (2004), ch-¬ng tr×nh sÏ tËp trung vµo c¸c céng ®ång cã tû lÖ nhiÔm cao bao gåm: c¸c tØnh vµ khu ®« thÞ Qu¶ng Ninh, H¶i Phßng, Hµ néi vµ Thµnh phè Hå ChÝ Minh. Trong nh÷ng n¨m tiÕp theo sÏ triÓn khai ch-¬ng tr×nh t¹i mét sè tØnh träng ®iÓm kh¸c dùa trªn tû lÖ nhiÔm HIV, n¨ng lùc vµ vÞ trÝ ®Þa lý còng nh- trªn c¬ së ý kiÕn cña chÝnh phñ ViÖt nam.

Theo chiÕn l-îc nµy, c¸c ch-¬ng tr×nh hiÖn cã cña ChÝnh phñ Hoa kú t¹i ViÖt nam sÏ më réng c¸c ho¹t ®éng dù phßng vµ ch¨m sãc cïng víi hç trî triÓn khai c¸c ch-¬ng tr×nh ®iÒu trÞ. Ngoµi ra, c¸c ho¹t ®éng míi sÏ ®-îc triÓn khai t¹i c¸c tØnh träng ®iÓm th«ng qua viÖc hç trî c¸c ®èi t¸c míi. Dù kiÕn c¸c ch-¬ng tr×nh míi vµ c¸c ch-¬ng tr×nh hiÖn cã sÏ ®-îc lång ghÐp vµ giíi thiÖu chuyÓn tiÕp víi nhau vµ víi c¸c ho¹t ®éng kh¸c (vÝ dô: c¸c ho¹t ®éng do c¸c nhµ tµi trî vµ c¸c thµnh phÇn kh¸c tµi trî) ®Ó hç trî m« h×nh m¹ng l-íi céng ®ång trong viÖc dù phßng, ch¨m sãc vµ ®iÒu trÞ HIV.

Trong lÜnh vùc dù phßng, c¸c ch-¬ng tr×nh nh»m vµo quÇn thÓ “nguy c¬ cao nhÊt” bao gåm tiÕp cËn céng ®ång, gi¸o dôc truyÒn th«ng thay ®æi hµnh vi vµ can thiÖp dù phßng ®èi víi nh÷ng ng-êi nhiÔm HIV. C¸c th«ng ®iÖp lu«n lu«n sö dông bao cao su vµ sö dông bao cao su ®óng c¸ch céng víi viÖc cung cÊp bao cao su cho c¸c quÇn thÓ cã nguy c¬ cao lµ nh÷ng phÇn quan träng cña c¸c ch-¬ng tr×nh nµy. Thªm vµo ®ã, ch-¬ng tr×nh sÏ tµi trî c¸c ho¹t ®éng dù phßng cho mét sè quÇn thÓ nhÊt ®Þnh t¹i c¸c tØnh träng t©m nh- c¸c ch-¬ng tr×nh dù phßng l©y truyÒn HIV tõ mÑ sang con, c¸c ch-¬ng tr×nh tiªm vµ truyÒn m¸u an toµn, tuyªn truyÒn cho giíi trÎ cã nguy c¬ c¸c th«ng ®iÖp vÒ dù phßng theo m« h×nh tiÕt dôc, kh«ng quan hÖ t×nh dôc sím vµ “chung thuû” víi mét b¹n t×nh.

Trong lÜnh vùc ®iÒu trÞ, ch-¬ng tr×nh sÏ tµi trî thuèc kh¸ng retro-virus an toµn vµ hiÖu qu¶ cho c¶ ng-êi lín vµ trÎ em, c¸c thiÕt bÞ xÐt nghiÖm vµ lµm c¸c xÐt nghiÖm liªn quan ®Õn viÖc ®iÒu trÞ HIV, theo dâi vµ kiÓm so¸t chÊt l-îng xÐt nghiÖm, x©y dùng c¸c hÖ thèng mua, qu¶n lý vµ ph©n phèi thuèc.

ViÖc ch¨m sãc HIV bao gåm mét lo¹t c¸c ho¹t ®éng liªn quan ®Õn ng-êi nhiÔm HIV nh- t- vÊn vµ xÐt nghiÖm HIV tù nguyÖn, ch¨m sãc gi¶m nhÑ, cung cÊp thuèc ®Ó dù phßng hoÆc ®iÒu trÞ c¸c nhiÔm trïng c¬ héi, vµ mét sè can thiÖp nhÊt ®Þnh ®èi víi nhãm ®èi t-îng tiªm chÝch ma tuý. Ch¨m sãc HIV còng bao gåm c¶ c¸c ho¹t ®éng hç trî trÎ må c«i vµ trÎ cã nguy c¬. C¸c lÜnh vùc träng t©m trong chiÕn l-îc 5 n¨m bao gåm hç trî phèi hîp c¸c h-íng dÉn quèc gia vµ t¨ng c-êng tiÕp cËn vµ hç trî c¸c dich vô t- vÊn vµ xÐt nghiÖm HIV tù nguyÖn; hç trî chÈn ®o¸n vµ ®iÒu trÞ c¸c bÖnh l©y truyÒn qua ®-êng t×nh dôc trong nhãm “ nguy c¬ cao nhÊt”, hç trî th«ng b¸o kÕt qu¶ xÐt nghiÖm, t- vÊn cho b¹n t×nh vµ ho¹t ®éng chuyÓn tiÕp cho c¸c kh¸ch hµng nhiÔm HIV; më réng kh¶ n¨ng tiÕp cËn c¸c liÖu ph¸p dù phßng nhiÔm trïng c¬ héi; më réng ho¹t ®éng chÈn ®o¸n vµ ®iÒu trÞ c¸c bÖnh nhiÔm trïng c¬ héi, tiÕp cËn c¸c can thiÖp khèng chÕ c¬n ®au; thóc ®Èy c¸c ch-¬ng tr×nh lång ghÐp HIV vµ lao; c¸c nghiªn cøu thÝ ®iÓm vÒ ch-¬ng tr×nh thuèc thay thÕ vµ c¸c chiÕn l-îc mang tÝnh s¸ng kiÕn nh»m c¶i thiÖn chÊt l-îng cuéc sèng cña ng-êi nhiÔm HIV; vµ n©ng cao m¹ng l-íi chuyÓn tiÕp cho c¸c dÞch vô dù phßng, ch¨m sãc vµ ®iÒu trÞ HIV mét c¸ch toµn diÖn

T¹i ViÖt Nam, mét phÇn lín trong quÇn thÓ cã nguy c¬ nhiÔm vµ l©y truyÒn HIV lµ thanh niªn hiÖn ®ang bÞ qu¶n chÕ trong c¸c trung t©m cai nghiÖn cÊp tØnh. Mét th¸ch thøc ®èi víi chiÕn l-îc hiÖn thêi cña KÕ Ho¹ch khÈn cÊp lµ cho ®Õn thêi ®iÓm nµy ChÝnh phñ Hoa Kú vÉn ch-a cã chÝnh s¸ch cho viÖc sö dông ng©n s¸ch tµi trî cho c¸c ho¹t ®éng t¹i nh÷ng trung t©m nµy.

ChiÕn l-îc nµy ®-a ra c¬ héi hç trî c¸c can thiÖp bæ sung víi môc ®Ých ®em l¹i mét sù l·nh ®¹o rã rµng trong chØnh phñ tõ trung -¬ng ®Õn ®Þa ph-¬ng vµ toµn x· héi, c¸c can thiÖp tËp trung vµo tÝnh æn ®Þnh cña c¸c ch-¬ng tr×nh vµ x©y dùng n¨ng lùc, t¨ng c-êng ®iÒu phèi vµ phèi hîp gi-· c¸c c¬ quan chØnh phñ vµ c¸c nhµ tµi trî quèc tÕ kh¸c. ChiÕn l-îc còng ®Ò xuÊt phèi hîp víi Bé Y TÕ ViÖt Nam vµ c¸c nhµ tµi trî quèc tÕ kh¸c trong viÖc hç trî ChiÕn l-îc Quèc gia trªn c¸c lÜnh vùc gi¸m s¸t, ®¸nh gi¸, l-u tr÷ vµ ph©n tÝch sè liÖu.

# I. Introduction & Background

## 1.1. Vision

***By 2008 the Government of Vietnam and its partners will have the capacity to provide a full range of HIV/AIDS prevention, treatment and care services in accordance with the needs of the people of Vietnam.***

This will be accomplished by supporting a sustainable national HIV control program based on Vietnam's National HIV Strategy, strong government leadership and multi-sectoral participation. Such a national program will support a system of prevention, care and treatment integrated at the national, provincial and community level.

The U.S. Government (USG) Vietnam Program will cooperate with all entities of the Government of the Socialist Republic of Vietnam (GVN), as well as international and donor organizations, community- and faith-based organizations local and international non-governmental organizations and peer-support groups in building capacity to implement comprehensive HIV prevention, care and treatment protocols through the development of a diversified network system.

The Emergency Plan in Vietnam will also support provincial and district health professionals in developing comprehensive strategies that link prevention programs to care, treatment and other support programs, both in the public and private sector.

## 1.2 Principles of USG HIV/AIDS programs in Vietnam:

1. **Comprehensive quality programs: USG will assist Vietnam to develop comprehensive models of HIV/AIDS prevention, treatment, care, and support networks.** All USG-supported programs will incorporate evaluative components to monitor the quality and evaluate the effectiveness of services at every level of the integrated prevention, treatment and care network. Furthermore, all USG-supported programs will link with other GVN and donor programs to effectively promote the network model.

2. **Government leadership:** USG-supported projects will engage leadership at all levels of government to develop a well-informed, motivated system of care, prevention and treatment and support comprehensive care and support networks.

3. **Client-centered services:** The USG-supported program assumes that all services will be provided on a voluntary basis, without coercion, that information will be kept confidential (private) and names or other personally identifying information will not be

shared with others other than for direct provision of services, and that services will be conducted with utmost respect for the individual client, keeping his or her perspective at the forefront.

4. **Stigma/Discrimination:** The USG will continue to support the Government of Vietnam's (GVN) efforts to reduce stigma and discrimination against people living with HIV/AIDS (PLWHA), and people affected by HIV/AIDS thereby protecting their rights according to international standards. This support will include support for GVN policy development efforts relative to stigma and discrimination as well as the best public health approaches to vulnerable groups.

5. **High quality of services**: The USG supports use of model "best practices" adapted to fit the Vietnamese context, development and consistent use of standard operating procedures and routine monitoring to ensure that services are conducted as needed

.6. **Universal Precautions:** USG-supported services will ensure that community clinical services use universal precautions, providers have access to occupational exposure prophylaxis consistent with international standards and all providers (including outreach workers, pharmacists and people living with HIV/AIDS [PLWHA]) are fully supported within the context of Vietnamese law. [Note: Currently individuals who contract HIV/AIDS as part of their job are not covered by disability insurance.]

7. **Support for multi-sectoral involvement for HIV prevention, care and treatment, including local non-governmental organizations (NGOs):** The response to the HIV/AIDS epidemic in Vietnam is growing at all levels. Due to limited public capacity and coverage at national and local levels, the USG anticipates the need to support the infrastructure and capacity of NGOs while ensuring that government service delivery is scaled up concurrently.

8. **Greater involvement of PLWHA:** The USG recognizes the necessity of involving PLWHA in the decision-making processes at all levels of program development, implementation and monitoring, including the development of nascent PLWHA organizations.

9. **Flexibility**: The nature of the HIV/AIDS epidemic in Vietnam is dynamic, and as more data become available, as care, treatment and prevention programs are enacted, and as the infrastructure in Vietnam improves, programmatic shifts may be necessary to fill identified gaps.

## 1.3 USG Targets in Vietnam

By March 2008, the USG Emergency Plan in Vietnam will work in collaboration with partners to:

- Provide treatment to 22,000 HIV-infected people;
- Prevent 660,000 new HIV infections; and
- Provide care to 110,000 people infected and affected by HIV/AIDS, including orphans and vulnerable children.

(Note: Targets are currently under review and it is anticipated they will be revised).

## 1.4 The HIV/AIDS Crisis in Vietnam

### 1.4.1 Basic Indicators of the HIV/AIDS Epidemic

Vietnam's first case of HIV was identified in 1990 in a Ho Chi Minh City (HCMC) native through premarital screening for Vietnamese marrying foreigners. By the end of August 2004, all 64 provinces in Vietnam had reported HIV cases, with a total of 84,484 people infected, of whom 13,315 developed AIDS and 7,595 died of AIDS. In 2004, the GVN estimated that 215,000 people are living with HIV/AIDS within a dense national population of 82 million. These estimates may be underestimates as surveillance is not conducted routinely among general population or in certain high-risk groups. A prevalence rate of 0.44% in the general population indicates that Vietnam's epidemic remains "concentrated" by UNAIDS and WHO criteria as it is below 1% of adults aged 15-49. Male HIV prevalence rates are 2.3 times higher than rates for females (Estimates and Projections 2004).

Without effective interventions, the national prevalence rate is projected to rise to 0.51% by 2005 and the number of HIV-infected persons to total up to 308,000. Of these, it is estimated that 72,000 persons will develop AIDS and 56,000 adults and children will die of AIDS. Data regarding HIV prevalence in Vietnam is primarily obtained through HIV Sentinel Surveillance (HIV SS) conducted annually in 40 provinces for six sentinel populations: injection drug users, female sex workers, antenatal women, sexually transmitted infection clinic patients, tuberculosis patients, and military recruits. Data from 1996 through 2003 indicates an epidemic disproportionately distributed among two sentinel groups: injection drug users and female sex workers and that they are key drivers of the epidemic in Vietnam as detailed below.

- **Injection drug users (IDU).** The HIV epidemic in Vietnam has been driven by a co-existing epidemic of injection heroin use. To date, at least 60% of reported HIV/AIDS cases have been in IDU. Drugs transit the coastal cities of Vietnam and South China to North America and Australia, making heroin widely available and inexpensive. Crude HIV prevalence in IDU was estimated at 30% (HIV SS, 2003). However in 2003,

prevalence approached or exceeded 50% in IDU in urban areas in HCMC (54%), Hai Phong (61%) and Quang Ninh (75%). IDU in Vietnam are young (e.g., mean age 19.5 yrs in Quang Ninh Province and 21 yrs in Hanoi (both 2000 street-based samples). IDU appear primarily in the rising middle class and commonly share needles and equipment. Behavioral surveillance and qualitative studies indicate injection drug use is occurring increasingly among women and that female IDU frequently turn to sex work for financial support. In a 2004 respondent-driven sample of 300 street-based sex workers, 50% reported drug use (mainly heroin injection) and 45% were HIV positive. Recent data also suggest that many drug users go back and forth between injecting and noninjecting and that many non-injectors become injectors. These data underscore that all drug users should be considered in the category of most at risk.

**Table 1: Vietnam HIV/AIDS Epidemic Indicators**

HIV prevalence in IDU: 30%*
HIV prevalence in FSW: 4% (Hanoi 15%; HCMC 11%; Can Tho 11%; An Giang 15%)*
Number of HIV-infected adults (15-49): 215,000**
HIV Prevalence in adults: 0.44% **
HIV Prevalence in pregnant women: 0.3%*
Number of AIDS deaths: 7,595***
Number of individuals on anti-retroviral therapy (ART):
HIV prevalence in STI clinic patients: 2.2%*
HIV prevalence in TB patients: 3.7% (Quang Ninh 22%; Hai Phong 12%; HCMC 10%)*
HIV prevalence in military recruits: 0.64%*

*GVN HIV Sentinel Surveillance 2003; ** GVN Estimate 2004; *** GVN reported August 2004

- **Commercial sex workers (CSW).** A growing sex worker industry (street based as well as bar/restaurant/karaoke based) has played an important role in HIV transmission. Sex workers are primarily female (FSW), however male sex workers (MSW) are increasingly observed in urban centers. HIV sentinel data also show increasing prevalence rates in FSW in several of the 40 provinces. Overall HIV prevalence in FSW was 4% (HIV SS, 2003), but approached or exceeded 10% in certain urban areas rates (e.g., Hanoi (15%) and HCMC (11%)) and the Mekong Delta region (e.g., Can Tho Province (11%) and An Giang Province (15%)). MSW are increasingly common, but no data exist regarding HIV in MSW.

- **Antenatal women (ANW).** Overall HIV prevalence in ANW was 0.3%, but ranged from 0% in nine provinces to over 1.3% in Quang Ninh (HIV SS, 2003).
- **Sexually transmitted infection (STI) clinic patients.** Overall HIV prevalence in STI patients was 2.2% with a range: 0-10% (HIV SS 2003).
- **Tuberculosis (TB) patients.** Overall HIV prevalence in TB patients was 3.7%;

however, HIV prevalence in TB patients has climbed to over 7% in seven provinces, including HCMC (10%), Hai Phong (12%) and Quang Ninh (22%) (HIV SS 2003).

- **Military recruits.** The overall HIV prevalence in military recruits was 0.64%, but exceeded 1% in seven provinces including HCMC (2.5%) (HIV SS, 2003). Conversion rates in active duty forces are unknown, as no routine testing takes place.

Two additional important populations to study are blood donors and men who have sex with men (MSM). Currently neither of these populations is included in the sentinel surveillance system. Studies of blood donors indicated 2/10,000 donors screened positive for HIV (15% tested positive for Hepatitis B). Information remains limited for MSM in Vietnam and they are still widely unrecognized. However, a 2001 survey of 219 MSM in HCMC found MSM reported multiple sex partners, did not use condoms consistently and were often married.

USG-supported Monitoring and Evaluation Programs will improve the capacity and strengthen existing surveillance systems such that estimates will be able to reflect the experience of the wider population of Vietnam.

### 1.5 Country HIV/AIDS Context

**1.5.1 GVN response: Institutional arrangements.** The national response to the HIV epidemic began in 1987 with the establishment of the AIDS Prevention Committee within the Ministry of Health (MOH). The body gained national coordinating authority in 1994 as the National AIDS Committee (NAC), which stood apart from the MOH to include other sectors across the government. The National AIDS Bureau served as the administrative and programmatic arm of the NAC, as well as the government partner for several large bilateral and multilateral organizations. Parallel AIDS committees were created in all 64 provinces, as well as at the district level. These committees, together with their member organizations, including the Vietnam Women's Union, the Vietnam Youth Union and the Vietnam Red Cross, became focal points for planning and delivering HIV/AIDS-related services.

In 2000, the inter-ministerial coordinating authority shifted to a new body that established the National Committee for AIDS, Drug and Prostitution Prevention and Control. Also in 2000, the National AIDS Bureau (renamed the National AIDS Standing Bureau, NASB) returned to the MOH and in a 2003 reorganization merged with the Preventive Medicine Department to create the General Department for Preventive Medicine and HIV/AIDS Prevention and Control. The MOH thus regained overall responsibility for HIV/AIDS programs and coordination.

**1.5.2 Social and cultural context -- stigma and discrimination.** Discrimination against PLWHA and people affected by HIV/AIDS, especially families, is still common. Similarly, stigma and discrimination is directed at many of the most at risk populations within the community. These negative views are prevalent in Vietnam, especially in provinces with low rates of HIV infection. Stigma and discrimination poses a major challenge to fighting the HIV epidemic and must be addressed to enable people to seek services, receive needed support and allow caregivers and social supporters to do so openly.

**1.5.3 Enabling Environment**. The 2004 National Strategy, reviews and reforms of HIV-related legislation and recent public statements by the President of Vietnam reflect significant achievements in HIV/AIDS policy, especially as it relates to stigma and discrimination. In addition, policy reforms are necessary to allow greater flexibility to organizations to take less traditional approaches to prevention and care, thus improving the overall reach and input to the HIV/AIDS response. However, the policy environment in Vietnam is complex, involving not only strategic and multi-sectoral approaches, but must address policy issues related to IDU and CSW. The Emergency Plan will also support policy advocacy efforts in concert with ministry partners.

**1.5.3.1 GVN National HIV/AIDS Strategy**. In March 2004, the GVN released the *National Strategic Plan on HIV/AIDS Prevention for 2004-2010 with a Vision to 2020*. The strategy provides the vision, guidance and measures for a comprehensive national response to the epidemic, calling for mobilization of government, party and community level organizations across multiple sectors. The strategy takes a progressive and proactive stance to reducing drug-related HIV transmission and calls for efforts to diminish HIV/AIDS-related stigma, including de-linking HIV/AIDS from 'social evils' such as drug use and prostitution. The strategy calls for nine action plans to be developed; the Action Plans constitute operational HIV/AIDS policy and the government is (at the time of writing) negotiating with national and international stakeholders on development of these documents. The action plans will cover the following areas: behavior change communication (BCC), harm reduction, care and support, surveillance, monitoring and evaluation, access to treatments, prevention of mother to child transmission (PMTCT), STI management and treatment, blood supply safety and HIV/AIDS capacity building and international cooperation.

**1.5.3.2 Legislative Issues**. The MOH and other Vietnamese decision makers at the highest levels are currently implementing a review of national HIV/AIDS legislation (the 1995 HIV/AIDS Ordinance on Prevention and Control of HIV/AIDS). Other developments include HIV/AIDS planning and policy environment assessment in the Vietnamese military sector conducted by the Vietnamese military, in cooperation with the U.S. military and international organizations. The Emergency Plan will support input as appropriate as requested.

**1.5.3.3 Drug and Prostitution Prevention and Control.** The national drug control policy of Vietnam has remained consistent over the past decade, combining strict law enforcement, socio-economic development and mass education. Since 1997, policy implementation has fallen to the Vietnam Standing Committee for Drug Control within the Ministry of Public Security. Law enforcement approaches dominate. No laws proscribe selling needles/syringes, although most pharmacists do not sell sterile equipment to presumed IDU. Detoxification with traditional therapies and "reeducation" are the mainstays of drug abuse treatment in Vietnam. Government policy prescribes community-based education and detoxification as a first step in the treatment of IDU and CSW. Those failing to abstain from drug use or commercial sex work are enrolled in program rehabilitation centers. These rehabilitation centers, also known as 05/06 centers (05 centers house FSW, 06 centers house IDU), constitute the provincial government programmatic response to IDU and sex workers.

In and around HCMC, 17 new rehabilitation centers have been constructed, now housing more than 32,000 IDU. The high cost and considerable health concerns (reportedly, 40% of detainees are HIV-infected and many have TB or acquire TB in the centers), along with unclear benefits, have led some to discuss alternatives to rehabilitation centers.

## 1.6 Healthcare Infrastructure and Support in Vietnam

The nation's health care system is vertical, originating in the Central Government and extending down through the provincial, district and commune levels. Private hospitals provide no HIV services. There is a widespread hospital system (22.6 beds/10,000 persons in 2001, of which 18.3 were government-run). The nation's medical schools ensure a large supply of trained physicians (52 MDs/100,000 persons in 2001). Training for non-physician health care providers, including nurses has only recently been widely supported. Government wages for health care workers, although increasing, remain low ($50/month for government MDs); most have private practices or other alternative income sources. A separate health care system exists within the Ministry of Defense (MOD) for active military, their families, and retirees and, in many cases, civilians who for various reasons do not have access to the MOH facilities. This system has its own medical school and training.

Since 1988, the government has allowed private medical practice that has contributed to increasing access to health care services and choice in providers. Because individuals pay for most health care services, affordability is a limiting factor to access. Production and distribution of drugs have also been deregulated, with the result that drug and vaccine shortages are now unusual.

While Vietnam has a relative advantage in human resources, the demands of augmenting HIV/AIDS treatment, care and prevention are exposing serious gaps in the nation's capacity to provide personnel able to implement the necessary policies and programs. Policy, planning and program management skills are lacking at the provincial level. Each province has an AIDS Division, but few full-time specialized workers in AIDS prevention. In the past 10 years, a new emphasis on public health education has led to development of public health departments in most medical schools. The Hanoi School of Public Health (founded 1998) currently offers baccalaureate as well as post-graduate (MPH, PhD) degrees.

**1.6.1 Care, diagnosis and treatment limitations.** The number of health care providers in Vietnam trained in basic diagnosis and treatment of HIV/AIDS totals about 350-400 professionals trained by USG, USG partners, and international NGOs such as Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau (ESTHER) and World Wide Orphans. However, far fewer physicians have been trained to provide anti-retroviral (ARV) therapy and they practice primarily in four provinces: Hanoi, HCMC, Quang Ninh and Hai Phong. In 1999, the National AIDS Standing Bureau (NASB) estimated that only one-third of HIV-infected persons received treatment in health facilities. Home-based care plays an important role for HIV-infected persons due to a combination of fear of stigma by health care workers and inability to pay for health care. The numbers of PLWHA seeking care in provincial hospitals continues to increase in 2004.

Faith-based organizations are moving the hospice agenda forward in Vietnam. While the amount of hospice care (linked to home-based care) is limited, it exists. Fuller development of hospice-based care for HIV/AIDS patients would lessen the burden of families and provide a more personalized care environment more efficiently than hospitals and improve both services and prevention.

1.6.2 **Laboratory capacity and limitations.** A USG-supported laboratory assessment in May 2004 reported laboratory capacity as follows:

- Appropriately educated, competent and committed staff is present within the MOH system at each level of the laboratory system (national, provincial and district);
- Laboratories show considerable differences in the quality of their outputs – this stems in part from variations in resources, especially equipment but, overall, techniques require improvement to assure the quality of testing;
- Quality assurance and quality control (QA/QC) are not practiced systematically or consistently throughout the laboratories – the laboratory system requires coordination;
- Laboratory safety is not always sufficient to assure the safety of workers;
- The pre-analytical and post-analytical components of the test process lack a strong orderliness to support cost-effective and timely laboratory services; and,
- Laboratory maintenance resources and staff are limited.

**1.6.3 ARV availability.** In early 2004, a WHO task force visited Vietnam to assess the nation's viability to enter the WHO 3 by 5 Program (three million people on ARV treatment by 2005). The WHO team estimated that, in January 2004, less than 100 people had access to ARV treatments and described the major barriers to greater access to ARV in Vietnam:

- The high cost of the drugs produced or purchased in Vietnam;
- Limited coordination within the MOH and with others government sectors;
- Limited coordination of partners for care and treatment (including ARV procurement);
- A high level of stigma and discrimination, particularly within the health care system:
- An absence of human resources development and training plans; and
- A lack of policies and programs that include training for health care workers and persons infected and affected by HIV.

**1.6.4 International assistance and NGOs.** The GVN has engaged mass organizations such as the Fatherland Front, Women's Union and Youth Union in the national HIV control effort, but few
National NGOs exist. The GVN plays the dominant role in determining use of health aid. USG funds available for HIV/AIDS activities in Vietnam totaled approximately $U.S.18 million in 2004; international support totaled about $30 million USD for the same period. The number of international NGOs active in health, currently estimated at 100, has increased substantially since 1990. The Global Fund has currently approved about $7.5 million USD for HIV/AIDS programs in Vietnam supporting community-based care and services for PLWHA in 20 provinces. Scale-up programs sponsored by international organizations, such as the Department for International Development (DfID)/WHO (21 provinces), World Bank

(20 provinces) and others will be conducted in multiple provinces. The UN provides leadership and coordination among GVN bodies, multilateral and bilateral donors and NGOs**.**

**1.6.5 Existing USG initiatives.** USAID began funding HIV/AIDS activities in Vietnam in 1999, with an initial investment of $820,000 USD. In 2002, USAID developed a framework for support to the national HIV/AIDS program for the period 2003-2008, with FY 2004 base funding of $ 4.5 million USD. The main objectives are to contain the spread of HIV/AIDS and to mitigate the impact on those infected and affected by HIV/AIDS. Three intermediate results underpin the USAID framework: increased national capacity to respond effectively to the HIV/AIDS epidemic, improved prevention of HIV and other STI, and implementation of appropriate care and support strategies to mitigate the impact of the HIV epidemic.

In October 2001, a formal cooperative agreement between the U.S. Centers for Disease Control and Prevention and the Vietnam MOH initiated Global AIDS Program (GAP) activities was signed for HIV prevention and control activities and capacity building in 40 provinces and 10 national institutes. To manage these activities, the GVN developed a new government coordinating office, the LIFE-GAP Project Office, overseen by a 12-member Steering Board under the direction of a Vice Minister of Health.

USG has also supported HIV prevention initiatives in the workplace through ***SMARTWork (Strategically Managing AIDS Responses Together) Vietnam,*** a joint initiative of the U.S. Department of Labor (DOL), the Academy for Educational Development (AED) and the Ministry of Labor, War, Invalids and Social Affairs of Vietnam (MOLISA) launched in January 2003 with funding of $1.35 million USD over four years. The Emergency Plan will provide an additional $400,000 USD in FY 2004. SMARTWork fosters appropriate policies to prevent discrimination in the workplace against HIV/AIDS-positive employees. The project is currently in place in six provinces (HCMC, Balia-Vung Tau, Dong Nai, Hai Phong, Thai Binh and Quang Nam) selected through criteria that included current HIV/AIDS prevalence, the nature of industries in the province and the capacities of provincial government.

The U.S. Department of Defense, through the U.S. Pacific Command (PACOM), has funded HIV/AIDS training courses at its Regional Training Center (RTC) in Bangkok, Thailand since September 2004. Vietnamese military medical providers have attended RTC courses on HIV/AIDS prevention, laboratory diagnosis, counseling and policy development. Finally PACOM has begun the renovation of laboratory facilities at the Military Institute of Hygiene and Epidemiology. The upgrade of laboratory infrastructure, equipment, and training and QA functions is scheduled to begin after completion of renovations.

## 2. Critical Interventions

### 2.1 Introduction

The Emergency plan for AIDS Relief provides an opportunity to develop new approaches and work in new ways to strengthen and expand a comprehensive continuum of prevention, care and treatment services working in close partnership with host country governments and other local and international partners. The 15 focus countries in the plan are all tasked with developing strategies in country with host country partners that each are unique to the environment in which they will operate with common message of delivering sustainable results in prevention, care and treatment services.

In Vietnam based on the nature of the epidemic, the most appropriate interventions are those that aggressively address the most at risk populations in the country who are the main driving forces behind the spread, and simultaneously providing a network of care and treatment services for those who are infected. This targeted intervention approach will also first be focused on "hotspots" (provinces with the highest prevalence) in Vietnam to turn back the tide of the epidemic.

Additional essential overarching themes in the plan that will be a focus in Vietnam are capacity development, sustainability, the use of new partners, especially faith-based and community-based organizations, and public-private partnerships. USG Vietnam will work with local partners and implement a variety of approaches to accomplish the goals that have been set out for Vietnam to ensure their full contribution to achieving program targets.

In summary, data from multiple sources indicate that, unlike other Emergency Plan countries, Vietnam's epidemic is concentrated among most at risk populations (MARPs): injection drug users, commercial sex workers and their clients and males who have sex with males. Available data in fact indicates that the epidemic is primarily concentrated within the young IDU population and secondarily among sex workers. Furthermore, the epidemic in Vietnam remains heavily concentrated geographically in specific provinces as well as specific urban centers. Therefore, in order to most effectively impact the current epidemic, the best strategic response is to focus prevention, care and treatment strategies on MARPs, in the provinces and urban areas with the highest burden of HIV.

### 2.2. Critical Intervention: Prevention

#### 2.2.1 Prevention: Introduction

A few groups, mainly IDU and CSW, are fueling the concentrated epidemic in Vietnam To turn the tide and prevent a generalized epidemic an aggressive strategy must be implemented targeting these groups and focusing prevention efforts on the provinces most affected. The prevention interventions outlined build upon existing efforts and are developing new ways of quickly reaching these populations to prevent the spread of HIV.

The GVN has supported various interventions to reduce the number of new IDU and CSW and their risk for acquiring and transmitting HIV, including community outreach using peer educators; one-on-one counseling; information, education and communication (IEC); mass media campaigns; community-based detoxification programs and provincial social labor rehabilitation (05/06) centers. Currently, USG supports the GVN prevention activities in 33 provinces. These programs include community outreach using peer groups and community leaders, drop-in center support groups, prevention of mother to child transmission programs (commune, district and provincial levels) and anonymous VCT services. In addition to providing financial support, USG has also provided technical support in developing training curricula, procedural manuals and monitoring and evaluation systems. Despite this assistance, service coverage – especially of MARPs – is not adequate. The Emergency Plan will support expansion of comprehensive services in the hardest hit provinces and urban areas and scale up rapidly.

### 2.2.2 Prevention Goal and Vision:

Within 5 years, 660,000 new HIV infections will be prevented.

The strategic approach will accomplish this by first providing opportunities for scaling up existing comprehensive programs targeted at MARPS in high prevalence provinces. This will include strengthening and expanding partnerships existing with the GVN, UN agencies and international NGOs and developing new partnerships with faith-based and community-based organizations (FBOs and CBOs) and private sector businesses and improve coordination with international donors. These partnerships will develop and implement HIV prevention programs, to include a variety of interventions such as abstinence, be faithful/partner reduction, correct and consistent condom use [ABC] messages, community outreach interventions to MARP, behavior change communications and PMTCT. The Emergency Plan in Vietnam will support provincial and district health professionals in developing comprehensive program plans, where prevention programs are linked to care, treatment and other support programs, both in the public and private sector.

### 2.2.3 Prevention: Summary of Challenges and Opportunities to Achieve Five-Year Prevention Targets.

Accomplishing the above stated programs involves better education of the general public about HIV/AIDS, and reaching populations who are highly stigmatized, might not want to be reached and are not found in the locations that historically government-supported health programs have targeted (schools, health centers, workplaces, etc.) Therefore, securing access and trust of these populations is crucial. As well, condom promotion and targeting MARPs remains a critical element to effective prevention among the high-risk and hard to reach.

Additionally, reaching IDU and CSW in the 05/06 rehabilitation centers, where a large number of high-risk individuals reside, remains challenging. The Emergency Plan will work with the GVN and donors and organizations providing services to this population to establish transitional services, including access to medical care, drug treatment, family counseling,

psycho-social support and vocational rehabilitation, for those returning to communities from the centers.

Also, the Vietnamese military understands the potential impact of increasing HIV infections but does not yet have uniform training materials, training curricula, or prevention programs across the eight military zones so the Emergency Plan can quickly begin supporting such efforts.

In Vietnam, the lack of programs for the training and education of social workers is an important deficiency. In other societies, social workers play an important role counselors as well as bridges between clients and needed services, such as child protective services, referrals to appropriate service providers. While the Emergency Plan does not address the formal education and training of social workers, other donors and appropriate organizations will be engaged to begin the process of training appropriate individuals to provide prevention services customarily provided by social workers.

Issues relating to each most at risk group and vulnerable populations are highlighted below:

#### 2.2.3.1 IDU and their sexual partners

Intravenous drug use is a highly stigmatized and illegal behavior that both puts individuals at risk for HIV and makes it difficult to reach users with prevention messages and services. Seroprevalence data in Vietnam indicates that IDU transmission is the most critical element in the epidemic. While the Emergency Plan is unable to provide needles for needle exchange/harm reduction activities, it can and will support and complement other aspects of a comprehensive IDU HIV prevention, care and treatment program.

#### 2.2.3.2 Female Sex Workers (FSW) and their clients

Prostitution is an illegal activity in Vietnam. Because of this, and because of the social shame and stigma associated with prostitution, FSW generally do not access government health clinics and services, and only access non-governmental clinics and services when such services specifically target, or are otherwise viewed as FSW-friendly. Therefore, reaching FSW and their clients with prevention, care and treatment will be a focus of activities. Experience in Vietnam and other countries indicate that effective FSW-focused interventions require BCC targeting the FSW, combined with prevention messages targeting the male clients of FSW. Therefore, USG-supported activities will include both of these elements. Female sex workers who also inject drugs are perhaps the most influential "bridging population" in Vietnam's current epidemic and will receive special focus.

#### 2.2.3.3 MSM

Self-identifying MSM do not generally access government health clinics and services. Moreover, same-sex sexual relations are a highly stigmatized behavior. As a result, self-identifying MSM generally do not access clinics and services for VCT or STD treatment unless such services are viewed as MSM-friendly. As well, the larger populations of men

who engage in same-sex sexual behavior do not self-identify as MSM and so may not have a realistic assessment of personal risk. Therefore, reaching identifiable MSM with HIV prevention, care and treatment will be a focus of activities. Also, ensuring appropriate messages about male risk behaviors will also be included in general prevention activities so as to effectively reach the population of risk-taking but non-self-identifying males engaging in sexual behavior with other males.

Like MSM generally, male sex workers (MSW) are stigmatized and, further, are engaging in illegal activity (prostitution), and so unlikely to access health clinics or services. Reaching MSW will require different strategies than those used for reaching other identifiable MSM. MSW are more likely than other self-identifying MSM to have both male and female sex partners.

Information regarding the context and actual risk of MSM in Vietnam is only now emerging but given global data on HIV epidemics relative to MSM, it will be important to support outreach and interventions even as the Emergency Plan supports further information and data collection on this vulnerable population.

Of special concern are the female sex partners and spouses of MSM and men who frequent female CSW. Reaching this largely hidden population will require special attention of those developing educational and counseling materials for the general public and partners of infected individuals.

#### 2.3.3.4 PLWHA

In a low prevalence setting such as that in Vietnam, HIV/AIDS remains a very distant and unreal threat to many. A key focus must be to mainstream PLWHA into the greater community. Opportunities as educators and spokespersons for prevention, care and support and treatment messages not only empower PLWHA but also serve to de-stigmatize the disease by reducing the social distance between those who are infected and those who are not. The participation by skilled representatives of the PLWHA community can personalize the AIDS epidemic by showing the range of people affected by the epidemic, thereby making prevention messages more relevant and meaningful as an awareness creating element of behavior change intervention activities. Furthermore, the availability of treatment has highlighted the need for continuing prevention among PLWHA.

#### 2.3.3.5 Other Vulnerable Groups

While the most at risk populations are currently the highest priority for targeting prevention strategies, other segments of the adult population including the partners and clients of CSW, IDUs and MSM are clearly at higher risk than the general population for contracting HIV/AIDS. Furthermore, mobile workers in other countries who frequent sex workers have been shown to be an important bridging population to the general population.

Orphans and families of vulnerable children and the children themselves should be targeted for prevention intervention programs. While the messages may not necessarily be

exclusively focused on the prevention of HIV/AIDS but they should attempt to influence decision-making that avoids risky life choices.

### 2.2.4 Strategic Approaches to Achieve Five-Year Prevention Targets

A comprehensive set of systems, policies and interventions will have to be developed and scaled up quickly to achieve the ambitious, yet achievable goal of preventing 660,000 new infections by 2008 (Note: Targets are currently under review and it is anticipated they will be revised). For each targeted population, these include the following:

#### 2.2.4.1 IDU

USG will provide support in developing and implementing community outreach programs for IDU using peer groups and community leaders. Outreach activities will provide information and education messages, condoms and bleach packets, prevention "skills" such as correct condom use, needle cleaning skills and referrals to other services such as VCT. Referral systems will incorporate the broad range of HIV prevention interventions for IDU supported the GVN and other international donors. Outreach workers, including PLWHA, will be trained and supported in delivering services using existing models developed with USG assistance. Pilot drug replacement programs for IDU will be initiated and evaluated. Peer educators will be the first priority, followed by HIV-positive IDU and finally HIV-negative or status-unknown IDU. The growing number of female IDU need to be addressed in the context of their special needs and targeted for specific prevention activities such as female only drop-in centers and support networks, routing of female IDUs to specially trained female clinic staff and counselors, and specialized IEC material.

#### 2.2.4.2 FSW

USG will provide support in developing and implementing community outreach programs for FSWs using peer groups and community leaders. Outreach activities will provide information and education messages, condoms, prevention "skills" such as correct condom use and referrals to other services such as VCT. Work will be done to expand referral and linkage to effective STI clinics and treatment. Expanded incentives including lubricant and male and female condoms for FSW will be explored for acceptability in Vietnam. All USG-sponsored programs will ensure that women have equal access to prevention, treatment and care services. Model programs for FSW who inject drugs need to be expanded and evaluated.

#### 2.2.4.3 MSM

USG will provide support in developing and implementing community outreach programs for MSM using peer groups and community leaders. Outreach activities will provide information and education messages, condoms, prevention "skills" such as correct condom use and referrals to other services such as VCT. Model programs for MSM who inject drugs need to be expanded and evaluated.

#### 2.2.4.4 Other Vulnerable Groups

Groups that bridge high-risk populations to the general population will be targeted through peer outreach activities that will expand to reach other groups at risk, including sex partners and clients of drug users and sex workers, MSM, other groups (e.g., mobile workers, such as, truck drivers, mobile construction workers, and soldiers) and discordant couples. Working with these bridging populations will be important in preventing the epidemic from becoming generalized.

While the Emergency Plan will target youth that fall into categories of most at risk populations with primary prevention interventions. USG will also support age-appropriate abstinence and be faithful messages that can be disseminated to the broader youth populations.

### 2.2.5 Expanding prevention programs specifically targeting HIV positive individuals

PLWHA play a critical role in preventing the further spread of HIV and support will be provided to expand prevention programs specifically targeting HIV positive individuals, including risk reduction, prevention of transmitting the virus to sexual and drug-sharing partners, and counseling and testing for discordant couples. Activities will be carried out at outpatient HIV services, VCT centers and community services.

### 2.2.6 Promoting comprehensive HIV prevention programs

#### 2.2.6.1 Vulnerable youth

Orphans and vulnerable children ages 10-15 years old are at great risk for falling into drug use and sex work. Counseling and age appropriate education about HIV/AIDS, as well as other services to prevent drug abuse and movement into sex work, are key prevention strategies for this group.

In cooperation with the Ministry of Education and Training and private and public organizations involved in the education of children, Emergency Plan funds will support the development and testing of school-based prevention programs. In addition, programs to train teachers and parents to effectively deliver prevention messages will be explored. USG will support a situational analysis on the precursors to drug abuse among Vietnamese youth. Emergency Plan funds will support FBO/CBO and mass organizations, such as the Fatherland Front, Women's Union and Youth Union and others), to provide interventions targeting youth to promote greater awareness of the risks of HIV/AIDS, abstinence and postponing sexual debut and these activities will be linked to existing prevention, care and treatment programs. Interventions can include media as well as peer education.

#### 2.2.6.2 Promoting referrals to network models

Support will be provided to promote referrals to health facility-, community- and home-based comprehensive prevention programs. STI services currently report up to 6% HIV prevalence

among attendees and serve as an important site for new VCT services with linkages to HIV treatment. As part of prevention programs for CSW, STI diagnostic treatment services will be offered in selective locations with high HIV prevalence. Coordination with existing STI programs supported by other donors will be critical to increase outreach and leverage resources in the identification, care and treatment of HIV positive individuals in both focus and nonfocus provinces.

**05/06 rehabilitation centers**

HIV/AIDS prevention activities already exist in some 05/06 centers, supported by other bilateral and multilateral organizations and international NGOs. Components of a program for strengthening HIV/AIDS prevention will include development of a provincial steering committee/HIV prevention unit, and development of community-based outreach for those transitioning from the rehabilitation centers to the community and strengthening linkages with counseling.

### 2.2.7 Building capacity

All USG-supported programs will focus on building capacity for effective long-term prevention, care and treatment networks. This will be accomplished by:

- **Enhancing multisectoral collaboration**. Current prevention programs depend on the support of various government and non-government organizations to ensure continuity of HIV prevention programs targeting vulnerable populations. The support and involvement of MOLISA and the provincial Departments of Labor, War Invalids and Social Affairs (DOLISA) in drug treatment and employment is critical. Furthermore, future support and engagement of all facets of the government including ministries, the Party and National Assembly and others given the responsibility to respond to the HIV/AIDS epidemic is critical to long-term effectiveness and sustainability of the Emergency Plan.

- **Establishing and strengthening effective linkages between community outreach and other HIV program services.** Health department staff at all levels will be trained in establishing and maintaining effective linkages between community outreach programs and other referral services. Program staff will meet and negotiate with other services providers (such as pharmacies, VCT, care and treatment facilities) and establish links to enhance benefits for clients. To ensure coordination and development of stronger community involvement in prevention linkages with community-based activities sponsored by international and local organizations and donors are necessary.

- **Collecting strategic information to monitor and evaluate progress and ensure compliance with Emergency Plan strategies.** One of the principles for an effective program is that on-going and thorough evaluation should be conducted. Results will be used to adjust programs to adapt to real conditions and an ever-changing epidemic. Provincial staff will be supported to be trained and empowered in using program data to adjust their programs to cope with changing HIV situations in their provinces. They will

take the lead role in sharing lessons with other program staff to enhance the impact of national programs.

## 2.3 Critical Interventions: Treatment

### 2.3.1 Introduction

Access to antiretroviral therapy and treatment of opportunistic infections can dramatically reduce morbidity and mortality in Vietnam. A major component of the Presidents Emergency Plan for AIDS Relief is to get 2 million people on treatment by 2008 globally. Treatment prolongs life and allows parents to continue parenting, teachers to continue teaching and civil servants, including health care workers, to continue serving their nations and fellow citizens for years to come.

The MOH reports that 13,315 HIV-infected persons had developed AIDS by the end of August 2004 (cumulative) and would have met criteria for ARV treatment. However, considering that AIDS is still largely unreported in Vietnam, WHO and other expert's estimate 20,000 to 25,000 HIV-infected adults and children currently qualify for treatment. Of note, 20% to 25% (4,000 to 6,500) of these currently reside in social labor/rehabilitation (05-06) centers. It is estimated that just under half of persons meeting criteria for Highly Active Anti-Retroviral Therapy (HAART) are 35 years old or younger and 90% are less than 50 years old. Though the rates of HIV among children less than 13 years old are poorly documented, the MOH reports that there are fewer than 300 cases nationwide.

### 2.3.2 Treatment Goal and Vision

Within five years, the USG will support in Vietnam the treatment of 22,000 HIV-infected adults and children with HAART. In the first year, at least 1,000 HIV-infected persons will start on HAART; at least 3,000 more will begin treatment during the second year. During the second year, an assessment of the evolution of the epidemic will inform decisions on expanding treatment programs to more provinces.

### 2.3.3 Summary of Challenges and Opportunities to Achieve Five-Year Treatment Targets

- Vietnam has the opportunity to establish an effective multi-sectoral ARV treatment program while its epidemic is still concentrated among vulnerable populations. Vietnam's vertical system has eliminated or controlled many infectious diseases and has been effectively used to develop excellent disease control programs. For example, the National TB program is considered a "gold standard" because of its strict adherence to international standards of care and uniform high quality across provinces. Even so, this program recognizes that it has encountered difficulty in reaching some high risk and vulnerable groups.

- As previously noted, technical capacity for effective HIV treatment is limited, but is increasing with more training and mentoring. While USG-supported regional training programs have trained more than 400 physicians in over 40 provinces (including infectious disease, TB, STI and rehabilitation center doctors), the number of providers

who can adequately treat and care for PLWHA is still insufficient. HIV management training has focused on HIV diagnosis, prevention, occupational exposure, universal precautions, PMTCT, prevention, diagnosis and treatment of opportunistic infections (OI), and basic anti-retroviral therapies; but not follow-up evaluation of treatment. Specialty training in working with IDU, clinical mentoring and on-going supervision of care needs further support.

- Model outpatient programs in both the public and private sectors, which can eventually form a framework for outpatient ARV programs, are already underway in 33 provinces. Newly revised national guidelines on ARV therapy are expected in late 2004 and dissemination plans are underway. Early draft ARV guidelines are consistent with current WHO recommendations.

- Many patients with advanced HIV infection in Vietnam have undiagnosed active TB disease. Patients with TB who are started on ARV therapy may become severely ill. An important challenge in Vietnam will be developing adequate methods to screen for TB prior to beginning ARV therapy and to develop ways to manage patients who become severely ill after starting ARVs.

- Although great strides have been made, stigma and discrimination about HIV still exist among healthcare workers and will need to be addressed in training programs and through professional associations. HIV stigma and discrimination are compounded by the fact that many PLWHA are also members of marginalized groups such as IDU, CSW and MSM.

- Large numbers of these groups may move in and out of government-run rehabilitation centers therefore transitional programs to provide continuity of care will be crucial. Some patients in the rehabilitation centers may be started on HAART through government programs, but maintaining regimens must be addressed in the community. In addition, some members of the community participating in USG-supported ARV programs will be detained in the centers and strategies to ensure continuing treatment regimens must be addressed.

### 2.3.4 Strategic Approaches to Achieve Five Year Treatment Targets

For all treatment programs, strong coordination and collaboration with other donors, government and NGOs through a network system will create an effective national HIV treatment strategy capable of being implemented at all levels and reduce program duplication. Approaches to achieving the 5 year treatment targets include a range of activities from a rapid expansion of existing ARV services, especially targeting MARPs, including PMTCT+, and establishing services for children, to improving the laboratory and pharmaceutical capacity, and integrating treatment with care and prevention.

USG support for ARV treatment will include policy and guidelines development; establishment of effective drug procurement and dispersal systems; adequate laboratory infrastructure; enhanced human capacity; and effective monitoring and evaluation systems.

In addition, mechanisms to link treatment, care and support systems will ensure a comprehensive approach that allows the most effective treatment of the patient.

#### 2.3.4.1 Rapid expansion of ARV services

A phased approach consistent with the MOH-approved 3 x 5 Plan, and with coordination with other government sectors and other donors (e.g., GFATM, WHO, ESTHER) is planned. Effective ARV therapy will be promoted first in the public sector at central, regional, and provincial programs in high prevalence provinces with existing capacity. At the same time, NGO medical clinics will scale-up ARV treatment services at the local level in the hardest hit districts. This combined approach will ensure rapid expansion and maximal coverage of PLWHA who need treatment.

#### 2.3.4.2 Scaling up PMTCT+

A commune-to-provincial level PMTCT program is currently being supported by USG in 3 provinces with ~ 1% prevalence among antenatal clinic (ANC) attendees (Hai Phong, Quang Ninh, and HCMC). Currently, women identified as HIV-positive in the prenatal period are provided Zidovudine / Lamivudine (AZT/3TC) at 34 weeks gestation, and infants are provided nevirapine at delivery. With the Emergency Plan, it will be possible to begin triple drug regimens for women who qualify for ARV in the PMTCT programs, and to ensure that infants and mothers are (as necessary) provided HAART during the post-natal phase through appropriate referrals. In addition, this program will allow identification of fathers for participation in ARV programs.

Scaling up of PMTCT services will focus on four high prevalence provinces until all districts are covered. Subsequently, additional provinces can be brought into the program, preferably based on order of HIV prevalence among ANC attendees.

#### 2.3.4.3 ARV services for children

The model PMTCT programs being implemented in 3 provinces and being introduced in Hanoi will allow early identification of HIV infected children born to an infected mother detected with HIV in this program. Currently, a small ARV program for HIV-infected children is being supported in HCMC. The National Pediatrics hospital (Hanoi) and regional hospitals in HCMC are also potential sites to begin or expand ARV for HIV- infected children. Current laboratory systems will need support to enhance Polymerase Chain Reaction (PCR) identification techniques, for early recognition of infants who will need therapy. Additionally, HIV-infected children resident in the military health care system and in 05/06 centers can be similarly supported.

#### 2.3.4.4 Strengthening laboratory capacity and infrastructure

USG programs have supported and will continue to provide laboratory capacity strengthening through a contract mechanism. Evaluation of laboratory infrastructure needs

will be done within the first phase of implementation for the initial program facilities and proceed treatment program expansion.

#### 2.3.4.5 Addressing policy issues

The USG has helped to address significant policy issues related to ARV treatment through USG program staff serving on national committees developing policies related to treatment protocols and access to services. Even so, much remains to be done. USG and NGO partners will continue to work with GVN to address policy issues related to ARV. This will be supported in the context of USG and NGO partners. work with GVN on policy related to other issues (such as policy and vulnerable populations, confidentiality, stigma and discrimination, GIPA, etc.).

#### 2.3.4.6 Integrating treatment effort with prevention and care

Integrating HIV treatment into the community care system is critical, and is proposed to be obtained through development of a "health facility to home" community model that involves caseworkers at higher-level health facilities referring patients to community levels. Current referral systems (e.g., referrals of HIV positive persons from VCT to HIV outpatient clinics, and from Community Outreach programs into HIV outpatient clinics) will be maintained, evaluated and strengthened as necessary. HIV treatment programs for HIV positive persons will include a strong component, including counseling on transmission, on encouraging partners to come in for testing, and on discordant couple counseling.

#### 2.3.4.7 Linking treatment interventions with other non-emergency plan such as food security, education

Needs assessments will be conducted to look into these programs and to ensure coordination with other donors for best support of government, and least likelihood of duplication of efforts.

#### 2.3.4.8 Pharmaceutical management

No national formulary has been issued, nor have national procurement mechanisms been determined. Vietnam has limited in-country production of generic ARV, but quality assurance testing has yet to be performed. The USG program has begun addressing strategies for drug procurement and dispersal. The USG will purchase drugs approved by the FDA.

## 2.4 Critical Interventions: Care

### 2.4.1 Introduction

Care and support for people infected with HIV is a major component of the Presidents Emergency Plan for AIDS Relief in Vietnam. The care activities of the Presidents Emergency Plan in Vietnam will comprise a model of continuum of care from the time a person is diagnosed with HIV infection until death. It will include a comprehensive set of activities including routine clinical care, voluntary counseling and testing, treatment of opportunistic infections and tuberculosis, preparing people for treatment and providing supportive counseling and adherence programs. Care for orphans and vulnerable children will also be a major focus of care activities to ensure they receive a basic care package and essential services. Additional elements of Vietnam's comprehensive care and support package will include a network of healthcare services; social and legal support services and a policy and advocacy environment intolerant of discrimination.

### 2.4.2 Care Goal and Vision

Over the next five years, 110,000 people infected and affected by HIV/AIDS, including orphans and vulnerable children, will receive HIV/AIDS care in Vietnam.

USG Vietnam Program will cooperate with government agencies, faith and community-based organizations, international NGOs, mass organizations and peer support groups in building capacity to implement comprehensive HIV care and support through the development of a diversified network system.

### 2.4.3 Summary of Challenges and Opportunities to Achieve Five-Year Care Targets

#### 2.4.3.1 Opportunities

Vietnam has:

- government and donor commitment to caring for PLWHA
- a functioning health infrastructure with a cadre of relatively well-trained physicians and caregivers
- a growing private sector with a focus on HIV/AIDS care providing opportunities for a comprehensive network model for the delivery of care and support services
- nascent community- and faith-based HIV/AIDS care and support organizations
- a society that values community unity and volunteerism at its core

Many of the ingredients of a network model already exist, but require the catalyst to develop linkages across sectors and services.

#### 2.4.3.2 Challenges

Key challenges include:

- Lack of affordable quality care and clinical management with the full range of treatment options from the provincial level to ward level; low numbers of clinically qualified staff and poor remuneration and incentives for staff motivation; understaffed health management units

- Minimal management experience; limited capacity of local leadership to advocate for comprehensive, multi-sectoral approaches to care and support; a lack of effective Vietnamese models for comprehensive care and support for rapid scale-up; and a lack of history of managing and ensuring confidentiality of lab testing in the HIV/AIDS arena

- Community activism remains relegated to quasi-governmental mass organizations; the absence of a strong civil society sector poses the greatest challenge to developing truly beneficiary-driven care models

- Relatively low HIV prevalence and ten years of public campaigns associating HIV/AIDS with drug use, crime and sex work have led to powerful stigma and discrimination, with roots in the healthcare sector; efforts to improve the legal framework for rights-based advocacy of PLWHA will prove fruitful only if those rights are enforced and there is still a dearth of advocacy leadership at both the central and local levels

The Emergency Plan brings Vietnam the opportunity to partner with the USG and international NGOs to build on a good health infrastructure capacity while developing client-focused care models that link health facilities and communities from the provincial to the ward level.

### 2.4.4 Strategic Approaches to Achieve Five Year Care Targets

#### 2.4.4.1 Voluntary HIV Counseling and Testing (VCT)

While testing is available in most provinces in Vietnam, quality VCT services are available in about half of Vietnam's 64 provinces, concentrated in urban areas. Several difficulties limit provision of effective VCT services. The *UNAIDS Assessment on Counseling and Support for People Living with HIV/AIDS (PLWHA)* (2001) raised concerns that counseling in Vietnam is often limited to rudimentary and didactic medical and prevention information and that the number and quality of services and counselors is insufficient. Prior to 2001, most VCT sites were located in Provincial Preventive Medicine Centers, where confidentiality of services is not certain. As a result, the majority of clients, including IDU and CSW, may feel marginalized and stigmatized when using the services. To date, there are no official national guidelines for VCT but multiple counselor training curricula.

The MOH currently uses the WHO #3 HIV testing algorithm. The MOH has shied away from rapid testing strategies because of a series of well-publicized false positive tests with poor outcomes related to inappropriate use of rapid testing. Currently, greater than 40 provinces have confirmatory testing capacity and the ability to provide HIV test results in less than 7 days. The MOH has allowed dual rapid testing in certain situations (e.g., labor) where results are needed immediately.

The USG programs aim to expand access to high-quality, diversified HIV VCT (government and NGO) targeted specifically at groups that practice high-risk behaviors and to develop strong referral systems to clinical and community care and support programs, psycho-social support and peer support groups. The goal of VCT expansion is to reduce new HIV infections among individuals who practice high-risk behaviors, reduce transmission from infected persons and to link positive persons to HIV care and support services. The following outline strategies for fulfilling the goal:

- **Support coordination of donors and multiple government sectors on the development of national guidelines on VCT.** USG programs will provide technical assistance for development of national guidelines, in addition to supporting cross-agency efforts to disseminate lessons learned and allow for model diversification. Programs will also support such activities across non-health sectors, including military, labor, education and public security, to promote adoption of high-quality and non-discriminatory VCT services.

- **Strengthen training and support for VCT service providers for increased quality, availability and referral of services.** USG programs will provide training for supported sites to strengthen the capacity of managers, counselors, laboratory technicians, administrative staff and where possible, PLWHA. Programs will employ the Training of Trainers (TOT) model at the national and provincial levels to ensure ownership and sustainability for VCT expansion. At government sites, QA will be conducted by a mix of USG and GVN partners to assist provinces and military districts in meeting technical and infrastructure requirements for confirmatory testing based on The MOH guidance. Additional QA will stem from internal and external supervision, client satisfaction surveys, counseling session observation and feedback and case review meetings. Evaluation of the quality and effectiveness of the referral network will be used to strengthen the system. Abstinence, being faithful and correct and consistent condom use strategies will be employed in the risk reduction hierarchy in a maximally effective manner.

- **Expand access to and diversification of quality VCT services, especially for people who practice high-risk behaviors.** USG programs will focus on people who practice high-risk behaviors, including IDU, CSW and their clients, MSM, military recruits, deployed military personnel, migrant workers and sex partners of HIV-positive persons. VCT sites will be focused mostly in urban centers where prevalence is highest and will operate with flexible hours. Programs will experiment with mobile VCT models, in addition to integrated and stand-alone sites. Various VCT strategies, including “opt-out” approaches, will be explored and expanded in TB clinics in provinces with >5% HIV

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prevalence among TB patients and in public STI clinics. USG programs will also partner with high-quality private sector testing facilities to support national VCT guidelines and referral to services and community support groups. Partner agencies will collaborate with the government on the development of progressive social marketing campaigns for VCT services. Finally, further evaluation of use of rapid HIV tests will be made, in partnership with the MOH, other appropriate government partners, and NGOs.

- **Enhance the referral network for comprehensive HIV prevention, care and support and treatment services, with a focus on both clinical and community care and support.** Strong referral networks will be established between VCT sites and outpatient clinical care services with free or low-cost OI and ARV treatment, TB treatment, STI services, antenatal care and PMTCT services, local and international peer support groups, legal assistance, employment and psycho-social services, drug treatment, prevention services and community- and faith-based care and support programs. Specific support will be given to coordinate across donor and government PMTCT programs, in addition to strengthening linkages with mother-child health programs, BCC interventions and monitoring efforts. Strong referral networks for HIV-infected persons at high risk for STI will encourage rapid testing for syphilis and, if possible, gonorrhea, along with single dose, directly observed treatment if appropriate.

- **Support for clients in test results disclosure and partner referral, and anonymous test availability.** USG programs will emphasize test result disclosure and partner notification in counseling for both HIV-negative and positive clients. Training curricula and QA supervision will help counselors encourage their clients to inform their partners of test results. Additional counseling will be employed for HIV-positive clients who may be reluctant or afraid to disclose their status. Clients will be encouraged to bring their partners to VCT sites. Finally, USG-supported programs will assist in the expansion of anonymous testing sites.

- **Develop innovative marketing strategies to stimulate demand**. Creative marketing and advertising approaches will be applied to accelerate coverage of VCT services. Approaches may include mass media such as TV, radio and newspapers. Additional persons benefiting from USG-supported programs will be encouraged to access VCT sites, including community outreach, safe motherhood, disability-focused programs, workplace-based interventions, TB services and condom social marketing programs.

#### 2.4.4.2 Palliative Care

Palliative care for HIV/AIDS in Vietnam ranges from clinical care and support to home and community-based services, involving community members. Although drugs for most OI are available, the quality of medications varies. The availability of high-quality, non-discriminatory care is relatively low in most of the country. Caregivers, especially nurses, receive insufficient training; many physicians lack the knowledge to prescribe and administer OI drugs and other palliative and pain management medications effectively. A growing civil

sector has assumed some of the palliative care burden, but there is still a need to link symptom management, treatment of OI and end-of-life care and support.

**Palliative Care Goals.** The Emergency Plan aims to improve the quality of life for people living with HIV and AIDS in Vietnam through the provision of comprehensive clinical, psychological, spiritual and social services and bereavement support for family and community.

- **Identify and assess existing palliative care services.** Community-based palliative care and support models in focus areas will be identified and lessons learned will be disseminated to government and NGO service providers. Specific emphasis will be placed on the actual or potential linkages to the network model. Access to, availability and quality of pain management medications will be assessed.

- **Expand access to and linkages between VCT and care and support services to prepare and support PLWHA up to and through the introduction of ARV therapies.** USG programs will train clinical support staff in VCT centers on basic palliative care, identification of psychosocial and nutrition needs, referral system linkages and the supportive care needs of families and individuals living with HIV. These steps will develop PLWHA support and treatment readiness through treatment education, peer training and development of PLWHA advocacy models.

- **Expand access to pain medication.** Needs include training nurses to dispense pain medication and support policies and drug management staff to prevent the diversion of pain medications. USG programs will work with the MOH and the MOD to advocate for the appropriate use of pain medication in HIV treatment programs, including community-based primary care clinics, HIV specialty clinics, inpatient wards and hospice care.

### 2.4.4.3 Palliative Care: TB/HIV

Vietnam is a high-burden TB country. At the same time, Vietnam's DOTS program for TB treatment and control is considered a global gold standard program. Therefore, while the high burden of TB means that TB is a major OI concern in Vietnam, the success of the Vietnam TB program means that there are many opportunities for success in TB/HIV treatment.

**Goals for Palliative Care: TB/HIV.** The USG program will improve the quality of life of people living with HIV/AIDS by improving care and treatment of TB among PLWHA.

**Promote the collaboration between TB and HIV programs.** Collaboration between TB and HIV programs is a vital component of the Emergency Plan. TB is the leading cause of death in PLWHA, and combined ARV and TB treatment may save lives. USG program goals will include increasing the proportion of TB patients who are tested for HIV, increasing the proportion of HIV-infected TB patients who are given ARV therapy, and improving the detection of active TB among PLWHA. USG programs support development of national

policies on integration of services, establishment of routine diagnostic HIV testing within TB facilities, and development of a TB/HIV case manager model in provinces with a high burden of HIV and TB. Early detection of active TB in PLWHA will be accomplished by implementing and evaluating strategies for screening HIV-infected patients for TB prior to initiating ARV therapy.

### 2.4.4.4 Care for Orphans and Vulnerable Children (OVC)

Due to the relatively recent introduction of HIV into Vietnam and its high concentration among IDU and SW and due to a dearth of research on the situation of OVC in Vietnam, HIV/AIDS orphans , infants born to HIV-infected mothers, HIV-infected and affected children lack integrated and comprehensive services. In order to allocate resources effectively, the Emergency Plan will first focus on a national assessment of the situation of HIV/AIDS OVC. This assessment will address and document existing practices regarding orphan care in local communities and review existing laws and policies regarding the rights of the child, protection measures, legal safeguards to claims of inheritance and existence and implementation of a national policy for the protection, care and support of OVC.

**Goals for Care and Services for OVC.** The USG program will help to improve the lives and protection of orphans, other vulnerable children and their families. Based on the outcome of the initial assessment, specific projects in this area will be developed and specific attention will be paid to promoting collaboration and linkages across existing programs of prevention, care and treatment.

- **Participatory development of strategic and program planning.** The Emergency Plan will support the development of holistic programs that address health care and suppressive therapies and, wherever possible, HIV treatment programs using ARV therapies. Programs will address comprehensive care and support services for OVC across myriad sectors, including education, legal rights, psychosocial and socioeconomic support.
- **USG will expand its current activities providing Pneumocystis Carinii Pneumonia (PCP) prophylaxis, HIV PCR testing and clinical care to infants born to HIV positive mothers.**
- **Strengthen community mobilization and linkages with the network system.** USG programs will increase the capacity of communities to identify vulnerable children and to design, implement and monitor their own OVC community- and faith-based support activities. Special attention will be paid toward training for individual case managers to provide counseling and succession planning for children affected by HIV/AIDS. In addition, programs will encourage strong linkage to strengthened clinical care and support services and will contribute to overall monitoring for quality of care. The USG funding will assist in integrating OVC support with home-based care, VCT and PMTCT prevention programs. These programs will support interventions to reduce institutionalization and abandonment of children.

## 3. Supportive Interventions

### 3.1 Engendering Bold Leadership

With the rise in HIV/AIDS prevalence since identification of the first cases, Vietnam's leaders have come to recognize the potential impact of a generalized HIV/AIDS epidemic on desired economic growth and societal development. The government has proved increasingly receptive to outside input into programs for the prevention, care and treatment of individuals with HIV/AIDS. The National Strategy focuses energies and resources towards preventing or reducing HIV/AIDS at all government levels and assigns to almost all ministries, roles and responsibilities in responding to the HIV/AIDS epidemic. The Emergency Plan funding will help to encourage implementation of key parts of the National Strategy, while enabling inter-ministerial cooperation and supporting ministerial activities.

The private sector is a rapidly growing entity in Vietnam that could expand greatly in the next five years, particularly if Vietnam succeeds in its application to the World Trade Organization. Engaging both Vietnamese and U.S. community business leaders (through organizations such as the American Chamber of Commerce) to support programs to reduce discrimination against PLWHA in the workplace will improve chances for PLWHA to remain productive members of the community.

Over the past decade, the government's emphasis on providing education for all and opening the country's doors to economic reform has given the people of Vietnam access to a good education and a high literacy rate.

**Leadership challenges**. A lack of management and administrative systems training among the nation's healthcare leadership may hinder the quick dispersal and utilization of funds required by the Emergency Plan. Frequent reorganization of ministries and a strict, hierarchical leadership structure are likely to inhibit the ability government officials to lead decision-making and policy formulation initiatives.

**Media willingness and ability to present clear and transparent information remains limited.** Information dissemination about HIV/AIDS to those at risk is a critical element of prevention as well as access to care and treatment. Media also offer a key channel to promoting fair and equitable treatment of all individuals affected by HIV/AIDS. HIV/AIDS education messages have been slow to diffuse and pockets of individuals (including some in the healthcare community) still remain misinformed. In some parts of society, particularly among minority populations, women are less well educated and gender discrimination exists in the form of violence, salary, hiring and stigma.

**Developing bold leadership on HIV/AIDS activities in Vietnam over the next five years.** USG programs will encourage a national leadership profile for HIV/AIDS activities that includes coordinated inter-ministerial, multi-sectoral policy and planning approaches and inclusive technical implementation committees. Both national and local leadership should be engaged in a coordinated and integrated fashion with new and emerging partners, including NGOs and FBOs. At the highest levels of government, USG will foster commitment to coordinate donor funding allocation through multi-sectoral coordinating bodies. All of these depend on improved systems of communication among government, non-governmental partners and the media to better provide HIV/AIDS programmatic and systematic messages to all persons who need to receive those messages. The end goal of the five year strategy also includes the presence of a robust MOD HIV/AIDS program that is proving an essential part of the country's solution.

**Strategic approaches to engender bold leadership.** Vietnam has many well-educated, energetic and dedicated individuals with the potential to become strong leaders in many sectors. The USG, with its partners, particularly in collaboration with UNAIDS and UNDP can assist by building government commitment to addressing the HIV/AIDS epidemic at all levels; developing a sustained level of capacity improvement at both the institutional and human resource levels in the government; advocating at the highest levels of government for inter-ministerial collaboration and coordination in designing and implementing HIV/AIDS programs; involving new partners who have not been engaged in HIV/AIDS activities, including new government entities, other donors ,CBO/FBO, local partners, and NGOs; engaging the GVN to work with UN partners to improve donor coordination and collaboration; engaging and training media to responsibly and accurately portray HIV/AIDS information, thus affecting public conceptions of HIV/AIDS and reducing stigma and discrimination of PLWHA and those most at risk; emphasizing the roles of labor and the private sector in reduction of stigma and discrimination and HIV/AIDS prevention and treatment programs; collaborating with and training community leaders (including mass organizations) in all aspects of HIV/AIDS programs, including stigma reduction; ensuring collaboration and cooperation between all levels of government and partners, including NGOs and mass organizations; educating leadership at all levels about the need for advocacy for improved prevention, treatment and care and stigma reduction to fight the epidemic; developing leadership among PLWHA at all levels of society; and developing and implementing innovative alternatives to existing and less effective treatment and prevention activities.

### 3.2 Achieving Sustainability and Human Capacity Development

Unlike many sub-Saharan African and Caribbean countries facing inadequate human resources and weak institutions, Vietnam has a comparatively strong healthcare work force, sound public health infrastructure and a leadership engaged (at least to some degree) to address the HIV/AIDS epidemic. Vietnam initially developed its national AIDS program with support from UN and other international organizations in the late 1980's; the program has undergone numerous organizational changes, particularly in the past four years. The current National Committee for AIDS, Drug and Prostitution Prevention and Control, chaired

by the Deputy Prime Minister, includes 18 member ministries of the government and a number of other sectors, socio-political organizations and federations and central institutions. The government has recognized that coordination has not been ideal, as summarized by a statement in the National Strategy: "there is no solution for activities to reduce harms among the drug-using group, to increase condom use among sex workers to prevent HIV/AIDS transmission." The National Committee has emphasized coordination that rests on one national HIV/AIDS action framework.

Although provincial AIDS committees have been established and are functioning, the planning process for HIV/AIDS activities is still in development in most provinces. Most provincial AIDS committees lack an adequate number of trained staff in public and allied health. It is anticipated that the reorganization of HIV/AIDS programs at the national level will also occur at the provincial level. On the positive side, several factors provide an institutional platform for an effective response to the epidemic, including well-organized and extensive mass organizations (e.g., the Women's Union and the Youth Union) and the capacity to organize rapid and effective responses to health threats (such as the response to the Severe Acute Respiratory Syndrome outbreak).

As with any developing nation, Vietnam has limited financial resources committed toward HIV/AIDS activities and thus depends heavily on international support. The GVN currently commits about $ 4 million USD per year to HIV/AIDS; international support currently totals more than five times that amount. The Emergency Plan aims to provide technical guidance to The GVN in diversifying its assistance base to include more commitment from the national budget and the private sector and less from international donors. Sustainability and human capacity development have been key principles on which the current USG-supported government programs are developed and will be continued and expanded in the Emergency Plan activities.

All programs supported thus far have been requested by the MOH and the MOD and thus elicited government commitment from the initial stages. New programs will be planned in a similar fashion to ensure central government commitment. Local personnel will participate in the initial situational assessments, proposal development and mapping exercises and will be encouraged to adapt national procedures to fit the local context and to be part of the decision-making process. This will establish immediate "ownership" of the programs by their local implementers.

Emergency Plan activities will continue to encourage local health officials to develop linkages to other leaders critical to program success, such as police, local labor officials, mass organizations, health care providers and pharmacies. The plan will support national HIV conferences for local program staff to present results of their work and local site visits that allow program staff to visit their counterparts in adjoining provinces.

Great emphasis has been placed on training physicians, although more is needed; less has been placed on auxiliary professionals such as nurses, social workers and counselors, although these fields are also growing. Human capacity building in Vietnam will focus not only on training, but also on ensuring that training opportunities for HIV care and support

providers link with existing programs and involve "learning by doing" approaches, with support for national dissemination of lessons learned. Training courses will be conducted in the context of existing or new programs, making the training practical and meaningful. USG support will be given for training in program management, resource allocation, long-term planning and impact monitoring. Capacity building will run a continuum from district to central level and vice versa, through focused study tours and policy and resource management workshops.

The Emergency Plan activities will emphasize *utilizing* existing capacity effectively rather than changing systems. Emphasis will be placed on engaging decision-makers who make policy at the central level; community leaders who implement policy at the local level; institutional leaders who develop curricula for various professionals; the professionals (physicians, laboratory staff, nurses, counselors, social workers) who teach or provide services to the public; community figures such as businessmen, pharmacists and traditional healers; and local spiritual leaders (e.g., monks and nuns).

Historically, Vietnam has substituted strong mass organizations built on volunteer power and good will for civil society. However, The GVN interest in the role that civil society can play in prevention, care and support and mitigation of the harmful effects of HIV/AIDS has increased. The Country Strategy will focus both on mass organizations and nascent civil society to pilot community-based care and support for PLWHA, linkage and referral to public sector services and awareness raising and stigma reduction programs in target provinces. Groups will include the Women's Union, the Youth Union, the Fatherland Front, faith-based organizations and community-based advocacy and PLWHA groups. Special attention will be paid to the role of PLWHA in decision-making and policy development. Support to international NGOs and universities, through twinning programs, will be directed at capacity-building efforts to boost local ownership of effective care and support networks.

Given a growing private sector in healthcare and the overwhelming majority of public sector clinicians who conduct private practices, the Emergency Plan activities will focus on building public-private linkages. These will include private provider training of clinicians and pharmacists in HIV/AIDS, OI and palliative care, assistance in developing and disseminating public and private sector quality management guidelines and effective referral between public and private services supported by the Emergency Plan and other international and local initiatives.

### 3.3 Strengthening Coordination and Collaboration

Within Vietnam, strong coordination and collaboration already exist among USG agencies, as well as between these organizations and, UN agencies, international donors and others. Historically, CDC programs primarily support government partners, whereas USAID programs primarily support international and local NGOs, providing the opportunity for these programs to interact and "synergize" through development of community referral networks, provision of co-trainings (as in the area of VCT) and in encouraging coordinated provincial project development. Other USG agency programs (DOD, DOL) have also combined efforts

with existing CDC- and USAID-funded projects to leverage funding for coordinated, non-duplicative efforts.

USG agencies work collaboratively with other donors, foundations and UNAIDS and other UN entities through a variety of mechanisms. The agencies participate in the international HIV Technical Working Group and Subgroups; USAID and CDC representatives have chaired these groups on several occasions over the past three years. USAID and CDC also participate with the Community of Concerned Partners (CCP), a committee of donors working to harmonize support organized through the auspices of UNAIDS. Through the CCP, USG agencies worked with other international donors and UNAIDS in providing support and feedback during development of the National Strategy for HIV/AIDS.

**Collaboration over the next five years.** The USG will continue to collaborate with the UN and bilateral and non-governmental organizations through existing mechanisms such as the CCP and coordination of large scale-up projects. Emergency Plan funds can help support these useful coordinating activities. USG partners will continue to work with the GVN, the UN, multilateral and bilateral donors and NGOs in technical areas with long-standing projects, such as Surveillance, Monitoring & Evaluation, VCT, community outreach and HIV outreach. USG partners will work through UN agencies in areas where these agencies have a strategic advantage, such as promoting local NGO and civil society HIV/AIDS efforts and in certain policy areas (such as HIV in the workplace, PLWHA ).

Specifically, over the next five years USG efforts for strengthening coordination will include: strengthening existing partnerships with government, the UN and donor organizations to best leverage the comparative advantages of each agency; building new partnerships with NGOs, CBO/FBO and organizations within the GVN (e.g., mass organizations and ministries not currently engaged by USG); encouraging an open, participatory, high-level process for implementing the National Strategy; advocating for a high-level, inter-ministerial body for Emergency Plan GVN coordination and planning; encouraging communication and transparency by all organizations involved HIV/AIDS activities in Vietnam; reducing redundancy in donor programs and encouraging coordination and collaboration, whenever possible; building on the existing very strong USG interagency collaborations to optimize staffing and leverage the technical advantages of each agency; and advancing regional programs where these programs exist and can be adapted to the country situation.

### 3.4 Managing Strategic Information

Both the Emergency Plan and the Vietnam National Strategy on HIV/AIDS make collecting strategic information on HIV/AIDS activities a priority. The National Strategy calls for the development of a coordinating body specializing in monitoring and evaluation and data storage to create a strategic information management system. Vietnam has a solid foundation on which to build a system for monitoring implementation and evaluating effectiveness of HIV/AIDS programs, with a long tradition of district-provincial-central government reporting and accountability. MOH holds responsibility for monitoring and supervising provincial HIV/AIDS prevention and control agencies. Subcommittees reporting to MOH

manage various aspects of HIV programs, and ad hoc review teams can be pulled together across agencies for program evaluation. A similar reporting network exists within the MOD system. Coordination of this system with the MOH network is crucial.

With the support of the World Bank, the MOH is in the process of developing a national M&E framework, upon which one national HIV/AIDS coordinating authority will be established. The MOH is building from strong experience in seroprevalence surveillance. Surveillance capacity has broadened vastly to incorporate second generation surveillance, which includes behavior sentinel surveillance (BSS) and STI surveillance. There have been concerns, however, over the quality of the results due to low capacity of local implementing bodies and weak monitoring and supervision. Also, weak coordination among different donors and implementing agencies have compromised the utilization of the study results for programmatic and policy decisions.

The health management information system for HIV/AIDS at the national level is limited, and M&E capacity at the central and provincial levels requires strengthening. Facility-based data collection, mostly conducted at the provincial level by departments of health, has been burdensome. Limited numbers of health department staff have been available to meet major donor reporting needs in the more than 20 provinces with two or more donor-funded scale-up programs. Integrating data collection requirements and harmonizing indicators for the various donor-funded projects will allow full utilization of data for program management and policy decisions. Except for USG facilities, QA is unclear for clinic-based interventions throughout the country, as no national facility surveys exist. The human resource base for national surveillance capacity is concentrated within a small group of experts at the National Institute of Hygiene and Epidemiology who have multiple projects. In addition, Demographic Health Surveys (DHS), conducted in 1997 and 2002, consisted of limited HIV/AIDS indicators.

The USG can play a major role in helping Vietnam establish one national M&E system by addressing the current strategic information challenges in coordination with international donors, the central government and provincial implementing bodies. The USG strategic information plan embraces the following key elements through 2008:

- **Achieve one national M&E system.** Because Vietnam is already receiving World Bank support to establish a national M&E framework, USG will concentrate its efforts on building a steering committee comprised of international donors (USG, UNAIDS, WHO, World Bank, DfID, etc.) to support the government in achieving the national M&E framework. Where possible, USG programs will provide technical assistance in implementing the activities toward a national M&E system, such as harmonizing USG and international indicators, the Vietnam Presidential Emergency Plan database, and data collection and reporting systems with the national system.

- **Strengthen and build national strategic information capacity for use in program management and policy formulation.** USG programs will seek to strengthen and expand surveillance through instituting an on-going monitoring system, including laboratory QA/QC and validating estimations and projections. The Emergency Plan will

encourage integration of sentinel studies so that they offer comparable results that can be applied at the national level, and support the planning and development of a pilot HIV/STI surveillance program targeted at high-risk populations. USG programs would support AIDS Indicator Survey efforts in the GVN's biannual population-based health survey to better understand the extent of the risk factors driving the epidemic. Programs would also support size estimation among the most at-risk populations including IDU, CSW and their clients, and MSM, as well as estimates of HIV/AIDS-related mortality through development of a Sample Vital Registration through Verbal Autopsy (SAVVY). Goals would include assessing and strengthening systems to improve HIV/AIDS-related Health Management Information Systems, supporting workplace policy surveys, and supporting DOD in behavioral tracking of active duty forces.

- **Build institutional and human capacity for systems information (SI) related to HIV/AIDS surveillance.** The USG can assist in building such capacity by assessing national SI infrastructure and human resource capacity; supporting basic SI management training for national public health program personnel; identifying and supporting local institutions with the technical skills to take ownership of SI activities in order to reduce reliance on foreign assistance; supporting national authorities in training and supervising provincial personnel in conducting SI activities; and supporting evidence-based analysis and advocating utilization of information for policy and program planning and design at the national and provincial level.

- **Measure USG program effectiveness.** Operational research of USG in-country support will include analysis of every aspect of USG programs to determine effectiveness and guide changes to the network model that integrates all USG-supported programs (as well as related community programs supported by GVN, other donors, and international and local NGOs). These include access to, and procurement, distribution and management of pharmaceuticals; coverage for MARPs, particularly IDU, CSW, and MSM in target geographic areas; care and support; quality of life and risk behaviors of PLWHA (comparing those receiving and not receiving ARVs); care and support for OVC; and signs of stigma and discrimination. An initial step will be to assess the needs for and develop an information system for monitoring treatment, ARV therapy adherence, and viral resistance to ARVs. The USG program will support systemization of program monitoring (including data quality monitoring) and data management systems. The Emergency Plan will also support evaluations to measure the impact of USG support for prevention programs, including VCT, community outreach, behavior change interventions, PMTCT programs, as well as care and treatment programs.

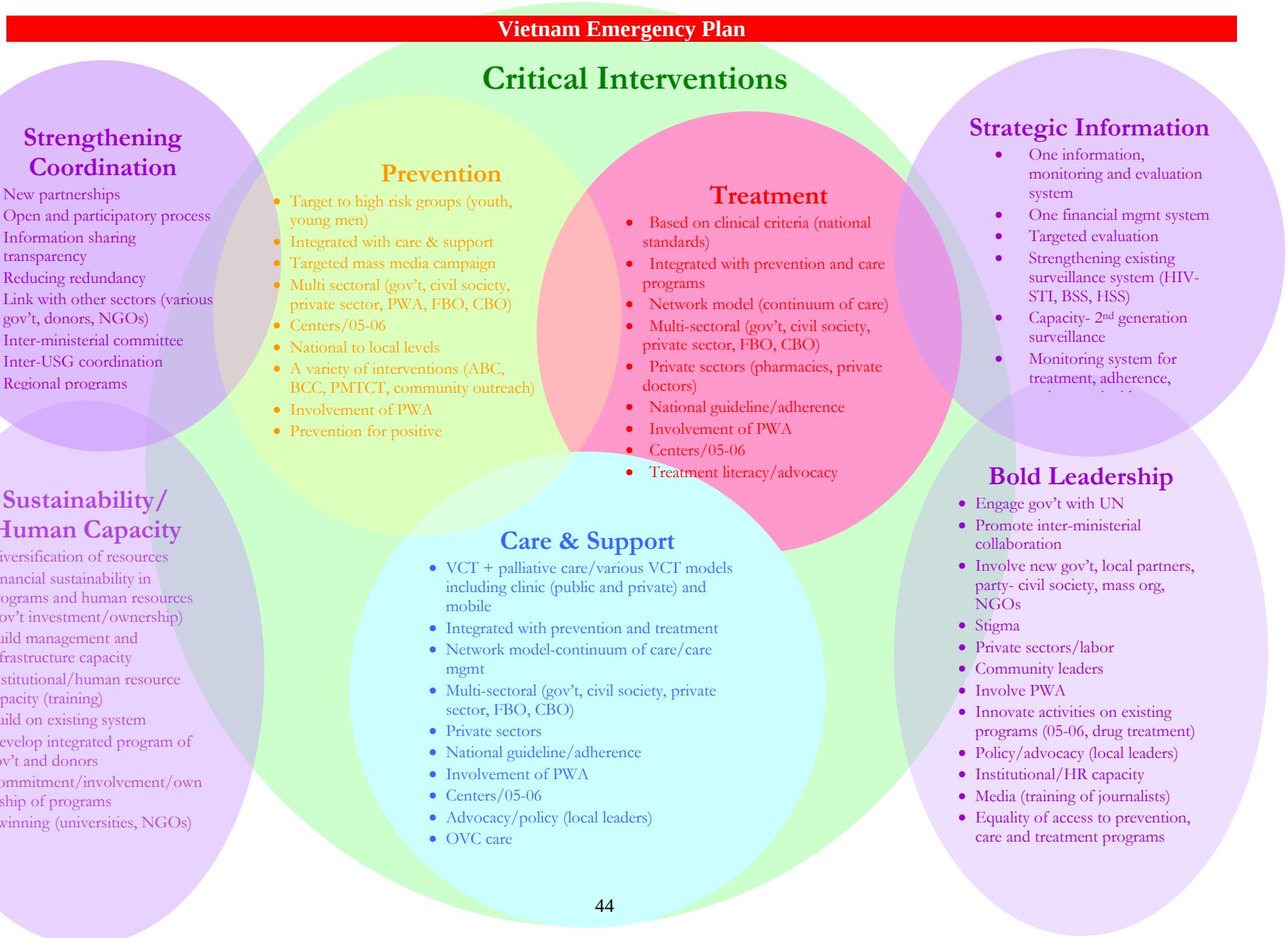
## 4.Appendices

### 4.1 Appendix 1: Acronyms

| | |
|---|---|
| ABC | Abstinence-be faithful-correct and consistent condom-use |
| AED | Academy for Educational Development |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Ante-natal care |
| ANW | Antenatal women |
| ART | Antiretroviral therapy |
| ARV | Antiretroviral (drug) |
| AZT/3TC | Zidovudine / Lamivudine |
| BCC | Behavior change communications |
| C&T | Counseling and Testing |
| CBO | Community-based organization |
| CCP | Community of concerned partners |
| CDC | Centers for Disease Control and Prevention (US) |
| CSW | Commercial sex worker |
| DflD | Department for International Development (U.K.) |
| DHHS/CDC | U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (USG) |
| DHS | Demographic Health Survey |
| DoD | Department of Defense (U.S.) |
| DoL | Department of Labor (U.S.) |
| DoLISA | Department of Labor, War Invalids and Social Affairs (GVN) |
| DOTS | Directly observed treatment, short course |
| Emergency Plan | U.S. Emergency Plan for AIDS Relief |
| ESTHER | Ensemble pour une Solidarite Therapeutique Hospitaliere en Reseau |
| FBO | Faith-based organization |
| FDA | U.S. Food and Drug Administration |
| FSW | Female sex worker |
| FY | Fiscal year |
| GAP | Global AIDS Program |
| GVN | The Socialist Republic of Vietnam |
| GTFATM | The Global Fund to fight AIDS, Tuberculosis and Malaria |
| HAART | Highly Active, Anti-Retroviral Therapy |
| HBC | Home Based Care |
| HCD | Human capacity development |
| HCMC | Ho Chi Minh City |
| HIV | Human Immunodeficiency Virus |
| HIV SS | HIV Sentinel Surveillance |
| IDU | Injection drug user |
| IEC | Information, Education, Communication |
| ILO | International Labor Organization |
| LIFE-GAP | Leadership Initiative in Fighting Epidemic-Global AIDS Program |

| | |
|---|---|
| MARP | Most at risk population |
| M.D. | Medical Doctor |
| MSM | Men who have sex with men |
| MOD | Ministry of Defense (GVN) |
| MOH | Ministry of Health (GVN) |
| MoLISA | Ministry of Labor, War Invalids and Social Affairs (GVN) |
| M.P.H. | Masters of Public Health |
| MSW | Male sex workers |
| M&E | Monitoring and evaluation |
| NAC | National AIDS Committee |
| NASB | National AIDS Standing Bureau |
| NIHE | National Institute for Hygiene and Epidemiology |
| NGO | Non-governmental organization |
| O/GAC | Office of the Global AIDS Coordinator |
| OI | Opportunistic infection |
| OVC | Orphans and other vulnerable children |
| PACOM | US Pacific Command |
| PCR | Polymerase Chain Reaction |
| PhD | Doctor of Philosophy |
| PLWHA | People living with HIV and AIDS |
| PMTCT | Prevention of mother to child transmission |
| QA | Quality assurance |
| QC | Quality control |
| RTC | Regional training center |
| SAVVY | Sample Vital Registration through Verbal Autopsy |
| SMARTWORK | Strategically Managing AIDS Responses Together (Work) |
| SI | Strategic Information |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| ToT | Training of Trainers |
| UN | United Nations |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development (USG) |
| USD | U.S. Dollar |
| USG | United States Government |
| VTC | Voluntary Counseling & Testing |
| WHO | World Health Organization |

## 4.2 Appendix 2: Critical Interventions Diagram



## 5. Annex

## Annex 1: Implementation and Management Plan

### A. Agency Roles and Coordination

The US Government (USG) Mission in the Socialist Republic of Vietnam, led by Ambassador Michael W. Marine, directs and coordinates the USG interagency Emergency Plan response. The Deputy Chief of Mission (DCM), John Boardman, heads the interagency team, while the HHS Health Attaché plays a key interagency coordinating role.

In the Socialist Republic of Vietnam, the Emergency Plan encompasses the following USG agencies: U.S. Agency for International Development (USAID), Department of Defense (DOD), Department of Labor (DOL), Department of Health and Human Services Office of Global Health Affairs (HHS), and the Centers for Disease Control and Prevention (CDC). Historically, CDC programs have primarily supported government partners, whereas USAID programs have supported international and local NGOs. This structure provides an opportunity for these programs to interact and "synergize" through development of community referral networks, provision of co-trainings, and coordinated provincial project development efforts. Other USG agency programs (DOD, DOL) have also combined efforts with existing CDC and USAID projects to leverage funding for coordinated and non-duplicative efforts.

United States Agency for International Development:
USAID initiated its activities in the Socialist Republic of Vietnam in the spring of 1998. Although it does not have a formal bilateral program in the country, USAID/Vietnam has been operating under the umbrella of USAID's Regional Development Mission in Asia. USAID/Vietnam has been managing the implementation of several HIV/AIDS initiatives to prevent and mitigate the effects of the HIV/AIDS epidemic for those infected and affected by HIV/AIDS. Current programs focus on scaling up effective prevention interventions for at-risk populations in selected provinces, developing provincial level implementation plans and increasing institutional capacity. Programs also focus on promoting an effective policy environment, improving surveillance, reducing stigma and discrimination, developing advocacy for PLWHA, and expanding model interventions for care and support. Policy related activities include advocacy training for PLWHAs and research on advocacy for drug treatment. Prevention activities target CSW, IDU, clients of sex workers and mobile populations with IEC, BCC and condom social marketing. Funds also support the dissemination of stigma and discrimination research findings and the development of HIV/AIDS anti-stigma materials.

Additional activities include the development and scaling up of HIV/AIDS prevention interventions for the nation's injecting drug user population, the development of new and effective models for community-based care and support, and clinical capacity building at the district and community levels. During the past year, USAID-funded programs have also focused on technical assistance in rolling out the national strategy for HIV/AIDS at the provincial level,

and the development of a national-level institutionalized training curriculum for policy makers to implement a multisectoral response to the epidemic.

Department of Defense:
The US Pacific Command (PACOM) HIV prevention initiative engages military forces throughout the PACOM area in HIV/AIDS prevention activities. Through its Regional Training Center (RTC) in Bangkok, Thailand, PACOM and its partners – the Royal Thai Army, the US/Thai Armed Forces Research Institute for the Medical Sciences (AFRIMS), and the University of Hawaii – have held a series of multilateral training workshops in HIV/AIDS prevention. Content areas of the PACOM program include: practical training in counseling, diagnostic laboratory work and policy development; utilizing regional "best practices" through sharing of experiences in HIV/AIDS prevention (neighbors teaching neighbors); and leveraging of other U.S. Government, international and/or local organization expertise.

Through its bilateral program with the Government of Vietnam, PACOM has focused on enhancement of laboratory capacity, policy development, and HIV counseling and education. Specific instruction on the use of antiretroviral agents, both in the U.S. and in resource-limited settings has been provided. Appropriated funds for the program have not been used to support treatment programs.

In Vietnam, PACOM has held workshops targeting commanders and other military medical leaders and it has been the first to engage the Vietnamese military in matters pertaining to HIV/AIDS. In addition, a PACOM engineering team consisting of personnel from COE, PACOM, JUSMAG-Thai, and AFRIMS has recently completed an engineering assessment of the HIV laboratory facilities at MIHE.

Department of Labor:
Working together with the Academy for Educational Development (AED), the Ministry of Labor, and the Invalids and Social Affairs of Vietnam (MOLISA), U.S. Department of Labor supports a joint HIV/AIDS initiative, SMARTWork (Strategically Managing AIDS Responses Together). SMARTWork Vietnam seeks to mobilize a tripartite national level effort to establish and expand HIV/AIDS programs and policies to reduce stigma and discrimination in the workplace by increasing the number of enterprises and business establishments with effective workplace HIV/AIDS prevention and support programs. The initiative provides training for workers, supports campaigns to prevent the spread of the epidemic, and works towards developing policies at the workplace supporting workers and families affected by HIV/AIDS.

Department of Health and Human Services/Centers for Disease Control and Prevention (CDC):
In 2001, a five-year cooperative agreement between CDC-Global AIDS Program (GAP) and the Vietnam's Ministry of Health (MOH) was established to identify needed support for the national HIV/AIDS prevention and care program. The agreement established the MOH/LIFE-GAP program office. The program is in charge of coordinating, managing, and monitoring the overall project, while receiving technical assistance from ten central institutes. Program components of MOH/LIFE-GAP are Voluntary Counseling and Testing Services (VCT), Community Outreach Programs for Vulnerable Populations, Prevention of Mother-to-Child Transmission of HIV (PMTCT), and Treatment and Care.

USG-supported VCT programs are currently operating in 33 provinces and will be expanded to a total of 40 provinces by 2005. Through community outreach programs, former injecting drug users in 28 provinces have been trained to be peer educators carrying out HIV/AIDS prevention activities in their communities. Peer educators provide information about drug-related HIV transmission and methods for prevention of transmission, make referrals to VCT and clinical care services, and use a referral network to other prevention services that enable IDUs to reduce their risk of HIV infection.

The MOH /LIFE-GAP project office has developed a PMTCT demonstration project focusing on promoting early identification of HIV and early initiation of antiretroviral drugs for HIV-infected pregnant women and their newborns. The demonstration project is currently being carried out in three provinces: Quang Ninh, Haiphong, and Ho Chi Minh City. In these provinces HIV prevalence in pregnant women approaches or exceeds 1%. One project objective is to provide MOH with reliable data to help build a comprehensive national PMTCT program that is feasible and practical for Vietnam.

As the number of people living with HIV/AIDS in Vietnam continues to grow, MOH/LIFE-GAP's Care and Treatment program collaborates with the National Institute of Clinical Research in Tropical Medicine, Bach Mai Hospital in Hanoi, regional hospitals, and the provincial and district hospitals in 40 provinces to provide routine outpatient services to HIV- infected clients. In addition to providing basic clinical and laboratory services, the program strives to promote healthy living practices in patients with HIV/AIDS and to reduce HIV infections to partners. The program office also collaborates with the National TB Program to promote early identification, referral and treatment of HIV-TB co-infected patients using a variety of programs.

Department of Health and Human Services/Office of Global Health Affairs:
Under the direction of the HHS Health Attaché, the HHS/Office of Global Health Affairs offers support to the interagency efforts through facilitating communications with the Ambassador and other official channels and assisting the DCM in team management.

Other USG contributors:
Other USG contributors in Vietnam include the Department of Health and Human Services National Institutes for Health (NIH), which funds research projects through a number of US universities and research organizations.

**Process of Coordination and Decision-making**
Coordination of Emergency Plan activities is achieved through an interagency Mission Team lead by the Deputy Chief of Mission (DCM). The Interagency Coordinator and the Team Liaison work closely with the DCM to facilitate communication and coordinate activities among the widely spread Vietnam Mission Team members. Team members include: the Health Attaché (HHS); Country Director and Deputy Director (CDC/Vietnam); Country Manager and the HIV/AIDS Office Director (USAID); representatives from AFRIMS-Bangkok USDOD and Center for Excellence, Trippler Army Medical Center, USDOD; and State Department Economic Section Chief and representative. Decision-making process is carried out through consensus, with recommendations being presented to Ambassador Marine.

## B. Staffing

Staffing is allocated to support adequate and timely implementation of the priorities outlined in this plan. The proposed staffing will ensure provision of a broad range of expertise required to successfully manage the strategy during the next five years. Given this is the first year of Vietnam's participation in EP, significant staff increase will be anticipated over the next five years for most USG agencies involved. The following tables demonstrate each USG agency's proposed staffing pattern.

## USG Staffing Table (CDC)

| | (OE funded) | | | | (Program funded) | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | U.S. Direct Hire or Dire Equivalent | | FSNs | | U.S. Direct Hire, Direct Hire or Non-Direct Hir | | FSNs | | | |
| | # of Positions | % of Time | # of Positions | % of Time | # of Positions | % of Time | # of Positions | % of Time | # of Positions | % of Time |
| **HEALTH/HIV STAFF** | | | | | | | | | | |
| **Existing** | | | | | | | | | | |
| 1. Technical Leadership/ Managem | | | | | 4 | 100 | | | 4 | 400 |
| 2. Technical Advisors | | | | | 4 | 100 | 10 | 100 | 14 | 1400 |
| 3. Administrative Support | | | | | | | 5 | 100 | 5 | 500 |
| 4. Basic Support | | | | | | | 3 | 100 | 3 | 300 |
| **Planned** | | | | | | | | | | |
| 1. Technical Leadership/ Managem | | | | | 1 | 100 | | | 1 | 100 |
| 2. Technical Advisors | | | | | 1 | | 4 | 100 | 5 | 500 |
| 3. Administrative Support | | | | | | | | | | |
| 4. Basic Support | | | | | | | 1 | 100 | 1 | 100 |
| **NON-HEALTH/HIV STAFF** | | | | | | | | | | |
| **Existing** | | | | | | | | | | |
| 1. Contracting Officer | | | | | | | | | | |
| 2. Financial Management Officer | | | | | | | 1 | 100 | 1 | 100 |
| 3. Executive Officer | | | | | | | | | | |
| 4. Program Officer | | | | | | | | | | |
| **Planned** | | | | | | | | | | |
| 1. Contracting Officer | | | | | | | | | | |
| 2. Financial Management Officer | | | | | | | | | | |
| 3. Executive Officer | | | | | | | | | | |
| 4. Program Officer | | | | | | | | | | |

## USG Staffing Table (USAID)

| | (OE funded) | | | | (Program funded) | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | U.S. Direct Hire or Direct Hire Equivalent | | FSNs | | U.S. Direct Hire, Direct Hire Equivalent or Non-Direct Hire | | FSNs | | | |
| | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time |
| **HEALTH/HIV STAFF** | | | | | | | | | | |
| **Existing** | | | | | | | | | | |
| 1. Technical Leadership/ Management | | | | | 1.33 | 100 | | | 1.33 | 133 |
| 2. Technical Advisors | | | | | 1 | 100 | 5 | 100 | 6 | 600 |
| 3. Administrative Support | | | | | | | 1 | 100 | 1 | 100 |
| 4. Basic Support | | | | | | | 1 | 100 | 1 | 100 |
| **Planned** | | | | | | | | | | |
| 1. Technical Leadership/ Management | | | | | 1 | 100 | | | 1 | 100 |
| 2. Technical Advisors | | | | | 2 | 100 | 1 | 100 | 3 | 300 |
| 3. Administrative Support | | | | | | | | | | |
| 4. Basic Support | | | | | | | 1 | 100 | 1 | 100 |
| **NON-HEALTH/HIV STAFF** | | | | | | | | | | |
| **Existing** | | | | | | | | | | |
| 1. Contracting Officer | | | | | | | | | | |
| 2. Financial Management Officer | | | | | | | | | | |
| 3. Executive Officer | | | | | | | | | | |
| 4. Program Officer | | | | | | | | | | |
| **Planned** | | | | | | | | | | |
| 1. Contracting Officer | | | | | | | | | | |
| 2. Financial Management Officer | | | | | | | | | | |

## USG Staffing Table (DOD)

| | (OE funded) | | | | (Program funded) | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | U.S. Direct Hire or Direct Hire Equivalent | | FSNs | | U.S. Direct Hire, Direct Hire Equivalent or Non-Direct Hire | | FSNs | | | |
| | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time |
| **HEALTH/HIV STAFF** | | | | | | | | | | |
| **Existing** | | | | | | | | | | |
| 1. Technical Leadership/ Management | | | | | | | | | | |
| 2. Technical Advisors | | | | | | | | | | |
| 3. Administrative Support | | | | | | | | | | |
| 4. Basic Support | | | | | | | | | | |
| **Planned** | | | | | | | | | | |
| 1. Technical Leadership/ Management | | | | | 2* | 100 | | | 2* | 200 |
| 2. Technical Advisors | | | | | | | 1 | 100 | 1 | 100 |
| 3. Administrative Support | | | | | | | | | | |
| 4. Basic Support | | | | | | | | | | |
| **NON-HEALTH/HIV STAFF** | | | | | | | | | | |
| **Existing** | | | | | | | | | | |
| 1. Contracting Officer | | | | | | | | | | |
| 2. Financial Management Officer | | | | | | | | | | |
| 3. Executive Officer | | | | | | | | | | |
| 4. Program Officer | | | | | | | | | | |
| **Planned** | | | | | | | | | | |
| 1. Contracting Officer | | | | | | | | | | |
| 2. Financial Management Officer | | | | | | | | | | |

* Pending Chief of Mission approval

## USG Staffing Table (HHS)

| | (OE funded) | | | | (Program funded) | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | U.S. Direct Hire or Direct Hire Equivalent | | FSNs | | U.S. Direct Hire, Direct Hire Equivalent or Non-Direct Hire | | FSNs | | | |
| | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time | Number of Positions | % of Time |
| **HEALTH/HIV STAFF** | | | | | | | | | | |
| **Existing** | | | | | | | | | | |
| 1. Technical Leadership/ Management | 1 | 30 | | | | | | | 1 | 30 |
| 2. Technical Advisors | | | | | | | | | | |
| 3. Administrative Support | | | 1 | 30 | | | | | 1 | 30 |
| 4. Basic Support | | | | | | | | | | |
| **Planned** | | | | | | | | | | |
| 1. Technical Leadership/ Management | | | | | | | | | | |
| 2. Technical Advisors | | | | | | | | | | |
| 3. Administrative Support | | | 1 | 20 | | | | | 1 | 20 |
| 4. Basic Support | | | | | | | | | | |
| **NON-HEALTH/HIV STAFF** | | | | | | | | | | |
| **Existing** | | | | | | | | | | |
| 1. Contracting Officer | | | | | | | | | | |
| 2. Financial Management Officer | | | | | | | | | | |
| 3. Executive Officer | | | | | | | | | | |
| 4. Program Officer | | | | | | | | | | |
| **Planned** | | | | | | | | | | |
| 1. Contracting Officer | | | | | | | | | | |
| 2. Financial Management Officer | | | | | | | | | | |
| 3. Executive Officer | | | | | | | | | | |
| 4. Program Officer | | | | | | | | | | |

## C. Additional Country Context Information

Government of Vietnam policy on rehabilitation for injecting drug users (IDU) prescribes detoxification and community-based education as first steps in treatment. Those failing to abstain from continued injecting drug use are enrolled in rehabilitation centers. In addition, female sex workers (FSW) who continue sex work are enrolled in rehabilitation centers. These rehabilitation centers, called 05/06 centers (05 centers house FSW and 06 centers house IDU) include a large population at risk for acquiring or transmitting HIV. One challenge to the existing Emergency Plan strategy is that, as yet, no policy has been set by the U.S. Government for use of funds supporting activities in these centers. Currently, there are 114 rehabilitation centers in the country (84 of which are state-owned), with more under construction. The total number of residents in 05/06 centers nationwide is roughly 40,000-42,000, with about 30,000 residing in 05/06 centers in Ho Chi Minh City. The average prevalence among IDU in the 06 centers is between 40-45%, and between 20% and 70% of detainees are HIV-infected in a given center, and may likely have or acquire TB in the centers, further impacting HIV-related morbidity and mortality.

Therefore, a significant proportion of HIV-infected persons and Most at Risk Populations are currently in rehabilitation centers. Most critical aspects of the Emergency Plan, including treatment, care, counseling, prevention messages and HIV testing, could be implemented in these centers and would significantly mitigate the HIV/AIDS epidemic in Vietnam. Development of a policy to work in these centers is a critical aspect of a comprehensive and effective five-year strategy.