

HIV/AIDS in Vietnam

Final Report of the
CSIS HIV/AIDS Task Force Mission to Vietnam,
January 8–13, 2006

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The CSIS Task Force on HIV/AIDS is cochaired by Senators Bill Frist (R-Tenn.) and Russell Feingold (D-Wis.) and is funded by the Bill and Melinda Gates Foundation. Senator John Kerry (D-Mass.) was an original cochair at the commencement of the Task Force in 2001 and remains an honorary cochair. The Task Force seeks to build bipartisan consensus on critical U.S. policy initiatives and promote U.S. leadership in strengthening prevention, care, and treatment of HIV/AIDS in affected countries. CSIS is grateful to Senator Frist and Senator Feingold for their leadership and to the Bill and Melinda Gates Foundation for its continued support and vision.

HIV/AIDS in Vietnam

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J. Stephen Morrison and Phillip Nieburg

Major Findings and Recommendations

The CSIS delegation returned from Vietnam relatively optimistic about the potential for successfully controlling the spread of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) there. However, this hope was tempered by awareness of specific serious obstacles facing both Vietnam and its international partners as they expand their respective efforts.

Vietnam has several favorable circumstances that improve its chances for success in its struggle to combat HIV/AIDS. Stemming its HIV epidemic will require the country's leadership, its citizens, and its international partners to continue mobilizing quickly around a prevention-centered strategy that intensively and effectively addresses the core activities driving the epidemic—*injection drug use (IDU) and female sex work (FSW)*—while also reaching men who have sex with men (MSM) and launching a large-scale prevention effort targeting youth in both rural and urban settings. Although it will not be easy, it should be possible at the same time to expand access to effective treatment and care for Vietnamese already living with HIV.

This comprehensive yet prevention-focused strategy will require overcoming significant barriers: pervasive stigma; the current lack of a comprehensive national plan for treating and preventing injection drug use; lack of a national legal framework and legal remedies to limit discrimination and ensure confidentiality; at-risk populations' lack of access to prevention, care, and treatment; and failure to date to provide injection drug users with therapies to end addiction and manage HIV.

These and other obstacles hamper effective responses by Vietnamese and foreign agencies alike. If there is sufficient political will to overcome them, a well-focused strategy can succeed. If not, progress against HIV/AIDS in Vietnam is likely to be stymied, and its epidemic will continue to spread rapidly.

Why Is a Promising Outcome within Reach in Vietnam?

Vietnam is a nation imbued with dynamism and hope and endowed with institutional strengths that make it a place of remarkable opportunity. It is a country visibly on the

move—economically, politically, socially—and increasingly confident in its abilities to achieve and sustain major progress. Vietnam possesses a health system far stronger than many other countries already highly impacted by HIV/AIDS. It has distinguished itself globally by its handling of severe acute respiratory syndrome (SARS) in 2003 and by its response to the threat of avian influenza beginning in 2004 and accelerating in 2005 and 2006. For purposes of HIV/AIDS control, Vietnam is able to draw on its mass organizations (e.g., the Vietnam Women's Union and Vietnam Youth Union), which are connected to the highest levels of the Communist Party leadership but are also grounded in local communities. In addition, nongovernmental organizations (NGOs) such as the Buddhist Association are now making important contributions to HIV/AIDS control efforts. Taken together, these indigenous organizations possess enormous potential leverage for controlling HIV/AIDS if they receive sufficient resources and guidance.

In public health terms, Vietnam's HIV/AIDS epidemic is still at a concentrated stage—not yet a generalized epidemic—that is of manageable proportions. Under these circumstances, intensive, focused HIV-prevention efforts can stem the disease's spread. Three at-risk groups— injection drug users, commercial sex workers (and their clients), and men who have sex with men—account for most of the estimated 265,000 persons living with HIV in Vietnam. It is these groups, along with their sexual partners, that are at the highest immediate risk of the spread of HIV.

In the domestic political sphere, the Communist Party, the National Assembly, and the government have recently turned their attention seriously to the epidemic, introducing in 2004 a national AIDS policy strategy and enlarging the space for innovation and action, including allowing creation of associations of people living with HIV/AIDS.

The year 2006 appears to be a time of decision for Vietnam. A multiyear generational shift in Vietnam's national leadership is under way that may be further advanced by the 2006 Party Congress. A new national law on HIV/AIDS is expected to be approved by the National Assembly. In November 2006, Vietnam will host, for the first time, the Asia Pacific Economic Cooperation (APEC) summit, at which infectious diseases will likely figure as a priority regional concern and at which Vietnamese leadership will shape debate.

A not insignificant segment of the IDU population living with HIV is incarcerated—and therefore inaccessible—in rehabilitation centers (known as 06 centers; 05 centers are populated mostly by female sex workers). Within these incarcerated populations, a sizeable segment living with HIV—including some already sick with AIDS—is slated for release in 2006. The government is under intensifying pressure to outline how this population, once released, will be successfully integrated into home communities, avoid relapse into drug use and sex work, and receive adequate services for IDU and HIV/AIDS. For now, there are only partial answers. If this urgent challenge is managed effectively in 2006, new partnerships and models for access and care for this population could be put in place. If managed poorly, the resulting failure could set back Vietnamese and international efforts to slow the spread of HIV/AIDS in Vietnam and could seriously damage Vietnam's international image.

In the international sphere, donors are now stepping forward, increasing resources from \$5 million per annum in 2000 to over \$50 million in 2006, and developing new partnerships with the Vietnamese government, mass organizations, and nongovernmental

groups. At this juncture, insufficient funding is no longer a barrier to action for effective HIV prevention. Although AIDS care and treatment is relatively more costly, current and projected funding levels should allow relatively high coverage of infected people to be achieved, provided that effective prevention can soon slow the rate of HIV's spread.

The United States is to be commended for designating Vietnam, in mid-2004, as the 15th focus country in the President's Emergency Plan for AIDS Relief (PEPFAR). Since that moment, the United States has staked out an HIV/AIDS leadership position for itself, encouraged other donors to increase their engagement, and generated substantial new hope in Vietnam among Vietnamese, international NGOs, and implementing partners. International partners have improved their coordination in Vietnam, and among them the United States now carries a very considerable potential and responsibility to lead.

Why Are there Continuing Concerns?

More needs to be done, on an urgent basis, to improve the odds for success. The CSIS delegation's optimism about Vietnam's potential for success is tempered by serious concerns about the pace and focus of the current response to HIV/AIDS and related issues in Vietnam. Despite recent promising gains, the approaches taken by the government of Vietnam, the United States, and other donors still fall short of the comprehensive, strategic approach that is needed to achieve and sustain control over the spread and impact of HIV/AIDS. High-level leadership and oversight are uneven. Political and cultural barriers that block effective action need to be surmounted systematically.

The Centrality of Vietnamese Leadership

Vietnam's "Three Reductions Campaign" labels drug use and sex work as two of the "Three Evils" (crime is the third). This campaign has in recent years worsened an already deeply embedded stigma experienced by people in those risk categories, both those already living with HIV and those not yet affected. In this context, donors have remained hesitant and stepped only half-way forward in attempting to reach these key populations with the most effective approaches.

Stigma is clearly the most powerful obstacle and will require higher leadership engagement and a major cultural and attitudinal shift, if people already infected with HIV and the still-uninfected people in the high-risk populations are to be treated less as pariahs and more as deserving of compassion and public health intervention.¹ At Vietnam's national political level, certain critical policy and legal reforms are either stalled or not yet finalized. Most significantly, with respect to civil liberties, a strategy is lacking for transitioning persons out of rehabilitation centers into home communities and for creating effective programmatic approaches for dealing simultaneously with drug addiction and HIV/AIDS.

HIV-prevention efforts directed at IDUs need to operate inside rehabilitation centers. Syringe distribution programs have been implemented on a limited basis, primarily

¹ Delegation members heard on more than one occasion that, as is sometimes true in other countries, the stigma against HIV-infected people exists even among some Vietnamese health workers.

through internationally funded programs. Effective, community-based drug treatment programs (e.g., substitution therapies such as methadone and buprenorphine) have not been implemented despite the concentration of Vietnam's HIV epidemic among heroin injectors. Many infected individuals will need treatment for their drug dependence, care and treatment for their HIV infection, and education and access to condoms to avoid infecting spouses and other intimate partners. Vietnam has the opportunity to demonstrate a truly integrated response to these dual epidemics, yet there has been noticeable delay in the start-up of pilot methadone programs.

The Centrality of U.S. Choices

The United States itself has not yet fully or coherently come to terms, in Vietnam or elsewhere, with how best to reduce the risk of HIV and other infections (e.g., hepatitis C) among people who are injection drug users.

Judged on the basis of resource allocation, the U.S. approach in the high-prevalence, generalized epidemics in African countries has been—and remains—care and treatment intensive. Prevention efforts in those countries are broadly spread across society, and those prevention efforts follow the “A-B-C” approach (Abstinence–Be faithful–Condoms). Vietnam needs a prevention-intensive approach with a different focus in order to successfully address behaviors at the core of the epidemic—drug use, female sex work, and sex among men. Efforts to address this need have begun but still fall short of the scope, intensity, flexibility, and scale needed. There has been enduring hesitation and caution to directly tackle—and advocate that the Vietnamese tackle—these complex and difficult societal challenges.

The current U.S. approach in Vietnam features multiple, scattered programs. While programs may be effective individually, a coherent strategy is needed to effectively address the structural aspects of HIV/AIDS. Priority setting has not been well coordinated between the Office of the U.S. Global AIDS Coordinator (O/GAC) in Washington and the U.S. mission in Hanoi. In-country programming choice has been further limited by rules from Washington. For instance, one rule limits awards to any single contractor to no more than 10 percent of the total U.S. country budget, creating high administrative overheads and excessive internal coordination demands. As another example, the insistence that implementing NGOs contracted with U.S. funds overtly declare their opposition to commercial sex work has provoked reactions in Vietnam that have weakened the U.S. ability to address the reality of the spread of HIV through female sex work.

There is need for a concerted effort to accelerate the provision of affordable treatment, including antiretroviral drugs. A major lag that occurred in the delivery of essential medications and other critical inputs challenged U.S. credibility. As of the January 2006 delegation visit, Vietnamese manufacturers had not yet applied for approval of their antiretroviral medications through the U.S. Food and Drug Administration (FDA). While the new supply-chain management system may increase access to lower-cost FDA-approved generic products, the U.S. programs currently rely on higher-cost brand name products.

In terms of sustainable financing, the Vietnamese leadership has a legitimate concern over whether the United States will be committed over the long term to HIV/AIDS control efforts in Vietnam beyond the initial phase of PEPFAR, which commits U.S. support through September 2008. While reauthorization of the congressional legislation behind PEPFAR is widely expected, it is not guaranteed, and the process is not well understood by the Vietnamese government. A more coherent and transparent U.S. approach on this matter is needed.

The Critical Role of the United Nations

There has been significant progress by UNAIDS in coordinating international donors and agencies and in providing advocacy and technical support to the party, government, and international partners. The heads of UN agencies in Vietnam have high-level access to senior party and ministerial leaders, and their advice on HIV/AIDS policy, guidelines, and protocols is actively sought by the government of Vietnam. The United States, through PEPFAR, has begun funding some UN programs that show considerable promise. Serious consideration should be given to expanding these efforts in the future.

At present there is not sufficient common agreement on strategic priorities and responsibilities among donors, nor does Vietnam yet have a strategic plan of its own to coordinate and allocate resources. These are two critical areas where the emerging U.S.-UN partnership can and should concentrate.

In sum, while the combination of domestic and external monetary resources dedicated to HIV/AIDS is 10 times the levels of 2000, no clear targeted plan of action unifies the leadership and programs of Vietnam, the United States, the United Nations, and other donors. Rather, there are significant gaps in leadership, vision, reform, and coordination; an insufficient sense of urgency; and a lack of clear, strategic focus on the essential prevention, treatment, and care interventions required to adequately address the high-risk activities of IDU, FSW, and MSM.

What Key Changes Are Needed to Achieve Success?

For Vietnam, it is essential that the top political leadership and ministerial officials become more directly engaged in setting forth a vision for control of HIV/AIDS, in resolving difficult and enduring policy issues, and in directing a truly multi-sectoral approach.

Only high-level national leadership can effectively confront the deep stigma that surrounds HIV/AIDS and the high-risk behaviors at the center of the epidemic— injection drug use, female sex work, and men having sex with men.

Successfully addressing injection drug use will require balancing public security objectives with compassionate rehabilitation services, introducing substitution therapies, and bringing online HIV-prevention and AIDS- and IDU-care services that have been demonstrated in other settings to reduce transmission of HIV.

Successfully addressing the issue of female sex work will require establishing a comprehensive program to decrease the number of women entering sex work, increasing

effective access to condoms and the power to insist on their use, empowering women to leave sex work, and finally, reducing the demand for commercial sex services.

These shifts require clear communications from the leadership to the Vietnamese public and expedited national legal and policy reforms that strengthen the rights of both individuals and the emerging associations of persons living with HIV/AIDS.

They require concrete steps that begin to resolve the clash between public health and public security objectives. And they require concrete steps that clarify how the rehabilitation centers for FSW and IDU are to be managed in a way that is both rights sensitive and effective at addressing the associated public health problems of IDU and HIV/AIDS that have grown in their midst. Solutions must be informed by a credible plan to prevent HIV infections within these centers, treat those who are already infected at the time they enter, and finally, transition incarcerated residents to a new lower-risk life outside rehabilitation centers.

For the United States, it is essential that it quickly capitalize on its early achievements by championing a more robust, comprehensive approach.

That expanded approach requires that the United States clearly affirm to its Vietnamese and international partners the long-term U.S. commitment to sustain its engagement to control the spread of HIV in Vietnam through effective prevention efforts and to emphasize care and treatment programs delivered in a way that does not undermine the critical prevention activities.

To be effective, however, it will be essential to place high-risk activities—IDU, FSW, and sex between men—with scaled-up and well-targeted prevention, care, and treatment interventions squarely at the center of U.S. strategy. This emphasis will require overcoming squeamishness and working out with Vietnamese leadership and international partners an agreement on a common approach.

Success requires making a clear commitment to assist the Vietnamese to reach high-risk populations where they are—including meeting the dire humanitarian needs of those in rehabilitation centers—and to develop effective social and community services and other bridging strategies for transitioning these populations into better life opportunities while ensuring ongoing access to adequate care, treatment, and prevention services.

Success requires substantially accelerating the delivery of adequate, reliable volumes of affordable antiretroviral drugs and other essential medications. This should include working with Vietnamese manufacturers to enter the fast-track qualification process recently established by the FDA for just this purpose. For instance, the U.S. government should send an FDA team to Vietnam to explain and facilitate the process, similar to an FDA team sent to India and South Africa at the beginning of their processes.

Success requires working effectively and formally to coordinate U.S. activities with those of Vietnamese and other agencies in accordance with the “Three Ones”—one national HIV/AIDS coordinating authority, one national plan, and one monitoring/evaluation system. Success in this aspect will depend on intensified engagement with the UN system in Vietnam, which is well positioned to play a leadership role in this effort.

And finally, success requires establishing a more effective U.S. decision structure, centered in Vietnam.

This last point can be accomplished by lengthening U.S. planning horizons and by providing greater U.S. flexibility to adapt to local circumstances. Some current requirements, apparently created with heavily impacted, high HIV-prevalence countries in mind, are obstacles to the U.S. ability to help the Vietnamese create programs to effectively prevent or reduce HIV transmission. Odds of success will be enhanced if decision power resides in a senior coordinator based in the U.S. mission in Vietnam,² and if a way forward can be found to address the deadlock around condom distribution borne of the belief that the anticommercial sex work declaration prevents condom distribution to sex workers and their clients.

² This step has apparently been agreed to since the January 2006 CSIS delegation visit to Vietnam.

The Spread and Impact of HIV/AIDS in Vietnam

The Spread of HIV/AIDS

Vietnam's HIV epidemic is still highly concentrated in high-risk populations, but it has clearly entered a rapid growth phase. Because it is still early in the epidemic, with many more people becoming infected than dying each year, HIV prevalence will continue to rise. Nonetheless, Vietnam has an unprecedented opportunity to rapidly apply and scale up effective prevention interventions to contain and reduce the spread of HIV. If effective prevention programs are not quickly put into place, a much larger epidemic could yet emerge. Among developing countries, Vietnam's surveillance system is considered to be one of the strongest and most reliable. Yet there are still a number of unknowns that make measuring the spread and impact of HIV/AIDS more difficult and that ultimately will hinder effective prevention programming.

The first report of HIV by the Ministry of Health (MOH) in Vietnam was in 1990. Since then, the number of Vietnamese reported with HIV has grown to more than 102,000.³ However, reported cases represent less than half of those living with HIV/AIDS. The MOH estimates that in 2003 there were approximately 215,000 HIV-infected people in the country, representing an adult (15–49 years old) prevalence of 0.44 percent.⁴ In the same report, it was estimated that 39,000 Vietnamese become newly infected each year, a number close to the estimated 40,000 new infections in the United States each year.⁵ Based on these estimates, there are today more than 300,000 people living with HIV in Vietnam.

The magnitude of the epidemic varies greatly from province to province in Vietnam. HIV prevalence in Ho Chi Minh City (1.2 percent), Hanoi (0.7 percent), Hai Phong (1.1 percent), and other urban areas is comparatively high, while prevalence in the country's central provinces remains low. Ho Chi Minh City alone has reported about one-fourth of all HIV-infected people in Vietnam to date.

Injection drug users (IDUs) are by far the largest population of HIV-infected people in Vietnam (53 percent of reported HIV infections are among IDUs), most of whom inject heroin. Like Thailand and China, HIV prevalence among IDUs began rising

³ Socialist Republic of Viet Nam, *Second Country Report on Following Up to the Declaration of Commitment on HIV/AIDS*, adopted at the 26th UN General Assembly Special Session (UNGASS) (Hanoi: Socialist Republic of Vietnam, January 2006), p. 4, http://www.unaids.org.vn/resource/topic/natstrat/ungass_17jan06_e.pdf

⁴ An online publication from the World Health Organization (WHO), dated December 2005 but released in March 2006, estimated the 2005 prevalence to be 0.5 percent based on "national estimates." See "Summary Country Profile for HIV/AIDS Treatment Scale Up," WHO, Geneva, <http://www.who.int/hiv/countries/en/index1.html>.

⁵ A 2005 MOH report on the future of the HIV epidemic in Vietnam estimated that, in the absence of a stronger HIV-prevention program, approximately 40,000 people would become infected with HIV each year (incidence) making the estimate of HIV case load in Vietnam approximately 319,000 at the end of 2006. The same report also warned that AIDS-related illnesses and deaths will climb rapidly in coming years and that HIV will spread more rapidly through sex work and husband-to-wife (or other heterosexual) transmission.

sharply in Vietnam in the late 1990s and now exceeds 70 percent in some places. Alarming, the epidemic of drug use is continuing, and the number of IDUs, today estimated between 128,000 and 183,000, continues to rise. Although data are scarce, HIV prevalence among IDUs currently detained in rehabilitation centers is estimated at 50 to 70 percent, and some already have AIDS. These numbers add urgency to the need to address HIV/AIDS and IDU in a comprehensive manner.

Another population of concern is female sex workers (FSWs). Although FSWs only represent 3 percent of all HIV-infected people reported in the most recent surveillance data, the prevalence of HIV infection among FSWs has risen sharply since the late 1990s to 6.5 percent nationally and higher in some provinces. In addition, the proportion of women who acknowledge their involvement in sex work rose 10-fold between 1994 and 2001, and an increasing number of FSWs are also injection drug users.

Recent data indicate rising numbers of HIV infections among women who are not in any of the officially acknowledged HIV/AIDS risk groups. Not surprisingly, the numbers of children infected through mother-to-child transmission of HIV have also begun increasing. These increases suggest that many of these newly infected women are sex partners (including spouses) of either male IDUs, men who are FSW clients, or men who have sex with men (MSM, many of whom are bisexual).

Although these and other trends are clear, some important surveillance gaps remain in assessing the magnitude and spread of HIV. For example, more than a third of HIV-infected people reported in the surveillance system, including the surveillance categories of blood donors, tuberculosis (TB) patients, and “AIDS suspects,” do not have a transmission source indicated for their HIV infection. There are no surveillance categories for MSM, for male clients of FSWs, or for women who are sex partners of IDUs.⁶ These gaps limit the usefulness of surveillance data for HIV-prevention program planning or for program evaluation.

With U.S. government assistance, Vietnam has made major strides in recent years in establishing HIV counseling and testing services, with as many as 60 sites in operation in early 2006. Many of these sites are linked with peer education programs and are able to target their services to high-risk populations such as IDUs, FSWs, and MSM. While this expansion of services is laudable, HIV counseling and testing services are still not accessible to most of Vietnam’s population.

Behavioral and Other Risk Factors

Some of the risk behaviors important in the spread of HIV (e.g., IDU, FSW, MSM) have not been systematically or reliably assessed on a population basis, at least in part because they are criminalized and/or highly stigmatized behaviors. However, some limited data are available. For example, the recent Survey Assessment of Vietnamese Youth⁷ reported that a very high proportion of Vietnamese youth are aware of the dangers of HIV/AIDS itself. However, the survey also indicated lower levels of accuracy in youth knowledge of

⁶ In an increasing number of countries, the categories of MSM, FSW, and sex partners of IDUs are included as risk behaviors.

⁷ See, UNICEF Vietnam et al, *Survey Assessment of Vietnamese Youth* (Hanoi: UNICEF Vietnam, August 2005), http://www.unicef.org/vietnam/media_2383.html.

how to prevent infection. In addition, more than 21 percent of young men interviewed acknowledged having had sex with an FSW. In general, school-based education about HIV/AIDS, beyond a few pilot programs, has reached only a small proportion of the school-age population, and its effectiveness in Vietnam is unknown.

Finally, Vietnam's National Institute of Hygiene and Epidemiology has developed an integrated HIV/AIDS behavioral and biological survey (IBBS) to obtain better information on trends in HIV/AIDS knowledge and risk behavior. Eventually, the IBBS is likely to become an important supplement to the HIV/AIDS sentinel surveillance system.

The Impact of HIV/AIDS

HIV is already having a substantial impact on Vietnam. Approximately 30,000 AIDS-related deaths had already occurred by 2003, the last year for which data are publicly available, and many more people have certainly died since that year. There are striking increases in the numbers of hospitalized AIDS patients in most of Vietnam's urban areas. But the actual number or proportion of hospital or clinic beds occupied by people with AIDS-related conditions—data that could estimate the current magnitude of HIV/AIDS burden on the health system—is not yet available.

The estimated numbers of people on multidrug highly active antiretroviral treatment (HAART) remain low, approximately a thousand at the time of the CSIS delegation visit.⁸ However, the numbers of HAART programs—and numbers of people being treated—are expected to increase rapidly over the course of 2006, as programs supported by the U.S. government and other donors are progressively implemented. Because much of Vietnam's HIV/AIDS epidemic remains largely hidden, the number of HIV-infected people who presumably could benefit from HAART is not known. Estimates ranged from 25,000 (WHO/UNAIDS) to 39,500 (Ministry of Health) at the end of 2005. However, a major voluntary counseling and testing (VCT) site in Ho Chi Minh City is registering a 45 percent infection rate among newly arrived clients, and many of those clients already have advanced AIDS. This striking finding suggests that the actual population of HIV-infected people requiring HAART may be larger than most estimates to date. If this proves to be true, early HAART treatment capacity could be quickly overwhelmed by the numbers of ill patients needing care, as has happened in other countries.

What Else Don't We Know about HIV/AIDS in Vietnam?

Several questions are repeatedly raised regarding the nature of the spread of HIV/AIDS in Vietnam. Will Vietnam develop an epidemic comparable to that of Thailand, Cambodia, or Burma? Could there eventually be a generalized "African style" HIV/AIDS pandemic in Vietnam? How much will HIV/AIDS add to the country's health burden? How much could HIV/AIDS undermine the country's striking progress in economic development? While these and other key questions cannot be answered at the moment,

⁸ The same World Health Organization (WHO) publication noted in footnote 3 estimated that sufficient antiretroviral medications had been distributed to the provinces in 2005 to treat 3,000 to 3,500 people. Numbers of people actually known to be under treatment were not provided.

continued expansion of HIV/AIDS surveillance and behavioral surveillance activities can clarify the nature and magnitude of such threats.

TB and HIV, when they exist together, make the successful treatment of the other infection more difficult. In many other countries, the spread of HIV has had a deleterious impact on national TB control efforts. While limited information is available systematically describing the proportion of people under treatment for TB in Vietnam who are coinfecting with HIV, recent agreements between TB and HIV programs give reason for optimism on future collaboration.

Some sporadic data suggest that many of the HIV-infected IDUs are also infected with hepatitis C, itself a serious infection and one that is more severe—and perhaps less responsive to antiretroviral treatment—in people coinfecting with both viruses; however, the CSIS delegation was not presented with any population-based data on HIV–hepatitis C coinfection.

Although there are male sex workers in Vietnam, their numbers and HIV risks are not known. However, those HIV risks could be substantial and should be examined.

Although the delegation was told that drug dealers are sent to prison rather than to rehabilitation centers, the delegation was unable to find information about HIV/AIDS programs within prison populations. This issue may be important because prisons in other countries have acted as transmission amplifiers for HIV/AIDS, TB, and other diseases.

Finally, while there was some discussion about HIV risks associated with reuse of needles and syringes for injections of antibiotics or other medication in medical or pharmacy settings, the delegation was unable to identify information clarifying the existence or magnitude of this problem.

In summary, having accurate information on the spread and impact of HIV/AIDS is not by itself sufficient to ensure an effective response in the absence of a comprehensive approach to the complex societal issues posed by the spread of HIV. But there is little doubt that such information can help motivate policymakers and society to respond and can contribute immensely to the precise targeting of effective control efforts once the decision to mount such a response has been made.

While some of the important information necessary to craft an effective and comprehensive HIV/AIDS response in Vietnam is not yet available, the absence of such key information should not be an obstacle to beginning *now* to expand effective prevention and care programs for people and groups already identified as at risk or as HIV infected. However, strengthening surveillance capacities, including collecting information on HIV/AIDS-related deaths, and expanding surveillance to all provinces of Vietnam will be an important component of the HIV/AIDS response and will greatly enhance the ability of Vietnamese and those working to assist them to act comprehensively over the longer term.

Male-Male Sex and HIV/AIDS in Vietnam

Although male-male sex is not a criminalized behavior in Vietnam, it is highly stigmatized. A general discomfort with addressing the topic of men having sex with other men is at least part of the reason that this particular HIV/AIDS risk behavior has not received much official attention in Vietnam.

Actual numbers of MSM are unknown, and since the national surveillance system does not currently have an MSM category, the HIV/AIDS burden in this population is also unknown. Despite that lack of attention and information, data from several small studies indicate that HIV-transmission risks among Vietnamese MSM, including male sex workers, could be substantial:

- A 2001 survey in Ho Chi Minh City reported that less than one-third of MSM questioned were aware that MSM were at higher risk of HIV infection than heterosexual men.
- An 8 percent prevalence of HIV was found among 600 MSM in Ho Chi Minh City in 2004.
- 22 percent of MSM in Vietnam reported buying sex from other men, while 31 percent of MSM had sold sex.
- In another study, a group of male sex workers in Hanoi reported that most of their clients were Vietnamese.

Bisexuality is another complicating issue for MSM and their sex partners. In one recent study, 22 percent of MSM in Ho Chi Minh City had reported also having sex with women. This perspective was confirmed in part when delegation members heard from peer educators at Ho Chi Minh City's Blue Sky Club, one of only a few MSM-support facilities in the country, that a number of MSM known to them were also married to women. Unknowing spouses of MSM therefore may also be at increased risk of HIV infection.

While wholesale changes in societal attitudes will not occur quickly, some steps can be taken now to begin to address this issue. For example, MSM can be included as a category in Vietnam's national HIV/AIDS surveillance system. Health workers providing primary care can be educated about MSM and their specific health needs. The numbers and coverage of health and social service programs and trained staff delivering services to MSM populations can be expanded as new information indicates a need. Services in this case include not only voluntary HIV testing and counseling but also diagnosis and treatment of other sexually transmitted infections, as well as distribution of risk-reduction counseling, condoms, and water-soluble lubricants. Finally, national leadership should ensure that neither care providers nor their MSM clients are put at risk by law enforcement authorities.

Response of Vietnamese Leadership

The leadership of Vietnam is at a critical transition point in its evolving efforts to control HIV/AIDS. Several big decisions lie on the horizon. In the view of the CSIS delegation, 2006 provides an exceptional opening for the United States and other donors to inform discourse and help Vietnam make the best choices to prevent a larger, even more threatening national HIV pandemic from emerging.

The Vietnamese leadership has undertaken multiple positive initiatives since the beginning of the decade that have expanded capacities and services, fostered a more open discussion of the challenges of controlling HIV/AIDS, and begun to address the deep stigma that surrounds the behaviors associated with greatest risk: injection drug use, female commercial sex work, and men having sex with men. The leadership has increasingly signaled its willingness to open and expand the dialogue on sensitive subjects such as the role of rehabilitation centers and alternative strategies, for instance introducing pilot substitution therapy programs. It has entered multiple new partnerships with donors: in the past two years, the UN, the World Bank, the Asian Development Bank, AusAID, the UK Department of International Development, and the United States, among others, have all expanded HIV/AIDS programs. And the government has begun to expand its public health infrastructure by fostering the operations of nongovernmental groups, including associations of persons living with HIV/AIDS, as a key component of that strategy.

There are several distinctive factors in Vietnam that provide significant advantage with respect to public health and that could contribute positively to HIV/AIDS control efforts.

A sense of optimism and progress today pervades Vietnam. The country possesses impressive, enduring capacities in its health system. Its population has high literacy (over 90 percent), and Vietnam's strong health indicators make it comparable to many middle-income countries. Building on past success, the government of Vietnam has continued to attract over \$200 million per annum in external donor support to health programs. In 2003–2004, Vietnam demonstrated its ability to control SARS, and more recently in 2005–2006, it has performed in a similarly impressive way in dealing with avian influenza. Neonatal tetanus has been virtually eliminated as a public health problem. In November 2006, Vietnam will for the first time chair the Asia Pacific Economic Cooperation summit. That meeting will provide an historic opportunity for Vietnam's leadership to promote coordinated international action on infectious diseases that threaten the region.

Positive Momentum Is Building

Recent progress in Vietnam on HIV/AIDS has been manifest in several ways.

National strategy: A national strategy on HIV/AIDS, developed through an active interministerial process with quiet input from external experts, was ratified and introduced in 2004. Thereafter, Vietnam's deputy prime minister assumed the formal duties of leading a national coordinating body. A recent directive of the Communist Party's Central Committee (number 54, issued November 30, 2005) highlighted the

expanding threat that HIV/AIDS poses to Vietnamese society. The directive emphasized a number of imperatives: to strengthen national prevention and control efforts through party structures, government agencies, and mass organizations; to concentrate prevention on youth, adolescents, and high-risk groups (IDUs, FSWs, and MSM); and to actively “prevent stigma and discrimination towards persons living with HIV/AIDS.” At the same time, a policy of decentralization has created the opportunity for public health leaders in Ho Chi Minh City, where 25 percent of those reported with HIV reside, to launch innovative plans for prevention, treatment, and care. Quietly, officials have signaled their recognition that heavy reliance on 05/06 rehabilitation centers is not succeeding. They have begun to seek external help in stemming what is at risk of becoming a public health emergency and what could easily become a public relations calamity, the continuing and expanding linked epidemics of injection drug use and HIV/AIDS.

Strengthening surveillance: Vietnam’s HIV/AIDS surveillance system has extended its reach to more provinces and sites. Though still limited in its coverage and reliability, it is nonetheless superior to surveillance systems in many other developing countries and is capable of forecasting major trends in the HIV/AIDS epidemic. Additional expansion and fine tuning of the surveillance system can make it even more useful.

Expanding numbers of trained personnel: The number of Vietnamese working on HIV/AIDS programs has more than doubled in the past five years. In comparison to only five years ago, Vietnamese staff in the national government, the Ho Chi Minh City government, and nongovernmental implementing groups are significantly more experienced, knowledgeable, and better trained on how to implement HIV prevention, care, and treatment programs. In addition the Ho Chi Minh Political Academy has begun training future national leaders on HIV/AIDS policy issues.

Expanding voluntary HIV testing and counseling: In 2001, there were few opportunities for anyone in Vietnam to be tested and learn their HIV status. Trained counselors were essentially unavailable in the country. By early 2006, national and local health authorities were supporting more than 50 voluntary counseling and testing (VCT) sites with trained counselors who have provided thousands with services. In comparison with many other countries, the Vietnamese VCT program provides more comprehensive services and is more targeted to high-risk populations. VCT sites are often closely linked to peer outreach programs and can be effective in reaching “hidden” populations such as MSM. Unlike other countries, Vietnam’s program in some provinces includes reaching, counseling, and confidentially testing sex partners of people found to be HIV infected. The experience gained in this innovative approach to VCT can be used to expand this important practice across the country.

Expanding care and treatment: In 2001, outside of services from a few private physicians and small programs at the tropical hospitals, the HIV/AIDS care and treatment program in Vietnam had very low coverage, and antiretroviral therapy was unavailable. By 2006, the infrastructure for care and treatment programs had progressed substantially. Currently, such programs in Vietnam are poised to reach thousands, but await sufficient antiretroviral drugs to become available. If access to generic drugs can be arranged, greater numbers of people will be served, but these numbers may still fall far short of those that will be or can be identified as being in need of treatment. Furthermore, many Vietnamese officials and others involved in the program expressed concerns that the

PEPFAR program will not continue beyond 2008 and that people put on HAART in the next several years will not be maintained on lifelong treatment.

Small-scale efforts reach at-risk populations: In 2001, the government of Vietnam was still reluctant to admit that there were thousands of sex workers and MSM in the country. Today, government authorities are clearly more open to discussing the existence of these groups and the need to reach at-risk populations with prevention interventions that reflect local adaptations of international best practices. Outreach programs supported by the Centers for Disease Control and Prevention (CDC) and the U.S. Agency for International Development (USAID) have demonstrated their capability to work with these populations; the USAID-supported program has already reached more than 4,500 MSM in Ho Chi Minh City alone, with many accepting counseling and testing. However, overall, VCT programs in Vietnam still have low levels of coverage and are reaching only a small fraction of those in need.

Involvement of the Vietnamese military: Although initially small, the military's HIV/AIDS program seems both ambitious and well planned, with a goal of reaching 40,000 service members and 160,000 dependents by the end of this fiscal year.

Challenges Ahead

Despite these gains, the Vietnamese leadership's record remains mixed and the policy environment uncertain.

Lack of a comprehensive approach: Operational leadership on HIV/AIDS remains the domain of the Ministry of Health, but a more multi-sectoral approach, backed by sustained high-level party leadership, has been missing. No strategic plan has been put in place that sets clear goals, directs the allocation of resources, and reconciles the tensions, explored below, between public security and public health. A national law is still awaited to enshrine new legal protections for HIV-infected people—including the confidentiality of testing results—and to outline an approach to national insurance.

Stigma remains an overriding concern: People living with HIV/AIDS are highly stigmatized in Vietnam, regardless of how they became infected, leading to reluctance to seek prevention, testing, and treatment services. Those who are identified as HIV-positive face expulsion from work and family, leading to less stable living situations that can often lead to continued risk behaviors and therefore to an expansion of the epidemic. Government policies and legislation, backed by rigorous education and enforcement, are needed to protect people from discrimination.

Continued clash of policy interests: the government of Vietnam is most profoundly challenged by the persistent clash between two opposing policy interests: the imperative to control burgeoning crime, especially drug use and sex work, for which HIV/AIDS is seen as a secondary, derivative phenomenon, and the public health imperative to control an expanding HIV/AIDS epidemic, which for the moment happens to be concentrated among IDUs, FSWs, and MSM. Reducing the tension between these two national policy interests is the single greatest challenge before Vietnam in its evolving efforts to control HIV/AIDS. Without high-level action to better reconcile these tensions through a strategic and comprehensive approach that succeeds at all levels of government and

U.S Military Support for HIV/AIDS Activities in Vietnam

The involvement of the U.S. military with HIV/AIDS activities in Vietnam began in February 2003, when the Military Medical Department of Vietnam's Ministry of Defense (MOD) agreed to have HIV prevention included among topics presented at a joint military medical conference in Hanoi. The Center of Excellence in Disaster Management and Humanitarian Assistance (COE), Tripler Army Medical Center, and the University of Hawaii's Hawaii AIDS Clinical Research Program (HACRP) received \$330,000 from the U.S. Department of Defense HIV/AIDS Prevention Program that year to support collaborative military-to-military HIV-prevention activities. By mid-2004, Vietnam had been named the 15th PEPFAR country, and joint military HIV-prevention activities between the U.S. Pacific Command (PACOM) and the People's Army of Vietnam (PAVN) were successfully written into the FY 2004–FY 2006 PEPFAR Country Operational Plans.

Military-to-Military HIV/AIDS Activities

PACOM support funded travel of approximately 15 Vietnamese military physicians to the PACOM/Royal Thai Army/Armed Forces Research Institute of Medical Sciences (AFRIMS) Regional Training Center in Bangkok. The training to date has included HIV counseling, HIV laboratory diagnosis, policy development, and HIV care and treatment. Physicians trained in these courses are currently providing care to HIV-infected persons at the military's Hospital 175 in Ho Chi Minh City. Following a PAVN request, a policy-advocacy workshop for approximately 80 senior medical leaders was held in Hanoi at the Military Institute of Hygiene and Epidemiology (MIHE) in April 2004, and a counseling workshop was held for 80 military medical providers at Hospital 175 in Ho Chi Minh City in September 2004. PEPFAR funds were used to renovate and partially equip the HIV laboratory at MIHE in April 2005. Additional purchased equipment is pending delivery.

The first group of Vietnam military medical providers received month-long HIV clinical preceptorships at the HACRP, Tripler Army Medical Center, and AFRIMS in January 2006. A total of six groups are being trained in HIV care and treatment. In addition, two groups of persons have now received laboratory training at AFRIMS in HIV diagnosis, CD4/CD8 counting, immunophenotyping, viral load measurement, and quality assurance, with six additional groups scheduled for training. Five new CD4 lymphocyte counters have been purchased with PEPFAR funds for the Ministry of Health. The Blood Bank at Military Hospital 103 and the diagnostic capabilities at the Center for Preventative Medicine in Can Tho have been assessed, and renovations are underway at Hospital 103 for an improved Blood Bank and a new Voluntary Counseling and Testing Center.

In December 2005, PAVN held its first HIV/AIDS workshop for senior line officers, with about 400 senior officers attending. A new and ambitious policy directive (the "five 100s") was issued: (1) 100 percent of Army units will have an HIV/AIDS-control program; (2) 100 percent of soldiers will know about the methods and importance of HIV prevention; (3) 100 percent of recruits will be screened for HIV prior to entry; (4) 100 percent of blood transfusion units will be screened for HIV; and (5) 100 percent of HIV-infected soldiers and dependents will be treated by antiretroviral drugs using international standards.

This policy largely moves the MOD in line with the national HIV/AIDS plan created by the civilian parts of the government.

Progress and Obstacles with Military-to-Military Cooperation

Vertical integration of the Military Medical Department within the MOD and the requirement that U.S. military activities be entirely within approved structures of the MOD have meant that coordination of all military-to-military activities is greatly simplified. It also means that various activities can be coordinated and replicated across MOD organizations. However, several other aspects of organization within—but not unique to—MOD pose potential problems for effective engagement in HIV prevention, care, and treatment.

In addition to U.S.-supported programs, the MOH also has HIV/AIDS programs supported by the UK Department for International Development (DFID), the Global Fund, and AusAID. Each contributes to HIV/AIDS care, treatment, and prevention. However, there is significant “stove-piping,” and it is not clear to what extent the different programs are coordinated. In addition, there is little apparent collaboration or formal cooperation at a ministerial level between MOD and MOH, although informal collaboration sometimes occurs.

MOD, a more “powerful” ministry than MOH, participates in PEPFAR discussions with MOH but does not consider MOH priorities to be its own. MOD has been disinclined to integrate or coordinate its programs and activities with those of MOH or the Ministry of Labor, War Invalids, and Social Affairs (MOLISA), resulting in geographic “redundancy” of operations.

Finally, great attention is now being focused on the important issues of HIV diagnosis and access to effective antiretroviral treatment programs. As these activities progress, however, it will be important to maintain a consistent U.S. message with the Vietnamese military about the ultimate importance of successful HIV-prevention efforts.

The openness of the Vietnamese military medical leadership to U.S. engagement in HIV/AIDS activities provides an important opportunity for building additional trust between the United States and Vietnam. In addition, continuing support to the ongoing military-to-military HIV/AIDS collaboration is particularly important because the well-planned MOD programs could ultimately serve as models for other ministries.

society, Vietnam’s policy and operational environment will seriously limit how far, and how much, donors and Vietnamese agencies and groups can accomplish in bringing to scale effective prevention, care, and treatment programs best fitted to Vietnam’s realities.

Heavy but unsuccessful reliance on rehabilitation centers to address the IDU and female sex work issues: the anticrime imperative dominates the “Three Reductions Campaign” that labels drug use and commercial sex work (general crime is the third) as two of the “Three Evils.” This approach worsens stigma, accounts for at least some of the continued resistance to the introduction of pilot substitution therapy programs (which have been under discussion for use in Hai Phong), and undergirds a heavy reliance on rehabilitation centers for IDUs and FSWs (06 and 05 centers, respectively).

In recent years, the population in these centers (approximately 80 camps for IDUs) has varied between 40,000 and 80,000. People, most of them young, are confined through judicial/police action and family and community referrals. Although the delegation was able to visit only one such center, members heard repeatedly that there is significant variation from province to province in the quality and conditions of the centers. Some centers provide vocational training and have reasonable medical facilities available. But the delegation was concerned to hear that most centers have only limited services and that HIV-tested residents do not always receive their test results.

Pressures are mounting to clarify whether and how Vietnam will modify its approach to rehabilitation centers to provide prevention, care, and treatment services to injection drug users and female sex workers inside the centers before they are released back to their local communities. Further, the government will need to devise credible transition plans to move the estimated 15,000 to 18,000 persons scheduled for release in 2006 into a

The Women's Union and Empathy Clubs of People Living with and Affected by HIV/AIDS

The Vietnam Women's Union (VWU), which includes among its members at least 50 percent of all women in Vietnam who are older than 18 years, has been involved with HIV/AIDS prevention and care issues since 1999. The strategic focus of VWU itself is empowering women through education, training, and micro-finance. VWU, which has called persistent gender inequity in the society a major challenge to be faced, was involved with the establishment in 2005 of the National Center on Women, AIDS, and Reproductive Health. VWU groups have also been involved with anti-stigma activities, anti-trafficking activities, and with distribution of condoms and clean needles and syringes.

One of several major initiatives being promoted by VWU is the concept of the Empathy Club (EC). The more than 300 ECs are groups of women working locally with people living with HIV and AIDS (PLWHA) and their families to help counteract stigma, to build local capacity for self-help, and to provide direct care and support. ECs, which were operating in 10 provinces in early 2006 with plans to expand to others, comprise PLWHA, their spouses and other family members, and other interested volunteers; each is governed by a local board of directors. Depending on availability of local resources, activities of ECs with PLWHA and affected families can include: direct provision of food and school fees; group and individual meetings to provide emotional support; advocacy on behalf of PLWHA and families with local authorities, including support for care and treatment access; provision of guidance on good nutrition, palliative care, and traditional medicines; and finally, help with funerals.

After a recent evaluation, VWU has decided to begin integrating EC activities with other VWU programs (e.g., poverty reduction, family planning, micro-credit, etc.) as a way of facilitating greater access to ECs.

During the January 2006 visit, delegation members met in Hanoi with VWU president Mme. Ha Thi Khiet and her senior staff and later met with members of the Wives and Mothers Club, a local EC in Hai Phong City, to learn more about their individual and family experiences. Delegation members were impressed with the gravity of the situations being faced by these families of PLWHA and by the dedication of the EC members to their support goals and activities.

new life outside the centers. How they will be cared for is currently unknown. A high proportion (30 percent or more) of these persons live with HIV, and many are likely to have already progressed to AIDS. The government will also need to clarify whether the political will exists to lower and eventually phase out official reliance on this model of IDU and FSW control, which has proven ineffective in controlling crime, which has IDU recidivism rates of 80 percent or higher, and which is generally agreed to be serving as an accelerator for transmission of HIV and other infectious diseases. There is reportedly a shared sense among those who staff the centers, government officials, and international experts that the centers are not effective in reducing drug use or female sex work. Nonetheless, the delegation was told that more centers are being built.

At present, IDU remains the driving force behind the spread of HIV/AIDS in Vietnam. Yet little apparent progress has been made in preventing IDU, reducing its infection risks, or effectively treating drug abuse. Global efforts directed at HIV prevention among IDUs have clearly and repeatedly demonstrated that expanded access to needle and syringe exchange programs is effective in reducing the spread of new HIV and other infections.

Such exchange programs are cost effective and can effectively serve as linkages to drug treatment, HIV care, and other health services.

Expanded U.S. Engagement

The June 2004 designation of Vietnam as the 15th focus country in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was a commendable step that creates great promise for Vietnam. Beginning in 1999, the Centers for Disease Control and Prevention had put in place a small but important U.S. HIV/AIDS program that focused on the technical and policy aspects of HIV/AIDS surveillance, counseling, and testing and operational research. Functioning within the Ministry of Health, that initiative created considerable good will and important professional linkages. The subsequent decision to make Vietnam a PEPFAR focus country built upon the CDC platform, added a USAID and U.S. military component, and significantly raised the stakes. It was suddenly possible to imagine that the early U.S.-Vietnamese partnership to combat HIV/AIDS could be expanded onto a national scale.

In the four months of FY 2004 that remained after the initial PEPFAR announcement, Vietnam received \$17.3 million in U.S. assistance, followed by more than \$27 million in FY 2005. Projected funding for FY 2006 is approximately \$34 million, although over \$21 million of that amount remained unallocated as of March 1, 2006, pending final approval in Washington of the Country Operational Plan for FY 2006.

In the nearly two years that the PEPFAR program has been evolving in Vietnam, the United States has staked out a leadership position for itself, encouraged other international donors to increase their engagement, and generated substantial new hope in Vietnam among Vietnamese, international NGOs, and implementing partners. A talented, enthusiastic, and committed U.S. country team has worked overtime to develop programs, aided at different points by expert teams from Washington and Atlanta. In this period, international partners also improved their coordination, in part owing to U.S. leadership, frequently in partnership with the United Nations.

In this same two-year period, however, the United States has also struggled, with only partial success, to surmount several difficult challenges. Some are policy and political obstacles within Vietnam itself; others are rooted in U.S. institutional and political considerations. As a consequence, the United States has not been able to take the lead in a robust effort to reduce HIV-infection risk among injection drug users and female sex workers. Instead, the U.S. approach has featured a number of diverse programs that may be effective individually but cumulatively do not add up to the strategic approach required for success in Vietnam: namely, a focused, prevention-intensive approach that addresses in a comprehensive way the behaviors at the core of the epidemic—unsafe injection drug use and unprotected sex between commercial sex workers and their clients and between men who have sex with other men. Nor has it been able to meet the humanitarian and public health imperative of reaching those living in the rehabilitation centers with effective HIV prevention and AIDS care and treatment.

Taking the critical dual steps of prioritizing IDUs, FSWs, and MSM and bringing effective HIV/AIDS prevention and care interventions to people living inside the 06 and 05 centers has proven difficult to date for the U.S. team in Washington and Hanoi. It requires managing—smartly and sensitively—the political risk that stems from the complex human rights issues associated with the 05 and 06 centers. Doing so requires a

well-thought out comprehensive action plan; a clear and forceful understanding of what is at stake, in humanitarian and public health terms, in reaching—or not reaching—the vulnerable populations inside these centers and helping them transition out of these sites; and a durable consensus between managers in Washington and U.S. embassy personnel in Vietnam. These pieces were not yet in place at the time of the CSIS visit, but there has been continued progress in each aspect and hope of a comprehensive resolution in the near term.

With sufficient political will and focus, a successful U.S. approach can be crafted in Vietnam that includes a defensible, comprehensive, and scaled-up approach to HIV prevention, including working within the rehabilitation centers with both HIV-infected and uninfected youth. That approach will also involve reaffirming to Vietnamese partners the long-term nature of U.S. commitments on prevention, treatment, and care; intensifying prevention activities focused on youth; accelerating the delivery of adequate, reliable volumes of affordable medications; pressing ahead on comprehensive care and access to effective treatment for heroin injectors; and putting in place in the U.S. embassy in Hanoi a senior-level decision structure.

In sum, there are urgent, compelling humanitarian and public policy reasons to support comprehensive HIV prevention and other health activities—including drug treatment itself—among Vietnam’s injection drug users, both inside and outside the 05/06 centers. There are complex—and very real—human rights concerns that will require equally careful attention. However, a comprehensive approach to IDU and sex work inside and outside the centers is imperative and eminently defensible. It is ultimately a matter of doing the right thing on public health and humanitarian grounds and having the sustained political will to carry through.

The high HIV prevalence among residents of the 05 and 06 centers probably means that many already need HIV/AIDS care. The high HIV prevalence also identifies an important objective for HIV-prevention activities—to minimize the further spread of HIV to their spouses and other intimate partners after their release from the centers. HIV-infected IDUs who are not treated for their drug addiction (both before and after their release) in a comprehensive way—including substitution treatment, drug counseling, and community and family support—are likely to have high recidivism rates, thus fueling HIV transmission and reducing adherence to AIDS care and treatment. And waiting to provide HIV/AIDS care, drug treatment, and other prevention interventions to individuals until after their release will miss an important opportunity to begin actively engaging residents in the many HIV-related and IDU-related decisions they will have to make after release. Delaying the delivery of these interventions is also missing an opportunity to link residents with the community resources that will be required ultimately for successful transition. The prospect of successfully finding a high proportion of these individuals only *after* their release seemed unlikely to both the CSIS delegation members and the various Vietnamese officials with whom the delegation spoke.

According to the O/GAC Second Annual Report to Congress,⁹ issued in February 2006, community outreach HIV/AIDS-prevention activities that promote abstinence and/or being faithful have reached 265,500 individuals in Vietnam, while other prevention activities, including promotion of condoms, have reached 165,200. The United States has contributed to providing antiretroviral treatment (ART) to 700 persons, 3 percent of the 22,000 targeted for the first five years. Approximately 13,000 persons receive other forms of care, with a five-year target of providing care to 110,000.

Dual Challenges

Challenges to the Success of PEPFAR Posed by the Vietnamese Response

The United States and other donors have remained hesitant and stepped only halfway forward in attempting to reach highly stigmatized, at-risk populations with the most effective approaches. To a significant degree, this hesitancy is in reaction to Vietnam's policy environment.

Evidence of progress in HIV/AIDS-control activities in Vietnam is described in the previous section of this report. That section also outlines the most formidable issue for the Vietnamese—and the single greatest challenge to PEPFAR's success in Vietnam—namely, the uncertainty surrounding the Vietnamese approach to preventing, or at least slowing, the continuing spread of HIV from illegal and/or highly stigmatized activities such as injection drug use, female sex work, and men having sex with men. The government of Vietnam has to date lacked a truly multi-sectoral strategic approach: there is no consistent and integrated high-level oversight; no clear setting of priorities; and insufficient high-level determination to fight stigma, set new legal protections, expedite national medical insurance, and introduce substitution therapy and other IDU care and treatments that have been demonstrated to be effective.

There is a continued clash of policy interests—between the imperative to control burgeoning crime and drug use and the public health imperative to control a nascent but growing HIV/AIDS epidemic—and a continued heavy reliance on 05/06 centers as a method of “curing” and reducing the spread of injection drug use. The government of Vietnam's “Three Reductions Campaign” has worsened stigma, especially against IDUs and FSWs, and no obvious efforts have been made to reduce the stigmatization of MSM—even while government health officials acknowledge the importance of reaching these populations with HIV-prevention interventions.

Institutional, Political, and Policy Challenges Internal to the U.S. Approach

The HIV/AIDS epidemic in Vietnam differs fundamentally from that of the other 14 PEPFAR focus countries. There is an overall low HIV prevalence, relatively few AIDS cases, and a high concentration of HIV in populations engaged in risky, illegal, and/or stigmatized behaviors. This HIV/AIDS profile calls for a large-scale and intense targeting

⁹ Office of the Global AIDS Coordinator, *Action Today, A Foundation for Tomorrow: The President's Emergency Plan for AIDS Relief: Second Annual Report to Congress* (Washington, D.C.: U.S. Department of State, February 2006), <http://www.state.gov/documents/organization/60950.pdf>.

of effective prevention activities focused on those behaviors now at the core of the epidemic: IDU, FSW, and MSM.

Prior to the designation of Vietnam as a PEPFAR focus country, the U.S. government had not yet been challenged to devise a response model for a country with this HIV/AIDS profile, where preventing a large proportion of ongoing HIV transmission has the potential of actually staunching the spread of HIV *before* extensive financial and personnel resources are required to create, staff, and maintain massive antiretroviral treatment programs. In addition, the congressional mandate that certain proportions of funding be spent on the “A” and “B” aspects of the “A-B-C” policy (Abstinence–Be faithful–Condoms) is inherently problematic in a country where injection drug use and female sex work account for the great majority of HIV transmission events. Under such circumstances, any prevention strategy must have the flexibility and authority to give overwhelming emphasis to protection against transmission by these core risk behaviors.

A further requirement that NGOs implementing U.S.-funded programs overtly declare their opposition to commercial sex work is no less problematic. One long-term implementer of HIV-prevention programs in Vietnam, the most experienced agency operating in Vietnam’s condom social marketing arena, was unwilling to meet this condition and lost its grant funding. As a consequence, the speed, volume, and capacity of condom marketing and distribution were set back.

The Office of the U.S. Global AIDS Coordinator recognized Vietnam’s unique needs early on and exempted the country from some of the A-B-C–focused prevention requirements put into force in the other 14 PEPFAR focus countries. However, a new and comprehensive prevention-focused strategy for Vietnam is only now being formulated in its stead. This gap in part reflects the absence of U.S. policy guidance on injection drug use in PEPFAR programs between August 2004 and March 2006, when the guidance first became available.¹⁰ It also reflects an unspoken apprehension among U.S. planners about the domestic (U.S.) political risk inherent in making a serious commitment to prevention programs that predominantly focus on injection drug users, female sex workers, and men who have sex with men and that include working with high-risk individuals wherever they can be located, including within the rehabilitation centers. Such a commitment might set Vietnam even more conspicuously apart from other PEPFAR focus countries and, in so doing, attract undue criticism from within the administration or on Capitol Hill. However, if there is to be an effective and successful U.S. prevention strategy set in place in Vietnam, a conscious push from a high level will be essential to reassure those managing these programs that they are on the right course and are guaranteed the full political support of the U.S. government.

A set of internal institutional factors complicated early U.S. efforts to establish a smooth functioning PEPFAR program in Vietnam. As the Vietnam program began in the second half of 2004, O/GAC in Washington had assumed the Herculean responsibility of launching ambitious, complex HIV/AIDS programs simultaneously in 15 focus countries.

¹⁰ Released to Congress in February 2006.

HIV/AIDS in the Border Province of Lang Son

Several CSIS delegation members visited Lang Son province, situated in northeast Vietnam, on the border with the Chinese province of Guangxi. Beginning in the early 1990s, Lang Son has experienced dual epidemics of IDU and HIV. HIV prevalence among injection drug users is currently about 35 percent, and recent HIV-prevalence data among female sex workers, pregnant women, and the overall adult population in northern Vietnam suggest the beginnings of a generalized epidemic. The proportion of women among newly reported HIV cases reached 17 percent in 2004. Sentinel surveillance among pregnant women in Lang Son shows an average HIV prevalence of 0.6 percent between 1998 and 2004, compared to the national figure of 0.3 percent reported in 2004. Voluntary counseling and testing data from the province for the September 2003–February 2004 period documented a 25 percent HIV prevalence among men and a 10 percent prevalence among women, including female IDUs, sex workers, and sexual partners of IDUs. In the neighboring northern province of Bac Ninh, where HIV prevalence among IDUs is similar to that in Lang Son, female sexual partners of IDUs were also found to be at high risk for HIV, due at least in part to low rates of condom use.

Currently, 14 public and 22 private health facilities in Lang Son conduct HIV tests, and there are 2,200 estimated PLWHA, about 100 of whom have already been diagnosed with AIDS. At the time of the delegation visit, there were no patients on antiretroviral treatment, although the Global Fund has committed to support ART for 36 patients in the province in 2006.

As in border areas between many countries, HIV/AIDS prevention and control in the region is challenging, in part due to high mobility. Cross-border movement is extensive because of the open travel and trade policies developed by local leadership and because this border area is situated along a heroin trans-shipment route. There is also thought to be substantial in-migration of Vietnamese to the area, driven by employment opportunities at the border.

The growth of border trade and business in recent years has brought an increased demand for “entertainment services,” including a variety of enterprises associated with commercial sex work on both sides of the border. According to peer educators whom the delegation met in Tan Thanh, directly across the border from the Chinese commercial zone of Puzhai, many of these women are apparently trafficked by their families or by unscrupulous businessmen. In addition to the “service girls” working in entertainment businesses or beauty shops on both sides of the border, there is a more transient group of “street girls” who are managed by “bosses.” Delegation members spoke with one group of street girls and their female boss, a peer educator who distributes condoms to the women she supervises.

Serious challenges of language, culture, control, and cross-border coordination will clearly have to be overcome if prevention services are to be effectively delivered and cross-border spread of HIV halted.

Lang Son province is home to the Cross-Border Project, an HIV-prevention program for IDUs. Interventions were implemented in Lang Son and across the border in Ning Ming County of Guangxi Province in 2002, with the support of the Ford Foundation. The interventions employ a peer outreach model in which salaried peer educators contact IDUs in the community, provide HIV-risk reduction information, leaflets, condoms, new needles and syringes, and vouchers that can be used in participating pharmacies for new needles and syringes. The peer educators also collect and safely dispose of used injection equipment being discarded by IDUs.

A recent evaluation of the Cross-Border Project reveals substantial progress since 2002. Interventions have reached 60 to 75 percent of IDUs in the project sites. Statistically significant reductions in self-reported HIV risk behaviors related to drug use and sexual activity were documented. Both HIV prevalence and apparent HIV incidence among IDUs has declined in Lang Son province, although HIV transmission has not been halted entirely. The Ford Foundation is supporting the next phase of the project, which will employ women peer educators to reach female

sex workers and sexual partners of IDUs to help them learn to negotiate condom use with their clients and partners.

Also, a new project of the UK Department for International Development (DFID), the World Health Organization, and the Vietnam Ministry of Health has begun employing peer educators to reach IDUs and sex workers and their clients in a number of sites in the province.

CSIS delegates were told that substance-abuse treatment in the province is largely confined to community- and family-based support in which a group of IDUs live in a single house and follow the Ministry of Health–approved detoxification regimen (with tranquilizers or traditional medicine) supervised by local health department staff. The recently opened 06 drug rehabilitation center in Lang Son provides only detoxification, manual labor, and education on drug-use cessation.

At the time, there was no USAID mission in Vietnam, and the U.S. embassy was in transition—between ambassadors, between health attachés, and between CDC program directors. The current USAID office is still staffed mostly by contractors and still run administratively from the Bangkok USAID office. The U.S. military component of PEPFAR¹¹ is also managed by the U.S. component of the Armed Forces Research Institute for Medical Sciences (AFRIMS) in Bangkok, although there are plans to assign a U.S. military medical officer to Hanoi to directly manage that aspect of the PEPFAR program.

The HIV/AIDS country team in Vietnam, composed of personnel from USAID, the Department of Health and Human Services (DHHS), and the U.S. military, is highly qualified technically and highly motivated to succeed, but it has limited experience with addressing strategic policy issues on a national or international level and managing relations with Washington. The team sorely needs a senior-level coordinator.

The U.S. embassy in Hanoi has a health attaché and a senior administrator from DHHS. From 2005 on, however, the threat posed by avian influenza consumed an ever greater share of that adviser's time. In this period, there was no designated senior position to coordinate PEPFAR's Vietnam programs internally and manage relations with senior officials in the government of Vietnam and with Washington. However, this gap has been recognized. In February 2006, after returning from Vietnam, CSIS delegation members were told that an agreement had been reached between the U.S. embassy and O/GAC in Washington to create and fill a PEPFAR coordinator's position based in the U.S. mission.

On the HIV/AIDS treatment side, the introduction of highly active antiretroviral treatment has proceeded more slowly than envisaged owing to several policy constraints. During PEPFAR's first year in Vietnam, a U.S. implementing partner imported HAART drugs to Vietnam without the proper import license. Once this error came to light, the process of obtaining an import license was begun, but importation was effectively suspended for a six-month period. In addition, permission to use PEPFAR funding to purchase generic antiretroviral drugs was delayed, thereby increasing the cost of drugs several-fold and reducing the numbers of persons who could be placed quickly on treatment. Supply management has also been a problem, with some clinics reporting up to nine-month delays in getting branded ART medications. These delays have

¹¹ See the section on military-to-military programs on p. 16 herein.

IDUs and HIV: Policy Choices in Achieving Long-term Success

To successfully address the dual intersecting epidemics of injection drug use and HIV/AIDS, Vietnam will need effective interventions that both prevent or slow the spread of each epidemic to new victims *and* mitigate the impact of each on already affected individuals, families, and communities. It will also need to better reconcile the public health imperative to gain effective access to the affected populations versus the predominant imperative to control crime.

To address HIV/AIDS, large numbers of current drug users, some inside rehabilitation centers and others on the outside, will require HIV testing and counseling. Persons who are HIV-infected drug users will require effective monitoring of and care for HIV/AIDS and opportunistic infections. Perhaps equally important, they will require effective measures to reduce their risks of spreading HIV (and other infections) to others through sexual activity or, until their IDU behavior is brought under control, through the sharing of injection equipment. In other countries, both short-term and long-term success has often been achieved through reductions in the sharing of injection equipment and through provision of clean injection equipment.

To address drug addiction, IDUs will require new and expanded treatment services. Drug addiction is a chronic medical disease. In other countries, approaches relying solely on short-term detoxification have not been successful on a long-term basis. The most effective long-term solutions to date in helping IDUs stop using drugs have involved comprehensive programs that include medication-assisted therapy and long-term community support. When these elements are provided, it has been possible to reduce recidivism and relapse. Drug treatment has the additional benefit of helping to reduce the transmission of HIV.

In Vietnam, the national strategy acknowledges the possible role for harm-reduction programs, and pilot programs have shown promise in reducing the spread of HIV in some settings (see the cross-border section on page 24 herein). There is at present, however, no clear national policy and no broad access to harm-reduction programs. Effective national programs to accomplish these goals on a long-term basis will need to confront a number of difficult realities: (1) the pervasive stigma against people perceived to be using illegal drugs and against people thought to have AIDS or to be infected with HIV; (2) the current absence of an effective legal framework to limit discrimination and reconcile the tension between the need for public health access and crime control; (3) the lack of access of many high-risk populations to effective HIV/AIDS prevention, care, and treatment programs; (4) the absence of a comprehensive national plan for effectively treating IDU while preventing the spread of HIV and other diseases; and (5) the existing structure of drug rehabilitation centers, which has to date limited the ability of the United States and other donors to provide support for effective HIV-prevention activities among injection drug users.

complicated relations with the government of Vietnam and affected the overall credibility of U.S. programs among the many clinicians anxious to serve their patients: they occurred at the same time that the United States was supporting the accelerated scale-up of voluntary counseling and HIV-testing facilities to identify people in need of treatment.

Treatment access is being better addressed now, following the recently expanded availability of FDA-approved generic drugs and the onset of new supply chain procurement arrangements. In addition, discussions have begun with the Vietnamese government about submitting the locally manufactured generic antiretroviral drugs for FDA approval. The FY 2006 operational plan for Vietnam, while not yet finalized as of early March 2006, is said to include a still further expansion of care and treatment

funding, including creation of a more effective drug procurement and distribution system. Such a streamlined system can be a key element of a more effective and comprehensive HIV/AIDS response in Vietnam.

Continued Progress in the Face of Challenges

Despite obstacles, significant progress has occurred in PEPFAR's Vietnam programs. The delegation was moved by the many dedicated Vietnamese, Americans, and others engaged in battling HIV/AIDS in Vietnam; impressed by recent shifts in policy that open space for focused prevention, care, and treatment efforts; and convinced of the considerable opportunity Vietnam presents for future success in stemming the HIV/AIDS epidemic. The U.S. programs are clearly a committed force for good in these efforts and have the potential for building ever more effective partnerships and programs within Vietnam.

Although details are not yet available publicly, although congressional concurrence has not been sealed, and although implementation has not yet begun, O/GAC and the PEPFAR country team in Vietnam have reportedly agreed internally on a plan for supporting HIV/AIDS prevention and care services for people in 05 and 06 rehabilitation centers. Creation and rapid implementation of a realistic plan for these centers—including a plan for the transition of individuals from the centers to their communities in a way that minimizes IDU recidivism—would remove a major obstacle to effective countrywide HIV/AIDS prevention efforts. More broadly, the United States is planning additional support for Vietnam's comprehensive strategy to address the larger injection drug use issue, both within and outside the 06 centers. The Vietnam portion of the February 2006 O/GAC Second Annual Report to Congress states "...the emergency plan has scaled up activities that address the needs of IDUs...and has completed policy guidance to assist the field in programming for this important population."¹² Clarification of the HIV-prevention aspects of this policy guidance and its subsequent implementation in coordination with the Vietnamese and other donors are urgently needed next steps.

¹² Office of the Global AIDS Coordinator, *Action Today, A Foundation for Tomorrow*, p. 30.

International Response

A large number of other donor and policy organizations are now actively engaged in supporting efforts to control the spread and impact of HIV/AIDS in Vietnam. These efforts range from funding to policy development (including coordination) to procurement.

The list of organizations that follows is not intended as an exhaustive listing of all donors, international organizations, implementing groups, and projects but rather represents a sample of those that were specifically brought to the attention of CSIS delegation members prior to and during the January 2006 visit.

United Nations agencies are working on a large number of aspects of HIV/AIDS control, both together and separately. A partial list of projects includes: support for surveillance development, harm reduction, and reduction of stigma and discrimination (WHO); support for the development of a national strategy on HIV/AIDS (UNAIDS, WHO, UNDP); policy development regarding legal and structural approaches to addressing discrimination (UNDP and UNAIDS); HIV/AIDS issues incorporated into development planning (UNDP); community support for care of HIV-affected individuals (UNICEF); volunteer support of local indigenous AIDS-control efforts (UN Volunteers); HIV prevention among injection drug users (UNODC); and creation and support of the Community of Concerned Partners (UNAIDS and others). With UNAIDS as the secretariat, the UN agencies are jointly sponsoring a technical working group to enhance coordination and collaboration among international NGOs.

The UN theme group chair and UNAIDS country coordinator are in active dialog with Vietnamese leadership on a number of coordination, planning, and policy issues. Delegation members noted that the UN agencies in Vietnam are collaborating with each other to a degree not always achieved in other countries. UN agencies appear from their accomplishments to have the ear of Vietnamese policymakers.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) has three grants operating in Vietnam, one each for HIV/AIDS, TB, and malaria, with a total funding level of \$35 million. GFATM provided Vietnam with a round-one HIV/AIDS grant of \$7.5 million in early 2004; that grant was extended in round two with an additional award of \$4.5 million through late 2008. The focus of these grants, awarded through the Ministry of Health, is the scaling-up of an existing—and recently evaluated—three-province pilot program of community-based care, support, and counseling to 17 additional provinces. Specific activities supported to date have included health worker training, establishment of laboratory capacity for HIV testing, development or strengthening of specific VCT sites, care and support to persons living with HIV/AIDS, provision of medications for opportunistic infections, and antenatal counseling and testing. Distribution of antiretroviral drugs has been planned for some time but was delayed until recently due to procurement difficulties. These apparently have now been addressed, in part by designating UNICEF as the procurement agent. The first patients began receiving HAART in December 2005.

In order to help address the complex issues of program coordination, Vietnam's GFATM country coordinating mechanism now includes additional donors (including the

U.S. embassy) and NGOs. GFATM administrators—and PEPFAR staff—are optimistic that coordination of PEPFAR and GFATM (and other donor) activities, especially those related to the use of antiretroviral medications, will benefit the programs and beneficiaries of all implementing groups.

The World Bank approved and began in late 2005 a six-year \$35 million HIV/AIDS Prevention Project for Vietnam that has an explicit goal of supporting a key objective of the government of Vietnam’s National HIV/AIDS Strategy, that of reducing and maintaining national HIV prevalence below 0.3 percent. This project is being implemented in 18 provinces (including Ho Chi Minh City and Hai Phong) through support for the design and implementation of annual Provincial Action Plans.

Provincial activities to be emphasized are the development of innovative, effective prevention and treatment approaches among vulnerable groups, including demonstration sites for community-based treatment models for addressing injection drug use in comprehensive HIV treatment and care settings. Activity-based policy research (presumably based at least in part on program evaluation) and subsequent information dissemination are also included activities.

The Asian Development Bank has in place a five-year \$20-million program targeting communication change among youth nationally, with an emphasis on 15 specific provinces. The goal of this project is to reduce HIV transmission among 15–24 year olds through primary prevention, using national and local media campaigns, and development of community-based HIV-prevention resources, peer education, and development of local leadership. This project includes an explicit focus on gender awareness issues, including education about HIV risk and protective factors that differ between men and women. The project gives special attention to the participation of beneficiaries in program design and implementation and includes a specific monitoring and evaluation component. Project designers are hopeful that social, health, and economic benefits will each be demonstrated.

The ESTHER Project (Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau) or Network for Therapeutic Solidarity in Hospitals is a “twinning” partnership among several European countries and selected developing countries. In general, these programs are built around existing structures and facilities and seek to improve access to quality care for patients in the coverage area of the facilities. The three-year Vietnam project is sponsored and supported by the French government component of the ESTHER network and is functioning under UN guidelines to create a system to provide antiretroviral treatment and associated care in Hanoi’s Dong Da Hospital (which members of the CSIS delegation visited).

The UK Department for International Development, along with the Norwegian government, has begun a \$17-million project focused on HIV prevention in 21 provinces. The specific focus in the project is reduction of high-risk behaviors among commercial sex workers, injection drug users and their sexual partners, and includes condom distribution.

The Australian Government Aid Agency (AusAID) is providing approximately \$7 million in a current project through ACIL (an Australian NGO) and the MacFarlane

Burnet Institute to strengthen Vietnam's capacity to use and promote evidence-based approaches to reduce HIV-related harms of injection drug use.

AusAID has also recently provided approximately \$510,000 to the Vietnam Youth Union (VYU) to field a "training of trainers" concept to train VYU members in four provinces in models of HIV-related behavior change. The goal is to create a cadre of VYU members able to carry out training and education about HIV risks and HIV prevention among young people at district and commune levels. This project is being directly supported by the national VYU structure.

Other bilateral and nongovernmental organizations working in Vietnam include (but are not limited to) the following: the Academy for Educational Development, the SMART Project, ActionAID, Australian Red Cross, CARE International, Coopération Internationale pour le Développement et la Solidarité (France), DKT International, Family Health International, Ford Foundation, Futures Group International (POLICY Project), Marie Stopes International, Médecins du Monde/Canada, Médecins du Monde/France, PATH/Canada, PATH/U.S., Pathfinder International, Plan International, Population and Development International, the Population Council, Save the Children (UK), Save the Children (U.S.), World Population Foundation, World Vision, Vietnamese HIV/AIDS Training and Treatment Program, Agence Nationale de Recherches sur le SIDA (France), the Norwegian Mission Alliance, the Danish International Development Agency, the Center for AIDS Prevention Studies in San Francisco, the British Council, the Swedish International Development Agency, and KPMG International.

Private-sector Responses and Roles in Fighting HIV/AIDS in Vietnam

In many countries around the world, especially those hard-hit by the HIV/AIDS epidemic, the business community has taken a significant leadership role in the national response to HIV/AIDS. The engagement of this sector has ranged from the creation and implementation of HIV/AIDS workplace policies, education, and prevention programs for employees, to support for local community programs and advocacy for government leadership, to resource mobilization in the fight against HIV/AIDS.

The CSIS delegation noted very little evidence of the active involvement of the business community in Vietnam in any of these areas. Some multinational pharmaceutical companies such as Bristol-Myers Squibb, Merck, and Pfizer—traditional players and often the first among private firms in supporting HIV/AIDS efforts—have provided funding for training of health care workers and HIV/AIDS programs of local NGOs. The Vietnam Chamber of Commerce and Industry launched an effort in 1999 to educate companies in Vietnam about HIV/AIDS in the workplace and its potential impact on business and is now starting training programs for workplace policies in four provinces with the support of the Danish government.

As long as the current HIV/AIDS epidemic in Vietnam is viewed as a low-prevalence problem that remains concentrated among IDUs and FSWs, the business community may conclude the epidemic will have little impact on productivity, profitability, or human resources. However, business leaders have a tremendous opportunity to partner with governments, NGOs, and other key stakeholders to reduce the spread of HIV and to keep it from becoming a more generalized epidemic. Through workplace educational programs (including VCT) and prevention policies, companies can contribute to increase the knowledge of HIV/AIDS among the working population—which for many companies includes a significant proportion of migrant workers who are at increased risk for HIV. Such programs not only serve an educational role, but can boost employee morale and bring recognition to companies as good corporate citizens. CEOs and other business leaders should also recognize the potential impact of a much larger HIV epidemic on political stability, on the labor market, and on the overall climate for business investment. CEOs can serve as credible and influential advocates of increased national leadership and sufficient allocation of resources to prevent HIV/AIDS from destabilizing communities, the economy, and the market environment in Vietnam for both national and international companies.

Appendix A: CSIS Delegation Members

Tommy G. Thompson, Delegation Chair

Partner, Akin, Gump, Strauss, Hauer and Feld, LLP

Former Secretary, U.S. Department of Health and Human Services

J. Stephen Morrison

Director, CSIS Africa Program, and Executive Director, CSIS Task Force on HIV/AIDS

Robert Cogorno

Floor Director to the Democratic Whip, U.S. House of Representatives

Jason Denby

Special Assistant to Tommy G. Thompson, Akin, Gump, Strauss, Hauer and Feld, LLP

Linda Distlerath

Vice President, Global Health Policy, Merck & Company, Inc. (Hong Kong)

Kelley Hampton

Research Assistant, CSIS Africa Program and Task Force on HIV/AIDS

LTC Jerome Kim

Chief, Department of Retrovirology, U.S. Army Medical Component, Armed Forces Research Institute of the Medical Sciences (Bangkok)

David Metzger

Director, HIV Prevention Research Division, Center for Studies of Addiction, University of Pennsylvania

Phillip Nieburg

Senior Associate, CSIS Task Force on HIV/AIDS

Todd Summers

Senior Policy Officer for Global Health, Bill and Melinda Gates Foundation

Gary West

Senior Vice President, Family Health International

Appendix B: Delegation Agenda

Sunday, January 8: Hanoi

Initial delegation HIV/AIDS briefing by U.S. embassy PEPFAR team

Reception and dinner with U.S. Ambassador Michael Marine, Deputy Chief of Mission John Boardman, PEPFAR delegates, and prominent Vietnamese guests

Monday, January 9: Hanoi

Meeting with Madame Nguyen Thi Xuyen, Vice Minister of Health

Meeting with representatives of the Prevention Department, Ministry of Labor, War Invalids and Social Affairs

Meeting with Madame Ha Thi Khiem, President of the Vietnam Women's Union

Meeting with Mr. Doan Van Thai, Director General of the International Youth Cooperation Development Center and Secretary of the Vietnam Youth Union

Lunch meeting with resident representatives of various United Nations agencies

Meeting with the Buddhist Association

Meeting with members and peer educators of the Bright Futures group to discuss support of People Living with HIV/AIDS

Hosted public event addressing "The Role of Leadership in Controlling HIV/AIDS"
Hon. Tommy G. Thompson, keynote speaker

Tuesday, January 10: Hai Phong

Early morning travel to Hai Phong by van

Meeting with senior officials of the Hai Phong Provincial Department of Health

Site visit to LIFE-GAP voluntary testing and counseling center and outpatient clinic

Site visit to Women's Health Club, which provides care and counseling to female sex workers

Lunch meeting with members and peer educators of the Red Flame Tree Group, a PLWHA support group, and with members of Wives and Mother's Club, an NGO comprising relatives of PLWHA that is sponsored by the Vietnam Women's Union

Meeting with outreach workers at the Hai Au Club, an injection drug user drop-in center

Return to Hanoi by van

Dinner with representatives of the Asian Development Bank, Catholic Relief Services, the Australian Agency for International Development, Family Health International, and local NGOs

Wednesday, January 11: Hanoi

Site visit to Dong Da Hospital antiretroviral treatment and care facility, which is sponsored by the French ESTHER project

Meeting with Director Chairman Dr. Cao Duc Thai and representatives from the Vietnamese Institute of Human Rights, Ho Chi Minh National Political Academy

Meeting with staff of DKT International to discuss condom social marketing

Meeting with Brig. Gen. Cuong, Surgeon General, People's Army of Vietnam, and Senior Col. Nguyen Xuan Thanh, Director of the Military Institute of Hygiene and Epidemiology

Evening flight to Ho Chi Minh City

Thursday, January 12: Ho Chi Minh City

Meeting with Dr. Le Truong Giang, Vice Chairman, Ho Chi Minh Provincial AIDS Committee

Site visit to Nhi Xuan rehabilitation center with representatives of the Vietnam Youth Union

Site visit to Médecins du Monde (MDM)/France at the District 6 outpatient clinic

Site visit to Tam Binh Orphanage for children born to HIV-infected women

Press briefing with remarks by delegation chair Tommy G. Thompson, J. Stephen Morrison, and Dr. Le Truong Giang

Dinner hosted by U.S. Consul General Seth Winnick, with representatives from local and U.S. NGOs and U.S. government agencies

Friday, January 13: Ho Chi Minh City

Site visit to District 4 outpatient clinic, voluntary counseling and testing and peer outreach program

Site visit to Binh Thanh outpatient clinic

Site visit to the Blue Sky Club, an MSM drop-in center

Final delegation meeting prior to departure

Appendix C: Sources of Additional Information about HIV/AIDS in Vietnam

U.S. Government

Office of the U.S. Global AIDS Coordinator
<http://www.state.gov/s/gac/countries/fc/vietnam>

PEPFAR IDU Guidance
<http://www.state.gov/s/gac/partners/guide/prevent/64035.htm>

International Organizations

UNAIDS in Vietnam
<http://www.unaids.org.vn>

World Health Organization
<http://www.who.int/hiv/countries/en/index1.html>

Vietnamese Leadership

Communist Party of Vietnam
http://www.cpv.org.vn/content_e.asp?topic=65

Vietnam Chamber of Commerce
http://vibforum.vcci.com.vn/news_detail.asp?news_id=5438

Socialist Republic of Viet Nam
Second Country Report on Following Up to the Declaration of Commitment on HIV/AIDS, adopted at the 26th UN General Assembly Special Session (UNGASS), Hanoi, January 2006,
http://www.unaids.org.vn/resource/topic/natstrat/ungass_17jan06_e.pdf

Nongovernmental Organizations

Family Health International (FHI)
<http://www.fhi.org/en/HIVAIDS/country/VietNam/index.htm>

Monitoring the AIDS Pandemic (MAP), “MSM in Asia, including Vietnam,”
<http://www.eldes.org/static/DOC19058.htm>

