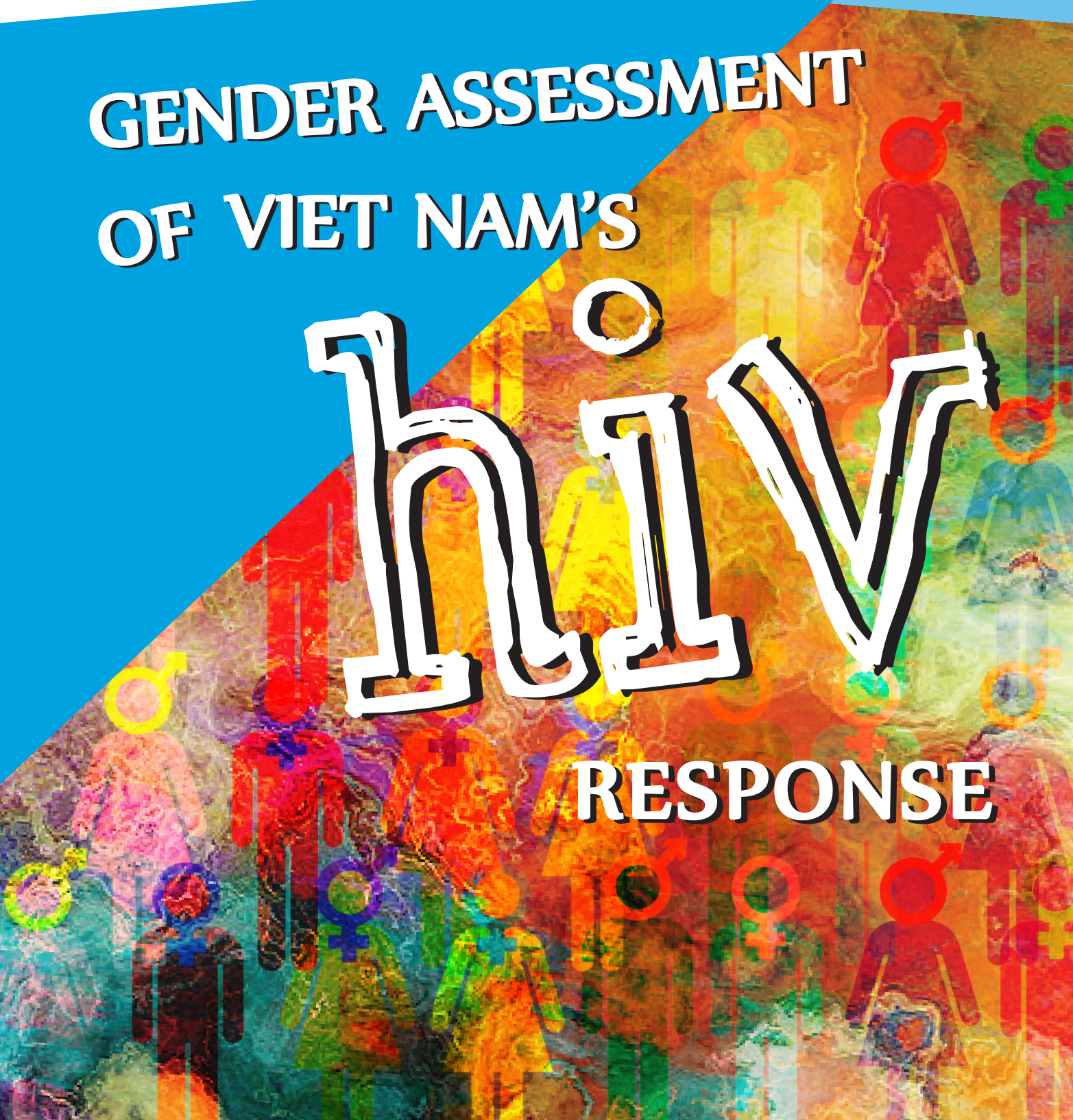




GENDER ASSESSMENT OF VIET NAM'S

hiv

RESPONSE





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Gender assessment of Viet Nam's HIV response

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United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

Viet Nam Country Office

304 Kim Ma, Hanoi, Viet Nam

Tel: +84 24 3850 0100

Fax: +84 24 3726 5520

Website: <http://vietnam.unwomen.org>

The view expressed in this publication are those of the authors and do not necessarily represent the views of UN Women, the United Nations or any of its affiliated organizations.

Written by Dr. Vicci Tallis and Ms. Ha Thi Minh Nguyet

Edited by Ms. Nina Allen

Production coordinated by Ms. Miho Watanabe and Mr. Bui Hoang Duc

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GENDER ASSESSMENT OF VIET NAM'S HIV RESPONSE

There is a man living with HIV in our village. He lives with his sister, who used to lock him in an old pigsty and give him 3 meals a day. When I went to the house to meet her, and help explain how to take care of him, she kicked me, and insulted me, because I am also living with HIV.

But I returned, many times, and told her many things. In the end, she listened to me and took better care of her brother. I encouraged her to take him to [the HIV clinic] and she agreed. So you can see that men living with HIV face stigma and discrimination – and women living with HIV are much more likely to face this issue than men. But we are more determined to live.

Woman living with HIV and peer educator

FOREWORD

In 2013, male-to-female intimate partner transmission accounted for an estimated 28% of new HIV infections.¹ Studies show that more than half of women living with HIV reported that their only possible exposure to HIV had been through their male sexual partners who had engaged in high risk behaviours.²

In June 2016, General Assembly adopted the Political Declaration on Ending AIDS. In this Declaration, UN Member States have agreed to the global mandate to Fast Track the AIDS response with a set of specific, time-bound targets that must be reached by 2020 to end the AIDS epidemic by 2030 within the framework of the 2030 Agenda for Sustainable Development. Importantly, this ambitious Political Declaration commits to invest in gender equality and the empowerment of women and girls as a priority in efforts to end the AIDS epidemic by 2030. Among key priorities, the Declaration includes commitments to ensuring access to sexual and reproductive health services, and addressing intersections of violence against women, harmful practices and HIV. It sets a target to reduce new HIV infections among young women and adolescent girls, and recognizes the vital importance of women's leadership and engagement in the AIDS response.

Viet Nam is committed to end the AIDS epidemic by 2030, and has demonstrated political leadership and commitment to join global efforts to address gender inequality and HIV. However, gender equality commitments have yet to be translated into HIV policies, programmes and budgets, and the current national response to HIV fails to adequately respond to the diverse needs and rights of key affected women and girls. Further, there is a lack of civil society engagement in HIV policy development and its implementation, particularly women's groups representing women living with HIV. As a result, women living with HIV face gaps and constraints in accessing prevention, treatment, and care and support services. Women, particularly those most affected by the epidemic, also largely remain on the margins of policy and decision-making spaces.

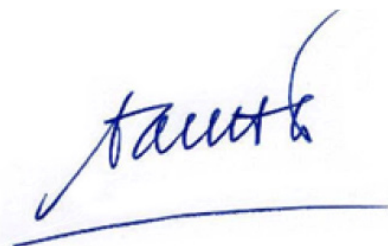
1. VAAC. Viet Nam AIDS Epidemic Model. 2014.

2. UNAIDS/UN Women, *Measuring Intimate Partner Transmission of HIV in Viet Nam: A Data Triangulation Exercise*, 2012.

In this context, and given the upcoming revision of the HIV Law and implementation of the National Working Plan for HIV Prevention and control 2016-2020, we believe that this gender assessment is timely to accelerate and strengthen the national HIV response to meet the global goal of Ending AIDS by 2030. Led by the Vietnam Authority of HIV/AIDS Control (VAAC) and conducted by the National Gender Task Force, this assessment presents a situation analysis of the gender dimension of HIV epidemic in Viet Nam. It identifies opportunities, gaps and challenges in mainstreaming gender equality and empowerment of women in the national HIV response, and provides a set of recommendations for improved HIV policies and programmes. Our hope is that the call for renewed political commitment, stronger policies, laws, and gender-responsive services, better data and evidence, and engagement and participation of women living with HIV will be heard and action will be taken.

Dr. Phan Thi Thu Huong

Vice Director General,
Viet Nam Authority of HIV/AIDS Control
(VAAC), Ministry of Health



Shoko Ishikawa

Country Representative
UN Women Viet Nam



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- Dr. Bui Hoang Duc – Department of Surveillance, Monitoring, Evaluation and Testing, Viet Nam Administration of HIV/AIDS Control (VAAC), Ministry of Health. Focal point of Gender Task Force.
- Ms. Pham Thanh Binh – Ministry of Health
- Ms. Trinh Thi Le Tram – Center for Consulting on Law and Policy on Health and HIV/AIDS (CCLPHH)
- Mr. Do Huu Thuy – Department of Information, Education and Communication (IEC), Viet Nam Authority of HIV/AIDS Control (VAAC), Ministry of Health
- Ms. Nguyen Kim Dung – Center for Supporting Community Development Initiatives (SCDI)
- Ms. Lai Minh Hong – Viet Nam Network of Women Living with HIV (VNW+)
- Ms. Quach Thi Mai – Viet Nam Network of Women Living with HIV (VNW+)
- Ms. Huynh Thi Lan Phuong – Joint United Nations Programme on HIV/AIDS (UNAIDS)
- Ms. Miho Watanabe – United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

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Within UN Women, the assessment was coordinated by Miho Watanabe under the overall guidance of Shoko Ishikawa and with the support of Leika Aruga, Vu Phuong Ly and Tran Thi Thuy Trang.

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour change communication
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSO	Civil society organization
GARPR	Global AIDS Response Progress Report
GRB	Gender-responsive budgeting
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
HRQL	Health-related quality of life
HSS	HIV sentinel surveillance
HSS+	HIV sentinel surveillance integrated short behavioural questionnaire
IEC	Information, education and communication
MDG	Millennium Development Goals
MOLISA	Ministry of Labour, Invalids and Social Affairs
MMT	Methadone maintenance therapy
MOH	Ministry of Health
NCFAW	National Committee for the Advancement of Women
NGO	Non-governmental organization

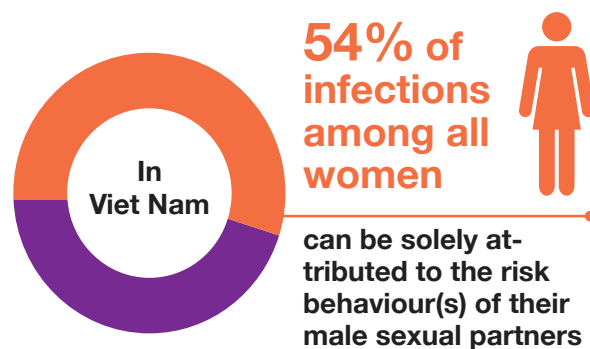
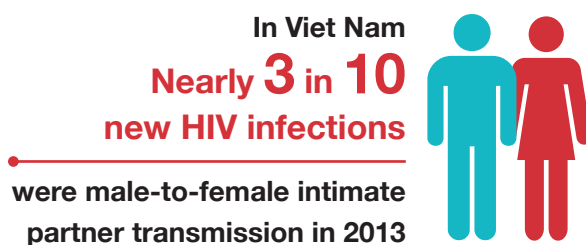
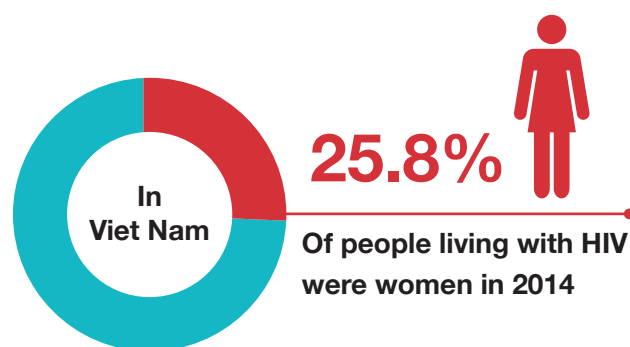
NSP	Needle and syringe programme
PAC	Provincial AIDS Centres
PMTCT	Prevention of mother-to-child-transmission
SAVY	Survey Assessment of Vietnamese Youth
STI	Sexually transmitted infection(s)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
VAAC	Vietnam Authority of HIV/AIDS Control
VCT	Voluntary counselling and testing
VNMSM/TG	Viet Nam Network of Men who have Sex with Men and Transgender
VNP+	Viet Nam Network of People Living with HIV
VNPUD	Viet Nam Network of People Who Use Drugs
VNSW	Viet Nam Network of Sex Workers
VNW+	Viet Nam Network of Women Living with HIV
WVU	Viet Nam Women's Union
WHO	World Health Organization

EXECUTIVE SUMMARY

INTRODUCTION

In 2014 there were an estimated 256,000 people living with HIV in Viet Nam, 25.8% (66,000) of whom were women. The epidemic is concentrated primarily among people who inject drugs, men who have sex with men (MSM) and female sex workers. The number of new HIV infections in Viet Nam decreased rapidly between 2007 and 2009, and has stabilized at around 14,000 per year since 2010. However, a substantial proportion of all new infections are occurring among women who are in long-term sexual relationships with men who are living with HIV, particularly men who inject drugs, but also MSM and men who buy sex. In 2013, male-to-female intimate partner transmission accounted for an estimated 28% of new HIV infections. Studies show that nearly 54% of infections among all women in Viet Nam can be solely attributed to the risk behaviour(s) of their male sexual partners, and that condom use by men who inject drugs is particularly inconsistent when a female partner does not know the man's HIV status.

As it stands that National Strategy on HIV/AIDS Prevention and Control till 2020 with a Vision to 2030 does not adequately address the gender dynamics of the epidemic in Viet Nam, nor does it deal with the disproportionate impact of HIV on women and girls, including women and girls in key populations and the female partners of MSM



or men who inject drugs. Most responses to HIV in Viet Nam are gender blind: that is, they do not take into account the different experiences, lived realities of men and women, boys and girls, and neither do they address the layers of marginalization that stems from intersectionality.

Gender inequality contributes to the spread of HIV. It can increase infection rates, and reduce the ability of women and girls to cope with the epidemic. Often, they have less information

about HIV and fewer resources to take preventive measures. They face barriers to the negotiation of safer sex, because of unequal power dynamics with men. Violence against women and the fear of violence, exacerbates the risk of HIV transmission. Evidence suggests that marriage can be a major risk factor, especially for young women and girls. Many women living with HIV struggle with stigma and exclusion, aggravated by their lack of rights. Women widowed by AIDS or living with HIV may face property disputes with in-laws, complicated by limited access to justice to uphold their rights. Regardless of whether they themselves are living with HIV, women generally assume a disproportionate burden of care for others who are sick from or dying of AIDS, along with the orphans left behind. This, in turn, can reduce prospects for education and employment.

In 2015, the National Gender Task Team conducted the gender assessment of HIV national response, looking at how gender is integrated into Viet Nam's HIV response, and specifically at how the needs and experiences of women and girls are addressed. The National Gender Task Team was led by the Vietnam Authority of HIV/AIDS Control (VAAC), and consisted of government agencies, representatives from civil society promoting women's rights and groups representing women living with HIV and key affected women in their diversity, and UN agencies. The research included a desk review of relevant documents, key informant interviews in three provinces, three focus group discussions with women living with HIV and women in key affected populations, and a one-day validation meeting, at which the key findings and recommendations were

discussed. A key outcome of the assessment was to provide recommendations for strengthening efforts to address gender in the HIV response in Viet Nam. Internationally developed tools for the gender analysis of HIV responses were used as a framework for the analysis. The CEDAW definition of substantive equality – to ensure equality of results – was used throughout as the basis for examining national efforts to address gender inequality.

A gendered approach to HIV needs to inform both policy and practice, and must address the structural factors that impact on the socio-economic and political context in which women and girls live. The analysis therefore had at its core the need to have policy and programmes that: reduce women's vulnerability to HIV infection by transforming gender inequality; are based on sound research and evidence that highlights the realities of women in Viet Nam, including but not limited to women from key populations; address the barriers in access to services for key populations, and the legal and policy context which makes them vulnerable to HIV; address the specific issues and barriers facing women who are at risk of HIV but invisible to policymakers; and are rooted in ensuring women's human rights.

SUMMARY OF FINDINGS

Gender inequality is mentioned in the guiding framework for the response to HIV, including the Law on HIV/AIDS Prevention and Control (2006) and the National Strategy on HIV/AIDS Prevention and Control till 2020 with a

Vision to 2030. The framework does provide a starting point from which to tackle the gender dimensions of the epidemic, with objectives, activities and targets that can be built on, refined and implemented. However, as it stands the National Strategy does not adequately acknowledge of the ways in which gender inequality and HIV are linked, or of the need for gender responsive HIV-related policy, laws and strategies reinforced by a strong rights-based approach.

One of the problems in the current response is the acknowledgement of how gender inequality and HIV are linked: policy, laws and strategies to address HIV and AIDS need to be reinforced by a strong rights approach that has at its core gender equality and gender equity and at the same time be mindful of women and girls living with HIV in all their diversity and examine the impact that gender inequality has on making women and girls vulnerable to HIV including gender based violence. Another critical gap is a tendency to view women and girls as homogeneous and focus on pregnant women and the exclusion of other women. Whilst women as a whole are less equal to men, there are certain subject positions, or identities that push women further into the margins such as race, ethnicity, class, religion, sexual orientation, and gender identity. Greater visibility of women in discourse, policy and practice is needed through engaging key affected women and girls including women who use drugs and female sex workers, female partners of high risk men, transgender women, young women, women living with HIV and women belonging to an ethnic minority, to acknowledge how the impact of

intersectionality and layers of marginalization impact on their vulnerability to HIV infection, their experiences and behaviours in accessing vital services. In addition, the current national M&E framework does not require data disaggregated by age or sex. Age and sex disaggregated data is essential to understand the prevalence of HIV among key affected women and how the national response reaches out to the most marginalized population of Viet Nam.

Although Viet Nam's response has made progress in the four areas that underpin a successful response to addressing HIV – prevention; treatment, care and support; stigma and discrimination; and challenging gender inequality – gaps remain and will need to be remedied if women in all their diversity are to be adequately catered for.

Prevention: A strong prevention programme is needed that provides targeted information and enables women and girls to seek prevention. However, there is still not universal access to male condoms, and no access to female condoms. The mainstay of the prevention programme is information and communication, yet in many instances the messages are generic and do not properly target women and girls, especially those most at risk (particularly women from key populations, female partners of high risk men and ethnic and migrant women). Harm-reduction programmes are targeted at men, failing to take into account women who use drugs.

Treatment, care and support: Affordable, accessible and appropriate holistic treatment care and support that address HIV and

related women's health issues are essential. A gendered approach to treatment and care needs to address gendered differentials in access to health care; drug regimens and dosage; opportunistic infection; palliative care needs; and care burdens. While Viet Nam has made progress in increasing access to antiretroviral treatment, closer attention needs to be paid to the different health-seeking behaviours of men and women the ways in which women's multiple roles (reproductive, productive and community) hamper access. The expense of CD4 counts and viral load testing and treatment for opportunistic infections can also prove a barrier for women in particular. Despite considerable gains in the prevention of mother-to-child transmission (PMTCT), the integration of these services into maternal health services has not been fully implemented due to funding restrictions, which may put the programme at risk. In addition, although research points to the importance of involving men in PMTCT there is no clear strategy to do so. Further research is needed into gender differences in opportunistic infections and AIDS defining illnesses.

Stigma and discrimination: Ending stigma and discrimination against women and men living with HIV and key populations is vital. Gender inequality impacts on how stigma and discrimination is experienced – men and women experience both stigma and discrimination, and the fear of stigma and discrimination, differently. Gender norms and roles affect the types of stigma associated with being a woman living with HIV, which can be compounded by stigma related to risk behaviours, ethnicity, poverty and so on.

Fear of being stigmatized impacts on health-seeking behaviours, with women choosing to delay a visit to the clinic or hospital or pay extra to visit a private health care provider.

Challenging gender inequality and ensuring women's rights to reduce women's risk and increase their access to services are also crucial. Gender-transformative approaches are critical in addressing the root causes of gender inequality and women's inferior position in intimate relationships, the household, family, community and society. Although such programmes may not appear to fall within the remit of the HIV response, they are crucial in challenging the gender/social norms that play out daily and are the reasons why women are unable to protect themselves from HIV infection and why women living with HIV experience greater stigma and discrimination, face more barriers to services, and are more marginalized or even invisible in the response. Relevant issues include:

- Gender-based violence (physical, sexual, emotional, economic) – which is a daily occurrence in the lives of many Vietnamese girls and women. However, the link between gender-based violence and HIV is not well documented in Viet Nam, and women seeking services for violence-related injuries are rarely offered HIV testing or post-exposure prophylaxis. Likewise women living with HIV seeking treatment care and support services are not screened for gender-based violence.

- Limited access to sexual and reproductive health services - although sexual and reproductive health issues are addressed by family planning and reproductive health services, and successes include declines in maternal mortality, there is still a high level of unmet need for contraception and particularly severe restrictions on services for adolescent girls, and ethnic minority women and girls. In addition, there are reports of women living HIV who have been “coerced” into sterilization and/or abortion, and some women are concerned about the consequences of using services, especially when pregnant, due to punitive approaches to sex work and drug use. HIV programming has given little attention to the sexual and reproductive health decision making of women living with HIV.
- Poverty - key signifiers of poverty in Viet Nam are ethnic minority and gender. The experience of poverty is not gender-neutral but is affected by gender inequality. Although social protection is available in the form of social insurance schemes and social welfare services, they are not meeting the needs of vulnerable women living with HIV. In particular, women are concerned about the affordability of social health insurance, particularly

under new rules regarding household enrolment, and may be unaware of their right to access social protection.

- Viet Nam has a wide range of legislation to protect the rights and legal interests of people living with HIV, and mechanisms for legal redress where the provisions of Law on HIV are violated. Women living with HIV particularly face losing their home, custody of their children, and property and inheritance rights, while women who engage in sex work report high levels of discrimination. Although people living with HIV are eligible for free legal aid, accessing it involves disclosing their status and thus increasing the risk of stigma and discrimination, which again has gendered implications. In addition, access to such aid is not consistent around the country and insufficiently funded.

The following elements are needed to ensure that the gendered dimensions of HIV are addressed:

Structural

- Challenging harmful norms and unequal power relations in order to prevent and address gender-based violence and improve access to justice.

- An enabling environment that upholds human rights and protects and promotes women and girls sexual and reproductive health in order to reduce vulnerability and risk.
- Guaranteeing social, legal and economic empowerment.
- Reducing gender-related barriers, including stigma and discrimination, to accessing programmes and services, while improving the uptake and quality of services, by tailoring these to the needs of women and girls in all their diversity.

Four pillars, each with gender dimensions, underpin a successful response to addressing HIV. The four pillars are prevention; treatment, care and support; stigma and discrimination and challenging gender inequality. Viet Nam has made some progress in all four but there are gaps that need attention if women in all their diversity are to be adequately catered for.

Programming

- Design programmes aimed at addressing the challenges that are specific to women living with HIV and women from key populations in relation to stigma, discrimination, their human rights and the law.
- Improving access to sexual and reproductive health services for all women.

Community

- Supporting the community to challenge and influence harmful policies and practices that place them at greater risk of HIV and obstruct their ability to respond to risk and vulnerability.

RECOMMENDATIONS

Based on the gender assessment process the following recommendations highlight specific issues that need attention:

I. ENHANCING POLITICAL COMMITMENT

Political commitment is evident in the commitments made to both HIV and Gender by the government of Viet Nam as shown in the Constitution, the setting up of gender machinery and commitments made to international treaties such as CEDAW and 90-90-90. Moving forward, the following opportunities exist to increase the attention on the intersections of HIV and gender:

- i. Act upon the commitments made under the *Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030*. In particular, realize the commitments made to pursuing transformative AIDS responses to contribute to gender equality and the empowerment of all women and girls under the Political Declaration.³
- ii. Seize the opportunities provided by the 2030 Agenda for Sustainable Development to accelerate action and to recast gender responsive approach to AIDS.
- iii. Commitment to and implementation of gender responsive budgeting.

II LEGAL AND POLICY REFORM

There are a number of laws and policies that guide and regulate programmes to improve gender equality and address HIV (See Appendix A). There is space however, to amend existing laws and policies to provide a more enabling environment – especially in responding to CEDAW Committee’s recommendations to Viet Nam in July 2015⁴.

- i. The Prime Minister has approved the action plan to respond to CEDAW Concluding Observations in May 2017. There are opportunities for MOH to coordinate with MOLISA to implement the health-related action of the plan in collaboration with CSOs including the women living with HIV network (VNW+).
- ii. Revise the existing Law on HIV/ AIDS Prevention and Control from a gender perspective and in line with the international conventions including CEDAW, to ensure appropriate focus and targets on HIV that take into account the realities of women and girls in all their diversity.
- iii. Undertake a systematic mainstreaming of gender into HIV policies including the National Working Plan for HIV Prevention and Control 2016-2020, detailed operational plan and other relevant policies and programs. This would involve a review and analysis of existing policies and reworking policies to ensure that

3. United Nations General Assembly, 2016. *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*. A/70/L.52

4. UN Committee on the Elimination of Discrimination Against Women (CEDAW), Concluding observations of the Committee on the Elimination of Discrimination against Women : Viet Nam, 24 July 2015, CEDAW/C/VNM/CO/7-8.

women, girls and key populations are adequately addressed and catered for.

- iv. Build strong accountability mechanisms for the implementation of laws and policies relevant to gender equality in HIV prevention and response including in the Law on HIV Prevention and Control (2006) and the National Work Plan on HIV Prevention and Control (2016-2020) with clear timelines, targets and indicators, clear allocation of responsibilities, mechanisms for monitoring its implementation, and allocation of adequate human, technical and budgetary resources.
 - v. There is little mention of HIV as an issue in the gender equality programmes and policies. It is recommended to conduct a review of the gender programme and policy environment to identify possible opportunities to address women's sexual and reproductive rights, gender based violence and HIV.
 - vi. Language is an important consideration when addressing HIV: there is a need to revisit current terminology and its impact on stigma and discrimination and gender inequality. Ways to refine language so that it promotes a common understanding and reduces discrimination and others could include:
 - *Developing an understanding of gender – to include issues of power differences and to move towards a gender sensitive and transformatory focus;*
- *Changing the language of HIV/AIDS to HIV and AIDS which is in line with international discourse, and which implies the distinction between HIV and AIDS – this is critical as a starting point to address stigma and discrimination [Law on HIV/AIDS and the National Strategy]; and*
 - *Using the term sex worker instead of prostitute and to not continue the discourse on social evils for sex workers and people who use drugs.*
- vii. Ensure effective coordination among Ministries, in particular MOH and MOLISA as well as other relevant parties to ensure gender is adequately reflected in HIV programs, and vice versa, with clear mandate and defined responsibilities for each party and allocate adequate human, technical and financial resources and authority to effectively discharge their mandates.
 - viii. Enhance women's awareness of their rights and increasing their legal literacy to empower them to avail themselves of the procedures and remedies to claim their rights under existing laws and CEDAW.

III. UNDERSTANDING THE EPIDEMIC: BUILDING KNOWLEDGE AND EVIDENCE

There is a growing body of knowledge on the epidemic in Viet Nam; however, there are gaps in knowledge, especially for women and girls in all their diversity – including women who use drugs, female sex workers, intimate partners of key populations. It is important to address the gaps in knowledge through:

- i. Enhancing data collection, analysis and dissemination of comprehensive data, disaggregated by sex, age, disability, ethnicity, location and socioeconomic status. Current indicators should be amended to gender sensitive indicators in line with international standard, to assess situation of women and shed lights on currently invisible populations such as transgender women, women who use drugs in HIV prevention and response;
- ii. Building knowledge/evidence of factors or social determinants, including socio-cultural norms and practices that may contribute to increased risk of HIV transmission;
- iii. Building in-depth knowledge on different realities of women and girls in vulnerabilities to and experiences of HIV especially to identify the “hidden”-women, for example migrant women, ethnic women, transgender women, women who use drugs; and
- iv. Understanding the specific issues and experiences for women living with HIV including impact of disclosure, property, inheritance and child custody rights, differences in disease manifestation and experiences of violence.

IV. SERVICE PROVISION AND IMPLEMENTATION

The national response to HIV is well developed in some areas – for example, access to ARVs has been increased. However, there are certain programmes that need further attention (for example, prevention programmes, treatment and care) and access to services is not consistent across provinces.

- i. Ensure consistency across the provinces and increasing access to, and building of, a comprehensive and holistic approach to treatment, care and support beyond ARVs that takes into account the gender dimensions and different realities for women and men.
- ii. Design and scale-up of prevention programmes including tools, information and services to address women’s current lack of access to services for primary prevention.
- iii. Increase access to free condoms, needle exchange and STI treatment for women most at risk, including female sex workers and women who use drugs.
- iv. Strengthen health systems: include capacity building for health care worker around HIV and gender, and allocations of adequate resources to address women and girls.
- v. Ensure that women and girls, men and boys have access to free and quality sexual and reproductive health services including contraception, assistance and counselling, regardless of their HIV status, occupation, marital status, disability or geographical location.

- vi. Sterilization and use of contraceptive must be made based on full informed consent and voluntary will of women and girls concerned, based on their full understanding. Ensure that health sector personnel at all levels are adequately trained and held accountable for rights violations.

V. STRENGTHENING COMMUNITY ENGAGEMENT AND PARTICIPATION

Community engagement and participation of women living with HIV, and other key populations is critical: as a vital component of international best practice there are current strategies to increase women's engagement – including strengthening civil communities and ensuring that platforms exist for meaningful participation. There is a need for:

- i. The provision of technical and financial support to networks and organizations of women living with HIV, woman most affected by HIV and women from key population groups to enhance engagement. Support institutional capacity development through training and mentoring to develop strong, sustainable networks with diverse leadership;
- ii. Platforms for, and indicators to track the meaningful participation of women for deeper engagement in planning and policy making processes; and

- iii. Identifying key places where women's voices should be heard and to define meaningful participation. It is critical that women living with HIV, woman most affected by HIV and women from key population groups participate in, for example:

- Government/Civil society structures that are responsible for visioning, planning, implementation and review.
- Country Coordination Mechanism, Global Fund and other funding platforms.
- Research – both clinical and social science – that includes women in the processes of design, data collection analysis and the setting of recommendations.
- Involvement in future GARPR reporting
- Human rights reporting processes under CEDAW, Universal Periodic Review (UPR) and the Convention on the Rights of the Child (CRC) and others.

VI. ADDRESSING THE STRUCTURAL BARRIERS TO GENDER EQUALITY

Despite progress made on international gender equality indicators, and the adoption of law and policy to address women's unequal status, Viet Nam is still a patriarchal country and women remain disadvantaged which is evidenced by political representation, access to resources and opportunities, high levels on intimate partner violence and a preference for boy children. This increases women's vulnerability to gender based violence and HIV and impacts on their sexual, reproductive, social, cultural, political and economic rights. There is a need to:

- i. Intensify efforts to address inequality by increasing resources (human and financial) to meet redefined and more ambitious targets;
- ii. Address inherent sexism and challenge gender stereotypes and norms in society by using rights based discourse that ensures women's rights are understood and upheld through policy and practice;
- iii. Address gender based violence through revised law and policy, creating a more enabling environment and culturally accepted norms that result in greater reporting and a more stringent application of the law;
- iv. Raise awareness of men, including men living with HIV and men with risk behaviours, on their role in reducing transmission of HIV to their sexual partners;
- v. Engage men and boys in programmes to challenge gender norms;
- vi. Adopt strategic measures to address the root causes of gender inequality and challenge gender stereotypes and traditional social norms;
- vii. Enhance awareness raising program to eliminate stigma and discrimination in particular at health care settings. Target government officials, judiciary and law enforcement personnel, health care personnel, teachers, community leaders, as well as women and men, on evidence informed knowledge of HIV and the negative effects of stigma and discrimination on women's enjoyment of their rights.
- viii. Enhance awareness raising about women's particular risk to HIV transmission, and provide support services at health clinics with information related to protection;
- ix. Coordinate with the media to enhance understanding of concept of non-discrimination and non-stigma, and equality of women and men in public and private life and convey positive images of women in particular women living with HIV; and
- x. Coordinate with MoET in revision of educational materials to ensure that knowledge on HIV and transmissions are adequately included, and ensure that discriminatory stereotypes are removed from all school text books, teaching materials and curricula.

NEXT STEPS

VAAC, as the leaders of this process, is committed to taking the next steps in ensuring that the gender assessment findings are integrated into the HIV response, and in particular to:

- Ensure strong collaboration with UN Women and other gender equality experts and organizations going forward, including on the recommendation for further studies and a costing exercise to increase access to HIV services for vulnerable populations, and to develop a plan to build capacity in gender and HIV.
- Use the gender assessment for advocacy and policy-making, possibly beginning with publishing the key findings as a policy fact sheet.
- Meet with other Ministries and departments to discuss the gender assessment and the CEDAW findings, and to improve coordination.
- Revise the HIV monitoring and evaluation framework to ensure that it is both gender-sensitive and in line with the current National Strategy.

CHAPTER 1

INTRODUCTION

Globally, over the last decade there has been growing acknowledgement of, and commitment to, addressing the structural factors that increase women's vulnerability to HIV infection and recognizing the gender differences in how HIV is experienced. Tackling gender inequality is now seen as a critical component of any HIV programme – at the global, regional, national and local levels. Many useful resources exist to assist national HIV programmes to identify the gender dimensions of the continuum of HIV prevention, treatment and care.⁵

Viet Nam is a signatory to various international treaties and declarations, and continues to demonstrate political leadership and commitment to global development efforts. One sign of the seriousness of these commitments is that the government has been vigilant in reporting, and some of the country's progress towards international targets is encouraging. It was noted, however, in the national Millennium Development Goals (MDG) review and report that Viet Nam did not completely fulfil the MDG targets for Goal 6 (Combating HIV/AIDS, malaria and other diseases) and there are still elements of the HIV goal that need to be achieved.⁶ Going

forward, Viet Nam has committed to both the UNAIDS Fast-Track strategy⁷ and the 17 new Sustainable Development Goals. The Political Declaration on HIV/AIDS: On the fast-track to accelerate the fight against HIV and to end the AIDS epidemic by 2030 presents further opportunities for Viet Nam to implement the commitments to promote gender equality and empower women and girls.

In 2014 there were an estimated 256,000 people living with HIV in Viet Nam, 25.8% (66,000) of whom were women.⁸ The epidemic is concentrated primarily among people who inject drugs, men who have sex with men and female sex workers. The number of new HIV infections in Viet Nam decreased rapidly between 2007 and 2009, and has stabilized at around 14,000 per year since 2010.⁹ However, a substantial proportion of all new infections are occurring among women who are in long-term sexual relationships with men who are living with HIV, particularly men who inject drugs, but also men who have sex with men and men who buy sex. In 2013, male-to-female intimate partner transmission accounted for an estimated 28% of new HIV infections.¹⁰ A study has shown that nearly 54% of infections among all women in

5. See, for example:

Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. www.whatworksforwomen.org

UN Women (United Nations Entity for Gender Equality and the Empowerment of Women) *Gender Equality and HIV/AIDS: Comprehensive Web Portal for Gender Equality Dimensions of the HIV/AIDS Epidemic at:* <http://www.genderandaids.org/> Accessed 16 May 2016.

6. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.

7. UNAIDS (Joint United Nations Programme on HIV/AIDS). 2014. *Fast-Track - Ending the AIDS Epidemic by 2030*. http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report Accessed 16 May 2016.

8. Ministry of Health EPP Technical Working Group. 2013. *Preliminary results of HIV estimations and projections in Viet Nam 2013*.

9. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Viet Nam AIDS Response Progress Report 2014*.

10. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Viet Nam AIDS Epidemic Model. 2014*.

Viet Nam can be solely attributed to the risk behaviour(s) of their male sexual partners, and that condom use by men who inject drugs is particularly inconsistent when a woman does not know her partner's HIV status.¹¹ However, HIV transmission from men who inject drugs to their long-term female sexual partners has received limited attention in prevention efforts to date.

In 2010, UNIFEM¹² supported a gender assessment similar to this one, which served as a baseline for the further development of Viet Nam's response to HIV.¹³ The country is currently implementing the National Strategy on HIV/AIDS Prevention and Control Viet Nam till 2020 with a vision until 2030,¹⁴ which aims for comprehensive intervention, universal access, and improved quality and sustainability of HIV/AIDS prevention and control programmes. More widely, there is a well-developed national policy environment

to address gender inequality, and strides have been made to reduce such inequality in Viet Nam, especially in respect to early education and greater political engagement. The rise in HIV infections amongst women is of concern to the government and there is a genuine commitment to address the gender dimensions of HIV – both the causal effects of gender inequality in increasing HIV vulnerability and the consequential impact of HIV on women. As a lower middle-income country with a rapidly changing society, Viet Nam faces a number of the challenges that face nations in transition, including a shrinking donor base. This latter threatens to disrupt the gains made in the response to HIV, and will impact on what programmes and strategies will be prioritized in the future. In this context, it was deemed appropriate to look at how gender is integrated into the HIV response, and specifically at the experiences of women and girls.

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11. UNAIDS (Joint United Nations Programme on HIV/AIDS) and UN Women (United Nations Entity for Gender Equality and the Empowerment of Women). 2012. *Measuring Intimate Partner Transmission of HIV in Viet Nam: A Data Triangulation Exercise*.
 12. The United Nations Development Fund for Women. Since replaced by the UN Women (United Nations Entity for Gender Equality and the Empowerment of Women).
 13. UNIFEM (United Nations Development Fund for Women) and UNAIDS (Joint United Nations Programme on HIV/AIDS). 2010. *Gender analysis of the Vietnam National HIV/AIDS Strategy to inform the development of a gender-responsive national HIV response in the next National HIV/AIDS Strategy*. [UNPUBLISHED].
 14. Note: The UNAIDS terminology guide identifies HIV and AIDS as two different but interlinked epidemics. The Vietnamese approach is to use HIV/AIDS, which will be used in this document where it is part of the official titles of entities and documents. Elsewhere, 'HIV' or 'HIV and AIDS' will be used. The need to differentiate between HIV and AIDS will be raised as a key recommendation.

1. PRINCIPLES AND UNDERLYING PHILOSOPHY OF THE ASSESSMENT

Gender inequality leads to a lack of policy and programmes that protect and provide services for women and key populations. Failing to address gender inequality can therefore exacerbate inequality – and if underlying gender barriers are not addressed, good health and HIV outcomes cannot be met. Challenging and effectively addressing gender inequality require coordinated effort.

This assessment will use the principle of “substantive equality” elaborated by the treaty body to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which has noted that “the terms ‘equity’ and ‘equality’ are not synonymous or interchangeable”.¹⁵ CEDAW’s basis for evaluating equality for women and men is equality of results – which is the logical corollary of substantive equality.¹⁶ Achieving substantive equality requires not only that

women are provided with equal opportunities under the law, but also that they be given an equal start and that they be empowered by an enabling environment. This may require non-identical treatment of women and men.

*It is not only necessary that women have equal opportunities with men but also that we have equal access to these equal opportunities. The State is obligated to create the social and economic conditions and the services ... to enable women to take advantage of the opportunities offered.*¹⁷

Substantive equality requires “a real transformation of opportunities, institutions and systems so that they are no longer grounded in historically determined male paradigms of power and life patterns”.¹⁸

Global and regional research and discourse highlight the critical need to address gender across the HIV continuum of prevention and care¹⁹ in order to identify where national programmes are delivering and where greater attention is needed. Gender-conscious responses to HIV need to incorporate

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15. (United Nations Committee on the Elimination of Discrimination against Women). 2007. *38th Session, Comments of the Committee on the Elimination of Discrimination Against Women: Vanuatu*. CEDAW/C/VUT/CO/3. Note: The term “equity” will be used when it appears in quotes from official Vietnamese legal or policy documents. Its use is evidence that Viet Nam has not yet fully adopted the concept of substantive equality.
 16. (United Nations Committee on the Elimination of Discrimination Against Women). *General recommendation No. 25, on article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures*.
 17. Facio, Alda and Morgan, Martha I. 2009. “Equity or equality for women? Understanding CEDAW’s equality principles.” *Alabama Law Review* Vol. 60:5:1133.
 18. (United Nations Committee on the Elimination of Discrimination Against Women). *General recommendation No. 25, on article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures*.
 19. Note: Although the literature and policy on HIV often refer to the ‘care continuum’ – from testing, through diagnosis and treatment to viral suppression – and to the ‘prevention continuum’, this assessment will use the ‘continuum of prevention and care’ to encompass the interlinkages between prevention, care and treatment (for example, in relation to intimate partner transmission) and reflect the need to include gender systematically throughout the response.

interconnected elements: addressing structural barriers; ensuring human rights are central to the legal and policy framework; improving programming, implementation, monitoring and evaluation; and finally in allocating sufficient technical and financial resources through gender-responsive budgeting. A gender-sensitive approach, at the very least, is essential if women's vulnerability is to be reduced and the impacts of HIV for women and girls are to be mitigated. Gender-transformative responses that address women's practical needs and tackle the underlying structural factors that add to their vulnerability are mandatory if HIV targets are to be achieved.²⁰

In addition, central to this assessment is intersectionality: that is, the understanding that 'women and girls' are not a homogeneous group, and that gender is not the only determinant of their vulnerability in relation to HIV. This applies to both individual women and to sub-groups of women, and is particularly important in the context of Viet Nam's concentrated epidemic, in which women who engage in sex work are a key population at greater risk, as are women who use drugs. Compounding and complicating gendered issues relating to power, access to power, privilege and stigma are those of poverty, ethnicity, occupation, health status, migration status, geography and others. Women and girls have multiple (and shifting) identities that must be incorporated into considerations of how best to respond to their needs.²¹

This assessment had as its core focus the need to identify policy and programmes that:

- Reduce women's vulnerability to HIV infection (this also involves addressing broader women's rights issues, such as gender-based violence, that have a similar root cause to, and impact on, vulnerability to HIV);
- Are based on sound research and evidence that highlight the realities of women in Viet Nam, including but not limited to those of women from key populations;
- address the structural barriers for key populations and their intimate partners to access services, and the legal and policy context which makes them vulnerable to HIV;
- Address the specific issues and barriers facing women in key affected groups, who are often invisible;
- Are rooted in human rights, while also cognizant of women's rights; and
- Address the specific (and often neglected) issues that affect women living with HIV, such as cervical cancer, gendered side effects of antiretroviral therapy (ART), increased care burdens etc.

20. A more detailed analysis of the gender/HIV interface, including these types of responses, can be found in section 2 of this report.

21. For a further discussion of intersectionality see Hankivskay, O et al. 2012. "Why Intersectionality Matters for Health Equity and Policy Analysis" in Hankivsky, O. (Ed.). 2012. *An Intersectionality-Based Policy Analysis Framework*.

2. PARAMETERS OF THE RESEARCH

The goal of this assessment was not to provide a general review of the HIV response in Viet Nam and therefore does not comment on many of the strengths of the current national HIV programme. Instead, the analysis examines how gender is addressed more broadly in Viet Nam (as it relates to HIV), and how gender is dealt with specifically within the HIV response. The aim was to look closely at the experiences of and issues for women and girls, and to address the issues of key populations: to unpack the experiences of women and girls who are identified as members of key populations and those of the female sexual partners of men in key populations (men who inject drugs and men who have sex with men).

It is important at this juncture to emphasize that the focus of the assessment was on heterosexual cisgender women and girls – that is, women and girls who identify as the sex (female) they were assigned at birth. Whilst mention is made of some of the particular challenges and issues facing transgender women – women who do not identify as the sex (male) they were assigned at birth – and men who have sex with men, based on gender identity

and sexual orientation, it was beyond the scope of this report to do an in-depth and thorough analysis. However, it is clear that the current legal and policy environment – as well as cultural norms around homosexuality – in Viet Nam, although slowly changing, impacts negatively on the vulnerability of both transgender men and women, and men who have sex with men, and there is a need for further, more focused attention on the challenges and issues of these populations.²²

This paper provides:

- A conceptual framework for understanding gender and HIV (Chapter 2).
- A situation analysis of the gender dimensions of the HIV epidemic in Viet Nam, with a particular focus on the overall situation and issues facing women, girls and key populations (particularly women and girls who are members of key populations, and female sexual partners of male members of key populations). This includes an epidemiological snapshot and a review of the legal and policy environment that guides the approaches to both gender and HIV (Chapter 3).

22. Note: “Vietnamese culture does not conceptualize sexual orientation and gender identity in the same way as Western cultures. As a patriarchal and patrilineal society, non-normative sexual orientation and gender identity are traditionally viewed and discussed as male homosexuality. Male-to-female transgender identity and transvestism are viewed as extreme and visible forms of homosexuality. Lesbians and female homosexuality, if discussed at all, are typically not consequential or contentious as long as the woman conforms to the social norm of finding a husband, having children and raising a family ... This is further complicated by the fact that the word “homosexual” in Vietnamese is often used to identify the LGBT community as a whole. The media often perpetuate this confusion by equating homosexuality with gender identity. Many gays and lesbians do not agree with being categorized as transgender and believe that transgender people are the cause of stigma and discrimination against gays, lesbians and bisexuals. This leads to transphobia as lesbians, gay men and bisexuals distance themselves from transgender people and further isolate them from society.” UNDP (United Nations Development Programme) and USAID. 2014. *Being LGBT in Asia: Viet Nam Country Report*.

- A gender analysis of current HIV programmes and policies that identifies opportunities, gaps and challenges in achieving gender equality within the national HIV response, including programmes that focus on the empowerment of women and girls (Chapter 4).
- Key recommendations for strengthening Viet Nam's approach to both HIV and gender equality (Chapter 5).

3. METHODOLOGY

This gender assessment was a rapid exercise conducted by a national and an international consultant, guided by members of a national Gender Task Force led by the Viet Nam Authority of HIV/AIDS Control (VAAC) and supported by UN Women (both in Viet Nam and regionally). Its purpose was to analyze the extent to which Viet Nam's response to HIV acknowledges, and then acts on, the recognition of gender inequality as a key determinant of HIV. A key outcome of the assessment was to provide suggestions and recommendations for strengthening and increasing efforts to address gender in the response, including practical recommendations for the National Work Plan on HIV/AIDS Prevention and Control 2016-2020 and other relevant sectoral policies and plans, as well as Viet Nam's Law on HIV/AIDS.

The methodology for the assessment was based on clear and widely disseminated theory and best practice of gender and feminist approaches, including: participation; hearing as many diverse voices as possible; and highlighting personal experience as

a critical component of understanding the reality on the ground. An important prerequisite was therefore to ensure that the process was informed by the realities of those most affected through a participatory approach which engaged all stakeholders to develop empowering partnerships and to feel a high degree of ownership both of the assessment process and of any future actions taking the recommendations forward. It was especially important to include the voices of key and marginalized populations, with a special focus on women living with HIV.

The assessment required the collection of both qualitative and quantitative data, with five main sources of data:

- Semi-structured interviews – with specific targeted question sets for each key informant.
- Focus-group discussions – to elicit experiences and suggestions from members of key government departments working on gender and HIV, and the interface between the two.
- Focus-group discussions – to elicit experiences and suggestions from women living with HIV and women from key populations.
- A desk review and analysis of key documents (including: policy documents; strategic and operational plans; contextual evidence-based research; recorded best practices).
- A validation workshop, at which the draft recommendations were discussed, commented upon and reworked.

For the purposes of data collection, a number of internationally developed tools were used which provide the elements of an integrated response to HIV and gender that takes into account women and girls, men and boys, as well as key populations, and extends to the partners of key populations. These have been developed because although many national HIV programmes – Viet Nam’s included – have a commitment to addressing gender and reducing women’s vulnerabilities and those of marginalized key populations, it is often difficult to actually ensure that the gender dimensions of each aspect of the HIV response are addressed. The sources for the assessment’s questionnaire schedules (specific data-collection instruments for different categories of stakeholders tailored for the focus-group discussions and individual interviews) included the *UNAIDS Gender Assessment Tool*,²³ the *Framework for Women, Girls and Gender Equality in National*

Strategic Plans,²⁴ *What Works for Women and Girls*²⁵ and the WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations,²⁶ which were adapted for the Vietnamese context.

Key informants were identified in collaboration with the Gender Task Team through a mapping of sector stakeholders. The final list of 44 interviewees in both individual interviews and focus-group discussions included people from government agencies (the Ministries of Health and of Labour, Invalids and Social Affairs and the National Assembly, at both the national and local levels), research agencies/academia, UN agencies (UN Women, UNAIDS and UNDP), donors, non-governmental organizations (NGOs), networks of key populations and marginalized groups (see Appendix B). A total of 16 women living with HIV, female sex workers and women who use drugs were interviewed. The need for more civil

23. UNAIDS (Joint United Nations Programme on HIV/AIDS). 2014. *UNAIDS Gender Assessment Tool: Towards a gender-transformative HIV response*. http://www.unaids.org/sites/default/files/media_asset/JC2543_gender-assessment_en.pdf Accessed 16 May 2016.

24. ATHENA Network and HEARD. 2010. *Framework for Women, Girls, and Gender Equality in National Strategic Plans on HIV and AIDS in Southern and Eastern Africa* <http://www.athenanetwork.org/assets/files/NSPs/Framework%20for%20Women,%20Girls,%20and%20Gender%20Equality%20in%20NSPs.pdf> Accessed 16 May 2016.

25. Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. www.whatworksforwomen.org Accessed 16 May 2016.

This is a comprehensive website documenting the evidence for effective HIV interventions to guide donors, policymakers, and programme managers in planning effective HIV/AIDS policies and programmes for women and girls. It spans more than 2,000 articles and reports with data from more than 90 countries. It contains—in one centralized, searchable location—the evidence of successful gender-specific programming from global programmes and studies, with a focus on the Global South.

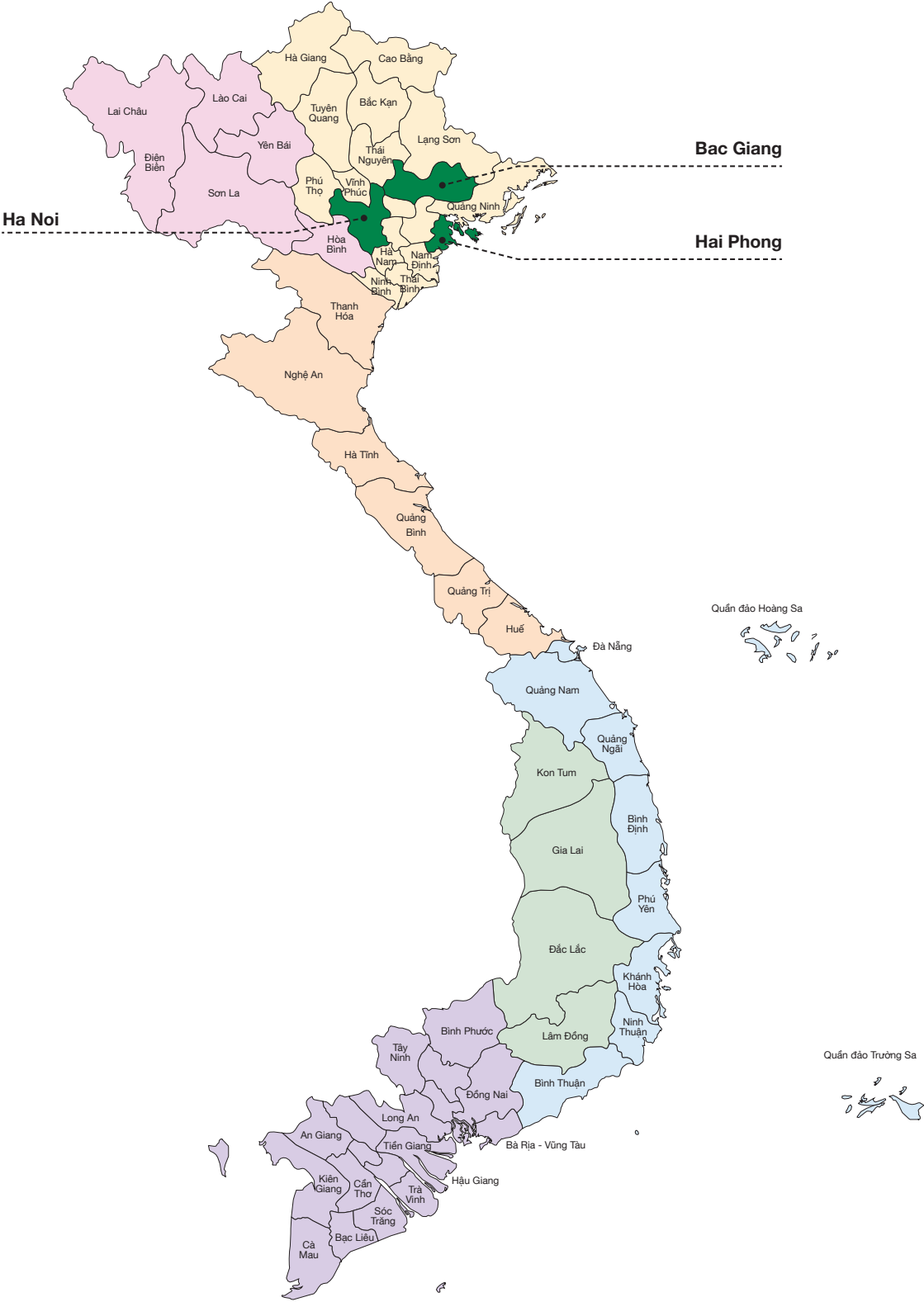
26. WHO (World Health Organization). 2014. *Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations*.

These consolidated guidelines bring together all existing guidance relevant to five key populations – men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people – and provides updates for selected guidance and recommendations. The guidelines aim to: provide a comprehensive package of evidence-based HIV-related recommendations for all key populations; increase awareness of the needs of and issues important to key populations; improve access, coverage and uptake of effective and acceptable services; and catalyze greater national and global commitment to adequate funding and services.

society voices was rectified by the inclusion of such groups in the validation workshop. The majority of interviews were conducted in Vietnamese with simultaneous interpretation into and from English by the international and national consultants. Key VAAC and other Ministry documents were collected and supplemented through online research and on the basis of recommendations from the Gender Task Team and interviewees.

The data were collected over a 10-day period in early November 2015 in 3 provinces: Hai Phong, Bac Giang and Ha Noi. These were selected because they provide both an urban and a rural perspective, have strong networks of women living with HIV and some of the highest prevalence rates (especially among female sex workers) in the country, and are geographically close to each other.

Figure 1: The provinces where data were collected



The assessment's initial findings were shared with the Gender Task Team for comment, and the report also underwent an extensive review process conducted by VAAC and UN partners. A one-day validation meeting provided a platform to share the findings with a broader group of stakeholders. The validation meeting was attended by 45 participants, and presented an opportunity for feedback and discussion on the findings and recommendations (see Appendix C for a list of participants).

4. LIMITATIONS

As with any undertaking of this nature, there were certain limitations in the process:

- Not all voices and experiences could be included. As noted above, the focus of the study is on women and girls and – whilst some acknowledgement is made of gender diversity – specifically on gender-conforming women and girls. The analysis refers to the complex interlinking factors between gender identity, sexual orientation, gender, sex and age, all of which impact on people's voice, choice and safety in the context of HIV, but the voices and experience of transgender and gender

non-conforming people, men who have sex with men and gay men are not directly represented.

- Time constraints meant that only 3 provinces were visited. Viet Nam has 63 provinces, many with HIV and/or strong gender programmes and given that it was not possible to visit them all, this is not a review of the response that can claim to have identified all the relevant elements and programmes.
- The review relied on available research and other data. In many areas there are information gaps, pointing to the need for more research to better understand both women's realities and HIV.

This report, therefore, cannot be seen as a definitive analysis of gender and HIV throughout Viet Nam and it does not in any way capture all of the innovative and effective programmes at the provincial and district levels. It does, however, provide an analysis of the policy environment and how that is reflected in planning; the context in which HIV and gender inequality are addressed; and recommendations based on what is known to work both regionally and internationally.

5. TRACKING GENDER: PREVIOUS ASSESSMENTS

There has been a number of related reviews over the last few years that have been useful in framing this assessment and in developing the recommendations. These include:

- Gender Analysis of the National HIV Response in Viet Nam (commissioned by UNAIDS and UNIFEM, completed in 2010).²⁷
- HIV/AIDS Policy in Viet Nam – A Civil Society Perspective (2007).²⁸
- USAID/Vietnam Gender Analysis (2012).²⁹
- CEDAW State Party report and shadow reports (2015).³⁰
- Ministry of Health reviews and report on HIV programme (various).
- The Government’s National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly (2014).³¹

Of particular relevance is the 2010 gender analysis, which identified three priorities for the response: a greater focus on the diversity of women; redirecting the focus on men and masculinity; and the imperative to intensify efforts to address intimate partner transmission. Many of the findings in this current review echo those from 2010, which points to a gap in implementing solutions to better address gender. The 2010 gender analysis was developed with the aim of ensuring that gender was incorporated into the National Strategy on HIV/AIDS Prevention and Control till 2020 with a vision to 2030. However, as a UN-led exercise, there was insufficient engagement from national stakeholders and ultimately the National Strategy did not reflect its findings. There is now far greater understanding in Viet Nam of the HIV and gender interface, and a greater commitment to addressing gender inequality. Indeed, VAAC has taken the lead in this assessment, and will take its findings forward.

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27. UNIFEM (United Nations Development Fund for Women) and UNAIDS (Joint United Nations Programme on HIV/AIDS). 2010. *Gender analysis of the Vietnam National HIV/AIDS Strategy to inform the development of a gender-responsive national HIV response in the next National HIV/AIDS Strategy*. [UNPUBLISHED].
28. Khuat Thi Hai Oanh. 2007. *HIV/AIDS Policy in Vietnam – A Civil Society Perspective*.
29. Ray-Ross, Sumali. 2012. *USAID/Vietnam Gender Analysis*.
30. Reports available at http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/countries.aspx?CountryCode=VN-M&Lang=EN.
31. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly*.

CHAPTER 2

**WHY IS ADDRESSING
GENDER INEQUALITY
IMPORTANT FOR
THE HIV RESPONSE?**

*Gender inequality and the failure to recognise and uphold women's human rights are reflected in the realities of many women's lives, including the violation of bodily integrity through gender-based violence; the denial of sexual and reproductive rights; limited and/or unequal access to and control over resources; and a gendered division of labour which benefits men and disadvantages women.*³²

1. HOW GENDER AND HIV INTERSECT

Unequal gender relations are key to understanding women's vulnerability, and inhibit women's attempts at prevention and protection. The cultural and social implications of gendered relations of power have alarming implications for women's ability to prevent the sexual transmission of HIV or other sexually transmitted infections (STIs), given that within the realm of intimate relationship, women have less power than men. In many cases the realities of women's lives at the household and intimate relationships levels are the most oppressive: gender inequality and unequal power relations at these levels remain the most difficult to challenge. However, challenging power at the relationship and household levels is critical if women's vulnerability to, and the impact of, HIV and AIDS are to be dealt with effectively.

The factors driving any HIV epidemic are embedded in the same power relations which define male and female roles and positions, including certain cultural practices, inadequate access to and control of wealth and resources (especially health care, education and welfare), violence and stigma and discrimination. All of these elements have gender dimensions. For example, a lack of control by poor women over the circumstances in which sexual intercourse occurs may increase the frequency of intercourse, lower the age at which sexual activity begins and prevent the use of condoms. There are many difficulties for a woman in challenging male power in the most intimate moment when the negotiation of safer sex is most necessary and when she often has the least access to power.³³ This is reflected in the current surge of infections amongst women in Viet Nam. In Viet Nam, too, there is a culture of silence about sex and sexuality: this enables male dominance over women's sexuality, denies women their sexual rights and ensures that both men and women remain ignorant and at risk.

A key feature of HIV is the multiple nature of cause and effect. As we saw above, gender inequality leads to increased vulnerability to HIV, especially in intimate relationships. However, HIV can also be a cause of gender inequality: women have lost sexual and reproductive rights as a result of HIV. For example, increased reproductive control over

32. Tallis, V.A. 2012. *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability*.

33. Tallis, V.A. 2012. *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability*.

women living with HIV has resulted in forced abortions and/or sterilization:

When I went to hospital to give birth ten years ago, the doctor asked me to sign a form agreeing to be sterilized. At the time, I was so hurt and upset, I could only agree and sign.

(Interview, woman living with HIV)

2. THE KEY ELEMENTS OF A GENDERED HIV RESPONSE

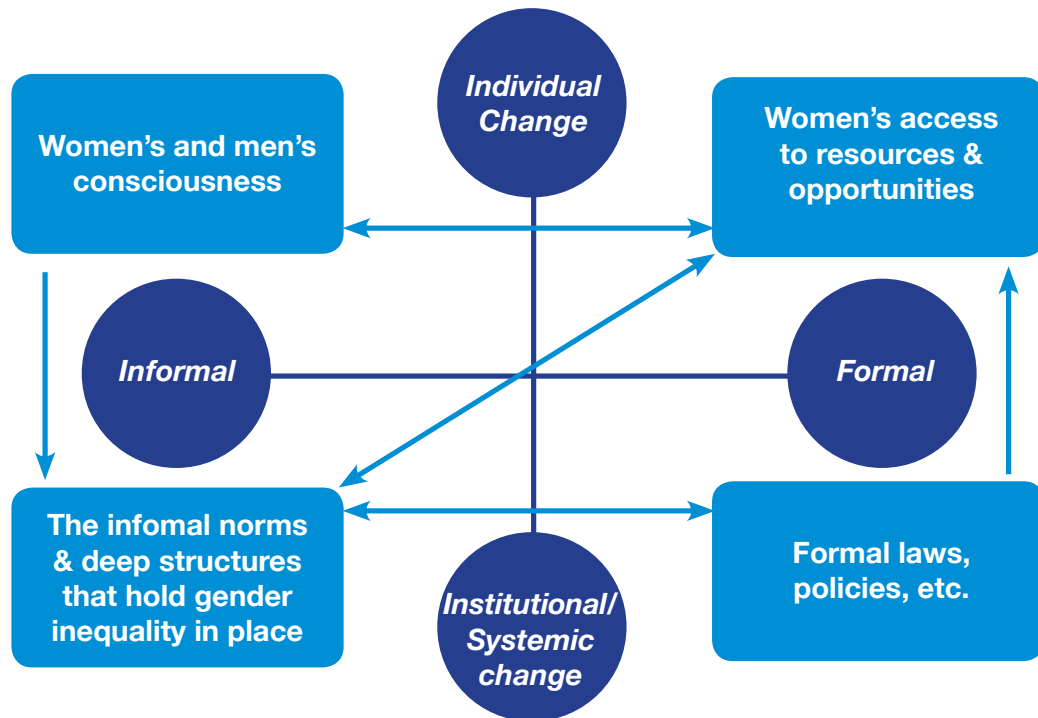
There are different understandings of gender, which determine how gender issues are dealt with. It is vital that gender inequality is not simply regarded as a matter of difference, but that the unequal nature of the relationship is central to any analysis. Critical to understanding gender inequality is the power imbalance between women and men, and the resulting oppression of women.³⁴ It is also important to address both women's condition (that is, their daily realities that are a result of their unequal status) and women's position (the socio-economic and political situation of women as a whole).

The 'Gender at Work' framework usefully demonstrates "the role of social institutions or rules – both formal and informal – in maintaining and reproducing women's unequal position in society".³⁵ The top two clusters are individual – changes in measurable individual conditions, such as resources, voice, freedom from violence, access to health – and individual consciousness, that is, knowledge, skills, political consciousness and commitment to change toward equality. The bottom two clusters are systemic. The cluster on the right is of formal institutional rules as laid down in constitutions, laws and policies. The cluster on the left is the informal norms and cultural practices that maintain inequality in everyday practices. Change in one quadrant is related to change in the others. The arrows show possible directions of relationship. So, for example, formal laws and policies can impact on both the informal norms that entrench gender inequality and women's access to resources and opportunities, which in turn can improve both women and men's consciousness and the informal norms. Viet Nam will need to undertake change in all four quadrants in its efforts to 'gender' its HIV response.

34. Tallis, V.A. 2012. *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability*.

35. Gender at Work. [no date]. "What Is Gender at Work's Approach to Gender Equality and Institutional Change?" <http://www.genderatwork.org/Portals/0/Uploads/Documents/Gender-Equality-and-Institutional-Change.pdf> Accessed 22 May 2016.

Figure 2: Gender at Work framework³⁶



A gendered approach to HIV must inform both policy and practice, and address the structural factors that impact on the socio-economic and political context.

Across the world, most responses to HIV are **gender-blind**: that is, they do not take into account the different experiences and lived realities of men and women, boys and girls, nor do they address multiple layers of marginalization. At the very least, successful approaches need to be gender-sensitive.

Gender-sensitive approaches respond to the different needs and constraints of women, men, girls and boys, based on their gender and sexuality. Many current HIV and AIDS programmes operate at this level, where

women's practical daily needs are identified and attempts are made to meet those needs through service delivery.³⁷ Gender-sensitive approaches go a long way in ensuring that the unique needs and experiences of women and girls living with and affected by HIV and AIDS are not hidden but addressed.

Gender-transformative approaches go one step further, in that they tackle the structural factors that underpin gender inequality. Gender inequality is both upheld by, and results in, unequal power relations, and provides a context or environment in which violence against women, trafficking, HIV and AIDS are able to occur. It is thus essential that the core of gender inequality – that

36. Gender at Work. [no date]. *The Gender at Work Framework* <http://www.genderatwork.org/OurWork/OurApproach/GWFramework.aspx> Accessed 17 May 2016.

37. Tallis, V.A. 2012. *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability*.

is, male dominance, or “power over” – is challenged and that doing this is central to responses addressing women’s vulnerability to and the impacts of HIV and AIDS. It is important to be mindful that the socialization of women is at odds with the skills and qualities generally associated with expressing power: for example, the “female-associated” characteristics of dependence, passivity and nurturance do not generally function to empower.

There is also a tendency to view women and girls as homogeneous, and to categorize women as either the ‘innocent victim’ or the ‘vector of transmission’. So-called ‘innocent victims’ are afforded better health care and services, whilst marginalized groups – such as female sex workers – who are seen as responsible for the spread of HIV are stigmatized and discriminated against. In addition, women continue to be viewed solely in their role as mothers, to the detriment of their own realities, needs, and treatment and prevention issues.³⁸ Further, whilst women as a whole are less equal to men, there are certain subject positions, or identities, that push women further into the margins – such as poverty, race, ethnicity, class, religion, sexual orientation, gender identity, and so on. Greater visibility of women in discourse, policy and practice is needed as a starting point to fundamentally change these underlying assumptions.

It is therefore crucial to look at intersectionality and layers of marginalization. In the context of Viet Nam, women are vulnerable to both HIV infection and its impacts as women – but this vulnerability can be compounded where a woman engages in sex work, uses drugs, belongs to an ethnic minority, is poor and/or in precarious or informal employment, is young, or is in an intimate relationship with a man living with HIV or who engages in risk behaviours – among other factors. All of these ‘layers of marginalization’ increase risk of infection and can present barriers to proper care and treatment. When women’s lives encompass more than one of these ‘layers’, their vulnerability is compounded yet further. For example, sex workers experience multiple oppressions and human rights violations, which increase vulnerability to HIV infection.³⁹ Violence towards them is rife, including sexual assault, rape and beatings. The negative attitudes of health care workers also marginalize sex workers and deny them access to proper care. The lives of sex workers in Viet Nam have not been adequately researched: however, the Stigma Index⁴⁰ and the interviews for this review do indicate that female sex workers face high levels of stigma and discrimination. While evidence relating to women who use drugs is a major gap in the evidence, this study shows that they, too, face stigma and discrimination:

38. Tallis, V.A. 2012. *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability*.

39. Jenkins, C. 2006. *Violence and Exposure To HIV Among Sex Workers in Phnom Penh, Cambodia*.

40. VNP+ (Viet Nam Network of People Living with HIV). 2015. *People Living with HIV Stigma Index 2014*.

My mother has a shop selling water. She has taken care of me from the day that I was thrown out by my husband because he discovered I used drugs. When I returned to live with my mother, some of our neighbours told her customers that my brother died from AIDS and that I use drugs. The stigma and discrimination from our community has made it more difficult for my mother to earn money from selling water. I don't know how to live now.

(Focus-group discussion, woman who injects drugs)

The following elements are therefore needed to ensure that the gendered dimensions of HIV are addressed:⁴¹

Structural elements

- Challenging harmful norms and unequal power relations in order to prevent and address gender-based violence and improve access to justice.
- Building an enabling environment that upholds human rights and protects and promotes women and girls' sexual and reproductive health in order to reduce vulnerability and risk.

- Guaranteeing social, legal and economic empowerment.
- Reducing gender-related barriers, including stigma and discrimination, to accessing programmes and services, while improving the uptake and quality of services, by tailoring these to the needs of women and girls in all their diversity.

Programming elements

- Designing programmes aimed at addressing the challenges that are specific to women living with HIV and women from key populations in relation to stigma, discrimination, their human rights and the law.
- Improving access to sexual and reproductive health services for all women.

Community elements

- Supporting the community to challenge and influence harmful policies and practices that place them at greater risk of HIV and obstruct their ability to respond to risk and vulnerability.

41. UNAIDS (Joint United Nations Programme on HIV/AIDS). 2014. *Gender-responsive HIV programming for women and girls*. http://www.unaids.org/sites/default/files/media_asset/genderresponsiveHIVprogramming_en.pdf Accessed 16 May 2015.

CHAPTER 3

SITUATION ANALYSIS: EPIDEMIOLOGICAL AND CONTEXT ANALYSIS

1. OVERVIEW OF THE EPIDEMIC

Viet Nam has a national HIV surveillance system for case reporting, and conducts regular HIV sentinel surveillance (HSS) to track behavioural trends among key populations. However, a number of gaps in the data result in a less-than-complete picture of both epidemic trends and specific vulnerabilities.⁴²

per year between 2010 and 2013.⁴³ However, these decreases in HIV infections are not reflected amongst women. There has been a steady increase of HIV prevalence among women,⁴⁴ which has been linked to sexual transmission within intimate partnerships: in 2013, male-to-female intimate partner transmission reportedly accounted for an estimated 28% of new HIV infections.⁴⁵

1.1. EPIDEMIC TRENDS

In 2013, Viet Nam reported a national HIV prevalence rate in adults aged 15 to 49 of 0.45%, with the number of new diagnoses of HIV infection decreasing between 2007 and 2009, and leveling out at about 14,000 cases

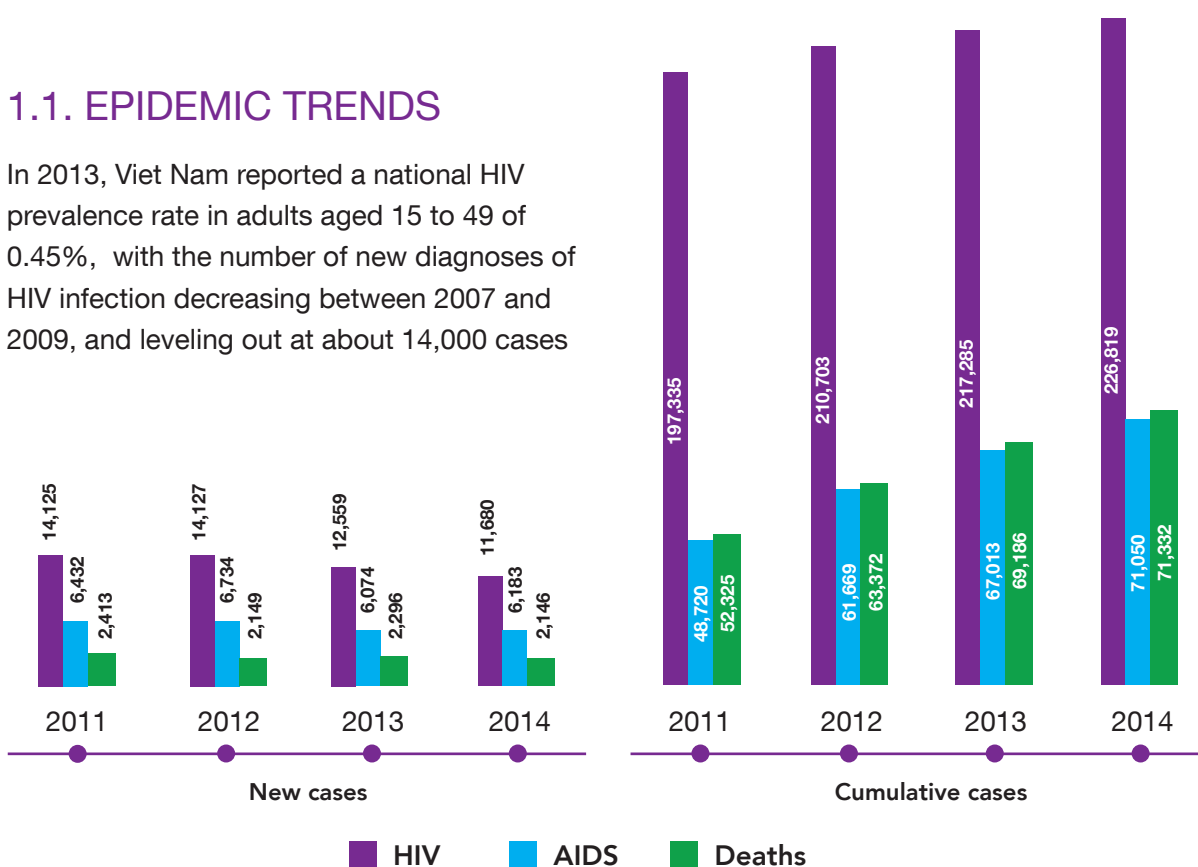


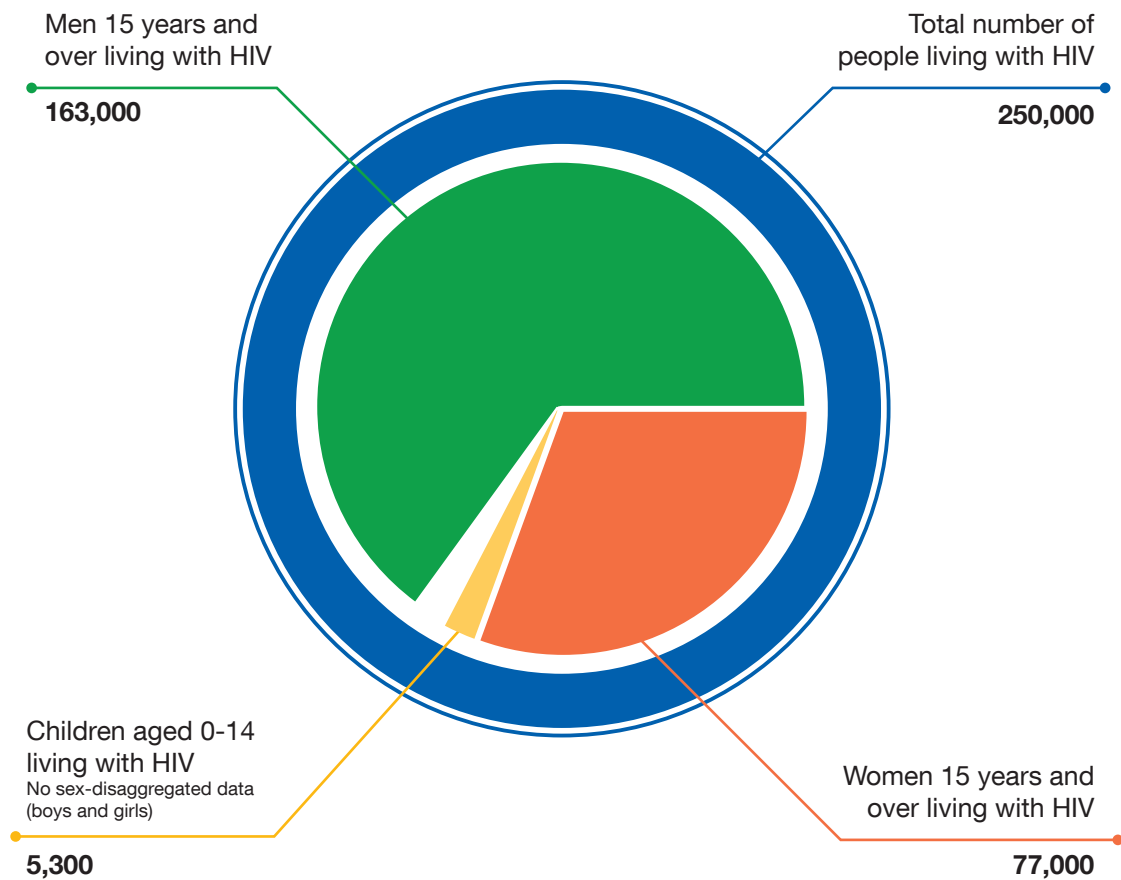
Figure 3: HIV prevalence and new reported cases of HIV and AIDS and AIDS-related deaths 2011-2014⁴⁶

42. For a more complete picture, see: VAAC (Viet Nam Authority of HIV/AIDS Control). (unpublished). Gender, HIV and Monitoring and Evaluation in Viet Nam: A Review.
 43. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.
 44. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Annual report on HIV case reporting*.
 45. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Viet Nam AIDS Epidemic Model*.
 46. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Annual report on HIV case reporting*.

The available data on HIV prevalence and cases of HIV infection cover a wide range, with figures for new diagnoses of HIV among women within a range of 10,000. UNAIDS data (see Figure 4) indicate that 77,000 adult women were living with HIV in

Viet Nam in 2014, making up almost a third (31%) of all people living with HIV. National estimations and projections in 2013 showed the total number of people living with HIV at 256,000, with 25.8% (66,000) women living with HIV.⁴⁷

Figure 4: HIV and AIDS estimates 2014⁴⁸



47. Ministry of Health EPP Technical Working Group. 2013. *Preliminary results of HIV estimations and projections in Viet Nam 2013*. Please note the discrepancies between these data and those in the 2014 VAAC report on case reporting (op. cit.). The EPP data are used for planning the response.

48. UNAIDS (Joint United Nations Programme on HIV/AIDS). 2014. *HIV and AIDS estimates 2014*. <http://www.unaids.org/en/regionscountries/countries/vietnam> Accessed 16 May 2016.

National case reporting also indicates a small but steady increase in the proportion of women infected, from 31% in 2011 to 33.4% in 2014, with a corresponding decline in the proportion of men infected (see Figure 5). Given the wide range in available data for new diagnoses of HIV infection, this

may not (yet) be statistically significant. However, in light of other gaps and challenges in the context of gender-transformative HIV and AIDS programming (see further below), it is important to continue observing these patterns and improving HIV data-management standards and practices.

Figure 5: Distribution of People Living With HIV/AIDS by sex 2011-2014⁴⁹

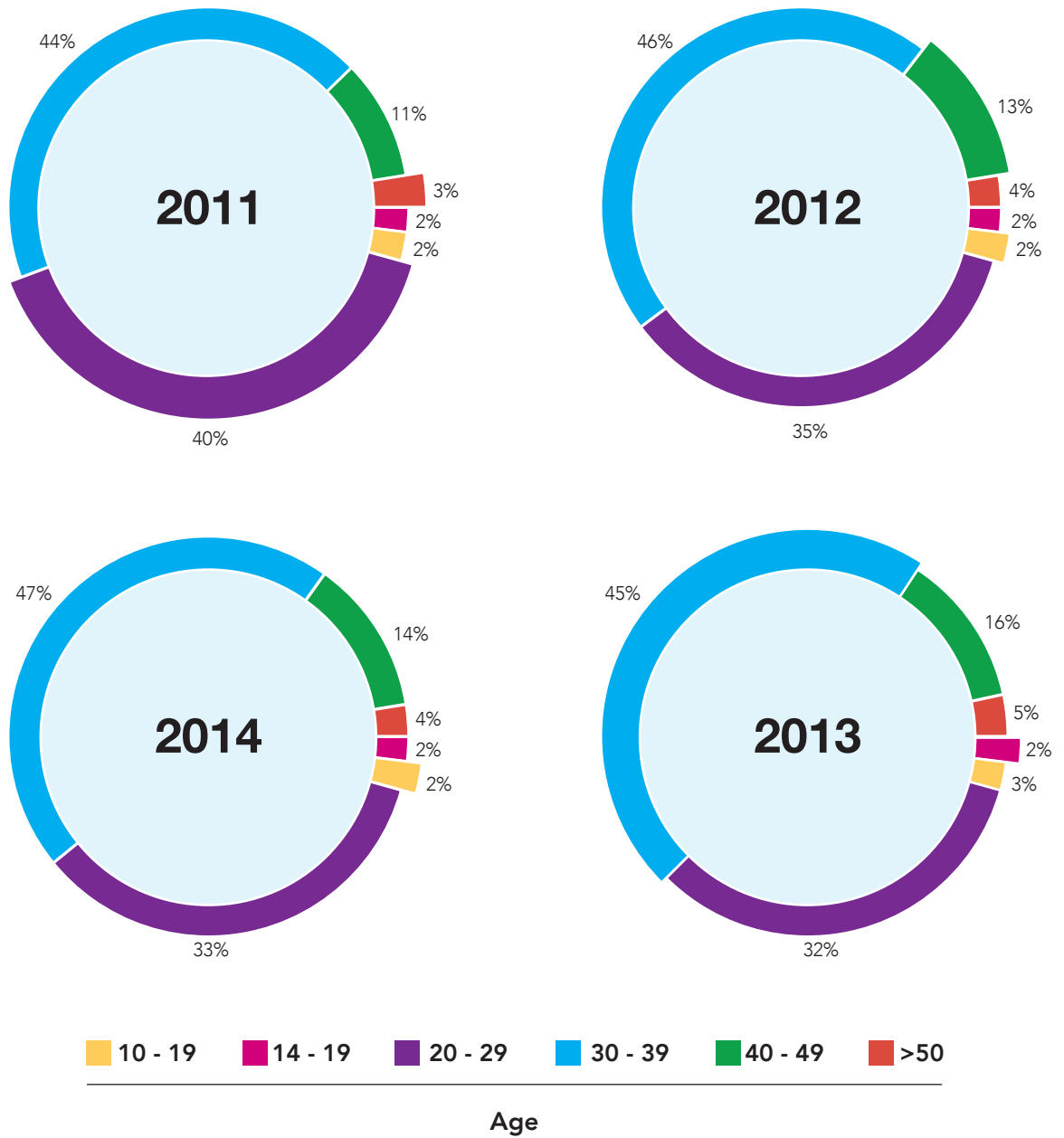


The data in figure 6 also show a steady decrease in HIV prevalence among men and women aged 20-29, and a slight increase among adults aged 40-49. Again, these trends need to be monitored, and

age-related data to be disaggregated by gender, so that age- and gender-related nuances in prevalence and new infections can be identified, enabling more targeted responses.

49. VAAC (Viet Nam Authority of HIV/AIDS Control). 2011-2014. *HIV case reporting 2011-2014*.

Figure 6: Distribution of People Living With HIV/AIDS by age 2011-2014⁵⁰



50. VAAC (Viet Nam Authority of HIV/AIDS Control). 2011-2014. *HIV case reporting 2011-2014*.

In addition, these shifting trends in the epidemic point to the need for more quantitative and behavioural surveillance among non-key populations, and particularly among women and young people in the general population. In the most recent National Survey Assessment of Vietnamese Youth (SAVY), while 98% of the young people interviewed had ever heard about HIV and AIDS, only 57% correctly answered all the questions about HIV transmission.⁵¹ Specifically, more young men (44.1%) than young women (40.8%) correctly identified ways of preventing the sexual transmission of HIV. The SAVY also revealed an urban-rural divide in terms of knowledge and understanding about condom use and HIV transmission, with young people in urban areas displaying more knowledge than their counterparts living in rural areas. Meanwhile, other data (from 2009) show that 93% of the young Vietnamese interviewed (aged 15-24) reported using a condom the last time they had sex; however, these data are not disaggregated by sex and therefore shed little light on gendered differences.⁵² Such gaps in the data need to be remedied before the response can fully address different vulnerabilities and needs.

1.2. A CONCENTRATED EPIDEMIC AMONG KEY POPULATIONS

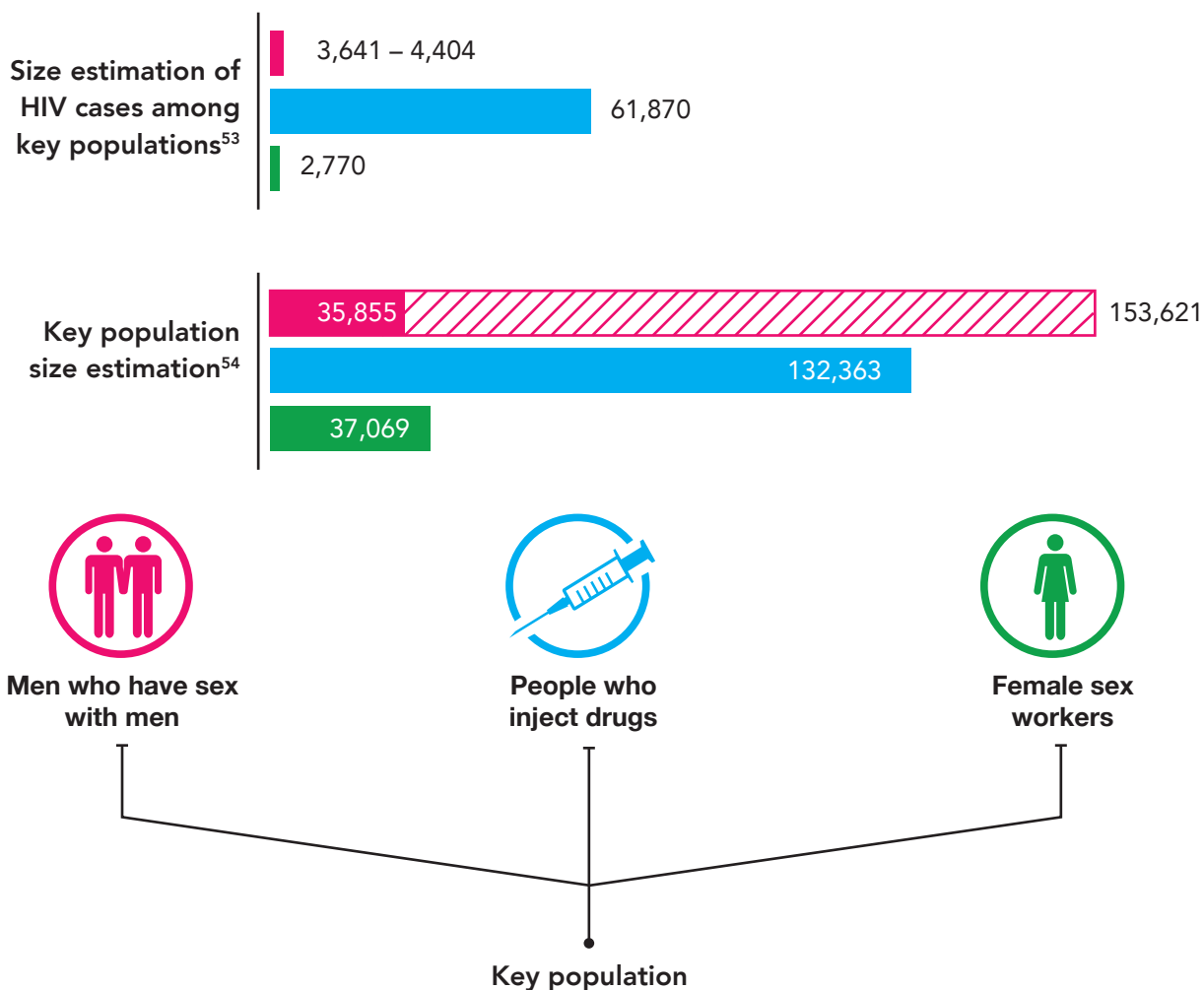
As noted above, the epidemic in Viet Nam remains concentrated among three key populations: people who inject drugs (including women, although very little data is available), female sex workers and men who have sex with men. It should be noted here, and borne in mind throughout this analysis, that all sex workers in Viet Nam are assumed to be female, just as all people who inject drugs are assumed to be male. This renders a number of vulnerable populations (particularly women who inject drugs, men and transgender people who engage in sex work, the intimate partners of male sex workers) effectively invisible, and has tremendous impacts on both data collection and HIV-related interventions.

As Figure 7 shows, key population size estimations, as well as prevalence data for key populations, can differ dramatically, in part because of difficulties in accessing such populations and in part because of limitations on the part of the monitoring and evaluation system for the response. Both the range of estimates, and a lack of data, indicate the need to systematize and regulate data collection and analysis for these key populations.

51. Ministry of Health, GSO (General Statistics Office), WHO (World Health Organization) and UNICEF (United Nations Children's Fund). 2010. *Survey Assessment of Vietnamese Youth Round 2*.

52. HIV and AIDS Data Hub for Asia Pacific. 2016. *Evidence to Action, Overview in Slides – Viet Nam*. <http://www.aidsdatahub.org/Overview-in-Slides> Accessed 16 May 2016.

Figure 7: Key population size estimations 2014



For example, there are a number of different prevalence rates available for the population of people who inject drugs, with Viet Nam’s 2014 AIDS Response Progress Report citing 11.6%,⁵⁵ and the Ministry of Health’s EPP Technical Working Group citing 23.9% (Figure 8).

The Progress Report also notes elsewhere that “as many as 40% of the estimated 271,000 [people who inject drugs] (range: 100,000-335,000) are living with HIV.”⁵⁶ Meanwhile, no sex-disaggregated data are available for people who inject drugs.

53. Ministry of Health EPP Technical Working Group. 2013. *Preliminary results of HIV estimations and projections in Viet Nam 2013*.
 54. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Viet Nam AIDS Epidemic Model*.
 55. Ministry of Health EPP Technical Working Group. 2014. *2014 Report on HIV Sentinel Surveillance Plus among key populations, in 14 provinces*.
 56. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

There are similar issues with the data on female sex workers. A 2012 behavioural survey focusing on female sex workers reported a large range of HIV prevalence, from 6.8% to 22%, in four provinces surveyed.⁵⁷ The average of these figures is 15.6%, which is much higher than that cited in the 2013 HIV Sentinel Surveillance Plus (HSS+) study, conducted in 11 provinces, which found an average prevalence of 2.6%. This discrepancy raises questions about the selection process for survey target areas and the resulting accuracy when extrapolating for a 'national average'. In particular, there is an issue relating to the exclusion of areas which are known to high prevalence: the 11 provinces selected for the HSS+ study did not include Ha Noi or

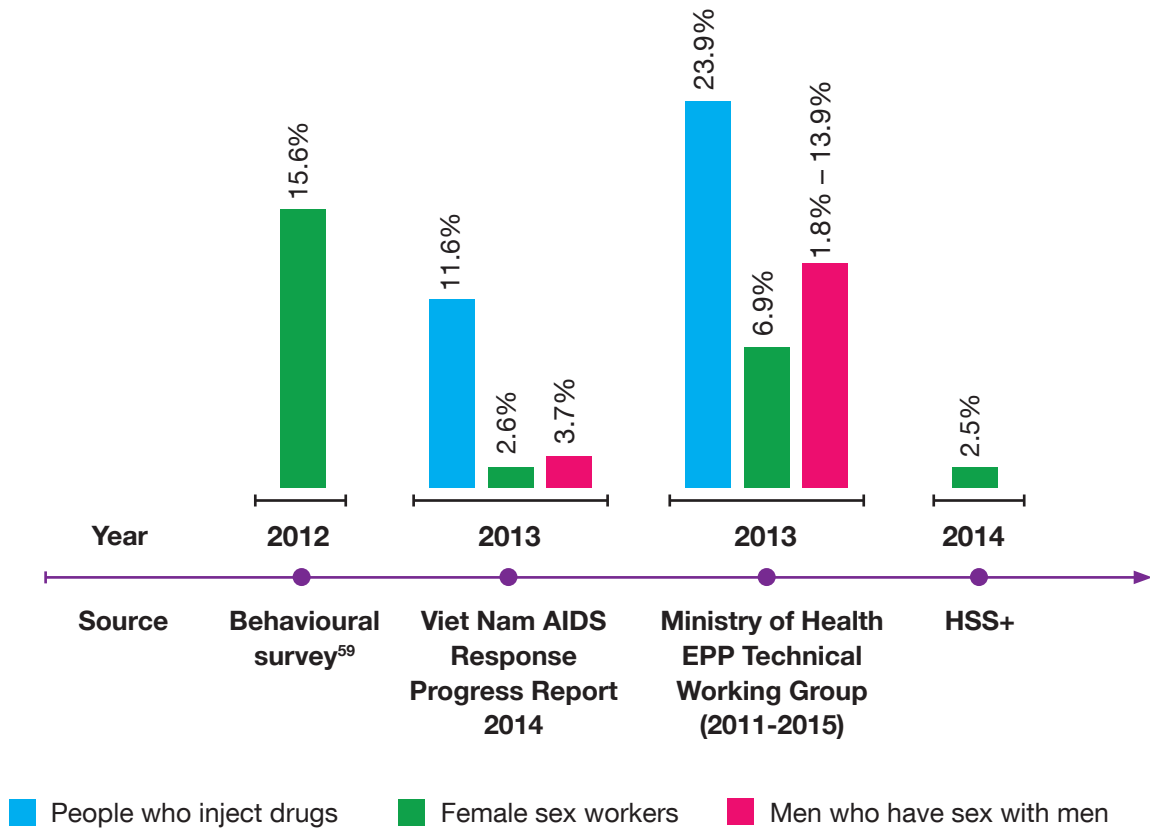
Hai Phong, which in the 2012 behavioural survey cited above had prevalence rates of 12.3% and 22%, respectively. In 2014 the HSS+ was implemented in 35 provinces – including Ha Noi and Hai Phong – and found HIV prevalence among female sex workers to be 2.5%.

Similarly, the 2014 GARPR notes that, according to 2013 estimations and projections from the VAAC, “the estimated population [of men who have sex with men] ranges from 191,000 to 573,000. Data remain sparse on men who have sex with men in Viet Nam.”⁵⁸ It should be noted here that part of the challenge here is that the definition of “men who have sex with men” is contested; see more below.

57. USAID Social Marketing for Prevention Project. 2013. *Behavioural Survey Among Female Sex Workers & Female Sex Workers Who Inject Drugs - Vietnam Report 2013*.

58. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

Figure 8: HIV prevalence among key populations 2012-2014



In addition, the prevalence rate among key populations is much higher in some cities than others. National HIV prevalence rates, which are already high among key populations, mask even higher prevalence

among these populations in certain cities, as indicated in Figures 9 to 11 below. It is important that these variations in prevalence be taken into consideration in the design of interventions.

59. USAID Social Marketing for Prevention Project. 2013. *Behavioural Survey Among Female Sex Workers & Female Sex Workers Who Inject Drugs - Vietnam Report 2013*.

Figure 9: HIV prevalence among people who inject drugs (PWID) by city/province 2012⁶⁰

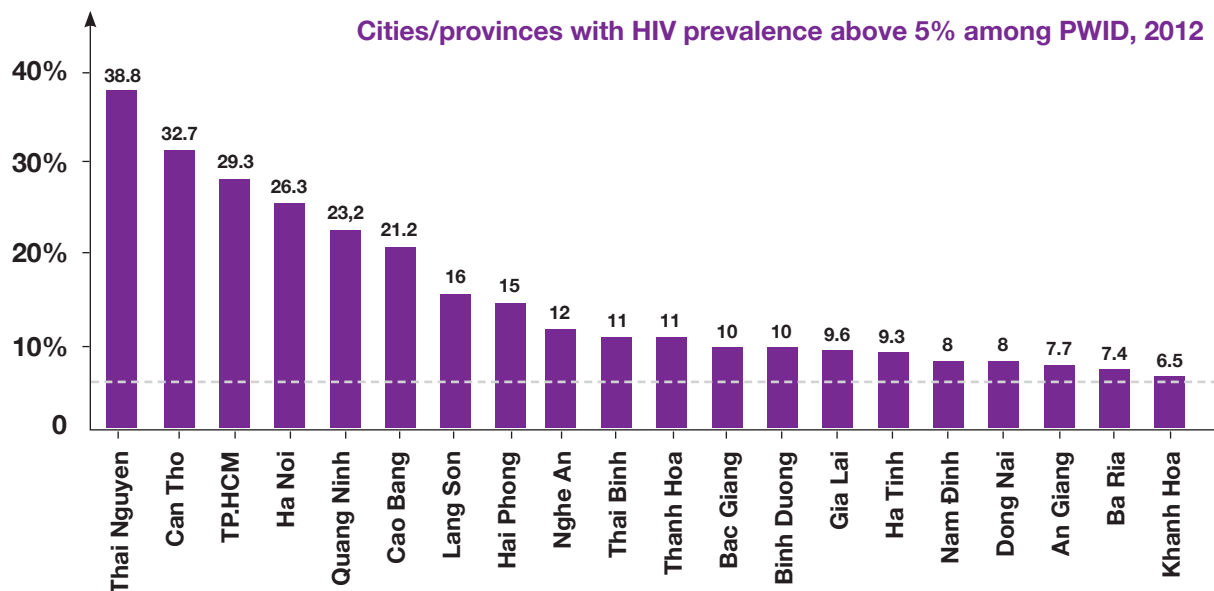
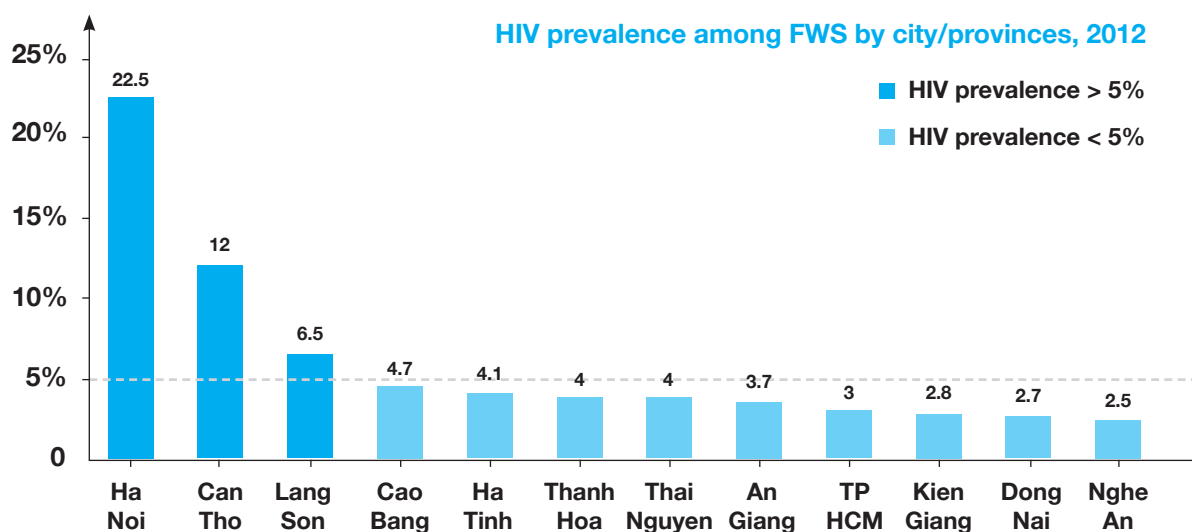


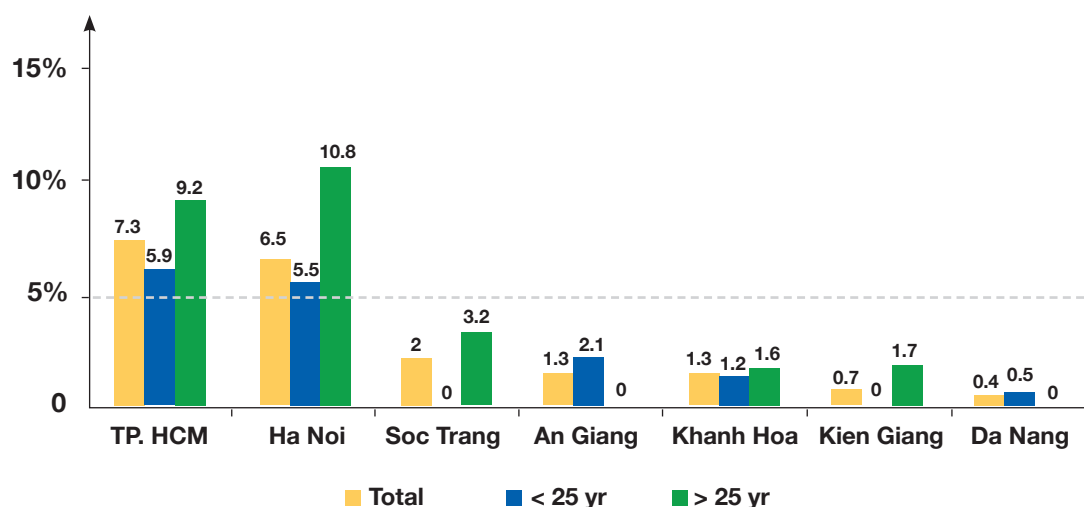
Figure 10: HIV prevalence among female sex workers (FSW) by city/province 2012⁶¹



60. HIV and AIDS Data Hub for Asia Pacific. 2016. *Evidence to Action, Overview in Slides – Viet Nam*. <http://www.aidsdatahub.org/Overview-in-Slides> Accessed 16 May 2016.

61. HIV and AIDS Data Hub for Asia Pacific. 2016. *Evidence to Action, Overview in Slides – Viet Nam*. <http://www.aidsdatahub.org/Overview-in-Slides> Accessed 16 May 2016.

Figure 11: HIV prevalence among men who have sex with men (MSM) by city/province 2012⁶²



Within the country’s national response, the vast majority of interventions have been targeted towards the three key populations, yet the government has very clearly expressed concerns about the overall effectiveness of the current response:

“...although the numbers of [people living with HIV], HIV incidences and HIV/AIDS related deaths have decreased, the reduction has been insignificant, unstable and the number of current HIV incidences remains at a high level...the HIV/AIDS epidemic has spread widely to all areas, 100% of provinces, 98% of districts and 78% of communes/wards. There were communes, villages

reporting the HIV/AIDS prevalence over 10 times higher than the average prevalence of the country, especially the ones in mountainous, remote and ethnic minority areas. In some areas, the HIV/AIDS prevalence has reached the level of the generalized epidemic. HIV sexual transmission tends to increase, warning the epidemic spread to the community including people who are considered having low-risk behaviours. In addition, it remains very difficult to manage and carry out interventions among the high-risk populations such as [female sex workers, people who inject drugs and men who have sex with men].”⁶³

62. HIV and AIDS Data Hub for Asia Pacific. 2016. *Evidence to Action, Overview in Slides – Viet Nam*. <http://www.aidsdatahub.org/Overview-in-Slides> Accessed 16 May 2016.

63. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

Available data on the mode of HIV transmission lend further credence to these concerns. According to the 2014 HSS+ survey, while sharing used needles and syringes has historically been the main mode of transmission, the proportion of newly reported cases of HIV transmitted through sexual contact has been steadily increasing: from 12% in 2004, to 38% in 2010, and finally to 52% – the majority – in 2014.⁶⁴

1.3. WOMEN: INCREASING VULNERABILITY TO HIV

Given the rising prevalence of HIV among women, and the increase in sexual transmission of HIV, there is an urgent need to re-examine transmission within intimate partnerships. It is also vital to ensure that the experiences of women members of key populations do not get lost: for example, whilst there is data available on female sex workers, women who inject drugs are not captured in surveillance data, and so very little is known about HIV prevalence or incidence in this group.

As noted above, male-to-female intimate partner transmission accounted for an estimated 28% of new HIV infections in 2013.⁶⁵ In 2012, a joint UNAIDS/UN Women exercise highlighted intimate partner

transmission of HIV to female partners of men in high-risk groups as a neglected but key issue:

Of the HIV positive cases detected in women at [voluntary counselling and testing sites], 53.9% were attributable to exposure to male partner risk behaviour only. Combined risk behaviours from both male and female partners comprised 22%, while women's personal risk alone comprised 5.1% of new infections.⁶⁶

Such data can be linked to other evidence, such as very low condom use among men in key populations. According to the HSS+ survey results, only 48.9% (2012), 41.2% (2013) and 59.0% (2014) of men who inject drugs reported the use of a condom at last sexual intercourse. This behaviour increases the risk of HIV transmission from men who inject drugs to their partners. As a result of these and other data, Viet Nam's leaders have recognized that “[s]exual partners of ... [key populations] are an additional at-risk population that requires targeted programme interventions.”⁶⁷ This population includes the wives and female sexual partners of men who inject drugs, the female sexual partners of male clients of sex workers, and the wives or female sexual partners of men who have sex with men.

64. Figures for 2004 and 2010 from: VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Report on the Results of HIV Sentinel Surveillance integrated short behavioural questionnaire (HSS+) Among High-risk Populations in Viet Nam in 2014*.

65. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Viet Nam AIDS Epidemic Model*.

66. UNAIDS (Joint United Nations Programme on HIV/AIDS) and UN Women (United Nations Entity for Gender Equality and the Empowerment of Women). 2012. *Measuring Intimate Partner Transmission of HIV in Viet Nam: A Data Triangulation Exercise*.

67. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

*Surveillance data shows that in several of Asia's concentrated epidemics [including Viet Nam], the contribution of intimate partner transmission to the number of new adult HIV infections is significant... Data also indicates that the majority of men living with HIV belong, or once belonged, to a key population group. Consequently, a significant number of women become infected as a result of their sexual relationships with men who are, or once were, engaged in high-risk behaviours. This calls for greater attention and investment in prevention programmes regarding men from key populations and their intimate partners. It also underscores the need for prevention interventions with serodiscordant couples.*⁶⁸

It should be noted that these women include women from key populations – female sex workers and women who use drugs – as well as women with ‘other risk behaviours’: 22% of the women living with HIV identified by the intimate partner transmission study had contracted HIV as a result of both their and their partner’s risk behaviour(s). It will not be helpful to the response to create an artificial distinction between women in key populations and the ‘innocent’ victims of

intimate partner transmission. Rather, the multiplication of risk of such transmission for women already vulnerable to HIV needs to be further examined and taken into account.

Neither should the female intimate partners of men who have sex with men be neglected. In Viet Nam, sexuality is (now) presented as exclusively heterosexual and homosexuality is a “social evil”.⁶⁹

*With modernity, a model of gender and sexual relationships was institutionalized, one that prescribed who people should be and who they should love, at the same time marginalizing those who did not belong to that model.*⁷⁰

In such a heteronormative context, many men who have sex with men are married, some with children, or if unmarried, in sexual relationships with women (including sex workers) as well as men.⁷¹ This has been attributed to wanting to conceal their sexual identity, to bisexuality, to experimentation or to wanting to ‘reconfirm’ their sexual identity.⁷² There is evidence, too, of non-optimal rates of condom use (in 2013, 66% used a condom the last time they had anal sex with a male partner) and HIV testing (in 2013, only 28.8% had taken a test and knew their results in the

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68. UNDP (United Nations Development Programme). 2015. *Preventing HIV Transmission in Intimate Partner Relationships: Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia*.
69. Note: Although the English translation for “social evil” has recently been changed to “social vice”, the Vietnamese original remains the same. For this review, “evil” will be retained.
70. UNDP (United Nations Development Programme) and USAID. 2014. *Being LGBT in Asia: Viet Nam Country Report*.
71. Khuat Thu Hong et al. 2005. *Men who have sex with men in Ha Noi: Social profile and sexual health issues. (Draft)*.
72. Khuat Thu Hong et al. 2005. *Men who have sex with men in Ha Noi: Social profile and sexual health issues. (Draft)*.

last 12 months) among men who have sex with men.⁷³ In addition, the 2014 Stigma Index showed that over 61% of men who have sex with men who knew their status had not disclosed it to their sexual partners – probably from a fear of stigma and discrimination on the basis of both HIV status and sexuality – which has clear implications for these partners’ ability to protect themselves from HIV.⁷⁴ It is also a clear symptom of the fact that men, even those with less power – like those who have sex with men – will (in many instances) have more power and privilege than women: enough to expose them to HIV.

Actively targeting women in intimate relationships with male members of key populations is therefore essential to creating appropriate interventions and a long-term transformation of the epidemic in Viet Nam. Evidence from the region indicates that a ‘combination prevention’ approach, that “involves the coordinated use of different types of HIV prevention activities that operate on many levels (i.e. behavioural, social, structural) to address HIV risk and vulnerability among men and women in their intimate partner relationships,” is most effective.⁷⁵

Meanwhile, a key way to reach women with HIV-related interventions is through sexual and reproductive health services. However, in Viet Nam, women’s needs for these services remain unmet. Many women are not able to access information about contraceptive methods, family planning services or HIV.⁷⁶

In 2011, the level of unmet need for contraception among unmarried sexually active women (34.3%) was about three times higher than that among married women (11.2%).⁷⁷ The government has also reported that adolescent pregnancy rates increased from 2.92% in 2010 to 3.2% in 2012, and 35.4% of the contraceptive needs of 15 to 19-year-old girls, and 3.46% of 20 to 24-year-old women, were unmet.⁷⁸ Also according to the government, poverty exacerbates the unmet need for contraception among adolescents, which results in “misconceptions regarding reproductive health and the use of condoms [and] a significant number of unwanted pregnancies and unsafe abortions among young women”.⁷⁹ Viet Nam’s adolescent birth rate in 2014 was 45 per 1000 women aged 15-19 years which is often linked to early marriage and early initiation of sex, as well as inadequate sexual and

73. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

74. VNP+ (Viet Nam Network of People Living with HIV). 2014. *People Living with HIV Stigma Index 2014*.

75. UNDP (United Nations Development Programme). 2015. *Preventing HIV Transmission in Intimate Partner Relationships: Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia*.

76. Focus group discussion, women living with HIV and VNW+ members.

77. UNFPA (United Nations Population Fund). 2013. *Unmet needs for sexual reproductive health services and HIV/AIDS: Evidence from MICS 2011 analysis*.

78. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly*.

79. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.

reproductive health counselling and other services for adolescents and young people. The adolescent birth rate is higher among rural adolescents than in urban areas.⁸⁰ The 2010 SAVY, meanwhile, found that 8.4% of young women aged 15-24 reported having had an abortion, and that young people – especially young women – have lower levels of knowledge about HIV – pointing again to a lack of adequate sexual and reproductive health services for this group.⁸¹

Restrictions on access to sexual and reproductive health services are particularly acute among ethnic minority women, among whom contraceptive use is very low, the rate of antenatal checkups is a third of that among Kinh women and the maternal mortality rate eight times higher.⁸² Ethnic minority girls are particularly vulnerable to early marriage and trafficking – which have impacts on their sexual activity, risk of sexual and other violence, and vulnerability to HIV – and have a lower awareness of sexual and reproductive health.⁸³ Adolescent birth rates among ethnic minority girls are three times higher than among Kinh girls.⁸⁴

In addition, there is a lack of targeted services for female sex workers and women who use

drugs, combined with high levels of stigma and discrimination that may result in these women deciding not to use public health facilities. This compounds the unmet need for sexual and reproductive health services among many women in general – which is further worsened where these women are poor, young and/or from an ethnic minority. Meanwhile, women living with HIV face similar challenges (outside the framework of PMTCT interventions, which focus primarily on the health of the child).

Abuse and denial of sexual and reproductive rights were a key feature in the interviews, and women living with HIV also spoke of their experiences at the validation meeting. For these women, too, access to free contraceptives (including condoms) and free treatment for STIs remains a challenge; some have been coerced into having an abortion or being sterilized; and women who use drugs and female sex workers were particularly worried about the consequences of using health services when pregnant.

The unmet need for contraception and other sexual and reproductive health services (including antenatal services) combined with other risk factors, such as low levels

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80. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.
81. Ministry of Health, GSO (General Statistics Office), WHO (World Health Organization) and UNICEF (United Nations Children's Fund). 2010. *Survey Assessment of Vietnamese Youth Round 2*.
82. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly and* -. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.
83. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly*.
84. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.

of knowledge about HIV, have clear and serious implications for HIV prevention and increased vulnerability among all women, but young women and ethnic minority women in particular. Very little is known about – or provided for – the specific sexual and reproductive health needs of women living with HIV, sex workers and women who use drugs. The CEDAW Committee has expressed concerns over these shortcomings, and has recommended that Viet Nam:

*Ensure that women and girls, as well as men and boys have access to free, age-appropriate and quality information on sexual and reproductive health and to affordable family planning services and contraceptive, regardless of their marital status, disability, ethnicity or geographical location. Sterilization and use of contraceptive should be made based on full informed consent and voluntary will of women and girls concerned.*⁸⁵

A more differentiated population-based survey, targeted at women, on the use and type of contraception would be a useful starting point for attempts to address the shortcomings of the sexual and reproductive health system, including as it relates to HIV.

The abovementioned issues for ethnic minority women are not the only ones that increase their vulnerability to HIV. These women, and other poor women living in remote areas, have been largely omitted from HIV surveillance and other data collection, as well as from national HIV strategic planning and programme implementation. The 2014 People Living with HIV Stigma Index found that, of the 1.7% of respondents in one province who were ethnic minority people living with HIV:

*[t]here were more ethnic minority women living with HIV than ethnic minority men. These ethnic minority women living with HIV may need special attention from intervention programmes because they are more likely to be illiterate and experience difficulties in accessing health services than women in the Kinh majority ethnic group.*⁸⁶

Other sources emphasize that “ethnic minority women [in Viet Nam] ... suffer more than other groups of women”⁸⁷ in terms of poverty and economic (dis-)empowerment, both of which are indicators for increased vulnerability, including to HIV. At the same time, although the 2014 GARPR mentions ethnic minority and/or indigenous people⁸⁸ only rarely, and then as sub-populations in footnotes, it does highlight the fact that:

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85. UN CEDAW (United Nations Committee on the Elimination of Discrimination Against Women). 2015. Concluding observations on the combined seventh and eighth periodic reports of Viet Nam. CEDAW/C/VNM/CO/7-8.
86. VNP+ (Viet Nam Network of People Living with HIV). 2015. *People Living with HIV Stigma Index 2014*.
87. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly*.
88. It is also not fully clear whether ‘ethnic minorities’ and ‘indigenous people’ are the same population.

[s]ome communes and villages report HIV prevalence of over 10 times the national average, especially those in mountainous, remote and/or ethnic minority areas where people still have limited knowledge and services do not yet address needs.⁸⁹

The government has also showed awareness of some of these issues in its emphasis on the need to address ethnic minority women's lack of access to sexual and reproductive health care.⁹⁰ Nevertheless, there is a clear need for more – and sex-disaggregated – national HIV surveillance data on these populations, as there is for migrant/mobile women, and for targeted interventions.

Further, the invisibility of women who use/inject drugs is an area that needs urgent attention. It has already been noted that it is almost always assumed that people who inject drugs are male, that sex-disaggregated data are not readily available – including on the recipients of current interventions – and that data on women who inject drugs are sorely lacking. However, the limited and small-scale evidence provided by the 2014 Stigma Index highlights that some respondents on methadone maintenance therapy (MMT) were women and transgender women.⁹¹ In addition,

a recent independent study indicates that women who inject drugs in Viet Nam are much more vulnerable than their male counterparts: they tend to progress faster to dependence and inject more frequently; they are likely to have intimate partners who also inject, and to die from AIDS. They also have a greater combined risk of HIV – partly because they may sell sex to purchase drugs.⁹² This vulnerability is compounded by the fact that women who inject drugs are marginalized in both society and networks and groups of people who use drugs, and that they experience even higher levels of stigma than men who inject drugs (in part because “injecting drug use is often seen as contrary to the socially derived roles of women as mothers, partners and caretakers”).⁹³ Evidence from Eastern Europe also shows that women who use drugs and suffer from punitive policies have less access to health services and are unlikely to access sexual and reproductive health services, while those who are pregnant are yet more stigmatized and avoid health services such as MMT or antenatal care out of fear of punishment or loss of custody.⁹⁴ Beyond the basic need for sex-disaggregated data on women who inject drugs, and HIV prevalence among them, there is a further need for an analysis of their vulnerabilities and constraints.

89. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

90. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.

91. VNP+ (Viet Nam Network of People Living with HIV). 2015. *People Living with HIV Stigma Index 2014*.

92. Khuat Thi Hai Oanh et al. 2015. “Social context, diversity and risk among women who inject drugs in Vietnam: descriptive findings from a cross-sectional survey.” *Harm Reduction Journal* 12:35 DOI 10.1186/s12954-015-0067-9.

93. Khuat Thi Hai Oanh et al. 2015. “Social context, diversity and risk among women who inject drugs in Vietnam: descriptive findings from a cross-sectional survey.” *Harm Reduction Journal* 12:35 DOI 10.1186/s12954-015-0067-9.

94. International Harm Reduction Development Program. 2007. *Women, Harm Reduction and HIV*.

Finally, gender-based violence is a pressing issue affecting the HIV epidemic in Viet Nam. Like HIV, gender-based violence has its roots in gender inequality: because women are unequal they are therefore vulnerable, and violence or the fear of violence maintains the (unequal) gender status quo. Gender-based violence can take many forms – sexual, physical, emotional, economic and structural – and be experienced in a myriad of ways, including sexual assault, rape, human trafficking, sexual harassment at school and in the workplace, child marriage, sex-selective abortion, limited access to household funds and so on.⁹⁵ The direct causal impacts of gender-based violence on HIV transmission among women and girls has been part of the HIV discourse for many years and include:

- Sexual violence, including forced or coerced sex or rape, is likely to cause vaginal or anal tearing, lacerations or abrasions, thus increasing the risk of contracting an STI or HIV.
- The fear of violence may prevent women from insisting on the use of condoms or other safer sex methods.
- Structural violence, such as denial of services, mandatory testing, forced sterilization, etc. – serve as barriers to accessing information and services.
- Economic violence, such as extortion (especially of sex workers), withholding access to family resources/funds.

In addition, many women and girls who disclose their HIV status to partners, family members, and communities are physically and emotionally abused. Indeed, recent research has revealed high levels of violence against women living with HIV globally, although the experiences of women living with HIV in Viet Nam are not known.

It is known that violence is a daily occurrence in the lives of many Vietnamese girls and women. According to the government, “[v]iolence against women is still a critically severe phenomenon... in 2012, 85.1% of the domestic violence victims were women.”⁹⁶ A 2010 national study on domestic violence revealed that:⁹⁷

- 32% of ever-married women reported that they had suffered physical violence from their husbands, 6% in the 12 months preceding the study.
- 10% of ever-married women reported in interviews that they experienced sexual violence in their lifetime, 4% in the 12 months preceding the study.
- 58% of ever-married women reported experiencing at least one type of domestic violence in their lifetime.
- Women in Viet Nam are three times more likely to have experienced violence perpetrated by intimate partners rather than by someone unknown.

95. United Nations Viet Nam 2014. *From Domestic Violence to Gender-based Violence: Connecting the dots in Viet Nam. A UN discussion paper.*

96. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly.*

97. GSO (General Statistics Office). 2010. *“Keeping silent is dying” – Results from the National Study on Domestic Violence against Women in Viet Nam.*

- Physical violence starts early in a relationship and lessens with age.
- The proportion of ever-pregnant women who experienced physical violence in at least one pregnancy was 5%.
- 54% of women reported lifetime emotional abuse from their husbands, 25% reported current emotional abuse.

Although the current (limited) discourse focuses on domestic violence, it is vital to expand it to include all aspects of gender-based violence, as outlined above. There are ample examples of such violence:

- Although the legal minimum age of marriage for women is 18, the number of girls aged 15-19 who are married or in union increased from 5.4% in 2006 to 10.3% in 2014, and child marriage

remains common among certain ethnic minority groups and in mountainous areas.⁹⁸

- Trafficked women and girls face high risks of exploitation and abuse and the incidence of reported cases of trafficking of women for sexual exploitation, domestic servitude, or domestic violence at the hands of new husbands is on the rise.⁹⁹
- A survey conducted in Ha Noi and Ho Chi Minh City in 2014 found that 87% of the women and girl respondents confirmed that they have experienced sexual harassment in public places.¹⁰⁰
- A 2012 study showed that 35.2% of female sex workers had experienced psychological violence, 27.6% had experienced sexual violence, and 20.6% had been raped.¹⁰¹

98. GSO (General Statistics Office). 2014. *Viet Nam 2014 Multiple Indicator Cluster Survey (MICS)*.

99. Oram, S. et al. 2012. "Prevalence and Risk of Violence and the Physical, Mental, and Sexual Health Problems Associated with Human Trafficking: Systematic Review." *PLoS Med.* 2012 May; 9(5): e1001224.

100. ActionAid International Viet Nam. 2014. *Policy Brief: Safe Cities for Women and Girls: Can Dreams Come True?*

101. MOLISA (Ministry of Labour, Invalids and Social Affairs) and IOM (International Organization for Migration). 2012. *Sex Work and Mobility from A Gender Perspective: Findings from Three Cities in Viet Nam.*

1.4. GAPS IN THE DATA

Standardized and consistently available age- and sex-disaggregated data are crucial for an improved, more gender-sensitive national response to Viet Nam’s HIV epidemic. However, as in the Asia-Pacific region as a whole, there are a number of gaps in HIV-related data, including “information on transgender people, young key populations and prisoners; inconsistent disaggregation by age and gender; and availability of city and sub-national data”.¹⁰²

As seen above, Viet Nam’s current HIV data are problematic from a gender perspective, in part due to issues that affect accuracy in data collection, compilation, and subsequent analysis. Although data collected as part of routine surveillance are sometimes disaggregated by sex and/or age, disaggregated data are not collected systematically, nor are they often compiled and included in a final data analysis. For example, the data on “people who inject drugs” must be

generally assumed to include only men who inject drugs. Women – including sex workers – who inject drugs rarely appear in the data. Meanwhile, sex workers are explicitly female in all the data, with male sex work appearing only in behavioural surveillance on men who have sex with men (see below). There is also a lack of both sex and disaggregation for the (in any case very limited) data gathered on other “vulnerable sub-populations”, such as prisoners, ethnic/indigenous minorities, migrants/mobile people, internally displaced people, refugees, and elderly and disabled people.¹⁰³

There has also historically been a paucity of data on the key population of “men who have sex with men”, although the situation has improved in recent years thanks to data collected through HSS and HSS+. Compounding this lack of information is the fact that, in Viet Nam, four sub-populations are included in this one group: men who identify as gay; men who have sex with men (who may not identify as gay and may also

102. HIV and AIDS Data Hub for Asia Pacific. 2016. *Evidence to Action, Overview in Slides – Viet Nam*. <http://www.aidsdatahub.org/Overview-in-Slides> Accessed 16 May 2016.

103. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

have sex with women); male sex workers; and transgender women. This means that the specific vulnerabilities of each of these groups cannot be known. This is particularly true for transgender women, who are effectively “invisible”, since they have been categorized as men, and there is a further issue relating to transgender men, who (presumably) are categorized as women and even more invisible.¹⁰⁴ It would go some way to addressing these issues if male sex workers were surveyed as a – disaggregated – part of the key population of sex workers (not of men who have sex with men), and if the surveillance surveys included sex-disaggregated population data and behavioural data on the intimate partners of men who have sex with men: both cis and trans women and men.

2. GENDER INEQUALITY IN VIET NAM

Globally, women suffer the most pervasive discrimination... Laws can explicitly discriminate against women in matters of family, marriage, economic rights and violence... They may also limit women’s rights to land ownership and require spousal consent for women’s access to contraception and family planning... Women may also face discrimination from social institutions – such as early marriage, discriminatory inheritance practices, higher burdens of unpaid care work, violence against women [and] son preference.¹⁰⁵

104. As already noted, it is unfortunately beyond the scope of this assessment to deal in full with the issue of gender identity, which is essentially “[a]n individual’s internal sense of being a man or a woman, or neither of them. Since gender identity is internal, one’s gender identity is not necessarily visible to others.”

- UNDP (United Nations Development Programme) and USAID. 2015. *The Right to Adoption of LGBT People in Viet Nam - Reality and Recommendations*.

“For transgender people, understanding this ‘internal sense’ is essential. Transgender can be defined as: an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders or alternative genders. Transgender individuals may self-identify as transgender, female, male, transwoman or transman, transsexual, hijra, kathoey, waria or one of many other transgender identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways.”

- UNAIDS (Joint United Nations Programme on HIV/AIDS). 2015. *UNAIDS Terminology Guidelines*. http://www.unaids.org/en/resources/documents/2015/2015_terminology_guidelines Accessed 16 May 2016.

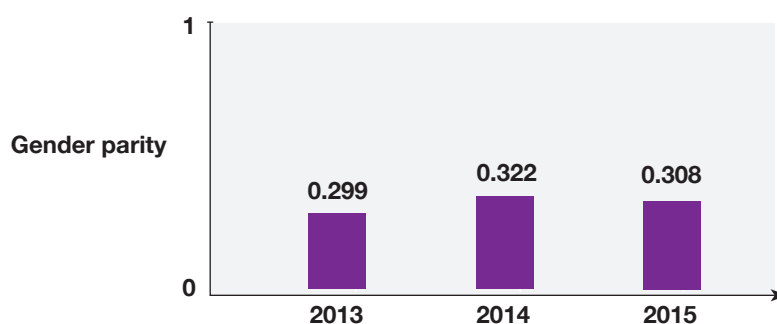
105. UNDP (United Nations Development Programme). 2014. *2014 Human Development Report – Sustaining Progress: Reducing Vulnerabilities and Building Resilience*.

Viet Nam's global Gender Inequality Index¹⁰⁶ ranking deteriorated from 48 in 2013 to 58 in 2014 and 60 in 2015, despite the fact that its Human Development Index ranking improved from 127 to 121 to 116 over the same period.¹⁰⁷ This discrepancy can be linked

to a lack of improvement in the adolescent fertility rate, the percentage of seats held by women in parliament, educational attainment (and a considerable gap between men and women) and labour force participation among women.

Figure 12: Gender Inequality Index figures for Viet Nam 2013-2015

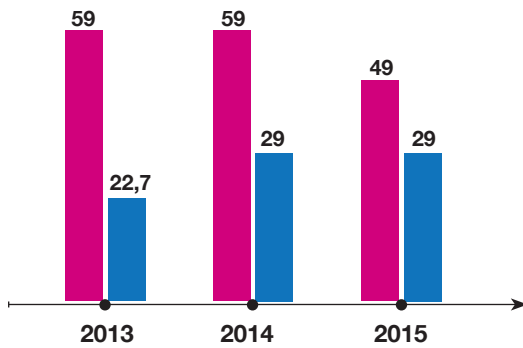
Re- port year	Rank	Value	Maternal mortality ratio	Adolescent fertility rate	Share of seats in parliament	Population with at least some secondary education (%)		Labour force participation rate (%)	
						Fe- male	Male	Fe- male	Male
	Out of 155		Deaths per 100,000 live births	Births per 1,000 women aged 15-19	% held by women				
2015	60	0.308	49	29	24.3	59.4	71.2	73.0	82.2
2014	58	0.322	59	29	24.4	59.4	71.2	72.8	81.9
2013	48	0.299	59	22.7	24.4	24.7	28	73.2	81.2



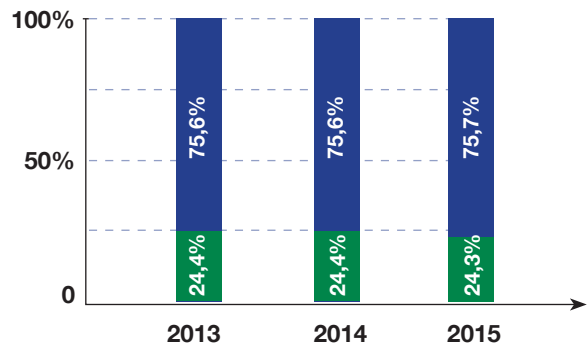
106. The Gender Inequality Index (GII) reflects gender-based inequalities in three dimensions – reproductive health, empowerment, and economic activity. Reproductive health is measured by maternal mortality and adolescent fertility rates; empowerment is measured by the share of parliamentary seats held by each gender and attainment at secondary and higher education by each gender; and economic activity is measured by the labour market participation rate for each gender. The GII replaced the previous Gender-related Development Index and Gender Empowerment Index. The GII shows the loss in human development due to inequality between female and male achievements in the three GII dimensions.

- UNDP (United Nations Development Programme). 2013. *2013 Human Development Report - The Rise of the South: Human Progress in a Diverse World*.

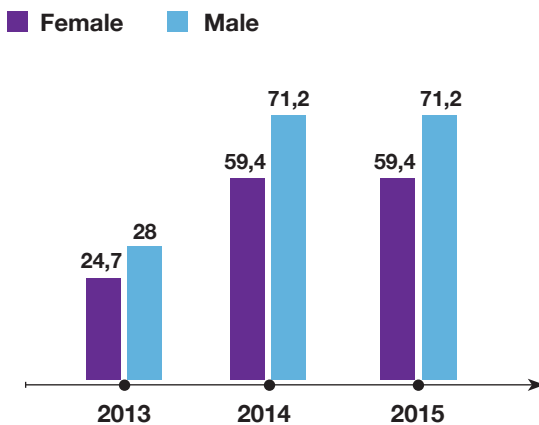
107. UNDP (United Nations Development Programme). 2015. *2015 Human Development Report – Work for Human Development*; 2014. *2014 Human Development Report – Sustaining Progress: Reducing Vulnerabilities and Building Resilience*; and 2013. *2013 Human Development Report – The Rise of the South: Human Progress in a Diverse World*.



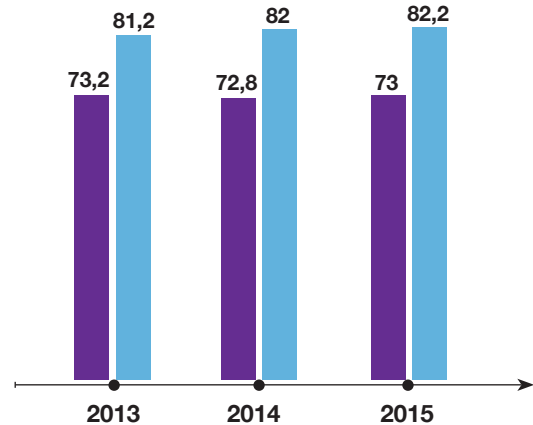
■ **Maternal mortality ratio**
 (Deaths per 100,000 live births)
■ **Adolescent fertility rate**
 (Births per 1,000 women aged 15-19)



Share of seats in parliament
 (% held by women)
■ Female ■ Male



■ Female ■ Male
Population with at least some secondary education (%)



Labour force participation rate (%)

Meanwhile, Viet Nam’s 2015 Country Report on achievements relating to the Millennium Development Goals celebrates, in particular, progress towards Goal 3: Promote gender equality and empower women.¹⁰⁸ The report claims that Viet Nam has “eliminated gender inequality in education across all

levels...”,¹⁰⁹ with the number of girls attending higher secondary school even surpassing the number of boys. The difference in literacy rates has also been “continuously narrowing”, with 93.1% of adult women and 96.6% of adult men literate by 2013.¹¹⁰ The Ministry of Labour, Invalids and Social

108. Measurement of progress towards this Goal is against Target 4: “Eliminate gender disparity in primary and secondary education preferably by 2005 and at all levels by 2015” and according to the following indicators: ratio of girls to boys in primary, secondary and tertiary education; ratio of literate women to men, 15-24 years old; share of women in wage employment in the non-agricultural sector; and proportion of seats held by women in national parliament. United Nations. Millennium Development Goal 3. <http://www.unmillenniumproject.org/goals/gti.htm#goal3> Accessed 16 May 2016.

109. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.

110. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.

Affairs (MOLISA) also refers to Viet Nam's encouraging achievements in its work on gender equality, with the country considered among those in Southeast Asia to have most quickly narrowed its gender gap in the last 20 years.¹¹¹ It notes achievements in improving the position and roles of Vietnamese women in socio-economic and political areas, and a high percentage of women deputies to the National Assembly (compared to other Asia-Pacific countries), as well as the abovementioned reduction in the gender gap in access to education. A 2012 USAID Viet Nam Gender Analysis also points to substantial progress in several key measures of gender equality, including economic participation, educational attainment, health and security, and political empowerment.¹¹² Successes such as these have short, medium and long-term impacts on women and girls' lives, including to reduce HIV vulnerability.

However, there remain a number of challenges, as acknowledged by MOLISA, with gender inequality persisting in many sectors and much to be done.¹¹³ Firstly, as can be seen from the GII figures (above), there is a discrepancy in the data on educational achievement. Secondly, as noted by the National Review of the 20-Year Implementation of the Beijing Platform for Action in Viet Nam (henceforth Beijing Platform Review), certain groups of women – particularly ethnic minority women and those

living in economically disadvantaged areas – have fewer opportunities to access education than men.¹¹⁴ Furthermore, while almost equal numbers of girls and boys may be attending school, the Beijing Platform Review points out that “gender stereotypes still persist in the learning materials and textbooks at all levels of education, which is possible to generate gender bias in behaviours of school boys and girls.”¹¹⁵ These stereotypes are also perpetuated in the Vietnamese media. Such gender stereotyping not only undermines successes in achieving gender parity in school attendance, but can have negative impacts on the response to HIV. For example, perceptions of gendered “bad” or “inappropriate” behaviour – such as around sex, drugs and assertiveness – engrained in people's minds from a young age, may lead to greater stigma and discrimination against women living with HIV than against men living with HIV, particularly if these women are perceived to have transgressed gendered expectations. Such perceptions, internalized, may also impact on women's own ability to negotiate intimate relationships and to access prevention, care and treatment services. So too does the fact that “violence against women and girls persists.”¹¹⁶ Meanwhile, there is limited societal understanding of the importance of gender equality and women's human rights. Further qualitative analysis and a more nuanced response to these issues is

111. MOLISA (Ministry of Labour, Invalids and Social Affairs). 2015. *National Action Plan for Gender Equality 2016-2020*.

112. Ray-Ross, Sumali. 2012. *USAID/Vietnam Gender Analysis*.

113. MOLISA (Ministry of Labour, Invalids and Social Affairs). 2015. *National Action Plan on Gender Equality 2016-2020*.

114. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly*.

115. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly*.

116. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly*.

required in order to address deeply engrained social and cultural gender norms over the long term.

Meanwhile, in employment, women workers remain disadvantaged in the non-farm sector when compared to men, they continue to earn less income despite having the same level of qualifications, and they also constitute the majority of workers in the informal sector or in vulnerable jobs.¹¹⁷ In terms of both political and business leadership and management, women also still have a long way to go towards equal representation:

In politics, the proportion of female leaders at all levels is small, and more so at the high levels. By December 2014, the percentage of People's Committee chaired by women was 1.6% at provincial level, 3.6% at district level, and 3.2% at commune level. In business, women account for only one quarter of the total owner/director positions in enterprises nationally. In agriculture, only 8.64% farm owners are women."¹¹⁸

The Beijing Platform Review includes “the burden of housework” as well as “prejudices on management capacity of women” as

among the reasons for this imbalance in political participation.¹¹⁹ The regulation setting women's retirement age at 5 years earlier than men's is also problematic.¹²⁰ Women's continuing lower status in the economic and political arenas is not only a challenge in itself, but presents barriers in accessing and responding fully to HIV and AIDS-related prevention, treatment and care efforts.

Additional issues of concern in terms of gender inequality include a preference for male children and consequent sex selection. Within a short period, the sex ratio at birth rose from 106.2 male births per 100 female births in the year 2000 to 110.5 in 2009 and 112.6 in 2013.¹²¹ A UNFPA report on this issue highlights the links between sex-based preference and gender-based violence, especially the fact that:

*[c]ombating domestic violence is getting more and more difficult as the social and cultural norm to give privilege to boys and men remains acceptable even among women. Indeed, the MICS survey 2014 (UNICEF) found that by 2014, up to 28.2% of women believe that it is acceptable for husbands to hit their wives in various circumstances.*¹²²

117. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly.*

118. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly.*

119. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly.*

120. Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly.*

121. UNFPA (United Nations Population Fund). 2014. *Policy Brief: The Imbalanced Sex Ratio at Birth in Viet Nam: Connecting Research and Policy for Change.*

122. UNFPA (United Nations Population Fund). 2014. *Policy Brief: The Imbalanced Sex Ratio at Birth in Viet Nam: Connecting Research and Policy for Change.*

This includes all women age 15-49 years who state that a husband is justified in hitting or beating his wife in at least one of the following circumstances: 1) she goes out without telling him, 2) she neglects the children, 3) she argues with him, 4) she refuses sex with him, 5) she burns the food.

As already noted, sub-populations of women are even more vulnerable, including those living in poorer and ethnic minority-dominated regions. Such women – like sex workers, or women who use drugs – are likely to experience double discrimination as women and as members of otherwise marginalized groups (and, further, as women living with HIV). At the same time, economic dependence – mainly on male spouses – also contributes to women’s vulnerability in relationships, and poses an obstacle to their ability to negotiate intimacy and sexual relations. The 2014 Human Development Report emphasizes the danger in such structural vulnerabilities:

*The poor, women, minorities (ethnic, linguistic, religious, migrant or sexual), indigenous peoples, people in rural or remote areas or living with disabilities, ... tend to face higher barriers, sometimes of a legal nature, to build capabilities, exercise choices and claim their rights to support and protection in the event of shocks. And even if laws do not explicitly discriminate, the absence of effective policies can leave people excluded and vulnerable.*¹²³

Finally, the Beijing Platform Review mentions a number of political and structural challenges to improving gender equality. According to the Review, mainstreaming gender into legal and policy documents has been difficult; there is insufficient national research on gender – sex-disaggregated data are inadequate and there has been a shortage of national comprehensive and periodical surveys on gender equality – which hampers policymakers; and finally, the government machinery on gender has limited personnel and resources, particularly at the provincial and district level. Meanwhile, government staff at all levels have limited awareness of the need for gender equality and related issues. All of these issues led CEDAW to note its concern:

*[t]hat the implementation of laws and policies remains weak owing to the lack of accountability mechanisms and insufficient human, technical and budgetary resources and unawareness of the concept of substantive gender equality by lawmakers and policymakers and government officials [and that] the general lack of knowledge about gender equality persists.*¹²⁴

123. UNDP (United Nations Development Programme). 2014. *2014 Human Development Report – Sustaining Progress: Reducing Vulnerabilities and Building Resilience*.

124. UN CEDAW (United Nations Committee on the Elimination of Discrimination Against Women). 2015. *Concluding observations on the combined seventh and eighth periodic reports of Viet Nam. CEDAW/C/VNM/CO/7-8*.

Viet Nam is today considered a progressive, thriving lower middle-income country in a rapidly developing region. However, the many gains the country has achieved in the health, education and economic sectors are less impressive when examined from a gender perspective. It remains a patriarchal (and profoundly unequal) society that is modeled on a Confucian social order. Traditional gender roles remain entrenched and are perpetuated in the community, household and intimate relationships. Many women are denied access to the formal employment sector – and those who have paid employment are often in lower level, poorly paid jobs. Research points to the country facing high levels of gender-based violence; and while there is (limited) discussion of intimate partner/domestic violence, other forms of gender-based violence have not been adequately researched and are invisible in both public discourse and policy.¹²⁵

More consistent gender-transformative and -differentiated approaches in all of these sectors, supplemented by a more systematically sex-disaggregated, cross-cutting HIV-related data-management system, would strengthen the national response to HIV and render it more sustainable.

3. THE LEGAL AND POLICY CONTEXT: GENDER EQUALITY AND HIV

Part of the brief for the assessment was to analyze the policy and laws that govern national approaches to addressing both HIV and gender inequality, and to identify opportunities and gaps. It should be noted here again that the purpose of this assessment is to identify the specific issues for women and girls in the current response. No analysis has therefore been undertaken of the considerable strengths of the HIV response overall, nor of any challenges to the response that are unrelated to addressing gender inequality and/or the impacts of the epidemic on women and girls.

Nevertheless, an enabling environment is the cornerstone of effective HIV programmes and political commitment to addressing HIV is high. Viet Nam's Government has committed to the Millennium Development Goals, the new Sustainable Development Goals and the United Nations General Assembly Political Declaration on HIV/AIDS, adopted at the 2011

125. See, for example: GSO (General Statistics Office). 2010. "Keeping silent is dying" – Results from the National Study on Domestic Violence against Women in Viet Nam and UN Women (United Nations Entity for Gender Equality and the Empowerment of Women). 2012. *Estimating the Costs of Domestic Violence Against Women in Viet Nam*.

High-Level Meeting on AIDS, the targets of which are reflected in Viet Nam's National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2020 with a vision to 2030. Viet Nam has also signed up to the global "90-90-90" targets (by 2020, 90% of all people living with HIV will know their HIV status; 90% of all people diagnosed with HIV will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have durable viral suppression), and supports the global goal of "Ending AIDS by 2030".¹²⁶

At the same time, special attention is needed to address the specific needs of key populations, and women members of these populations. The government of Viet Nam has been very active in developing a range of policies and laws to address HIV and eradicate gender inequality. These include clauses on non-discrimination in a number of laws and regulations, which offer some measure of protection to the three key populations, as well as to people living with HIV, migrants/mobile people, orphans and other vulnerable children, people with disabilities, people who use drugs, prisoners, sex workers, women and girls, and young people. The Amended Civil Code, which was passed in November 2015 and came into effect in January 2017, takes a step towards recognizing transgender rights by legalizing gender reassignment surgery and allowing those who have undergone such

reassignment to register under their new sex and name.¹²⁷ Administrative fines for holding same-sex weddings were abolished in 2013, and the amended Law on Marriage and Family (2014) removed a provision prohibiting same-sex marriage. However, such marriages are not yet legally recognized.

Despite such progress, the Government remains aware of the number of national laws and policies that continue to pose barriers to the effective implementation of HIV programmes for affected groups, including transgender men and women; people living with HIV; men who have sex with men; female sex workers; migrants/mobile populations; people who use drugs; and prisoners.¹²⁸ Such laws and policies also infringe the rights of marginalized communities, who already face multiple forms of stigma and discrimination. Failing to address a punitive and harmful legal environment will result in further discrimination and exacerbate gender inequality.

3.1. THE LEGAL AND POLICY FRAMEWORK FOR HIV¹²⁹

A rapid review of the policy environment guiding the HIV response showed that many of Viet Nam's HIV-related policies lack a systematic approach to incorporating gender. Although some policies do acknowledge

126. Ministry of Health. 2014. *Optimizing Viet Nam's HIV Response: An Investment Case*.

127. Thanh Nien News. 24 November 2015. *Vietnam recognizes transgender rights in breakthrough vote*. <http://www.thanhniennews.com/politics/vietnam-recognizes-transgender-rights-in-breakthrough-vote-54168.html> Accessed 16 May 2016.

128. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

129. See Appendix A for a full list of laws and policies.

gender inequality, this is not necessarily translated into gender-transformative analysis or interventions.

3.1.1 THE LAW ON HIV/AIDS PREVENTION AND CONTROL (2006)

The 2006 Law on HIV/AIDS Prevention and Control (henceforth “Law on HIV”) asserts the rights of all people living with HIV to: live in the community; have access to treatment, health care, education and work; and privacy. Such equality of treatment under the law provides a basis upon which to challenge the issues faced by women living with HIV, many of which were articulated by people interviewed for this assessment (see more below).

The Law on HIV highlights [presumably female] sex workers and pregnant women as populations to be given priority access to IEC (in addition to other populations “at risk”). Pregnant women are also entitled to free antiretroviral (ARV) medications and HIV tests (if undertaken voluntarily), underscoring the value placed on women in their traditional reproductive role, and undermining that of women who may not be pregnant or who choose not to be mothers. Any future amendment of the Law on HIV should extend the focus of initiatives beyond pregnant women to ensure that women outside of antenatal and mother-and-child clinics have access to primary prevention, a point that is particularly important in light of the increase in intimate partner transmission.

- The Law also outlines the obligations of people living with HIV: to prevent transmission to others; to inform their spouse or fiancé(e) (but not other sexual partners) of their status; and to observe instructions about ARV treatment. However, these obligations do not take into account a number of constraints, especially for women: Women’s ability to disclose their status is compromised by high rates of domestic violence and other consequences (such as stigma and discrimination, and the potential of being further deprived of property, inheritance and family rights)
- Women’s ability to negotiate safer sex and condom usage compromises their ability to prevent transmission.
- Women – especially sex workers – may be particularly prone to harassment and discrimination at the workplace if their status is disclosed.
- Women’s lack of access/barriers to services – including knowledge about HIV, testing and treatment – can impact on their ability to be diagnosed and on their treatment retention.

It is particularly imperative that the consequences of disclosure – which are deeply influenced by gender inequality and norms and expectations around women’s behaviour – be addressed.

3.1.2 NATIONAL STRATEGY ON HIV/AIDS PREVENTION AND CONTROL TILL 2020 WITH A VISION UNTIL 2030

Viet Nam is currently implementing a National Strategy on HIV/AIDS Prevention and Control till 2020 with a vision until 2030. The National Strategy aims for comprehensive interventions, universal access, and improved quality and sustainability of HIV-related activities. It has the following areas of focus:

- Prevention of HIV transmission.
- Comprehensive care, treatment and impact mitigation.
- Health systems strengthening.
- Surveillance, monitoring and evaluation.
- Organization of implementation.

A recent review by the National Committee for AIDS, Drugs and Prostitution Prevention and Control demonstrates that the strategy has not yet been implemented comprehensively and flagged the following areas for attention:¹³⁰

- The hidden risks of an expanding HIV epidemic due to continued high-risk behaviours.
- The coverage of interventions, in terms of the number of sites and people, is still low and service provision is uneven across provinces and groups.
- Knowledge about HIV is still restricted, especially among those living in remote and mountainous areas.

- Only 40-50% of the demand for combination antiretroviral therapy (ART) has been met.

Although the gender dimensions of these four issues were not interrogated, all point to the vulnerability of women and girls in terms of risk, lack of access to information, and gaps across the continuum of prevention and care services.

Underlying the National Strategy is the belief that the HIV epidemic remains complicated and that risk behaviours among ‘high-risk groups’ are still at a level which enables high HIV transmission rates. The Strategy makes mention of “double risk behaviours” that will rapidly increase HIV transmission:

- Injecting drug use by female sex workers and men who have sex with men (although women other than female sex workers are not mentioned)
- Men who inject drugs who also sell sex to both men and women (but the female intimate partners of men who inject drugs or have sex with men outside sex work are not mentioned)

It goes on to state that interventions are needed that are “appropriate to the current situation”.¹³¹ However, as noted above, the picture of that situation is incomplete due to the lack of adequate data, including sex- and age-disaggregated data and data on marginalized and invisible groups.

130. National Committee for AIDS, Drug and Prostitution Prevention and Control. 2014. *Vietnam AIDS Response Progress Report 2014*.

131. National Committee for AIDS, Drug and Prostitution Prevention and Control. 2011. *National Strategy on HIV/AIDS Prevention and Control until 2020 (Fifth draft)*.

There is mention of gender and/or women and girls in the National Strategy, and this is to be commended. Indeed, the Strategy provides a major entry point for addressing gender inequality:

National Strategy Guiding Viewpoint 2

*Ensuring human rights and combating stigma, discrimination against people infected with HIV / AIDS, strengthening responsibility of families and the society to people infected with HIV / AIDS and of PLHIV to their families and the society, ensuring equity in provision of care and support to PLHIV, ensuring gender equity, caring for children, vulnerable groups, ethnic minority groups and people living in remote areas.*¹³²

However, further mentions of gender, women and girls are sporadic, and if the Strategy were implemented as it stands, many gender-related issues would fail to be addressed. For example, the Strategy does not adequately address the gender dynamics of the epidemic in Viet Nam, nor does it deal with the disproportionate impact of HIV on women and girls (including women and girls in key populations) and the female partners of men who have sex with men or men who inject drugs.

The National Strategy does strongly prioritize pregnant women, with an emphasis on early detection and treatment for pregnant women living with HIV, as well as IEC for both pregnant women and women of “childbearing

age”. It contains specific targets related to this priority:

- 100% of pregnant women with positive HIV testing results will receive prevention treatment with ARV by 2015.
- Early detection and treatment of STI for women in reproductive ages.

Although it will be important to keep these services for pregnant women, it is also crucial to expand the reach and focus to all women, regardless of motherhood status, covering a wider variety of women and including women who fall outside the defined reproductive age. This would include: women over 45, transgender women, women who choose not to have children, women who have decided not to have more children, women who are unable to have children, and women who have no plans to become pregnant in the near future. This is definitely not the case in the current Strategy.

However, the National Strategy nevertheless provides a good starting point for tackling gendered dimensions of the epidemic, as it contains objectives, activities and targets that can be expanded, refined and then implemented. Monitoring and evaluation of the impact of newly gendered strategies will be important to ensure that they are effective. The following could provide a solid basis from which to build a more gendered approach that meets the needs of all, including women living with HIV, women most affected by HIV and women from key populations.

132. National Committee for AIDS, Drug and Prostitution Prevention and Control. 2011. *National Strategy on HIV/AIDS Prevention and Control until 2020 (Fifth draft)*.

Figure 13: National Strategy on HIV/AIDS Prevention and Control till 2010 with a vision to 2030: Objectives and activities to address gender¹³³

Objective and activity	Strategy & target	Approach
Enhancing the understanding and ensure the role, equal rights of women so that they would actively participate in HIV/AIDS prevention and control.	Prevention	Gender-sensitive
Ensure women to participate in learning, exchanging life experience and life-skill.	Structural	Potentially gender-transformative
Study to apply new technologies in HIV prevention: measures to prevent transmission among women such as HIV preventing substances (microbicides), HIV prevention treatment, early treatment for prevention or HIV prevention vaccine.	Prevention	Gender-sensitive
Affirming the role and tasks of the National Assembly in the development and amendment of legislation to ensure universal access, gender equality and human rights in HIV/AIDS and ensure budget to create sustainable development of HIV/AIDS programmes.	Coordination	Gender-transformative
Developing gender equality polices, specific policies for each HIV vulnerable group, especially children who are affected by HIV/AIDS or living with HIV/AIDS.	Prevention, Treatment and care	Gender-sensitive
Educating, ensure the gender equality of people living with HIV/AIDS as well as individual's rights living in the community on responsibility of HIV/AIDS prevention and control.	Stigma and discrimination, Rights	Potentially gender-transformative
Revising, supplementing report forms and guidelines on data collection, consolidation in accordance with the new period, classifying data by ages and genders, ensuring the analysis requirements to evaluate, improve the programme quality, evaluate the programme effectiveness and gender equity report analysis.	Monitoring and evaluation, surveillance	Gender-sensitive
Maximizing capacity to collect data by genders to support evaluation on gender equity in HIV/AIDS prevention and control.	Monitoring and evaluation, surveillance	Gender-sensitive

133. All quotes in this table are sourced from the English translation of the National Strategy and have not been edited for language.

3.2. THE LEGAL AND POLICY FRAMEWORK FOR ADDRESSING GENDER INEQUALITY

Viet Nam has shown high-level commitment to tackling gender inequality and has developed a legal and policy framework to guide related efforts, including:

- Constitution of the Socialist Republic of Viet Nam (2013) – which guarantees substantive equality between men and women.
- Law on Gender Equality 2006.
- National Strategy for Gender Equality 2011-2020.
- National Action Programme on Gender Equality 2016-2020.

The Government can claim some success in reducing gender inequality, but acknowledges that there is still much to be done (see section 3.2 Gender inequality in Viet Nam).¹³⁴ The official and accepted definition of gender is an important gauge as to how gender inequality is understood and addressed. According to the Law on Gender Equality:¹³⁵

- Gender indicates the characteristics, positions and roles of man and woman in all social relationships (Article 5.1).

- Gender equality indicates that man and woman have equal position and role; are given equal conditions and opportunities to develop their capacities for the development of the community, family and equally enjoy the achievement of that development (Article 5.3).
- The measures to promote gender equality are not considered gender discrimination (Article 6.3).
- Policies aimed at protecting and supporting the mother are not considered gender discrimination (Article 6.4).

These definitions fail to acknowledge certain crucial issues, including the impacts on women of unequal power relations in society, and the issue of gender identity. This weakens the foundations of the Law and all related strategies and plans that spring from it.

With regard to HIV, the Law on Gender Equality makes a single reference in the section on gender equality in the field of public health.

- Man and woman are equal in choosing and deciding on contraceptive measures, measures for safe sex and for preventing and protecting against HIV/AIDS and other sexually transmitted infectious diseases.¹³⁶

134. MOLISA (Ministry of Labour, Invalids and Social Affairs). 2015. *National Action Plan for Gender Equality 2016-2020* and Socialist Republic of Viet Nam. 2014. *National Review of 20-Year Implementation of the Beijing Platform for Action (BPFA) in Viet Nam and the Outcomes of the 23rd Special Session of the General Assembly*.

135. These points are direct quotes from the English translation and have not been edited. Socialist Republic of Viet Nam. 2006. *The Law on Gender Equality No.73/2006/QH11*. <http://www.ilo.org/dyn/travail/docs/934/Law%20on%20Gender%20Equality%202006.pdf> Accessed 14 May 2016.

136. Socialist Republic of Viet Nam. 2006. *The Law on Gender Equality No.73/2006/QH11*. <http://www.ilo.org/dyn/travail/docs/934/Law%20on%20Gender%20Equality%202006.pdf> Accessed 14 May 2016.

Again, this is insufficient: it does not in any way address the structural basis for inequality, nor does it acknowledge that intimate relationships are, for many women, a site of struggle in which the gendered power differential is most acute.¹³⁷ Furthermore, aspects of gender inequality and HIV treatment and care, as well as stigma and discrimination – among others – are ignored.

Similarly, the National Statistical Indicators on Gender Development, approved by the Prime Minister in 2011, has 105 indicators to measure a wide range of gender equality initiatives – of which only two specifically deal with HIV. Both are related to pregnant women:

- Number of pregnant women aged 15 – 25 years old infected with HIV.
- Percentage of pregnant women accessing with health care service and prevention HIV infection from mother to child.¹³⁸

Despite a rich policy environment addressing both gender and HIV, and some efforts to mainstream these issues, there are obvious gaps in both sets of policies, and very limited interaction between the two. It should be noted, however, that many of the people interviewed for this assessment, and participants at the validation meeting, felt that there were sufficient policies to address HIV and gender. They therefore did not recommend the introduction of new policy,

but rather the amendment of existing policies. They also emphasized the need to focus on: the current status of implementation of these policies (in terms of effectiveness and relevance); how to use the legal frameworks to eliminate the current high levels of stigma and discrimination; and the integration of HIV and gender. It was noted that unfortunately the expertise to do so does not exist in many provinces and districts.

Case study: Legal and policy change: Sex work

Sex work is a contentious issue in Viet Nam: although widespread, it is illegal and classified as a “social evil” to be eliminated, and sex workers are “managed” by the Department of Social Vices Prevention and Combat (under the Ministry of Labour, Invalids and Social Affairs (MOLISA)). “Social Vices Prevention Units”, run by the police, heighten the vulnerability of female sex workers. As stated in the CEDAW shadow report, the emphasis on “prostitution as a social evil, increases already high levels of stigma and discrimination”.¹³⁹

Historically attempts to address sex work in Viet Nam have been punitive. Such approaches endanger sex workers in various ways:

- Fear of detection limits their access to health care and means that STIs, including HIV, go undetected and consequently untreated while the women continue to work;

137. Tallis, V.A. 2012. *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability*.

138. GSO (General Statistics Office). *The Gender Statistical Handbook*. http://gso.gov.vn/default_en.aspx?tabid=490&idmid=5&ItemID=1817 Accessed 9 December 2015.

139. FIDH (International Federation for Human Rights) and VCHR (Viet Nam Committee on Human Rights). 2015. *Violations of the Rights of Women in the Socialist Republic of Viet Nam. Alternative Report on the Implementation of the UN Convention on Elimination of Discrimination against Women (CEDAW) on the combined seventh and eighth periodic reports of Vietnam*.

- They rely upon self-treatment or ignore symptoms;
- Punitive approaches lead to increases in the arbitrary arrest, detention and extortion of, and violence against, sex workers, increasing their risk of HIV and human rights abuses;
- When they were detained (this is no longer the case: see below), their means of income was cut off, thereby increasing the burden of those in debt. This was particularly the case when a woman had dependent children or relatives who, although relying upon her earnings, were unaware of their source, because she was then obliged to borrow to maintain the pretense. In such cases, too, incarceration was likely to mean disclosure, and increase stigma and discrimination against both the woman and her family.¹⁴⁰ Under current law, sex workers are subject to punitive fines, which again can increase debt;
- There is also evidence that police (along with clients) are sex workers' most feared perpetrators of violence, and that sex workers do not seek redress when such violence is enacted.¹⁴¹

The main legal document relating to sex work – the 2003 Ordinance on Prostitution Prevention and Control – has as its fundamental objective to “prevent and combat prostitution”. It strictly prohibits the buying and selling of sex, as well as the related activities of harbouring, organizing, and protecting prostitution.¹⁴² Its focus is almost entirely on the prevention and punishment of prostitution. It both prohibits sex workers from deliberately transmitting HIV and directs that prostitution prevention and control be closely combined with HIV prevention and control, but provides no specifics on how this should be done. Condoms and condom provision are not mentioned as a prevention strategy, and indeed the police have been known to treat the possession or presence of condoms as evidence of sex work – which of course acts as a deterrent to carrying them.¹⁴³ This is a particular problem for street-based sex workers, who are more prominent and therefore more likely to be stopped and searched by the police.¹⁴⁴

The introduction of the Law on HIV in 2006 represented a measure of progress in its recognition of sex workers as a key population for the HIV epidemic and the need for harm reduction and IEC initiatives specifically for sex workers. However, the 2008 amendments to the 2002 Ordinance

140. Doussantousse S. and Tooke L. 2002. *Women involved in prostitution in Viet Nam – a Ha Noi snapshot*.

141. ILO (International Labour Organization). 2016. *Working Conditions of Sex and Entertainment Workers in Viet Nam*. [DRAFT]

142. Harbouring and organizing sex work are also criminalized under Viet Nam's Penal Code.

143. USAID/PEPFAR (United States President's Emergency Plan for AIDS Relief). *Policy Brief: The Evolution of Vietnam's Legal and Policy Framework on Sex Work and HIV/AIDS*. 2013. http://pdf.usaid.gov/pdf_docs/PA00JDV4.pdf Accessed 14 May 2016.

144. Godwin, J. 2012. *Sex Work and the Law in Asia and the Pacific*. UNDP, UNFPA, UNAIDS and APNSW.

on Administrative Violations continued to stipulate that sex work (alongside drug use) was an administrative violation resulting in detention for up to two years in centres (“05 Centres”) managed by MOLISA.^{145 146} The inconsistencies between these legal documents continued to hamper attempts to address the needs of sex workers.

However, there have been further efforts to expand public health and harm-reduction approaches to sex work and HIV. The National Programme of Action on Prostitution Prevention and Control 2011-2015,¹⁴⁷ while remaining focused on the enforcement of the 2003 Ordinance, and the elimination of sex work and “harm to society”, included a range of harm-reduction approaches targeting female sex workers (such as the provision of condoms); access to HIV and STI treatment and other health services; and social and legal protection services. Voluntary and community-based efforts to help female sex workers to build alternative livelihoods – through education and vocational training – and reintegrate into the community were

also key parts of the Programme of Action.¹⁴⁸ In addition, the programme called for the review and amendment of the legal framework to further enable harm-reduction measures for sex workers, allocated national budget to pilot harm-reduction programmes in selected provinces, and specified responsibility for integrating programmes for HIV and sex work prevention and control. Although this represents clear progress, it should also be noted that this programme could potentially heighten stigma and discrimination against sex workers, both because it requires their public identification and because it fails to address the ‘social evil’ characterization of sex work.

In 2010, the United Nations Country Team in Viet Nam argued that the fear of administrative detention keeps sex workers from accessing HIV services, and called for “the harmonization of the policy and legal regulations on sex work and the law on HIV/AIDS Prevention and Control.”¹⁴⁹ The UN also reported that campaigns to ‘clean the streets’ of sex workers had created an

145. VAAC (Viet Nam Authority of HIV/AIDS Control). 2012. *Vietnam AIDS Response Progress Report 2012*.

146. UNFPA (United Nations Population Fund). 2010. *Reducing HIV transmission among sex workers through stronger partnerships*.
<http://www.un.org.vn/en/feature-articles-press-centre-submenu-252/1594-strongerpartnershipsagainstshiv.html>
Accessed 16 May 2016.

147. MOLISA (Ministry of Labour, Invalids and Social Affairs). 2011. *National Programme of Action on Prostitution Prevention and Control 2011-2015*.

148. VAAC (Viet Nam Authority of HIV/AIDS Control). 2012. *Vietnam AIDS Response Progress Report 2012*.

149. United Nations Country Team in Viet Nam. 2010. *Speech by Bruce Campbell, UNFPA Representative, on behalf of the UN Country Team at the Review Workshop on the 5-year implementation of sex work prevention in the period 2006-2010 and Plan of Action for sex work for the period 2011-2015*.

atmosphere in which HIV prevention activities are difficult and sex work has been driven further underground.¹⁵⁰ This joint stance was echoed in 2012 by a global United Nations statement on compulsory drug detention and rehabilitation centres, which highlighted the detention without due process of people who have engaged in sex work (among others) as a “serious concern,” and called for the immediate closure of such centres and the release of detained individuals.¹⁵¹

Also in 2012, the Government of Viet Nam approved a new Law on Handling of Administrative Sanctions that put an end to the administrative detention of sex workers. Sex workers remain subject to a fine, up to a maximum of 5 million Viet Nam Dong (approximately 250 United States Dollars).

These developments in the legal and policy environment – and particularly the 2012 Law on Administrative Sanctions – demonstrate that coherence and consistency around HIV and gendered issues (including sex work) are possible. However, it remains to be seen to what extent the provisions in the 2012 Law are implemented. Further, as CEDAW recommended, it will be important to review the Law on Handling of Administrative Sanctions (2012) with a view to fully decriminalizing women who engage in sex work.¹⁵² In addition, major issues remain to be addressed, including the implications of sex work as a “social evil”, and the fact that the framework continues to insist that all sex workers are (cis) female (and not male or transgender).

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150. See, for example, UNFPA (United Nations Population Fund). 2010. “Reducing HIV transmission among sex workers through stronger partnerships”.
<http://www.un.org.vn/en/feature-articles-press-centre-submenu-252/1594-strongerpartnershipsagainstshiv.html>
Accessed 16 May 2016.
- and UNFPA ((United Nations Population Fund). 2011. “Partnering with Sex Workers in Viet Nam to Contain the HIV Epidemic and Protect Human Rights”.
<https://www.unfpa.org/news/partnering-sex-workers-viet-nam-contain-hiv-epidemic-and-protect-human-rights>
Accessed 29 August 2016.
151. ILO (International Labour Organization); OHCHR (Office of the High Commissioner for Human Rights); UNDP (United Nations Development Programme); UNESCO (United Nations Educational, Scientific and Cultural Organization); UNFPA (United Nations Population Fund); UNHCR (United Nations High Commissioner for Refugees); UNICEF (United Nations Children’s Fund); UNODC (United Nations Office on Drugs and Crime); UN Women (United Nations Entity for Gender Equality and the Empowerment of Women); WFP (World Food Programme); WHO (World Health Organization); and UNAIDS (Joint United Nations Programme on HIV/AIDS). 2012. *Joint Statement: Compulsory drug detention and rehabilitation centres*.
https://www.unodc.org/documents/southeastasiaandpacific//2012/03/drug-detention-centre/JC2310_Joint_Statement6March12FINAL_En.pdf Accessed 29 August 2016.
152. UN CEDAW (United Nations Committee on the Elimination of Discrimination Against Women). 2015. *Concluding observations on the combined seventh and eighth periodic reports of Viet Nam*. CEDAW/C/VNM/CO/7-8.

4. COORDINATION, PARTICIPATION AND FUNDING

4.1. COORDINATION

There are many actors in both the implementation of the gender inequality strategy and the HIV response. While this is positive in that many people have a responsibility to deliver, input from the interviews and the validation meeting showed that it does create challenges in communication and coordination, and often the approaches are “silo-ed” – that is, they are isolated from others, and even insular. This has resulted in very little coordination and integration between the governmental HIV and gender machinery. There is no platform at any level – national, provincial or local – to engage the people working on the intersections between HIV and gender, but such a structure is much needed. Indeed, there is no single agency or department that is responsible for coordinating gender-related factors in the HIV response: further investigation is needed to establish whether VAAC, the Department for Social Vices Prevention and Combat (under MOLISA) or the Gender Equality Department (also under MOLISA) have designated staff to look at gender/HIV issues.

Again according to interviewees, this challenge is compounded by a lack of capacity to integrate gender into the response, and to translate political will into action. It is important to note that this is not unique to Viet Nam. In any context, without a single policy that addresses both gender and HIV, or an HIV strategy in which gender has been mainstreamed, any integration of

HIV and gender, coordination of efforts, and monitoring and evaluating of progress will be very difficult. Participants at the validation meeting therefore agreed that it is therefore necessary to develop a clear mechanism to integrate gender and HIV programming, and that this would also require the development of a coordination and monitoring framework. Capacity building in gender equality for the leaders of the National Committee for AIDS, Drugs and Prostitution Prevention and Control was also suggested.

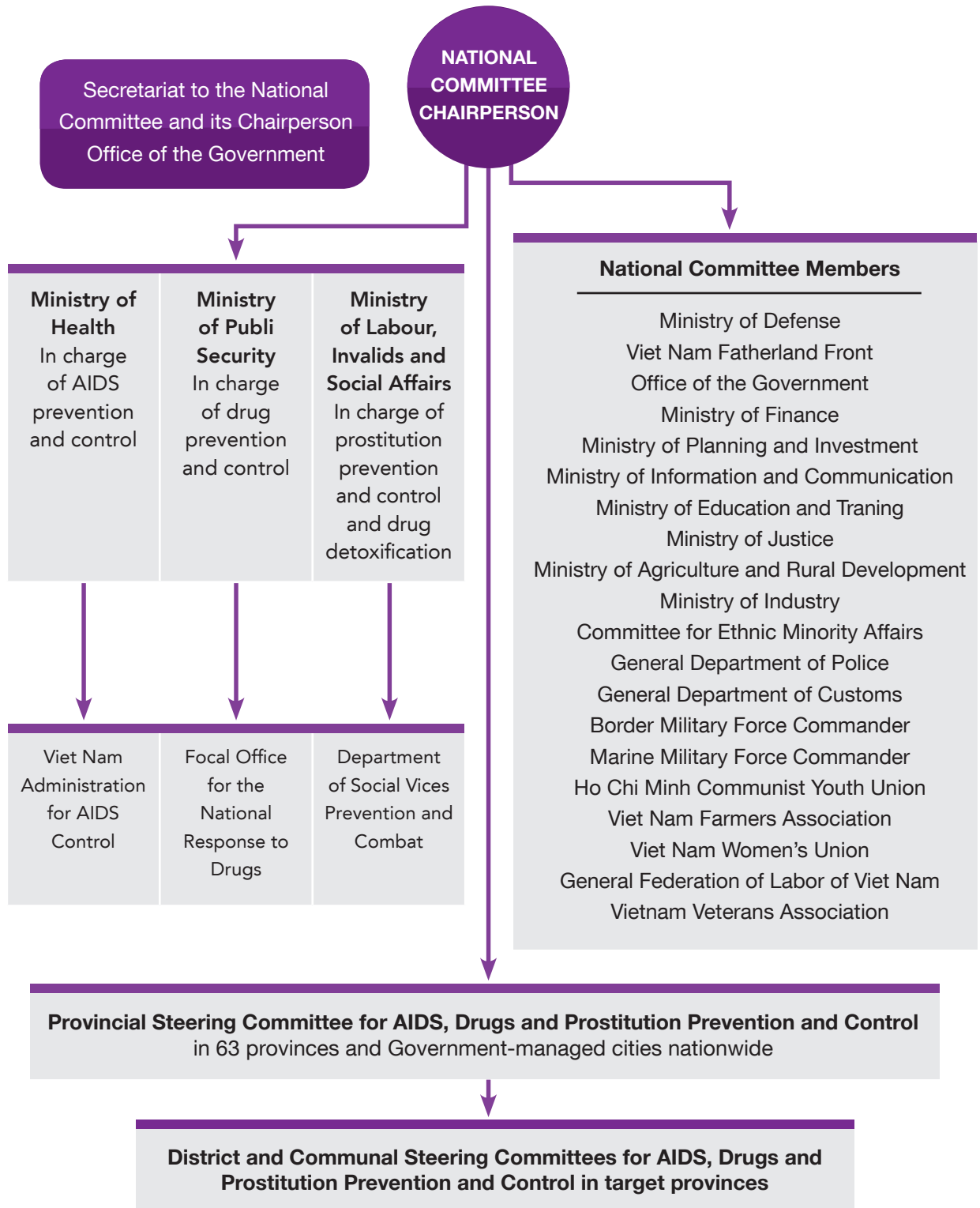
4.1.1. NATIONAL HIV AND NATIONAL GENDER MACHINERY OF GOVERNMENT

The focus on this section is on the machinery of government relating to HIV and gender. However, any coordination effort would need to include all sectors, including civil society, international donors and networks of affected people.

HIV

The national HIV response is led by the National Committee on AIDS, Drugs and Prostitution Prevention and Control, under the leadership of the Deputy Prime Minister (see Figure below). Within the National Assembly, the Committee on Social Affairs is in charge of both the HIV and gender portfolios. The responsibility for HIV and AIDS programming lies with the Ministry of Health, through VAAC, which is mandated to implement the National Strategy through its national and provincial structures. There is currently no gender focal person within any branch of the HIV response. The Country Coordinating Mechanism (CCM) oversees grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and has recently been strengthened in line with Global Fund requirements: it now includes representatives from both civil society organizations and networks of people living with HIV.

Figure 14: Organizational structure of the National Committee on AIDS, Drugs and Prostitution Prevention and Control



Gender

The Ministry of Labour, Invalids and Social Affairs (MOLISA) takes the lead in ensuring that gender inequality is addressed.

The Minister of MOLISA is the current Chair of the National Committee for the Advancement of Women in Viet Nam (NCFAW), which was established in 1993 and is an intersectoral collaborative government body tasked with studying, promoting and coordinating intersectoral issues related to the advancement of women nationwide. Committee members comprise Deputy and Vice Ministers of government ministries, as well as similarly ranked officials from other government bodies and mass organizations. The NCFAW reports to the Prime Minister.

The Gender Equality Department, under MOLISA, has primary responsibility for the implementation of the Law on Gender Equality and related implementation plans, including the National Strategy on Gender Equality 2011-2020, the National Programme on Gender Equality 2011-2015, and the National Action Programme on Gender Equality 2016-2020. The Department coordinates with line ministries, provides guidance on the implementation of the Law, evaluates the inclusion of gender equality in the drafting of all national laws, reviews related material and provides reports to other agencies, and reports annually to the National Assembly. It is also responsible for CEDAW implementation and monitoring. However, there are provincial

differences in how the law and programme gets implemented, with activities delegated to (very few) Gender Equality Divisions at the provincial level or (more often) to a focal person within the provincial Department of Labour, Invalids and Social Affairs and therefore very much dependent on individual capacity.

The Ministry of Sport, Tourism and Culture is responsible for overseeing the implementation of the Law on Domestic Violence Prevention and Control; and the Ministry of Public Security (MPS) is responsible for overseeing the Law on the Prevention and Combat of Human Trafficking on trafficking in persons.

The Viet Nam Women's Union (VWU) is a mass organization, formed in 1930 to mobilize women for an independent Viet Nam. It has over 13 million members in over 10,000 local Women's Unions throughout the country and at all administrative levels. Its current role is to support the Communist Party and Vietnamese government in the implementation of policy related to women and gender equality.¹⁵³ The VWU plays an active role in the HIV response, including through prevention campaigns, counselling, reducing stigma and discrimination and providing income-generation assistance for women living with HIV. The VWU has also recently taken on a more active role in coordinating work on gender equality at the provincial and local levels. Given their extensive network throughout Viet Nam, the VWU is a resource

153. Viet Nam Women's Union. 2013. *Report on Ensuring and Promoting Women's Rights (As inputs to the consolidated document of the Office of the United Nations High Commissioner for Human Rights to serve the Universal Periodic Review UPR)*.

that could potentially take on a greater and more systematic role in HIV and gender work. However, VWU members tend to have conservative attitudes about the roles of women, and reflect societal values that need to be challenged.

4.2. ROLE, INVOLVEMENT AND PARTICIPATION OF CIVIL SOCIETY

The involvement of civil society – including non-governmental organizations (NGOs), community-based organizations, and networks and organizations of women living with HIV and other key affected populations – is a cornerstone of any effective response to HIV. Civil society organizations (CSOs) are active partners in service delivery, monitoring the quality of services, ensuring accountability, and conducting advocacy and research.

Civil society in Viet Nam is developing rapidly, with a recent USAID report noting that there are currently 246 CSOs working in the HIV response, implementing prevention interventions among populations at risk and providing care and support for people living with HIV. They include community-based organizations, networks, self-help groups and professional associations.¹⁵⁴ Perhaps most crucial has been the development of networks of people living with HIV and of key populations (including, in this case, women):

- The Viet Nam Network of People Living with HIV (VNP+) - launched in 2009.
- The Viet Nam Network of Women Living with HIV (VNW+) (see more below)
- The Viet Nam Network of People who Use Drugs (VNPUD) - established in 2012 and has expanded from the original 20 members to 56 by the end of 2013.
- The Viet Nam Network of Sex Workers (VNSW) - also established in 2012, represents 4,800 current or past sex workers through an association of twenty-nine self-help groups.¹⁵⁵
- The Viet Nam Network of Men who have Sex with Men and Transgender People (VNMSM-TG) - launched in 2013 with 91 members across the country.

However, serious obstacles remain to CSOs assuming their rightful place in Vietnam's national HIV response. As both this assessment's interviews and the literature make clear, such barriers include:¹⁵⁶

- The limited organizational capability of NGOs.
- Legal barriers to CSO registration and a lack of a clear and consistent legal framework governing CSO activities.

154. Ray-Ross, Sumali. 2012. *USAID/Vietnam Gender Analysis*.

155. International Labour Organization (ILO). 2016. *Summary study report: Viet Nam's Sex Industry - A Labour Rights Perspective*.

156. Nguyen Hai Hong. 2013. *Civil Society and democratisation in Viet Nam*.

<http://www.eastasiaforum.org/2013/02/02/civil-society-and-democratisation-in-vietnam/> Accessed 16 May 2016.

- The lack of technical, human and financial resources within civil society organizations.
- Unregistered organizations find it difficult to secure the necessary funding to become effective and sustainable.

Meanwhile, high levels of stigma and discrimination from broader society and individual communities often make it very difficult for people to participate in structures and organizations. The consequences of being identified as a person living with HIV or a member of one of the key populations can be devastating – and this is especially true for women, as indicated in the interviews and focus group discussions, who already suffer from ‘double discrimination’ as women, which may be compounded if they are both living with HIV and a member of one (or more) key populations.

However, women’s voices in national networks are often marginalized, with participants in this assessment telling us that networks and organizations do not necessarily advocate on issues women feel are important when they are different to those of men.¹⁵⁷ For example, the Viet Nam Network of People who Use Drugs is mainly led by men, and there is little space for women to participate – reflecting the more general marginalization of women who use drugs in both society and the HIV response. It is therefore vital that women living with HIV and other groups of women are mobilized and enabled to ensure that their unique challenges

and issues are raised. Until recently, women living with HIV in Viet Nam were organized under the banner of VNP+ (Viet Nam Network of People Living with HIV). In response to their need to have their issues acknowledged and addressed, some women living with HIV have organized themselves to form the Viet Nam Network of Women Living with HIV (VNW+), with members identifying the following aims:

- To develop the network and recruit membership across all the provinces.
- Capacity building for their members, including leadership, know-your-rights campaigns and skills development.
- Advocacy and campaigns to challenge and eliminate stigma and discrimination.
- To increase access to ART for women living with HIV, in all their diversity.
- Policy advocacy on prevention, treatment and care issues.
- Information sharing for members on important issues for women living with HIV, including through a network website to provide updates.

VNW+ faces the same challenges as many other CSOs in Viet Nam, but is receiving growing acknowledgement from the government as the voice of women living with HIV, as well as technical and financial support from UN Women and UNAIDS. This has enabled the network to start building the network and elaborate the above goals.

157. Focus-group discussion, Ha Noi.

VNW+ was also actively involved in the CEDAW review process, which provided an important space to raise their issues and capacity-building experience.

4.3. FUNDING¹⁵⁸

Unfortunately, there is no way to track money that is currently spent on gender and HIV in the near-absence of gender-specific and gender-related goals in the National Strategy, and with no specific gender-related activities or allocated staff. This also makes it impossible to measure gender-specific activities (with the exception of PMTCT or harm-reduction among female sex workers), or activities that potentially contribute to gender equality (mainstreaming). Gender-responsive budgeting is not part of any HIV-related financial analysis or reporting.

The 2014 HIV Investment Case for Viet Nam – among many other sources – notes that Viet Nam is facing formidable challenges in sustaining its response to HIV, with shrinking contributions from international donors and limited domestic resources.¹⁵⁹ It points to the real danger of losing hard-fought gains if Viet Nam does not significantly increase the budget for HIV in the coming years. Although specific targets for addressing – and funding

– gender-related HIV interventions are not discussed in the Investment Case, the issue of intimate partner transmission is highlighted. In the interviews for this assessment, too, the issue of funding and resources was a consistent theme.

The shrinking funds for HIV have already meant cuts to some programmes that did specifically address gender, especially at the provincial and district levels. These include the peer-educator programme among female sex workers and women living with HIV; access to free (male) condoms; and the fact that although ART is funded, the infrastructure to administer it is not. However, the integration of gender into the HIV response will require a dedicated budget, and mechanisms to better address the realities of women and girls within the HIV response will need additional resources. It is unclear in the context of such cuts, and the prospect of further financial constraints, where such funds will come from.

In 2015, UN Women supported the National Institute of Finance/Ministry of Finance to develop a gender-responsive budgeting (GRB) project, which may contribute to fundraising for gender and HIV interventions. Indeed, GRB will be essential to the future allocation of funds for the HIV response.

158. Socialist Republic of Viet Nam. 2014. *Global Fund to Fight AIDS, Tuberculosis and Malaria TB and HIV Concept Note – Investing for impact against tuberculosis and HIV, Viet Nam 2015-2017*.

An extensive analysis was not possible for all efforts to secure donor investment; however, the latest concept note submitted to the Global Fund with the Ministry of Health (Lung Hospital and VAAC) as the principal recipient was reviewed. Submitted in 2014 for a joint TB and HIV programme for 2015 -2017, the concept note is weak on analysis of gender disparities and gendered issues, noting only an indicator on *Better access to TB testing and treatment services by women*. With the Global Fund becoming more committed to ensuring that gender is an integral part of the HIV response, a more thorough and detailed gender analyses will be required in future.

159. Ministry of Health. 2014. *Optimizing Viet Nam's HIV Response: An Investment Case*.

GRB initiatives provide information that allows for better decision-making on how policies and priorities should be revised – and the accompanying resources needed – to achieve the goal of gender equality. GRB can help governments uphold their commitments and assist them in monitoring the implementation and gender impacts of policies and programmes. In addition, GRB improves governance and financial management through increasing accountability, participation and transparency.

GRB provides a way of assessing the impact of government revenue and expenditure on women and men, girls and boys and can thus provide feedback on whether a government is meeting their needs. It should also provide data that can be used in advocacy. GRB is not about dividing government money 50–50 between men/boys and women/girls: while this looks equal, it is often not fair. Neither does GRB create separate budgets to address women’s or gender concerns: “[s]pecial allocations for women and gender are sometimes helpful in addressing specific needs, but they are of limited use if the rest of the budget continues to privilege some citizens above others”.¹⁶⁰ GRB is:

*About ensuring that government budgets are allocated in an equitable way so that the most pressing needs of individuals and groups are satisfied. They are about ensuring that when resources are scarce, the available resources are used to assist those who are least able to provide for themselves.*¹⁶¹

In the context of Viet Nam’s declining resources for HIV, gender-responsive budgeting will not only contribute to substantive gender equality in the response, but make that response more effective and efficient.

In addition, the following areas bear further investigation:

- Whether it makes financial and programmatic sense to link HIV and gender with the health-sector related aspects of the Plan of Action for Gender Equality - assessing this will particularly depend on monitoring the development of health-sector human resources trained in gender under the Plan of Action.
- Gender-responsive budgeting will require more and better (and disaggregated) data.

160. Budlender, Debbie and Hewitt, Guy. 2003. *Engendering Budgets: A Practitioners’ Guide to Understanding and Implementing Gender-responsive Budgets*.

161. Budlender, Debbie and Hewitt, Guy. 2003. *Engendering Budgets: A Practitioners’ Guide to Understanding and Implementing Gender-responsive Budgets*.

RECOMMENDATIONS

Monitoring and evaluation of the epidemic

- Viet Nam must build on existing successes in responding to the epidemic by rectifying the gaps and deficiencies of the HIV data-management system and in the country's policy framework. Areas requiring particular attention are the inaccuracies in available information about the epidemic and an actively discriminating environment for certain vulnerable people (including women and sub-populations such as transgender people)
- Increase the parameters of data collection to better understand the sex/age distribution
- Collect data to better understand marginalized and missing populations, including transgender women, ethnic minority/indigenous women, young women and older women, women who use drugs, and migrant/mobile women
- Increase behavioural data sets to understand the epidemic in Viet Nam more fully – including knowledge, attitude and behaviour studies of women most at risk

Addressing gender inequality

- Systematically mainstream gender into all HIV-related laws and policies, based on sound evidence about Viet Nam's epidemic

- Review the gender programme and related policies to identify opportunities to address issues relating to women's sexual and reproductive rights, gender-based violence and HIV
- Build capacity to address gender and HIV among departmental staff (including in the legal and health sectors) at the national, provincial and district levels
- Add HIV-related indicators that shift the focus from pregnant women to all women in the National Statistical Indicators on Gender Development

Role, involvement and participation of civil society

- Provide technical and financial support to build networks and organizations of women living with HIV, woman most affected by HIV and women in key populations
- Support institutional capacity development through training and mentoring to develop strong, sustainable networks with diverse leadership
- Identify key places where women's voices should be heard and define meaningful participation. It is crucial that women living with HIV, woman most affected by HIV and women from key populations participate in (among others):

- Government/civil society structures responsible for visioning, planning, implementation and review
- The Global Fund Country Coordination Mechanism and other funding platforms
- Clinical and social research that includes women in the processes of design, data collection and analysis and the elaboration of recommendations
- Future Global AIDS Response Progress reporting
- Human rights reporting and accountability processes, such as CEDAW, UPR and CRC
- Build capacity and support mechanisms to ensure that the participation of women and girls is meaningful, strategic and outcomes-based
- Provide increased financing for community systems strengthening, advocacy and capacity development
- Increase the funding pool by identifying new donors specifically to fund gender and HIV strategies and seek specific funding for programmes aimed to improve the empowerment of women
- Work with existing donors (such as the Global Fund, which has recently adopted a new gender strategy) to increase dedicated funding for gender and HIV
- Ensure gender-responsive budgeting for HIV. This will be dependent on the elaboration of a national strategy with clear indicators to monitor and ensure systematic attention to all elements that address women and girls in all their diversity and across programmes
- Strengthen synergies/interlinkages to achieve programme efficiencies, and scale-up services for women from multiple entry points, including by integrating HIV services with those related to gender-based violence and family planning/sexual and reproductive health services. This would mean such services could reach a wider group of women, including women from key populations and others with specific vulnerabilities

Funding

- Once a clear framework to address gender and HIV is in place, increase national capacity in gender analysis to ensure the integration of gender in planning and writing HIV funding proposals, and reporting on results

CHAPTER 4

GENDER AND THE RESPONSE TO HIV: PROGRESS, GAPS AND CHALLENGES

Four key pillars are needed to address the gender dimensions of HIV:

- 1) A strong **prevention** programme that provides targeted information and enables women and girls to protect themselves through increasing their negotiation skills and access to, and knowledge about, prevention tools, such as male and female condoms, and that is linked with
- 2) affordable, accessible, appropriate and holistic access throughout the **treatment, care and support cascade** – that addresses both HIV and related women’s health issues¹⁶²
- 3) **ending stigma and discrimination** within families, the community and society against women and men living with HIV and key populations
- 4) **challenging gender inequality and ensuring women’s rights** through providing solutions to those realities of women’s daily lives that put them at more risk, increase vulnerability and limit their access to services and opportunities. This includes addressing gender-based violence, improving sexual and reproductive health and rights and access to justice, and providing social protection measures.

1. PREVENTION

A comprehensive prevention programme that addresses the needs of women, girls, key populations and the female partners of men who have sex with men and men who inject drugs needs to incorporate at all levels efforts to end stigma and discrimination, and should include:¹⁶³

- Harm reduction that includes at a minimum a comprehensive condom and lubricant programme, a needle and syringe programme and methadone maintenance therapy (MMT)
- Behavioural interventions, including information, education and communication (IEC)
- Access to pre-exposure prophylaxis
- Prevention of mother-to-child transmission (PMTCT) (as this intervention straddles the continuum of prevention and care, it will be discussed below in the section on care and treatment)
- A sexual and reproductive health and rights approach (again, this approach cuts across the continuum of prevention and care; it will be discussed below in the section on challenging gender inequality and promoting women’s rights)
- Appropriate HIV testing and counselling.

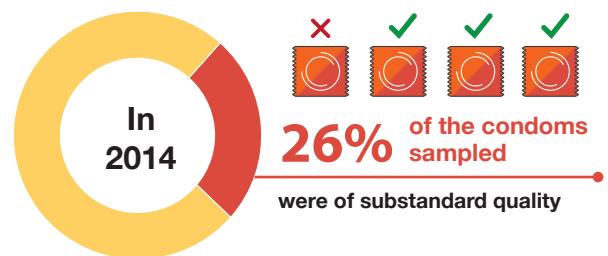
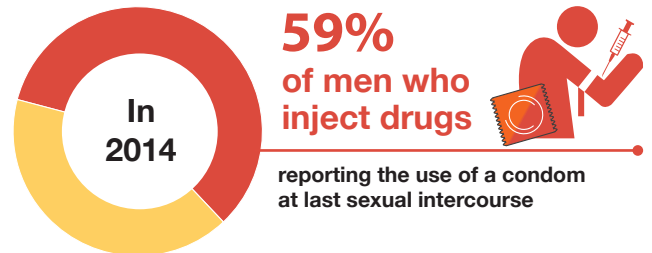
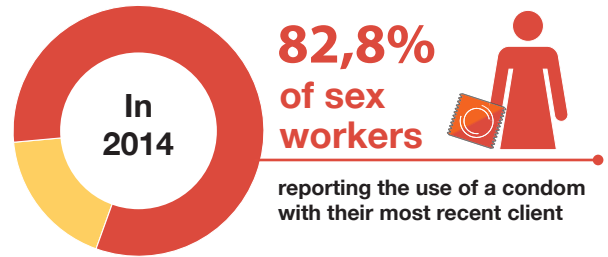
162. Note: For the purposes of this part of the analysis, prevention and care have been separated. However, it should be borne in mind that these services remain to a great extent interdependent, and that gendered impacts affect the whole continuum of prevention and care.

163. Gay, J., Croce-Galis, M., Hardee, K. 2012. *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. www.whatworksforwomen.org Accessed 16 May 2016.

1.1. HARM REDUCTION

1.1.1. COMPREHENSIVE CONDOM AND LUBRICANT PROGRAMME

Following a successful pilot in 2000, Viet Nam has a 100% Condom Use Programme in place, aiming to increase condom use among sex workers. This was bolstered by the Ministry of Culture, Sports and Tourism-approved condom programme aimed at tourism establishments, with a target of making condoms available in 80% of all hotels and guest houses across the country by 2015. By 2013, 14 million free male condoms had been distributed and 32 million had been sold through social marketing. According to the Population Services International, in 2013 alone 8.7 million male and female condoms were sold and circulated to over 4,200 non-traditional outlets accessible to key populations in 9 provinces.¹⁶⁴ Condom use is relatively high amongst female sex workers, with 82.8% of sex workers reporting the use of a condom with their most recent client in 2014.¹⁶⁵ Unfortunately, the HSS+ survey does not currently ask specifically about consistent use of condoms. Condom use among men in key populations is lower, with only 54% of men reporting the use of a condom the last time they had anal sex with a male partner and 59% of men who inject drugs reporting the use of a condom at last sexual intercourse in



2014.¹⁶⁶ This has implications for their female partners.

Access to free condoms is not universal – and many women interviewed and participating in the validation workshop raised this as an issue: condom supply does not meet the needs or demand. This situation will only worsen as funding for the response reduces – for example, one proposed strategy

164. Population Services International (PSI). *Viet Nam: Solutions: HIV*. <http://www.psi.org/country/vietnam/#solutions>. Accessed 16 May 2016. The 9 provinces are a priority for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

165. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Report on the Results of HIV Sentinel Surveillance Plus Among High-risk Populations in Viet Nam in 2014*.

166. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Report on the Results of HIV Sentinel Surveillance Plus Among High-risk Populations in Viet Nam in 2014*.

is only to provide free condoms to street-based sex workers as they are assumed to be most vulnerable. Adolescents face particular challenges in accessing free condoms, and so either purchase them or go without.¹⁶⁷ Furthermore, the quality of condoms available on the free market in Viet Nam is not reliable: a 2014 study showed that 26% of the condoms sampled were of substandard quality.¹⁶⁸ Again, this creates barriers not only for sex workers, but also young women and girls and the female partners of male members of key populations – among others – to being able to protect themselves from HIV.

Social marketing campaigns are therefore an important part of condom distribution, and indeed provide the only source of female condoms, which are not freely available in Viet Nam. There was a general feeling throughout the interviews that female condoms would not be “popular”. However, more than half of the sex workers in a (2000) study on the acceptability of female condoms amongst sex workers in Viet Nam said they would continue to use female condoms if they were provided free of charge, or sold at an affordable price.¹⁶⁹ This is positive, since it is vital that alternatives to male condoms are provided for (all) women (including, but not limited to, sex workers), especially alternatives over which they have more control – and this shows there

is at least a niche market for female condoms that can either be distributed for free or part of social marketing campaigns. In addition, the National Strategy makes reference to microbicides, a positive move that indicates a commitment to providing microbicides once they are available. A viable microbicide would potentially increase (all) women’s ability to both negotiate and practice safer sex.

1.1.2. HARM REDUCTION: NEEDLE AND SYRINGE PROGRAMME AND METHADONE MAINTENANCE THERAPY

Given the high rates of infection amongst people who inject drugs it is critical that relevant harm-reduction programmes are scaled up. Viet Nam’s approach to harm reduction for injecting drug users includes a needle and syringe programme (NSP) – which has over time increased both coverage and the provision of free needle and syringes through the use of peer educators, voluntary counselling and testing (VCT) sites and outpatient clinics – and opioid substitution with methadone maintenance therapy (MMT). The average number of needles and syringes provided through the NSP to people who inject drugs increased from 140 per person in 2011 to 180 in 2012; this was reduced to 98 in 2013, and 76 in 2014.¹⁷⁰ Nevertheless, the

167. Interviews: women from key populations.

168. Crown Agents survey and UNFPA validation workshop <http://www.crownagents.com/news-and-know-how/news-archive/article/2014/04/23/crown-agents-condom-inspections-provide-vital-quality-statistics> Accessed 14 May 2016.

169. UNAIDS (Joint United Nations Programme on HIV/AIDS), SHAPC (STI/HIV/AIDS Prevention Centre), WHO (World Health Organization). 2000. *Needs and Acceptability of Female Condoms among Women in Thanh Xuan Commune and Dong Da District, Hanoi*. <http://www.nzdl.org/gsd/mod?e=d-00000-00---off-0unaids--00-0---0-10-0---0---0direct-10---4-----0-11--11-en-50---20-about---00-0-1-00-0--4----0-0-11-10-0utfZz-8-00-&cl=CL1.7&d=HASH01ad6a64d5c2cdceca417b80.1>=1> Accessed 1 June 2016.

170. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected has slightly increased, from 95.3% in 2011, to 96.4% in 2012, and 97.3% in 2013.¹⁷¹ Evidence from the key informant interviews points to the NSP being less effective, plagued by a lack of funding and insufficiently rolled out. This has implications for all drug users, but for women in particular, who are less likely to be able to access services in any case. In contrast, many of the interviews pointed to the success of the MMT programme; indeed, the discourse revolved less around the NSP and more on MMT provision.

The 2012 Decree on Substitution Treatment for Opioid Dependents simplified administration procedures and increased access to MMT services. As a result, MMT provision has been expanded from 41 sites (6,931 patients) in 2011, to 80 sites in 30 provinces (15,542 patients) in 2013, to 364 sites in 41 provinces (25 223 patients) in 2014. A 2013 WHO-supported VAAC study on the benefits of integrating MMT, HIV testing and counselling, and ART showed that men living with HIV and receiving MMT were more likely to be enrolled in care and to start ART, and have higher retention rates, than men not receiving MMT.¹⁷² Clearly, before such an approach is rolled out for women as well, the impacts for them also need to be studied.

1.2. INFORMATION, EDUCATION AND COMMUNICATION (IEC) AND BEHAVIOUR CHANGE COMMUNICATION (BCC)

Most people interviewed spoke of HIV-related IEC campaigns as widespread and the mainstay of the prevention response. VAAC, Provincial AIDS Centres and the Women's Union are all involved in IEC, which ranges from media campaigns, to materials development and distribution, to the provision of information for both key populations and the general population. No content analysis was done on the IEC materials, so it is unclear whether they are targeted to specific groups and address women's issues and/or the gender dimensions of HIV. However, evidence from the interviews and the validation workshop suggests both that the materials are generic, and that more targeted materials would be more effective. This would be in line with the Law on HIV, which mandates appropriate and targeted IEC that takes into account education level, age, gender and traditions, which is non-discriminatory and does not affect gender equality.¹⁷³ The evidence pointed specifically to a lack of materials (and services in general) for women who use drugs, female sex workers, female students and migrant women.

171. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

172. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

173. Socialist Republic of Viet Nam. 2006. *Law on HIV/AIDS Prevention and Control*.

Behaviour change communication is carried out through training, counselling, hotlines, various types of edutainment and peer education – although it became clear in the interviews that the reduction in funding is severely hampering peer education alongside other prevention programmes. It is focused on migrants and mobile populations, ethnic minorities, youth and prisoners, and different ministries are involved in providing BCC programmes and campaigns to these different target groups. Again, it is unclear how gender-sensitive or gender-transformatory such campaigns are, but it is essential that gender is a consideration in their content, and that women and girls are targeted separately and in ways that ensure their participation.

1.3. VOLUNTARY COUNSELLING AND TESTING (VCT)

Access to VCT has been scaled up, from 157 sites providing HIV testing and counselling services in 2005 to 485 sites in 2013.¹⁷⁴ However, there has also been a decrease in the number of people actually receiving these services, as well as considerable provincial variations in service uptake.¹⁷⁵ These challenges clearly need to be addressed through BCC and IEC campaigns. In addition, the data on HIV testing among people outside the key populations of female sex workers, men who have sex with men and people who inject drugs are incomplete.

This assessment did not explore the counselling provided, or whether counsellors have been trained in gender-related issues. It is therefore unclear whether counsellors are able to address the particular issues facing women who undergo HIV testing, especially those who received a positive result. While HIV counselling can also provide valuable entry points for women to discuss issues such as domestic and gender-based violence, counsellors do need specific and relevant training.

The 2014 Stigma Index revealed concerns about the quality and confidentiality of health care: 60.1% of the respondents living with HIV reported not having been able to discuss their treatment with a health care worker.¹⁷⁶ Service delivery can also be unfriendly, and sometimes unethical. Of particular concern is the fact that 3.1% of the respondents (and 5.6% of respondents who inject drugs and 7.7% of recently diagnosed respondents) said that they were coerced into testing, while 7.6% of all respondents were tested without their knowledge. There are also very high rates of disclosure to others without the consent of the person involved, with over one-third of all respondents (37.5%) and nearly half of respondents who inject drugs (45.3%) reporting this. The Stigma Index indicated that high levels of stigma and discrimination, combined with low confidence in the confidentiality of HIV testing, mean that many people living with HIV only seek an HIV test after they become ill, which is

174. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

175. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

176. VNP+ (Viet Nam Network of People Living with HIV). 2015. *People Living with HIV Stigma Index 2014*.

generally several years after infection. This results in very late initiation of treatment, which is dangerous for the health of the person, and reduces the preventive benefits of antiretroviral therapy.

Concerns about the quality of health care were echoed by women living with HIV in interviews and at the validation meeting, who shared their often negative experiences at the clinics. Such experiences have a direct influence on future health-seeking behaviours, as they undermine women's confidence in settings that should be safe spaces.

2. TREATMENT, CARE AND SUPPORT

A gendered approach needs to be applied throughout the continuum of treatment, care and support, and should address the following issues:

- Access – understanding that women's lived realities are different from men, they have different health-seeking behaviours and different barriers to overcome, including financial and time constraints and the impacts of stigma and discrimination.
- Drug regimens and dosage – women often experience different side effects from men which may impact on wellness, self-esteem and sexuality, among other things.
- Opportunistic infections – women have different patterns of such infections; for example, women living with HIV are at increased risk of cervical cancer.
- Access to palliative care – there is evidence of gender differences in experiences of pain and responses to pain management. Palliative care may be needed at various stages along the continuum, from HIV diagnosis to end-of-life pain management.
- Women as caregivers – women's traditional roles as family caregivers often means that they are less likely to access care and support themselves, and are often unable to undertake paid work in addition to these caregiving duties.

2.1. ACCESS TO ANTIRETROVIRAL THERAPY (ART)

Viet Nam has gone a long way in increasing access to ART: by the end of 2014, 93,298 adults and children (60,435 male and 32,863 female) were receiving ART at 302 sites nationwide. Viet Nam also undertook a 2012 pilot of the UNAIDS/WHO "Treatment 2.0" approach – which aims to expand earlier access to ART, and promote the sustainability of HIV treatment, by integrating related services into primary health care systems – and is now rolling it out, which will further increase the number of people on treatment. Unfortunately, as elsewhere in the response, these gains may be under threat due to funding constraints.

There are also long-standing differences in the coverage and use of health services between regions, rural and urban populations, and ethnic groups. According to recent research,

inequities and resultant disparities in use of services and health outcomes continue to persist and even widen, particularly among ethnic minorities in hard-to-reach, remote and/or mountainous areas.¹⁷⁷ Meanwhile, HIV prevalence is increasing in such areas, where people's access to transportation, information about HIV and AIDS, and HIV-related services, including ART, are limited. Such difficulties – and uptake of ART – are certainly compounded for women, but again the data on women who are neither pregnant nor engaging in sex work are very limited.

Access to ART is not the only issue: understanding and addressing the health-related quality of life (HRQL) outcomes of HIV-related treatment is also important. One study that assessed the predictors of HRQL in Viet Nam found significant gender differences in these predictors among men and women who were ART patients. Men were found to be better off than women in terms of morbidity, environment and psychological dimensions. Women who had a child experienced reductions in quality of life in terms of the social support, psychological, environment and performance dimensions. Findings such as this highlight the need to develop comprehensive interventions for people

living with HIV, that include not only gender-appropriate treatment but also strategies to mitigate the gendered impacts of treatment.¹⁷⁸

The ART programme must therefore be strengthened by closer attention to the different health-seeking behaviours of men and women, and relevant subpopulations (including ethnic minority, migrant, mobile and young women). It must address the ways in which women's multiple reproductive, productive and community roles, as well as structural barriers such as lack of education, income and ability to engage outside the household, hamper access to treatment and their quality of life.

Free CD4 counts and viral load tests are a crucial element of the management of people on ART. Many women interviewed highlighted a lack of funding as an additional major barrier to these services, a situation that needs to be resolved.

Finally, despite growing concerns about intimate partner transmission, concrete efforts (including targets and specific programming) to implement treatment-as-prevention for the intimate partners of members of key populations have not yet been made.

177. CEMA (Committee for Ethnic Minority Affairs), MDRI (Mekong Development Research Institute) and UNDP (United Nations Development Programme). 2015. *Ethnic Minority Poverty: What can be learnt from the success and failure cases?*

178. Tran, B.X, Ohinmaa, A., Nguyen, L.T., Ossterhoff, P., Vu, P.X., Larsson, M. 2012. "Gender differences in quality of life outcomes of HIV/AIDS treatment in the latent feminization of HIV epidemics in Vietnam". *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV* 2012;24(10):1187-96. doi: 10.1080/09540121.2012.658752. Epub.

2.2. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT)

PMTCT is being analysed as part of the treatment, care and support continuum to emphasize the need to view the programme beyond its preventive function. This will enable a more holistic approach that takes into account the health and wellbeing of the mother, and not just the prevention of HIV transmission to the child.

Unsurprisingly, given Viet Nam's strategic focus on PMTCT, and the prioritization of pregnant women (and future mothers), testing coverage for pregnant women had increased to 49.7%, and 56.5% of pregnant women living with HIV received ARV prophylaxis for PMTCT, in 2013.¹⁷⁹ By 2014, 1,733 pregnant women living with HIV had received such prophylaxis in the previous 12 months, while a total of 1,864 infants received ART.¹⁸⁰ In addition, in order to increase access and offer a more holistic approach, PMTCT has been integrated into reproductive health services, with decentralized testing for pregnant women falling within the National Strategy on Population and Reproductive Health 2011-2020. A similar strategy within the National Action Plan on Maternal Health has unfortunately not been implemented in

its entirety due to funding constraints. A pilot programme for the provision of Option B+ (early ART initiation for pregnant women) in 6 districts was introduced in 2014.

It should be noted here again that an exclusive focus on PMTCT, in the absence of other detailed programmes and services for women, tends to focus more on saving children than women. It also fails to challenge gender stereotypes that entrench women as mothers and place more value on their reproductive role, and also fails to help women who are not pregnant or who are not of 'reproductive age. Where such women are living with HIV, they too need access to the full continuum of treatment, care and support services.

In addition, research points to the involvement of men in PMTCT as critically important, both in challenging gender stereotypes about women's reproductive and caring roles and in increasing adherence and providing better outcomes for both women and children.¹⁸¹ Although the National Strategy does include an IEC/BCC activity for men on their "role in the community" as part of PMTCT activities, there is no clear strategy for engaging men in PMTCT, a situation which needs to be improved alongside broader changes in the gender stereotypes portrayed in the media and in educational settings.

179. 49.7% of pregnant women tested for HIV and knew their results. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

180. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Decision 28 Routine report*.

181. See, for example: Aluiso A et al. 2011. "Male antenatal attendance and HIV testing are associated with decreased infant HIV infection and increased HIV-free survival." *Journal of Acquired Immune Deficiency Syndrome* 56(1): 76-82. Summary at: <http://www.aidsmap.com/Male-partner-involvement-in-PMTCT-reduces-HIV-transmission-risk/page/1581480/> Accessed 21 May 2016.

2.3. TREATMENT OF OPPORTUNISTIC INFECTIONS

Accessing information on gendered differences in reported opportunistic infections (and their treatment) proved difficult. Although data on patterns of morbidity and mortality that may highlight issues around cervical cancer and other gendered differences may well exist, these were not known among the people interviewed, including those providing clinical services. This lack of knowledge and/or information is certainly linked to the lack of connections between HIV and sexual and reproductive health services: although there are plans to improve these, there is currently little action. Further investigation into such gendered differences, and the implementation of the National Strategy plan to integrate these services, are needed.

Meanwhile, although the majority of people living with HIV have access to ART, the same cannot be said for the treatment of opportunistic infections.¹⁸² It is clear that great effort is placed on improving access to ART, but that other treatment issues are less developed. Indeed, treatment for opportunistic infections (especially more severe ones) is not even available at outpatient clinics providing HIV services and ART, so patients are required to move into the general health sector. This is not only inconvenient and expensive, but may increase stigma and discrimination through disclosure of status and a lack of understanding from health staff. The issue of affordability

of treatment for opportunistic infections was raised in the focus groups and at the validation meeting by women living with HIV.

A key issue for women living with HIV is the increased risk of cervical cancer, particularly among women with low CD4 counts. As cervical cancer is one of the most prevalent reproductive cancers affecting women in Viet Nam, it was a key issue in the National Strategy on Population and Reproductive Health for 2011-2020. However, screening for cervical cancer has not been widely carried out because a detailed implementation plan was not developed, nor were the necessary resources allocated. It remains unclear whether there is free access to cervical screening, free treatment for sexually transmitted infections (STIs) – some sex workers reported paying for treatment – or other free treatments, although according to one key informant, pap smears are freely available to women over the age of 40. There should be further investigation into revising guidelines on the prevention and treatment of cervical cancer specifically for women living with HIV – and diagnostic services should be offered to women living with HIV before the age of 40.

Without addressing the whole continuum of treatment, care and support of patients (and especially women) living with HIV, the effort and resources devoted to increasing access to ART will be far less effective. Careful monitoring, regular testing of CD4 counts and quick and aggressive management of both side-effects and opportunistic infections are

182. VAAC (Viet Nam Authority of HIV/AIDS Control). 2014. *Vietnam AIDS Response Progress Report 2014*.

all vital to maintaining or increasing quality of life. The effective management of HIV also requires more data on the gendered health considerations people living with HIV, and more follow-up of patients once they are in the system.

Women and girls: the burden of care

*Even when drugs are free, and where treatment and care are free, access continues to be limited by the time and energy women need to spend on caring responsibilities, on lack of money for transportation (particularly severe for the women who are financially dependent on men) and by the power imbalances in the household. Treatment can ameliorate the drain on women's caring roles, but it cannot be effective if the serious obstacles raised by gender inequality are ignored.*¹⁸³

A key issue related to the continuum of HIV-related treatment, care and support is that of women as carers – in the household as well as in the formal and informal sectors. However, the scarcity of national information and data on the role of women and girls as carers in Viet Nam is in inverse proportion to the amount of international evidence that “health systems rely heavily on women’s

contributions, both paid and unpaid” and that “[f]emale health workers are more likely to be unpaid or underpaid than men”.¹⁸⁴ Undertaking unpaid or underpaid care work means that women have less time to engage in paid work, to network, to participate in activities for change, or even to rest or take care of their own health. This “women’s time poverty” undermines well-being, generates insecurities, fosters financial dependence and limits options for decent work, even to the point of restricting women to low-status, part-time jobs in the informal sector.¹⁸⁵

In the context of HIV, women’s care burdens interfere with their ability to care for themselves and access treatment if they are sick or living with HIV; to access prevention services to protect themselves; and to access opportunities outside the household, such as education or employment, that support their efforts to access HIV services (among other things). Globally, HIV and AIDS have greatly increased the burdens of care work on women and girls, with up to 90% of home care created by illness provided by them.¹⁸⁶ Looking after people living with HIV who fall sick does not merely create health-care related work, but also additional housework and “health-promotion” activities – cooking, cleaning, laundry and

183. Commission on Women and Health. 2015. “Women and Health: the key for sustainable development”. The Lancet. Volume 386, No. 9999, p1165–1210, 19 September 2015.

184. Commission on Women and Health. 2015. www.womenandhealthcommission.org Accessed 17 May 2016.

185. Sida (Swedish International Development Agency). 2012. *Quick Guide to What and How: Unpaid Care Work – Entry Points to Recognise, Reduce and Redistribute*. http://www.sida.se/English/publications/Publication_database/publications-by-year1/2012/november/quick-guide-to-what-and-how-unpaid-care-work/ Accessed 17 May 2016.

186. Sida (Swedish International Development Agency). 2012. *Quick Guide to What and How: Unpaid Care Work – Entry Points to Recognise, Reduce and Redistribute*. http://www.sida.se/English/publications/Publication_database/publications-by-year1/2012/november/quick-guide-to-what-and-how-unpaid-care-work/ Accessed 17 May 2016.

so on – which multiply women and girls’ already strenuous tasks in the home. Care work in the home can also cause isolation, burnout and a range of health problems, but women seek help less frequently than men and wait longer to seek such help.¹⁸⁷ The 2016 United Nations General Assembly Political Declaration on HIV notes the deep concern that “globally, women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the caregiving burden” and includes a number of related recommendations, including the strengthening by United Nations Member States of HIV-sensitive social protection mechanisms that may serve to alleviate this burden.¹⁸⁸

In Viet Nam, as elsewhere, traditional gender roles mean that it is assumed that women (and girls) will play a major role in the provision of home-based care for their partners, children and other family members (including parents and siblings) affected by HIV. In Viet Nam, too, the impacts of an increased HIV-related care burden may be multiplied by the many additional factors that already disempower women and affect their ability to care for themselves and

their families, such as poverty; precarious employment; stigmatized behaviours such as drug use or sex work; and ethnicity (among others). This is particularly true of access to health care: women whose access is already limited may find it further constrained by their own burden of care.

The lack of existing evidence that the above is already happening is another instance of the links between gender and HIV that have yet to be made in Viet Nam. For example, there is literature on women’s burden of housework and childcare, particularly in relation to their participation in the work force (where they have to assume a ‘double burden’ of formal and housework), the need for men to take on more of this burden and the conflict of this with the social expectation that it is women’s work.¹⁸⁹ There is also acknowledgement that:

[t]he majority of women work as unpaid family workers, and in largely “invisible” areas of informal employment ... society assigns both a lower status and most of the unpaid care work to Vietnamese women, and expects them to engage in productive work in subsistence agriculture and the market economy.¹⁹⁰

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187. Commission on Women and Health. 2015. “Women and Health: the key for sustainable development”. *The Lancet*. Volume 386, No. 9999, p1165–1210, 19 September 2015.
188. United Nations General Assembly. 2016. *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*. A/70/L.52.
189. Ngoc Vo, Anne and Strachan, Glenda. 2008. *Gender equity in a transforming economy*. http://www98.griffith.edu.au/dspace/bitstream/handle/10072/24285/52797_1.pdf?sequence=1 Accessed 22 May 2016.
190. ILO (International Labour Organization). *Areas of work: Equality and discrimination in Viet Nam*. <http://www.ilo.org/hanoi/Areasofwork/equality-and-discrimination/lang--en/index.htm> Accessed 22 May 2016.

However, the additional burden for women of caring for sick family members is rarely visible, and neither is the housework/ childcare/home-based care burden in the context of HIV addressed. The specific role of women formally working in Viet Nam's health care system is also invisible.

Similarly, the impacts of the HIV epidemic on the care burden of grandmothers have been well documented (in South Africa, for example), but not in Viet Nam. This is despite the fact that research has been conducted in Viet Nam on “the effects of high levels of migration of working-age parents on resource-constrained grandmothers who typically take on the care of their grandchildren” – including high levels of time (and resource) poverty¹⁹¹ – and that the interviews for this assessment showed that grandparents may take custody of children away from their HIV-positive mothers, or that women living with HIV return home to live with their own mothers. The study on childcare also showed that girls are affected by increased care burdens:

“Because my parents are old, nobody cares for the family... only my 12-year-old sister doesn't go to school... my parents have so many children, some of my siblings are too young, at the

same time all other siblings go to school, no one is there to help my parents except her.”¹⁹²

At the same time, female health care workers working in the formal health care system also contribute disproportionately to national health systems, including HIV-related services. However, they are often undervalued and unsupported, with lower-skilled and lower-paid jobs than men. They are rarely represented in higher-level positions and often exposed to gender-related occupational health risks. Such undervaluing and lack of support may be particularly acute among community health workers, who are essential to responses to HIV (including in Viet Nam) but experience gender-based discrimination, low wages, low status, unsatisfactory working conditions and a lack of training. They may also encounter difficulties with being recognized by and interacting with more formal aspects of the health sector. A key issue is that:

The most vulnerable women typically receive care from the most disenfranchised members of the health system, leading to ill health and perpetuation of inequities among population groups.¹⁹³

191. Samman, Emma et al. 2016. *Women's work: Mothers, children and the global childcare crisis*. <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/10333.pdf> Accessed 22 May 2016.

192. Samman, Emma et al. 2016. *Women's work: Mothers, children and the global childcare crisis*. <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/10333.pdf> Accessed 22 May 2016.

193. Commission on Women and Health. 2015. “Women and Health: the key for sustainable development”. *The Lancet*. Volume 386, No. 9999, p1165–1210, 19 September 2015.

Women and girls' care work will be an important area for research moving forward, especially since the National Strategy increasingly focuses on the role of the "community" and "family" in care and treatment – with the implicit assumption that this role will be undertaken (mainly, and probably informally) by women. Firstly, as the realities of women and girls' care burdens are currently excluded from the data informing policymaking, further research will be required. It will also be important to acknowledge that "the paid and unpaid health-care-related duties that women undertake in health systems and in their homes and communities ... are a hidden subsidy to health systems and societies".¹⁹⁴ In addition, it is essential to estimate the value of women's paid and unpaid contributions to health care and recompense their invisible subsidy to health systems and societies, and to ensure that men and women receive equal compensation for equal work in health and other sectors.¹⁹⁵ Finally, gendered norms and inequalities in power in the household must be addressed to disassociate the concept of 'care' from femininity.

In this context, the Recognition, Reduction, and Redistribution framework elaborated by Diane Elson may be of use. It can contribute to addressing the burden by strengthening women as economic actors, while acknowledging that an adequate level of care and other social reproduction activities

are essential for the well-being of society and the sustainability of human development. It relies on:

- Making the contribution of carers visible, in part by increasing quantitative and qualitative information on the care burden (recognition)
- Reducing unpaid work, including unpaid care work, to free time for women to engage in formal jobs and/or social and political activities and/or health-seeking behaviours (and ensuring that this time is not consumed by other forms of unpaid work or care work), by supporting investments in time and labour-saving infrastructure, technologies and practices and reducing legal and economic barriers to women's access to the formal labour market (reduction)
- Establishing a framework for redistributing responsibilities, time and resources more equally between women and men, government, the private sector, communities and households, including through policies and laws that support families; ending discriminatory legislation; and challenging the gender norms that place care burdens on women and girls' shoulders (including by engaging with men and boys) (redistribution).

194. Commission on Women and Health. 2015. "Women and Health: the key for sustainable development". *The Lancet*. Volume 386, No. 9999, p1165–1210, 19 September 2015.

195. Commission on Women and Health. 2015. "Women and Health: the key for sustainable development". *The Lancet*. Volume 386, No. 9999, p1165–1210, 19 September 2015.

3. STIGMA AND DISCRIMINATION

As with most aspects of the HIV response, gender inequality impacts on how stigma and discrimination are experienced: men and women experience stigma and discrimination differently. Stigma is evident in and impacts on all levels of the continuum of prevention and care, as well as family, society, education and the world of work. Stigma invokes powerful psychological feelings in people living with HIV, including how people view themselves (internalized or self-stigma) and prevents them from accessing HIV-related and other services to which they are entitled, and which they need. For example, many women living with HIV have internalized and absorbed from broader society the belief that it is ‘wrong’ for them to want to have children. Women living with HIV not only experience stigma and discrimination, but also fear being stigmatized or discriminated against (including within the health care system). This, combined with a fear of criminal sanctions (such as for sex work or drug use) and/or violence, impacts on the health-seeking behaviours of women (and men), who may choose to avoid or delay a visit to the clinic or hospital; pay extra to visit private health care providers (as mentioned in the interviews); or decline to reveal their status, even to intimate partners. Again, different sub-groups of women (and men) experience stigma

and discrimination differently: not all groups of people are dealt with in the same way, and many have different levels of access to prevention, treatment and care services.¹⁹⁶ Sex workers, drug users, mothers, intimate partners of men in key populations – and women who are some or all of these – will have different experiences and needs.

Both government and civil society interviewees spoke of the high levels of stigma and discrimination as a key barrier to addressing HIV in Viet Nam. There is high-level recognition of the problem: the CEDAW Committee recommends strengthening the “enforcement of the Law on HIV ... to address stigma and discrimination against women living with HIV”.¹⁹⁷ The National Strategy also states that a coherent legal and policy environment must “[a]ddress the issue of stigma and discrimination and ensure gender equity for people living with HIV in accessing social services” – although it makes no mention of the different levels and kinds of stigma and discrimination experienced by women and key populations.¹⁹⁸

Thanks to Viet Nam’s People Living with HIV Stigma Index, there is some differentiated data available in the area of stigma and discrimination against people living with HIV and the complexities of layered stigma and self-stigma are better understood. Two iterations of the Stigma Index have been completed, in 2011 and 2014, which have

196. Tallis, V.A. 2012. *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability*.

197. UN CEDAW (United Nations Committee on the Elimination of Discrimination Against Women). 2015. *Concluding observations on the combined seventh and eighth periodic reports of Viet Nam*. CEDAW/C/VNM/CO/7-8.

198. National Committee for AIDS, Drug and Prostitution Prevention and Control. 2011. *National Strategy on HIV/AIDS Prevention and Control until 2020 (Fifth draft)*.

showed some positive change over time, with the overall reduction in rights violations. In 2014, 10.6% fewer people living with HIV – as well as 25.5% fewer female sex workers and 8.5% fewer people who inject drugs – reported having experienced rights violations within the 12 months prior to the survey date.¹⁹⁹ However, the 2014 Stigma Index also notes that:

Despite these positive results, the data also show that the incidence of many types of stigma and discrimination remains unacceptably high, and particularly so for [people living with HIV] who also engage in transactional sex, injecting drug use and same-sex relationships. These results are in line with other recent findings on stigma and discrimination in Viet Nam ... [female sex workers], other women living with HIV and [people who inject drugs] were most likely to have experienced violations of their rights as [people living with HIV].²⁰⁰

Despite the improvements in the framework on sex work (see above), there are also still reports of periodic anti-sex-work crackdowns

by the police which have an adverse impact on HIV prevention and treatment initiatives.²⁰¹

The Stigma Index, the CEDAW Committee and estimations and projections 2011-2015 also highlight a particularly high level of stigma and discrimination in health care settings, which was also mentioned frequently in the interviews and validation meeting.²⁰² This takes many forms, including forced testing, lack of confidentiality, mistreatment by health staff, and forced sterilization.

Finally, the 2014 Stigma Index recorded increasing and high rates of non-disclosure of HIV status to spouses or partners – confirming the findings of the 2012 Intimate Partner Transmission study,²⁰³ and putting these partners at higher risk of HIV transmission:

...among recently diagnosed [people living with HIV], 63.7% of those interviewed in 2014 had not disclosed their status to their husband/wife/partner compared to 38% of those interviewed in 2011.²⁰⁴

Such non-disclosure can be directly linked to the fear of stigma and discrimination.

199. VNP+ (Viet Nam Network of People Living with HIV). 2015. *People Living with HIV Stigma Index 2014*.

200. VNP+ (Viet Nam Network of People Living with HIV). 2015. *People Living with HIV Stigma Index 2014*.

201. Interviews, focus-group discussions.

202. VNP+ (Viet Nam Network of People Living with HIV). 2015. *People Living with HIV Stigma Index 2014*; UN CEDAW (United Nations Committee on the Elimination of Discrimination Against Women). 2015. *Concluding observations on the combined seventh and eighth periodic reports of Viet Nam*. CEDAW/C/VNM/CO/7-8.

203. UNAIDS (Joint United Nations Programme on HIV/AIDS) and UN Women (United Nations Entity for Gender Equality and the Empowerment of Women). 2012. *Measuring Intimate Partner Transmission of HIV in Viet Nam: A Data Triangulation Exercise*.

204. VNP+ (Viet Nam Network of People Living with HIV). 2015. *People Living with HIV Stigma Index 2014*.

It is crucial to address the reality that women living with HIV (and women living with HIV who are sex workers, injecting drug users and/or transgender women) are bearing the brunt of human rights violations in different settings. Issues raised by respondents in the Stigma Index included: low quality of care for people living with HIV; coerced or forced testing; being tested without being informed; and stigma from the family and community. Sex workers and men and women who use drugs, men who have sex with men and transgender men and women who are living with HIV are often subject to double (or multiple) stigma, affecting their ability to access HIV services and their own mental and physical health.

4. CHALLENGING GENDER INEQUALITY AND ENSURING WOMEN'S RIGHTS

As gender inequality is at the root of women and girls' vulnerability to HIV, gender-transformative approaches are critical in tackling women's inferior position in intimate relationships, the household, family, community and society. They are essential to challenging the gender/social norms that mean that women are unable to protect themselves from HIV infection, and that women living with HIV experience greater stigma and discrimination and barriers to services, and are more marginalized and often invisible in the response.

Despite growing awareness in Viet Nam of the interface between gender and HIV, the response remains mainly bio-medical and does not yet include addressing gender inequality and unequal power relations as a way to reduce HIV infections and mitigate AIDS. For long-term change and progress, the response needs to be broadened to encompass more structural interventions that improve women's position and gender norms by addressing gender-based violence, sexual and reproductive health, social protection and access to justice.

4.1. GENDER-BASED VIOLENCE

One of the most serious results of gendered relations of power is male violence against women and girls of all ages, which is pervasive in all societies including Viet Nam, and has serious implications for women's ability to protect themselves from HIV infection (see above).

The Law on the Prevention and Control of Domestic Violence (2007) specifies regulations on the prevention of domestic violence; the provision of protection and support to victims of domestic violence; the responsibility of individuals, families, agencies and organizations in the prevention of domestic violence; and the handling of law violations. However, there is no definition of, or law pertaining to, gender-based violence more broadly. This needs urgently to be addressed to strengthen and broaden the response to GBV (and to HIV).²⁰⁵ Compounding this gap in the law is a lack of coordination mechanism to address gender-

205 UN Women (United Nations Entity for Gender Equality and the Empowerment of Women) and UNODC (United Nations Office on Drugs and Crime). 2015. *Joint Recommendations on the draft amended Penal Code for strengthening effective response to violence against women*. CEDAW shadow report.

based violence. While the Ministry of Culture, Sports and Tourism is in charge of domestic violence, the Ministry of Public Security is in charge of trafficking in persons, the General Office for Population and Family Planning is in charge of child marriage, and the Ministry for Labour, Invalids and Social Affairs is responsible for gender equality and gender-driven acts of violence. Nor is gender-based violence a meaningful component of the HIV response: for example, while there is brief mention of pre-exposure prophylaxis for key populations in the National Work Plan on HIV/AIDS Prevention and Control 2016-2020, post-exposure prophylaxis for victims of sexual violence is not included.²⁰⁶

In addition, despite the Law, domestic violence is considered a norm, and is rarely reported due to gender stereotyping, moral traditions and an emphasis on the maintenance of family harmony (including in national legislation) and a cumbersome legal process that has an extremely low rate of conviction.²⁰⁷ According to UN Women and UNODC, only 43% of domestic violence cases disclosed in one study had

come to the attention of the police; only 12% of reported cases resulted in criminal charges; and only 1% of reported cases led to conviction.²⁰⁸ Rape is even more hidden due to high levels of taboo and shame, with low disclosure and reporting rates linked to ideas of family honour, kinship and social belonging,²⁰⁹ as well as gender stereotypes and victim-blaming. There is discomfort in either acknowledging or talking about rape, and it is not part of the national discourse on gender-based violence. Clearly more research needs to be done. Femicide is not referred to in the literature but the CEDAW shadow report notes that in Viet Nam, one woman dies every three days as a result of domestic violence.²¹⁰

The links between gender-based violence and HIV are not well-known or documented in Viet Nam, which affects the provision of care. Women seeking services for gender-based violence-related injuries are rarely offered HIV testing, and women living with HIV seeking treatment care and support services are not screened for gender-based violence.²¹¹ Similarly, while interviewees from the Viet Nam Women's Union mentioned their role in

206. Ministry of Health. 2015. *National Work Plan on HIV/AIDS Prevention and Control 2016-2020*.

207. UN Women (United Nations Entity for Gender Equality and the Empowerment of Women) and UNODC (United Nations Office on Drugs and Crime). 2015. *Joint Recommendations on the draft amended Penal Code for strengthening effective response to violence against women*. CEDAW shadow report.

208. UN Women (United Nations Entity for Gender Equality and the Empowerment of Women) and UNODC (United Nations Office on Drugs and Crime). 2013. *Assessment of the Situation of Women in the Criminal Justice System in Viet Nam: In support of the Government's efforts towards Effective Gender Equality in the Criminal Justice System*; and UNODC (United Nations Office on Drugs and Crime), Research Centre for Gender and Development in Ha Noi and HEUNI (the European Institute for Crime Prevention and Control). 2011. *Research on the Quality of Criminal Justice Services available to Victims of Domestic Violence in Viet Nam*". Working paper.

209. Nguyen Thu Huong. 2012. "Rape disclosure: the interplay of gender, culture and kinship in contemporary Vietnam". *Culture, Health & Sexuality An International Journal for Research, Intervention and Care*. ISSN: 1369-1058 (Print) 1464-5351 (Online) Journal homepage: <http://www.tandfonline.com/loi/tchs20> Accessed 21 May 2016.

210. Vietnam Committee on Human Rights (VCHR) and International Federation of Human Rights (FIDH), June 2015, *Alternative Report to the Committee on the Elimination of Discrimination against Women (CEDAW) on the combined seventh and eighth periodic reports of Vietnam*.

211. Spratt, Kai and Quach Thi Thu Trang. 2012. *USAID AIDSTAR-One Case Study Series – Public Sector Response to Gender-based Violence in Vietnam*.

providing safe houses for women and children victims of trafficking and domestic violence through the Peace House project, it is not clear whether women living with HIV use these services.

In order for gender-based violence to be properly addressed, the followings are needed:²¹²

- Address the root causes of gender oppression that fuel gender-based violence and the disproportionate impact of HIV.
- Advance the policy and legal framework and increase access to justice.
- Improve services by promoting and broadening the sexual and reproductive rights and health framework.

4.2. SEXUAL AND REPRODUCTIVE RIGHTS

Women's access to sexual and reproductive health and rights is central to all four pillars of a gendered response to HIV. In Viet Nam, sexual and reproductive health issues are addressed by family planning and

reproductive health services. There have been some notable successes, with around two-thirds of the considerable decline in maternal mortality between 1990 and 2009 attributable to safer pregnancy.²¹³ In 2012, progress had also been made in: expanding access to quality reproductive health, including maternal and neonatal health; family planning; establishing stronger programmes, policies and laws on reproductive health and rights; and developing measures to provide quality services to the poor and other vulnerable groups.²¹⁴ By 2014, according to the government, contraceptive prevalence among women had reached 75.7% nationwide, and the adolescent birth rate had fallen.²¹⁵ Most women had access to antenatal care during pregnancy, with 95.8% pregnant women having at least one antenatal appointment and 73.7% having at least four.²¹⁶ These achievements can be attributed to programmes focusing on improving the quality of birth attendants through training, improving health-centre infrastructure and expanding communication campaigns.²¹⁷

However, progress has slowed significantly in recent years.²¹⁸ As we have already seen, serious challenges remain to ensuring the sexual and reproductive health and rights of women, including women living with HIV

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212. UNAIDS (Joint United Nations Programme on HIV/AIDS). 2013. *Gender-based Violence, HIV and the Post-2015 Framework*. [UNAIDS and U.S. Government High-Level Consultation. Discussion Paper].
213. United Nations in Viet Nam. 2012. *Achieving the MDGs with Equity – MDG 5: Improve Maternal Health*. http://www.un.org.vn/images/stories/MDGs/2012/MDG_5.pdf Accessed 21 May 2016.
214. United Nations in Viet Nam. 2012. *Achieving the MDGs with Equity – MDG 5: Improve Maternal Health*. http://www.un.org.v/images/stories/MDGs/2012/MDG_5.pdf Accessed 21 May 2016.
215. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.
216. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.
217. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.
218. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals*.

and women from key populations – and particularly those who are young, poor and/or from an ethnic minority.

In addition, HIV programming has paid little attention to the sexual and reproductive health decision-making of women living with HIV. As a 2012 study noted, there is also a disconnect between the reproductive desires and needs of women living with HIV and what is medically possible and available in Viet Nam, as well as the advice given by health care providers. Viet Nam does have a good range of facilities, and is able to provide holistic sexual and reproductive services – but only for some women, and not for women living with HIV. Of equal concern is poor and even misinformed advice: over 40% of the women living with HIV interviewed for the study reported being advised by health-care workers and family members to abstain from sex. Only 14% of the women interviewed who did not want a child at the time of the study used contraceptive services, and there were reports of pregnant women living with HIV being advised to have an abortion.²¹⁹ Another study of 300 women living with HIV showed that, of all the women who were pregnant at the time of the study, 13% had been advised to have an abortion, of whom 41% had received this advice from healthcare providers.²²⁰ The 2012

Stigma Index also reported that some PLHIV received “inadequate, inaccurate or coercive reproductive health advice”, including “being advised not to have children or to undergo sterilization, or obliged to use contraception” – for example by predicating access to treatment on certain contraceptive choices.²²¹ These data link with other evidence that women (and men) living with HIV experience stigmatizing attitudes from health care workers. Another 2012 study, by the Women of the Asia Pacific Positive Network of people living with HIV, highlighted similar issues on access to services, health care worker attitudes, coercion and other violations in Viet Nam.²²² These concerns have also repeatedly been raised by women living with HIV through CEDAW shadow reporting, and the interviews and validation meeting during this assessment.

4.3. SOCIAL PROTECTION

Discourse and policy around social protection has grown over the past decade, motivated by a desire to reduce residual poverty and vulnerability.²²³ Viet Nam now has an array of social protection programmes in place, including social assistance, social insurance and a range of social services and social equity measures.²²⁴ However, despite progress

219 Messersmith, Lisa J. et al. 2012. “Women living with HIV in Vietnam: desire for children, use of sexual and reproductive health services, and advice from providers.” *Reproductive Health Matters* 2012;20(395).

220. Messersmith, Lisa J. et al. 2012. *Engendering the Care and Treatment response: Addressing the Needs of Women living with HIV in Vietnam: Evaluation Report*.

221. VNP+ (Viet Nam Network of People Living with HIV). 2012. *People Living with HIV Stigma Index 2012*.

222. WAPN+ (Women of the Asia Pacific Network of People Living with HIV). 2012. *Positive and Pregnant: How dare you. A study on access to reproductive and maternal health care for Women Living with HIV in Asia . Findings from six countries: Bangladesh, Cambodia, India, Indonesia, Nepal, Viet Nam*.

223. Socialist Republic of Viet Nam. *Socio-Economic Development Plans (2001-2005, 2006-2010, 2011- 2015)*.

224. Jones, Nicola and Tran Thi Van Anh. 2012. *Background Note: The politics of gender and social protection in Viet Nam: opportunities and challenges for a transformative approach*.

towards development goals for the people of Viet Nam, there remain pockets of poverty and vulnerability in the country. Poverty is not a gender-neutral context, and gender inequality causes women to experience poverty differently. Indeed, in Viet Nam, being a woman and belonging to an ethnic minority are key signifiers of poverty. As we have already seen, while the wage gap between men and women has decreased it still exists, and women have less access to employment than men.²²⁵

The relationship between HIV and poverty is complex. While most people living with HIV are poor, many non-poor people are also living with and/or affected by HIV. However, people living in poverty and with HIV are more vulnerable: they are more likely to become sick, and generally die more quickly, in part due to poverty-related inadequate nutrition and lack of access to appropriate health care. The link between poverty and HIV also serves to fuel stigma and discrimination, which disproportionately impacts both the poor and those living with HIV, and is compounded for those living with both. Poor households are often socially excluded through a lack of financial and other assets, as well as political and social marginalization. This further increases their difficulty in accessing HIV-prevention services and treatment and care for both people and families affected by HIV. Furthermore, the experience of HIV

and AIDS by individuals, households and communities that are poor often intensifies poverty, as it can reduce income-generating opportunities through ill-health or exclusion while simultaneously requiring additional expenditure.²²⁶ All of this means that women – who are more likely to be poor – are more likely to be vulnerable to, and suffer from the impacts of, HIV.

What is available for women and girls? Social insurance schemes (those aiming to protect people's health, livelihoods and well-being against risks and shocks) – which do not target women and girls specifically but can help to protect them – include:

- The Health Care Fund for the Poor, created in 2003 to provide healthcare to the poor, ethnic minorities and the disadvantaged. From 2005, free health services in public facilities were offered to all children under the age of six. In accordance with the new National Health Insurance Law in 2008, all of these services have been incorporated into the social health insurance scheme. This scheme offers free or subsidized health insurance to specific groups such as all children under six, poor people, pensioners and veterans.²²⁷ The Law on Health Insurance was revised in 2014.²²⁸

225. Jones, Nicola and Tran Thi Van Anh. 2012. *Background Note: The politics of gender and social protection in Viet Nam: opportunities and challenges for a transformative approach.*

226. Tallis, V.A. 2012. *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability.*

227. Jones, Nicola and Tran Thi Van Anh. 2012. *Background Note: The politics of gender and social protection in Viet Nam: opportunities and challenges for a transformative approach.*

228. Socialist Republic of Viet Nam. 2014. *Law No. 46/2014/QH13: Amendments to the Law on Health Insurance.*

- Voluntary health insurance was first introduced in 1992, and now covers those not eligible for the Health Care Fund.
- Social welfare services targeting members of marginalized groups in need of special care or those who would otherwise be denied access to basic services due to their particular social characteristics.
- Initiatives and services for children and women who are “victims” of trafficking, domestic violence and abuse.

This issue of social protection was a key feature of interviews with women living with HIV and women from key populations, including female sex workers and women who use drugs. These women spoke particularly of being unable to afford health insurance, and other research (such as that for Viet Nam’s Investment Case) indicates that continued provision of free ART going forward is a real and pressing concern for all people living with HIV.²²⁹ As part of discussions on addressing the sustainability of the response as international funds for HIV decline, the Government is currently investigating coverage of HIV-related treatment and care services by social health insurance. However, there are challenges to this approach: under

the revised Law on Health Insurance, from January 2015 health insurance enrolment must take place on a household basis – meaning that women (and other household members) cannot enroll as individuals. Children up to 6 years old are fully covered, as are adults who work for the government or are retired (having paid for insurance for 20 years), and those working in the formal sector are partially covered (compensatory insurance). This poses challenges for informal workers, such as people who are self-employed or work in the agricultural sector (who account for more than 70 percent of Viet Nam’s total labour force), and for ethnic minority and migrant workers, who are also likely to work in the informal sector. These people are more likely to have inadequate or non-existent social assistance and safety nets, as well as other work benefits/ rights, including affordable quality health care.²³⁰

They are also more likely to be women, who are more frequently found in vulnerable and precarious forms of employment, either as own-account workers or as unpaid family workers.²³¹ The concern raised by women during the interviews was that neither they nor their husbands work in the formal sectors and are not even partially covered by social health insurance. Because of the household insurance enrolment regulation, if these women living with HIV want to access social insurance, they will need to pay 100% for

229. Ministry of Health. 2014. *Optimizing Viet Nam’s HIV Response: An Investment Case*.

230. Socialist Republic of Viet Nam. 2015. *Country Report: 15 Years Achieving the Viet Nam Development Goals and United Nations in Viet Nam. Our Voices, Our Future: Consolidated Report on Viet Nam’s Post-2015 Consultation Process*.

231. GSO (General Statistics Office of Viet Nam). 2015. *Report on Labour Force Survey 2014*.

themselves and their husbands, and for any children over six, which creates a huge financial burden.

In 2014, the Committee on Economic, Social and Cultural Rights highlighted that:

In spite of the progress achieved in expanding enrolment in health insurance, its low coverage among workers in the informal economy as well as the co-payment requirement impedes access to health care among disadvantaged and marginalized groups.

and noted:

*The limited availability of quality health-care services, particularly in remote areas ... [and] ... the health protection divide in the society and the adverse impact of privatization on the affordability of health care.*²³²

4.4. ACCESS TO JUSTICE

As we have seen, Viet Nam does have legislation that protects the rights and legal interests of people living with HIV, notably the 2006 Law on HIV/AIDS Prevention and Control. However, the implementation of the Law on HIV remains weak due to “late introduction of developed policies to commune authorities, law enforcement agencies and the community, and a limited understanding of HIV-related policies among

those who implement them.”²³³ Specific factors constraining enforcement of both the Law on HIV and related regulations include:

- A lack of knowledge about the Law among law-enforcement officers; limited knowledge about Decree 69 (on administrative sanctions for discrimination among people at the commune level, or in health facilities and enterprises).
- A lack of mechanisms enabling civil society organizations to provide feedback to government on whether the laws are enforced.
- very weak mechanisms for law enforcement, with the vast majority of issues related to legal sanctions not taken seriously.
- Inconsistencies regarding support for harm-reduction interventions between the Law on HIV and laws that require the detention of people who use drugs.

The Vietnamese government also provides mechanisms for legal redress and free legal aid where the provisions of the Law on HIV are violated. The consultants visited the Centre for Consultancy on Health Policy and Law on HIV and AIDS in Ha Noi, which is one of five legal centres in Viet Nam providing information, counselling and legal support for people living with HIV, as well as advice

232. Committee on Economic, Social and Cultural Rights. 28 November 2014. Concluding observations on the second to fourth periodic reports of Viet Nam (E/C.12/VNM/CO/2-4).

233. VAAC (Viet Nam Authority of HIV/AIDS Control). 2012. *Vietnam AIDS Response Progress Report 2012*.

and training on the Law on HIV and related laws and policy. The Ha Noi Centre also has a free telephone hotline. Between 2009 and 2011, the Ha Noi Centre handled a total of 8,238 queries (not including calls to the hotline).²³⁴ Many cases and referrals deal with stigma and discrimination in various settings, including the family, workplaces and educational establishments.²³⁵

However, in order to access legal aid, people living with HIV must disclose their HIV status, which increases the risk of stigma and discrimination and breaches their right to confidentiality under the Law. In addition, access to legal services is not consistent throughout the country, and the services themselves are not far-reaching enough; there are not sufficient resources to address all violations. The issue of payment for – and therefore access – to legal aid was raised in a 2013 regional study on legal protection for people living with HIV, which recommended that Viet Nam’s Law on Legal Aid be amended to cover people living with HIV.²³⁶ As we have seen, affordability is a major gender-related barrier to HIV services, and in this case it impacts on women’s ability to access legal services. Finally, the compulsory detention of people who use drugs means that they may try to avoid detection by the authorities, including any contact with the

legal system to enforce their rights, out of fear of detention. For women who use drugs, this fear compounds the access issues created by their invisibility and specific stigma and discrimination against them – again, however, a great deal of further research is needed.

For these, and other, reasons, people living with HIV in Viet Nam are unlikely to seek legal redress. According to the 2014 Stigma Index, 94% of respondents who reported rights violations had not done so: “[m]any said they had been advised not to or that they had no confidence in the outcome”.²³⁷ A greater proportion of men than women among all respondents had sought legal redress (6.5% compared to 4.8%), although female sex workers were more likely than other women to do so (7.1% had sought redress). This indicates that while access to justice is limited for all people living with HIV, there are particular challenges for women – and that, in this case, female sex workers may be better off than others. It is unclear why this is the case, although more female sex workers living with HIV reported violations of their rights than any other group in the study, and also had the second highest level of income, meaning they had both the reason and the resources to seek legal redress. However – as with so many aspects of this issue – further investigation is required.

234. UNAIDS (Joint United Nations Programme on HIV/AIDS) UNAIDS and UNDP (United Nations Development Programme). 2012. *Legal services for people living with HIV and key at-risk populations in Viet Nam: an assessment of the current situation and recommendations for the future*.

235. Interviews.

236. UNDP (United Nations Development Programme). 2013. *Legal protections against HIV-related human rights violations: Experiences and lessons learned from national HIV laws in Asia and the Pacific*.

237. Viet Nam Network of People Living with HIV (VNP+). 2015. *People Living with HIV Stigma Index 2014*.

The interviews reflected a number of the legal issues specifically faced by women living with HIV that were identified in the study on legal protection, including the loss of their home, of custody of their children, and of property and inheritance rights:²³⁸

“I was infected with HIV by my husband. We have one son but he is not infected. When my husband died, my parents-in-law kicked me out of my house and stole my son from me. I miss my son, but I can’t see him. We need support so that women living with HIV have the right to take care of their children.”

(Focus-group discussion, woman living with HIV)

Meanwhile, the CEDAW report, while welcoming Viet Nam’s efforts to build judiciary capacity on gender equality, remained concerned that:

The frequent use of reconciliation and mediation for dispute resolution privileges men over women, including in cases of domestic violence and property disputes, and hinders women’s access to justice and remedies;

Women’s access to legal aid remains low and under the Legal Aid Law (2006) legal aid is not free of charge for women whose household income is above poverty line, even if they do not have access to household income and/or are survivors of domestic violence.²³⁹

Like the 2013 study on legal protection, recommendations include amendments to the Legal Aid Law,²⁴⁰ specifically:

The development of a comprehensive legal aid scheme in order to ensure effective access by women to courts, including on cases of discrimination and violence against women, with clear timeline and mechanism for monitoring, for criminal cases ... [as well as measures to] enhance women’s own awareness of their rights and legal literacy in all areas of the law, to empower women to avail themselves of procedures and remedies to claim their rights.²⁴¹

In order for women living with HIV to have full access to the justice they deserve, further improvements will need to be made.

238. Interviews and UNAIDS (Joint United Nations Programme on HIV/AIDS) UNAIDS and UNDP (United Nations Development Programme). 2012. *Legal services for people living with HIV and key at-risk populations in Viet Nam: an assessment of the current situation and recommendations for the future.*

239. UN CEDAW (United Nations Committee on the Elimination of Discrimination Against Women). 2015. *Concluding observations on the combined seventh and eighth periodic reports of Viet Nam.* CEDAW/C/VNM/CO/7-8.

240. This law has been amended in 2017.

241. UN CEDAW (United Nations Committee on the Elimination of Discrimination Against Women). 2015. *Concluding observations on the combined seventh and eighth periodic reports of Viet Nam.* CEDAW/C/VNM/CO/7-8.

RECOMMENDATIONS

Prevention

All elements of the prevention programme need to address the realities of women and girls and the ways in which gender inequality heightens risk. Key activities include:

- Increasing access to free harm-reduction tools: male and female condoms with lubricant; clean needles and syringes.
- Developing targeted IEC and BCC materials and programmes that address diverse groups of women and girls at risk. For ethnic minority women, who have lower levels of literacy and/or may not be fluent in Vietnamese, alternative (visual) methods might be needed.
- Ensuring that women-friendly harm-reduction programmes are available and accessible to women who use drugs. This will require research and a pilot project that could later be scaled up.
- Training counsellors to address the specific issues faced by women and girls around testing, diagnosis and disclosure/confidentiality.
- Training health personnel in HIV counselling and testing and the importance of maintaining confidentiality, as well as avoiding stigma and discrimination.

- Providing couples counselling and testing: the process must ensure that women have an equal say and are not coerced by their male partner.

Treatment, care and support

- Conduct urgent further research into the gendered issues and challenges relating to treatment, care and support as these are not yet known.
- Address the current focus on PMTCT by offering HIV-related treatment, care and support to a broader range of women.
- Encourage and promote male involvement in PMTCT programmes.
- Ensure that women who are intimate partners of male members of key populations have access to and can use HIV prevention, treatment and care services.
- Ensure that women receive adequate support, including financial support for the care of their children, family members and community members living with HIV. Challenge the social norms around HIV caregiving by engaging men and boys. Ensure that the caregiving role is reflected and costed in HIV national strategic plans and operational plans.

Stigma and discrimination

Addressing stigma and discrimination requires an enabling environment. Although national information campaigns to provide education about HIV in order to reduce stigma and discrimination exist, their effect is (at least partly) negated by the continued “social evils” discourse which stigmatizes sex workers and drug users.

- Increase awareness among health personnel of intersecting and overlapping stigma and discrimination in health care settings, particularly that towards women living with HIV and members of key populations (men and women who inject drugs, sex workers, men who have sex with men and transgender women), and provide mandatory training on the relevant law and policy, including the need for confidentiality.
- Provide accessible and safe mechanisms through which people can raise issues of stigma and discrimination and actively address violations.
- Develop campaigns and communication materials aimed at educating the community about HIV, gender, stigma and discrimination. Ensure that these are not restricted to ‘AIDS week’ but are conducted on a continuous basis.
- Engage the media in raising awareness in the community, especially among people who are not living with HIV.
- Engage men in challenging gender stereotypes and norms.
- Develop the institutional capacity of networks of women living with HIV and key populations to advocate against discrimination.
- Strengthen the enforcement of the relevant provisions in the Law on HIV and other legislation to address stigma and discrimination towards women living with HIV and women in key populations.

Gender-based violence²⁴²

- Integrate awareness and prevention messages about violence against women and HIV into broad and comprehensive campaigns. Such campaigns should highlight leadership from government, involve all sectors of society, and keep women, girls and transgender communities as the focus.
- Ensure that appropriate, effective and free legal services are part of the responses to both gender-based violence and HIV.

242. UNAIDS (Joint United Nations Programme on HIV/AIDS). 2013. *Gender-based Violence, HIV and the Post-2015 Framework*. [UNAIDS and U.S. Government High-Level Consultation. Discussion Paper]

- Ensure that law-enforcement and judicial officers have adequate knowledge about HIV and gender-based violence issues, and their inherent relationship with the promotion and protection of people's human rights, including those of criminalized populations.
- Prioritize funding for know-your-rights training sessions and other human rights interventions for communities most impacted by violence and HIV and particularly for women and girls living with or affected by HIV, sex workers, women who use drugs, transgender communities and women migrants.
- Ensure that women living with HIV and women from key populations have access to appropriate contraceptive choices.
- Ensure free access to STI treatment for all women and men.
- Amend the relevant legal framework to ensure that the decision to use contraceptives and/or be sterilized is taken voluntarily and with the full and informed consent of the woman or girl concerned.
- Improve the quality of comprehensive sexuality education in schools and ensure that it addresses gender norms and stereotypes, power and gender inequality.

Sexual and reproductive rights

- Provide training for health care staff on human rights, the principle of non-discrimination and appropriate behaviours and skills for working with vulnerable groups, and particularly women living with HIV and women from key affected populations. In particular, ensure that such staff do not undermine women's decision making process, or use coercive strategies such as abortion or sterilization to deny women their reproductive rights.

Social protection

- Conduct an awareness-raising campaign to ensure that women know what social protection mechanisms are available to them.
- Re-examine the relevant policies to ensure that women living with HIV have access to health insurance which will enhance their health and well-being.

Access to justice

- Conduct know-your-rights campaigns aimed at women, including women living with HIV, women who engage in sex work and women who use drugs.
- Increase access to legal aid and other legal services for women, and encourage women to challenge and report rights violations in the home, community, health care settings and workplace.
- Strengthen the law, and the implementation of the law, to protect the custody, property and inheritance rights of women living with HIV.

CHAPTER 5

CONCLUSIONS AND FINAL RECOMMENDATIONS GOING FORWARD

There is much on which to build in Viet Nam's approach to both HIV and gender equality. The current legal and policy framework provides a solid basis from which to better address the needs of women and girls in all their diversity by creating a more gendered approach to the benefit of all, but particularly women living with HIV, woman most affected by HIV and women in key populations. The interviews for this assessment with government staff made it clear that commitment to such an approach exists.

However, while there is widespread acknowledgement that HIV and gender inequality are linked, improvements can be made in policy and practice. National policies, laws and strategies to address HIV and AIDS must be underpinned by a strong rights-based approach that has substantive gender equality at its core. Equally, strategies to eradicate gender inequality must be mindful of women and girls living with HIV in all their diversity and address the impacts of gender inequality on making women and girls vulnerable to HIV and its effects.

At the same time, throughout the interviews for this assessment, respondents referred to the challenges of translating policy and strategy into practice: understanding the need and having the will to address the diverse experiences of men and women have not necessarily led to the implementation of effective programmes or activities. This was partly attributed to a lack of capacity in gender analysis and programming at all levels (national, provincial and district). If gender mainstreaming and other strategies are to be implemented systematically and meaningfully,

then gender cannot be the domain of a few experts – capacity must be built at all levels. Clear programmes with defined targets that move beyond numbers and address complex behaviours to enable change must also be developed.

Specific recommendations on each of the areas reported upon have been included above. The following overarching recommendations – based in part on analysis and feedback provided at the validation workshop – are provided to address the broader context and highlight key opportunities that can have maximum impact, but are mindful of Viet Nam's funding limitations.

ENHANCING POLITICAL COMMITMENT

The Government of Viet Nam's political engagement in addressing both HIV and gender issues is evident in the new Constitution, the establishment of gender machinery and international commitments (such as to CEDAW and the global "90-90-90" targets.) Moving forward, the following opportunities exist to further increase national attention to the intersections of HIV and gender:

- i. The commitments made under the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 presents opportunities to pursue transformative AIDS responses to contribute to gender equality and the empowerment of all women and girls.²⁴³

243. United Nations General Assembly. 2016. *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*. A/70/L.52.

- ii. Further, the 2030 Agenda for Sustainable Development calls upon governments to accelerate action and to recast gender responsive approach to AIDS.
- iii. The Government's recent commitment to and implementation of gender-responsive budgeting also provides an opportunity to evaluate gender-related efforts in the HIV response.

LEGAL AND POLICY REFORM

There are a number of laws and policies that guide and regulate attempts to improve gender equality and address HIV (see above and Appendix A). However, there is still room for improvement, and amending these laws and policies to provide a more enabling environment will be important – especially for responding to the CEDAW July 2015 recommendations for Viet Nam.²⁴⁴ Actions should include:

- i. The Prime Minister has approved the action plan to respond to CEDAW Concluding Observations in May 2017. There are opportunities for MoH to coordinate with MoLISA to implement the health-related action of the plan in collaboration with CSOs including the women living with HIV network (VNW+).
- ii. Revising the existing Law on HIV/AIDS Prevention and Control from a gender perspective and in line with international conventions, including CEDAW, to ensure an appropriate gender focus as well as HIV targets that take into account the realities of women and girls in all their diversity.
- iii. Undertaking a systematic mainstreaming of gender into HIV policies, including the National Working Plan for HIV Prevention and Control 2016-2020, the detailed operational plan and other relevant policies and programmes. This would involve a review and analysis of existing policies, as well as reworking policies to ensure that women, girls and key populations are adequately addressed and catered for.
- iv. Building strong accountability mechanisms for the implementation of laws and policies relevant to gender equality in the HIV response (including the Law on HIV and the National Work Plan 2016-2020) with clear timelines, targets and indicators, a clear allocation of responsibilities, and mechanisms for monitoring implementation.
- v. Ensuring adequate human, technical and budgetary resources for gender equality and women's empowerment within the HIV response through gender-responsive budgeting.
- vi. Given the lack of HIV-related content in gender equality programmes and policies, a review of the gender programme and policy environment should be undertaken to identify possible opportunities to address women's sexual and reproductive rights, gender-based violence and HIV.

244. UN CEDAW (United Nations Committee on the Elimination of Discrimination Against Women). 2015. *Concluding observations on the combined seventh and eighth periodic reports of Viet Nam. CEDAW/C/VNM/CO/7-8.*

- vii. Revisiting current terminology and its impacts on stigma, discrimination and gender inequality. Ways to refine the language used by all actors, in writing and in speech, so that it promotes common understanding and reduces stigma and discrimination could include:
 - Developing the national understanding of gender, to include issues of power differences and to move towards a gender-sensitive and transformatory focus.
 - Using the term “HIV and AIDS”, rather than “HIV/AIDS”, in line with international discourse, and to emphasize the distinction between HIV and AIDS. This is a vital starting point for addressing stigma and discrimination (and should be used in both the Law on HIV and the National Strategy, as the primary texts for the response).
 - Using the term “sex worker” instead of “prostitute” and to discontinue the current discourse on ‘social evils’ relating to sex workers and people who use drugs.
 - Unlinking HIV-related issues from those related to drug use and sex work.
- viii. Enhancing women’s awareness of their rights and increasing their legal literacy to empower them to avail themselves of the procedures and remedies to claim their rights under existing laws and CEDAW.

UNDERSTANDING THE EPIDEMIC: BUILDING KNOWLEDGE AND EVIDENCE

It is important to address the remaining gaps in knowledge about the epidemic, especially those relating to women and girls in all their diversity and including women who use drugs, female sex workers and female intimate partners of members of key populations – and women who are in more than one of these categories – through:

- i. The collection, analysis and dissemination of comprehensive data that are disaggregated by sex, age, disability, ethnicity, location and socioeconomic status. Current indicators should be converted to gender-sensitive indicators in line with international standards, and to assess the situation of women and shed light on currently invisible populations (such as transgender women and women who use drugs) in the HIV response.
- ii. Build knowledge and evidence of factors, including social determinants such as sociocultural norms and practices, that may contribute to increased risk of HIV transmission among women and girls.
- iii. Build in-depth knowledge about the realities of different groups of women and girls in terms of their vulnerabilities to and experiences of HIV, and particularly about “hidden” women: women who use drugs,

migrant women, ethnic minority women and transgender women.

- iv. Build knowledge and understanding of the specific issues and experiences of women living with HIV, including: the impacts of disclosure; property, inheritance and child custody rights; differences in disease manifestation; and experiences of violence.

SERVICE PROVISION AND IMPLEMENTATION

Addressing gender in the HIV response will require:

- i. Ensuring consistency in service provision across the provinces.
- ii. Building and increasing access to a comprehensive and holistic system of treatment, care and support beyond the provision of ART that takes into account the gender dimensions and different realities of HIV for women and men.
- iii. Designing and scaling-up prevention programmes, including tools, information and services, that address women's current lack of access to primary prevention services.
- iv. Increasing access to free condoms, needle exchanges and STI treatment for women most at risk, including female sex workers and women who use drugs.
- v. Health systems strengthening, including capacity building for health care workers around HIV and gender and the allocation of adequate resources to addressing women and girls' issues.

- vi. Ensuring that women and girls, men and boys have access to free and quality sexual and reproductive health services – including contraception, assistance and counselling – regardless of their HIV status, age, sexuality, gender identity, occupation, marital status, disability or geographical location.

- vii. Ensuring that the decision to be sterilized or use contraceptives is made voluntarily and with the full and informed consent of the woman/girl concerned. Health sector staff at all levels must be adequately trained and held accountable for rights violations.

- viii. Addressing the gendered issues surrounding women's caregiving burden and increasing social protection and other mechanisms to alleviate this burden.

STRENGTHENING COMMUNITY ENGAGEMENT AND PARTICIPATION

Community engagement and the participation of women living with HIV and women members of other key populations are crucial. Current international best practice suggests a number of strategies to increase women's engagement, including strengthening civil society and ensuring that platforms exist for meaningful participation. There is a need for:

- i. Technical and financial support for networks and organizations of women living with HIV, woman most affected by HIV and women from key populations.

- ii. Platforms for and indicators to track the meaningful participation of women in planning and policy making processes.
- iii. Measures to empower, educate and build the capacity of women (particularly young women) and women's networks, including:
 - Support for surveys and research (including a mapping exercise) on access to sexual and reproductive health care for girls aged 15-18 living with and affected HIV, in order to build evidence to advocate for policy and programmes that address their unique needs.
 - Support training that improves understanding of the rights of girls living with HIV and their reproductive health and sexuality.
 - Support for know-your-sexual-and-reproductive-rights campaigns.
 - Capacity building in service monitoring and accountability.

ADDRESSING THE STRUCTURAL BARRIERS TO GENDER EQUALITY

Despite progress made towards international gender equality indicators, and the adoption of laws and policies to address women's unequal status, Viet Nam is still a patriarchal country and women remain disadvantaged. This can be seen in the lower levels of political representation and access to resources and opportunities, high levels of intimate partner

violence and a society-wide preference for boy children. Such structural disadvantages increase vulnerability to gender-based violence and HIV, and impact on women's ability to access their sexual, reproductive, social, cultural, political and economic rights. There is a need to:

- i. Intensify efforts to address inequality by increasing both human and financial resources to meet redefined and more ambitious targets.
- ii. Address inherent sexism and challenge gender stereotypes and norms in society by using a rights-based discourse that ensures women's rights are understood and accessed through policy and practice.
- iii. Address gender-based violence through revised laws and policies and by creating a more enabling environment and culturally accepted norms that result in greater reporting and a more stringent application of the law.
- iv. Raise the awareness of men, including men living with HIV and men with risk behaviours, on their role in reducing transmission of HIV to their sexual partners.
- v. Engage men and boys in wider programmes to challenge gender norms.
- vi. Adopt strategic measures to address the root causes of gender inequality and challenge gender stereotypes and traditional social norms, including in the media.

- vii. Enhance awareness-raising about HIV and the negative effects of stigma and discrimination on women and their ability to enjoy their rights, in particular in health care settings. Target audiences should include: government officials; judiciary and law enforcement personnel; health care personnel; teachers; and community leaders, as well as women and men.
 - viii. Enhance awareness-raising about women and girls' particular vulnerabilities to HIV transmission, and provide protection-related support services at health clinics
 - ix. Collaborate with the media to enhance public understanding about the equality of women and men in both public and private life and the importance of non-stigma and non-discrimination, and to convey positive images of women, in particular women living with HIV.
 - x. Coordinate with the Ministry of Education and Training to revise educational materials to include accurate knowledge about HIV and its transmission, and remove discriminatory stereotypes from all school text books, teaching materials and curricula.
- Ensure strong collaboration with UN Women going forward, including on the recommendation for further studies and a costing exercise to increase access to HIV services for vulnerable populations, and to develop a plan to build capacity in gender and HIV.
 - Use the gender assessment for advocacy and policy-making, possibly beginning with publishing the key findings as a policy fact sheet.
 - Meet with other Ministries and departments to discuss the gender assessment and the CEDAW findings, and to improve coordination.
 - Revise the HIV monitoring and evaluation framework to ensure that it is both gender-sensitive and in line with the current National Strategy.
 - Implement some of the assessment's recommendations in 2016, and develop a comprehensive plan to address the others over the next few years.

NEXT STEPS

VAAC, as the leaders of this process, committed to taking the next steps in ensuring that the gender assessment findings were integrated into the HIV response, and in particular to:

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UN Women (United Nations Entity for Gender Equality and the Empowerment of Women); WFP (World Food Programme); WHO (World Health Organization); and UNAIDS (Joint United Nations Programme on HIV/AIDS). 2012. *Joint Statement: Compulsory drug detention and rehabilitation centres*.

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APPENDIX A

LIST OF KEY OFFICIAL DOCUMENTS

LAWS AND POLICIES

- Constitution of the Socialist Republic of Viet Nam (2013)
- Law on HIV/AIDS Prevention and Control (No. 64/2006/QH11) (2006)
- Law amending and Supplementing a Number of Articles of the Law on Vietnamese Nationality (No. 56/2014/QH13) (2014)
- Land Law (No. 45/2013/QH13) (2013)
- Labour Code (No. 10/2012/QH13) (2012)
- Law on the Prevention and Combat of Human Trafficking (No. 66/2011/QH12) (2011)
- Law on Marriage and Family (52/2014/QH13) (2014)
- Law on Legal Aid (No. 11/2017/QH14) (2017)
- Law on Gender Equality (No. 73/2006/QH11) (2006)
- Law on Domestic Violence Prevention and Control (No. 02/2007/QH12) (2007)
- Law on Social Insurance (No. 58/2014/QH13) (2014)
- Decree No. 136/2013/NĐ-CP on Support Policies for Social Protection Beneficiaries (2013)

PLANS AND PROGRAMME DOCUMENTS

- National Strategy on Gender Equality 2011-2020
- National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030
- National Action Plan on Gender Equality 2016-2020
- National Plan of Action on the Prevention and Combating of Human Trafficking 2011- 2015
- National Guidelines for Reproductive Health Care Services

CIRCULARS AND DECISIONS

- Ministry of Health Circular 15/2015/TT-BYT guiding the medical examination and treatment by health insurance for people living with HIV and people who use HIV- and AIDS-related health care services, dated 26 June 2015
- Ministry of Health Decision 4994/QĐ-BYT guiding the implementation of HIV/AIDS prevention and control activities at the commune and ward levels, dated 14 December 2012
- Ministry of Health Decision 4620/QĐ-BYT issuing the National Guidelines for Reproductive Health Care Services, dated 25 November 2009
- Prime Minister's Decision 136/2000/QĐ-TTg approving the National Strategy on Reproductive Health Care 2001-2010, dated 28 November 2000

APPENDIX B

LIST OF PEOPLE INTERVIEWED

	Name	Organization	Location
1	Huynh Thi Lan Phuong	UNAIDS	Ha Noi
2	Trinh Thi Le Tram	Center for Consulting on Legal and policy on HIV/AIDS	Ha Noi
3	Lai Minh Hong	VNW+	Ha Noi
4	Quach Thi Mai	VNW+	Ha Noi
5	Dinh Ngoc Quy	Sub-Committee on Gender and Family, Viet Nam National Assembly	Ha Noi
6	Nguyen Thi Nga	MOLISA	Ha Noi
7	Tran Thi Hong	Institute for Family and Gender Studies	Ha Noi
8	Le Nhan Tuan	PAC Ha Noi	Ha Noi
9	Nguyen Dinh Hien	Department of Labour, Invalids and Social Affairs	Ha Noi
10	Nghiem Thi Cong	Ha Noi Women's Union	Ha Noi
11	Nguyen Phuong Hoa	M&E Department, PAC Ha Noi	Ha Noi
12	Bui Nguyen Hong	OPC Dong Da	Ha Noi
13	Doan Thi Thu	PAC Hai Phong	Hai Phong
14	Nguyen Thi Lan Huong	PAC Hai Phong	Hai Phong
15	Luong thi Dan Phuong	Hai Phong Women's Union	Hai Phong
16	Vu Thi Bich Hanh	Department of Population and Family Planning	Hai Phong
17	Dao Hai Yen	Department of Reproductive Health Care	Hai Phong
18	Nguyen Duc Phan	Department of Labour, Invalids and Social Affairs	Hai Phong
19	Nguyen Thi Van	Active Life self-help group	Hai Phong
20	Nguyen Thi Tham	Peer educator, female sex workers, Lang Giang district	Bac Giang

21	Nguyen Thi Nhung	Woman living with HIV	Bac Giang
22	Khong Thi Lien	MMT patient	Bac Giang
23	Vu Thi Huong	Bac Giang Women's Union	Bac Giang
24	Nguyen thi Chung	Department of Reproductive Health Care	Bac Giang
25	Ha Thi Minh Thu	Department of Population and Family planning	Bac Giang
26	Doan Van Cuong	Department of Health	Bac Giang
27	Nguyen Tien Hung	Department of Labour, Invalids and Social Affairs	Bac Giang
28	Duong Van Vinh	M&E Department, PAC Bac Giang	Bac Giang
29	Trieu Thi Hien	Woman living with HIV	Ha Noi
30	Bui Huyen Trang	Woman living with HIV	Ha Noi
31	Hoang Vu Thu Huyen	Woman living with HIV	Ha Noi
32	Nguyen Hong Hau	Woman living with HIV	Ha Noi
33	Nguyen Thi Thuy	Woman living with HIV	Ha Noi
34	Nguyen Thanh Hoa	Woman living with HIV	Ha Noi
35	Nguyen Thi Thu	Woman living with HIV	Ha Noi
36	Quach Thi Mai	Woman living with HIV	Ha Noi
37	Do Thi Luan	Woman living with HIV	Ha Noi
38	Tran Anh Thu	Viet Nam Women's Union	Ha Noi
39	Kristan Schoultz	UNAIDS	Ha Noi
40	Shoko Ishikawa	UN Women	Ha Noi
41	Leika Aruga	UN Women	Ha Noi
42	Ly Vu Phuong	UN Women	Ha Noi
43	Lieu Anh Vu	UNDP	Ha Noi
44	Dr Bui Duc	VAAC	Ha Noi

APPENDIX C

PARTICIPANTS: VALIDATION MEETING

	Name	Organization
1	Phan Thi Thu Huong	VAAC
2	Vu Duc Long	VAAC
3	Vo Hai Son	VAAC
4	Bui Hoang Duc	VAAC
5	Do Huu Thuy	VAAC
6	Vu Van Chieu	VAAC
7	Hoang Thi Thu Huyen	MOLISA
8	Nghiem Thi Cong	Ha Noi Women's Union
9	Pham Thi Tuyet Mai	PAC Ha Noi
10	Nguyen Thi Lan Huong	PAC Hai Phong
11	Luong Thi Dan Phuong	Hai Phong Women's Union
12	Duong Van Vinh	PAC Bac Giang
13	Tran Xuan Thanh	PAC Bac Giang
14	Lai Minh Hong	VNW+
15	Vuong Thi Dinh	VNW+
16	Nhung Nguyen	PEPFAR
17	Dong Duc Thin	HAHP
18	Phi Thi Hien	VNW+
19	Phia Thi Hoan	VNW+
20	Nguyen Thi Thu	VNW+
21	Nguyen Thi Tham	Peer educator, female sex workers, Lang Giang district, Bac Giang province
22	Dan Tien Phuc	Dan Tien Phuc Law office in Hoa Binh province
23	Nguyen Thi Lan Huong	CEPHAD
24	Cao Vinh Hai	CERPA

25	Kristant Schoultz	UNAIDS
26	Huynh Thi Lan Phuong	UNAIDS
27	Nguyen Thanh Van	UNAIDS
28	Miho Watanabe	UN Women
29	Leika Aruga	UN Women
30	Ly Vu Phuong	UN Women
31	Tran Thi Thuy Anh	UN Women
32	Vicci Tallis	Consultant
33	Le Mai Phuong	Consultant
34	Le Anh Tuan	VAAC
35	Nguyen Viet Nga	VAAC
36	Pham Thanh Phong	VAAC – US. CDC
37	Quach Thi Mai	VNW+
38	Tran Thi Thanh Loan	IFGS
39	Hoang Thanh Hai	US Embassy
40	David Stephen	RAFH
41	Nguyen Thu Huyen	CCIHP
42	Nguyen Thi Thao	CCIHP
43	Dao Minh Nguyet	IPFCS
44	Le Thi Ngan Giang	CWD
45	Pam Price	CWD



**United Nations Entity for Gender Equality
and the Empowerment of Women (UN Women)
Viet Nam Country Office**

304 Kim Ma, Hanoi, Viet Nam

Tel: +84 24 3850 0100

Fax: +84 24 3726 5520

Website: <http://vietnam.unwomen.org>