UN recommendations on the proposed amendments and supplements of some articles of

The Law on HIV/AIDS Prevention and Control

Summary Note – 10 February 2020

Over the last 10 years, the HIV epidemic and response have evolved in Viet Nam with significant progress in terms of reduction of new infections thanks to new effective prevention interventions and expansion of HIV treatment access but there are also new challenges and a changing financial landscape. Generally, discrimination against and stigmatization of vulnerable groups increase their vulnerability to HIV by inhibiting the ability to reach these populations with prevention efforts.[1] In line with this, the Human Rights Committee in 2019 recommended that Viet Nam intensify its efforts to eradicate all forms of discrimination and violence against and social stigmatization of persons, including based on HIV status.[2] Viet Nam moreover expressed its commitment in this regard by accepting a UPR recommendation on eliminating all forms of discrimination against people living with HIV.[3]

In line with this clear commitment, Viet Nam is amending the Law on HIV/AIDS Prevention and Control (hereinafter the Law). The UN highly appreciates the inclusive consultation process for the amendment of the Law and recognizes many substantive improvements in the September 2019 draft amendment. The UN would like to take this opportunity to provide a number of recommendations for further improvements. The comments below focus around a few key overall issues while a more comprehensive set of detailed and specific recommendations will be shared directly with the drafting team.

Terminology

Language shapes beliefs and may influence behaviours. Globally, UNAIDS recommends considered use of appropriate language which may strengthen the global response to the AIDS epidemic[4] and help reduce the lingering stigma related to HIV. In this regard, terminology should ensure a people centered focus rather than infection centered. Indeed, membership of groups does not place individuals at risk; behaviours may. In this regard, the term 'target group', as used in the Law, imply that the risk is contained within the group. However, all social groups are interrelated. Identifying "target groups" may create a false sense of security in people with behaviours that put them at risk of HIV but who do not identify with such groups. Moreover, in the case of married and cohabiting people, particularly women, the behaviours putting a sexual partner at risk may also place the other partner in a situation of risk despite not engaging in such behavior her- or himself. For these reasons, the term 'key population', in the sense of being key to the epidemic's dynamics or key to the response is recommended globally.[5]

In this regard, it is recommended that:

- Throughout the Law the following is replaced:
  - "People infected with HIV" and "AIDS patient" by "People living with HIV";
  - "risky behaviour" by "behavior that put people at risk of HIV";
  - "Target groups with risky behaviours" by "Key populations affected by HIV" or by describing the behaviors each population group is engaged in that place individuals at risk of HIV exposure.
- Throughout the Law "Interventions" is used as a broader umbrella term for programme activities and initiatives when implying outreach for information and counselling, testing, medical treatment, health systems and healthcare.

Scope

The UN recognizes the efforts by the Law drafting team in broadening the scope to ensure greater inclusiveness of the Law and calls for further attention to some key dimensions of inclusivity.

As per international guidance, prevention includes a wide range of interventions including harm reduction. Prevention services have and must continue to evolve informed by the needs of key populations as well as new

[1] https://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx.

[2] Para. 16, Human Rights Committee, Concluding observations on the third periodic report of Viet Nam, CCPR/C/VNM/CO/3.

[3] Recommendation number 38.96: Continue to conduct studies with a view to amending existing or introducing new legal instruments to eliminate all forms of discrimination against people living with HIV (Malaysia), Report of the Working Group on the Universal Periodic Review* Viet Nam, A/HRC/41/7.

[4] UNAIDS Terminology guidelines (2015) available at: https://www.unaids.org/en/resources/documents/2015/2015_terminology_guidelines, p.3

[5] ibid. 8.

evidence-informed prevention interventions that may be recommended by international organizations and be made available in the future. For these reasons, it is important that the Law be phrased to ensure flexibility in this regard to further optimize prevention services for impact.

Regarding key populations, there is clear evidence that transgender people are at a much higher risk of HIV globally.[6] They often face, from a young age, stigma, discrimination and social rejection in their homes and communities for expressing their gender identity. Such discrimination, violence and criminalization prevent transgender people from getting the HIV services they need to stay healthy.[7]

The same is true for people in closed settings.[8] Globally, the prevalence of HIV, hepatitis B and C, and TB among prison populations tends to be much higher (up to 50 times)[9] than the prevalence in the community. The high rates of morbidity and mortality related to HIV in closed settings stem from the higher vulnerability of people entering prison and the overrepresentation of key populations along with overcrowding, poor hygiene and nutrition, violence, a lack of access to basic health services and the higher prevalence of various communicable diseases.

Moreover, globally and in Viet Nam, there is a high number of new HIV infections among spouses and intimate partners of key populations.[10]

In Viet Nam as well as around the world, social organizations including Community-based Organizations (CBO) play a critical role in HIV prevention by reaching groups that are otherwise difficult to reach, providing care and support, and meaningfully engaging to inform more effective policies and interventions. This critical role should be further institutionalized in the Law to ensure its sustainability .[11]

In this regard, it is recommended that:

- "Prevention" or "Preventive measures" is used as a broader scope for programme activities and initiatives rather than "Harm reduction" which is more specific in Article 2, while keeping the concept of "Harm reduction"[12] for use in other Articles to ensure that persons from key populations using harmful substances are provided interventions specifically tailored to these issues[13] such as needle and syringe programmes, opioid substitution therapy, naloxone and other evidence-based interventions including psychosocial interventions.
- "Transgender people", "People in closed settings" and "Spouses and intimate partners of people whose behavior put them at higher risk of HIV" are included among key/priority populations for accessing HIV information and counselling, prevention, testing, care and treatment services, in suitable Articles (Article 21 or Article 11).
- "Social health insurance for HIV-related healthcare services" or another, broader title for Article 40 on Social health insurance for People living with HIV is used and a general text added that "The Government regulates the provision of such coverage" to provide room for potential coverage of prevention services in the future.
- Explicit language is included in Article 19 of the Law to legally recognize the critical role of social organizations, especially community-based organizations of people living with HIV and other key populations affected by HIV, in HIV outreach, prevention, testing, linkage to treatment, and care.
- The right to social protection is explicitly referenced in Article 4.

[6] Transgender people are 49 times more likely to acquire HIV than all adults of reproductive age. Transgender rights are human rights, UNAIDS, March 2017, available at: https://www.unaids.org/sites/default/files/transgender-rights-are-human-rights.pdf

[7] Ibid.

[8] Closed settings include pretrial detention centres, jails, prisons, immigration detention centres and juvenile detention centres. Guidance note on Services for people in prisons and other closed settings, UNAIDS, UNODC, WHO and UNDP: (UNDP). https://www.unaids.org/sites/default/files/media_asset/2014_guidance_servicesprisonsettings_en.pdf, p.2

[9] Ibid.

[10] Viet Nam AEM Technical Working Group, "Inputs and Results of the AEM Modelling Exercise," 2018

[11] Global AIDS Update 2019: Communities at the Centre, UNAIDS, 2019: https://www.unaids.org/en/resources/documents/2019/2019-global-AIDS-update

[12] Drug-related harm reduction refers to policies, programs and practices that aim primarily at reducing the adverse health, social and economic consequences of drug use – such as HIV transmission – without necessarily reducing drug consumption itself (WHO, 2004 at www.who.int/hiv/pub/idu/e4a-outreach/en/index.html)

[13] Such as needle and syringe programmes, opioid substitution therapy, naloxone and evidence-based interventions, which include brief psychosocial interventions involving assessment, specific feedback and advice.

Government investment in the HIV response

Resolution 20/2017 of the Communist Party of Viet Nam's Central Committee commits to providing sufficient State budget allocation to ensure essential public healthcare services' provision. There is strong evidence that more domestic investment is needed to effectively address the HIV epidemic[14] and the national commitment to achieve the end of AIDS by 2030, especially from Government in a context of rapidly declining external resources. Without such investments, in particular for HIV prevention, there is a risk of "a resurgence of the HIV epidemic and rapidly increase [in] costs for the public health care system".[15] Such investment can be most efficient and effective and bring the best value for impact when combining public health facilities and social organizations capacities. Indeed, alongside HIV treatment mainly provided by the public health sector, a significant share of the HIV prevention services which are essential to sustain for HIV epidemic control and in line with Resolution 20/2017, is effectively provided by social organizations.[16]

In this regard, it is recommended that:

- Article 6, Clause 5 is amended to replace 'suitable to the national socio-economic condition and the HIV/AIDS epidemic situation in each period' by 'appropriate to the socio-economic condition of the country and to end AIDS by 2030'.
- Article 43, Clause 1 on Resources for the HIV response is amended to include a clear provision on prioritizing State budget allocation for HIV prevention service provision.
- Article 19 on Social organizations participating in the HIV response is amended to include a clear provision on the use of State budget to fund HIV service provision by non-government entities.

Privacy and Confidentiality

The right to privacy, including regarding health,[17] is guaranteed in a number of human rights treaties ratified by Viet Nam.[18] According to OHCHR and UNAIDS, lack of confidentiality may lead to people avoiding HIV-related counselling, testing, treatment and support.[19] In this regard, confidentiality is of utmost importance in scaling up Viet Nam's national HIV response.

This Law's revision must establish effective and sustainable regulatory mechanisms to ensure strong privacy protections, safety of individual information and strict conditions for data disclosure. This would be aligned with the Civil Code and the Law on Medical Treatment and Examination, which provide the fundamental basis for medical confidentiality. Cohesiveness between the revised Law and these legal documents is crucial to provide comprehensive privacy protection in HIV-related healthcare services.

As a general rule, a person's HIV status should only be voluntarily disclosed by the people living with HIV themselves, this includes regarding notification to partners. The UN does not support a legal obligation to disclose one's HIV positive status.[20] As per confidentiality and disclosure of HIV status, the International Guidelines on HIV/AIDS and Human Rights[21] recommend that legislation ensure that information relative to the HIV status of an individual be protected from unauthorized collection, use or disclosure in health-care and other settings, and that the use of HIV-related information requires informed consent. International human rights law allows states to impose limitations on certain rights, but only where the state can establish that the restriction is:

[14] Page 29, http://unaids.org.vn/wp-content/uploads/2016/09/VIET-NAM-INVESTMENT-CASE_-En_FINAL_Oct2014.pdf
[15] Ibid.
[16] Global AIDS Update 2019: Communities at the Centre, UNAIDS, 2019: https://www.unaids.org/en/resources/documents/2019/2019-global-AIDS-update
[17] See for example CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) para. 23 on the importance of ensuring privacy and confidentiality in health care.
[18] Including the ICCPR (art. 17), the CRC (art. 16) and the CRPD (art. 22). The right to privacy is also protected in the Universal Declaration of Human Rights, art. 12.
[19] The same is true for other negative consequences. Para. 96, International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version, OHCHR and UNAIDS.
[20] See UNAIDs and UNDP Policy Brief on Criminalization of HIV Transmission (https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/undp-and-unaids-policy-brief-on-criminalization-of-hiv-transmission.html).
[21] P. 28-30, International Guidelines on HIV/AIDS and Human Rights. Political Declaration on HIV/AIDS (UN Resolution 20/262). UNAIDS and OHCHR (2006). Available at https://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx, p. 30.

- Provided for and carried out in accordance with the law, i.e. according to specific legislation that is accessible, clear and precise, so that it is reasonably foreseeable that individuals will regulate their conduct accordingly;
- Based on a legitimate interest, as defined in the provisions guaranteeing the rights;
- Necessary to protect that interest, proportional to it and constitutes the least intrusive and least restrictive measure available and actually achieves that interest in accordance with the law.

Within the bounds of these restrictions, health-care professionals can be authorized, but should not be required, to decide whether to inform their patients' sexual partners of the HIV status of their patient. Such decision should be made only on an individual case-by-case basis with due regard to ethical considerations and only when certain criteria[22] are met.

In this respect, WHO recommends that voluntary assisted partner notification services should be offered as part of a comprehensive package of testing and care offered to people with HIV.[23] However, for successful and effective programme implementation supportive policies are essential.[24]

In this regard, it is recommended that:

- Article 4, Clause 2.b requiring people living with HIV "To inform their HIV positive test result to their spouse or fiancé (fiancée)" is deleted. Instead the Law should authorize, but not require, health-care professionals to decide whether to inform their patients' sexual partners of the HIV status of their patient. Such a decision should be made only on an individual case-by-case basis with due regard to ethical considerations and only when the following criteria are met: i) The concerned person living with HIV has been thoroughly counselled; ii) Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes; iii) The concerned person living with HIV has refused to notify, or consent to the notification of his/her partner(s); iv) A real risk of HIV transmission to the partner(s) exists; v) The concerned person living with HIV is given reasonable advance notice; vi) The identity of the concerned person living with HIV is concealed from the partner(s), if this is possible in practice; and vii) Follow-up is provided to ensure support to those involved, as necessary.
- Provisions be added in Article 25 to enable the competent authorities to impose penalties for breach of confidentiality by considering it as professional misconduct.
- The Government officially regulates the list of health care professionals and Social Health Insurance agency's officers who can access HIV testing results as needed to ensure HIV treatment for People Living with HIV and reimbursement of services through Social Health Insurance (Article 39 and 30).

Testing, and linkage to treatment

The United Nations encourage universal access to knowledge of HIV status. WHO and UNAIDS do not support mandatory or compulsory testing of individuals on public health grounds; "HIV testing, no matter how it is delivered, must always respect personal choice and adhere to ethical and human rights principles".[25] All HIV testing services must adhere to the WHO "5 Cs": Consent - from the person who is tested, Confidentiality - of the testing services, Counselling - for pre-test and post-test, Correct – test results have to be guaranteed as accurate, and Connections - HIV prevention need to be linked to treatment and care and support services.[26]

Based on the principles above, key issues of the Law related to HIV testing and its linkage to treatment of the Law are:

[22] These include that: i. The HIV-positive person in question has been thoroughly counselled; ii. Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes; iii. The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s); iv. A real risk of HIV transmission to the partner(s) exists; v. The HIV-positive person is given reasonable advance notice; vi. The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and vi. Follow-up is provided to ensure support to those involved, as necessary. List of criteria from Guidelines for State Action, Guideline 3: Public Health Legislation, P.28 from UNAIDS and OHCHR (2006). International Guidelines on HIV/AIDS and Human Rights. Political Declaration on HIV/AIDS (UN Resolution 20/262). Available at https://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx.

[23] Supplement Guidelines on Self Testing and Partner notification (2016)

[24] In some settings, medical secrecy laws may prohibit HIV partner notification; in other contexts, restrictive laws and policies may put clients and their partners at risk of stigmatization, discrimination, criminalization and punitive actions.

[25] Page 2, https://www.unaids.org/sites/default/files/media_asset/2017_WHO-UNAIDS_statement_HIV-testing-services_en.pdf

[26] Ibid.

HIV Testing and Counselling for Minors

The current Law specifies the age of consent for HIV testing of 'full 16 year older or above' and requires written consent of a parent or guardian for people aged less than 16 years. Adolescents should be counselled about the potential benefits and risks of disclosure of their HIV-positive status and empowered and supported to determine if, when, how and to whom to disclose. WHO recommends that Governments revisit age-of-consent policies, considering the need to uphold adolescents' rights to make choices about their own health and well-being (considering different levels of maturity and understanding).[27] Indeed, while the intention of age of consent laws for medical services is often to protect children, in practice such laws do the opposite, by discouraging adolescents from accessing the services they need to stay healthy.[28] Indeed, any stipulated definitive and prescriptive legal age of consent to HIV testing and counselling may create difficulties for young people to know their HIV status and access HIV treatment when needed as well as for health workers to respond to adolescents' special needs by each case accordingly. This is also important for epidemic control.

Voluntary and confidential HIV testing and counselling should be accessible and available to adolescents and provided in ways that do not put them at risk. The legislation should consider young people's rights to confidentiality and to consent to testing and treatment, independent of their parents. The legislation should also address the circumstances in which consent may be provided without the consent of a parent or guardian. Young people who use drugs must also have legal and safe access to HIV and health services.

In this regard, it is recommended that:

- Article 27, Clause 2 be amended to remove, or at least lower, the minimum age of consent for HIV testing and counselling[29] and to allow more options for counterparts, such as older siblings or relatives, to provide consent.
- If the age of consent for HIV testing and counseling cannot be removed or lowered, Article 27 be amended to add that any young person aged below 15 years old who is pregnant or engaged in behavior that put him/her at risk of HIV shall be eligible for HIV testing and counseling with the assistance of a licensed social or health worker. Consent to voluntary HIV testing shall be obtained from the child without the need of consent from a parent or guardian. In other cases, consent to voluntary HIV testing shall be obtained from the child's parent or legal guardian if the person is below 15 years old or is mentally incapacitated. If the child's parents or guardians refuse to give consent, it shall be obtained from the licensed social worker or health workers. To protect the best interest of the child, the assent of the minor shall also be required prior to testing. The result may be disclosed to either of the child's parents, legal guardian, or a duly assigned licensed social or health worker, whichever is applicable.
- Consequently Article 30, Clause 1 be amended in accordance with the above recommendation.

HIV Response at the Workplace

The UN strongly recommends that HIV testing or other forms of screening for HIV should not be required of workers, including migrant workers, jobseekers and job applicants.[30] Regarding the workplace, ILO recommends that the result of HIV testing should be confidential and not jeopardize access to jobs, tenure, job security or opportunities for advancement.[31] Testing must be genuinely voluntary and free of any coercion, and testing programmes must respect international guidelines on confidentiality, counselling and consent. Moreover, "Real or perceived HIV status should not be a ground of discrimination preventing the recruitment or continued employment, or pursuit of equal opportunities consistent with the provisions of the Discrimination (Employment and Occupation) Convention, 1958",[32] as ratified by Viet Nam. Article 14 and 24 should also be consistent with the Labour Code, Article 8 prohibiting discrimination, including on the basis of HIV infection (Art. 3). In this regard, temporary absence from

[27] WHO Consolidated guidelines on HIV testing services for a changing epidemic (2019) available at: https://www.who.int/publications-detail/consolidated-guidelines-on-hiv-testing-services-for-a-changing-epidemic
[28] https://www.unaids.org/en/resources/presscentre/featurestories/2019/april/20190415_gow_parental-consent
[29] In Lesotho and South Africa, the age of consent is 12 years old; in the Philippines, the age of consent is 15 years old.
[30] ILO (2010). R200 - HIV and AIDS Recommendation No. 200, 2010. Available at https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:R200
[31] Ibid.
[32] Ibid., para. 10.

work because of illness or caregiving duties related to HIV/AIDS should be treated in the same way as absences for other health reasons.

In this regard, it is recommended that:

- Article 14, Clause 1.b on suitable jobs for people living with HIV is removed, as it is inappropriate and impossible to define "suitable jobs". Moreover, the clause may be interpreted differently by different employers and trigger unnecessary disclosure of HIV status or unequal distribution of tasks or job positions in the workplace.
- Article 28, Clause 3 should be removed, as real or perceived HIV status should not be a ground of discrimination preventing recruitment or continued employment, or the pursuit of equal opportunities, in line with the Labor Code, Articles 3 and 8, prohibiting discrimination on the basis of HIV infection.

HIV Testing and Counselling for Pregnant women

The UN supports providing HIV testing and counselling to women as a routine component of the package of care in all antenatal, childbirth, postpartum and paediatric care settings. All pregnant women should be offered to get tested for HIV, Syphilis and Hepatitis B as per Viet Nam's adopted Triple Plan for the Elimination of the HIV, Syphilis and Hepatitis B. International good practices of providing HIV benefits packages in antenatal and postnatal care can also be taken as references.[33] The UN also recommend the implementation of provider-initiated HIV testing and counselling for all women attending antenatal care, childbirth and postpartum health care services and their infants and children.

In this regard, it is recommended that:

- All pregnant women be routinely offered to get voluntarily tested for HIV, Syphilis and Hepatitis B as per Viet Nam's adopted Triple Plan for the Elimination of the HIV, Syphilis and Hepatitis B.
- It is added to Article 35 that pregnant women who are voluntarily HIV tested, shall have the cost of the test and treatment covered by the state or the health insurance so that when a woman does not have or, for any reason, cannot use Social Health Insurance to cover the test and treatment, the State covers the related costs and treatment.
- Alignment is ensured between the amended HIV Law and the future amendment of the Social Health Insurance Law.

Compulsory Drug Detention

In March 2012, the UN issued a global Joint Statement on Compulsory drug detention and rehabilitation centres, which was signed by the Executive Heads of 12 United Nations agencies. In it, the United Nations entities call on States to close compulsory drug detention and rehabilitation centres without delay, release the individuals detained therein and implement voluntary, evidence-informed and rights-based health and social services for them in the community. This remains the position of the United Nations. Until all such centres are closed, it is important that the persons detained therein are provided proper treatment, care and services.

In this regard, it is recommended that:

- A provision is added to Article 18 to ensure that all people likely to witness an overdose in closed settings, including health workers, first responders, prison staff, enforcement officials, family members and peers, have access to naloxone to enable timely and effective prevention of deaths from opioid overdose among people who use drugs.
- That Article 39 includes People living with HIV who are in compulsory educational establishments, drug compulsory detoxification centers, reformatories, prisons and detention houses in the list of people benefiting from antiretroviral medicines (ARVs) covered either by social health insurance or the state.

[33] For Malaysia, MOH Malaysia, WHO, UNICEF, and UNAIDS press release (2018). Malaysia eliminates mother-to-child transmission of HIV and syphilis. Available at https://www.who.int/reproductivehealth/congenital-syphilis/emtct-validation-malaysia/en/. National guidelines in Singapore, and Thailand.