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Second Independent Evaluation 2002-2008
Country Visit to Vietnam - Summary Report

UNAIDS

Second Independent Evaluation

2002-2008

Country Visit to Vietnam

Draft Summary Report

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5th – 18th January 2009

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral treatment (or therapy)
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CBO	Community-based Organisation
CCM	Country Coordinating Mechanism (GF)
CDC	Centers for Disease Control (US)
COP	Country Operational Plan (PEPFAR)
CSO	Civil Society Organisation
DaO	Delivering as One
DHS	Demographic and Health Survey
DOL	Division of Labour
ERP	Enterprise Resource Programme
ExCom	Executive Committee
FBO	Faith-based Organisation
FHI	Family Health International
GFATM	Global Fund for AIDS, TB and Malaria (Global Fund)
GIPA	Greater and meaningful involvement of people living with HIV
GOV	Government of the Socialist Republic of Vietnam
GTT	Global Task Team
HCMC	Ho Chi Minh City
HCS	Hanoi Core Statement
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HoA	Head of Agency (UN)
HSDP	Health Sector Development Plan
HSS	Health System Strengthening
IDU	Injecting drug user
IEC	Information, education and communication
IGA	Income generating activity
IHP	International Health Partnership
IOM	International Office of Migration
JT	Joint Team
M&E	Monitoring and Evaluation
MARP	Most at risk population
MOET	Ministry of Education and Training
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
MOPS	Ministry of Public Security
MSM	Men who have sex with men
NAC	National HIV/AIDS Council
NASA	National AIDS Spending Assessment
NCADP	National Committee for AIDS, Drugs and Prostitution Prevention and Control
NFE	Non-formal education
NHA	National Health Account
NIHE	National Institute of Hygiene and Epidemiology
NPF	National Partnership Forum
OPMP	One Plan Management Plan
PAF	Programme Acceleration Fund
PAR	Public Administration Reform

PCB	Programme Coordinating Board (Governing body for UNAIDS)
PCG	Programme Coordination Group
PEPFAR	President's Emergency Programme for AIDS Relief (USG)
PLHIV	People living with HIV
POA	Plan of Action
PRSP	Poverty Reduction Strategy Paper
RC	Resident Coordinator
RCC	Rolling Continuation Channel (GF)
RST	Regional Support Team
STI	Sexually Transmitted Infection
TSF	Technical Support Facility
TWG	Technical Working Group
UA	Universal Access
UCC	UNAIDS Country Coordinator
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNCT	UN Country Team
UNDAF	UN Development Assistance Framework
UNGASS	UN General Assembly Special Session on AIDS
UNV	UN Volunteers
USG	United States Government
VAAC	Vietnam Administration for AIDS Control
VCSPA	Vietnam Civil Society Platform on AIDS
VNP+	Vietnam Network of Positive People
VWU	Vietnam Women's Union

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This draft has benefited from detailed comments from members of the joint team, which the evaluators have taken into account. All factual errors that were reported have been corrected and comments on interpretation by the evaluation team noted.

Disclaimer

Full responsibility for the text of this report rests with the authors. The views in this report do not necessarily represent those of UNAIDS or of the people consulted.

Note on terminology

The term UNAIDS refers to the Joint United Nations Programme on HIV/AIDS, and comprises the UNAIDS Secretariat and Cosponsors collectively. Where necessary to identify the actions of specific organisations reference is made in the text to individual cosponsors, or to the UNAIDS Secretariat country office or to the Joint UN Team on HIV (which includes some organisations that are not cosponsors).

1 Introduction

1.1 This report is a summary of findings from a short evaluation visit to Vietnam as part of the Second Independent Evaluation of UNAIDS. The country visit took place from 5th to 18th January 2009. The team consisted of Andrew Doupe, Nguyen Thi Thu Nam and Derek Poate. The team were based in Hanoi and made a field visit of two days to Ho Chi Minh City (HCMC).

1.2 The summary report draws on material in a set of evaluation framework tables (described in the inception report for the evaluation[1]), which are based on information gathered from meetings with a range of stakeholders (Annex 1) and from review of key documents (Annex 2).

1.3 Vietnam is one of 12 countries sampled for visiting during the evaluation[2]. The material in the framework tables from these country visits, visits to regional offices of UNAIDS Secretariat and Cosponsors, global visits and interviews, and surveys of other stakeholders will be synthesised together in an overall evaluation report due to be submitted in August 2009.

1.4 Following a brief overview of the country context in Section 2, the report presents the main findings from the visit in Section 3, which is structured in line with the conceptual framework of the evaluation (see Box 1). Section 4 highlights key issues and discussion points arising from the findings.

Box 1 Evaluation scope and objectives

The purpose of the second independent evaluation of UNAIDS is to assess the efficacy, effectiveness and outcomes of UNAIDS (including UNAIDS Secretariat, the PCB and cosponsors) at the global, regional and country levels and, specifically to what extent UNAIDS has met is ECOSOC mandate for an internationally coordinated response to the HIV/AIDS pandemic and the continuing relevance of its mandate and objectives in the current global environment. At country level, the evaluation focuses on the following questions:

a) The evolving role of UNAIDS within a changing environment
c) The response to the first Five Year Evaluation of UNAIDS (see Annex 3)
d) The Division of Labour between the Secretariat, Cosponsors, Agencies and Countries
e) Strengthening health systems
f) The administration of the Joint Programme
g) Delivering as One
h) Involving and working with civil society
i) Gender dimensions of the epidemic
j) Technical support to national AIDS responses
k) Human rights
l) The greater and meaningful involvement of people living with HIV

Note: Question b) on governance is not addressed by country visits

The conceptual framework for the evaluation organises these questions under three broad themes: how UNAIDS is responding to the changing context; how UNAIDS works; and how UNAIDS is fulfilling its mandate..

[1] The Second Independent Evaluation of UNAIDS 2002-2008 Inception Report. 20th October 2008
[2] Cote d'Ivoire, DRC, Ethiopia, Haiti, India, Indonesia, Iran, Kazakhstan, Peru, Swaziland, Ukraine, Vietnam

2 Country context[3]

2.1 Vietnam's HIV epidemic is still in a concentrated phase, with the highest sero-prevalence among key populations at higher risk. These include injecting drug users (IDUs), female sex workers (FSWs) and men who have sex with men (MSM). Prevalence in the general population is estimated at 0.53%. According to the 2005 Estimation and Projection Report, there were an estimated 293,000 people living with HIV (PLHIV) in 2007.

2.2 Cumulative reported data as of 31 August 2007 were 132,628 cases of HIV infection; 26,828 cases of AIDS, and 15,007 deaths due to AIDS. HIV cases were reported nationwide in all 64 provinces/cities, 96% of 659 districts and more than 66% of 10,732 wards/communes. Of all reported HIV cases, 78.9% are in the age group 20-39, with males accounting for 85.2% of the total.

2.3 There is great variability within Vietnam in the timing of local HIV epidemics. The epidemics in Ho Chi Minh City (HCMC) and the north-east coast started earlier, while epidemics in other parts of the country are more recent. This variability has resulted in a geographic concentration of HIV cases in big cities and provinces where the local HIV epidemic in groups of IDUs, FSWs and MSM is substantial. Quang Ninh province has the highest HIV prevalence, while HCMC has the highest number of reported HIV cases (as of 31/7/2006 a total of 23,321 HIV cases, accounting for 17.32% of HIV cases reported nationwide).

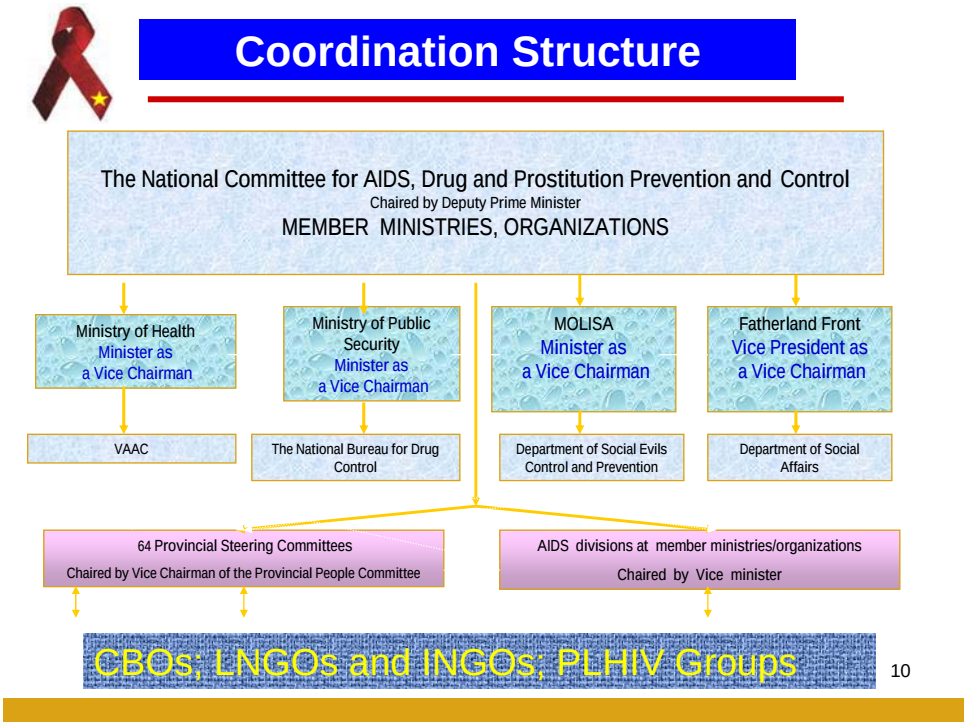
2.4 Treatment and Education Centres for drug users and sex workers (government-managed closed settings for IDUs and FSWs) play an important role in the epidemic. Transmission of HIV in Vietnam is associated with criminalised behaviours, making it difficult for the authorities to engage with high-risk groups. Vietnam runs a system of over 100 Compulsory Drug Rehabilitation Centres, in which no antiretroviral treatment (ART) treatment is available (other than through a donor-funded pilot in HCMC and a small number of centres where *ad hoc* provision is available to those families who purchase antiretroviral drugs outside the centre). These centres, and other closed settings like prisons, are key sites for HIV transmission. It is estimated that HIV prevalence among residents (mostly IDUs) ranges between 40% and 50%, with some 18,000-22,600 PLHIV residing in these centres, equivalent to 16-19% of reported HIV cases in Vietnam in 2006. As of June 2007, the Ministry of Labour, Invalids and Social Affairs estimates that the number of IDUs in Treatment and Education Centres had increased to approximately 60,000.

2.5 An effective response to HIV therefore requires collaboration across multiple sectors, including not just the Ministry of Health (MOH), but also the Ministry of Public Security (MOPS) for prisons and police and the Ministry of Labour, Invalids and Social Affairs (MOLISA) for the drug rehabilitation centres. It also requires collaboration between central ministries and provincial governments, who are responsible for delivering the bulk of HIV-related services.

2.6 The Government of Vietnam (GOV) acknowledges HIV as an important development issue which requires the mobilisation of different stakeholders outside the health sector. The Vietnam Administration for HIV/AIDS Control (VAAC) under the Ministry of Health reports on national HIV issues and progress to a multi-sectoral committee, the National Committee for HIV/AIDS, Drugs and Prostitution Prevention and Control (NCADP), which is chaired by the Deputy Prime Minister. Figure 1 shows the organisational structure of the national agencies.

[3] This section draws on data from the Third UNGASS Report, January 2008.

Figure 1



2.7 Vietnam has made major advances in the response to HIV since the 2004 launch of the *National Strategy on HIV/AIDS Prevention and Control in Vietnam until 2010 with a vision to 2020* (hereafter referred to as the 'National HIV Strategy') and the establishment of the VAAC. Under the National HIV Strategy and coordinated by VAAC, nine Programmes of Action (POAs) were called for to provide detailed guidance for the implementation of HIV programmes. The National Strategy also calls for members of the National Committee for HIV/AIDS, Drugs and Prostitution Prevention and Control (NCADP) to develop their own programmes of action to support the national AIDS response. This policy framework has enabled Vietnam to begin implementing the 'Three Ones' (One national AIDS coordinating authority, One national agreed upon HIV action framework and One Monitoring and Evaluation (M&E) system) and take steps towards its commitment to Universal Access to prevention, treatment, care and support. A timeline of important national and international events is in Annex 5.

2.8 In addition, Provincial AIDS Centres are increasing the number of full time staff working on the delivery of HIV related services at the provincial and district levels. Integration of national and donor-supported programmes at the provincial level is now emphasised as a mechanism for promotion of more active multi-sectoral involvement and improved service delivery.

2.9 HIV is an exceptional issue in Vietnam owing to the dominance of external assistance. Donor support has increased rapidly from US$7-8 million per annum in 2002-2004 to around US$51.8 million in 2006. Expenditure funded from the national budget has increased more slowly to around US$9.4 million in 2007. Between 80-90% of the total expenditure is thought to be donor funded. By comparison, only 10% of the national health budget is externally funded. Table 1 provides indicative donor funding estimates for 2008.[4]

[4] Data in this paragraph and Table 1 from Independent Monitoring Team (2008)

Table 1 Indicative HIV donor funding for 2008

HIV Programmes	US$ million
PEPFAR	85.00
DFID	7.67
ADB	6.20
World Bank	6.00
GFATM	3.90
Australia/Netherlands	2.00
Ford Foundation	1.85
Clinton Foundation	1.25
Sweden	0.42

3 Findings

How UNAIDS has responded to the five year evaluation

3.1 The Five-Year Evaluation put forward 29 recommendations. Of these, 18 have a direct application or influence at country level, although many are also linked to wider global and regional initiatives. Annex 3 lists these 18 country-oriented recommendations in note form with a comment on the situation in Vietnam. Of the 17 for which an assessment is relevant in Vietnam, 6 are judged to have seen a high level of progress, 7 a medium level and there are 4 for which progress in implementation has been relatively low.

How UNAIDS is responding to the changing context

3.2 This section deals with the ways in which UNAIDS (the secretariat and cosponsors) have responded to the changing aid architecture. Three topics are explored: the changing environment; reform within the UN, captured under the slogan 'Delivering as one'; and support to strengthen health systems.

The evolving role of UNAIDS within a changing environment

3.3 The main change in the external environment during the evaluation period has been the growth of funding from the Global Fund (GFATM) and PEPFAR. UNAIDS' relationship to both has been described as complementary. UNAIDS has provided technical assistance to help with applications to the Global Fund. Partners regard UNAIDS as playing the trusted, honest broker with Government, enabling PEPFAR to undertake programmatic work in the space that has been created through UNAIDS advocacy. The most notable example of this is the introduction and scaling up of methadone maintenance programmes.

Strengthening health systems

3.4 The UNAIDS position with regards to health system strengthening (HSS) in Vietnam is in the process of being articulated. At the 2008 retreat of the Joint UN Team on HIV, it was agreed that system strengthening and sustainability should be one of the priorities for the joint team's Common Action Plan in 2009.

3.5 There is a clear acknowledgement of the interaction between HIV programmes and the health sector in national strategies. Health system issues are addressed in the National HIV Strategy including strengthening national HIV surveillance, M&E and information systems; increasing investment in systems for diagnosis and treatment at district, provincial and national

levels; and strengthening human resource management. HIV prevention and control is included in the health sector objective on reducing and controlling infectious disease and epidemics. It is also elaborated in the social and poverty reduction target of the Socio-Economic Development Plan 2006-2010: *"Restrain the rate of HIV/AIDS transmission and minimize the effects of HIV/AIDS. Prevent to minimize the number of children infected by HIV/AIDS. Start restraining the growth rate of HIV/AIDS transmission by 2005 and halving this rate by 2010"*.

3.6 The Global Fund Round 8 proposal (geared towards scaling up harm reduction) clearly indicates the gaps in the health system that affect HIV outcomes and that need to be addressed. These include: health care costs, health programme management and human resources. For Round 8, UNAIDS coordinated technical support and assistance, ensured that sound programme and financial gap analysis was conducted and that the proposed activities, including those for HSS, were anchored and in line with the national strategy and nine Programmes of Action. UNAIDS has been involved in providing strategic information to PEPFAR and HSS is one of the budget allocation items in the Country Operational Plan (COP) 2009.

3.7 There is no mechanism to track the use of HIV funding for HSS. This arises owing to the weak and inconsistent information system on funding for the health sector in general. As mentioned in the National M&E framework approved by MOH, a National AIDS Spending Assessment (NASA) was planned to be carried out in 2007. However this has not yet taken place.

3.8 Funding for HSS comes from a wide range of multilateral and bilateral donors. However, it is difficult to assess the effectiveness and impact of aid, or the degree to which donors link their HSS and AIDS spending, because of a combination of factors including the weak and inconsistent M&E system and the lack of a shared health sector policy framework as noted in the next section.

Delivering as one

3.9 In September 2005, Vietnam and its development partners made a series of joint commitments to improving aid effectiveness in Vietnam, set out in the Hanoi Core Statement (HCS). Vietnam has gone further than perhaps any other developing country in articulating principles, commitments and targets on aid effectiveness. Many past and current assessments of aid in Vietnam point to the fragmented nature of external assistance. In the health sector there are around 75 ongoing projects, mostly under US$500,000 in size, and with 98 percent funded by a single donor.

3.10 A study by the Centre for Community Health Research and Development *Coordination, Management and utilisation of foreign assistance for HIV/AIDS prevention in Vietnam* (2006) commissioned by UNDP for a national conference on coordination and management of foreign aid concluded there were a range of problems:

- A lack of alignment of aid flows with the functions and responsibilities of central and provincial authorities.
- No clear focal point within the GOV for aid coordination, and no working system for aid coordination, resulting in scattered and overlapping assistance.
- Slow project implementation at provincial level, owing to a lack of harmonised management procedures among donors.
- No reporting system or database on aid flows.
- A general lack of interest in project-level monitoring and evaluation.

3.11 Against this background, a discussion paper on UN reform in Vietnam, also dated September 2005, was followed by a more detailed roadmap towards the One UN Initiative in early 2006. It recognised that the UN at country level is fragmented, with built-in inefficiencies,

and that the development impact of the UN's work would be enhanced if planned, implemented and monitored together. The objective of the One UN Initiative was to establish a One (integrated) United Nations. The paper outlined the necessary UN reform measures within the Vietnam aid effectiveness context.

3.12 Initially, the One UN Initiative consisted of UNICEF, UNDP and UNFPA. UNAIDS Secretariat, United Nations Volunteers (UNV) and UNIFEM joined the development of the One Plan 1 and its budgetary framework in the second half of 2006. An additional eight UN agencies (FAO, IFAD, WHO, UNIDO, UNESCO, UN-Habitat, UNODC and ILO) joined to form the One Plan 2, One Budget 2 and One Plan Fund in 2008. In addition, IOM and UNHCR will join other components of the One UN Initiative such as the One UN House.

3.13 A major achievement was the preparation and conclusion of the One Plan Management Plan (OPMP) in 2008. The OPMP is an internal management tool which articulates how the UN Country Team (UNCT) will organise itself to achieve better the results in the One Plan. As the principal reform tool, it outlines operational changes for enhanced effectiveness and coherence – ensuring that the One Plan is matched by an adequate management structure, human resources, and improved business practices and common services.

3.14 The OPMP is the closest document to a common vision within the UNCT of the reform process and where it is aiming to go. Whilst not complete, the underlying vision is of a UN that is 'Delivering as One' rather than of a 'One UN' as implied in the original proposals and the road map.

3.15 The issue of 'joint programming' is one of the key gains emerging from the experience; that is, how the UN can respond to national priorities by joint analysis, joint thinking, joint prioritisation and joint budgeting. The OPMP suggests that the Vietnam pilot has the potential to push this further than most other One UN pilots through the use of the Programme Coordination Groups (PCG). Vietnam is one of three pilot countries that are organising themselves to carry out joint programming across the whole programme.

3.16 Key to the implementation of the One Plan is the new harmonised and streamlined annual planning and review process that has been established through 11 inter-agency PCGs responsible for the UN's results in five outcomes areas. The PCGs are modelled on experience gained with the UNAIDS Joint Programme and the Joint UN Team. Each PCG is responsible for developing common annual workplans, carrying out joint annual reviews and planning meetings with implementing partners, defining efficient ways of working together (such as through virtual and/or physical meetings), and eventually co-locating in the One UN House. The PCGs introduce the concept of dual accountability. The PCG team members will be working together on a common topic area and are accountable to both their individual organisations and to the PCG.

3.17 If the PCGs are successful this would represent a radical change in roles and responsibilities within the UNCT and hence significant reform in how the UN works, allowing development of:

- Accountability to the group rather than only to the agency; and accountability of the group to partners.
- Peer pressure between groups based on divergent performance.
- Development of a results based management approach based on managing for outcomes.
- Avoidance of the need to proceed at the pace of the slowest, which is implicit in an approach based on inclusiveness rather than prioritisation, since one should expect different PCGs to develop differently and at different paces.

3.18 Vietnam has developed a code of conduct for the whole UNCT senior management and also outlines the boundaries for the actions and authority of the UN Resident Coordinator (RC).

Vietnam is the only country to have developed a Memorandum of Understanding that specifically defines the role and responsibility of the RC.

3.19 One UN has benefited from experience with UNAIDS and the joint team – during the past 18 months reforms have enabled a more coherent mobilisation of international support. When asked exactly how it has benefitted, respondents put forward three ideas: experience of a tested coherent approach to HIV; lessons from the joint HIV programme already in place; and the dedicated role of UNAIDS Secretariat country office in advocacy, coordination and resource mobilisation.

How UNAIDS works

3.20 Many of the changes in UNAIDS during the period covered by the evaluation have occurred as a result of reforms in organisation and management. This section addresses these by looking at the Division of Labour among the UNAIDS Secretariat and Cosponsors and arrangements for administration.

The division of labour between the secretariat, cosponsors, agencies and countries

3.21 The Joint UN Team on HIV (formed in 2006) is chaired by the UNAIDS Country Director (CD).[5] The team includes representatives from 12 organisations including the UNAIDS Secretariat country office, UNDP, WHO, UNODC, UNFPA, UNICEF, UNESCO, ILO, World Bank[6] and three (UNV, IOM and UNIFEM) that are not UNAIDS Cosponsors. It meets on the first and third week of every month. The team has created working committees bringing together agencies working on a specific issue (for example, education) that report to the joint team on their work. Under the One UN reforms the joint team is now one of 11 PCGs and is the only one to have a single chair rather than a co-chair.[7]

3.22 Interviews with members of the joint team, senior officials in government and development partners indicate that many of the benefits set out in UNAIDS Guidance on joint teams have been realised. Participants note a synergy in mutual collaboration, avoidance of programme overlap and duplication, and much better sharing of information. Three specific issues highlight the change. Firstly, there is greater consistency about the concentrated nature of the epidemic and importance of Most at Risk Populations (MARPs). Secondly, the joint team has enabled agencies to adopt a coherent position when dealing with government, especially when responding to proposed changes to legislation on drugs and violence. Thirdly, the collaborative preparation of the third UNGASS report covering 2006-2007 demonstrates how the team has provided an entry point to harmonise UN support for the national response.

3.23 Some progress has been made towards the second predicted benefit (a coherent package of UN-supported activities based on comparative advantage) as evidenced through the UN Consolidated Programme of Action on HIV and the annual workplans. UNICEF, UNFPA and UNESCO have collaborated well on a new education sector initiative; but in other areas of work joint team partners report that WHO has been slow to consult in advance of actions. Nor has the joint team yet been used consistently as an entry point to technical assistance (Benefit 5). Government officials and other development partners confirm these benefits although

[5] The Head of the UNAIDS Secretariat country office is usually appointed as the UNAIDS Country Coordinator (UCC). In Vietnam, owing to the One UN reform initiative, the post is designated Country Director, for consistency with other UN agencies present in country.
[6] The World Bank was more actively involved earlier in the period than later but is now showing interest again.
[7] PCG and JT are used interchangeably in these notes.

respondents stress some resistance in government about moving from long-established fragmented and project-driven relationships to a more coherent approach.

3.24 The UN orientation to HIV in Vietnam has been slow to recognise the concentrated nature of the epidemic. Only in the 2007 One Plan I document (in effect a revision of the 2006-2010 UNDAF) is there a clear statement about MSM (despite work with the MSM community going on since 2004). The same document highlights areas of overlap across agencies and potential for rationalisation that include behaviour change and access to HIV information. Interviewees note that the present UNAIDS Country Director has been instrumental in helping the joint team confront the concentrated nature of the epidemic and the need for the national response to focus on MARPs.

3.25 The process of adopting a Division of Labour (DOL) has been difficult. Some cosponsor respondents feel that the initial introduction was insufficiently sensitive to UN agency capacity and historical relationships in country and that the UNAIDS Secretariat country office tried to introduce the GTT recommendation as a blueprint. The main tensions have been over the respective roles of UNODC and WHO concerning harm reduction; the terminology of lead agency; and the idea that the allocation of roles would enable lead agencies to act as a single entry point.

3.26 Examination of the agreed Vietnam DOL reveals that it follows the global guidelines closely with only two locally-agreed different allocations to lead agencies: the UNAIDS Secretariat taking the lead role for support to *strategic, prioritised and costed national plans*, instead of the World Bank; and IOM – which is not a UN agency but has a relevant scope of work and is present in Vietnam – taking the lead on *addressing HIV among displaced and mobile populations*, instead of UNHCR, which does not have an office in country.

3.27 Problems arose over who should lead on harm reduction owing to a number of factors. Historically, injecting drug use is under the responsibility of MOLISA for which UNODC is a key counterpart; yet the major spending comes through VAAC for which WHO is a key counterpart. This is linked to the view in WHO that, because VAAC is located in the MOH and MOH is the lead government agency for HIV and because of WHO's mandated role in the health sector, WHO should be the lead in the joint team for IDU. Interviewees report that WHO initially bid to lead 7 or 8 of the 17 thematic areas. The arguments for allocation were based on the concept of agency mandate rather than the results-based programmatic focus that characterises thinking under the One Plan. WHO also criticised the capacity of some cosponsor country offices and specifically argued that UNODC was too closely associated with narcotics control and criminalisation in the region.

3.28 Whilst UNODC is the lead according to the DOL, an informal working compromise has been reached by which WHO leads with health care aspects of harm reduction, although with some interesting implications. For example, in the HIV Joint Programme Results Matrix March 2008, WHO is tasked with *Support development and dissemination of evidence-based plan of action on harm reduction* (Op 4.1.1); and UNODC with the similar *Support development and dissemination of evidence-based plan of action of MOLISA* (Op 4.1.3) and *of MOPS* (Op 4.1.4). Thus WHO has a thematic-based responsibility and UNODC an organisation-based responsibility but essentially covering the same thematic area.

3.29 The DOL is not widely understood outside the UN and has not yet had any discernable influence on working relations with government or development partners. The differences in operationalising harm reduction between WHO and UNODC are known and donors expressed strong views that UNODC should be working in this area as the agency brings such a broad base of engagement. The strong 'vertical' nature of government programmes leads to difficulties in some areas. For example, with regards to condoms, VAAC provides to MARPs and the General

Office in the MOH deals with supplies for married couples, but there is no similar allocation of responsibility to provide for unmarried people and clients of sex workers. UNFPA finds it consistently hard to discharge its DOL role as the MOH/VAAC looks to WHO as the first point of contact for condom programming.

3.30 There is no evidence yet of any substantive change in programming as a result of the DOL. UNAIDS Secretariat country office is reducing work with prisons as UNODC has built capacity and taken on this role, and would scale back work on MSM if UNDP were to have the capacity and commitment to engage.[8] It is acknowledged that the DOL has helped bring UNFPA, UNICEF and UNESCO together to initiate a comprehensive education sector response to HIV and AIDS and brought greater consistency and continuity among the three agencies.

3.31 Annual reviews of the PCG/joint programme take place, but with much less involvement of the regional offices of the secretariat and cosponsors than envisaged in the Global Task Team review. The role of team members in joint working is reflected in the terms of reference for all members with the exception of WHO and the World Bank (which does not currently participate actively in the joint team, but for which staff are assessed routinely for their contribution to donor coordination). The main thrust for accountability and joint team performance comes with the One UN reforms discussed in an earlier section.

The administration of the joint programme

3.32 UNAIDS Secretariat relies on two partner agencies, WHO in Geneva for international staff and UNDP for country offices and locally recruited staff, to provide administrative and support services. Some problems were reported with the new financial system that has been implemented by WHO – in particular with payments that need to be made out of HQ such as salaries.

3.33 The most recent global Memorandum of Understanding with UNDP has mostly solved any difficulties in the area of management control. Lingering problems persist such as the country office staff not being given access to ATLAS (the UNDP ERP) and from time to time having procurement decisions queried. But most issues, including management of personnel, were considered satisfactory by staff in the UNAIDS Secretariat country office. Government now deals with the UNAIDS Secretariat country office on a 'UN agency' basis rather than as a project which had been the case in the past. Staff at UNDP expressed strong concerns about UNAIDS acting outside its 'mandated areas' of advocacy, coordination and fund mobilisation and of behaving 'like an agency and implementer of projects'.

3.34 The Programme Acceleration Fund has been used in recent years and PAF funds are appreciated by recipient agencies. Since the advent of the joint team, decisions on applications are discussed by the team and this process was generally found to be working satisfactorily.

How UNAIDS is fulfilling its mandate

3.35 This section examines the substantive areas where UNAIDS, working through the joint team, is mandated to provide leadership and support for the national response. Achievements are examined for work with civil society, dealing with gender, provision of technical support, human rights and the greater and meaningful involvement of people living with HIV.

[8] UNDP did not apply for a funding opportunity of up to $100,00 for work with MSM from UNDP Headquarters during 2008 despite encouragement from the UNAIDS Secretariat country office to do so.

Involving and working with civil society[9]

3.36 Recognition of the need to work with civil society can be found throughout the evaluation period in the UNDAFs for 2001-2005 and 2006-2010. Plans were made to further develop the meaning of partnership with the wider development community, including civil society, in order to improve utilisation of international assistance and increase civil society and private sector participation and contribution to policy discussion and social and protection services.

3.37 Engaging civil society in the national response to HIV has been considered as one of five strategic objectives of UNAIDS and has been consistently supported by all UN agencies through the UNDAF and One Plan. Government has encouraged civil society to participate in all social and political process, including the national response to HIV. Early in the epidemic, civil society participation in policy making was mainly limited to mass organisations such as the Vietnam Women's Union (VWU) and Fatherland Front and some religious organisations. UNAIDS has adopted a broader notion of civil society organisation to include PLHIV groups, mass organisations, the private sector, religious organisations, international and local NGOs. Strategies for work with civil society have included ensuring civil society participation in all aspects of development and implementation, strengthening capacity for service delivery, and strengthening capacity to mobilise resources and engage in policy dialogue.[10]

3.38 In a group discussion with representatives of civil society organisations, a force field analysis exercise was carried out to examine civil society views about factors affecting progress towards an improved national response. The results are reproduced in Annex 6.

3.39 Unlike in other sectors, there has been an expansion of civil society organisations working in HIV and AIDS in the last decade, as the result of increased donor funding for HIV. However, establishment of organisations of more marginalised groups, such as MSM and PLHIV, and their participation in the national response is a more recent development. The joint team has taken advantage of UNAIDS' good reputation in Vietnam to advocate for the participation of marginalised groups in development of legislation and service delivery. The UNAIDS Secretariat country office has also facilitated partnership development among civil society organisations and marginalised groups. The most successful is the formation of the national umbrella PLHIV group, VNP+, which is in the process of official registration and has created a relationship with APN+, the regional network of organisations of PLHIV. The recent establishment of the Vietnam Civil Society Platform on AIDS (VCSPA), whose formation was facilitated by UNAIDS, provides an opportunity for un-registered groups to participate in the national response and gain access to resources.

3.40 Despite these positive developments, these groups still lack the capacity to participate fully in policy making, and capacity building is the focus of the UNAIDS Secretariat country office strategy for work with civil society in 2009.

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[9] Civil society and civil society organisations (CSOs) refers to the range of organisations outside government involved in the HIV and AIDS response including non-government organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), the private sector and the media.

[10] The Independent Monitoring Team on the Hanoi Core Statement (IMT 2008) states that '*policy making at the sectoral level tends to be highly fragmented in that policy decisions emerge from multiple institutional sites and processes, rather than through a single mechanism. The fragmented nature may also affect the quality of policy dialogue. Because the policy process is not centrally organised it often appears opaque to non-government stakeholders (both donors and civil society). Donors are often unsure of how best to engage in policy dialogue and there are relatively few opportunities for civil society participation in the policy process at the sectoral level.*' The report states that HIV is an exception to the statement above as donors do have an effective forum to influence policy (the Informal Heads of Agencies and Ambassadors Groups on HIV, and its sub-group - the HPC). But for civil society, this highlights the relative benefit of analytical events such as the periodic reporting on the UNGASS commitments and the forthcoming evaluation of the national strategy as vehicles for policy engagement.

3.41 Civil society access to funding varies, depending on their structure and capacity. Mass organisations, including the VWU, are funded by the GOV. International NGOs and some local NGOs are well structured and effective in mobilising resources. In contrast, PLHIV groups and networks have difficulty in securing donor funding, because of limited capacity or lack of legal status, and access both funding and capacity building from international NGOs under the auspices of local authorities. It is difficult to track funding for civil society in view of the diverse funding channels. In addition, reporting on aid flows is very poor and inconsistent.

3.42 Advocacy and technical support from the UNAIDS Secretariat country office and other organisations enabled civil society organisations to engage in developing the Law on HIV/AIDS, which was enacted in 2007. This resulted in the right for PLHIV associations to be legally registered, which will assist these associations to access direct funding from donors. The participation of civil society in the national response has made a significant contribution to a rights-based approach being adopted through the Law on HIV/AIDS, and to the subsequent revision of related legal documents to conform to the Law. While the VWU was the only civil society representative involved in the first UNGASS report and initially on the CCM, a wider range of civil society organisations were represented in the UNGASS 2008 reporting process and on the CCM for Global Fund Rounds 6, 7 and 8.[11]

3.43 Civil society has also participated in development and implementation of programmes and services. The establishment of the Centre for Consulting on Legal and Policy on Health and HIV/AIDS has provided the legal support to ensure equity and quality of health services. Many civil society organisations and PLHIV groups have actively disseminated HIV-related policies and the Law to increase community awareness and knowledge.

3.44 Nevertheless, the participation of civil society in legislation is passive as they lack. knowledge and understanding of legislation, and organisations are often only involved late in the process. The role of civil society organisations in monitoring and evaluation (M&E) of policies, programmes and services is not clear, despite participation at all stages in the national M&E framework. To address this, capacity building for involvement in policy making processes and implementation and M&E of policies and programmes is one of the objectives in UNAIDS Plan of Action (POA) 2009.

Gender dimensions of the epidemic

3.45 The UNAIDS Secretariat and Cosponsors have been working closely to support the National Assembly, government agencies and civil society organisations over legislation and policies to protect women and girls. The Law on Gender Equity and the Law on Prevention Domestic Violence were enacted in 2007.

3.46 The UNDAF 2006-2010 indicates gender mainstreaming is a cross-cutting issue and a Gender PCG was established in 2006 under the OPMP. Gender focal points represent the Gender PCG in all PCGs to ensure gender issues are integrated in development policies and programmes and to strengthen mainstreaming mechanisms within the UN.

3.47 Gender mainstreaming is also clearly indicated in the UN Consolidated Programme of Action on HIV in Vietnam 2008-2010. While some joint team agencies use their own gender mainstreaming tools, there is no UNAIDS guidance on gender mainstreaming in HIV/AIDS programming (the draft of a Strategy on Gender Mainstreaming has been in consultation by the Gender PCG). The Gender PCG is planning in 2009 to work with individual PCGs to support

[11] Civil society self selection process for the CCM is also of note here – each constituency (Local NGOs, International NGOs) held elections and voted for representatives on the CCM. This was the case for all of Civil Society including PLHIV.

them through training and mainstreaming gender into their work, and to develop individual strategies. UNFPA and UNIFEM are co-conveners of the Gender PCG.

3.48 Gender issues have been taken into account in many projects where UNAIDS is responsible for technical support. A gender-based approach is clearly articulated in the GIPA strategy, including the percentage of female UN Volunteers, gender issue inclusion in peer education and access to quality health services. In addition, MSM are encouraged to become involved in GIPA.[12] The main national counterparts for gender work are VAAC, MOLISA and VWU. The UNAIDS Secretariat has actively encouraged VWU to work on HIV and gender and has provided capacity building to VWU members. The AIDS, Women and Reproductive Health Centre (WARHC) was established in 2005.

3.49 UNAIDS has facilitated a number of mechanisms in which gender dimensions are incorporated such as the Global Fund CCM and the gender and sexuality TWG, although it is difficult to assess the outcomes of this work.

3.50 The National Monitoring and Evaluation Framework for HIV Prevention and Control Programs, developed with technical support from UNAIDS, was issued in 2007. Of the 54 indicators, 12 provide disaggregated data by sex including in the areas HIV prevalence, PMTCT, FSW and condom use, STI, care and treatment, and people's knowledge, attitudes and behaviours concerning HIV and AIDS. Currently, monitoring of the gender-differentiated impact of programmes is limited. .

3.51 UN agencies lack internal capacity for gender analysis. Tools for gender mainstreaming are available among UN agencies and from other sources, but these have not been applied consistently and coherently. This highlights the need for gender training to improve knowledge and strengthen capacity for gender mainstreaming within the UN. Gender focal points have received technical support from their agency headquarters and regional offices as well as from the UNAIDS Secretariat Regional Support Team (RST) for their work and plans for gender training. The UNAIDS Secretariat country office has a full time Gender and Human Rights Programme Officer who is a member of the Gender PCG and of the HIV PCG.

3.52 Through VCSPA, sexual minority groups have the opportunity to represent themselves and access resources. The UNAIDS Secretariat country office has facilitated a MSM TWG with a national MSM working group and 3 provincial MSM working groups. A capacity building and a technical needs assessment has been undertaken and a capacity building plan is being rolled out. Training has been provided at both national and provincial levels, the latter through the UNAIDS Secretariat grants scheme and with the support of other partners.

Technical support to national AIDS responses

3.53 Currently, there is no national technical support plan though coordinated efforts are being undertaken by the HIV PCG to produce one (see 3.54). The UNAIDS Secretariat country office sources technical support both through the TSF and through a national consultant roster. In the event that international consultants are engaged, the secretariat pairs them with national consultants to build capacity through 'on the job' training. .

3.54 The HIV PCG has taken up all thematic areas under its remit and is tackling issues one at a time. These include MSM, human resources, detention settings (MOLISA/MOPS) and developing an action plan, which includes identifying technical support needs. Evidence of the efficacy of this approach is the increased recognition of MSM-related issues by all stakeholders in the HIV response and the expansion in the number of provinces undertaking methadone

[12] Gender equity does not receive a high priority in the government administration. Of 64 Provincial AIDS Centres, fewer than 10 are headed by women (and all are from a medical background).

maintenance programmes. Work on human resources is also part of a broader attempt by partners, including PEPFAR and the World Bank, to identify, assess and develop strategies for supporting government ministries and agencies such as MOLISA, MOPS and VACC to improve their human resource capacities.

3.55 Monitoring the quality of technical support has to date not been undertaken through formal internal or external review processes, but rather through an *ad hoc* system of checks and balances. Where technical support has been provided, the outcomes are reported to the relevant technical working group, which in turn reports to the HIV PCG. The efficacy of this system is underlined by the fact that recipients of technical support, including government partners, civil society and PLHIV organisations were positive in their assessments. [13]

3.56 All stakeholders praised UNAIDS' coordination and provision of technical support across a broad range of technical and advocacy areas. Furthermore, the assistance that the UNAIDS Secretariat country office has provided on a number of sensitive issues, including MSM and methadone therapy, was highlighted as being instrumental in creating a dialogue on MSM-related issues and in the development and scale-up of pilot methadone maintenance therapy programmes. Technical support by UN partners is seen as flexible and responsive, underscoring the high level of trust and cooperation between UNAIDS and government agencies, in particular the National Assembly and its work on the HIV-related legal framework. While partners highlighted a number of issues which require future advocacy and technical support, namely transgendered people's needs, National AIDS Spending Assessment, gender mainstreaming, and communication skills for PLHIV, these unmet needs were not the result of a lack of technical expertise within UNAIDS but rather due to national priorities and time constraints.

3.57 Monitoring and evaluation (M&E) has made significant progress but remains a weak area of the national response. Routine reporting is under the management of the VAAC and follows a pattern that is conventional in Vietnam with cumulative reporting from commune to district to province to national levels. Reporting quality is problematic. Staff do not always understand the importance of the data; the need to submit reports on time still drives the flow of data; and there are excessive demands at commune level for reporting from all sectors.

3.58 A national M&E Technical Working Group (METWG) has been established and is working well, meeting bi-monthly and chaired by VAAC. Each provincial HIV/AIDS centre has an M&E Department. Decision 28 from MOH about data collection provides guidelines on collection of routine HIV data from all 63 provinces. Provinces decide the staffing level and fund posts; respondents report an urgent need for more English language training and technical training for national M&E staff.

3.59 Capacity and orientation varies considerably among the UNAIDS Secretariat and Cosponsors. During the evaluation period, UNAIDS Secretariat country office and UNICEF have had good capacity at times. M&E in the area of harm reduction has been a challenge and the joint team is pushing for UNODC to become more involved. In 2008, UNICEF and WHO worked with the UNAIDS Secretariat country office to harmonise reporting with UNGASS. At the global level, submission dates for the Universal Access in the Health Sector and PMTCT Report Cards were harmonised, while at country level, the three partners, WHO, UNICEF and UNAIDS Secretariat, worked closely on data validation with national partners. Donor partners commend

[13] Independent Monitoring Team (2008) '*The IMT concludes that while line ministries and provincial authorities often appear sceptical of the value of external capacity building and technical assistance, they are not effectively analysing their own capacity constraints and needs, or providing guidance to donors on their preferred forms of support. On the other hand, donors also appear weak at coordinating capacity-building and technical assistance initiatives with each other*.'

the role of the UNAIDS Secretariat country office for good coordination and support for strategic information.

3.60 In view of the weaknesses with routine reporting, evaluation studies are very important. None of the cosponsors has a systematic approach to or programme of evaluations of their work in HIV. The most influential study in recent years was the Integrated Biological and Behavioural Surveillance (IBBS) carried out between October 2005 and June 2006 by the National Institute of Hygiene and Epidemiology (NIHE) with PEPFAR support. This produced seven conclusions with a clear emphasis on the need to target MARPs. This is a challenge to the national strategy which has a strongly equitable approach and emphasis on prevention and awareness raising. Opinions differ as to how well the IBBS was disseminated, but there is agreement that a follow-up survey is necessary and this is currently scheduled as part of a suite of activities associated with an evaluation of the National AIDS Strategy in 2009, and which UNAIDS Secretariat country office is facilitating with financial support from PEPFAR.

Human rights

3.61 Human rights is a sensitive issue in the country, and the UN uses the content of human rights when advocating with the government rather than specific human rights language. Nevertheless, the HIV PCG takes a rights-based approach in its overall programme development and implementation, and has demonstrated commitment through the implementation of activities supporting access to prevention, treatment, care and support services for key populations at risk and the greater involvement of PLHIV in the national response. Most HIV PCG members have attended rights-based approach training and the work plan for 2009 includes developing a roadmap for further strengthening right-based approaches. In terms of other programmatic responses, the work of UNAIDS is ongoing and extensive, including the development of a draft Advocacy Strategy, which includes a focus on stigma and discrimination, review of legislation through a rights-based prism, and mapping of legal aid services for PLHIV. Furthermore, the development of the UNAIDS response follows the pragmatic guidance provided by UNAIDS Secretariat HQ and is supported by the RST Bangkok, which in 2009 will include further training.

3.62 The general consensus among interviewees was that the involvement of networks and organisations of vulnerable populations in policy development and in the design, implementation and M&E of programmes is less than that of PLHIV. This is particularly true in relation to sex workers and drug users, whose activities are illegal. While the situation of MSM organisations is improving; for example, they were involved in the UNGASS review process, and male-to-male sex is not illegal, there appears to be greater reluctance on the part of some ministries to discuss MSM-related issues than issues related to sex work and drug use. Other vulnerable populations such as migrants and mobile populations have not been involved.

3.63 The UNAIDS Secretariat country office has been instrumental in increasing awareness of MSM-related issues, acting as the convenor of the MSM TWG at a time when other agencies were unwilling or unable to take on the issue. MSM have actively participated in this information sharing forum and are currently co-chairing the TWG.

3.64 The majority of funding for programmes and services for vulnerable and marginalised groups is provided by donors and international NGOs. Government funding for these groups is provided by the VAAC under the direction of the MOH. This has implications for coordination of services, particularly in relation to programmes and services for sex workers and drug users, as these groups fall under the purview of MOPS and MOLISA.

3.65 As Vietnam is expected to reach middle income country status in 2012, the current withdrawal of donors or the reduction in their funding is likely to accelerate, with significant implications for maintenance or scale up of services for vulnerable and marginalised groups.

Continued advocacy on the part of the HIV PCG with the government is required to increase funding for services and programmes to these groups, particularly in light of the concentrated nature of the epidemic in Vietnam.

3.66 Advocacy for and work on drafting the HIV Law and subsequent decrees and directives has improved the policy environment for vulnerable and marginalised women, PLHIV, MSM, drug users and sex workers. As noted earlier in this report, the work of UNAIDS in relation to MSM and methadone maintenance therapy has been crucial to the increase in efforts to address the needs of MSM and to the introduction and expansion of methadone maintenance pilot programmes. Interviewees suggested that, as the overall policy environment has improved, stigma and discrimination in relation to PLHIV has decreased, although there is still a perception by many in the population that HIV is intrinsically bound to social evils. Despite these improvements, coverage of HIV prevention, treatment and care services is below the Universal Access commitments and below the estimated 80% required among key populations at higher risk to effectively control HIV transmission.[14]

3.67 Since the enactment of the HIV Law, a number of decrees and directives have been issued to strengthen its content. While these provide an effective framework in theory; implementation, particularly at the decentralised provincial level, is lacking, and the absence of an effective M&E framework is a major challenge. Many interviewees indicated that this as an area for increased UNAIDS advocacy and technical assistance. In addition, legal provisions in relation to sex work, the situation of migrants and mobile populations, and the prioritisation of ART for people who are actively participating in the AIDS response, are areas which may conflict with the HIV Law.

Greater and meaningful involvement of people living with HIV

3.68 Under the UN Consolidated Programme of Action on HIV, the HIV PCG is committed to supporting the establishment of a national network of PLHIV. Efforts in support of this began in 2006, although it was only in August 2008 that VNP+ was established and office bearers elected.[15] The UNAIDS Secretariat country office was instrumental in this process and is providing ongoing support to VNP+ for legal registration, which opens the way for government recognition and financial support, and for the development and implementation of an Action Plan 2008-2010, which includes skills building for leaders and the steering committee..

3.69 The UNAIDS Secretariat was also instrumental in facilitating a self-selection process by PLHIVs for electing a steering committee for VNP+ as well as a PLHIV representative and alternate for the CCM, and is assisting VNP+ to develop organisational development guidelines. All these measures are designed to ensure that PLHIV representation is legal, democratic as well as responsive to the needs of its constituents.

3.70 PLHIV have been involved in a diverse range of national level policy and programmatic activities, including the development of the National AIDS Strategy 2004, the drafting of the HIV Law 2006 and subsequent directives and decrees, the Programs of Action on Monitoring & Evaluation and Harm Reduction, the development of the country report for the UN High Level Meeting and attendance at the HLM, as well as participation on the CCM and the sub-CCM of the Global Fund (and as of November 2008, self-selected representation).

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[14] The MOH 'measurement' of prevention coverage is usually founded on geographic availability of services and not on most-at-risk population-based access to the services. This focus on 'geographic equity' rather than 'population access' is regarded by some observers as harming discussion around the more effective delivery of prevention services to most-at-risk people.

[15] The slow progress was mainly due to the lack of a legislative framework and the sensitive nature of establishing new civil society groups in Viet Nam.

3.71 However, some concerns have been raised about the fact that a significant number of PLHIV organisations (approximately one third) are not members of VNP+. This appears to arise from a number of factors, including fear of being co-opted by the government and personality issues. This raises questions about the representativeness of VNP+ and a challenge for the GOV and the HIV PCG in how to ensure that the views of all PLHIV are incorporated into policy making as well as programme development, implementation and M&E.

3.72 A number of interviewees noted that since 2006, PLHIV participation in the HIV response has increased markedly owing to both high level government support and increased financial and technical support from donors and the joint team. This evolution is also part of the improved HIV response in Vietnam that resulted from the UNGASS Declaration (2001), the National Strategic Plan (2004) and the HIV Law (2006). Nevertheless, it must be underscored that VNP+ and other PLHIV organizations require considerable investment in capacity building, particularly communication skills, if they are to play a meaningful role in policy making, and programme development, implementation and M&E.

3.73 While PLHIV leadership is nascent, the establishment of VNP+ and election of office bearers as well as the self-selection of CCM members (replacing the previously government-appointed ones) in 2008, signals the beginning of a more independent and coordinated PLHIV movement. The development of the Action Plan, which specifically includes skills building for office bearers, underscores both VNP+'s and UNAIDS' commitment to the long-term leadership role of PLHIV in the national response.

3.74 VNP+ representatives were appreciative of the UNAIDS Secretariat's role in providing technical support, though they did highlight a number of areas which could be improved, namely, an increased emphasis on gender issues and monitoring the implementation of the HIV Law, and the UNAIDS Secretariat implementing GIPA in-house by employing an openly HIV-positive staff member.

3.75 While PLHIV participation in developing the National AIDS Strategy, HIV Law and UNGASS Report as well as participation in the HLM and presence on the CCM were cited, stakeholders were unable to answer questions about the quality and effectiveness of this participation. The general consensus was that PLHIV participation in policy development and in planning and review of programme implementation is limited, again emphasising the need for capacity building for PLHIV organisations.

4 Discussion points

The evolving response

4.1 The history of the response to the epidemic in Vietnam shows how different forces have interacted and the ways in which UNAIDS has performed. The 1990s was a period when the Government was slow to respond to the disease, viewing it initially as something associated with foreign visitors. Only slowly did the nature of the epidemic become clear and the implications of the possible scale of the challenge become apparent. In part, owing to this changing awareness, the national response has been through several stages. The original National Bureau for HIV/AIDS was set up to coordinate a cross-sectoral response. However, as the implications of the role of injecting drug use and sex work in HIV transmission began to emerge, different branches of the leadership started to vie for control of the national response. A coincidental pressure on Government to reduce the size and number of entities under the Public Administration Reform (PAR) led to the closure of the National Bureau and the formation of a National Committee for AIDS, Drugs, and Prostitution Prevention and Control; but with principal responsibility for HIV programming passing to the Preventive Medicine Department of the Ministry of Health (as HIV was viewed as a medical condition). Programme coordination was subsequently restructured under the auspices of the Vietnam Administration for AIDS Control (VAAC), which sits within MOH but outside of its departmental structure.

4.2 The national institutional arrangement therefore both recognised the multisectoral nature of the problem (by the NCADP) but in the absence of a practical way to manage multisectoral working, allowed implementation (and control over most of the funding) to be under the MOH.

4.3 The joint team response to this changing environment reveals the challenges of working in a joint programme. Firstly, leadership has been uneven in addressing the nature of the epidemic. Only since 2007**,** during the tenure of the current UNAIDS Country Director, have the implications of a concentrated epidemic and the importance of targeting IDU, SW and MSM, been made clear in policy documents and dialogue with GOV. Secondly, cosponsors have not been consistently united behind a multisectoral response. The prominent role of the VAAC and its organisational structures intensifies vertical approaches to HIV with a narrow focus within the health sector, and it often fails to address issues beyond the health sector and even beyond HIV programmes within the health sector. This led WHO to claim a leading role over and above other cosponsors, most prominently in the area of harm reduction. Thirdly, this heath sector orientation fuelled a resistance to implementing the Global Task Team recommendations for the DOL.

4.4 The situation has improved markedly. The advent of the One UN reforms has brought greater pressure across all UN agencies for team working, not only in relation to HIV. The growth in funding from bilateral sources, particularly PEPFAR has included pressure to ensure that work on harm reduction is broadly based, with a strong involvement of UNODC alongside WHO. UNAIDS Secretariat country office advocacy and work with civil society and MARPs has stimulated a slow but steady change in awareness among the leadership about the nature of the epidemic and the need to foster a supportive, inclusive environment, including the active participation of civil society, in particular people living with HIV.

Good achievements

4.5 A number of areas stand out in which the Joint Team on HIV has made a substantial contribution to the national response:

- Advocacy and development of a common UN position on legal and administrative reforms.

- Lead in coordination of the international community and partners. UNAIDS Secretariat country office convenes the Ambassadors Heads of UN Agencies group responding to HIV, as well as the HIV Technical Working Group.
- Development of a Joint UN Team on HIV and sub groups on thematic areas.
- Development of a Consolidated Programme of Action on HIV 2006-2010.
- Pilot testing of harm reduction programmes, including methadone substitution therapy and needle exchange.
- Developing directives to implement the HIV law in non-health sectors such as education.
- Establishment of a working mechanism between UNAIDS and other large bilateral donor funded initiatives have successfully addressed the project-based fragmented approach and lack of coordination within the education sector, and provided opportunities to identify strategies to fill the gaps.
- Enhancement of the role of civil society, including PLHIV, in many areas, notably the CCM and UNGASS reporting.
- Human Rights – developing a strategy and providing leadership to develop an agenda for MSM; support to develop and implement the HIV Law and decrees and directives with involvement of civil society in policy-making process; perceptions of improvements in stigma and discrimination (in the leadership, media, PLHIV, and education); support to legal aid centres; work with the National Assembly on international commitments.
- GIPA – support for the creation of VNP+ and a self-selection process for leadership; development of an Action Plan to 2018 and capacity building; institution of a CCM self-selection procedure; PLHIV involvement in developing the National Strategy, HIV Law drafting, UNGASS reporting, CCM participation; and Government endorsement of the Call for Action.
- Gender – good progress on MSM. Appointment of a dedicated programme officer for Gender and Human Rights in the UNAIDS Secretariat country office, who is also member of the joint team.

4.6 Less progress has been seen in other areas. The DOL is not well implemented, with resistance from a number of cosponsors to the implications of developing programmes driven by capacity and results rather than mandate. Technical support has lacked a clear strategy and coherent programme, but work underway on a needs assessment provides an opportunity for progress in this area.

Issues to take forward

4.7 A number of opportunities present themselves for UNAIDS (Secretariat and Cosponsors) to consolidate what has been achieved. One of the biggest challenges will come with the next round of reforms for One UN. The third One Plan (OP3) will herald a new UN planning cycle and the intention is to move to programmes that are results-orientated rather than mandate driven. This will have implications for programme leadership and joint team decision-making on staffing levels and capacity. This will be an opportunity to rationalise any lingering uncertainties in the approach to harm reduction between WHO and UNODC and to decide UNDP's intentions for HIV in general, and MSM and human rights in particular, in Vietnam.

4.8 In supporting the national response, several areas demand attention. As an overarching issue the current arrangements fall short of a functional 'Three Ones'. The NCADP is only slowly

starting to function and the VAAC does not provide an adequate organizational structure for a single coordinating body; there is one national strategy but it is now very dated, without costed programmes, and does not reflect current understanding of the epidemic; and M&E systems are not yet robust.

4.9 Several opportunities present themselves for UNAIDS to support improvements to the national response. To start with, the need to 'Know your epidemic' is prominent. The forthcoming evaluation of the national strategy offers the chance to revisit and confirm the findings of the IBBS, and spell out implications for the future national response. This is likely to emphasise investments at provincial level and to target resources where the epidemic is most prevalent.

4.10 In view of the difficulties of engaging in policy development in Vietnam, events such as developing proposals to the Global Fund and reporting to UNGASS, create space for multisectoral interaction and policy influence, especially with civil society. The planned evaluation of the National Strategy during 2009 is such an event and needs to be supported for maximum policy interaction.

4.11 HIV has long been of lower priority for the GOV than poverty or corruption. A new Socio-Economic Development Plan is due for 2011-2015. Preparations for this, which will be supported by the UN, offer an opportunity to stress the link between HIV and poverty, to advance the argument for multisectoral working, and to mainstream HIV into national programmes. In view of the pressing national concerns about other multisectoral issues such as Avian Influenza and climate change, these are chances to contribute to national policy development and cross-ministerial working.

Annex 1: List of people met

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Annex 2: List of Documents consulted

Academy for Journalism and Propaganda and Institute for Studies of Society, Economy and Environmental (iSEE). The images of homosexuals on printed and online newspapers in Vietnam during period 2004 – 2008.

Centre for Community Health Research and Development (2006). Coordination, management and utilisation of foreign assistance for HIV/AIDS prevention in Vietnam

Claire Mahon and Tony Morris (2008) United Nations Country Team Vietnam. Human Rights and Human Rights Based Approaches Training Report. Melia Hotel, Hanoi,.

Communist Party of Vietnam. Central Committee. Government Decree No. 108/2007/Nd-Cp Of June 26, 2007, Detailing The Implementation Of A Number Of Articles Of The Law On HIV/AIDS Prevention and Control.

Compulsory Drug Treatment in Vietnam: Interview with a drug user who was sent to a drug treatment centre of Hanoi. 3 November 2008. http://www.ihrablog.net/2008/11/compulosry-drug-treatment-in-vietnam.html

Follow up to HOA Meeting – Human rights and gender mainstreaming

GFATM proposals round 1,6,8

Independent Monitoring Team (2008) Independent Monitoring on the Implementation of the Hanoi Core Statement at Sectoral and Sub-National Level in Vietnam

International Monetary Fund (2006) Vietnam: Poverty Reduction Strategy Paper—Annual Progress Report. IMF Country Report No. 06/70

Joint Programme on HIV - Activity Matrix with budget estimates by agency.

Joint UN Team on HIV Report 2008. Part 3: Joint Programming.

Memorandum of Understanding between the Participating UN Organizations and The United Nations Development Programme Regarding the Operational Aspects of the One Plan Fund for Vietnam (July 2007)

Ministry of Health (2005) – National strategy on HIV/AIDS control and prevention

Ministry of Health (2006) Results from the HIV/STI Integrated Biological and Behavioural Surveillance (IBBS) in Vietnam. Hanoi

Ministry of Health (2007) – National monitoring and evaluation framework for HIV prevention and control programs

Ministry of Health (2008) – Review on health sector in Vietnam 2008 – Report on health finance.

Report From The Joint UN Team On HIV Retreat Hoi An, 18-19 November 2008.

Socialist Republic of Vietnam. Decision of the Prime Minister approving the National Strategy on HIV/AIDS prevention and control in Vietnam till 2010 with a vision to 2020. Ha Noi, 17 March 2004. Ref.: 36/2004/QD-TTg.

Socialist Republic of Vietnam. Decree No.: 54-CT/TW. Hanoi, November 30, 2005. Directive of the Party Central Committee's Secretariat. Re.: Strengthening the leadership in HIV/AIDS prevention and control in new situation. Law on HIV/AIDS Prevention and Control.

Socialist Republic of Vietnam. National Strategy on HIV/AIDS Prevention and Control In Vietnam Till 2010 With A Vision To 2020. (Promulgated together with the Prime Minister's Decision No. 36/2004/QD-TTg of March 17, 2004)

Socialist Republic of Vietnam. The Third Country Report on Following Up the Implementation To The Declaration Of Commitment On HIV And AIDS Reporting Period: January 2006 – December 2007 Hanoi, January.

Socialist Republic of Vietnam (2008) The Third Country report on Following up the Implementation to the Declaration of Commitment on HIV and AIDS

Tuan, A.N., Ha, N.T.T., Diep, V.T.B., Thang, P.H., Long, N.T., Huong, P.T.T., Duc, B.H., Wilson, David., Oerlichs, Robert., Hien, N.T. (2008) A household survey in two provinces in Vietnam estimates HIV prevalence in an urban and a rural population. *AIDS Research and Human Retroviruses Vol 24 No. 8*

Tuan, A.N., Hien, T.N., Giang, T.L., Detels, Roger (2007) Prevalence and risk factors associated with HIV infection among men having sex with men in Ho Chi Minh City, Vietnam. *AIDS Behaviour* (DOI 10.1007/s10461-007-9267-y)

UN Consolidated Programme of Action on HIV in Vietnam 2008-2010

UN RCO Vietnam (2006) Guidelines for Programme Coordination Groups (PCGs)
UN RCO Vietnam (2006) Joint UN Team on HIV in Vietnam Terms of Reference
UNAIDS (2005) Three Ones Country Mission Vietnam - Mission Report
UNAIDS (2007) UNGASS - National Composite Policy Index. Asia & Pacific, Vietnam
UNAIDS (2008) The Far Away from Home Club. *UNAIDS Best Practice Collection*. Geneva
UNAIDS (2008) Vietnam Technical Support Division of Labour.
UNAIDS Checklist on general standards for HIV-related legislation.
UNAIDS Guidance Note Addressing HIV-related Law at National Level.
UNAIDS Terms of Reference Team of 2 consultants to develop and conduct training on human rights based approaches to programming for UN staff in Vietnam
UNFPA 2008 – Gender Mainstreaming Strategy (draft version)
United Nations (2007) Tripartite Stocktaking Report. UN Reform in Vietnam
United Nations Country Team request for funds allocated under PEPFAR COP 08 in Vietnam by the United States Government.
United Nations Vietnam (4th November 2008). A snapshot: Human rights and gender mainstreaming. Power Point.
United Nations Vietnam (2007) Guidelines for Programme Coordination Groups (PCGs)
United Nations Vietnam (2008) – How external support for health and HIV will evolve as Vietnam becomes a middle-income country
United Nations Vietnam (2008) 2007 One Plan Report. September 2007 - June 2008
United Nations Vietnam (2008) Joint Donor Assessment – One Plan 2
United Nations Vietnam One Plan 2006-2010
United Nations Vietnam UNDAF 2001-2005
United Nations Vietnam UNDAF 2006-2010
United Nations Volunteers (UNV) in partnership with: the Vietnam Women's Union and the Joint United Nations Programme of HIV/AIDS (UNAIDS). Promoting Greater Involvement of People Living with HIV/AIDS (GIPA) in Vietnam. Brief Project Description.
Vietnam Call to Action for the Greater Involvement of People Living With HIV/AIDS. August 2007.
Vietnam Women's Union (July 2008). Evaluation of the 'Promoting the Greater Involvement of People Living with HIV (GIPA) Project in Vietnam'. By Jack Wallace, Australian Research Centre in Sex, Health and Society and Tran Minh Gioi, Centre for Community Health Promotion.
Vietnamese National Assembly. Law on HIV/AIDS Prevention and Control. (No. 64/2006/QH11).

Annex 3: Assessment of progress towards five-year evaluation recommendations

Rec. No.	Abbreviated description	Notes on actions taken	Progress[16]
3	Support to the GFATM	Support for development of GF proposals by UNAIDS country office and various cosponsors; assistance with reform of the CCM and more effective involvement of civil society	H
10	UNAIDS …maintains global advocacy, with particular emphasis on political and resource commitments. Opportunities need to be taken to advocate for a gendered response and to promote the successful techniques of partnerships and horizontal learning	The 2001 Declaration of Commitment is widely seen as having prompted a succession of legal and administrative changes that have improved the national response. Specific examples of global advocacy influencing the programme include global guidance on Human Rights; 2005 HIV Prevention policy position paper and Joint Policy papers with WHO/UNODC and UNAIDS on Harm reduction are cited constantly in advocacy and TA to counterpart; also Testing and Counselling Guidelines. The Asia Commission Report support to focus on MARPS through regional comparisons has been used extensively.	H
11	Secretariat expands current work on information into a substantial functional area to support the roles of coordination, advocacy and capacity building.	Work on strengthened SI agenda started and role of UNAIDS Secretariat country office praised by partners.	M
12	Develop a strategy and workplan to promote evaluations and research into impact at national and regional levels, with the aim of generating data to inform national responses. Priority should be given to studies of behavioural change and contextual factors, including gender, stigma and poverty.	Support to the 2003 revisions and later development of the National M&E Framework. No clear strategy for evaluations and research until 2008 plans to evaluate the National Strategic Plan.	L
13	Develop CRIS with objectively measurable indicators of an expanded response at country level	CRIS used only in minimal way for UNGASS reporting. CRIS has always been used in Viet Nam for UNGASS Reporting as per the recommendations from UNAIDS Secretariat HQ. However, considering the complexity of databases in use in Viet Nam by	L

[16] H-High; M-Medium; L-Low. Assessment by the evaluation team

Rec. No.	Abbreviated description	Notes on actions taken	Progress[16]
		different donors and projects, it was not possible to harmonise the different databases into one tool which could serve the different needs of different partners. In addition, it should be noted that an effort has been made to have a national coherent approach to building a national HIV information system, led by PEPFAR with support of UNAIDS Secretariat country office and WHO.	
14	UBW to bring together all planned expenditure on HIV/AIDS by the cosponsors at global and regional levels should be continued and expanded to reflect all country level expenditure as well	Most country level expenditure is outside the UBW. Progress towards consolidated planning and reporting under the JT/ One UN PCG.	M
16	Humanitarian response	Not relevant to the country situation	-
17	Cosponsors should promote high standards of transparency and reporting by publishing and making publicly available all cosponsor country and regional budgets and the annual outturn	Information is available through UN websites at national level and reports on Outturn are published.	H
18	In those countries where a medium-term expenditure framework and public expenditure review process is underway, that HIV/AIDS be treated as a specific crosscutting topic for monitoring and reporting	No inclusion of HIV in a PER and no NASA yet.	L
19	OECD donors should link their own bilateral country programmes to national HIV/AIDS strategies and make financial contributions to HIV/AIDS work by the cosponsors conditional on demonstrated integration and joint programming, reflecting the comparative advantage of the cosponsors at country level	Donor programmes are in line with the national strategy (which is very broad) but suffer from GoV-directed allocation to provincial locations. PEPFAR funds members of the Joint UN Team on HIV; other donors are project oriented.	M
20	Continue with and expand the PAF facility, especially to support monitoring and evaluation, if current initiatives by the Secretariat can be shown to improve the allocation process, utilisation and speed of processing.	PAF funds used and appreciated by some cosponsors; no complaints about processing time; allocation decisions now reviewed by the JT; an example of going to one of three cosponsors in a joint programme application	M
21	Numbers and disposition of CPA (now UCC)	*Not applicable – evidence to be developed at global level*	-
22	Theme groups should have clear objectives with monitorable indicators of both substantive change and process contributions to	Workplan of PCG has clear objectives with Op and Oc targets linked into the One Plan	H

Rec. No.	Abbreviated description	Notes on actions taken	Progress[16]
	the national strategy		
23	Expanded theme groups should evolve into partnership forums, led by government	No partnership forum as such; nearest equivalent is the Big TWG largely focused on NGOs but with very wide membership and participation.	H
24	Expand and strengthen national systems to monitor and evaluate interventions, and analyse surveillance data	TS support has been given to VAAC which leads the national M&E effort. Has been progressive, with first survey of MSM in Vietnam and IBBS generally considered satisfactory quality. Routine monitoring and reporting suffers from general weaknesses in Vietnam government systems and is unreliable.	M
25	Programme of joint reviews led by national governments should be launched	Nascent use of joint reviews (e.g. December 2008 Annual review Meeting with counterparts). Absence of coherent, costed programme under the VAAC reduces opportunities for donor community and other work is project based. Nearest equivalent was the 2007 UNGASS reporting which was broadly based with good CS participation	L
26	UN system at country level must take a strategic view of implementation of national policies and strategies and exploit opportunities for synergy between the sectors	UN trying to create opportunities for multisectoral working between health, social and security ministries. Main opportunity with harm reduction.	M
27	UNAIDS to act as a broker of good practice for local-level efforts that are designed for horizontal learning and replication	Some evidence of innovative projects; TWG, subgroups and fortnightly seminars and MSM WG have been praised for horizontal learning they provide.	M
28	Increase support for scaling up by developing strategies as a service both to national governments and to partner donors	Help with GF proposals; PEPFAR planning and design; VAAC for their DFID and WB project have UNAIDS Secretariat country office and WHO on programme review committee each year. TA is provided to VAAC and National Committee to scale up HR such as methadone and NSP in prevention.	H

Annex 4: Material from the feedback workshop

Second Independent Evaluation of UNAIDS
Vietnam Country Visit Workshop

Evaluation Team:
Derek Poate, Andrew Doupe, Nguyen Thi Thu Nam

The Workshop

- The team will share some initial thoughts and issues for group discussion …

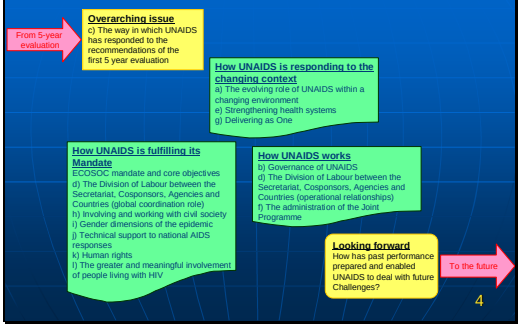
2

Purpose

- To assess the efficacy, effectiveness and outcomes of UNAIDS (including UNAIDS Secretariat, the PCB and Cosponsors) at the global, regional and country levels

3

Conceptual organisation of the evaluation questions



4

Many strong achievements:

- How UNAIDS works
  - Joint Team (PCG) operating largely in line with guidelines,
  - DOL implemented in parts: difficult issues with harm reduction; lead roles; and entry point concepts
  - Some progress with individual accountability; less so for programmes and agencies
  - JT workplan and programming
  - UNAIDS office capacity expansion with PEPFAR support
  - DaO drawn lessons from UNAIDS; but some distraction caused by One UN activities
  - Donors and NGOs appreciative of JT working
- How UNAIDS is fulfilling its mandate
  - HSS – recognised in GF Rnd 8; some work but fragmented; seen as linked to 'mandate' perspective; issues within VAAC/MOH
  - Technical Support – not yet a comprehensive plan and approach; needs assessment now going ahead; positive feedback from partners, especially for UNAIDS from CS; methadone substitution; forthcoming education sector work; support to M&E framework and upcoming evaluation also widely recognised

5

Achievements: more examples

- How UNAIDS is fulfilling its mandate (contd.)
  - Human Rights – strategy and leadership for MSM; support to HIV law and decrees; perceptions of improvements in stigma and discrimination (leadership, media, PLHIV, education); support to legal aid centres; work with National Assembly on international commitments
  - GIPA – broad but scattered work; VPN+ and self selection process; action plan to 2018 & capacity building; reform of CCM self-selection; involvement in National Strategy, HIV Law drafting, UNGASS reporting, CCM; GoV endorsement of Call for Action
  - Gender – good movement on MSM; gender audit was critical; some evidence of gender awareness in national programmes
  - Civil society – good progress - VNP+ (legal status); facilitation for VCSPA; advocacy for CS in CCM plus involvement in law and policy-making

6

Issues raised with the evaluation team

- (Health) System Strengthening
  - Need a roadmap for CB to 2012 (concern over sustainability of current work)
- Technical Support
  - Absence of a good overview; need better tracking of resources (NASA); monitoring of laws; reporting and programme M&E
- Human rights
  - Prevention leading over TCS; problems with MARPS – 05/06 centres and other closed settings (confidentiality & testing); migrants and mobile populations; mandatory testing of some occupation groups; weak monitoring and implementation of HIV law; gaps in epidemiological data affect advocacy; limited coverage of treatment and harm reduction programmes

7

Issues continued

- GIPA
  - Many PLHIV organisations outside VPN+; no known PLHIV staff member for direct contact; need more involvement in planning, implementation of CB; stigma and discrimination still a problem
- Gender
  - Need to strengthen joint team capacity and improve monitoring of gender mainstreaming
- Civil society
  - How can unregistered groups get resources – affects UN support and reputational risk
  - VCSPA exclusion of illegal groups
  - Late entry into processes
  - Internal conflicts

8

Challenges that will test the HIV PCG (UNAIDS JT)

- Internal
  - DaO (1P3); multisectoral programme effectiveness versus agency mandates
- External
  - Three ones
  - Know your epidemic – the need to emphasize provincial level work; and to target resources in the next strategy
  - Mainstreaming into the SEDP and NTP

9

Looking forward

- What will UNAIDS in Vietnam look like in 5 years time?

10

End

11

Annex 5: Timeline

	Vietnam	*Global*
2003	PM's Directive on Strengthening HIV/AIDS response	*Three Ones developed*
	1st National UNGASS Report	*3 by 5 initiative*
		US President George Bush launches the US$ 15 billion President's Emergency Plan for AIDS Relief (PEPFAR).
2004	Launch of National Strategy on HIV/AIDS Prevention and Control in Vietnam until 2010 with a vision to 2020	*Three Ones approved* *Global coalition on women and AIDS*
	Law on Child Care, Education and Protection	*High Level Forum on MDGs 2004-05*
2005	Vietnam Administration of AIDS Control (VAAC) created	*Global Task Team set up, facilitated by UNAIDS. Focuses on improving co-ordination among multilateral institutions and international donors.*
	Directive 54 issued by Central Communist Party Secretariat, providing the legal basis for mobilising support and involvement of party members	*Announcement of UN Division of Labour for technical support to assist countries to implement their annual priority AIDS action plans.*
	National Assembly: Consultation to Upgrade the Ordinance to the Law	*Children Unite Against AIDS*
	2nd National UNGASS Report on implementing Commitment Declaration on HIV/AIDS (UNGASS) covering the period of 2003 – 2005	*G8 Summit and UN World Summit both pledge to come as close as possible to universal access to ART worldwide by 2010.*
2006	Law on HIV/AIDS Prevention and Control (June 29th)	*Joint UN programme operational.* *UNGASS follow-up*
	Universal Access Initiative: Vietnam country report addressing critical challenges to universal access - Lack of financial and human resources - Aid coordination - Stigma and discrimination - Multi-sectoral commitment still weak - Lack of full social mobilisation	*UN General Assembly High Level Meeting on AIDS (monitoring the 2001 Declaration of Commitment) adopts Political Declaration on HIV and AIDS. Sets new global objective - moving towards the goal of universal access to HIV prevention programmes, treatment, care and support by 2010.*
	Vietnam Delegation's Participation in the UN General Assembly 2006 High Level Meeting on AIDS, 31 May – 2 June, New York. UNGASS 5 Year Review	*Global initiative on 'Scaling Up Towards Universal Access' set up. Facilitated by UNAIDS. Concentrates on obstacles to universal access and supporting countries to revise national AIDS plans and targets to scale up towards universal access by 2010.*
	National legal & policy developments related to HIV Response : - Gender Equality Law - Development of Domestic Violence Law	*UNITAID established*
	IBBS 2005-06	

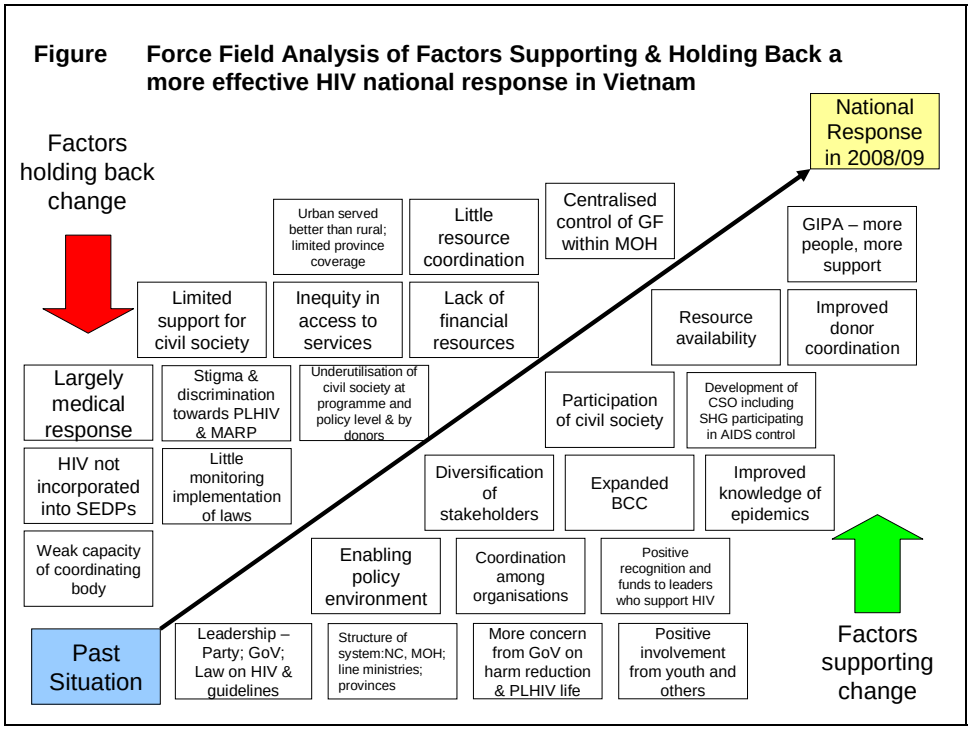
	Vietnam	*Global*
2007	3rd National UNGASS Report	
	Decision 108/2007/QD-TTg on National Targeted Programs on social diseases, epidemic and HIV/AIDS 2005-2010.	
	Nine Programmes of Action finalised by ministries: IEC/BCC (#1); Harm Reduction (#2) M&E (#4) Care & Treatment (#3&5) PMTCT (#6); Capacity Building & International Cooperation (#9)	
	Decree 108/2007 ND-CP with instructions for implementation of the Law (June 26th)	
	Inter-Ministerial Circular 147/2007/TTLB-BTC-BYT for implementation of the National Strategy on HIV and AIDS Prevention and Control; and National Programmes on Prevention and Control of Social Diseases, Dangerous Diseases and HIV and AIDS, period 2006-2010	
	Decision 29/2007/QD-TTg on Management , Care and Support, Treatment and Counselling for PLHIV in closed settings (educational, rehabilitation centres, detentions, prisons and social care centres)	
	Decision 60/2007/QD-TTg; 96/2007/QD-TTg; 67/2007/QD-TTg on support for people and children living with HIV	
	Decision 50/2007/QD-TTg on Strengthening the National Committee for AIDS, Drugs and Prostitution.	
	Establishment of National Partnership Platform on HIV/AIDS	
	Law on domestic violence passed	
2008	3rd National UNGASS Report, Vietnam Delegation's Participation In The 2008 UN General Assembly High Level Meeting on AIDS, 10 – 11 June 2008, New York.	
	Revision of the Law on Drugs	
	Increase in number of ARV Treatment patients by June: 23,695 patients	

Annex 6: Forcefield Analysis

Forcefield analysis and notes

***Context**: The information presented here are perceptions from representatives of civil society organisations during a discussion meeting. These views are not necessarily reflected in the main text of the report where evidence is validated from a range of sources.*

Figure Force Field Analysis of Factors Supporting & Holding Back a more effective HIV national response in Vietnam



Opinions on UNAIDS role in key factors for success:

- Policy and advocacy: improving awareness and enable Deputy Prime Minister and others to start talking about harm reduction (made possible through access to officials, which is better and more trusting than for PEPFAR)
- (But UNAIDS has little influence over bilateral donors)
- Key coordinating role in the 'big' TWG on HIV. Acts as Secretariat, ensure prompt translation of materials, information available on the website, knowledge about who is doing what etc. *"I have never been in a place with such well organised information sharing and coordination."* (*Quote*)
- Strong role to empower and facilitate the role of civil society (especially in preparation of the last UNGASS report)
- UNAIDS Secretariat country office helped facilitate the first national network of positive people (with Futures Group)
- UNODC good at pushing drug policy (with WHO)
- UNRC and UCC led among the UN in opening the door for the UN to work with government on HIV (Jordan Ryan)
- WHO was the first to work with the Communist Party and build trust, especially in sensitive area of harm reduction. UNDP also came to work with the CP on leadership
- More generally the UNGASS Declaration of Commitment acted as a spur for the GOV to develop a National Strategy

Areas where the UN has not been so strong

- UNICEF – work on HIV tends to get lost under child protection or PMTCT unless UNAIDS keep attention

- Greater attention necessary to underline the link of HIV to the MDGs and especially to get HIV into the SEDPs (is a requirement, but generally ignored)
- Integration of HIV and reproductive health is generally weak (struggle against PEPFAR which does not help here)
- Cosponsors and other UN much less interested in working with civil society than UNAIDS Secretariat country office
- CS see a danger that the DOL actually hinders interaction by the UN
- Some overlaps are seen in education (where apparently UN agencies have pilot projects in different provinces) but there is a sense of improvements under One UN
- Concerns that in the UN no one can act unless everyone agrees
- A sense that the UN did not support the NACP sufficiently to support the national response and pressure to reduce numbers of 'ministries' under PAR led to the change to VAAC