SOCIALIST REPUBLIC OF VIETNAM

COUNTRY REPORT ON FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS (UNGASS)

Reporting period: January-December 2002

Hanoi, April 2003
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I. STATUS AT A GLANCE

NATIONAL COMMITMENT AND ACTION

1. National Composite Policy Index: 90.2%
2. Government fund spent on HIV/AIDS: 4 million USD/year (this amount excludes resources mobilization from ministries, local authorities and community). Allocated Government fund comprise expenditures on the following three categories:
   - STI control activities: 2.5%;
   - HIV prevention: 90.9%;
   - HIV/AIDS care and treatment: 6.6%.

NATIONAL PROGRAMME AND BEHAVIOR

Prevention

3. Percentage of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year:
   - **UNAIDS indicator:** no national school-based survey
   - **Data available in Vietnam:** 100% of schools with teachers who have been trained on HIV/AIDS;

4. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes:
   - **UNAIDS indicator:** no national workplace survey
   - **Data available in Vietnam:** a survey conducted at 30 large enterprises in Hanoi, in March 2003 showed that the business sectors have made efforts in implementing HIV/AIDS prevention activities at workplaces but such activities are inadequate and uncomprehensive in comparison with UNAIDS guideline.

5. Percentage of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT:
   - **UNAIDS indicator:** not applicable in Vietnam
   - **Data available in Vietnam:**
     - Apply UNAIDS guideline in the calculation of this indicator shows that in 2002 estimated number of HIV infected pregnant women in Vietnam is 4,900 cases (this figure is too high estimated) and based on this estimation: 2.35% of them receiving ARV prophylaxis to reduce the risk of MTCT.
     - actual data shows that 25.4% of HIV-infected and reported pregnant women receiving a complete course ARV prophylaxis to reduce the risk of MTCT.

Care/Treatment

6. Percentage of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled:
   - **UNAIDS indicator:** no national health-facilities survey
   - **Data available in Vietnam:** a survey conducted by interviewing of health providers who provide STIs services in health facilities of the five mountainous and border provinces in 2002 shows that 38.3% of STI patients have received the appropriate diagnoses, treatment and counselling.

7. Percentage of people with advanced HIV infection receiving ARVs combination therapy:
   - **UNAIDS indicator:** 0.42%
   - **Data available in Vietnam:** apply UNAIDS guideline in calculation and based on available data shows that 1.06% of people with advanced HIV infection receiving
ARV therapy from Government budget. There is no data available related to the number of people with advanced HIV infection who pay ARVs from their own.

Knowledge/Behaviour

8. Percentage of young people 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention:
   - **UNAIDS indicator:** no population-based survey
   - **Data available in Vietnam:** a survey conducted in five mountainous and border provinces in 2002 shows that 26.4% of young people 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention.

9. Percentage of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner:
   - **UNAIDS indicator:** no population-based survey
   - **Data available in Vietnam:** a survey conducted in five mountainous and border provinces shows in 2002 shows that 52% of people aged 15-24 had sexual intercourse with a non-regular partner and reporting the use of a condom.

10. Percentage of injecting drug users who are covered with HIV/AIDS prevention services.
    - **UNAIDS indicator:** 62.7% of injecting drug users who are covered with HIV/AIDS prevention services

Impact alleviation

11. Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school: **No national survey**

IMPACT

12. Percentage of young people aged 15-24 years of age who are HIV infected
    - **UNAIDS indicator:** no population-based survey
    - **Data available in Vietnam:** a survey conducted in five mountainous and border provinces in 2002 shows that 0.6% young people aged 15-24 years of age who are HIV infected.

13. Percentage of HIV prevalence among sex workers, injecting drug users and STI patients (according to sentinel surveillance data in 2002)
   13a. 6% of HIV prevalence among sex workers;
   13b. 29.3% of HIV prevalence among injecting drug users;
   13c. 2% of HIV prevalence among STI patients.

14. Percentage of infants born to HIV infected mothers who are infected
    - **UNAIDS indicator:** 24.7% of infants born to HIV infected mothers who are infected
II. OVERVIEW OF THE HIV/AIDS EPIDEMIC

This section presents the status of the HIV prevalence in the Vietnam during the period January-December 2002 based on HIV/AIDS reported cases; sentinel surveillance and a sample of specific studies/researches conducted in the year 2002. Information sources are mainly from official reports of the Ministry of Health of Vietnam.

HIV/AIDS reported cases

- By 31 December 2002, the cumulative number of HIV infected people reported from 61 provinces throughout the country was 59,200 of which 8,793 are AIDS patients and 4,889 deaths. In 2002 alone, 12,540 new infections were detected nationwide.
- 10 provinces/cities reported to have highest HIV prevalence rate/100,000 population are Ho Chi Minh City, An Giang, Dong Nai, Dong Thap, Ba Ria - Vung Tau, Can Tho, Nghe An, Ha Noi, Quang Ninh and Hai Phong.
- Majority of HIV prevalence is among injecting drug users (IDUs), accounting for 60% of all reported cases.
- Men account for 85.3% of all HIV reported cases.
- HIV prevalence is mainly among less than 30 years of age group; accounting for 63% of the total HIV reported cases. By time, HIV prevalence rate tends to increase in the younger age group. HIV prevalence among population from 20-29 years old increases from 15% in 1993 to 60% in 2002.
- HIV newly infection cases among children less than 5 years of age increases from 7 cases in 1997 to 57 cases in 2002. By the time, the cumulative reported number of HIV-infected children, less than 5 years of age and were born from HIV infected mothers, are 328 cases.

HIV/AIDS estimation

According to the official data provided by the Ministry of Health in 2000 on “HIV/AIDS Infection Estimation and Projection in Vietnam for the period 2001-2005”, by the end of 2002, it was estimated that there are 160,000 HIV infections cumulatively and by 2005 the figure will rise to 197,000.

HIV prevalence rate and trends in Vietnam

The result of HIV sentinel surveillance in 30 provinces in Vietnam indicates that:

- HIV in Vietnam is in the concentrated epidemics stage (HIV prevalence rate over 5% among high-risk population and less than 1% among the pregnant women). However, HIV prevalence tends to increase in all surveillance population groups.
- **HIV infection form is mainly drug injection**: HIV prevalence rate among IDUs increases from 9.4% in 1996 to 29.3% in 2002. Sharing needles explains the rapid increase of infection rate among the IDUs in urban areas of Vietnam. A number of studies conducted in Ha Noi, Hai Phong, Quang Ninh and Ho Chi Minh City, drug users are getting younger (they are often under 30) and shift rapidly from smoking into injecting. They are sexually active while the rate of condom use is low.
- **HIV prevalence rate among sex workers and STI patients** is lower but tends to increase. The HIV prevalence rate among sex workers increases from 0.6% in 1994 to 6.6% in 2002. The HIV prevalence rate among the STIs patients increases from 0.5% in 1994 to 2% in 2002. HIV prevalence rate among sex workers in Ha Noi and Ho Chi Minh City increased rapidly at an alarming speed. The rate of those in Ho Chi Minh City increases from 3.1% in 1998 to 24.3%
in 2002 and in Hanoi from 3.1% in 1998 to 14.5% in 2002. Some studies show that the HIV infected sex workers often have some relation to drug injection.

- **HIV prevalence rate of pregnant women** increases from 0.03% in 1995 to 0.39% in 2002.
- **HIV prevalence among army conscripts/military candidates** also increases from 0% in 1994 to 0.7% in 2002.

### HIV prevalence at a glance

- **0.6% of young people 15-24 years of age who are HIV infected** *(according to a recent survey at five mountainous and border provinces)*
- **24.7% of infants born to HIV infected mothers who are infected** *(details will be presented in annex 3, form II-2)*

*Source: Ministry of Health of Vietnam*

### III. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

#### 1. National commitment and action

*This sub-section presents the change in commitment made by national stakeholders in the fight against HIV/AIDS during the period January-December 2002. Commitment covers increased resources, expanded partnerships and multi-sectoral policy development.*

**Active involvement of the National Assembly**

In the end of 2002, the Standing Committee of the National Assembly organized meetings theme on HIV/AIDS and agreed to the amendment of HIV/AIDS Prevention Ordinance that was promulgated in 1995. In December 2002, the Social Affairs Committee of the National Assembly in collaboration with Ministry of Health organized a series of workshop on HIV/AIDS prevention policy with the participation of more than 300 provincial Elected Officials in Northern, Central and Southern areas and chaired by the Vice-Chairman of the National Assembly. They all agreed to make 8 recommendations in relation to HIV/AIDS prevention policy to the leaders of the Party, National Assembly, Government and Provincial People's Committees.

**Participation of the social and religious organizations**

The participation of the social and religious organizations in taking care of the HIV infected people, particularly last stage AIDS patients at communities are greatly expanded. Those activities are conducted at and by catholic churches and Buddhist pagodas. The participation of local NGOs and business sectors was also intensified during last year.

In 2002, the ministries, communities and local authorities have actively strengthened and expanded activities related to HIV/AIDS prevention with the contribution from their own resources.

**Policy Forum on HIV/AIDS**

A forum on "Policies and HIV/AIDS" was organized in September 2002. At the forum, issues related to policies, coordination of the Government, coordination of the international organizations in
supporting national HIV/AIDS prevention programme was discussed. Fora on policies in specific topics will also periodically organized.

**HIV/AIDS National Strategy up to 2010**

At present, Vietnam is developing its HIV/AIDS National Strategy up to 2010. This strategy is to ensure and intensify the participation and multi-sectoral coordination in HIV/AIDS prevention.

**New Directive of the Prime Minister**

Early 2003, the Prime Minister issued Directive 02-2003/CT-TTg on the strengthening of the organization and intensifying HIV/AIDS prevention activities throughout the country. This Directive has set the guidelines for each ministry in the Government having their specific functions and responsibilities in order to improve the effectiveness of HIV/AIDS prevention activities. It also clearly states that ministries should coordinate with agencies and other political and social organizations to implement the Directive and report to the Prime Minister periodically.

**Budget**

National budget for HIV/AIDS Prevention Programme in 2002 was VND 60 billion (approx. USD 4 million), excludes the staff salary, administrative expenses, basic construction, equipment, electricity and water bills etc. In addition, this amount (4 USD/year) is only the Government official budget apart from contribution of the local authorities, social organizations and communities. It is often difficult to count and sum all those resources.

Government budget is allocated to the following programme categories:

1. **STIs prevention**
   - Main activities covered: capacity building of the physicians on STIs diagnosis and treatment; communication and education, monitoring and treatment of STIs cases; integrating STIs prevention into reproductive health services, providing biological test kit, drug and equipment for treatment, development of guidelines and training materials on STIs.
   - 2002 budget allocated to the Ministry of Health to conduct above-mentioned activities was approx. 2.5% of the total Government budget for HIV/AIDS Prevention Programme.

2. **HIV/AIDS prevention**
   - Main activities covered: behavior change communication among target groups (female sex workers, drug users, STIs patients, migrating population, HIV/AIDS infected people, pregnant women and general population); sentinel surveillance, blood screening; development guidelines and providing training on voluntary counselling and testing (VCT); ARVs prophylaxis for prevention of HIV transmission from mother to child;
   - 2002 budget allocated to 36 ministries and social organization and 61 provinces/cities to implement above-mentioned activities was approx. 90.9% of the total national budget for HIV/AIDS Prevention Programme.

3. **Care and treatment for people living with AIDS**
   - Main activities covered: capacity building, taking care of the HIV/AIDS infected people by community-based and home-based activities; providing ARV and opportunistic infections medicines to AIDS patients;
• In 2002, the Government budget allocated to the Ministry of Health for further down allocation to its subordinate hospitals was approx. 6.6% of the total national budget for HIV/AIDS Prevention Programme.

**National commitment at a glance**

- National Composite Policy Index: 90.2%
- Government funds spent on HIV/AIDS: USD 4 million/year

*Source: Ministry of Health, Ministry of Finance*

2. **National programme and behaviour**

This sub-section presents progress made during the period January-December 2002 in specific HIV/AIDS programme broken down by prevention and care/treatment.

In the recent period of time, facing the increasing HIV epidemics in many provinces/cities of Vietnam, under the leadership and support of the National Committee on AIDS, Drug and Prostitution Prevention and the Ministry of Health, provinces/cities, ministries, agencies and social organizations have implemented HIV/AIDS prevention activities at localities with a view to eliminate the spread of the epidemics in the country.

The scope and amplitude of the activities can be different from one area to another, from time to time, however such activities are available in all sectors: Information-Education-Communication; harm reduction interventions among HIV/AIDS vulnerable population; sentinel and behavioral surveillance surveys; blood safety and safe medical services; care and support to people living with HIV/AIDS; STI prevention; prevention of mother to child transmission of HIV; voluntary counselling and testing.

According to a report on ten years review of National AIDS Programme of a former National AIDS Committee (presently called National Committee for AIDS, Drug and Prostitution Prevention and Control) and the Ministry of Health stated “the Government’s efforts have eliminated the spread of HIV to community and have made an increase at low rate of HIV infection among general population (under 0.5%).”

The following information presents some main programme as per UNAIDS guideline:

2.1 **Prevention**

*The percentage of schools with teachers who have been trained in life-skill based HIV/AIDS education and who taught it during the last academic year.*

- **UNAIDS indicator:** no school-based survey
- **Data available in Vietnam:** 100% of schools with teachers who have been trained on HIV/AIDS

The HIV/AIDS education programme was first introduced into the general schools in 1991/1992 school years in the curriculum of biology subject of 9th grade. In 1993/1994 school years, this programme was introduced into all levels of general education. Before 1998, HIV/AIDS education was taught at 5th, 9th and 11th grades. After 1998, pupils have taught on HIV/AIDS at 3rd, 4th, 9th and 11th grades. In each primary, secondary and high school (in rural as well as urban areas) there
are teachers who have been trained and taught on HIV/AIDS. The training materials for teachers were developed by Ministry of Education and Training. In 2002, Ministry of Education and Training (MOET) in collaboration with UNICEF and some other international NGOs implemented a programme on "education for a healthy life and life-skills" in a pilot scale at some provinces and districts. The programme is completing the materials, pictures, songs to convey the messages on drug and HIV/AIDS prevention. The programme also equips the pupils/students with life-skills such as skills to make decision, to negotiate in order to help them protect themselves from drug and HIV/AIDS. This programme is applied in a pilot scheme for 6th, 7th, 8th and 9th grades. This programme, at the same time, also conducts training courses for parents via parents' association with a view to improving their understanding of the "healthy life". (Detail information related to this indicator will be presented in annex 3, form NPBI-1 and narrative report 1).

**Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes:**

- **UNAIDS indicator:** no workplace survey
- **Data available in Vietnam:** a survey conducted at 30 large enterprises in Hanoi, in March 2003, showed that the business sectors have made efforts in implementing HIV/AIDS prevention activities at workplaces but such activities are inadequate and uncomprehensive in comparison with UNAIDS guideline.

HIV/AIDS workplace activities was paid due attention to since the establishment of the National Committee on HIV/AIDS Prevention in 1990. However, due to financial constrain and thus the modest outcome was a "favourable legal environment" with a set of legal documents to support the work of HIV/AIDS prevention communication at state owned enterprises and to increase the awareness on HIV/AIDS in business sectors. Vietnam Chamber of Commerce and Industry (VCCI) and Vietnam Confederation of Workers (VCW) are the main agencies to participate in the movement of HIV/AIDS prevention at work places with strong support of the National Committee on HIV/AIDS Prevention. A recent survey conducted in Ha Noi on HIV/AIDS prevention at business sectors shows that by 31 December 2002, there were 997 businesses in Ha Noi, in which have more than 200 workers, set up their own HIV/AIDS Prevention Boards. In 2002 alone, 327 businesses, in which have more than 500 workers, participated in HIV/AIDS prevention programmes in businesses sector with the total expenses of approx. VND 2 billion (130,000 USD) from their own sources. A recent survey (March 2003) made a rapid assessment on HIV/AIDS prevention and policies at 30 businesses (22 State Own Enterprises and 8 non-state owned enterprises). The result of the survey showed that Viet Nam has made efforts in implementing HIV/AIDS prevention activities at workplaces but such activities are uncomprehensive and inadequate in comparison to UNAIDS indicators. (The result of the study is presented in details in annex 3, form NPBI- 2 and narrative report 2).

**Percentage of HIV infected pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT:**

- **UNAIDS indicator:** not applicable in Vietnam
- **Data available in Vietnam:**
  - Apply UNAIDS guideline in the calculation of this indicator shows that in 2002 estimated number of HIV infected pregnant women in Vietnam is 4.900 cases (this figure is too high estimate) and based on this estimation: 2.35% of them receiving ARV prophylaxis to reduce the risk of MTCT.
  - Actual data shows that 25.4% of HIV-infected and reported pregnant women receiving a complete course ARV prophylaxis to reduce the risk of MTCT.
According to the Ministry of Health report, among the 12,540 HIV new detected cases in 2002, 240 were pregnant women and 106 of them were detected in early stage of their gestation period (week 20-week 25) receiving a full course of ATZ and Nevirapine. Most of the expenses for testing, counselling and prophylaxis for HIV infected pregnant women are provided by the Government. Those HIV detected after week 40 of their gestation period (136 of them) have not received AZT. According to the Ministry of Health report, in 2002 there were 1,256,417 women gave birth and the HIV prevalence rate among pregnant women population was 0.39% (2002 sentinel surveillance data) and the corresponding estimated number of HIV infected women in Vietnam in 2002 is 4,900. This figure is too high estimate in comparison with the actual HIV epidemic in Vietnam. Since the end of 2002, with the assistance of Nevirapine Donation Programme of Boehringer Ingelhem, Vietnam has been started in implementing a programme on Nevirapine prophylaxis to HIV infected mothers. (Detail information related to this indicator is presented in annex 3; form NPBI-4 and narrative report 4).

2.2 Care and treatment

**Percentage of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled:**

- **UNAIDS indicator:** no health facility survey
- **Data available in Vietnam:** a survey conducted by interviewing health providers who provide STIs services in health facilities of the five mountainous and border provinces in 2002 shows that 38.3% of STI patients have received the appropriate diagnoses, treatment and counselling.

According to the report of the National Institute of Dermatology and Venerology (NIDV), the number of visits of STIs patients to the state owned health facilities was 171,975 in 2002. This figure does not include those STIs patients visiting private clinics. To the present point of time, Vietnam has not yet got adequate data to calculate the indicators according to UNAIDS guideline. Starting in 2003, Vietnam will implement regular surveillance of STIs in 10 provinces/cities and this source of information will reflect more precisely the STIs situation in Vietnam. Interviews of health providers at health facilities offering STIs services in 5 mountainous and border provinces (Lai Chau, Quang Tri, An Giang, Dong Thap and Kien Giang) conducted in 2002 showed that only 38.3% of the health providers who have provided the appropriate diagnosis, treatment and counselling to their STIs patients. (Detail information related to this indicator is presented in annex 3, form NPBI-3 and narrative report 3).

**Percentage of people with advanced HIV infection receiving ARVs combination therapy:**

- **UNAIDS indicator:** 0.42%
- **Data available in Vietnam:** apply UNAIDS guideline in calculation and based on available data shows that 1.06% of people with advanced HIV infection receiving ARVs therapy from Government budget. There is no data available related to the number of people with advanced HIV infection who pay ARVs from their own.

Of the cumulative total 59,200 HIV reported cases by 31 December 2002, 8,793 are AIDS patients and 4,889 deaths. According to UNAIDS guideline in the calculation of this indicator, the number of people receiving ARV therapy from Government budget is very low, 0.42% if based on HIV/AIDS estimation data in 2000 and 1.06% if based on reported surveillance data. According to
annual statistic data of HIV infections, the number of AIDS and death cases are higher in the next years than previous years. However, the number of people who advanced HIV infection are reported rather low than estimate data. Of the 2.149 HIV advanced infection cases as reported by 2002 through HIV/AIDS sentinel surveillance, only 4.6% have received with ARV combination therapy. This proportion might be excluded the number of AIDS patients who received prescriptions from state physicians and procured ARVs drug by their own. Antiretroviral combination therapy (double and triple regiments) was applied according to the nationally approved treatment guideline. (Detail information related to this indicator is presented in annex 3, form NPBI-5, and narrative report 5).

2.3 Knowledge and behaviour

Percentage of young people 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention:

- **UNAIDS indicator:** no population-based survey
- **Data available in Vietnam:** a survey conducted in five mountainous and border provinces in 2002 shows that 26.4% of young people 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention.

According to the 2001 General Population Census, the 15-24 years of age population is 15,598,390, or equivalent to 19.8% of the total population (in urban areas: 23.7%). The HIV/AIDS prevention programme for youth is mainly focused on changes in knowledge and behaviour. In addition, in 2002, many other activities were also conducted in provinces such as the integration of HIV/AIDS education into reproductive health/life skill programme; raising awareness on gender issue; counselling and environment, health and development programme.

Up to now, there is no population-based survey that can be used in calculation of this indicator. However, according to the qualitative survey on a risk of HIV/AIDS infection among 15-24 years of age, unmarried youth group in 5 mountainous and border provinces (Lai Chau, Quang Tri, An Giang, Dong Thap and Kien Giang) showed that young people have fairly low knowledge on the ways of preventing HIV infection. Only 26.3% (24.2% of male and 32.2% of female) gave correct answers about two ways of HIV prevention including regular use of condoms and faithfulness to HIV non-infected sexual partners. Despite the fact that this group is fairly high education level (70% of them have secondary education level and only 6.1% are illiterate), their knowledge on HIV/AIDS prevention are quite equivocal. While 79.4% of youth believe that condom use could help prevent HIV infection and 70.5% understand that having sex with only one HIV free partner is safe, still a large number of them believe that mosquito bites (53.85%) and having meals together with HIV infected people (52.1%) may keep them infected. (Detail information related to this indicator is presented in annex 3, form NPBI-7 and narrative report 7).
Percentage of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner:

- **UNAIDS indicator**: no population-based survey
- **Data available in Vietnam**: a survey conducted in five mountainous and border provinces shows in 2002 shows that 52% of people aged 15-24 had sexual intercourse with a non-regular partner and reporting the use of a condom;

Up to now, there is no population-based survey that can be used in calculation of this indicator. Qualitative survey on a risk of HIV/AIDS infection among 15-24 years of age population, unmarried youth in 5 mountainous and border provinces (Lai Chau, Quang Tri, An Giang, Dong Thap and Kien Giang) revealed that 22.7% of them have pre-marital sexual relations and the average age at which they have their first sexual intercourse is 18.9 years and no significant difference could be found between male and female youth. Among those youth and adolescents having sexual intercourse with non-regular sexual partners in the last 12 months, only 52.7% male and 33.3% female used condoms in the last time of sexual intercourse with non-regular sexual partners (the average percentage is 51.9%). A small survey conducted recently in Ho Chi Minh City, Central Plateau (Tay Nguyen), Ha Noi and Hai Phong discovered that about 10-20% of the youth have their first sexual intercourse between the ages of 16-18 when they are in high school education. Condom use promotion programme has been implemented throughout the country, in all provinces through "condom social marketing" programme. The source of condom supplies is mainly from drug stores (31.1%), population collaborators (28.7%), commune health service centres (14.3%), family planning collaborators (13.2%). In general, services provided to youth are often via channels such as: youth-friend clubs, mobile art performance teams, and hot-line telephone counselling and condom cafeterias. Those services are all in small scale. (Detail information related to this indicator is presented in annex 3, form NPBI-8 and narrative report 8).

The percentage of injecting drug users who are covered with HIV/AIDS prevention services

- **UNAIDS Indicators**: 62.7% of injecting drug users (IDUs) who are covered with HIV/AIDS prevention services

By the estimation of the Ministry of Public Security, in 2002, there were 142,000 drug users in Viet Nam, of them 30,000 in Ho Chi Minh City and 10,000 in Ha Noi. According to a study of the Ministry of Labour - War Invalids and Social Affairs (MOLISA), in 1999, the rate of drug injection were different from one province to another, while the average rate is 59%. Scale and amplitude of the intervention activities are different from one locality to another. However the most common HIV/AIDS prevention activities include: provide IEC at the rehabilitation centres for drug abusers; conducting community out-reach approaches; providing clean needles, syringes and condoms; HIV detection tests counselling and caring services for HIV infected drug users and their families. Those activities are all of small scale due the lack of one comprehensive implemented synchronically from central down to local levels. According to a behaviour surveillance survey conducted in 2000 in 5 big provinces/cities (Ha Noi, Hai Phong, Da Nang, Ho Chi Minh and Can Tho) and the qualitative survey on a risk of HIV/AIDS infection conducted in 2002 in 5 mountainous and border provinces (Lai Chau, Quang Tri, An Giang, Dong Thap and Kien Giang) showed that the average rate of the injecting drug users having access to peer education services is 32.3%. (Detail information related to this indicator is presented in annex 3, form NPBI-6 and narrative report 6).
2.4 National efforts in impact alleviate with a focus on orphans.

Currently, there are around 133,000 orphans, including 20% of them whose parents died, 80% of them whose one parent died. Viet Nam has no specific data and information on the number of orphans of both parents, orphans of one parent and orphans who can still go to school (by sex).

In 2000, the Government started a programme to help children in special difficult circumstances (orphans, street children and disable children). Starting in 2003, this programme will be expanded including children who are HIV/AIDS infected/affected.

IV. MAJOR CHALLENGES AND ACTIONS NEEDED TO ACHIEVE THE GOALS / AND TARGETS

1. Challenges to the national responses and the actions needed to deal with such obstacles to achieve the pre-set goals for 2005 and 2010.

1.1 Inadequate and asynchronous policy and law system, particularly those in relation to harm reduction interventions among high-risk population.

Recommendations:

- Promoting the amendment of HIV/AIDS Prevention Ordinances and the relevant documents to guide its implementation, particularly on:
  - Multisectoral involvement and coordination;
  - Implementation of harm reduction programme: peer education, needles and syringes and condoms distribution;
  - Health insurance, prophylaxis measures and treatment for staff who are HIV exposed as professional risk when participating in the programme;
  - Access to antiretroviral drugs including ARV treatment for poor people;
  - Comprehensive care for HIV infected people and AIDS patients, including HIV/AIDS infected/affected children and those supportless HIV infected people;
  - Confidentially, Counselling and Voluntary Testing;
  - Comprehensive programme on prevention of mother-to-child transmission (PMTCT);
  - HIV/AIDS Prevention workplaces,
  - Stigma and discrimination, including rights and responsibilities of people living with HIV/AIDS and their families;
  - Greater Involvement of People Living with HIV/AIDS;
  - HIV/AIDS prevention in prisons and rehabilitation centers.

- Promoting the formulation of HIV/AIDS National Strategy Plan up to the year 2010.
1.2 **Incomplete organizational system for HIV/AIDS prevention. HIV/AIDS staff, short in number, weak in capacity particularly in planning, social mobilization, monitoring and evaluation.**

**Recommendations:**
- Continuing to strengthen and complete organizational system for HIV/AIDS prevention system from central down to local levels,
- Increasing the number of full-time staff who participate in the HIV/AIDS prevention programme at all levels,
- Training and retraining of full-time staff who participate in the HIV/AIDS prevention programme at all levels,

1.3 **National resources for HIV/AIDS prevention programme are still limited**

**Recommendations:**
- Integrating the HIV/AIDS prevention programme into other health care and socio-economic and cultural programmes,
- Increasing Government annual budget for HIV/AIDS prevention programme,
- Resource mobilization from local authorities, social organizations, business sectors and communities,
- Enhancing and expanding international cooperation.

1.4 **Monitoring and Evaluation system is not yet completed, and could not provide data and information on indicators in line with international rules**

**Recommendations:**
- Establishment a monitoring and evaluation unit for data collection; information sharing and disseminating;
- Development of national indicators of the National AIDS Programme;
- Capacity building for full-time staff on planning, management monitoring and evaluation of the National AIDS Programme;
- Allocating sufficient budget for monitoring and evaluation of the national AIDS Programme.

2. **National data collection’s plan for the 2005 country report**

Due to limited availability of the information and data, the calculation of indicators on monitoring and evaluation of the national AIDS programme could not be made as stipulated by UNAIDS guideline as explained in the above sections. In the upcoming years, Viet Nam will
have to conduct surveys based on the standard methodologies developed by UNAIDS and WHO and MEASURE Project. The plan is proposed as it follows:

2.1 **National household sample surveys**

- Objectives: to collect data and information for the calculation of following indicators:
  - Knowledge/behaviour and HIV infection among 15-24 years of age group,
  - Ratio of current school attendance among orphans to that among non-orphans aged 10-14,
  - The percentage of injecting drug users practicing safe practices and access to HIV prevention services;
- Venue of the survey: samples will be selected from a number of provinces and different ecological areas in Viet Nam including both urban and rural areas.
- Methods and tools: according to the guidelines of WHO, UNAIDS and MEASURE.

2.2 **National school sample surveys**

- Objectives: to collect information for the calculation of the percentage of schools with teachers who have been trained in life-skills based HIV/AIDS education;
- Venue of the survey: samples will be selected at the schools in different provinces and ecological areas in Viet Nam, including urban and rural areas,
- Methods and tools: according to the guidelines of WHO, UNAIDS and MEASURE.

2.3 **National workplace sample surveys**

- Objectives: to collect information for the calculation of the percentage of large enterprises/companies (both state owned and private) having policies and HIV/AIDS prevention programmes at their work places,
- Venue of the survey: at a number of sample enterprises/companies (both state owned and private) in different provinces and ecological areas in Viet Nam,
- Methods and tools: according to guidelines of WHO, UNAIDS and MEASURE.

2.4 **National health facility sample surveys**

- Objectives: to collect information for the calculation of the indicators on
  - The percentage of STIs patients at health service centres receiving correctly diagnosed, treated and counseled,
  - The percentage of HIV infected pregnant women receiving a full course of ARV to reduce the risk of mother-to-child transmission,
  - The percentage of HIV advanced patients receiving the ARV combination therapy,
- Venue of the survey: at a number of sample hospitals in different provinces and ecological areas in Viet Nam,
- Methods and tools: according to the guidelines of WHO, UNAIDS and MEASURE.

2.5 **National desk reviews:**

- National reporting system:
o Regular reports (monthly, quarterly) and the annual reports on HIV/AIDS prevention programme from ministries, agencies and 61 provinces/cities;

o Reports of Ministry of Health:
  ▪ Monthly report on HIV/AIDS sero-surveillance from 61 provinces including the number of HIV/AIDS reported cases, deaths, and distribution by age, by gender and by risk population,
  ▪ Regular report on STIs normal rule surveillance: it was planned that starting in 2003, 10 provinces/cities will conduct this surveillance including on STIs rate in each target group, and distribution by age, by gender and by risk population,
  ▪ HIV/AIDS sentinel surveillance report of 40 provinces/cities by 6 target population, and distribution by age and by gender,
  ▪ Behavioral Surveillance Survey report of 5 provinces of Viet Nam,
  ▪ Reports of five sub-committees of the Ministry of Health: Therapy sub-committee, Mother and child protection sub-committee, Hematology and Blood Transfusion sub-committee, Pediatrics sub-committee, and Surveillance sub-committee.

- Reports of those quantitative studies of intervention projects and researches on HIV/AIDS situation and risk of transmission,
- Reports of the local NGOs currently working on HIV/AIDS/STI.

V. SUPPORT REQUIRED FROM COUNTRY’S DEVELOPMENT PARTNERS

1. **Formulation of HIV/AIDS National Strategic Plan up to 2010, which includes:**
   - HIV/AIDS prevention coordination mechanisms at all levels;
   - Mobilization of the involvement of new members in HIV/AIDS prevention;

2. **Development and implementation the nine following programmes:**
   - Sustainable communication and promotion of traditional cultural values in HIV/AIDS prevention in order to generate "safe communities",
   - Behavioral Change Communication, including the harm reduction programme among high-risk population,
   - Promoting the life-skills-based HIV/AIDS prevention education in general schools,
   - HIV counselling and voluntary testing,
   - Prevention of mother-to-child HIV transmission,
   - Care and support to HIV/AIDS patients,
   - Access to antiretroviral drugs,
   - STIs surveillance,
   - Researches of traditional medicines to supportive treatment of HIV infected people.

3. **Establishment of national system on monitoring and evaluation of National AIDS Programme.**
   - Setting up a unit for monitoring, evaluation, data collection and dissemination as well as management of information and data related to National AIDS Programme activities,
   - Developing a set of national indicators on monitoring and evaluation of national AIDS programme me.
   - Capacity building for full-time staff on planning, management monitoring and evaluation of the National AIDS Programme me.
VI. MONITORING AND EVALUATION

1. Current situation on HIV/AIDS monitoring and evaluation in Viet Nam

- The monitoring and evaluation of national AIDS programme has been mentioned in action plans of the national AIDS programme in Viet Nam in the recent years. However, in comparison with the guidelines of UNAIDS/WHO and MEASURE Project, Viet Nam has not yet met all criteria, it means that the current system could not provide information for the calculation of truly significant indicators for the evaluation of the effectiveness of the National AIDS Programme. Studies and researches are segmental, asynchronous and there is a lack of coordination at the national level. At present, there is no national plan and guideline on monitoring and evaluation of the national AIDS programme in Viet Nam. The current existing data and information collected are mainly focused on national programme activities.
- Currently, there are only two programme, sentinel surveillance and behaviour surveillance survey, in which provide information on trends of HIV transmission and a number of behaviour indicators of some targeted population.
  - **HIV sentinel surveillance**: started in 1994, in 8 provinces and last year has been expanded into 40 provinces implemented according to the WHO guidelines. The sentinel surveillance focuses on 6-targeted population: injecting drug users, female sex workers; STIs patients, tuberculosis patients, pregnant women and army conscripts or army candidates. Horizontal surveillance is repeated annually (during June - August period) and the sample size is 400 for the high-risk population and 800 for low-risk population.
  - **Behavioral surveillance survey (BSS)**: started in Viet Nam in 2000 with technical and financial assistance of the US Family Health Institute (FHI). Viet Nam conducted two rounds of BSS in 2000 and 2001 in 5 provinces: Ha Noi, Hai Phong, Da Nang, Ho Chi Minh and Can Tho. The selection of these cities was based on criteria of their large size, high risk and high HIV prevalence rate. HIV sentinel surveillance sites, availability of HIV/AIDS prevention and intervention, staff capable to implement the behaviour surveillance. The targeted population is: street female sex workers, female sex workers in karaoke, injecting drug users, migrating workers (male construction workers, long-distance drivers, seafarers/fishermen). The methods and tools for behaviour surveillance are based on the guideline of FHI.

- HIV/AIDS reporting system: AIDS Divisions at provincial health departments are responsible for collecting and compiling the monthly report on the result of tests, detection and monitoring of HIV/AIDS patients in their own provinces according to a national report format and following the reporting system (see chart below). Data and information will then be sent to local Pasteur Institutes and Institutes of Epidemiology and Hygiene and further up to the National Institute of Epidemiology and Hygiene and AIDS Division of the Ministry of Health. The result of the HIV sentinel surveillance is to be reported by the end of the year.
2. Proposals for strengthening of national monitoring and evaluation system on the National AIDS Programme in Viet Nam

- To establish a monitoring and evaluation unit: this should be located on the Ministry of Health with the participation of various experts/professionals/specialties in different field such as epidemiology; psychology; statistics; health issues; and data processing. The unit should also maintain good relations with research institutes and non-governmental organizations,

- To allocate sufficient fund from the national budget for monitoring and evaluation, about 10% of the total national HIV/AIDS/STIs prevention budget,

- The objectives of monitoring and evaluation should be made clear and could answer the following questions:
o Do the trends of HIV/STIs infection among sentinel surveillance population (injecting drug users, female sex workers, pregnant women, 15-24 years of age youth) increases or decreases?
o If there is any change in the trend, is because the behaviour of the targeted population changes?
o If there is any behaviour change, is it because of the intervention?

- To develop a set of indicators in line with the concrete situation and resources of Viet Nam, including priority indicators and additional indicators at various monitoring and evaluation levels that could be compared by time series and to other countries;

- To develop the instruction manuals for monitoring and evaluation of national HIV/AIDS prevention programme. Capacity building for full-time staff capacity on monitoring and evaluation;

- To disseminate the data and information including:
  o Making plan of disseminating the data and information related to monitoring and evaluation,
  o Organizing annual meetings to disseminate and discuss on research/studies results and monitoring and evaluation results with policies makers and planners,
1) Which institutions/entities were responsible in filling out the indicators forms?

| National Committee for AIDS, Drug and Prostitution Prevention and Control | Yes |
| Members participate in the National AIDS Programme | Yes |
| Other agencies include: | Yes |
| Centre for Social Development Studies; | Yes |
| Public Health Faculty, Hanoi Medical University; | Yes |
| National Institution for Mother and Newborn Protection; | Yes |
| HIV/AIDS Surveillance sub-committee, Ministry of Health; | Yes |
| HIV/AIDS Therapy sub-committee, Ministry of Health. | Yes |

2) With inputs from:

| Ministries | Education and Training | Yes |
| Health | Yes |
| Labor, Invalid and Social Affairs | Yes |
| Foreign Affairs | Yes |
| Others include: Finance, Police Security; Planning & Investment; National Committee for Children and Family; Defense. | Yes |
| Socio-economy-political organizations including Youth Union, Women Union, Vietnam Chamber of Commerce and Industry. | Yes |
| People Living with HIV/AIDS | No |
| Private sectors | No |
| Eight UN agencies (UNDP, UNICEF, UNFPA, UNESCO, UNDCP, ILO, WHO, UNAIDS and the World Bank) | Yes |
| Bilateral donors including SIDA, CIDA, USAID, AuAID, Ford Foundation, CDC. | Yes |
| International NGOs: FHI, SCF/UK, Australia Red Cross and Care International | Yes |
| Others: Local NGOs: VICOMC, SHAPC and SUCECON. | Yes |

3) Was the report discussed in a large forum? Yes

Two consultative workshops were held on April 1, 2003 and April 7, 2003 with the participation of more than 60 members from national and international agencies to discuss and comment on the country report.

4) Are the survey results stored centrally? Yes

Data and information are available in the Ministry of Health of Vietnam for further reference as well as for preparation of upcoming years country report.

5) Is data available for public consultation? Yes

Name/Title: Tran Thi Leung Quyen/Minister of Health

Date: 23/4/2003

Signature: [Signature]
ANNEX 2

NATIONAL COMPOSITE POLICY INDEX

STRATEGIC PLAN

1. Has your country developed multisectoral strategies to combat HIV/AIDS?  
(Multisectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors)

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Comments:

- The Ordinance on HIV/AIDS Prevention and the Government’s regulatory documents provide specific responsibilities and tasks of ministries, sectors and mass organizations; the organizational structure of the National Committee represents a multisectoral strategy on AIDS prevention (composed of representatives from 16 ministries and sectors including health, education, labour and agriculture);
- National HIV/AIDS prevention activities are based on the Mid-term Plan or the direction for HIV/AIDS prevention that are formulated on a 5-year basis. Ministries and sectors of the National Committee and 61 provinces/cities participated in development of such a national plan;
- Every year the National Standing Bureau of the Ministry of Health, is working with each ministry/sector member of the National Committee to develop a specific action plan and evaluates the implementation of activities in the end of the year;
- At present, the Deputy Prime Minister – Chairman of the National Committee on AIDS, Drug and Prostitution Prevention has issued a directive on the formulation of the National AIDS Strategy up to the year 2010. It is planned that the multisectoral National AIDS Strategy will be completed by the end of 2003;
- In the beginning of March 2003, the prime Minister issued the Directive on Strengthening AIDS Prevention, which assigned specific tasks to each and every ministry/sector.

2. Has your country integrated HIV/AIDS into its general development plans (such as its National Development Plans, United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Common Country Assessments)?  

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Comments:

In 2002, a series of national development plans were approved, in which the HIV/AIDS issue was always presented as priority targets. The Socio-Economic Development Strategy for the 2001-2010 Period and the Socio-Economic Development Action Plan for the 2001-2005 Period are broken down into the following specific action plans:

- The Comprehensive Poverty Reduction and Growth Strategy (CPRGS) up to 2010: with the goals of reducing the HIV prevalence in the age groups of 15-49 and reducing the HIV prevalence in children by the year 2010;
• The Millennium Development Goals (MDGs): with the goals is to slow the increase in the spread of HIV/AIDS by the year 2005, and to halve the rate of increase by 2010;
• The HIV/AIDS Programme has been included into the National Target Health Programme (the national programme for prevention of dangerous epidemics, social diseases and HIV/AIDS).

3. Does your country have a functional national multisectoral HIV/AIDS management / coordination body? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

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**Comments:**

• In the beginning of 1994, the National Committee on AIDS Prevention was established and chaired by the Deputy Prime Minister. This National Committee was operating with the participation of various ministries and sectors, including health, education, labour invalids and social affairs, and public security;
• In the mid-2000, the National Committee on AIDS, Drug and Prostitution Prevention was established according to Decision No. 61/QD-Ttg by the Prime Minister, also had a multisectoral structure because it had the participation of 16 member ministries and sectors. Each ministry/sector has its own focal point and a Vice Minister or an equivalent in charge;
• The National AIDS Standing Bureau, under the Ministry of Health, has been established to assist the Ministry of Health and the National Committee in coordinating AIDS prevention activities of member ministries and sectors, and of 61 provincial standing bureaus. Up to now, more and more social organizations, including People living with HIV/AIDS and their families; local NGOs, and local-based HIV/AIDS research institutions;
• Every year, the National Committee holds national conferences to review the implementation of HIV/AIDS prevention activities and to develop AIDS prevention plans for the following year. In addition, in 61 provinces/cities and 16 ministries/sectors also hold its review conferences. On a quarterly basis, meetings and briefings of leaders are held to be updated with reports and to provide guidance for the implementation of activities.

4. Does your country have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

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**Comments:**

• The National AIDS Standing Bureau, under the Ministry of health, is charged with the tasks of providing assistance to the National Committee and the Ministry of Health in coordinating AIDS prevention activities, especially communication and mobilization of the community involvement (including promotion of cooperation activities among Government agencies, the private sector and mass organizations).
• The AIDS Division, under the Ministry of Health, provides the assistance to the Ministry of Health in coordinating AIDS prevention activities in the health sector throughout the country;
• Every year, in national annual review conference and at semi-annual briefing conferences NGOs and social, economic organizations are always invited to present and contribute their ideas, their experiences and lessons learnt in strengthening of National AIDS Programme me;
• In 2002, the National AIDS Standing Bureau, under the Ministry of health, in coordination with the National Fatherland Front organized a conference on HIV/AIDS prevention and religion.

5. Does your country have a functional HIV/AIDS body that assists in the coordination of civil society organizations? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

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Comments:
• The National AIDS Standing Bureau, under the Ministry of Health, provides a support for such coordination;
• Every year, The National AIDS Standing Bureau, under the Ministry of Health holds at least 2 meetings with economic social organizations at the central level to discuss plans;
• Such civil organizations as the Fatherland Front, religious organizations and voluntary and charitable organizations are operating more vigorously and more actively. However, the majority of AIDS prevention activities of these organizations are still limited.

6. Has your country evaluated the impact of HIV/AIDS on its socio-economic status for planning purposes?

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Comments:
• The country is deploying a plan and seeking resources required for such an undertaking.

7. Does your country have a strategy that addresses HIV/AIDS issues among its national uniformed services, including armed forces and civil defense forces?

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Comments:
• The Ministries of Defense and have Public Security are members of the National Committee on AIDS, Drug Abuse and Prostitution Prevention. These ministries normally develop their annual action plans based on budgets allocated by the Government and support budgets of their own; The National AIDS Standing Bureau, assists the National Committee and the Ministry of Health in coordination, guidance and supervision of AIDS prevention activities of these ministries.
PREVENTION

1. Does your country have a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS?

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Comments:
- Information, education and communication (IEC) on HIV/AIDS have been regarded as the main tasks of the National AIDS Programme;
- Laws, policies and specific action plans all have been aimed to strengthen activities that increase the awareness of the general population on HIV/AIDS; communication policies have been regularly revised and amended in order to phase out the misconceptions of the general population related to HIV/AIDS, and to reduce stigma and discrimination towards people living with HIV/AIDS and their families;
- In addition, lessons learned from communication and education programmes for behavioral change in localities have been updated regularly, and shared with other localities, sectoral agencies and mass organizations that participate in AIDS prevention to secure a common message on HIV/AIDS.

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?

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Comments:
- In 2002, the Government approved the National Strategy on Strengthening Reproductive Health. This programme has been implemented both in and out schools.
- The reproductive health and sexual health education programmes have been regarded as one of the national priority programmes. The majority of HIV/AIDS communication activities targeting youth in Vietnam have been integrated into this Programme.
- Policies and strategies have been developed using an integrated approach whereby HIV/AIDS and reproductive health are not separated. However, these programmes are annually updated and revised to better reflect the situation of the epidemics and awareness and knowledge of young people.

3. Does your country have a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection? (Such groups include, but are not limited to, IDUs, MSM, sex workers, youth, mobile populations and prison inmates.)

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Comments:
- Alongside with national strategies to increase information, education and communication for the general population, Vietnam has additional laws, specific instructions and guidance to increase awareness among high-risk and vulnerable population such as: injecting drug abusers; sex workers; young people; migrants and inmates. There have not yet issued any separate instructions or regulatory documents targeting in men who have sex with men population. In addition, circulars and directives on communication give
attention to locations (i.e. urban and rural areas);
- Policies on medical interventions targeting the above-mentioned groups have been formulated and regularly revised and amended by the Ministry of Health with guidance on provision of interventions for each and every target population, applied to health facilities at different levels.

4. Does your country have a policy or strategy that promotes IEC and other health interventions for cross-border migrants?

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Comments:
- Information, education and communication targeting cross-border migrants have been attached with importance, and facilitated by the Government so that such activities are promoted through issuance of support policies;
- However, due to limited national budget resources, such activities have just been restricted to education and communication activities, and provision of health services in border areas has not yet implemented. Wherever such provision of health services is available, it is done on a small scale only but it receives supporting policy from local authorities to access and to provide services to targeted population.

5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities? (These commodities include, but are not limited to, condoms, sterile needles and HIV tests.)

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<th>Groups:</th>
<th>Commodities:</th>
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<td>Yes</td>
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</table>

Groups:
- Injecting drug users
- Sex workers
- Regular/ irregular clients of sex workers
- Mobile groups (sailors, long distance truck drivers and migrating workers)
- Young people
- Pregnant women

Commodities:
- Information;
- Condoms;
- Confidentially, Counselling and voluntary HIV / STI testing services
- Sterilized needles and syringes;

Comments:
- There have been no specific intervention policies for men who have sex with men population.

6. Does your country have a policy or strategy to reduce mother-to-child HIV transmission?

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<th>Yes</th>
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Comments:
- The Ministry of Health has issued policies at health/ medical facilities to secure that 100% of HIV positive mothers receiving counselling, care and prophylaxis ARVs treatments to prevent mother-to-child transmission.
HUMAN RIGHTS

1. Does your country have laws and regulations that protect against discrimination of people living with HIV/AIDS (such as general non-discrimination provisions and those that focus on schooling, housing, employment, etc.)?

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Comments:
- The Ordinance on AIDS Prevention passed by the Standing Committee of the National Assembly on 31 May 1995 clearly stipulates in Article 1 Chapter I that: “People infected with HIV/AIDS shall not be discriminated”. The regulation on professional handling of HIV/AIDS cases of the Ministry of Health (issued according to Decision No. 2557/QD-BYT dated 26 December 1996) also clearly stipulates in the part of General Provisions that: “Stipulations in this document completely secure the principle of non-discrimination, non-prejudices and confidentiality for people infected with HIV and AIDS patients”;
- Recent recommendations show that there is the need for some legal rulings on protection of the rights of HIV/AIDS infected people to be revised and enhanced.

2. Does your country have laws and regulations that protect against discrimination of groups of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

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Comments:

3. Does your country have a policy to ensure equal access, for men and women, to prevention and care, with emphasis on vulnerable populations?

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Comments:
- At present, Vietnam’s laws provide for and secure equity between men and women. The Protection of the People’s Health Code rules “all Vietnamese citizens are entitled to have access to health care services regardless of any population groups they belong to.”

4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee?

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Comments:
- An ethic appraisal committee in physiological researches has been established by a decision of the Minister of Health and is lodged in the Science and Training Department of the Ministry of health.
CARE AND SUPPORT

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

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<th>Yes</th>
<th>Groups:</th>
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<td></td>
<td>Injecting drug users</td>
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<td>Sex workers</td>
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<td>Regular/irregular clients of sex workers</td>
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<td>Mobile groups (sailors, long distance truck drivers, migrating workers)</td>
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<td></td>
<td>Young people</td>
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<td>Pregnant women</td>
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<td>HIV/AIDS infected people</td>
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<th>No</th>
<th>Commodities:</th>
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<tr>
<td></td>
<td>Information;</td>
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<td></td>
<td>Condoms;</td>
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<td></td>
<td>HIV/STI confidentially voluntary counselling and testing services; health care counseling services including direct counseling and counseling services via telephone;</td>
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<td></td>
<td>Care and treatments for STIs;</td>
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<td>Home-based and community-based care, other social support</td>
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Comments:
- Since 1996, the Ministry of Health has conducted a network of Counselling, Care, and Management at community. This model has been replicated to 20 provinces and cities, and now expanded to 40 provinces.

2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups? (HIV/AIDS-related medicines include antiretroviral and drugs for the prevention and treatment of opportunistic infections and palliative care.)

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<td></td>
<td>HIV/AIDS infected people;</td>
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<td></td>
<td>STI patients;</td>
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<td>Pregnant women;</td>
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<td>HIV exposed staff.</td>
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<tr>
<th>No</th>
<th>Commodities:</th>
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<tr>
<td></td>
<td>Free of charge provision of ARV drugs but still very limited;</td>
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<tr>
<td></td>
<td>Free of charge treatments of opportunity infections at health/medical centres.</td>
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</tbody>
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Comments:
- Moving towards encouraging patients to pay for their medicines; using generic drugs; and complementary treatments by commodities of traditional medicine.
3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children?

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Comments:

- Vietnam is one of the nations that signed the International Convention on Rights of Children, therefore all the rights of children are secured, and in addition the Government and related agencies also issued many regulatory documents providing specific guidance for the implementation of the rights of children.
- Decree No. 07/2000/ND-CP (dated 9 March 2000) on the Social Relief Policy as in Article 6 (Clause 1), Article 9 (Clause 1), Article 10, and Article 11;
- Decree No. 95/CP (dated 27 August 1994) on recovery of part of user fees as in Article 3, Clauses 2 and 4;
- Circular No. 27/LDTBXH (dated 24 October 1995) on guidance for granting of certificates to people entitled to part of user fees exemption when visiting State health/medical centres for examination and treatment.
- In 2000, the Government launched the programme for care and support to children with special difficulties (i.e. orphans, homeless children and children with disabilities). Starting in 2003, this programme will be expanded, including children affected/infected by HIV/AIDS.
ANNEX 3

NATIONAL PROGRAMME AND BEHAVIOR INDICATORS

Narrative report - NPBI-1:

Percentage of schools with teachers who have been trained in HIV/AIDS prevention and accessed to training materials on life-skills based HIV/AIDS education.

1. Data and information source
   1. Data source:
      - Reports, training materials on HIV/AIDS prevention activities of the Ministry of Education and Training (MOET);
      - Interviews of MOET/HIV/AIDS focal points, Physical Education Department of MOET.
   2. Measurement tool: Education programme review and using existing data and interviews
   3. Studied samples: Students in public and private schools, 3rd, 4th, 9th and 11th grades who are trained in HIV/AIDS.
   4. Sample selection procedure and sample size: All 61 provinces/cities in the country.

2. Method of measurement
   - Numerator: Number of schools who have been trained in HIV/AIDS prevention and accessed to training materials on life-skills based HIV/AIDS education. Data is collected from interviews of the HIV/AIDS focal points of the Physical Education Department of MOET;
   - Denominator: Total number of general schools in Vietnam as stated in 2001 Statistics Year Book of MOET.

3. Results and analysis
   - On the formal and informal training courses:
     Since 1998, students have been trained in HIV/AIDS at 3rd grade (2 periods/year in physical health education subject); at 4th grade (3 periods/year in physical health education subject), at 9th grade (1 period/year in biology subject) and at 11th grade (1 period/year in citizenship education subject). For grades in secondary and high education, students are trained on HIV/AIDS in their class meeting on the last Saturday of the month. That is to say the total time spent on this subject for a student at their high school graduation is (7 periods x 7 years) + 1 period (11th grade) + 1 period (9th grade) + 5 period 3rd and 4th grades) =56 periods. At present, MOET in collaboration with UNICEF and other INGOs are implementing in a pilot scheme “Healthy Education and life skills education” for grades (6, 7, 8, 9) in some provinces and districts. Training materials, pictures, songs and messages on a healthy life, information on HIV/AIDS and drug are being produced under this programme. The students will be equipped with life skills such as decision-making, communication in order to help them protect themselves. At the same time, seminars on "healthy life" are organized to help their parents raise their understanding. "Healthy life" is also communicated by the operation of the shock troops composing of advanced students and active teachers. The shock troops will organize activities on days such as World AIDS Day, No-smoking day and the day of the establishment of the youth league 26th of March.
• **Training materials:**
HIV/AIDS Steering Committee of MOET has developed and disseminated 50,000 booklets "For future life" to all schools throughout the country. This is the basic training material for life skills based HIV/AIDS education on themes: Preventive HIV/AIDS education in schools; summarizing basic concepts on HIV/AIDS; and guideline for informal activities in schools (health and diseases, healthy life, sentiment, advices of the ones who understand, building good relationship, social communication and behaviour).

• **Teachers:**
Since 1996, HIV/AIDS education has been introduced into the training programme of the Teachers Training Universities, one period for both university and college education and 10 periods for those students who will teach this subject when they graduate (students of biology). It is estimated that 1/6 of teachers who are teaching in general schools have been trained in this subject when they were in universities. According to the report of MOET, for 5 years now 100% of schools have teachers trained in HIV/AIDS. Trained teachers who are participating in teaching the subject are those of biology so in principle the quality of the education is ensured. Only in a number of provinces under the coverage of UNICEF project, teachers are trained in life skills based HIV/AIDS education while majority of the teachers accessed to this training method via "For future life" as mentioned above. However, there is no specific data on number and quality of teachers teaching this subject in each school and in the whole country. Apart from regular training, teachers can also have access to update information on HIV/AIDS from magazines such as "Education" or Education Development” "The World in ourselves” and also in seminars on content and methods to organize PC AIDS activities in primary and secondary schools as per the guidelines of the book "For future life".

• **Budget for HIV/AIDS prevention activities** in 2002 was too small to meet the demand. The majority of the budget was from the state. To the present time, there has been no budget allocated to schools for HIV/AIDS prevention and so schools meet difficulties in doing so.

• **Limitation of qualitative data:**
  o Data related to the schools with teachers who have been trained in HIV/AIDS in recent 5 years was only projected from the fact that HIV/AIDS education has been taught officially at all levels of education, in all public and private schools in the whole country. There is no official data available related to teacher who has received training in participatory life-skills-based HIV/AIDS education
  o There is a lack of data and information related to number and quality of teacher and the quality of HIV/AIDS education in schools, particularly life skills based HIV/AIDS prevention education; there is also lack of information on number of schools classified by urban and rural areas.
  o Definition in this report on schools with at least one teacher teaching life skills based HIV/AIDS education is not yet in line with the definition of UNAIDS guideline, in which provides that the school have at least 30 periods in each academic year for each grade.

4. **Conclusion:**
• Knowledge on HIV/AIDS has been universally taught at all schools, public and private in the whole country in both formal and informal courses. In addition, the programme “Healthy life and life skills education” jointly organized by MOET and UNICEF is in the pilot scheme to be expanded into large scale later.
• Teachers on jobs are updated with HIV/AIDS knowledge by retraining courses and by theme columns of professional magazines.
• Data quality: there is still a lack of data and information on quantity and quality of life skills based HIV/AIDS education.
NPBI-1
Life-skills-based HIV/AIDS education in schools

Data source: name
HIV/AIDS Steering Bureau of Ministry of Education and Training

Data source: type
Programme review and interviews

Data collection period
(day/month/year)
11 03 2003 to 14 03 2003

PART I:
Data requirements**

<table>
<thead>
<tr>
<th>Primary schools</th>
<th>Secondary schools</th>
<th>All schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>National</td>
<td>National</td>
</tr>
</tbody>
</table>

NUMERATOR

Instructions:
1. Select only those schools that provided information (excluding "don't know") to all 3 questions (i.e., questions 1 to 3 below)
2. Line 1: enter the number of schools that stated that they had a teacher trained in the last 5 years to teach life-skills-based HIV/AIDS education
3. Line 2: enter the number of schools that answered "yes" to the question in line 1 and who also reported that their trained teachers taught HIV/AIDS education on a regular basis to all classes in the last academic year

1. School has at least one teacher trained in the last 5 years to teach HIV/AIDS education
   - Public sector schools: 14084
   - Private sector schools: 79

2. School has staff member(s) trained to teach HIV/AIDS education in the last 5 years who has accessed to life-skills-based HIV/AIDS teaching materials and has taught the subject on all classes in the last academic year
   - Public sector schools: 14084
   - Private sector schools: 79

DENOMINATOR

3. Number of schools surveyed
   - Public sector schools: 14084
   - Private sector schools: 79

4. Total number of schools in the country:* (14084)
   - Public sector schools: 14084
   - Private sector schools: 79

PART II:
Indicator computation

INDICATOR SCORES BY TYPE & LOCATION OF SCHOOL

5. Divide the number of schools (public & private) that reported having a staff member trained to teach HIV/AIDS life-skills-based education (line 2) by the total number covered by the survey (line 3) and multiply the result by 100.
   - 100.0

INDICATOR SCORES BY TYPE OF SCHOOL (NATIONAL)

6. i) Calculate the weighted average of the urban and rural indicator scores (line 5) using the number of schools in urban and rural areas (line 4) as the weights
   - 100.0

   ii) Calculate the weighted average of the indicator scores (line 5) by type and location of school using the numbers for each type and location of school (line 4) as the weights
   - 100.0

* From Ministry of Education statistics.
** number calculated by national
1. Data and information sources

- **Data source:**
  - Reports of intervention projects and project reports of Care International.

- **Measurement tool:** programme review and using existing data and interviews and conducting a rapid assessment

- **Studied samples:** large state owned and private enterprises in Hanoi, each employing 100 or more workers.

- **Sample selection procedure and sample size:** 22 SOEs and 8 non-SOEs

2. Method of measurement

- **Numerator:** The number of enterprises/companies employing 100 or more workers having full set of HIV/AIDS prevention policies and programmes at their workplaces stated as listed below:
  - Prevention of stigmatization and discrimination on the basis of HIV infection status in (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits;
  - Workplace-based HIV/AIDS prevention, control and care programme that cover (as a minimum): (a) the basic facts on HIV/AIDS; (b) specific work-related HIV transmission hazards and safeguard; (c) condom promotion; (d) VCT; (e) STI diagnosis and treatment; and (f) provision of HIV/AIDS-related drugs.

- **Denominator:** 30 enterprises/companies each employing 100 or more workers.

3. Results and analysis

- **HIV/AIDS prevention programme at workplaces (by desk review and conducting a rapid assessment of 30 enterprises in Hanoi).**

The National AIDS Standing Bureau (NASB), Vietnam Chamber of Commerce and Industries (VCCI), and the Confederation of Labour of Vietnam (VCOL) are three main agencies to jointly initiate and manage the HIV/AIDS prevention activities at workplaces.

**HIV/AIDS education and communication:**
Communication on HIV/AIDS has been conducted by Vietnam Confederation of Labour since 1993, that includes the training for communicators on HIV/AIDS prevention, organizing meetings, propaganda as well as contests on HIV/AIDS prevention; disseminating leaflets, manuals and hanging posters with messages on HIV/AIDS prevention at workplaces. Some enterprises have also combined various forms of information dissemination such as communication seminars, peer education. According to the report, each year 300,000 workers
are communicated on HIV/AIDS prevention. However, such activities have not been conducted at private enterprises due to shortage of fund and staff.

**Anti-discrimination at workplaces policy**
Article A1, Decree 34-CP of the Government promulgated in June 1996 clearly stated: “State agencies, social organisations, economic entities and army units are responsible to disseminate HIV/AIDS prevention information and to protect their staff and employees from HIV/AIDS”. Article A5, section 2 provided: “Employers are responsible to keep secret HIV test results of their employees”. On health examination, Article A8, section 2 provided: “Employers have to organise periodic health check for their employees. Health staff are entitled to asking those who face high risk of HIV infection to have their tests”. Article A17 confirms: “Annually, the Government allocates appropriate budget for HIV/AIDS prevention programme”. According to the interview responses (3/2003) 6 ministries and agencies and 19 enterprises stated: “Employees are requested to have their health check but not requested to have HIV test”. However, 5 other enterprises said that they want their employees to have their HIV test at recruitment. All 30 interviewed enterprises (22 SOEs and 8 non-SOEs) said: “They will not recruit or terminate labour contract if the employee candidate or staff is HIV infected”. Even, some non-SOEs meant that “The benefits of the company will be first and thus if the worker is HIV infected will no longer be fit for work”. Another study conducted by the Institute of Sociology in 18 enterprises in Ha Noi, Da Nang, Ho Chi Minh City in April 2002 produced similar results.

**Supply of specific work-related HIV transmission hazards and safeguards**
A rapid assessment reveals that most of the enterprises confessed they only pay attention to communicate on main channels of HIV transmission because they believe work in the enterprises is a low risk of HIV infection. Five enterprises when interviewed said that they believe the nature of work in their enterprises is risky of HIV infection. However they have not yet applied any ways and means to protect the workers in addition to common practices of wearing boots and gloves. Only one enterprise said that their medical section has applied HIV prevention measures.

**Condom promotion**
Condom promotion is often integrated into the family planning programme, which has been implemented for years in all ministries of the Government. 10 of the 20 enterprises when interviewed answered that they have their programme to provide condoms free to all workers. Some enterprises applied the indirect ways meaning place condoms for free in bathrooms or toilets.

**Counselling and voluntary testing**
Of the 30 enterprises interviewed, none has implemented the programme of counseling and voluntary HIV testing.

**STIs services**
These services are not supplied independently. Workers can seek the services at specialized health service centres by their medical insurance scheme or at private clinics.

**Supply of HIV/AIDS antiretroviral drugs**
At present, in principle, HIV drug is provided to state employees under their health insurance scheme.

- HIV/AIDS Prevention programme at work places (by interviews/surveys on the on-going programme and projects)
Since 1996, the former National AIDS Committee and Vietnam Chamber of Commerce and Industries have mobilized the contribution of a number of donors and the technical assistance of the INGOs to develop a number of HIV/AIDS prevention programme at workplaces. The international organization that has actively participated since the first days (since 1997 to the present time) in HIV/AIDS prevention at workplaces is Care International. Programmes and projects of Care International were implemented in a number of enterprises in Ha Noi and Quang Ninh. Under the project “Work with AIDS” in enterprise based in Ha Noi, activities conducted include: HIV/AIDS prevention at workplaces with the participation of management and employees’ representative; HIV/AIDS information provision; condoms promotion and establishment of HIV/AIDS counselling network. Since the project closed in 2001, two large participating enterprises had their own HIV/AIDS prevention programme with full set of documents and training materials that were then shared for the use of other enterprises. Practical proposals to expand the programme were submitted to the Government. Another project started in early 2002 in 20 industrial companies in Quang Ninh “Confronting with HIV/AIDS at workplaces”. The main objectives of this project are to promote the HIV/AIDS prevention activities and to build up an applicable and multipliable model of care and support for HIV infected workers.

- Limitation of data

Available data and information do not allow the good evaluation of HIV control at workplaces in the whole country. A rapid survey results from 30 enterprises in Ha Noi could only serve as an example to calculate this indicator and it could not provide the national sample for the sample size is too small as the number of large private enterprises in Ha Noi is not as big as instructed in the UNAIDS set of indicators.

4. Conclusion

- The Ordinance and the Decree 34-CP provide the legal ground against stigma and discrimination practices at workplaces. However, we still need more concrete guidelines on the recruitment and promotion policies of the enterprises. On the other hand, attention has been paid only to the SOEs and the private sector has not yet been mobilized.
- HIV/AIDS prevention related activities in the enterprises are still very limited, mainly on education and communication. Only a small number of the enterprises have implemented pilot projects with distribution of condoms and STIs examination and treatment for their employees. There is, however, the question on the sustainability of these activities when the projects complete.
### Workplace HIV/AIDS control

#### Source of data used: name
Conducted a rapid assessment in Hanoi and programme reviews.

#### Source of data used: type
Interviews, surveys

#### Date data collected
10 3 2003 to 14 3 2003

#### PART I: Data requirements

<table>
<thead>
<tr>
<th>FORMAL SECTOR EMPLOYMENT</th>
<th>Men</th>
<th>Women</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7773</td>
<td>9624</td>
<td>17397</td>
</tr>
<tr>
<td>1. Formal sector workforce (000s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Population aged 15-64 years (000s)</td>
<td>21947</td>
<td>22940</td>
<td>44887</td>
</tr>
<tr>
<td>Formal sector employment rate</td>
<td>35.42</td>
<td>41.95</td>
<td>38.76</td>
</tr>
</tbody>
</table>

#### Numerator

<table>
<thead>
<tr>
<th>Public sector</th>
<th>Private sector</th>
<th>All employers in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-discrimination-at-work policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Staff recruitment &amp; promotion</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>4. Staff benefits</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td>5. Number of employers providing both of the above</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Workplace HIV/AIDS prevention, control &amp; care programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. HIV/AIDS education</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>7. Work-related hazards &amp; safeguards</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. Condom distribution</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>9. Voluntary counselling &amp; testing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10. STI services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11. Provision of HIV/AIDS-related drugs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12. Number of employers providing all of the above</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Comprehensive workplace policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Number of employers with anti-discrimination policies (line 5) and workplace programmes (line 12)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Denominator

| 14. Number of employers in sample | 22 | 8 | 30 |

#### PART II: Indicator computation

**INDICATOR SCORES BY EMPLOYMENT SECTOR**

<table>
<thead>
<tr>
<th>15.</th>
<th>Divide the number of employers with comprehensive workplace policies (line 13) by the total number of employers in the sample (line 14) and multiply the result by 100.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
1. Data and information sources

   - **Data source:**
     - Comprehensive report of the National Institute of Dermato-Venereology on the status of sexually transmitted diseases in all 61 provinces of the country during the year 2002.
     - Base line survey of health staff that giving STIs services in the state health facilities in 5 provinces under the ADB project “Community Action in HIV/AIDS Prevention”.

   - **Measurement tool:** health facility survey.

   - **Studied samples:** health staff working in STI services in five selected provinces.

   - **Sample selection procedure and sample size:**
     - Reported cases of STIs throughout the country in 2002;
     - Health staff at STIs treating centres in 5 mountainous and border provinces under the coverage of ADB project;

2. Method of measurement

   **Numerator:**

   - There was no survey by observations on STIs of examination and treatment as per instructions of UNAIDS (by following steps (a) history taking; (b) examination; (c) diagnosis and treatment; and (d) effective counselling on partner notification, condom use and HIV testing;

   - In 2002, project “Community Action in HIV/AIDS prevention” conducted a survey focusing on health staff by interviewing at the health centres offering STIs services in 5 provinces. The result of the survey reported the percentage of conducting a history taking; the percentage of giving a correct examination to male and female patients; the percentage of diagnosis and treatment of STIs; and the percentage of effective counselling on partner notification, condom use and HIV testing. So that the national research team applied the result of this survey to estimate this indicator as follows: Assume that the interviewed health staff under ADB project have conducted all steps as per the guidelines of UNAIDS (from “a” to “d” as previously described), the numerator will be calculated as follows:
     - Step (a): is estimated by the percentage of the health staff answered that they did “history taking” multiplies by the total number of STIs patients reported in Vietnam in 2002;
     - Step (b): is estimated by the percentage of the health staff answered that they did “correct examination” for male and female patients multiplies by the number of male and female STIs patients reported in Vietnam in 2002;
     - Step (c): is estimated by the percentage of the health staff answered that did “correct diagnosis and treatment” multiplies by the number of male and female STIs patients reported in Viet Nam in 2002;
     - Step (d): is estimated by the percentage of the health staff answered that they did “effective counselling on partner notification, condom use and HIV testing” multiplies by the number male and female STIs patients reported in Viet Nam in 2002;
     - STIs patients are grouped by ages, <15 and >=15.
Denominator: The number of STIs patients reported in the whole country in 200

3. Results and analysis

- The annual country report showed that in 2002, there was 171,975 STIs reported cases among them 3,435 were HIV positive and 317 AIDS and thus push up the number of STIs reported cases to almost 1 million.
- At present, Vietnam has not yet conducted any study on the medical services assessment at those medical centres related to provision of examination, diagnosis and treatment of STIs (by using observation methods on the process of examination, diagnosis, treatment and correct counseling)

4. Limitation of data:

- At present time, due to the lack of survey data on comprehensive management of STIs cases obtained from observations thus this indicator is only estimated on the base of the available data from other interviews;
- The data on STIs reported cases are grouped into under 15, 15-49 and over 50 years of age and that is why in the report, the data reflex the relative groups of under 15 and over 15 rather than under 20 and over 20 as per instruction of UNAIDS.

5. Conclusion

- According to the estimation based on the available data and information, the percentage of STIs patients were examined, diagnosed, treated and effectively counselled is only about 38.3%, and of all steps the one on examination, diagnosis, treatment and effective counseling produced the lowest rate (36.9% for female STIs patients) while the one on the patient’s history taking produce the highest rate (93.1% for female STIs patients);
- The STIs monitoring and reporting system is only available in the state sector health services and not yet at private clinics. In addition, even in the state sector the reports may not regularly and properly made. This is the biggest constrain to have data and information for analysis and thus the percentage or rate produced are only the estimates and do not reflex truly the real situation.
Sexually transmitted infections: comprehensive case management

**Data source:** AIDE Division, Ministry of Health

**Data source type:** Surveillance report, STIs treatment cases and ADB survey result.

**Data collection period:** 10 3 2003 to 17 3 2003

### PART I

#### Data requirements*

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
<th>Both sexes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15</td>
<td>15+</td>
<td>All ages</td>
<td>&lt;15</td>
<td>15+</td>
<td>All ages</td>
<td>&lt;15</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Numerator**

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>History taking</td>
<td>47</td>
<td>25797</td>
<td>136</td>
<td>133966</td>
<td>183</td>
<td>169753</td>
<td></td>
</tr>
<tr>
<td>Examinations</td>
<td>23</td>
<td>12483</td>
<td>54</td>
<td>63294</td>
<td>77</td>
<td>65777</td>
<td></td>
</tr>
<tr>
<td>Diagnosis &amp; treatment</td>
<td>92</td>
<td>17892</td>
<td>93</td>
<td>91868</td>
<td>135</td>
<td>109560</td>
<td></td>
</tr>
<tr>
<td>Counselling, informing partner notification, condom use &amp; HIV</td>
<td>46</td>
<td>25520</td>
<td>133</td>
<td>132516</td>
<td>179</td>
<td>166038</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

| Number of STI patients for whom correct procedures were followed on all of the above | 23    | 12483 | 12509 | 64    | 63394 | 63348 | 77    | 65777 | 65864 |

**Denominator**

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents for whom provider-client interactions were observed on all of the above (lines 1-4)</td>
<td>51</td>
<td>27739</td>
<td>27792</td>
<td>146</td>
<td>144039</td>
<td>144185</td>
</tr>
</tbody>
</table>

### PART II

**Indicator computation**

**Indicator scores by sex & age group**

<p>| | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>46.1</td>
<td>46.00</td>
<td>45</td>
<td>36.99</td>
<td>37.00</td>
<td>37.00</td>
<td>39.09</td>
<td>38.29</td>
<td>38.29</td>
</tr>
</tbody>
</table>

* Distribution by age is changed:

Note: Data are collected by interviewing of health providers at health care facilities offering STI services (not by observation)
1. **Data and information source**
   - **Data source:**
     - HIV sentinel surveillance data of the pregnant women population in 2002.
     - Data of women giving birth in 2002 who had positive HIV test results and had access to ARVs prophylaxis at the National Institution for Protection of Mothers and Newborns, Hospitals of Ob/Gyn of Tu Du and Hung Vuong Hanoi, Hai Phong, Nam Dinh and Thanh Hoa.
     - Data from 1999 General Population Census of the General Statistics Office.
   - **Measurement tool:** programme review and using existing data
   - **Studied samples:** those women giving birth in 2002 who were counselled, voluntary HIV testing and received a full course of ATZ since the 37th week of their gestation.
   - **Sample selection procedure and sample size:** all 61 provinces in the country.

2. **Method of measurement**
   - **Numerator:** The number of HIV infected pregnant women provided with a full course of ATZ + Nevirapine during last 12 month to reduce MTCT.
   - **Denominator:** Estimated number of HIV infected pregnant women in 2002: this number is calculated as the HIV prevalence rate among pregnant women (0.39% according to sentinel surveillance data in 30 provinces in the 2002.) and total number of women gave birth in 2002.

3. **Results and analysis**
   - Figure showed that estimated number of HIV infected women in 2002 is too high (4,900 cases, while only 492 cases detected). This figure is not applicable to the epidemic status in Vietnam. In 2002, only 12,149 new HIV infection were reported.
   - The proportion of women HIV infected and gave birth in 2002 who received AZT and Nevirapine was estimated at very low score (2.35%). However, in fact, 23.4% of 492 HIV reported pregnant women who gave birth in 2002 and receiving a full course of ARVs. This proportion is different between health centers, for example at the National Institution for Protection of Mothers and Newborns, in 2002 alone, 37/44 HIV infected pregnant women being treated with a full course of AZT prophylaxis to prevent MTCT (84.1%), and only in the first 3 months of 2003, 13/14 HIV infected pregnant women were treated with Nevirapine prophylaxis (92.9%).
   - Those HIV infected mothers were not provided with ARV prophylaxis because they were detected HIV positive at the later stage of their gestation (after week 36) and thus could not be treated with AZT. Since the beginning of 2002, in all Ob./Gyn. hospitals in Viet Nam, only AZT was used as the ARV prophylaxis drug to prevent MTCT.

4. **Conclusion**
   - The estimated proportion of HIV infected mothers who were provided with ARV prophylaxis to prevent MTCT in 2002 is presented at low rate (2.35%). This low estimate is possibly due to the use of the HIV infection rate of the urban women under sentinel surveillance and not representing all pregnant women in the whole country.
### NPBI-4

**MTCT: antiretroviral prophylaxis**

<table>
<thead>
<tr>
<th>Source of data used: name</th>
<th>AIDS Division, Ministry of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of data used: type</td>
<td>Sentinel surveillance data and treatment results</td>
</tr>
<tr>
<td>Date data collected</td>
<td>10 8 2003 to 17 3 2003</td>
</tr>
</tbody>
</table>

#### PART I: Data requirements

<table>
<thead>
<tr>
<th></th>
<th>Public sector</th>
<th>Private sector</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NUMERATOR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Number of HIV+ pregnant women provided with ARV therapy to reduce the risk of MTCT in the last month</td>
<td>115</td>
<td>0</td>
<td>115</td>
</tr>
</tbody>
</table>

#### DENOMINATOR

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Number of women who gave birth in the last 12 months*</td>
<td>1256417</td>
</tr>
<tr>
<td>3. HIV prevalence in pregnant women (%)**</td>
<td>0.0039</td>
</tr>
<tr>
<td>4. Estimated number of HIV+ pregnant women in the country in the last 12 months</td>
<td>4900.03</td>
</tr>
</tbody>
</table>

*To calculate line 4: multiply line 2 by line 3, and divide the product by 100.*

#### PART II: Indicator computation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>5. Divide the number of HIV+ pregnant women provided with ARV therapy (line 1) by the relevant sector by the number of HIV+ pregnant women in the country (line 4) and multiply the result by 100.</td>
<td>2.35</td>
</tr>
</tbody>
</table>

---

* Use national Central Statistics Office estimates of current annual births.
** In most countries, national sentinel surveillance estimates of HIV prevalence among antenatal clinic attendees can be used.
1. **Data and information sources**
   - **Data source:**
     - Annual reported data on new HIV cases, AIDS patients and AIDS deaths in 61 provinces/cities and data from hospitals;
     - Data on HIV infected people having access to ARV combination therapy during the period of 2000 to 2002 at the state hospitals;
     - Population of Viet Nam for analysis is from the result of the 1999 General Population Census and Annual Statistics Yearbooks.
   - **Measurement tool:** programme review and using existing data.
   - **Studied samples:** HIV infected people, AIDS reported patients who have received ARVs combination therapy;
   - **Sample selection procedure and sample size:** all 61 provinces of the country.

2. **Method of measurement**
   - **Numerator:** Number of HIV patients with advanced HIV infection who received ARV combination therapy according to the nationally approved treatment guideline (in 2000). The data related to HIV/AIDS patients who received ARV combination therapy collected from the National Institution on Clinical Research in Tropical Medicines; Centre for Tropical Diseases in Ho Chi Minh City; Hue Central Hospital and Dong Da Hospital in Ha Noi since 2000, which includes:
     - Number of AIDS patients started ARV drug treatment in 2000 to the beginning of 2002;
     - Number of AIDS patients started ARV drug treatment in 2002;
     - Number of AIDS patients received ARV drug treatment and died in 2002;
     - Number of AIDS patients who stopped ARV drug treatment;
   - **Denominator:** Based on Estimation and Projection 2001-2005, Ministry of Health, multiplies by default estimate of 15%.

3. **Results and analysis**
   - Of the total 59.200 HIV infected cases reported up to present, 8.793 cases have become AIDS and there have been 4.889 AIDS deaths. In 2002 there were 2.149 cases with advanced HIV infection according to regular HIV/AIDS surveillance reports. However, this figure is much lower than the estimates for 2000-2002 periods of over 20.089 cases with advanced HIV infection. The data as such do not correctly reflex the current status of HIV transmission in Viet Nam due to late updating in the reporting system. Total number of AIDS in-patients is 3,460 times and outpatients 4.120 times and the periodical health checks were organized at commune level for 2.400 HIV infected people.
   - The percentage of people with advanced HIV infection receiving antiretroviral combination therapy in Vietnam is presented too low.

5. **Limitation of data:**

   Estimates of HIV infection can be higher than the actual figure for it is based on the result of the sentinel surveillance in urban areas while 85% of the population is living in the rural area. Estimated 24,000 AIDS patients, while only 2.149 cases were detected and reported in 2002.
According to report, 101/8,793 people with advance HIV infection receiving ARVs therapy from Government budget. There is no data available related to patients who procure ARVs drugs by themselves.

4. Conclusion

- According to UNAIDS guideline in the calculation of this indicator, the number of people receiving ARVs therapy from Government budget is very low, 0.42% if based on HIV/AIDS estimation data in 2000 and 1.06% if based on reported surveillance data.
- According to annual statistic data of HIV infections, the number of AIDS and death cases are higher in the next years than previous years. However, the number of those HIV cases becoming AIDS as reported is much lower than the estimate, possibly due to HIV estimate is based on the result of the sentinel surveillance in the urban areas.
- Data collection excluded the number of people with advanced HIV infection receiving a standard prescriptions and following-up from state physicians. This data is not available at this stage.
**NPBI-5a**

**HIV treatment: antiretroviral combination therapy**

**Data source:** AIDS Division, Ministry of Health

**Data source type:** Treatment reports, HIV/AIDS prevalence data, AIDS patients and deaths.

**Data collection period:**

<table>
<thead>
<tr>
<th></th>
<th>Day</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>3</td>
<td>2003</td>
</tr>
<tr>
<td>to</td>
<td>15</td>
<td>3</td>
<td>2003</td>
</tr>
</tbody>
</table>

**PART I:**

**Data requirements**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Total</td>
<td>Public</td>
<td>Private</td>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Males</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of people receiving ARV therapy at the beginning of the year ('000)</td>
<td>0.062</td>
<td></td>
<td>0.016</td>
<td>0.078</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Number of people who commenced treatment in the last 12 months ('000)</td>
<td>0.019</td>
<td></td>
<td>0.004</td>
<td>0.023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Number of people receiving ARV therapy at the start of the year who died during the year ('000)</td>
<td>0.015</td>
<td></td>
<td>0.015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Number of people for whom treatment was discontinued for other reasons ('000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Number of people receiving ARV therapy at the end of the year ('000)</td>
<td>0.066</td>
<td>0.066</td>
<td>0.02</td>
<td>0.02</td>
<td>0.068</td>
<td>0.068</td>
</tr>
</tbody>
</table>

*Calculate line 5 by adding lines 1 & 2 and then subtracting lines 3 & 4.*

**DENOMINATOR**

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 6</td>
<td>Number of people (adults and children) with HIV infection in the total population ('000)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>135,155</td>
</tr>
<tr>
<td>Line 7</td>
<td>Percentage of people with HIV who are at an advanced stage of infection**</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Line 8</td>
<td>Number of people with advanced HIV infection ('000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20,273</td>
</tr>
</tbody>
</table>

*Calculate line 8 by multiplying line 6 by line 7 and dividing the product by 100.*

**PART II:**

**Indicator computation**

**INDICATOR SCORES BY SEX & HEALTH SECTOR**

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

*From national HIV sentinel surveillance estimates.
**Use default estimate of 15% if locally-specific data are not available.*
### NPBI-5h

**HIV treatment: antiretroviral combination therapy**

**Data source: name**
AIDS Division, Ministry of Health

**Data source: type**
Treatment reports, HIV/AIDS prevalence data, AIDS patients and deaths.

**Data collection period**

<table>
<thead>
<tr>
<th>(day/month/year)</th>
<th>10</th>
<th>3</th>
<th>2003</th>
<th>10</th>
<th>15</th>
<th>3</th>
<th>2003</th>
</tr>
</thead>
</table>

### PART I: Data requirements

#### NUMERATOR

1. Number of people receiving ARV therapy at the beginning of the year ('000)
   - Males: 0.062
   - Females: 0.016
   - Both sexes: 0.078

2. Number of people who commenced treatment in the last 12 months ('000)
   - Males: 0.019
   - Females: 0.004
   - Both sexes: 0.023

3. Number of people receiving ARV therapy at the start of the year who died during the year ('000)
   - Males: 0.015
   - Females: 0.0
   - Both sexes: 0.015

4. Number of people for whom treatment was discontinued for other reasons ('000)
   - Males: 0
   - Females: 0
   - Both sexes: ###

5. Number of people receiving ARV therapy at the end of the year ('000)
   - Males: 0.066
   - Females: 0.066
   - Both sexes: 0.086

   **Calculate line 5 by adding lines 1 & 2 and then subtracting lines 3 & 4**

#### DENOMINATOR

6. Number of people (adults and children) HIV infection were reported by end of December 2002 ('000)*
   - Public: 46.454
   - Private: 7.649
   - Total: 54.103

7. Percentage of people with HIV who are at an advanced stage of infection**
   - Males: 15
   - Females: 15
   - Both sexes: 15

8. Number of people with advanced HIV infection ('000)
   - Public: 6.968
   - Private: 1.147
   - Total: 8.115

   **Calculate line 8 by multiplying line 6 by line 7 and dividing the product by 100.**

### PART II: Indicator computation

**Indicator scores by Sex & Health Sector**

<table>
<thead>
<tr>
<th>9. Divide the number of people with advanced HIV infection currently receiving ARV therapy (line 5) by the total number with advanced HIV infection (line 8) and multiply the result by 100.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.95</td>
</tr>
</tbody>
</table>

* From national HIV reported cases
** Use default estimate of 15% if locally-specific data are not available.
1. **Data and information sources**
   - **Data source:**
     - Report of the Ministry of Labour – War Invalids and Social Affairs, Ministry of Public Security,
     - Behaviour surveillance survey conducted in 2000 in 5 large provinces/cities (Ha Noi, Hai Phong, Da Nang, Ho Chi Minh and Can Tho), and
     - Quantitative survey on HIV transmission risk conducted in 2002 in 4 mountainous and border provinces (Lai Chau, An Giang, Kien Giang and Dong Thap).
   - **Measurement tool:** programme review and using existing data
   - **Studied samples:** drug users and injecting drug users

2. **Method of measurement**
   - **Numerator:** The number of IDUs who reached with HIV/AIDS prevention services during last month plus the number of IDUs in abstinence-oriented treatment at the Drug Abstinent Centres during last month.
   - **Denominator:** estimated total number of injecting drug users.
   - **Calculating the indicator:**
     - Estimated number of drug users is projected from the data provided by the Ministry of Public Security. According to the report of this ministry, by December 2002, there were 142,001 drug users listed, among them 116,505 were in the community and 25,453 were in prisons, rehabilitation centres under the management of the Ministry of Public Security;
     - Estimated number of IDUs: the amount of drug use multiplies estimated the proportion of IDUs that have been estimated by each province as the result of the study of MOLISA in 1999 (the national average is 59%);
     - The results of behaviour surveillance survey (BSS) conducted in 2000 in 5 large provinces/cities Ha noi, Hai Phong, Da Nang, Ho Chi Minh and Can Tho showed that the proportion of IDUs reached with HIV/AIDS prevention services are 31.8%, 70.4%, 39.4% 39.2% and 82.5%, respectively. The result of the surveys in 2002 in 4 poor, mountainous and border provinces namely Lai Chau, An Giang, Kien Giang and Dong Thap showed that the proportion of IDUs reached with HIV/AIDS prevention services are 2.5% 41.9%, 3.5% and 0%, respectively. Estimated average the proportion of IDUs reached with HIV/AIDS prevention services in these 9 provinces/cities is 32.3%;
     - Estimated total number of IDUs reaches with outreach prevention services: the proportion of those IDUs reached with HIV/AIDS prevention services multiply the estimated number of IDUs.

3. **Results and analysis**
   - Many quantitative surveys revealed that the number of drug users in the recent years increased at lower rate than in the previous years. There are still new comers joining the contingent of drug users. However the number of them is small in comparison to the number of those collected for drug giving up treatment or died and that makes the reported cases remain unchanged or slightly changed;
• The scope and amplitude of the HIV/AIDS prevention intervention programmes can vary between provinces. However, in general, the activities are focused on the main areas such as: information, education and communication, harm reduction including: peer education (distribution of clean syringes and needles, condoms); counselling and HIV testing; care and support for HIV infected IDUs. However the activities are still limited and thus the impact alleviation interventions for the IDUs population are not highly effective in reducing the risk of HIV transmission from this population to others who are their friends or sexual partners;

• Appropriate policies have not yet been developed to mobilize resources of social organizations, individuals and communities for harm reduction related activities focusing on IDUs population. There is lack of coordination and integration of all activities and they are still formal and segmented. The participation of relevant entities for HIV/AIDS prevention is still limited, mainly in IEC related activities while other activities are thought as the responsibilities of the public health sector;

• The harm reduction activities via peer education, distribution of clean syringes and needles and condoms still meet with difficulties due to community rejection and the lack of fund. In a number of provinces, groups of peer educators have been formed. However their operation is still limited. The network of peer education is still fragrant, small in number of educators, low capacity and lack of technical, financial assistance and social support. The chance to approach members of high-risk targeted population for behaviour change communication is limited. Main communication channel is the distribution of leaflets. Information sources mainly come from friends and health staff. There is also the lack of other social services to generate job opportunities for IDUs after they have given up drug use in 06 rehabilitation centres;

• Experience of other countries show that there are three basic elements of an effective HIV/AIDS prevention programme for IDUs group, namely early intervention, distribution of clean syringes and needles and further outreach prevention. There is no evidence for the argument that “no distribution of clean injecting facilities can reduce the rate of drug injection”.

4. Limitation of data:

• Information on drug use is reported via the system of anti-social vices network from commune level may produce smaller figures than the actual ones for many of the new drug users hide their addiction from their families and similarly their families do not want to let the people of the communes and local authorities know about their addiction. There is also a lack of information to accurately estimate the number of drug users and IDUs;

• In many provinces, there is no adequate information on the proportion of IDUs among the drug users. The estimation of such figures for each region based on the proportion of drug users in some provinces may not produce exact estimation.

• There is also a lack of information on the proportion of IDUs reached with HIV/AIDS prevention services in many provinces. The estimated number of IDUs having access to peer education in 9 provinces at different points of time and thus could not represent all 61 provinces of the country.

5. Conclusion

• A HIV/AIDS preventive service is estimated to cover 62.3% of the IDUs in the whole country. However, HIV/AIDS prevention is still limited and thus the impact alleviation interventions for the IDUs target group are not effective in reducing the rate of HIV transmission. The epidemic is still in an upward trend in many provinces/cities, mainly among IDUs population, even after 10 years of the HIV/AIDS prevention programme in Viet Nam. The calculated figures may be not accurate and not representing all 61 provinces.
### NPBI-6

**Injecting drug users: coverage with HIV/AIDS prevention services**

**Data source: name**
The Ministry of Labor, Invalid and Social Affairs (MOLISA) and ADB/WB project

**Data source: type**
Programmes and projects review.

**Data collection period**

<table>
<thead>
<tr>
<th>Day</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>3</td>
<td>2003</td>
</tr>
</tbody>
</table>

#### PART I:

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All ages</td>
<td>All ages</td>
<td>All ages</td>
</tr>
</tbody>
</table>

### NUMERATOR

**Instructions:**
- [ ] Line 1: enter the number of injecting drug users reached through outreach, including needle and syringe programmes during the past month.
- [ ] Line 2: Number of injecting drug users in abstinence-oriented treatment during past month.
- [ ] Line 3: Enter the number of all injecting drug users enrolled in substitution therapy (methadone maintenance, buprenorphine, etc) during the past month.

#### 1. IDUs reached through outreach during last 6 months

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>27061</td>
<td></td>
<td></td>
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</tbody>
</table>

#### 2. IDUs in abstinence oriented treatment during last year.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>25453</td>
<td></td>
<td></td>
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</tbody>
</table>

#### 3. IDUs in the last month who receive substitution therapy.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<tbody>
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</tbody>
</table>

#### 4. Total

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>52514</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DENOMINATOR

#### 5. Estimated number of injecting drug users

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>88781</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INDICATOR SCORES

1. Divide the total of the numerator by total of the denominator

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>62.68</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*At this moment,入户率 is applied only for a small number of drug users in a pilot phase.*
1. **Data and information sources**
   - **Data source:**
     - Baseline survey on HIV/AIDS infection risk in 5 mountainous and border provinces under the ADB project “Community Action for HIV/AIDS Prevention”.
   - **Measurement tool:** using existing data and household survey
   - **Studied samples:** Youth of 15-24 years of age, single, living in the locality. The coverage of the study is 5 provinces Lai Chau, Quang Tri, Dong Thap, An Giang and Kien Giang, are the provinces that face increasing risk of HIV transmission; have high rate of migration and share the boarder with Laos and Cambodia; and are the poor provinces.
   - **Sample selection procedure and sample size:** 480 youths of 15-24 years of age in each province are selected by random selection of groups of 30 in proportion to the sample size (PPS).

2. **Method of measurement**
   - **Numerator:** the number of young people who answered correctly two questions related to prevention methods of sexual transmission of HIV (faithfulness, condom use) and rejected major misconceptions on HIV transmission (mosquito bites, having meals with HIV infected people).
   - **Denominator:** total number of interviewed youths of 15-24 years of age.

3. **Results and analysis**
   - Young IDUs number is increasing and pre-marital sexual relation is becoming more common. According to the survey result, 0.9% of the youth in all 5 provinces use drug. These are young, single people who are sexually active and even more active when they start using drug. However, their awareness of HIV transmission prevention methods is still limited. The percentage of youth having correct understanding is 26.3% (female 32.2% and male 24.2%);
   - Despite they have fairly high level of education (70% or more of secondary education level and only 6.1% illiterate), the understanding of 15-24 years of age youth of HIV/AIDS prevention methods is still limited, mixed between correct and wrong understandings. While 79.4% of them believe that condom use helps prevent HIV transmission and 70.5% understand that having sex faithfully with one HIV free sexual partner prevent HIV transmission, still a large number of youth believe that mosquito bites and having meals with HIV infected people may get them infected (53.8% and 52.1% relatively);
   - All 5 provinces of the project have conducted HIV/AIDS prevention communication activities at public places and on TV such as slogans, pictures, posters, meetings, marches and contests. In addition, HIV/AIDS prevention communication activities are integrated into other reproductive health programme or HIV/AIDS prevention education, Friendship Clubs etc. However, the survey results showed that the percentage of youth having access to HIV/AIDS prevention activities for change of behaviour is still low and the communication is often one way; There is not yet the counseling system for the youth in particular and for all people in general and where and when there is, its coverage is still limited;
4. **Limitation of data:**

- Data and information for the calculation of indicators are collected at hot spots in 5 provinces and thus they are not adequately representative. The studied group is composed of single youth.
- Information on the question ‘Can a person who looks healthy be HIV positive?’ was not collected in the study and thus not used to calculate the indicator.
- Data of the study are not categorized by urban and rural areas and thus it is not possible to calculate the indicators for each area as UNAIDS guideline.

5. **Conclusion**

- The percentage of 15-24 years of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission is still low, only 26.3% (female: 32.2% and male 24.2%). More than half of them have misconception in believing that mosquito bites and having meals with HIV infected people may get them infected (53.8% and 52.1% respectively).
- The indicator is not up to the expectation as requested by UNAIDS, because the study was conducted at hot spots, in five mountainous and borders provinces; on the single youth. The data are not categorized into those of urban and rural areas.
### Young people's knowledge about HIV prevention

**Data source:** AIDS Division, Ministry of Health and ADB Project "Community for Prevention E

**Data source: type**

Household survey

**Data collection period**

| (day/month/year) | 10 3 2003 | to | 15 8 2003 |

PART I:

**Data requirements**

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>National</td>
<td>National</td>
</tr>
</tbody>
</table>

**Numerators**

<table>
<thead>
<tr>
<th>Instruction</th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV can be avoided by having sex with only one faithful, uninfected partner</td>
<td>1200</td>
<td>482</td>
<td>1682</td>
</tr>
<tr>
<td>2. HIV can be avoided by using condoms</td>
<td>1365</td>
<td>508</td>
<td>1899</td>
</tr>
<tr>
<td>3. A healthy-looking person can have HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. A person can get HIV from mosquito bites</td>
<td>784</td>
<td>315</td>
<td>1099</td>
</tr>
<tr>
<td>5. A person can get HIV by sharing a meal with someone who is infected</td>
<td>808</td>
<td>333</td>
<td>1141</td>
</tr>
<tr>
<td>6. Numbers of respondents giving the correct answers to all of the above 5 questions</td>
<td>424</td>
<td>204</td>
<td>628</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Instruction</th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Numbers of respondents (aged 15-24) who gave answers (including &quot;don't know&quot;) to all of the above 5 questions or had never heard of AIDS</td>
<td>1750</td>
<td>633</td>
<td>2383</td>
</tr>
<tr>
<td>8. Percentage of the national population (aged 15-24) who live in urban areas*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PART II:

**Indicator computation**

**Indicator scores by sex & residence**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Divide the number of respondents who gave the correct answers to all 5 questions (line 6) by the number who answered all 5 questions (line 7) and multiply the result by 100.</td>
<td>24.2</td>
<td>32.227</td>
<td>26.4</td>
</tr>
</tbody>
</table>

**Indicator scores by sex (national)**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. i) Calculate the weighted average of the urban and rural indicator scores (line 9) using the percentages who live in urban and rural areas (line 8) as the weights.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) Take the simple average of the national scores for men and women to get the combined score.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*From National Census Office statistics.*
1. **Data and information sources**
   - **Data source:**
     - Baseline survey on HIV/AIDS infection risk in 5 mountainous and border provinces under the ADB project “Community Action for HIV/AIDS Prevention”.
   - **Measurement tool:** using existing data and household survey
   - **Studied samples:** Youth of 15-24 years of age, single, living in the locality. The coverage of the study is 5 mountainous and border provinces Lai Chau, Quang Tri, Dong Thap, An Giang and Kien Giang, are the provinces that face increasing risk of HIV transmission; have high rate of migration and share the border with Laos and Cambodia; and are the poor provinces.
   - **Sample selection procedure and sample size:** 480 youths of 15-24 years of age in each province are selected by random selection of groups of 30 in proportion to the sample size (PPS).

2. **Method of measurement**
   - **Numerator:** Number of 15-24 years of age youth having non-regular sexual partners in the last 12 months reported to use condom at the last sexual intercourse with that partner;
   - **Denominator:** Number of 15-24 years of age youth having non-regular sexual partners in the last 12 months (non-regular sexual partners include female sex workers and random partners)

3. **Results and analysis**
   - Sex is a sensitive and hard matter to discuss in public in Viet Nam, particularly among youth. In traditional conception, girls are to be virgins until their marriage and thus pre-marital sexual relation is generally not accepted by society and families. However, the survey results showed that up to 29% of male and 11.1% of female youth have their pre-marital sexual relation and the rate for both sexes is 22.7%. Most of the young people said they have sex because of the curiosity and pretension of youth or their belief in the sexual partners. The median age to have first sexual intercourse of 15-24 years of age youth is 19.6 without different between male and female. About 1/5 of youth answered that they had sexual partners in the last 12 months (male: 23.4% and female: 10.2%). When asked about sexual intercourse with non-regular sexual partners (including sex workers and random sexual partners) in the last 12 months, 8.3% of male and 0.9% of female youth admitted that they had sexual intercourse;
   - Distribution of free condoms via health service facilities of the National Committee of Population, Family and Children for family planning has been implemented for long period of time and so the number of people having access to such service has been increasing. The distribution of condoms is conducted by the family planning collaborators. In most of provinces, condoms are sold freely in drug stores. A number of provinces collaborate with DKT to market condoms via non-traditional channels. However, this system has limited coverage. Among the youth having non-regular sexual partners in the last 12 months, only 52.7% of male and 33.3% female used condoms in the most recent time of sex with this type of sexual partners (the average for both is 51.9%). There are various explanations for
the practice of not using condoms among male youth: reduction of pleasure, inconvenience, feeling shy when buying, feeling reluctant to keep it or mutual belief between sexual partners. In addition, only 3% of youth received condoms free in the last 6 months. Condoms are less used when they have sexual intercourse with their regular sexual partners or their lovers. That is the potential risk of HIV transmission in the future if we do not further promote the communication for the building a healthy and safe life among youth.

4. **Limited quality of data and information:**

- Data and information for the calculation of this indicator are not in line with the report format of UNAIDS;
- Data and information were collected at hot spots in 5 mountainous and border provinces and thus could not represent well the whole group.
- The target group include only the single youth.
- Data are not categorised into those of urban and rural areas and it is therefore not possible to calculate the indicators for these areas.

5. **Conclusion**

- 22.7% of 15-24 years of age youth have their pre-marital sexual relation and the median age to have first sexual intercourse is 18.9.
- The percentage of youth having sexual relation with non-regular sexual partners in the last 12 months is 8.3% for male and 0.9% for female youth, of them. Only 52.7% male and 33.3% female youth used condoms in the last sexual intercourse with this type of sexual partners (the average percentage for both sexes is 51.9%).
- This indicator is not in line with the report format of UNAIDS because the survey was only conducted in the single youth group at hot spots. The data are not categorized into those of rural and urban areas.
NPBI-3

Young people's condom use with non-regular partners*

<table>
<thead>
<tr>
<th>Data source: name</th>
<th>AIDS Division, Ministry of Health and ADB Project *Community for Prevention HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data source: type</td>
<td>Household survey</td>
</tr>
<tr>
<td>Data collection period</td>
<td>10 3 2008 to 16 8 2008</td>
</tr>
</tbody>
</table>

PART I:

<table>
<thead>
<tr>
<th>Data requirements</th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National</td>
<td>National</td>
<td>National</td>
</tr>
</tbody>
</table>

NUMERATOR

Instructions:

2. Select only those respondents (aged 15-24) who gave answers (excluding "don't know") to all of questions 2 to 5 below.
3. Line 2: enter the number of respondents who stated that they had commenced sexual activity
4. Line 3: enter the number of respondents who stated that they had had any form of sexual relationship in the last 12 months
5. Line 4: enter the number of respondents who stated that they had had a non-regular sexual partner in the last 12 months (NB: a "non-regular" sexual partner here is someone the respondent was not married to and not cohabiting with at the time they had sex)
6. Line 5: enter the number of respondents who answered "yes" to the question in line 2 and who reported using condoms when they last had sex with this non-regular partner

1. Median age at first sex*
   - [ ] 18.9
   - [ ] 18.8
   - [ ] 18.9

2. Commenced sexual activity
   - [ ] 471
   - [ ] 70
   - [ ] 541

3. Sexual partner within the last 12 months*
   - [ ] 410
   - [ ] 65
   - [ ] 475

4. Non-regular sexual partner within the last 12 months*
   - [ ] 146
   - [ ] 6
   - [ ] 152

5. Had a non-regular sexual partner within the last 12 months and used a condom the last time they had sex with this partner
   - [ ] 77
   - [ ] 2
   - [ ] 79

DENOMINATOR

6. Numbers of respondents (aged 15-24) who reported having had a non-regular sexual partner in the last 12 months (i.e., line 4 above)
   - [ ] 146
   - [ ] 6
   - [ ] 152

7. Percentage of the national population (aged 15-24) who live in urban areas**
   - [ ]

PART II:

Indicator computation

INDICATOR SCORES BY SEX & RESIDENCE

5. Divide the number of respondents who reported using condoms with their last non-regular partner (line 5) by the number who reported having had a non-regular sexual partner in the last 12 months (line 6) and multiply the result by 100.
   - [ ] 52.7
   - [ ] 33.3
   - [ ] 52

INDICATOR SCORES BY SEX (NATIONAL)

9. I) Calculate the weighted average of the urban and rural indicator scores (line 8) using the percentages who live in urban and rural areas (line 7) as the weights.
   II) Take the simple average of the national scores for men and women to get the combined score.

---

* The data collected here also provide the information needed for the first two additional indicators recommended in the UNAIDS indicator guidelines
** From National Census Office statistics (as for NPFI).
1. Data and information sources

- **Data source:**
  - Baseline survey on HIV/AIDS infection risk in 5 mountainous and border provinces under the ADB project “Community Action for HIV/AIDS Prevention”.

- **Measurement tool:** using existing data and household survey

- **Studied samples:** Youth of 15-24 years of age, single, living in the locality. The coverage of the study is 5 mountainous and border provinces Lai Chau, Quang Tri, Dong Thap, An Giang and Kien Giang, are the provinces that face increasing risk of HIV transmission; have high rate of migration and share the boarder with Laos and Cambodia; and are the poor provinces.

- **Sample selection procedure and sample size:** 480 youths of 15-24 years of age in each province are selected by random selection of groups of 30 in proportion to the sample size (PPS).

2. Method of measurement

- **Numerator:** Number of youth from 15-24 who have HIV positive test results through the three testing strategy.

- **Denominator:** Total number of youth from 15-24 tested for their HIV infection status

3. Results and analysis

- This is the first household survey with HIV blood test for 15-24 years of age single youth. The percentage of HIV infected is 0.6%, of which the rate of 15-19 years of age group is 0.7% and 20-24 years of age group is 0.3%. Youth of 18 years old have the highest rate of HIV infection (2.4%), then follow the groups of 20, 22 and 16 years of age;

- The group of youth under survey coverage in all 5 provinces use drug and the number of them tends to increase. The percentage of youth using drug is 0.9% and their average age of 17. In addition, pre-marital sexual relation tends to be more common and their median age to have first sexual intercourse is 19.6. The percentage of youth using condoms in the last sexual intercourse with random sexual partners in the last month was only 51.97% and fewer girls than boys.

4. Limitation of qualitative data

- According to UNAIDS guidelines, this indicator is the percentage of the number of antennal care (ANC) attendees (age 15-24) tested who HIV test results are positive. However, Vietnam is still in the stage of concentrated epidemics, and the rate of HIV infection in the general population is often very low, that is why this indicator is not appropriate for Vietnam. The substitute indicator is calculated by the percentage of the HIV positive tests 15-24 years of age youth over the total 15-24 single youth HIV tested;

- Data and information for the calculation of the indicator were collected at hot spots in 5 provinces and thus its representativeness low;
• Target group is composed of only single youth;
• The data are not categorized into those of urban and rural areas and it is therefore not possible to calculate the indicators for those areas.

5. Conclusion

• The percentage of HIV infected among 15-24 years of age, single youth is 0.6%. The rate of HIV infected in 15-19 years of age is 0.7%, higher than the 20-24 group (0.3%). 18 years of age group has the highest percentage of HIV infected (2.4%).
• This indicator is not in line with the report format of UNAIDS because the survey was only conducted on single youth of 15-24 years of age at hot spots in 5 provinces, therefore, this data would not delegate to national data. The data are not categorized into those of urban and rural areas.
### PART I:

<table>
<thead>
<tr>
<th>Data requirements</th>
<th>Capital city</th>
<th>Other urban areas</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV+ Tested</td>
<td>HIV+ %</td>
<td>HIV+</td>
</tr>
<tr>
<td>1. 15-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. 16-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 17-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. 18-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. 19-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. 20-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. 21-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. 22-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. 23-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. 24-year-olds</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. Percentage of the national population (aged 15-24) who live in capital city, other urban & rural areas:

### PART II:

#### Indicator computation

**INDICATOR SCORES BY URBAN/RURAL RESIDENCE**

<table>
<thead>
<tr>
<th></th>
<th>HIV+ Tested</th>
<th>HIV+ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. 15-19-year-olds</td>
<td>6 804 0.7</td>
<td></td>
</tr>
<tr>
<td>13. 20-24-year-olds</td>
<td>2 621 0.3</td>
<td></td>
</tr>
<tr>
<td>14. 15-24-year-olds</td>
<td>8 1425 0.6</td>
<td></td>
</tr>
</tbody>
</table>

*From National Census Office statistics*
1. Data and information collection

- **Information source:** HIV Sentinel surveillance
- **Timeframe for data collection:** Samples collection one time/year for sufficient size of the sample as stipulated. Time frame for the sampling starts in May and ends in August (not lasts more than 4 months). Avoid repetition of samples. Time frame for the sampling of the army conscripts or army candidates are conducted in November and December of the year.
- **Sample selection procedure and sample size:** sentinel surveillance data and sentinel surveillance population group.

### High-risk population of HIV transmission:

<table>
<thead>
<tr>
<th>No.</th>
<th>Studied group</th>
<th>Venue of sampling</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IDUs</td>
<td>Drug abuse treatment centres</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community</td>
<td>200</td>
</tr>
<tr>
<td>2</td>
<td>Sex workers</td>
<td>Detection and Collection spots</td>
<td>400</td>
</tr>
<tr>
<td>3</td>
<td>STIs patients</td>
<td>Hospitals, medical centres, Demator-Venere clinics</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private clinics</td>
<td>200</td>
</tr>
</tbody>
</table>

### Community representative population:

<table>
<thead>
<tr>
<th>No.</th>
<th>Studied group</th>
<th>Venue of sampling</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pregnant women</td>
<td>Hospitals, Ob/Gyn hospitals; Delivery Houses, Mothers and Newborns Protection and Family Planning Centres</td>
<td>800</td>
</tr>
<tr>
<td>2</td>
<td>Youth army conscripts</td>
<td>Recruitment places</td>
<td>800</td>
</tr>
</tbody>
</table>

### Other groups:

<table>
<thead>
<tr>
<th>No.</th>
<th>Studied group</th>
<th>Venue of sampling</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tuberculosis patients</td>
<td>Hospitals, centres, Dept. Examining and treating tuberculosis</td>
<td>400</td>
</tr>
<tr>
<td>2</td>
<td>Other groups</td>
<td>The venues are selected according to the concrete local conditions</td>
<td>800</td>
</tr>
</tbody>
</table>

### Sentinel surveillance:

30 provinces/cities of Lào Cai, Phú Thọ, Nam Định, Hà Nội, Hà Tây, Hà Tĩnh, Hải Dương, Hải Phòng, Lạng Sơn, Nghệ An, Quảng Ninh, Thái Nguyên, Thanh Hoá, Khánh Hòa, Đà Nẵng, An Giang, Bình Đồng, Bà Rịa-Vũng Tàu, Cà Mau, Cấn Thơ, Kiên Giang, Sóc Trăng, T.P Hồ Chí Minh, Lâm Đồng, Đắc Lắc, Gia Lai, Bình Thuận, Bình Định and Đồng Nai. Studied groups under sentinel surveillance provide their sample slices under the rules of voluntariness and confidentiality.
Sample collection procedure:
- Continuous samples
- Testing method: Method 2

1. Indicator calculation
   - Numerator: number of HIV positive people tested by method 2
   - Denominator: total number of people HIV tested

2. Results and analysis
   - HIV epidemics in Vietnam catches most the group of IDUs and spreads rapidly in all provinces/cities. In addition, IDUs are often young people, sexually active while the rate of them using condoms when having sexual intercourses with their sexual partners of all types is low and lowest when having sexual intercourses with their wives or lovers.
   - In general, the rate of HIV transmission is still low in the group of sex workers, STIs patients, pregnant women before their labour time and new army recruits. However, since 1998, there have been an increasing rate of HIV infection among the female sex workers in Ha Noi and Ho Chi Minh City. Results of a number of studies showed that HIV infection of the female sex workers is closely linked to drug injection. That will increase the risk of HIV infection by unsafe sexual contacts with non-regular sexual partners and non-IDUs.
   - Although there is strong increase in HIV infection rate among the sex workers in Ha noi, Ho Chi Minh City as well as the infection rate of the STIs patients and new army recruits groups in a number of provinces/cities, in general, the epidemics in Viet Nam is mainly concentrated in the IDUs group.

Shortcomings of the sentinel surveillance system
- Sex workers and IDUs groups are selected mainly at drug abuse reatment centres and rehabilitation centres and thus they may not be quite representative;
- In many provinces, the sample size is not as big as expected for IDUs and sex workers groups;
- Groups of IDUs and sex workers are not stable and they often migrate;
- The question of not applying the anonimous samplling may lead to error due to the refusal to cooperate of the persons in the sentinel surveillance program;
- Staff of the sentinel surveillance program are often changed and thus makes it difficult to ensure the identity of the working of the method applied in different provinces/cities at different points of time;
- The monitoring and assistance to the implementation of program of sentinel surveillance in provinces/cities as per instruction is often of limited impact.

3. Conclusion
   - Vietnam is still in the concentrated epidemics stage. The very high rate of infection is found among the IDUs and tends to increase among the female sex workers (also injecting drug) and syphilis patients. The rate is very low in the pregnant women before their labour time and the army conscripts (under 1%).
   - The data of the sentinel surveillance reflex the trend of HIV infection in female sex workers group at some hot spots but they may not be quite representative for all studied groups because they are concentrated in urban areas and so the indicator does not show the rate and trend of HIV infection in other rural, remote, mountainous areas.
### Reduction in HIV prevalence

#### Data requirements
Complete only those sections that are considered relevant to the country

<table>
<thead>
<tr>
<th>Data source:</th>
<th>30 sentinel surveillance sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Type</td>
</tr>
<tr>
<td>1. Female sex workers</td>
<td>Sentinel Surveillance AIDS Division, MOH</td>
</tr>
<tr>
<td>2. Clients of female sex workers</td>
<td></td>
</tr>
<tr>
<td>3. Injecting drug users</td>
<td>Sentinel Surveillance AIDS Division, MOH</td>
</tr>
<tr>
<td>4. Men who have sex with men</td>
<td></td>
</tr>
<tr>
<td>5. Other (specify): <em>STI patients</em></td>
<td>Sentinel Surveillance AIDS Division, MOH</td>
</tr>
</tbody>
</table>
1. **Data and information collection**

- **Information source:**
  - Data of HIV sentinel surveillance among pregnant women population in 2002 in 30 provinces/cities;
  - Number of HIV pregnant women who gave birth and were provided with ARV prophylaxis to prevent MTCT at National Institution for Protection of Mothers and Newborns, Hospitals of Ob/Gyn of Tu Du, Hung Vuong, Hai Phong, Nam Dinh and Thanh Hoa.
  - Data of the 1999 General Population Census of General Statistic Office;

- **Information collection technique:** programme review and collection of existing data.

- **Studied group:** The number of women who gave birth to their children in 2002 in all 61 provinces/cities, and who were received VCT and ARVs prophylaxis to prevent MTCT.

2. **Indicator calculation**

- This indicator is calculated by taking the average rate of risk of mother-to-child transmission with or without access to Anti-retroviral drug. This results in the rate of number of women having access to Anti-retroviral drug over the number of women having no access to Anti-retroviral drug, demonstrated in the following equation:

\[
\text{Indicator} = \{T \times (1-e) + (1-T)\} \times v
\]

In which:
- \( T \) = the rate of HIV infected pregnant women having access to Anti-retroviral drug
- \( v \) = the rate of mother-to-child transmission of the women having no access to Anti-retroviral drug
- \( e \) = Efficiency of the therapy scheme
- \( T \) = national programme and behaviour indicator # 4 (NPBI-4).

Default values of 25% and 50%, respectively, can be used for \( v \) and \( e \).
## II-2 Reduction in mother-to-child transmission

**Data source: name**  
AIDS Division, Ministry of Health

**Data source: type**  
PROGRAMME MONITORING

**Data collection period**  
10 3 2008 to 16 3 2008

### PART I:

#### Data requirements  
% of total

1. Proportion of HIV+ pregnant women provided with ARV treatment*  
   
   **T** 0.0235

2. MTCT rate in the absence of any treatment (%)  
   
   **r** 25.0

3. Efficacy of treatment provided  
   (proportionate reduction in MTCT rate)  
   
   **e** 0.5

List below the 3 most common forms of treatment provided during the last 12 months and the % of all treatment that each represents.

<table>
<thead>
<tr>
<th>Form</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PART II:

#### Indicator computation

**INDICATOR SCORE**

4. Calculate the indicator score using the formula:  

   \[ \left( \frac{T(e-r)}{r(T)} \right) \times r \]

   **24.7**

* From national programme and behaviour indicator 4.