

The Bell is Ringing: An Analysis of HIV/AIDS Policy and Programs in Vietnam

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Vietnam is now facing an accelerating HIV/AIDS epidemic with the total reported number of HIV infected people at 76,180 at the end of 2003. While the national HIV/AIDS program seems to consist of all needed interventions, new epidemiological data continue to show a worsening HIV/AIDS epidemic. This paper seeks to examine Vietnam's national HIV/AIDS program to identify its shortcomings. It argues that a combination of a lack of political will and leadership, unreliable epidemiological data, and inappropriate design of the intervention programs are the reasons why the government has failed in containing the HIV/AIDS epidemic. The last part of the paper consists of recommendations to surmount these shortcomings and make the national HIV/AIDS program more effective, responsive and sustainable.

Introduction

The name of Vietnam has been increasingly mentioned in official HIV/AIDS reports¹ because, while the country had little HIV present in the early 1990s, the country is now faced with an accelerating HIV/AIDS epidemic. Without swift and decisive actions, the total estimated number of HIV infected people and cumulative AIDS deaths in 2005 are expected to reach 377,000 and 70,000 respectively (Vietnam Technical Working Group on HIV Estimates and Projections (VTWG), 2004). In 2003 alone, the HIV/AIDS epidemic in Vietnam killed 1,901 people and an estimated 18,400 new people acquired HIV. The total reported number of people living with the virus in the whole country by the end of 2003 was 76,180 (National Strategy on HIV/AIDS Prevention & Control (NSHA), 2004). In a conference in Tokyo on October 5th 2004, the UNAIDS Executive Director Peter Piot also raised serious concerns over the “the alarming rate of HIV infections in China, Indonesia and Vietnam.”²

Vietnam responded to HIV/AIDS with the establishment of an HIV/AIDS sub-committee and the issuance of the first legal document on HIV/AIDS even before the first HIV case was locally detected. However, the rapid spread of the epidemic has put forward an essential need to review the HIV/AIDS policy and program in Vietnam and find out what should be done to more effectively cope with this epidemic.

In this paper, I will first examine the existing HIV/AIDS policy in Vietnam in regards to its legal documents, institutional framework, budget, intervention programs and the impacts of these policies and programs on the national fight against HIV/AIDS. I will then present in greater depth the shortcomings of these policies and programs. The last part of the paper consists of recommendations to surmount these shortcomings and make these policies and program more responsive, sustainable and effective in containing the HIV/AIDS epidemic in Vietnam.

HIV/AIDS Policy and Programs in Vietnam

Since the first HIV case was reported in Vietnam in 1990, the number of reported HIV and AIDS cases has risen rapidly from less than 2,000 per year in the early 1990s to 4,316 in 1998, 9,329 in 2000 and more than 15,000 in 2002 (Colby & Doussantousse, 2004). Although by the end of 2003, the cumulative total number of HIV reported cases reached 76,180 (Government of Vietnam, 2004), it was estimated that the HIV prevalence among adults age 15-49 by 2003 was approximately 0.6 percent and the actual cumulative number of HIV infected people was 287,000 including 207,000 males and 80,000 females (Government of Vietnam, 2004). Without stronger prevention programs, for the next several years, there will be over 55,000 new infections per year, making the total estimated number of 377,000 people living with HIV by 2005 (Government of Vietnam, 2004). According to the Ministry of Health (MOH), the HIV prevalence is highest among injection drug users (IDUs) and youth. Sixty percent of the HIV cases are among the IDUs; sixty five percent are between 10-29 years old. Another group engaged in high-risk behavior is female sex workers (FSWs), among which the infected rate increased from 0.6 percent in 1994 to 6 percent in 2002 (Khuat, Nguyen, & Ogden, 2004). The HIV/AIDS epidemic in Vietnam has spread from groups engaged in high-risk behavior such as IDUs and FSWs to the general population through two main transmission modes: injection drug use via contaminated needles and syringes and unprotected sexual contact (Government of Vietnam, 2004). Firstly, HIV can be transmitted among IDUs through their needle sharing and then from the HIV infected IDUs to their sexual partners. This mode is one of the primary means of infecting the general population as HIV prevalence is highest among IDUs. Secondly, HIV can be transmitted from FSWs to their clients and vice versa through unprotected sexual contact. The infection rate due to this mode is increasing rapidly due to the fact that FSWs often have multiple sexual partners and that many FSWs are IDUs at the same time. Men who contract HIV

through their visit to sex workers then will put their wives and their sexual partners at elevated risk of HIV and thus, spread HIV into general populations.

Vietnam's bureaucratic structures for dealing with the epidemic are important for understanding the government's overall response. Even before the first HIV case was detected, the Vietnamese government had established the Sub-Committee for AIDS Prevention and Control under the Committee for Prevention and Control of Communicable Diseases, a branch of the MOH. In 1990 the HIV/AIDS Sub-Committee was upgraded to the Vietnam National Committee for AIDS Prevention and Control, still under MOH. This agency then underwent a number of transformations. In 1994, the Committee was separated from MOH and chaired by a Deputy Prime Minister; however MOH continued to act as its standing body. Then in 2000, the National Committee for AIDS, Drugs and Prostitution Prevention and Control was set up and chaired by a Deputy Prime Minister. This Committee involved 18 cabinet ministries and a number of agencies. Acting as the focal point for the Committee was the Standing Office for AIDS Prevention and Control located at MOH, which was reorganized on the basis of the former office of the National Committee for AIDS Prevention and Control. In 2003, the Standing Office was merged with the Preventive Medicine Department of MOH into the Preventive Medicine and HIV/AIDS Prevention and Control Department under the administration of MOH (Government of Vietnam, 2004). Although Provincial AIDS Committees were established in all 61 provinces in the country, they are under the jurisdiction of the Preventive Medicine and HIV/AIDS Prevention and Control Department at MOH.

In regards to legal documents, since the first legal HIV/AIDS document was issued by MOH in 1987, several legal documents and two medium term plans have been formulated and implemented by the government. In February 2003, a directive issued by the Prime Minister emphasized the need for a comprehensive and multi-sector approach to HIV/AIDS. More than one year after, in March 2004, the first National Strategy on HIV/AIDS Prevention and Control was approved by the Prime Minister (Government of Vietnam, 2004). This Strategy set objectives for a six-year time period and outlined a vision to the year 2020. The government pointed out the need to consider HIV/AIDS prevention and control a pivotal, urgent and long term task that requires multi-sector coordination and intensified mobilization of the whole society. The overall objective set out in the strategy is to "control the HIV/AIDS prevalence rate among the general population to below 0.3% by 2010 and with no further increase after 2010, thus reducing the adverse impacts of HIV/AIDS on social-economic development." (Government of Vietnam, 2004, p. 2) The strategy also defined priority activities to be carried out in the near future consisting of: (i) intensifying behavioral change information, education and communication (IEC)

and collaborating with other related programs to prevent and reduce HIV/AIDS transmission; (ii) stepping up harm reduction intervention measures; and (iii) promoting counseling, care and treatment for HIV/AIDS-infected people (Government of Vietnam, 2004).

To finance the proposals, the government budget allocation to the HIV/AIDS program was increased dramatically from \$50,000 USD in 1992 to \$4,000,000 USD in 1994 and remained static at this level until 2001 (Nguyen, 2004). Programs included the national surveillance system, which was set up in 1994 and currently operates for six target groups in 40 provinces and cities out of 64 provinces and cities in the whole country. HIV testing sites have been set up in all 61 provinces. The government has also implemented a relatively successful program for blood safety; since the year of 2000, 100% of blood units and blood products have been screened (Government of Vietnam, 2004). The government's Information, Education and Communication (IEC) programs have been among the more effective national AIDS prevention programs, mobilizing participation of mass media and local organizations. This organization has contributed to informing 70% of the people of reproductive age on HIV transmission modes and prevention measures (Khuat et al., 2004). Other HIV prevention activities such as the condom social marketing program and peer education, although small in scope and coverage, have been carried out effectively (USAID, 2004).

Despite these efforts, new epidemiological data continue to show a steadily worsening HIV/AIDS epidemic in Vietnam. While the number of new HIV cases in 1995 was 118 per month, it jumped to 1,000 per month in 2000 and to 1,500 cases per month in 2003 with no sign of slowing down (Nguyen, 2004). In addition, there is an increased risk of HIV transmission spreading to the wider community. Evidence of this can be found in new HIV infections among new army recruits, where infection rates have increased from 0% in 1994 to 1.3% in 2001. Pregnant women have also shown an increased infection rate from 0.035% in 1995 to 0.39% in 2002 (Khuat et al., 2004).

While in Thailand, a neighboring country of Vietnam, the annual number of new HIV infections has dropped from 143,000 in 1991 to 19,000 in 2003 (UNDP, 2004), it is clear that the Vietnamese government's efforts to prevent HIV transmission are not enough. Therefore, the question here is: Why does a national policy and program, which seems to consist of all the needed interventions legally, institutionally, and financially fail to reach its desirable goal of containing the HIV/AIDS epidemic? The next section highlights the shortcomings in the HIV/AIDS policy and programs in Vietnam that have limited the government's effectiveness in combating with the HIV/AIDS epidemic.

Shortcomings in the Vietnamese HIV/AIDS Policy and Program

Lack of Strong Political Will and Leadership

One of the criteria for evaluating a country's political will and leadership in its efforts against HIV/AIDS is the annual budget it allocates for the national HIV/AIDS program. The Vietnamese state budget allocation for the national HIV/AIDS program is low and far from meeting the financial demand of the program. This problem has been exacerbated with the implementation of the Structural Adjustment Program (SAP), which was started in the early 1990s. One important component of the SAP is to reduce public expenditures in basic social sectors, including education and health-care through elimination of the state's subsidy in these sectors. As a result, local communities are required to contribute to the national health-care budget and individuals have to pay user fees for any health-care service they get. Under the pressure of the SAP, the national budget allocation for HIV/AIDS program did not increase at all for the whole period from 1994 to 2001 although the HIV prevalence among adults age 15-49 during the same period escalated from 0.056% to 0.42% (VTWG, 2004). The MOH has assessed that to successfully cope with HIV/AIDS, Vietnam needs at least \$128 million USD or 2,000 billion Vietnamese dong per year compared to the current spending of 130 billion Vietnamese dong (including foreign aid and contributions from local communities and individuals) (Nguyen, 2004). The low state budget allocation has shown that, despite the country's early response to HIV/AIDS and its continuing revision of the legal and institutional framework to adapt to the development of the epidemic in the country, HIV/AIDS has not yet been a priority in the government's agenda.

The lack of full commitment, as mentioned above, has resulted in the inability of many prevention programs -- although successful at a local level -- to meet the national demand (USAID, 2004). For example, one study found that men having sex with men (MSM), one group engaged in high-risk behavior, often cited the unavailability of condoms as a reason for not always using them (Colby & Doussantousse, 2004). Similarly, the unavailability of syringes and needles was the primary reason why the IDUs shared them (Dang, West, Valdiserri, & Phan, 2003). At the provincial level, the lack of funds is also a main reason for not being able to sustain or replicate good intervention programs. For example, the peer education program has proven to efficiently increase HIV/AIDS awareness, reduce high-risk behaviors and promote safer behaviors. However only 15 percent of provinces reported that funding would be adequate to sustain it (Dang et al., 2003). A study from the same authors also found that some provinces successfully implemented peer education in the past but would not have funds to continue the programs in the future. These deficiencies have had many negative effects on the success of the broader national HIV/AIDS program.

The Vietnamese government's lack of strong political will and leadership has also led to the lack of a mechanism to mobilize ministries and government agencies beyond MOH. While it has become globally accepted that to be efficient and effective a national HIV/AIDS program must apply a broad-based multi-sector approach (UNDP, 2004), from 1987 until 1994 the National Committee for AIDS Prevention and Control was always under the control of MOH, without any involvement from other ministries or agencies, let alone the community and private sector. The government's consideration of HIV/AIDS as MOH's sole responsibility was clearly reflected in both the way the budget of the national program was allocated and utilized. From 1992 to 1996, most national funds for HIV/AIDS were channeled to MOH. The largest expenditures from the national budget were for buying equipment, testing kits and medicines (Nguyen, 2004). Although the government recognized the need to separate the National Committee for AIDS Prevention and Control from MOH and move the Committee under a Deputy Prime Minister in 1994, the incorporation of HIV/AIDS prevention into other sectors and branches of the government (e.g., Education, Information, the Armed Forces, the Police, etc.) has been slow and limited on a national scale and almost non-existent on a provincial or local level (World Bank, 2004).

Inappropriate Design of the Intervention Programs

One of the weaknesses in the Vietnamese HIV/AIDS policy is that the government has a good strategy but many specific intervention programs are not appropriately designed or are only capable of covering a small geographical scope and a limited number of groups engaged in high-risk behavior. This weakness has negatively affected the government's efforts in slowing down the HIV/AIDS infection rate.

One of the biggest components of the national HIV/AIDS program is the IEC program aimed at providing basic knowledge of HIV/AIDS prevention and advocating behavior change. However, this IEC program has been closely linked to the government's "social evils" campaign which was launched in 1993 with aims to wipe out prostitution and drug use (Gorbach, Ryan, Saphon, & Detels, 2002). As an unexpected result of this linkage, the stigma and discrimination against the people engaged in high-risk behavior such as FSWs, IDUs, and HIV infected people have imposed a negative impact on the implementation of the HIV/AIDS IEC program. For example, several piloted harm reduction programs with peer education and distribution of condoms and clean needles were not accepted by the community and in some provinces were even stopped because it was felt that these programs were in conflict with the aims of the anti-social evils program (Hien, Giang, Binh, & Wolffers, 2000). A study from Khuat et al. (2004) also pointed out that linking prostitution, drug use and HIV/AIDS and using fear-tactics in order to warn people of the dangers of HIV/AIDS were exacerbating

the stigma experienced by people living with HIV and AIDS. Their research indicated that in the public mind, HIV/AIDS had become equivalent to a social evil and the people living with HIV/AIDS, in the eyes of the community, were suspected of having evil behavior as the source of HIV/AIDS transmission. As a result, HIV infected people often tried to keep their HIV status secret, making it more difficult for the government and the communities to provide support to them, to manage and monitor the HIV/AIDS transmission, or to have an accurate assessment of the size of the epidemic. More dangerously, linking HIV/AIDS with prostitution and drug use also gives the community a mistaken belief that they will be absolutely immune to HIV/AIDS provided that they are not FSWs or IDUs. This has paved the way for the HIV/AIDS epidemic to spread into the general population. Thus, instead of directing people towards safe behaviors the IEC programs caused unreasonable fears, stigma, discrimination and a careless view of HIV/AIDS transmission.

Another shortcoming of the IEC programs is the slow response to the changes of local HIV/AIDS patterns. While the HIV/AIDS epidemic started to show signs of spreading into the general population, the IEC programs still maintained their focus only on two groups engaged in high-risk behavior, i.e.: FSWs and IDUs, and almost ignored other groups such as the sexual partners of FSWs and of IUDs and youth (Dang et al., 2003). Research has also shown that those IEC programs that do directly address young people have been both inappropriate and inefficient (Dang et al., 2003). In addition, MSM, another group engaged in high-risk behavior which might fuel the spread of the epidemic, has never been targeted by the intervention programs (Colby & Doussantousse, 2004). Although there has been an ongoing project addressing MSM in Khanh Hoa since 2001, this project alone is apparently not sufficient to deal with the increasingly important impact of MSM on the HIV/AIDS epidemic. The focus of public education campaigns on IDUs and FSWs as routes for HIV transmission also led to deadly misunderstandings. For example most of the MSM believed that sex with men was safer than sex with women (Colby & Doussantousse, 2004).

The first assessment of the national HIV/AIDS peer education program conducted in 2000 also pointed out that the scope of the program was very limited. Although the program included distribution of information through word of mouth, pamphlets, or brochures and provision of condoms and clean syringes and needles, other well regarded activities such as skill building or goal setting interventions aimed at HIV risk reduction were absent in the program (Dang et al., 2003). Many other HIV prevention activities such as the condom social marketing program and peer education, although successful, have been unable to be sustained and replicated on a national scale due to limited resources (UNAIDS, 2004).

The lack of reliable epidemiological data, information and analysis
Data and information on HIV/AIDS plays an important role in the planning and implementation of the national HIV/AIDS programs. Policy-makers need to know accurately about the situation and the development trend of the HIV/AIDS epidemic in order to have appropriate and due actions. However, many researchers have voiced their concerns over the difference or inaccuracy in the HIV/AIDS data in Vietnam. This shortage has led to an inefficient monitoring mechanism as well as inaccurate estimates and projections for the epidemic (Nguyen, Nguyen, & Trinh, 2004; Colby & Doussantousse, 2004; Dang et al., 2003; Truong, Le, Vu, Lindan et al., 1997). These authors point out that it is difficult to obtain comprehensive data on the HIV epidemic in Vietnam and in many cases data contradict across sources, partly due to the multi-tiered reporting system and differences in the completeness of the national surveillance system (Lindan et al., 1997). At present, estimates and projections of HIV/AIDS in Vietnam have to be determined mainly based on the size and prevalence of the two biggest groups engaged in high-risk behavior, i.e.: IDUs and FSWs, and other lower risk groups such as women attending antenatal clinics (mostly urban women) or men being recruited into the military (VTWG, 2003). As a result, the infection rates among non-specified groups, such as MSM or pregnant women in rural areas are unknown (Lindan et al., 1997; Nguyen et al., 2004). In addition, there is a lack of data on the relative importance of homosexual sex in relation to other risk behaviors (Colby & Doussantousse, 2004). Moreover, the official number of HIV infected cases is likely to be under-reported because much of the data on HIV prevalence of IUDs and FSWs are taken only from detention, rehabilitation centers and from community surveys. Given the fact that drug injection and sex work are considered illegal and immoral in Vietnam, the data obtained from detention and rehabilitation centers may only reflect the tip of the iceberg. Perhaps of more severe consequence, the existing monitoring mechanism is weak and information, data and feedback to the system has not been used by many provinces (Nguyen, 2004).

Failure of the Government to Mobilize Participation of the Whole Society in the HIV/AIDS National Program

The stigma and discrimination against HIV/AIDS, which has unintentionally arisen from the national IEC program has distanced the general population from the fight against HIV/AIDS. The general perception among the population is that HIV/AIDS is a disease closely related to deviant social behaviors. Thus it is a problem of bad and immoral people, not of the general population. As a result, the general population has often shown unwillingness to support HIV/AIDS intervention programs and even boycotted programs such as the provision of condoms and clean needles to FSWs or IDUs (Hien et al., 2000). Experiences from other countries have shown the great benefits of involving the people living with HIV/AIDS in the program, because these people and their families are

often the most effective advocates for behavior change. They also intimately know about the factors that make people vulnerable to HIV and about the services that are needed to improve care and support (UNDP, 2004). However, the people living with HIV/AIDS in Vietnam have been discriminated against by the general population and have not been consulted during the formulation as well as the implementation of intervention programs.

It has been demonstrated in the case of Thailand that NGOs can play an important role in HIV/AIDS programs by pioneering community-based efforts at the local level, initiating activities when public sector service were absent or deficient and working very successfully with hard-to-reach groups and communities (UNDP, 2004). However, the participation of NGOs in the Vietnamese national HIV/AIDS program is very limited. In fact, the concept of NGOs as being independent from the government does not exist in Vietnam. Although being called NGO, all these organizations must be registered under and be led by an association which has been directly under the jurisdiction of the Prime Minister. In addition, social activism in Vietnam was historically repressed and open public discussions on socially sensitive behaviors such as sex and drug use were not encouraged (Gorbach et al., 2002). As a result, Vietnam does not have a strong NGO network and the few NGOs which are now focusing their activities on HIV/AIDS have not had sufficient knowledge and skills on advocacy. Even more directly, the Government does not recognize the important role of NGOs' participation, a position that has led to NGOs' absence in the national HIV/AIDS program (Nguyen, 2004). The Vietnamese government's failure to mobilize participation from the whole society has been one of the key reasons why the country has not been successful in stopping the HIV/AIDS spread.

Remedies for the National HIV/AIDS Program of Vietnam

The first and foremost remedy is to promote the political will and leadership in the national HIV/AIDS program. This is one of the key factors for the program's success. It would create an impetus and solid base for mobilizing resources and efforts of the whole society. Strong political will and leadership has to manifest itself in high investment and public spending for the HIV/AIDS program, an investment which is sufficient to sustain a range of comprehensive intervention programs with proper scope to achieve the optimal efficiency of the programs. In this regard, the government of Vietnam needs to increase the annual state budget allocation for the national HIV/AIDS program. Although the entire Vietnamese budget is fairly low compared to neighboring countries, there are still opportunities for the government to increase the HIV/AIDS budget. Priorities may need to shift as military spending accounts for over one-half of the national budget (Ha, 1996). All the pilot intervention programs that have demonstrated success must have sufficient funds to be sustained and implemented in a

wider scope.

Secondly, the government should locate the national HIV/AIDS Bureau in the Prime Minister's Office and regular meetings of this Committee must be chaired by the Prime Minister. This will promote the full cooperation from all relevant ministries and agencies. Full commitment to the HIV/AIDS program must also be achieved at the national level as well as at provincial and local levels through the positioning of the provincial HIV/AIDS Committee directly under the jurisdiction of Chairmen of provinces or cities.

Thirdly the government has to immediately de-link HIV/AIDS and the people living with HIV/AIDS from its "social evils" program. This distinction must be uniformly and articulately carried out both vertically from the office of the Prime Minister, ministries, provinces, and local departments and horizontally from the IEC program to all other intervention programs. Even though prostitution and drug use are officially illegal the government should, instead of trying to eliminate prostitution, drug use or alter public morality, focus its efforts on aggressively promoting safe sex, condom use and clean syringes and needles use among FSWs, IDUs and their sex partners. Experience from Thailand has shown that a pragmatic approach to regulating the commercial sex trade and drug use in line with the national AIDS strategy can bring remarkable outcomes (UNDP, 2004).

Fourth, the intervention programs must be qualitatively and quantitatively improved. The increased state budget for the national HIV/AIDS program will be one of the elements leading to this improvement. However, sufficient funding is not enough. The intervention programs can become successful and effective only when: (i) they are tailored to the local patterns of the epidemic and are responsive to changes in those patterns; (ii) they are designed to tackle the underlying factors that might fuel the spread of HIV/AIDS; and (iii) they involve the community and HIV infected people in the formulation as well as the monitoring and evaluation process to make sure that intervention activities are relevant and community-supported.

Fifth, a uniform and reliable information system on HIV/AIDS should be established. Without accurate reliable data and analysis on the HIV/AIDS epidemic in Vietnam, it is impossible for the government to formulate strategies or build a plan to effectively deal with this epidemic. To establish such a system the government will need to: (i) review and revise the existing surveillance system to adapt to the evolution of the HIV/AIDS epidemic; (ii) build a national standard data collection from the central level to the local levels; (iii) allocate funds for research that will foster a better understanding of HIV/AIDS and its evolution; and, finally and most importantly (iv) establish a mechanism where the data collected can effectively be fed back into the policy development process.

Last but not least, the government should facilitate

the establishment of a mechanism to develop the NGO network in the country and enable NGOs, the general population, and people living with HIV/AIDS, to engage in open public discussions and social activism. Moreover, these groups should be involved in policy development and delivery of services. A good model is the recent initiative of the World Bank in Vietnam to open a contest and to award start-up funds for community-based projects to NGOs, local communities or groups formed by the people living with HIV/AIDS who have innovative ideas and approach to deal with HIV/AIDS. Such a model could be replicated by the government to attract the active involvement of the whole society in the national HIV/AIDS program.

Conclusion

Although the HIV/AIDS epidemic in Vietnam has started to show some frightening signs, it is still in its early phase (Nguyen et al., 2004). There are substantial opportunities for the government of Vietnam to review and improve its HIV/AIDS policy and programs to make them more committed, sustainable and responsive. Many studies have shown that interventions are most effective in the early phase of an epidemic and that it is very difficult to reverse an established epidemic (Nguyen et al., 2004). A lesson can also be learned from the case of Thailand and Sub-Saharan African countries. In the early 1990s, the HIV/AIDS epidemic started at almost the same level in both areas; however, the early and strong intervention of the Thai government has made a dramatic difference in the number of HIV infected people relative to Sub-Saharan Africa. This should ring a bell for the government of Vietnam: the time is ripe to swiftly and decisively act. Otherwise the country will likely be confronted with an uncontrollable and costly HIV/AIDS epidemic within the next ten years.

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End Notes

- 1 See UNAIDS 2004 report on the Global AIDS epidemic.
- 2 The news was broadcasted on the Voice of America on October 5th 2004, retrieved from <http://www.voanews.com/english>.