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VIET NAM
NATIONAL
NETWORK
OF PEOPLE
LIVING
WITH HIV

People Living with HIV
STIGMA INDEX 2014

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VNP+

Viet Nam National Network of People Living with HIV

STIGMA INDEX 2014

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CD4	Cluster of differentiation 4
FSW	Female sex worker
HIV	Human immunodeficiency virus
IBBS	Integrated Behavioural and Biological Surveillance
MSM	Men who have sex with men
OPC	Outpatient clinic
PAC	Provincial AIDS Centre
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PWID	People who inject drugs
UNAIDS	Joint United Nations Programme on HIV/AIDS
USD	United States Dollars
VCT	Voluntary counselling and testing
VND	Vietnamese Dong
VNP+	Viet Nam National Network of People Living with HIV

FOREWORD

Since its establishment in 2008, the Viet Nam National Network of People Living with HIV (VNP+) and its member self-help groups and networks throughout Viet Nam have worked hard towards ensuring that people living with HIV are able to live free of stigma and discrimination, are accorded the rights due to them under the law, and can participate in the HIV response.

We are very proud of our part in the global effort to address the need for hard evidence of stigma and discrimination. We hope that the results of the Stigma Index survey in Viet Nam will influence national policy and programmes and improve the lives of people living with HIV. Establishing a stigma-free environment is critical to Viet Nam's efforts to scale up HIV testing and treatment services to achieve the new "90-90-90" target by 2020, and ending AIDS by 2030, especially as Viet Nam moves toward a domestically funded HIV response.

The Stigma Index was first conducted by VNP+ in 2011. In 2014, VNP+ undertook a second round of the Stigma Index to analyse the stigma and discrimination currently faced by people living with HIV in Viet Nam, and to establish what positive and/or negative changes – if any – have taken place in the last three years.

The success of the Stigma Index survey in Viet Nam was a collective achievement. Special appreciation must go to the people living with HIV who served as data collectors in the five provinces where the study was conducted: Can Tho, Dien Bien, Ha Noi, Hai Phong and Ho Chi Minh City. We would also like to thank the Ministry of Health's Viet Nam Administration of HIV/AIDS Control and the Provincial AIDS Centres in the five provinces for their support and collaboration. Our gratitude also goes to the experts from government, academia, international organizations and local organizations who provided input during the Stigma Index process.

We would also like to thank the Joint United Nations Programme on HIV/AIDS (UNAIDS) for its financial and technical support. We are also grateful to the European Union Delegation to Viet Nam for providing financial support through the European Instrument for Democracy and Human Rights.

Finally, our sincere thanks to Mrs Nguyen Thi Huong Thao, who provided technical assistance for the study design and the training of the data collectors, and to Professor Vu Thi Hoang Lan and Ms Nina Allen who provided technical assistance for the data analysis and the writing of the report.

We look forward to using the Stigma Index survey results and recommendations to advocate for greater respect of the rights of all people living with HIV in Viet Nam.

Do Dang Dong

Chairperson
Viet Nam National Network of People Living with HIV (VNP+) Council
30/4/2015

EXECUTIVE SUMMARY

HIV-related stigma and discrimination are recognized both globally and in Viet Nam as primary barriers to accessing essential prevention, treatment and care services. The People Living with HIV Stigma Index was designed to address the need for a quantitative recording and analysis of the different levels and types of stigma and discrimination experienced, as well as changes in trends and with time, to inform evidence-based policy and programmes. The process of conducting the Stigma Index is as important as the result: the survey is conducted "by PLHIV, for PLHIV".

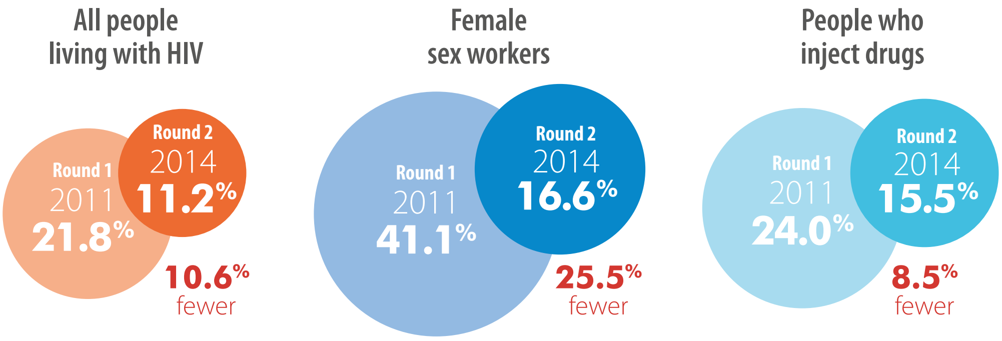
In Viet Nam the Stigma Index has been conducted by the Viet Nam National Network of People Living with HIV (VNP+). Following a first round in 2011, a second survey was conducted in 2014 to assess both current stigma and discrimination and any changes since 2011. There was a total of 1,625 respondents. Random sampling of 1,072 PLHIV attending outpatient clinics (OPCs) was conducted in five provinces (Ha Noi, Ho Chi Minh City, Can Tho, Dien Bien and Hai Phong). In addition, a purposive (snowball) sampling was undertaken among 553 HIV-positive people who inject drugs (PWID), HIV-positive men who have sex with men (MSM) and HIV-positive female sex workers (FSWs) in Ha Noi, Ho Chi Minh City and Can Tho to ensure that stigma and discrimination directed towards members of these key at-risk populations was identified and to measure any double stigma faced by these individuals.

The Stigma Index results

Decreases in stigma and discrimination

A comparison of the data from the two Stigma Indexes shows that there have been some positive changes with regard to the stigma and discrimination experienced by PLHIV in Viet Nam since 2011. Of particular note, 10.6% fewer PLHIV – and 25.5% fewer FSWs – reported having experienced rights violations within the 12 months prior to the survey date in 2014 than in 2011.

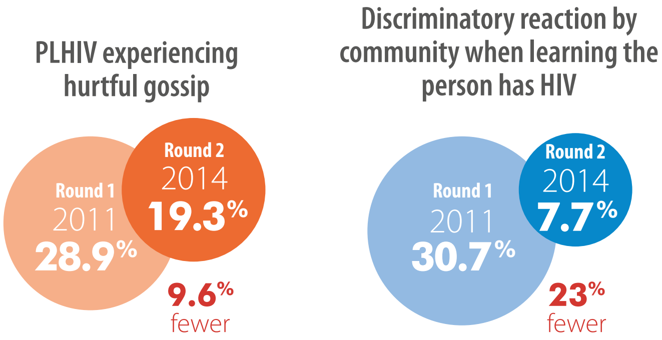
FIGURE 1:
Change in the percentage of respondents who reportd experiencing rights violations within the last 12 months*



* *percentages are from the 2011 and 2014 data sets adjusted for comparsion*

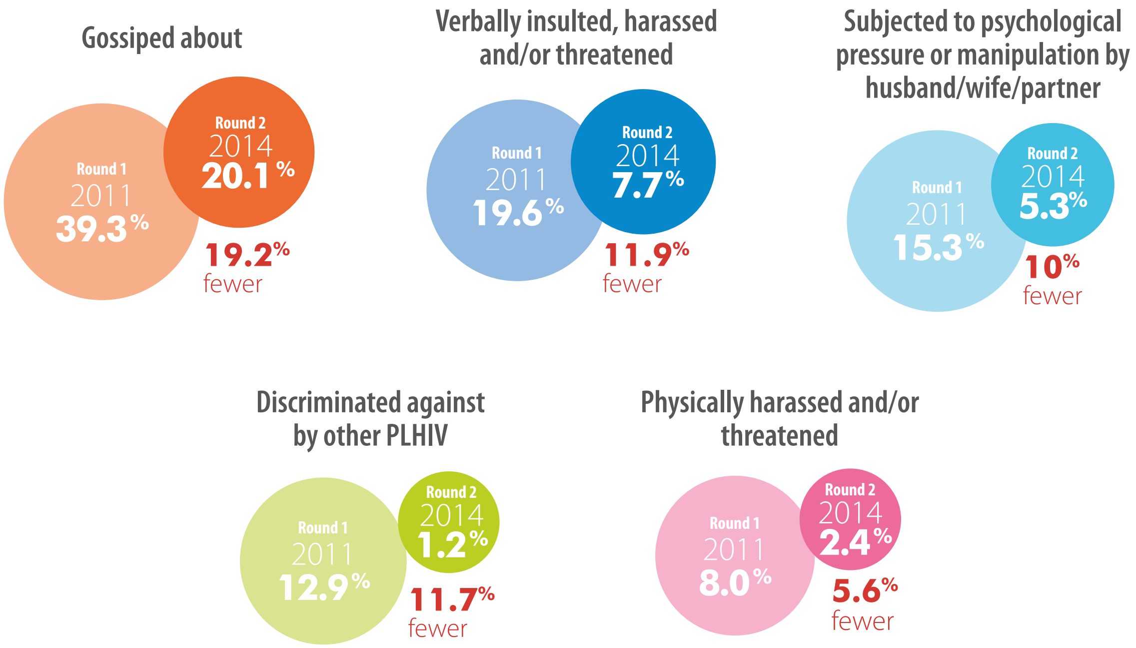
This overall reduction in rights violations was also reflected in more specific indicators of stigma and discrimination. The percentage of respondents reporting gossip reduced from 28.9% in Round 1 to 19.3% in Round 2.[1] Among recently diagnosed PLHIV, discriminatory reactions from friends, neighbours, colleagues and employers on first finding out the respondent's status was significantly lower, from 30.7% in Round 1 to 7.7% in Round 2 (see Figure 2). Among PWID, the decrease was even more marked: down from 31.9% to 4.4%. Particularly of note were significant reductions among FSWs in certain experiences of community and social stigma and discrimination (see Figure 3).

FIGURE 2:
Reduction in specific types of stigma and discrimination*



** Percentages from 2011 and 2014 are the data sets adjusted for comparison. Unadjusted percentages are used in the 2011 Stigma Index report and other sections of the 2014 report.*

FIGURE 3:
Change in the percentage of FSWs reporting community/social stigma and discrimination



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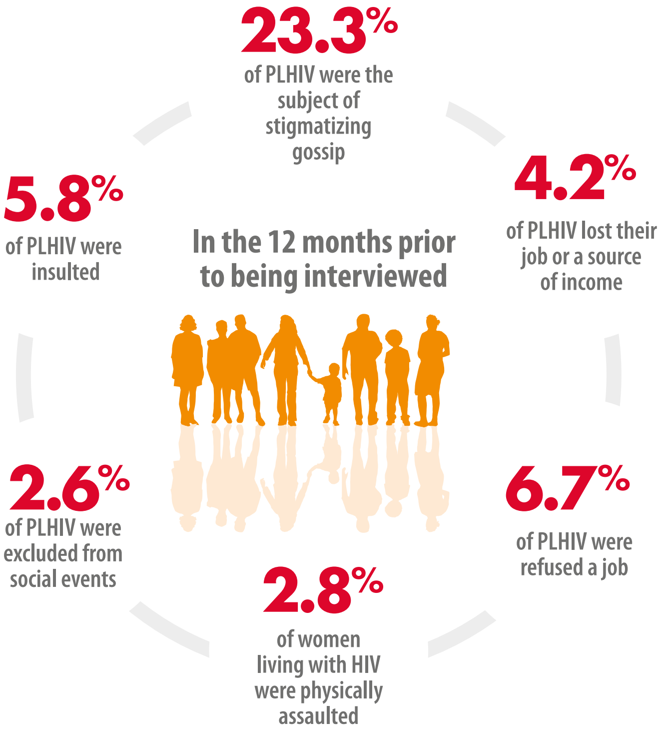
[1] Percentages reported in the comparisons of Round 1 and Round 2 are from the 2011 and 2014 data sets that were adjusted to ensure comparability. The percentage of all PLHIV who reported experiencing gossip in 2014 was 23.3%.

Stigma and discrimination remain unacceptably high

Despite these positive results, the data also show that the incidence of many types of stigma and discrimination remains unacceptably high, and particularly so for PLHIV who also engage in transactional sex, injecting drug use and same-sex relationships. These results are in line with other recent findings on stigma and discrimination in Viet Nam: for example, a 2014 national household survey found that fewer than one-third of women in Viet Nam express accepting attitudes towards PLHIV.[2]

According to the Stigma Index, FSWs, other women living with HIV and PWID were most likely to have experienced violations of their rights as PLHIV. In addition, the vast majority of all respondents who reported such violations – 94% – had not sought legal redress. Many said they had been advised not to or that they had no confidence in the outcome. PWID were the least likely to seek legal redress; MSM were most likely to.

FIGURE 4:
Unacceptably high rates of many types of stigma and discrimination



Gossip remained the most commonly reported form of stigma and discrimination, experienced by nearly one-quarter of respondents within the last 12 months. Insults and social exclusion were experienced by 5.8% and 2.6% of PLHIV respectively. FSWs living with HIV and other women living with HIV were the most likely to report physical assault (6.5% of FSWs and 2.8% of women) and verbal insults (13% of FSWs and 6.6% of women). FSWs, PWID and particularly MSM reported higher levels of both community/social stigma and discrimination and self-stigma (see below) than other respondents, indicating the existence of double stigma linked to risk behaviours as well as HIV status.

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[2] General Statistics Office and UNICEF. *Viet Nam Multiple Indicator Cluster Survey 2014, Key Findings.* 2014.

PLHIV also continue to encounter barriers to accessing and keeping employment, with no statistically significant improvements since 2011 in these areas. A total of 4.2% of respondents reported having lost their job or source of income in the previous 12 months, and 6.7% reported having been refused employment or a job opportunity in the past 12 months. The percentage of people losing their jobs was much higher among those whose employer knew their HIV status (48.8%) than among those whose employer did not (11%). These problems were even greater among key populations, particularly FSWs: 9.5% of FSWs reported losing a job and another 9.5% reported being refused a job.

In addition, 1.3% of respondents reported that they had been forced to relocate or unable to rent accommodation in the past 12 months and 1.8% of all respondents reported being denied health-care services. Again, FSWs seemed particularly vulnerable, with 5.9% reporting having to move or being unable to rent a home, and 3.6% being denied health-care services.

Quality and confidentiality of health care and HIV testing a concern

The Stigma Index revealed concerns about the quality and confidentiality of health care: many PLHIV (60.1% of all respondents in 2014) reported not having been able to discuss their treatment with a health-care worker. Service delivery can be unfriendly and sometimes unethical. Of particular concern is the fact that 3.1% of respondents (and 5.6% of PWID) said that they were coerced into testing, while 7.6% of all respondents were tested without their knowledge. Among recently diagnosed PLHIV,[3] 7.7% said they had been forced to take an HIV test.

In addition, there are very high rates of disclosure to others without the consent of the person involved, with over one-third of all respondents (37.5%) and nearly half of PWID (45.3%) reporting this. There was no statistically significant evidence that this has decreased since 2011, nor is there significant evidence of any improvement in respondent confidence in the health system's ability to keep their medical records and/or HIV status confidential. Recently diagnosed MSM have even less faith than other PLHIV that their results will be kept private – only one-quarter (25.5%) expressed such faith in 2014, compared to 40.5% of all recently diagnosed respondents.

Stigma and discrimination remain formidable barriers to ending AIDS

The Stigma Index results reveal formidable barriers to achieving Viet Nam's new "90-90-90" HIV testing and treatment targets and the global goal of ending AIDS by 2030. High levels of stigma and discrimination combined with low confidence in the confidentiality of HIV testing mean that many PLHIV only seek an HIV test after their immune systems become extremely weak and they develop symptoms of opportunistic infections: 37.7% of all male respondents, 29.7% of PWID, 21.9% of FSWs, 17.9% of MSM and 17.8% of all female respondents said they took a test because of suspected HIV-related symptoms. Testing only after symptoms appear results in the very late initiation of ART, which is dangerous for the health of the patient and, from a public health standpoint, fails to take advantage of the preventative benefits of antiretroviral treatment.

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[3] Those who selected "0-1 year" for the question "How long have you been living with HIV?"

FIGURE 5:
Among recently diagnosed PLHIV

At the same time, respondents – particularly men (22.6%) – reported high rates of non-disclosure to partners. Among recently diagnosed PLHIV, 63.7% of those interviewed in 2014 had not disclosed their status to their husband/wife/partner compared to 38% of those interviewed in 2011. There were also very high rates of non-disclosure by FSWs to their clients (91.1%) and by PWID to their injecting drug partners (33.3%). Such non-disclosure has clear implications for HIV prevention.

Self-stigma

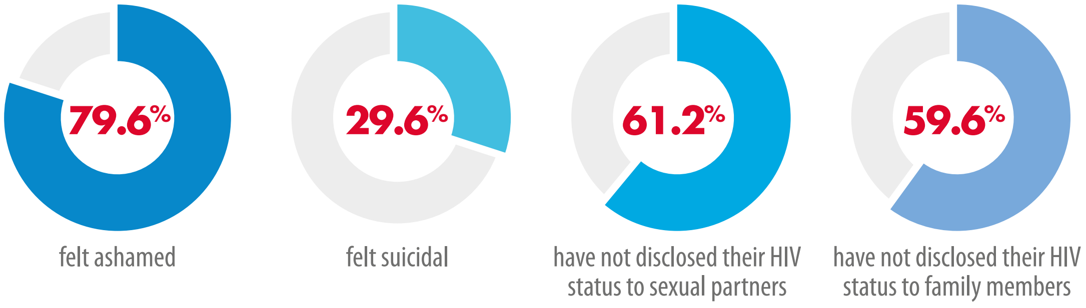
Over two-thirds of PLHIV continue to self-stigmatize, experiencing negative emotions relating to their HIV status and taking potentially harmful decisions. An alarming one in three MSM said they felt suicidal, compared to around 7% of all survey participants, and MSM and women were most likely to avoid seeking health care when they needed it (28.3% of MSM said they had avoided going to a local clinic and 21.8% of women said they had avoided going to hospital). However, a comparison of the 2011 and 2014 Stigma Index data suggests that self-stigmatization as a whole decreased. The percentage of respondents who did not report experiencing any negative emotions increased from 26.5% to 32.9% between Round 1 and Round 2, while the percentage of respondents who did not report taking any potentially harmful decisions increased from 14.1% to 30.1%.

Men who have sex with men

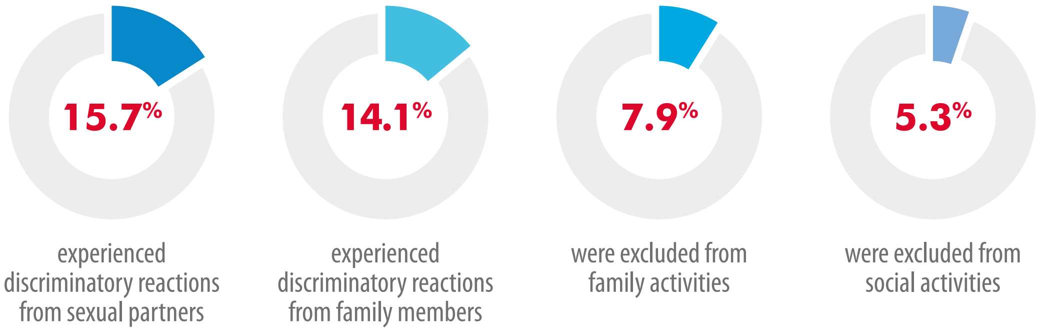
Throughout the Stigma Index data analysis, the results among MSM living with HIV often stood out. Despite having significantly higher levels of education and income than other PLHIV, they also seem to suffer higher levels of stigma and discrimination, including discriminatory reactions from partners and family (15.7% of MSM reported such reactions from sexual partners and 14.1% from other adult members in the family); familial and social exclusion (7.9% and 5.3% respectively); and self-stigmatization (nearly 80%, for example, reported feeling ashamed, and nearly 30% had felt suicidal). In addition, a very large proportion of MSM had not disclosed their status to sexual partners (61.2%) and family (59.6%), let alone others, with implications for both HIV prevention, and for support and health care for MSM themselves. These higher levels of stigma and discrimination can almost certainly be linked to their sexual orientation, which amounts to double stigma due to both their HIV status and their sexuality.

FIGURE 6:
MSM living with HIV report particularly high levels of stigma and discrimination

Percentage of MSM living with HIV who:



Percentage of MSM living with HIV who:



MSM were also more likely to report issues with health care, including a lack of access. They had very low rates of talking to health-care workers (only 16.6% reported having done so) and a total of 28.3% reported avoiding going to local clinics when they needed to because of self-stigma. Finally, MSM reported even less confidence in the confidentiality of their test results than other respondents, and much less than in 2011 (see above).

The MSM in the study were also younger and more recently diagnosed – possibly meaning they had not had as much time to initiate treatment, seek support and adapt to their status. These findings were in line with national epidemiological data that suggests the epidemic among MSM is newer and still growing, compared to older and more stable epidemics among PWID and FSWs.

Recommendations

Populations at higher risk of stigma and discrimination

Given their particular vulnerability to certain forms of stigma and discrimination, some groups of PLHIV need targeted interventions. FSWs and PWID living with HIV and suffering from double stigma because of their HIV status and their risk behaviours need:

- Increased outreach activities at the grassroots level to provide support for individuals facing stigma and discrimination;

- Support for the formation and maintenance of self-help groups to help them connect and cooperate with harm-reduction and community-integration services;
- Community-level training to increase knowledge about their rights to live free from stigma and discrimination and to have access to HIV, sexual and reproductive health care and other health services; and
- Meaningful involvement of FSW and PWID community leaders in the piloting of HIV service innovations and the adoption of lessons learned in national HIV service guidelines and policies.

FSWs living with HIV and other women living with HIV, who suffer higher levels of verbal abuse and/or harassment and physical assault, need:

- Awareness-raising programmes for FSWs living with HIV and women living with HIV on their rights and information on available support services;
- Measures to create an enabling environment for networks and groups to advocate for and provide support to female and transgender sex workers who are survivors of violence, including an online peer support channel; and
- Comprehensive and integrated support services including a hotline, one-stop crisis centres and shelters where survivors can receive counselling, health care, voluntary and confidential HIV testing and services, as well as legal support

MSM, given their isolation, high rates of stigma and discrimination and the challenges surrounding HIV testing and the quality of care, need:

- Behaviour change communication activities undertaken in collaboration with famous Vietnamese personalities, such as film actors, focused on supporting MSM living with HIV at the community level;
- Community monitoring surveys and mapping of quality, MSM-friendly testing and counselling and sexually transmitted infection (STI) and ART care and treatment services; and
- Further investigation and analysis into MSM as both an emerging key population at risk of HIV and as targets of stigma and discrimination.

Testing, disclosure and confidentiality

- Specific measures are needed to increase the confidentiality of test results. This will help to reduce the fear of disclosure without consent and the risk of stigma and discrimination, and to increase the likelihood that people will be tested early enough for the most effective outcomes and maximization of the preventative benefits of treatment in line with Viet Nam's new 90-90-90[4] targets and Investment Case strategy.

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[4] 90% of people living with HIV know their status; 90% of all people diagnosed with HIV receive sustained antiretroviral therapy (ART); and 90% of all people receiving ART have durable viral suppression.

Rights and legal support

- Local authorities must ensure compliance with the existing legal provisions that provide protection for PLHIV, in particular regarding rights to employment and education, through educational measures that target the community and workplaces and through consistent application of legal sanctions.
- State and non-state providers of legal aid should support PLHIV to seek legal redress when their rights are violated, in collaboration with self-help groups and networks of PLHIV.

Health care

- The quality of health care for PLHIV, particularly interactions with health-care workers and particularly for MSM living with HIV, should be improved through education and training for health-care staff and in collaboration with self-help groups and networks of PLHIV.
- Health-care services and VNP+ member groups should establish a collaborative mechanism to refer and support PLHIV who have experienced stigma and discrimination at the hands of health-care staff.

Further research

- More research is needed to further refine national understanding of stigma and discrimination and the development of anti-stigma laws and policies. Key areas include stigma and discrimination suffered by MSM, PWID, FSWs and women living with HIV and stigma-related barriers to health and HIV service delivery.
- In keeping with the global objective of the Stigma Index to track progress made regarding stigma and discrimination, another round of the Stigma Index should be conducted in four to five years.

I. INTRODUCTION

Viet Nam's HIV epidemic

Viet Nam's HIV epidemic is concentrated primarily among people who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSWs) (with prevalences in 2013 of 10.3%, 3.7% and 2.6% respectively).[5] Viet Nam has made great efforts to provide prevention, care and treatment services to people living with HIV (PLHIV) since the first case of HIV was identified in the country in 1990. As a result, the number of new infections has stabilized; there has been a significant decline in HIV prevalence among PWID and new infections among FSWs and their clients have also declined; there have been improvements in prevention of mother-to-child transmission (PMTCT) services; and AIDS-related morbidity and mortality have been reduced through the scale-up of testing, treatment and care services, including increased antiretroviral therapy (ART) coverage.[6]

Most recently, and in line with a growing global consensus, Viet Nam has committed to ensuring, by 2020, that 90% of people living with HIV know their status; that 90% of all people diagnosed with HIV receive sustained antiretroviral therapy (ART); and that 90% of all people receiving ART have durable viral suppression[7] (the "90-90-90" targets). These "90-90-90" targets form part of a wider strategy – Viet Nam's "Investment Case" for the HIV response – that will work towards Ending AIDS by 2030. This means reducing HIV incidence and AIDS-related deaths to levels that no longer represent a major health threat to any population.[8]

However, HIV remains a formidable challenge for Viet Nam: HIV and AIDS are a major public health problem. Investment in HIV prevention has not been sufficiently targeted on key populations, and harm-reduction intervention coverage[9] for these key populations is still far below the level required to contain the epidemic. The coverage of prevention and treatment services does not always match the distribution of reported HIV cases, meaning that people in some areas of high need are not being adequately served. There is an increasing gap between ART need and ART coverage.

There are also new and complex transmission dynamics. HIV infections are increasing in remote and mountainous areas, where socio-economic development is not as advanced as in urban areas, people's understanding of HIV and AIDS is limited, transportation is difficult and there is a lack of access to HIV services. Although data on the epidemic among MSM are still lacking, recent studies indicate that HIV prevalence in this key population is increasing, particularly in

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

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

[7] This means not only that the person living with HIV will be healthier, but that s/he is much less likely to transmit HIV to others. See, for example: World Health Organization (WHO). *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach*. 2013.

[8] The Investment Case priorities are: (1) Bring to scale evidence-based and comprehensive harm reduction for key populations; (2) Scale up HIV testing and treatment, including immediate treatment for key populations; (3) Focus resources on key populations in high-burden areas; (4) Sustainable financing, including increasing the state budget and the role of health insurance; (5) Integration and decentralization of HIV service delivery systems, including health systems strengthening; and (6) Sufficient supply of ARV drugs, methadone, reagents and other commodities for the HIV response. Viet Nam Ministry of Health. *Optimizing Viet Nam's HIV Response: An Investment Case.* 2014.

[9] Provision of clean needles and syringes and condoms and methadone maintenance therapy.

urban areas and among MSM who inject drugs.[10] In addition, a substantial proportion of all new infections are occurring within intimate partner relationships. In 2013, the greatest number of new infections occurred among men who share needles while injecting drugs and between high-risk men[11] and their long-term female sexual partners: 45% and 28% respectively.[12] Indeed, it has been estimated that nearly 54% of infections among all women can be solely attributed to the risk behaviour(s) of their male sexual partners.[13]

Stigma and discrimination in Viet Nam

PLHIV in Viet Nam continue to face stigma and discrimination from their families and communities. PLHIV and key population leaders at consultation meetings for the Investment Case were vocal about the challenges they face, and it has been found that fewer than one-third of women in Viet Nam express accepting attitudes towards PLHIV (28.9% in 2011 and 30% in 2014).[14] Not only is being HIV-positive stigmatized, but so are risk behaviours (such as injecting drugs, engaging in sex work, or male same-sex sexual relations).[15]

Stigma and discrimination can include insults, violence, ostracism and abandonment by family, friends and community; the loss of jobs; expulsion from school; and exclusion from health-care services. These experiences not only impact on the livelihoods and health of PLHIV, but also mean that they cannot access the care and support they need from the people around them; this is particularly serious where PLHIV are stigmatizing themselves and are therefore emotionally more vulnerable. Finally, and understandably, the fear of stigma and discrimination is a major barrier to the uptake of HIV-related services, including harm-reduction services, but in particular regular testing and early initiation of treatment. People at high risk of HIV infection may well be very afraid to learn their HIV status, meaning that they are unwilling to take a test and, when they do, they start treatment very late. This means that their health suffers, and that the preventive benefits of treatment are lost. There is substantial global evidence that early initiation of ART not only keeps PLHIV healthier and more productive, but also lowers the amount of virus in their blood, reducing the risk of transmission.[16] In this context, concerns about confidentiality are especially challenging.

The People living with HIV Stigma Index

HIV-related stigma and discrimination are recognized across the world as primary barriers to addressing prevention and care issues. As indicated above, when people face the risk of stigma and discrimination, or are afraid of stigma and discrimination, fewer may practice behaviours that protect them from infection, disclose their HIV status, or access voluntary counselling and testing (VCT), treatment, care and support services.

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[10] Viet Nam Administration of AIDS Control (VAAC). *Viet Nam AIDS Response Progress Report*. 2014.

[11] Men who have injected drugs, men who have sex with men and/or men who are clients of sex workers.

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

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

[14] As measured by women who: (1) think that a female teacher living with HIV should be allowed to teach in school; (2) would buy fresh vegetables from a shopkeeper or vendor living with HIV; (3) would not want to keep it a secret if a family member became infected with HIV; and (4) would be willing to care for a family member living with HIV who became sick. See: General Statistics Office and UNICEF. *Viet Nam Multiple Indicator Cluster Survey 2014, Key Findings.* 2014. and General Statistics Office. *Viet Nam Multiple Indicator Cluster Survey 2011, Final Report.* 2011.

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

[16] World Health Organization (WHO). *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach.* 2013. World Health Organization (WHO). *Antiretroviral treatment as prevention (TASP) of HIV and TB - Programmatic update.* 2012.

In order to understand the experiences of PLHIV of HIV-related stigma and discrimination in their communities, as well as changes in stigma and discrimination in Viet Nam over time, two rounds of the People living with HIV (PLHIV) Stigma Index were conducted in Viet Nam in 2011 and 2014. The PLHIV Stigma Index was developed by the Global Network of People Living with HIV/AIDS (GNP+) and the International Community of Women Living with HIV/AIDS (ICW) under a two-year programme funded by the United Kingdom Department for International Development (DFID) and the International Planned Parenthood Federation (IPPF), in partnership with the Joint United Nations Programme on HIV/AIDS (UNAIDS).

The Stigma Index process is as important as the result. Surveys are conducted "by PLHIV and for PLHIV": PLHIV implement the study, collect and analyse the data. In Viet Nam, the Stigma Index was undertaken by the Viet Nam National Network of People Living with HIV (VNP+), an organization run by and for PLHIV. VNP+ was officially established in 2008 and has since expanded to include 175 self-help groups across the country. VNP+ works to: advocate for the rights of HIV-positive people, including access to treatment, care and support; improve prevention activities; fight stigma and discrimination; and increase the involvement of PLHIV in all aspects of the HIV response. The organization creates and maintains information channels among groups, organizations and individuals, thereby helping to form linkages and facilitate information- and experience-sharing related to HIV activities. VNP+ was supported in conducting the Stigma Index by UNAIDS, the Government of Viet Nam and other partners, and the results will provide important inputs to the Government's efforts to increase uptake of HIV prevention, treatment, care and support services.

The Stigma Index comprises three main components which provide information about:

1. The demographic characteristics and socio-economic conditions of PLHIV;
2. Stigma and discrimination, including: community/social stigma and discrimination; access to employment, education and health services; self-stigmatization; rights, laws and policies; and capacity and support for effecting change; and
3. Health services, including: diagnosis and testing; treatment; reproductive health-care services; and information management and confidentiality issues.

The use of the Stigma Index enables a comprehensive quantification of the nature of the stigma experienced by PLHIV. For example, it is too often assumed that stigma is directly related to the HIV-positive status of an individual only. At the same time, it is also often assumed that individuals from key vulnerable populations (such as men who have sex with men, female sex workers and people who inject drugs) may face double stigma that stems not only from their posititive status but also their behaviour or sexual orientation. Such assumptions can be verified against the Stigma Index results. The Stigma Index also enables comparisons over time within a country, as well as between different countries.

This report uses data from the two rounds of the Stigma Index in Viet Nam to analyse stigma and discrimination against PLHIV in 2014 and to document changes in HIV-related stigma and discrimination between 2011 and 2014.

II. METHODOLOGY

2.1. Locations and target populations

In both 2012 (Round 1) and 2014 (Round 2), the survey was conducted in five provinces – Can Tho, Dien Bien, Ha Noi, Hai Phong and Ho Chi Minh City – to cover a range of geographical and economic conditions, HIV prevalence and donor presence and to enable a comparison between the two rounds.

As the HIV epidemic in Viet Nam continues to be concentrated among people who inject drugs (PWID), female sex workers (FSWs) and men who have sex with men (MSM), the samples for Round 2 were calculated to enable an analysis of the stigma and discrimination experienced by these key populations at higher risk.[17]

TABLE 1:
Stigma Index participants by province and gender

Province	Total sample			
	Men	Women	Trans-gender	Total
Ha Noi	190	191	1	**382**
Hai Phong	73	77	0	**150**
Dien Bien	79	47	0	**126**
Can Tho	68	59	0	**127**
Ho Chi Minh City	563	267	10	**840**
Total	**973**	**641**	**11**	**1625**

2.2. Sampling method

There were a total of 1625 participants. The sample sizes from each province were calculated to be proportionate to the number of reported HIV infections in each province, and then adjusted to ensure the representation of the key populations (PWID, FSWs and MSM).[18] The largest number of participants were in Ho Chi Minh City (840 participants), followed by Ha Noi (382 participants), Hai Phong (150 participants), Dien Bien (126 participants) and Can Tho (127 participants).

a. Selection criteria

Those responding to the survey were required to meet the following criteria:

- Man/woman living with HIV
- Aged 18 or above
- Willing to participate

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[17] For further explanation see below and Annex 1.

[18] The minimum sample size for each key population in each province was 30 respondents. The expected sample sizes were further adjusted in light of feasibility issues (ease of access to different key populations differs by province).

b. Sampling process[19]

Of the 1625 PLHIV participating in the study, 1072 were interviewed at outpatient clinics (OPCs) in the five provinces (the remaining 553 were interviewed in the community). These 1072 people were selected through systematic random sampling by VNP+ coordinators of a pre-screened list of OPC clients provided by Provincial AIDS Centre (PAC) staff. The PAC and VNP+ staff collaborated with OPC staff and peer educators to contact the selected participants, explain the process and ensure informed consent.

Where it was found that an insufficient number of members of key populations had been interviewed in OPCs, snowball sampling was used. In Dien Bien and Hai Phong, all respondents were sampled at the OPCs. However, in Can Tho, Ha Noi and Ho Chi Minh City, not enough PWID, FSWs and MSM had been interviewed. In these three provinces, 10 people were randomly selected by VNP+ leaders and coordinators from a list of members of PLHIV self-help groups and interviewed. At the end of the interview, each of the 10 people was asked to introduce the interviewer to 2 other members of the key population. This process was repeated until the required number of participants in each province was reached (a total of 553 people).

TABLE 2:
Sampling method by province

Province	Selected at OPCs	Snowball sampled
Ha Noi	257	125
Hai Phong	150	0
Dien Bien	126	0
Can Tho	52	75
Ho Chi Minh City	487	353
Total	**1072 (66%)**	**553 (34%)**

2.3. Qualitative and quantitative survey methods

The participants were interviewed using the same questionnaire as for Round 1 (see Annex 3). As in Round 1, the questionnaire was supplemented by qualitative research in the form of in-depth interviews, which aimed to obtain information on the personal experiences, opinions and perceptions of respondents. This was particularly important as the issue of stigma and discrimination is a sensitive one for PLHIV. It was hoped that the case studies would be a powerful advocacy tool and serve to complement the quantitative data collected by the index. Four in-depth interviews were conducted in each of the five study provinces, providing a total of twenty case studies. The subjects of the interviews were selected when the interviewer judged their case to be interesting. The interviews were conducted subject to the agreement of the respondent, and after review of their completed questionnaire by the survey team leader in each province.

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[19] For a full description of the sampling processes, please see Annex 1.

2.4. Ethics and confidentality

The survey was based on the principle of informed consent, with each participant being fully informed about the nature of the study, who was involved in it, how the data would be processed and stored, and what the data would be used for, and then asked to consent to the collection and processing of their personal data. Participants were also welcome to refuse to be interviewed, to withdraw from the survey, or to refuse to answer a specific question or set of questions, at any time.

Every effort was made to ensure that the data collected were kept confidential (i.e. secret), including through the use of safeguards such as the use of unique identifying codes so interviewees' names are never written on the questionnaire; the separate and secure storage of the informed consent forms and the lists of names and the contact details for each interviewee (alongside their unique identifying codes); and the planned destruction of these papers after the finalization of the study.

2.5. Data management

The data collection, data entry and analysis of the data were conducted by VNP+ members with technical assistance from independent consultants and UNAIDS. The data were entered and managed using Epi Info and were cleaned and analysed using SPSS 19.

2.6. Data analysis

The survey data was analysed along the same themes identified in Round 1, and included separate analysis for men and women and – in order to investigate double stigma – for key populations at higher risk living with HIV.[20]

An important objective of this second Stigma Index report is to identify any changes in HIV-related stigma and discrimination between 2011 and 2014. This was achieved by linking and analysing the data produced by the two rounds of surveys. Several important indicators were selected for comparison purposes, and some new indicators were developed. The analysis was conducted both for the whole sample and individually for the key populations of PWID, FSWs and MSM.

Following the data analysis, a meeting with stakeholders was held in Ha Noi (in October 2014) to validate the findings.

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[20] For more information on the analysis, please see Annex 1.

[21] For more information on the indicators, please see Annex 1.

2.7. Differences in the definition of key populations between the two rounds of the Stigma Index

There was an important change in the method of identifying key populations at higher risk (PWID, FSWs and MSM) in Round 2. In Round 1, the key population-specific analysis was conducted on data from the snowball sample alone (and not on data from members of the OPC-sampled group who were also members of key populations). However, in Round 2, the analysis was conducted on all respondents (in both the OPC and snowball samples) who self-identified as PWID, FSWs or MSM when answering the questionnaire.[22] This meant that a larger sample of key population members was available for analysis.

However, it also meant that the raw data from Round 1 of the Stigma Index – i.e. the data that appear in the 2011 report – cannot be directly compared to the raw data from Round 2 – i.e. the data that appear in the main analysis of this report –because the definitions of the key populations were different in the two rounds.[23] Further analysis was necessary in order to investigate any changes in stigma and discrimination over time. This involved reanalysing the data from Round 1 to include all respondents who self-identified as members of key populations, and not just those from the snowball samples, and adjusting the sets of data from both rounds to account for other significant differences in the populations (see Annex 1 for more details).

TABLE 3:
Members of key populations (Round 2) (self-identified)[24]

Province	MSM	FSWs	PWID	Total
Ha Noi	27	89	101	**217**
Hai Phong	0	2	66	**68**
Dien Bien	0	0	75	**75**
Can Tho	2	39	47	**88**
Ho Chi Minh City	123	39	267	**429**
Total	**152**	**167**	**556**	**877**

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[22] For more information, see Annex 1.

[23] For more limitations, see Annex 1.

[24] For further explanation see Annex 1.

III. FINDINGS

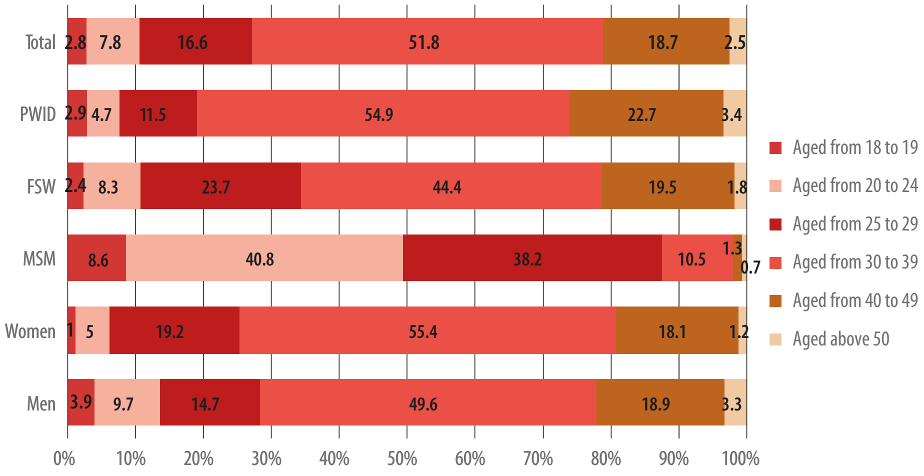
3.1. Demographic, socio-economic status and vulnerability

a. Age, years of knowledge of HIV status, geographical distribution, current relationship status and children

Of the 1625 PLHIV who were interviewed in Round 2, a total of 973 respondents were male (nearly 60%), 641 were female (about 40%) and 11 identified as transgender.

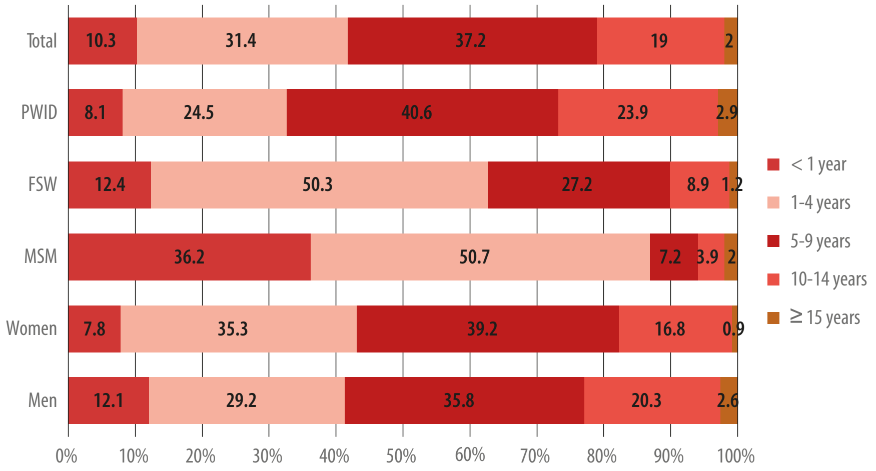
Figure 1 shows the age distribution of the respondents. Among both men and women, the most common ages were between 30 and 39 (49.6% of men and 55.4% of women). The MSM in the survey were younger than both the average of the whole sample and members of the two other key populations, with most MSM between the ages of 20 and 24 (40.8%) or 25 and 29 (38.2%) and more MSM respondents aged between 18 and 19 (8.6%) than either PWID or FSWs.

FIGURE 7:
Age distribution of PLHIV



The majority of respondents had known that they were HIV-positive for more than one year but less than nine years (Figure 2). MSM reported the highest proportion of recent diagnoses, with 36.2% saying that they had learned their status within the previous 12 months. This points to a newly emerging epidemic among MSM, and can also be linked to the fact that this population is younger than other groups of PLHIV. More PWID than other PLHIV had known their status for more than 15 years, reflecting the nature of Viet Nam's epidemic, which has historically been driven by injecting drug use.

FIGURE 8:
Years of knowledge of HIV status[25]



Most respondents lived in large towns or cities (73.6% of men and 70.6% of women). The distribution of PWID and FSWs is similar to that of the whole group of respondents, while even more MSM than others (84.2%) lived in large towns or cities. This may mean that these respondents have greater access to services, which tend to be concentrated in urban areas, than those who live in rural areas/villages/small towns.

FIGURE 9:
Geographical distribution by gender

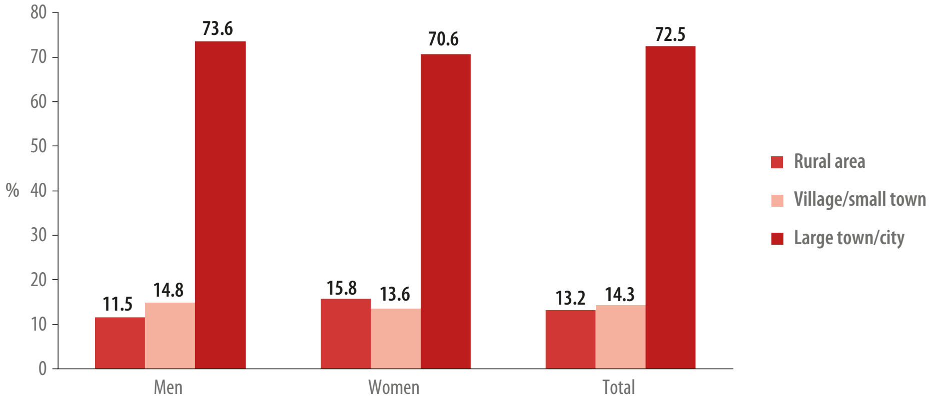


Figure 4 presents the current relationship status of the respondents. Many (45.1% of the women and 39.5% of the men) lived with their husband/wife/partner. Among the three key populations, the highest proportion of respondents who were living with their husband/wife/partner was among PWID. Meanwhile, 81.6% of MSM reported being single; this may be linked to the fact that they are younger than the other respondents. In addition, around 10% of all respondents

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[25] Answer to the question "How long have you been living with HIV?".

(except MSM) were divorced or separated, which is higher than the 2009 national average of 0.9% for men and 2% for women.[26] Finally, one in five (21.4%) of women living with HIV is a widow, probably reflecting the national increase in intimate partner transmission of HIV from a (now-deceased) husband.[27] Being widowed, like being divorced or separated, can contribute to increasing isolation and vulnerability to stigma and discrimination.

FIGURE 10:
Current relationship status

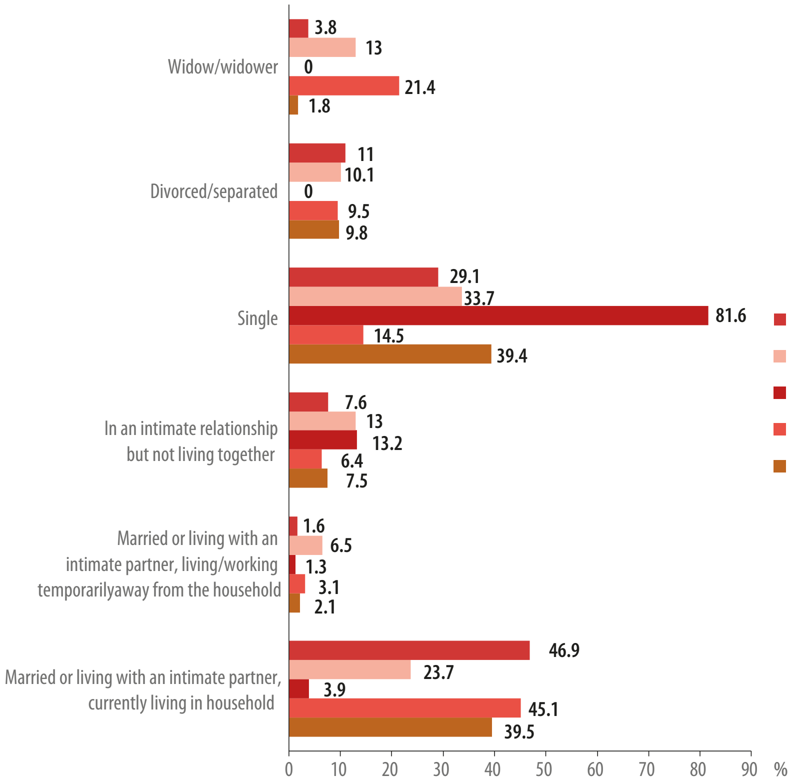

Figure 5 shows that 53.7% of the respondents had one child or more, with many more women (68.8%) than men (44%) with one child or more. Among the key populations, slightly over half of FSWs and PWID (approximately 51%) had one child or more, while only about 5% of MSM had one child or more.[28]

Of the respondents who had one child or more, 6.6% had one child or more known to be HIV-positive. The proportion is highest among women living with HIV who had a child/children, of whom 8.4% reported that at least one of their children was living with HIV. This is lower than the national average – in 2013, 19.7% of children born to women living with HIV were HIV-positive[29] – possibly because most of the female respondents were recruited at OPCs, meaning they had better access to treatment and prevention of mother-to-child transmission services.

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[26] Viet Nam Population and Housing Census 2009: Age-Sex Structure and Marital Status of the Population in Viet Nam. Ministry of Planning and Investment, General Statistics Office, 2009. http://unfpa.org/webdav/site/vietnam/shared/Census%20publications/6_Monograph-Age-Sex-Structure.pdf Accessed 24 November 2014

[27] For more on intimate partner transmission, see: Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Entity for Gender Equality and the Empowerment of Women (UN Women). *Measuring Intimate Partner Transmission of HIV in Viet Nam: A Data Triangulation Exercise. 2012 and Viet Nam Administration of AIDS Control* (VAAC). *Viet Nam AIDS Response Progress Report.* 2014.

[28] This may, again, be linked to their youth and single status.

[29] Viet Nam Administration of AIDS Control (VAAC). Viet Nam AIDS Response Progress Report. 2014.

FIGURE 11:
Respondents with one child or more

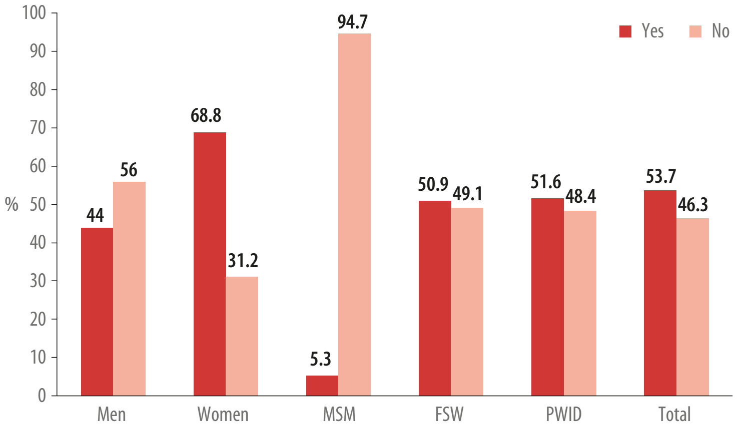
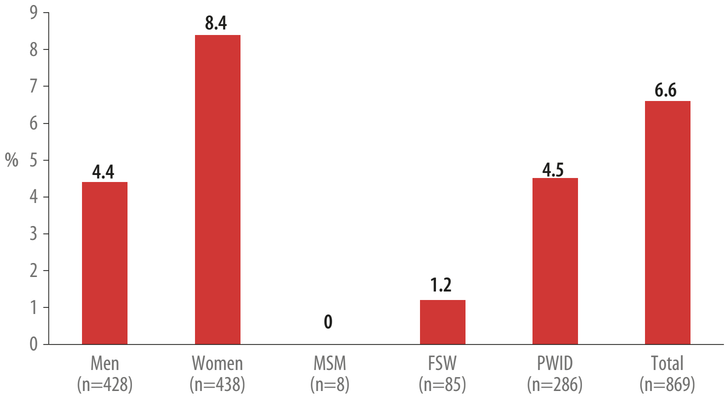


FIGURE 12:
Respondents' children known to be HIV-positive



b. Risk behaviours/vulnerabilities

All respondents were asked whether they were engaging/had ever engaged in HIV-related risk behaviours or been a member of any key population at higher risk (in the past or currently). These risk behaviours include injecting drug use, same-sex sexual activity among men and commercial sex work. In Viet Nam, all three of these behaviours are highly stigmatized, with injecting drug use and commercial sex work subject to administrative sanctions, including compulsory detention in 06 centres for drug users. PLHIV who are in these high-risk groups may suffer double stigma, which can result in additional barriers in accessing services.

In addition to those who engage in these risk behaviours, other groups are both vulnerable to HIV and may struggle to access health services. They include refugees, mobile populations, migrant workers, prisoners and ethnic minority people.

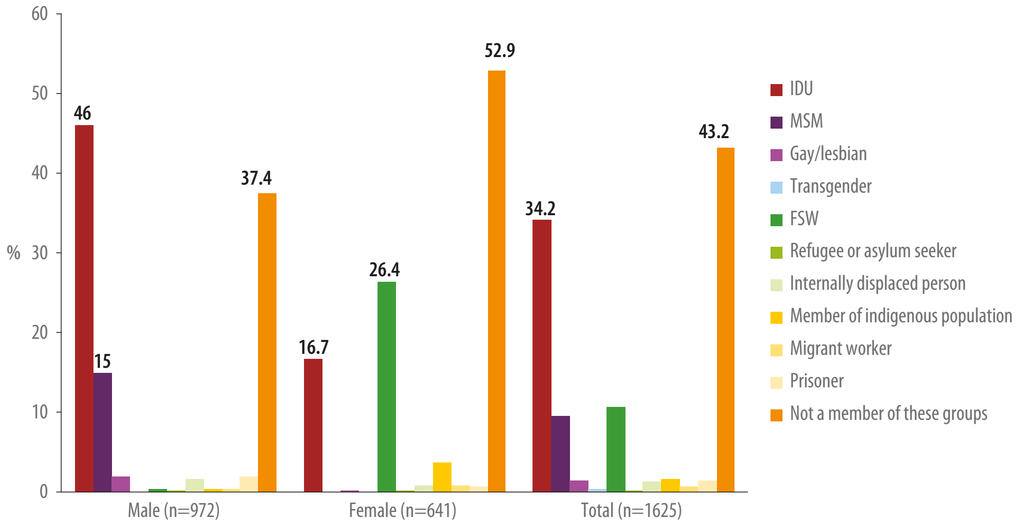
The most common high-risk behaviour reported by respondents was injecting drug use (34.2% of respondents reported this behaviour), with the percentage of men who reported injecting drugs (46%) significantly higher than that of women (16.7%). This finding supports national

HIV programme data showing that injecting drug use remains the main HIV transmission route in Viet Nam.[30]

Among all respondents, 10.7% reported engaging in commercial sex work and 15% of men reported engaging in male same-sex sexual activities. The percentage of FSWs among women living with HIV was 26.4% and the percentage of men living with HIV who identified themselves as MSM or gay was 16.9%.

The percentage of PLHIV who belonged to an indigenous population (ethnic minority) was 1.7%, of whom most lived in Dien Bien province. Of particular note is that there were more ethnic minority women living with HIV than ethnic minority men. These ethnic minority women living with HIV may need special attention from intervention programmes because they are more likely to be illiterate and experience difficulties in accessing health services than women in the Kinh majority ethnic group.[31]

FIGURE 13:
Respondent self-identified category



c. Multiple risk behaviours

It was also important to understand whether the survey respondents are engaging in multiple risk behaviours. This has ramifications for levels of stigma and discrimination – if a person living with HIV experiences HIV-related stigma and discrimination that is compounded by their engaging in stigmatized behaviours (double stigma), then this may increase further if more than one risk behaviour is involved. The data show that 0.7% of PWID engaged in male same-sex sexual activities, while 1.8% had undertaken commercial sex work. Meanwhile, 5.9% of FSWs and 2.6% of MSM reported injecting drug use, and 1.3% of MSM had undertaken commercial sex work.

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[30] In 2013, 45% of new infections occurred among men who share needles while injecting drugs. See: Viet Nam Ministry of Health. *Optimizing Viet Nam's HIV Response: An Investment Case*. 2014.

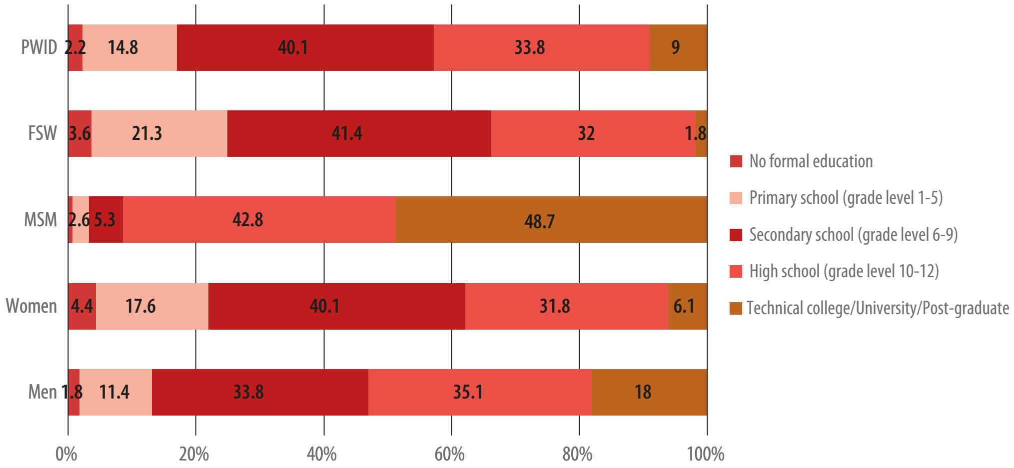
[31] For example: "Although the literacy rate of males is higher than that of females amongst ethnic groups, the rate is especially low for the Mong (nearly 26 per cent), Thai (20 per cent), and Khmer (11 per cent) suggesting females from ethnic minorities have to face many unfavorable conditions in accessing the education system."
Ethnic groups in Viet Nam: An analysis of key indicators from the 2009 Viet Nam Population and Housing Census. UNFPA Viet Nam. 2011. http://unfpa.org/webdav/site/vietnam/shared/Publications%202011/Ethnic_Group_ENG.pdf Accessed 19 November 2014
See also: Ethnic minority health in Vietnam: a review exposing horizontal inequity. Målqvist et al. Glob Health Action 2013, 6: 19803 - http://dx.doi.org/10.3402/gha.v6i0.19803 Accessed 19 November 2014

d. Educational and economic status

The majority of respondents reported that their highest level of education was secondary school (grade level 6-9) or high school (grade level 10-12). There was a gender imbalance, with more than 20% of women reporting that their level of education was primary school or less, compared to 13% among men. Men were also slightly more likely to report that their highest level of education was the completion of secondary school (35% compared to 32% among women), but men were three times more likely to report that they had obtained a university degree (18% vs 6%).

MSM reported the highest educational levels, with nearly half (48.7%) having completed technical college/university/postgraduate studies. Almost one-quarter (23.9%) of FSWs had not completed education beyond the primary school level.

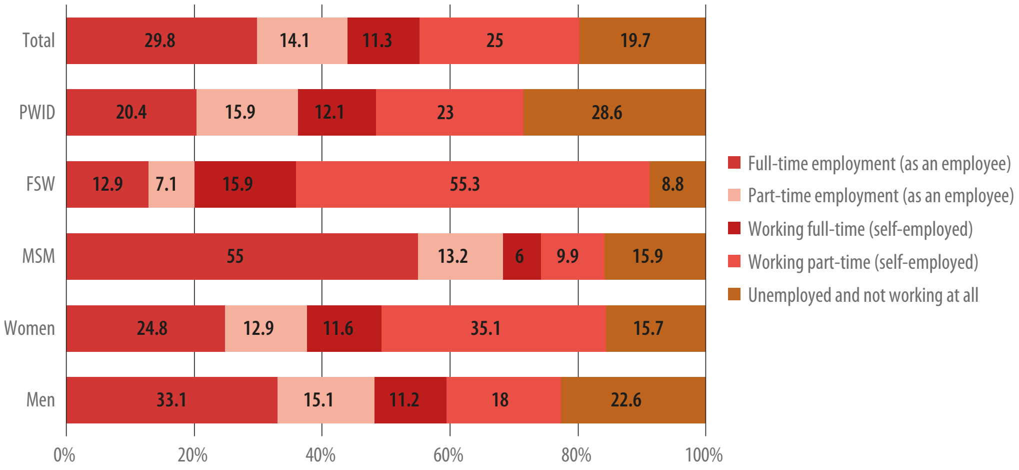
FIGURE 14:
Educational status



The majority of respondents were currently either in full-time employment (about 30%) or self-employed part-time (about 25%). Approximately 20% reported that they were unemployed. The largest proportion of men were in full-time employment (33.1%), while more than one-third of women (35.1%) were self-employed on a part-time basis. More men (22.6%) than women (15.7%) were unemployed.

FSWs had the lowest unemployment rates of all respondents (8.8%), while PWID had the highest (28.6%). Over 84% of MSM were in some form of employment, in line with their higher educational attainments, with the majority (55%) full-time employees, while the majority of FSWs (55.3%) were self-employed part-time.

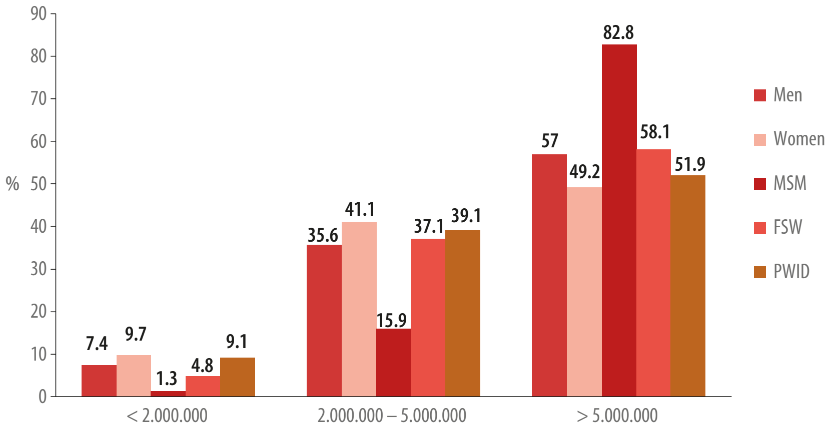
FIGURE 15:
Employment status



The percentage of households with a monthly income of more than 5 million Vietnamese Dong (VND) was 54%; only 8% of families of PLHIV had a monthly income of less than 2 million VND. Men reported higher household incomes than women, with 57% of men with a household income of more than 5 million VND compared to 50% of women.

In keeping with their higher educational attainments and rates of secure full-time employment, MSM reported much higher household incomes than other respondents: more than 80% had a monthly household income of more than 5 million VND. PWID had lower household incomes than most respondents – with the exception of women – with 51.9% in households earning over 5 million VND per month. FSWs reported the second highest levels of household income (58.1% had monthly household incomes of more than 5 million VND).

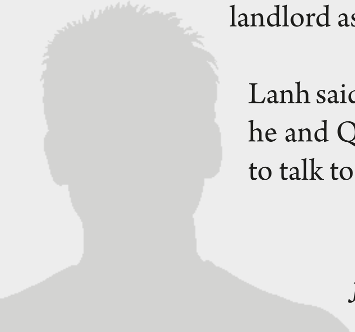
FIGURE 16:
Monthly household income levels (Vietnamese Dong)



3.2. Stigma and discrimination

The survey data show that a large proportion of the PLHIV interviewed had experienced one or more forms of stigma and discrimination. These ranged from violations of their rights as people living with HIV (notably the disclosure of their status without their consent); negative reactions from those around them on finding out their status; community/social stigma and discrimination (including gossip, insults, harassment and assault); and barriers to employment and health care. Respondents also reported high levels of self-stigma. All of these forms of stigma and discrimination prevent PLHIV from leading happy, healthy and productive lives.

Lanh and his wife Quynh had to move to cheaper accommodation because their HIV status was affecting their businesses. One day, a former neighbour, who was friends with their landlord, saw Quynh in the alley near their new house. Lanh and Quynh worried that she would tell the landlord about their status, and she did. The next day the landlord asked them to leave.



Lanh said that they had learned from this experience and now, whenever he and Quynh go out or come home, they wear masks and do not dare to talk to anyone in case people they know see them.

Case study: ***Lanh is a former injecting drug user and former client of female sex workers living with HIV in Can Tho***

a. Rights, laws and policies

Viet Nam has a wide range of legislation to protect the rights and legal interests of PLHIV, including the 2006 Law on HIV/AIDS Prevention and Control and mechanisms for legal redress where the provisions of Law on HIV are violated.[32] However, 11.2% of the respondents reported violations of their rights as PLHIV in the last 12 months. More FSWs (16.6%) than any other respondents reported such violations, followed by PWID (15.5%); more women (13.1%) than men (9.6%) reported violations; and the percentage was lowest among MSM (7.9%).

FIGURE 17:
Violation of respondents' rights in the last 12 months

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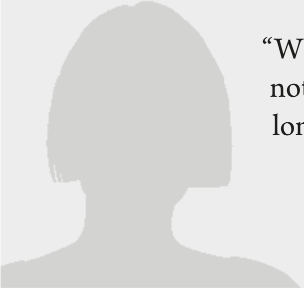
[32] See: Viet Nam Administration of AIDS Control (VAAC). *Viet Nam AIDS Response Progress Report*. 2014. and Viet Nam Administration of AIDS Control (VAAC). *Viet Nam AIDS Response Progress Report*. 2012.

Figure 12 shows the specific rights violated as reported by respondents. The right to non-discrimination and freedom from stigma (68.7% of the respondents reporting rights violations) and the right to privacy and confidentiality (62.1% of respondents reporting rights violations) were reportedly the most violated. Nearly 86% of FSWs who reported rights violations had experienced violations of the right to non-discrimination and freedom from stigma, while among MSM who reported rights violations, the highest rate was of violations of the right to privacy and confidentiality (75%).



> "When I tried to buy life insurance for myself, the insurance agent did not want to sell it to me because I am HIV-positive: who knows how long I will live?"
>
> **Case study:** ***Xuan is a former injecting drug user and former sex worker living with HIV in Dien Bien***

Of those who reported rights violations, MSM also reported the highest rate of violations to the right to study (8.3%) – despite high levels of education among MSM – the right to get married (8.3%)[33] and "other" rights (25%). Almost no respondents reported violations of the right to information and participation or (apart from MSM) the right to study.

FIGURE 18:

Type of rights violations experienced by respondents

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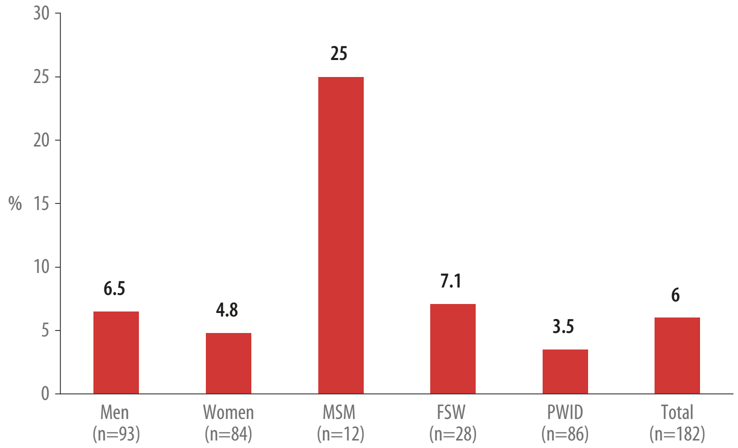
[33] At the time of the survey, gay marriage was illegal in Viet Nam. At the time of writing, gay marriage is no longer illegal (ie penalized) but it is not recognized by the State.

FIGURE 19:

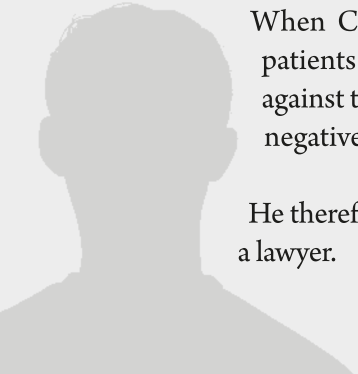
Incidence of seeking legal redress for any abuse of rights



Only 6% of those who reported rights violations had sought legal redress. More men (6.5%) than women (4.8%) did so. However, one-quarter of MSM had sought legal redress, perhaps because of higher levels of education and income, while FSWs had higher rates than either men or the wider group of women. The lowest percentage of respondents seeking legal redress was among PWID at 3.5%.

The most common reasons for not seeking legal redress for any abuse of rights were that respondents were advised not to take action by someone else (26.9%) – this is particularly true for women (38.9%) – or that they had no/little confidence that the outcome would be successful (24.1%). Nearly 38% of respondents said that none of the reasons provided in the questionnaire explained why they did not seek legal redress, but there was no opportunity for them to explain further. The case studies showed that people may be initiating proceedings, but abandoning them in the face of resistance or due to discouragement.

Despite the relatively high rates of MSM seeking legal redress and their comparative financial stability, more than one-third of MSM who did not seek redress said that this was because of insufficient financial resources, while around 20% said that the process of addressing the problem appeared too bureaucratic. Very few other respondents chose these reasons.

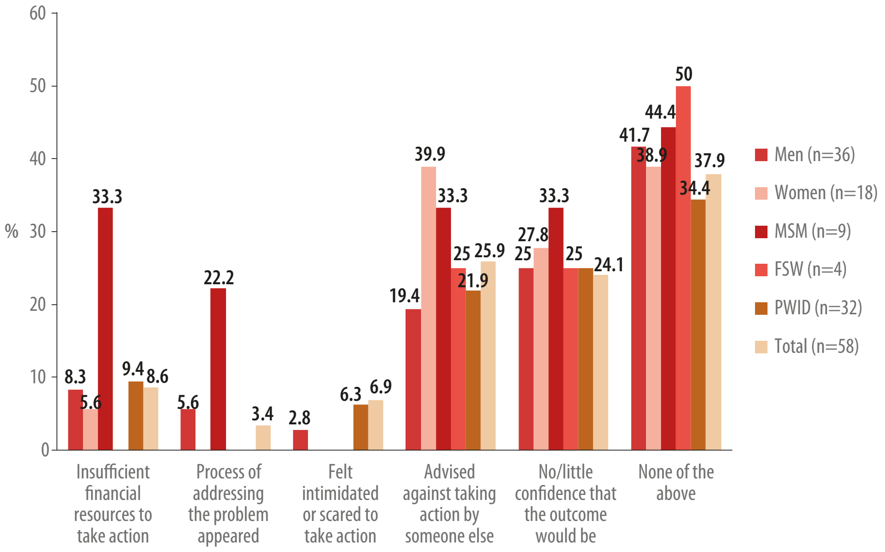


When Chinh visited a hospital, he was not treated as well as other patients who were not HIV-positive. Chinh tried asking for his case against the hospital to be addressed, but nothing changed, and he faced negative attitudes.

He therefore put a halt to proceedings; he hasn't even asked for help from a lawyer.

Case study: ***Chinh is a man living with HIV in Dien Bien***

FIGURE 20:
Reason(s) for not trying to seek legal redress



b. Testing and diagnosis

Early HIV testing enables PLHIV to access health-care services, begin treatment and engage in behaviours that prevent HIV transmission as soon as possible. The Law on HIV[34] provides guidance and protection regarding HIV testing, and includes provisions that testing must be voluntary and take place with the informed consent of the person involved (Article 27). The Law on HIV also states that (barring a few exceptions) employers are not allowed to ask job applicants, nor educational establishments to ask students/participants/candidates, to take an HIV test or produce a test result (Article 14). Decision No. 647 on the Promulgation of Voluntary HIV Counselling and Testing also states that HIV testing must be voluntary.

As Figure 15 shows, the majority of participants (86.9% of all respondents) made the decision to take an HIV test themselves. FSWs had the highest rates of voluntary test-taking and PWID the lowest, while overall more women than men took the decision to take a test voluntarily.

However, 7.6% of all respondents reported that they had been tested without their knowledge or consent and only informed of the result afterwards. More men (8.1%) than women (6.6%) reported this, as did 7.4% of PWID and 7.3% of MSM. A relatively small percentage of FSWs (4.1%) did so. Meanwhile, an alarming 3.1% of all respondents – and 5.6% of PWID – reported that they had been forced (coerced) to take a test. Again, more men than women reported this. MSM reported the lowest rates of coercion (1.3%)

Respondents were asked to give their reason for being tested for HIV.[35] For women living with HIV, the most common reason was that a husband/partner/family member was tested HIV-positive (20.5%): this is in line with HIV-testing data that the majority of infections among women are through intimate partner transmission (particularly from men engaging in high-risk behaviours,

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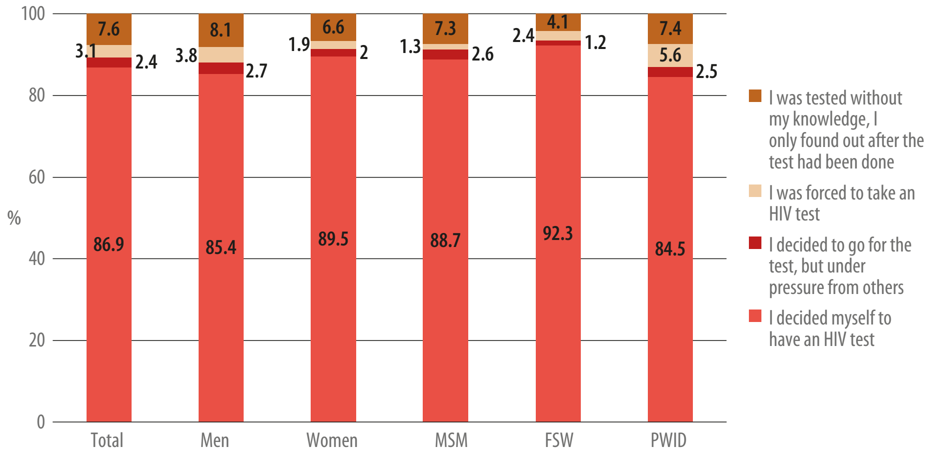
[34] Law on HIV/AIDS Prevention and Control No. 64/2006/QH11 promulgated on 01/01/2007.

[35] The following reasons were provided in the questionnaire: employment; pregnancy; preparation for a marriage/sexual relationship; being referred by a clinic for sexually transmitted infections; being referred due to suspected HIV-related symptoms; husband/wife/partner/family member tested HIV-positive; illness or death of husband/wife/partner/family member; I just wanted to know.

such as injecting drug use, to their wives).[36] For MSM it was "I just wanted to know" (49%), and for FSWs it was being referred by a clinic for sexually transmitted infections (28.4%).

Among men living with HIV and PWID, the most common reason was being referred due to suspected HIV-related symptoms, accounting for 37.7% of men and 29.7% of PWID. This reason was also widely reported by FSWs (21.9%), MSM (17.9%) and women living with HIV (17.8%). This finding has worrying connotations, as those who have already developed symptoms are likely to have been tested late, and therefore to begin treatment late. This not only has impacts on their own health, but also on the transmission of the virus to others. It has been shown that early treatment lowers the amount of virus in the blood, reducing the risk of transmission.[37]

FIGURE 21:
Was the decision to be tested up to you?

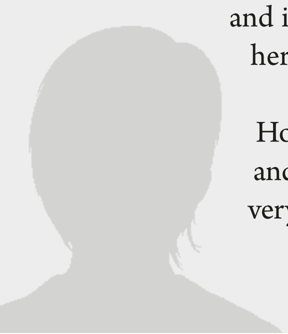


In 2009, Phuong decided to go for an HIV test because she knew that a person with whom she'd had unprotected sex was HIV-positive.

After Phuong tested positive, she said, she was not brave enough to register for treatment and in any case did not know where to register. She just wanted to keep her status confidential.

However, in 2013, Phuong got a fever, lost weight, suffered from diarrhea and was hospitalized. Hospital tests showed that her immune system was very weak and that she was suffering late-stage AIDS-related illnesses.

Case study: ***Phuong is a sex worker living with HIV in Can Tho***



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

[37] World Health Organization (WHO). *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach.* 2013.
World Health Organization (WHO). *Antiretroviral treatment as prevention (TASP) of HIV and TB - Programmatic update.* 2012.

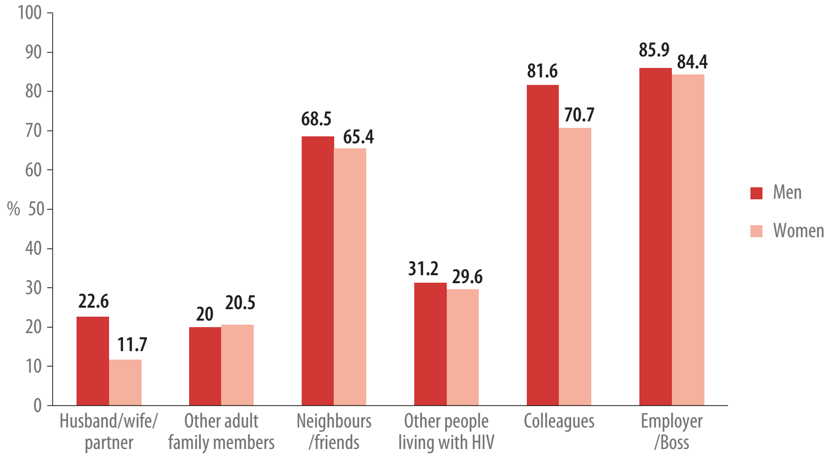
c. Disclosure and confidentiality

The disclosure of HIV status is an important step for PLHIV in seeking support from their families and the community and in accessing care and treatment and other services. Disclosure can also help protect their husbands/wives/sexual partners and, in the case of PWID and FSWs, injecting drug partners or clients, by enabling the initiation of harm-reduction measures for prevention (the use of condoms and clean needles and syringes) and harnessing the preventative benefits of treatment. Sexual partners and injecting drug partners will also be able to get tested and, where necessary, treatment.

Unfortunately, there is a clear two-way relationship between the disclosure of HIV status and stigma and discrimination: the consequences of disclosure may be stigma and discrimination, and the fear of stigma and discrimination may result in a failure to disclose status. When PLHIV do not disclose their status, they and those around them cannot benefit from the advantages of disclosure outlined above.

Figures 22 and 23 show the patterns of non-disclosure of HIV status by respondents. Although the Law on HIV provides for the obligation of PLHIV to inform their spouse or fiancé/fiancée of their status, 22.6% of men living with HIV had not done so; this is nearly double the rate among women living with HIV (11.7%) and again points to the increase in intimate partner transmission. In addition, most respondents had not revealed their status to people outside their own family, including friends/neighbours (67.3%), colleagues (77.3%) and employers (85.5%). This may indicate a fear of potential stigma and discrimination.

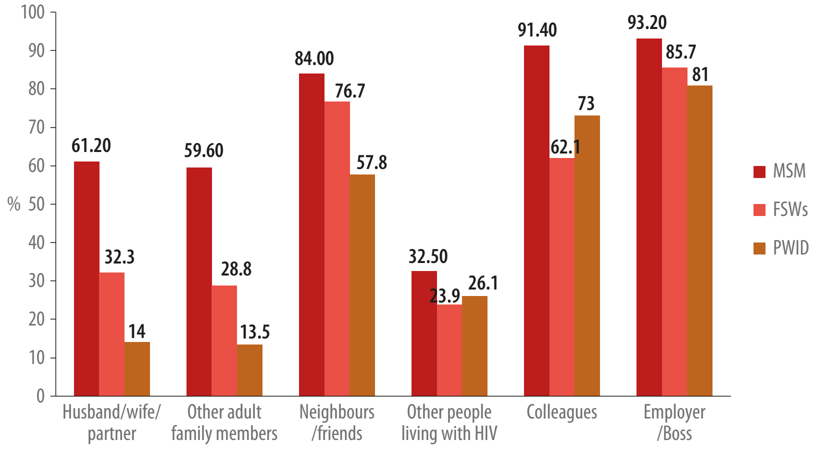
FIGURE 22:
Non-disclosure of status by gender



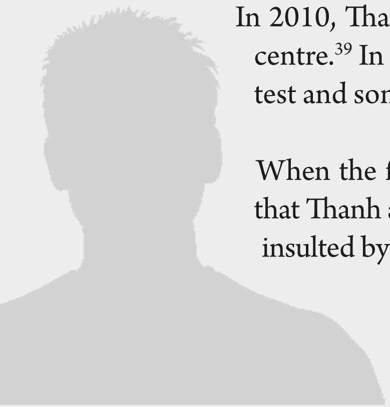
Of the three key populations, MSM found it most difficult to disclose their HIV status (with the exception of disclosure to other PLHIV), while both PWID and FSWs also found it more difficult to disclose status than the larger groups of men and women respondents. This may indicate a greater fear of stigma and discrimination among key populations and/or of double stigma (see more below). A total of 61.2% of MSM had not disclosed their status to their partners, 59.6% had not revealed their status to family members, and a very high percentage had not revealed their status to anyone outside the family. At the validation meeting, VNP+ member clarified this finding, saying that one reason for this lack of disclosure is the fear of discrimination from other

MSM – MSM may also be worried that they will not be able to seek sexual partners if their status is known. Of note is the fact that PWID are the least likely of all respondents to keep their status from their wives/husbands/partners and other family members (possibly because they have been living longest with HIV and the epidemic is oldest within this population). Meanwhile, 91.1% of FSWs had not disclosed their HIV status to their clients and 33.3% of PWID had not disclosed their HIV status to injecting drug partners. As pointed out above, this aspect of non-disclosure has ramifications for the protection of others.

FIGURE 23:
Non-disclosure of status among PWID, FSWs and MSM



Where disclosure is involuntary – that is, where HIV status is revealed without the consent of the person involved – it not only breaches the person's rights but can lead to stigma and discrimination and an unwillingness to get tested. The Law on HIV provides for the protection of the rights of PLHIV in this respect, including their right to have their privacy respected, and more specifically prohibits making public the name, address and image of PLHIV or disclosing information on a person's HIV status to another without their consent.[38]



In 2010, Thanh and his wife were sent to a compulsory drug treatment centre.[39] In order to enroll in the centre, they were forced to take a HIV test and some friends at the centre found out Thanh's result.

When the friends from the centre were released, they spread the news that Thanh and his wife were HIV-positive. The couple is now constantly insulted by Thanh's mother and their businesses have suffered.

Case study: ***Thanh is a former injecting drug user living with HIV in Can Tho***

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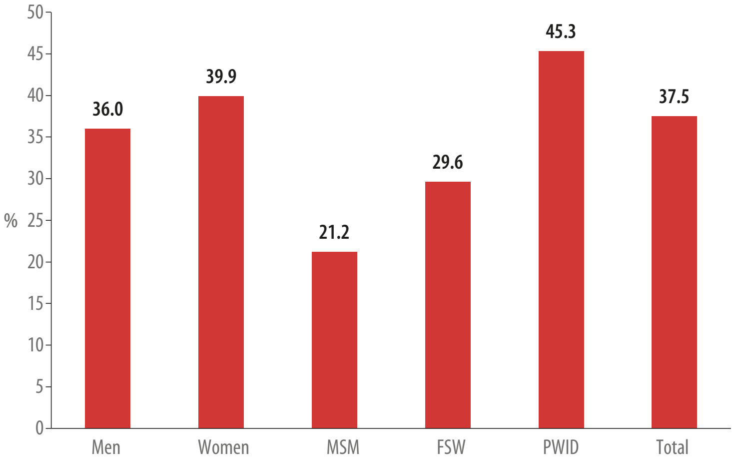
[38] Articles 4 and 8 of the Law on HIV (2006). Article 30 provides for exceptions to Article 8.

[39] In Viet Nam, drug use is punishable by administrative detention in compulsory drug treatment centres (06 centres).

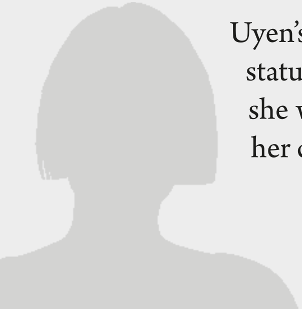
Figure 18 shows the worryingly high rates of PLHIV whose HIV status was disclosed without their consent. More women (39.9%) than men (36%) had their status disclosed without their consent, but rates were highest among PWID (45.3%). In addition, 24.1% of all respondents said they had no or little faith that their results would be kept confidential, with a shocking one-third (33.3%) of MSM reporting this.

FIGURE 24:
Disclosure of HIV status without consent



d. Family and community reactions to HIV status

Once Uyen knew she was living with HIV, her husband changed towards her. He did not take care of her and their child, but beat her and told his family about her HIV status. They also stigmatized her, and her brother-in-law even assaulted her several times.



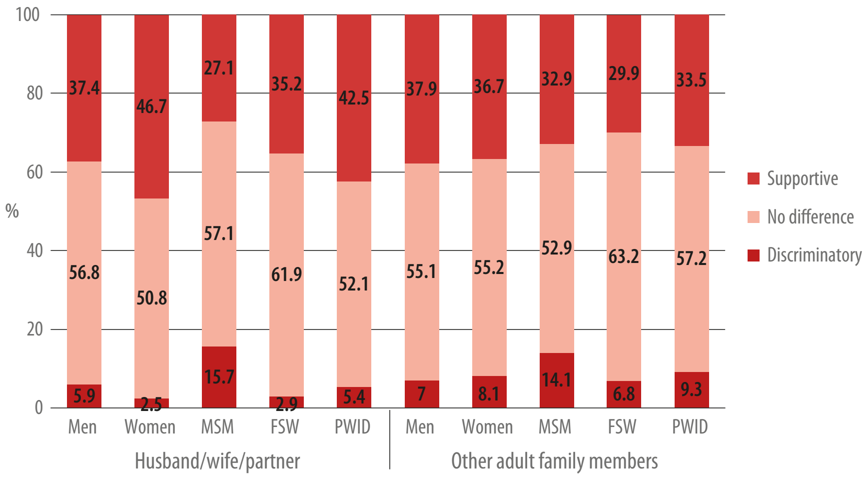
Uyen's in-laws also went to her parents' house and talked about her HIV status, loudly, to make sure the neighbours and others around knew that she was living with HIV so that she would not be allowed to look after her child.

Case study: ***Uyen is a woman living with HIV in Ha Noi***

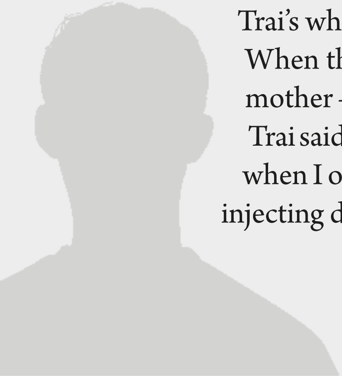
The support of family and community can prevent isolation and thus contribute to the physical and mental well-being of PLHIV. According to the data, 5.9% of men living with HIV and 2.5% of women living with HIV said that their husband/wife/partner had a discriminatory reaction when they first found out the respondent's positive status. Rates of discriminatory reactions were slightly higher among other adult family members (7% for men, 8.1% for women). MSM were most likely to report such reactions, with 15.7% of MSM suffering discriminatory reactions from sexual partners and 14.1% from other adult members in family. This may be due to double stigma because of their sexuality (see more below).

> Chau told us that since her husband learned about her HIV status, his family has repeatedly beaten her and chased her out of the house, saying: "You are infected with AIDS; you are not allowed to bring up your child – get out of our house".
>
> **Case study:** ***Chau is a woman living with HIV in Ha Noi***

FIGURE 25:
Reactions of husband/wife/partner and other adult family member(s) when they first found out the respondent's HIV status



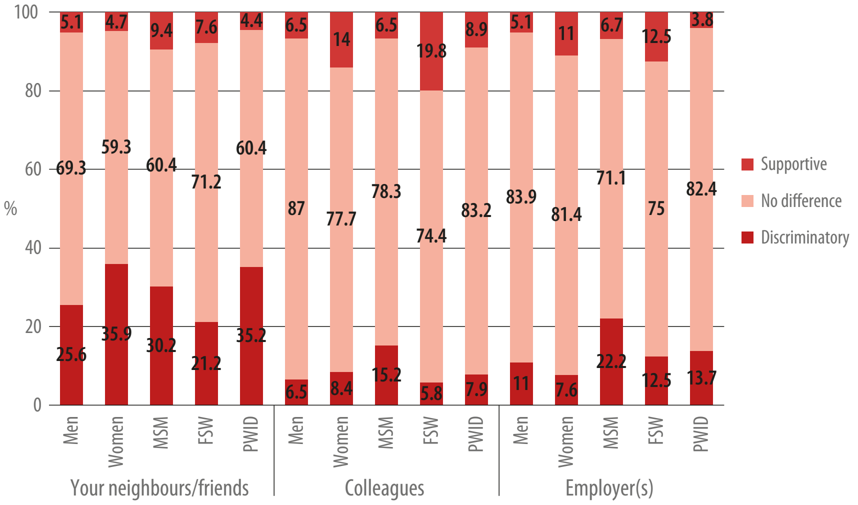
Respondents reported higher levels of discriminatory reactions from friends/neighbours and employers than from their families.



> Trai's whole family has experienced discrimination due to his HIV status. When the family was undergoing particular hardship, they all – even his mother – went to the neighbours to try to borrow some money. However, Trai said, "the neighbours refused to help, saying that they couldn't be sure when I or my mother would be able to repay them, or that an unemployed injecting drug user living with HIV could never return their money."
>
> **Case study:** ***Trai is a former injecting drug user living with HIV in Hai Phong***

More than 35% of women living HIV and over 25% of men living with HIV said that the reactions of their friends/neighbours when they first found out the respondent's HIV status were discriminatory, while 11% of men living with HIV and 7.6% of women living with HIV experienced discriminatory reactions from their employers. MSM experienced the most discriminatory reactions from colleagues and employers (15.2% and 22.2% respectively). Women living with HIV and PWID reported the most discriminatory reactions from friends/neighbours.

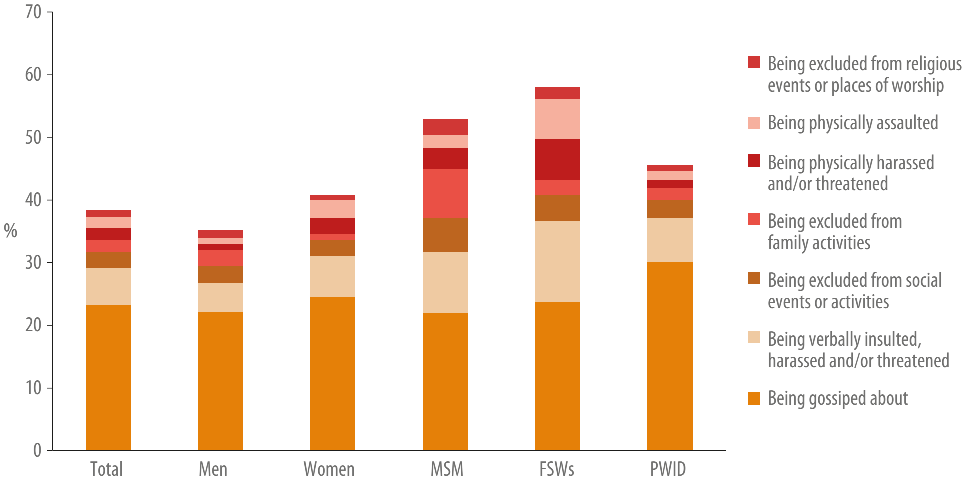
FIGURE 26:
Reactions of friends/neighbours/colleagues/employers when they first found out the respondent's HIV status



e. Community/social stigma and discrimination

Instances of community/social stigma and discrimination included verbal insults (gossip, rumours, insults and threats); exclusion (from family and social activities or religious events or places of worship); physical threats, harassment and assault; psychological pressure from partners and sexual rejection on the basis of HIV status; and discrimination by other PLHIV.

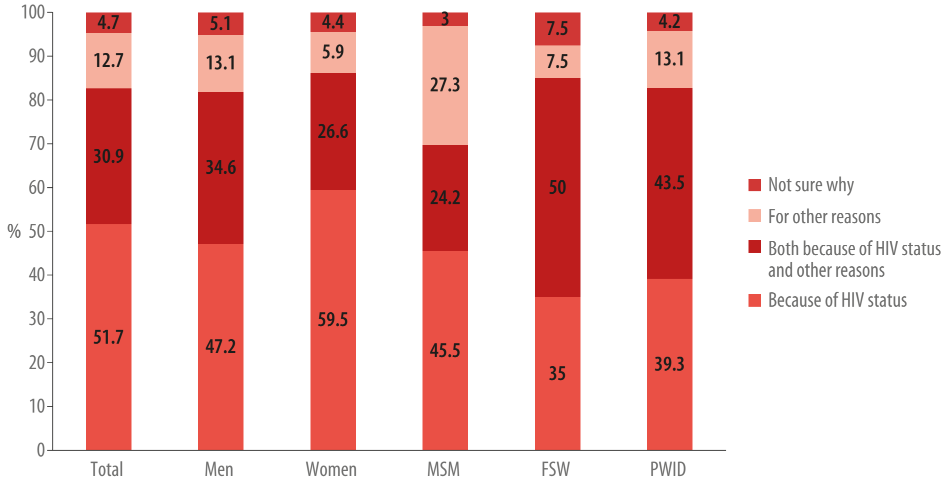
FIGURE 27:
Experiences of community/social stigma and discrimination in the last 12 months



The percentage of PLHIV who reported being gossiped about was higher than for other forms of stigma and discrimination, with 23.3% of all respondents and more than 30% of PWID reporting gossip in the past 12 months. As a group, 82.6% of respondents blamed their HIV status in part or in whole for this gossip, with women most likely to ascribe gossip entirely to their status (59.5%) and PWID least likely to do so (39.3%). MSM were most likely to attribute "other reasons" for the gossip (27.3%) – as they were for all of these categories of stigma and discrimination – and FSWs to cite “both HIV status and other reasons” (50%), pointing to double stigma linked to risk behaviours (see below).

FIGURE 28:

Reasons for gossip in the last 12 months

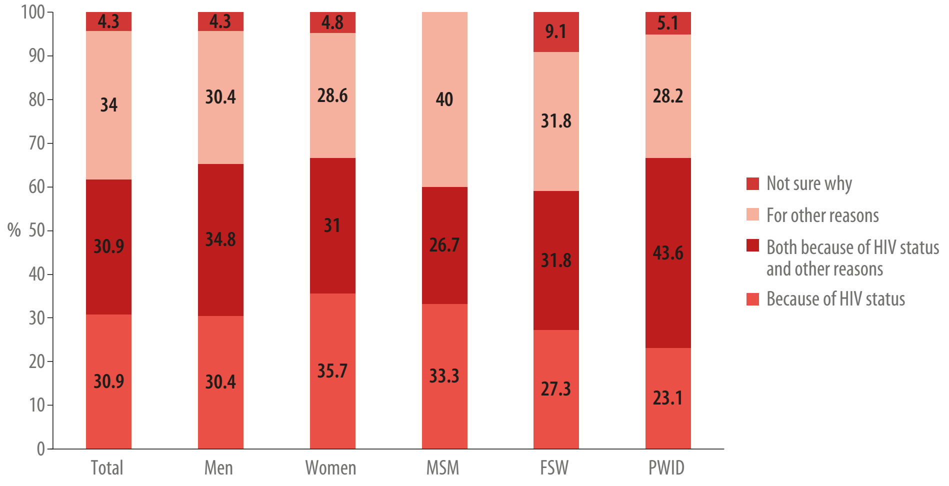


MSM appeared to suffer most social isolation from families and the community, with 7.9% excluded from family activities and 5.3% excluded from social events and activities in the past 12 months.

FSWs and MSM were most likely to report being insulted, harassed and threatened (13% and 9.9% respectively), along with more women (6.6%) than men (4.7%). FSWs were more likely than other women to experience verbal attacks (13% vs. 4.7%), while MSM were more likely to do so than other men (9.9% vs. 3.8%). Over 60% of all respondents said that these attacks were partly or entirely due to their HIV status.

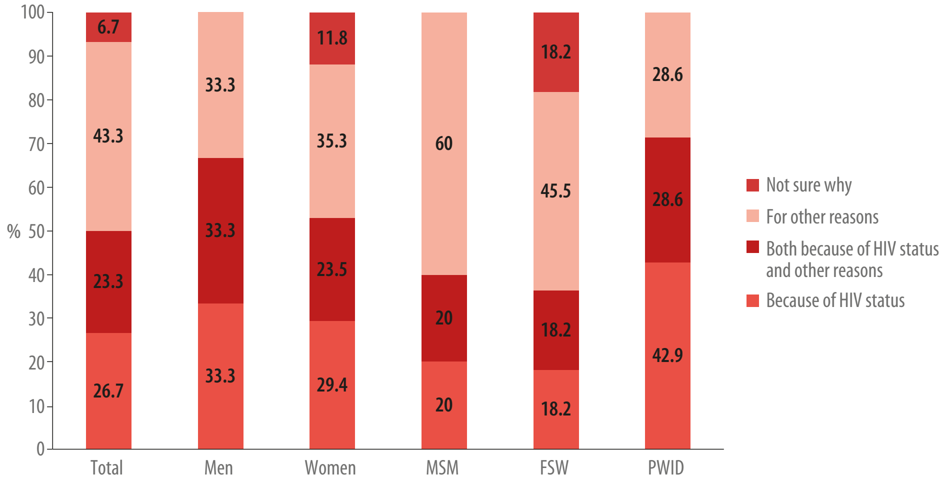
FIGURE 29:

Reasons for being verbally insulted, harassed and threatened in the last 12 months

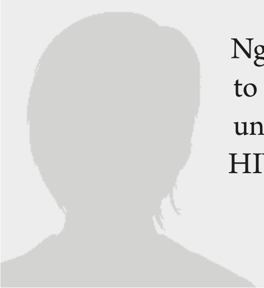


Among all respondents, 1.8% had been physically harassed and/or threatened in the past 12 months, with more FSWs and MSM than others reporting such abuse (6.5% and 3.3% respectively). Again, rates were higher among women (2.7%) than men (0.9%); among FSWs than other women (6.5% vs. 1.3%); and among MSM than other men (3.3% vs. 0.5%). However, while 50% of all respondents attributed these attacks in part or in full to their HIV status, only 36.4% of FSWs and 40% of MSM did so.

FIGURE 30:
Reasons for being physically harassed and/or threatened in the last 12 months



Among all respondents, 1.8% reported being physically assaulted in the past 12 months, with 45.1% saying this was due wholly or partly to their HIV status. Women were significantly more likely to report experiencing violence, with 1.5% of women who did not engage in sex work and 6.5% of FSWs reporting physical assault (compared to 1% of all men).



Ngoc has been beaten so violently by her clients – because she asked them to use condoms, but they did not want to, or because she was feeling unwell – that she has fainted with pain. She says she can't tell them she is HIV-positive because either they won't believe her or she won't be paid.

Case study: ***Ngoc is a sex worker living with HIV in Ha Noi***

MSM were also more likely than other men to report physical assault (2% vs. 0.9%). These data are in line with other research that has found that FSWs and MSM in Viet Nam experience high rates of physical violence.[40] This is further supported by the fact that only 36.4% of FSWs living with HIV (and 44.4% of the larger group of women living with HIV) ascribed this to their HIV status. Indeed, all respondents were less likely to blame their HIV status in whole or in part for physical violence than they were for other forms of stigma and discrimination.

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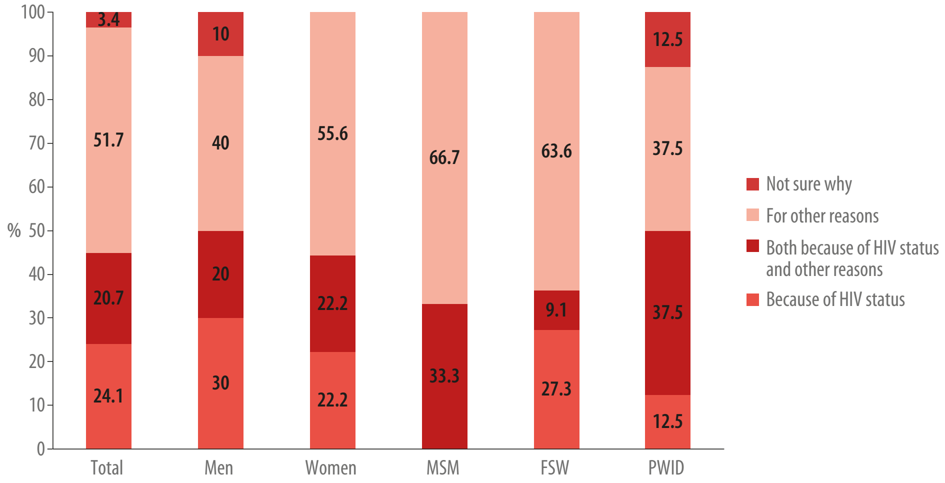
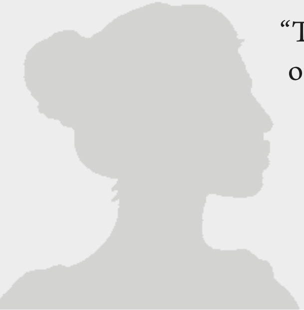
[40] See, for example: *Phạm Quỳnh Phương. Homosexual, bisexual and transgender people in Vietnam: Research Review.* 2013, and: Government of Viet Nam, United Nations in Viet Nam and International Organization for Migration. *Sex Work and Mobility from A Gender Perspective: Findings from Three Cities in Viet Nam.* 2012.

FIGURE 31:
Reasons for being physically assaulted in the last 12 months



Finally, women were most likely to be subjected to psychological pressure or manipulation by their husband/partner in which their HIV status was used against them: 5.3% of FSWs and 3.5% of other women reported this (as did 3.4% of PWID). FSWs, along with MSM (5.3% respectively) were also most likely to experience sexual rejection due to their HIV status. MSM were most likely to suffer discrimination from other PLHIV (3.9%). In both these latter cases, double stigma may be a factor.

"In the last year, I have been insulted and teased by other PLHIV at the methadone maintenance therapy clinic, and got into arguments with them, four times.

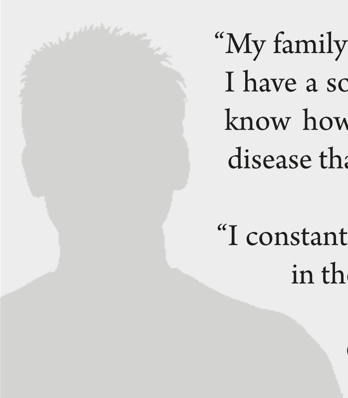


"Twice I was assaulted; I was disrespected and gossiped about by other people who were taking methadone. We quarreled and then they beat me. I tried to defend myself, but I could not beat them because I was weak and there were too many of them."

Case study: ***Mai is a former injecting drug user and former sex worker living with HIV in Hai Phong***

f. Self-stigmatization

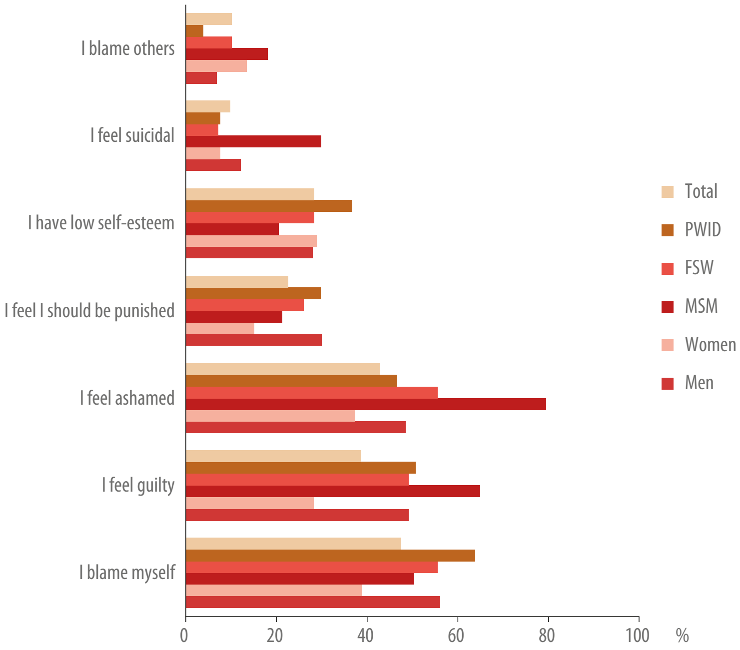
The Stigma Index also measures self-stigmatization by PLHIV. As Figure 26 shows, a very high proportion of respondents are stigmatizing themselves, with more than two-thirds (67.1%) reporting at least one negative emotion related to their HIV status in the last 12 months. Shame, guilt and self-blame were the most often-reported emotions, and more men than women reported negative emotions.



> "My family think I am a beast. My two brothers insult me, telling me that I have a social disease, that I am a playboy. They often attack me. I don't know how to react, because I have done something wrong and got a disease that has shamed my family.
>
> "I constantly feel ashamed, I constantly want to kill myself. I have tried to in the past. I don't know how I'm sitting here now."
>
> **Case study:** ***Duc is a man living with HIV in Ho Chi Minh City***

In addition, generally speaking, more MSM, FSWs, and PWID reported negative emotions than did the general sample, with MSM in particular reporting by far the greatest feelings of shame and guilt. An alarming minimum of 7% in every category of respondents reported feeling suicidal, with nearly 30% of MSM reporting such feelings.

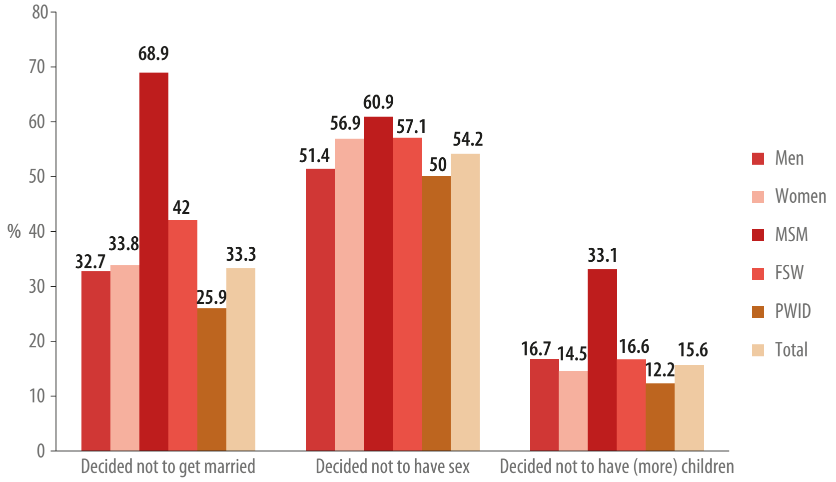
FIGURE 32:
Negative emotions relating to HIV status in the last 12 months



Self-stigmatization and negative emotions not only affect PLHIV in terms of psychological well-being and resources, but also in terms of the ways they react to and deal with their HIV-positive status and the decisions they take, all of which impact on their family and social relations, education and employment opportunities and access to health services.

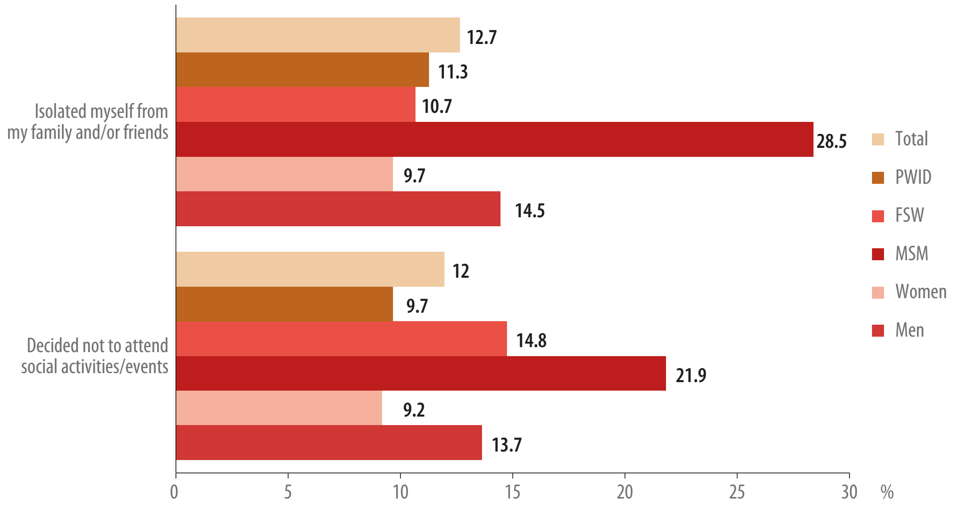
For example, many PLHIV decide not to get married and/or not to have sex as a result of their status, which may have ramifications for the type of emotional and other support they are able to access. A total of 32.7% of men living with HIV and 33.8% of women living with HIV surveyed have decided not to get married, while over 50% of respondents in all categories have decided not to have sex. MSM were most likely to report having taken these decisions, followed by FSWs. PWID were least likely of all respondents to do so.

FIGURE 33:
Decisions taken relating to relationships and family as a result of respondent's HIV status in the last 12 months

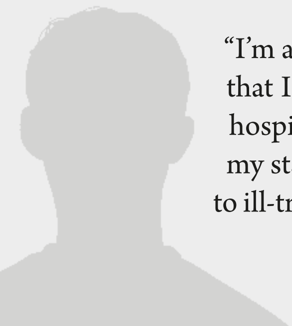


Respondents also isolated themselves from family and friends and decided not to participate in social activities. More men did so than women and, again, MSM reported high levels of such self-isolation (with nearly 22% not attending social events and nearly 29% isolating themselves from families and friends), compounding their reported isolation inflicted by others (see above). Nearly 15% of FSWs also reported deciding not to attend social events.

FIGURE 34:
Self-isolating decisions made and actions taken as a result of respondent's HIV status in the last 12 months



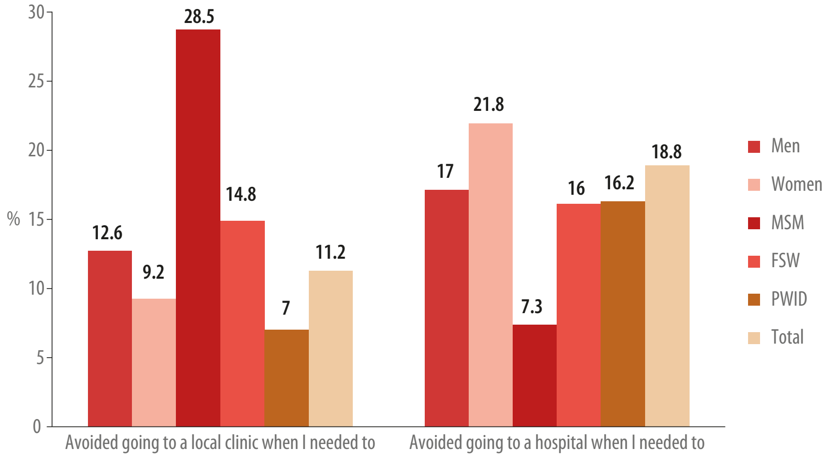
Also of concern is the fact that self-stigma leads to respondents avoiding the use of health-care services when they need them. In particular, women living with HIV avoided hospitals (central-level health facilities), while MSM were much more likely to avoid local clinics.



> “I’m afraid of the outside world. I have given up going to the social events that I used to attend. And I feel very scared when I think about going to hospital or a health facility. Last time I went, a health worker who knew my status didn’t dare help me. Now I understand that my illness can lead to ill-treatment, and I try to disclose my status to as few people as possible.”
>
> **Case study:** ***Bao is an MSM living with HIV in Ho Chi Minh City***

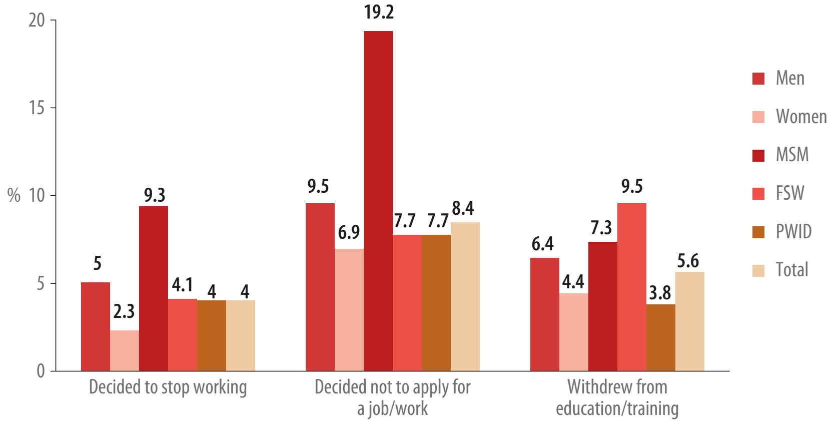
It is not clear why there is this difference, although it is possible that MSM may be more afraid of being recognized in local clinics, while women may face more barriers to accessing central-level hospitals (including expense, such as child care or travel costs).

FIGURE 35:
Avoidance of health facilities by respondents as a result of HIV status in the last 12 months



Self-stigmatization can also have negative impacts on livelihoods, income and education, making PLHIV more vulnerable in terms of poverty and therefore access to services, shelter and adequate nutrition, and further affecting their self-esteem. For example, 5% of men living with HIV, 2.3% of women living with HIV and 9.3% of MSM had stopped working in the past 12 months due to their status. Over 19% of MSM had decided not to apply for jobs or a promotion, while nearly 10% of FSWs had withdrawn from education.

FIGURE 36:
Decisions taken as a result of respondent's HIV status that negatively affected their livelihood and/or educational development



g. Access to work, health and education services

The rights of PLHIV to work, to use health services when necessary and to have opportunities for study and personal development are protected under Vietnamese law. However, HIV-related stigma and discrimination can mean that these basic rights are not respected, affecting access to employment and promotion opportunities and to health services, and making it more difficult for PLHIV to care for themselves.

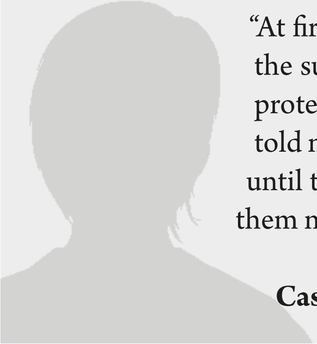
Having a reliable place to live is important for personal wellbeing, the development of family and social relationships and the ability to get and maintain a job and access other services. However, 1.3% of respondents reported that they had been forced to relocate or unable to rent accommodation in the past 12 months. At the same time, 1.8% of all respondents had been denied health-care services. FSWs were particularly vulnerable, with 5.9% reporting having to move or being unable to rent a home, and 3.6% being denied health-care services.

Hung has tried very hard to keep his status confidential – even his daughter doesn't know he has HIV. But somehow his landlords find out. Every time they discover that he is living with HIV, he has to find a new place to live because the landlord has to "repair the house". Hung said that just within the past year, he had to move twice, which also forced him to change his job and increased the daily commute to take his daughter to school.

Case study: ***Hung is a man living with HIV in Can Tho***

During the case study interviews, respondents also raised the issue of being denied health insurance due to their HIV status, which has significant impacts on their ability to pay for their treatment where necessary (and worsens fears that ART will no longer be freely available in the future – see more below).

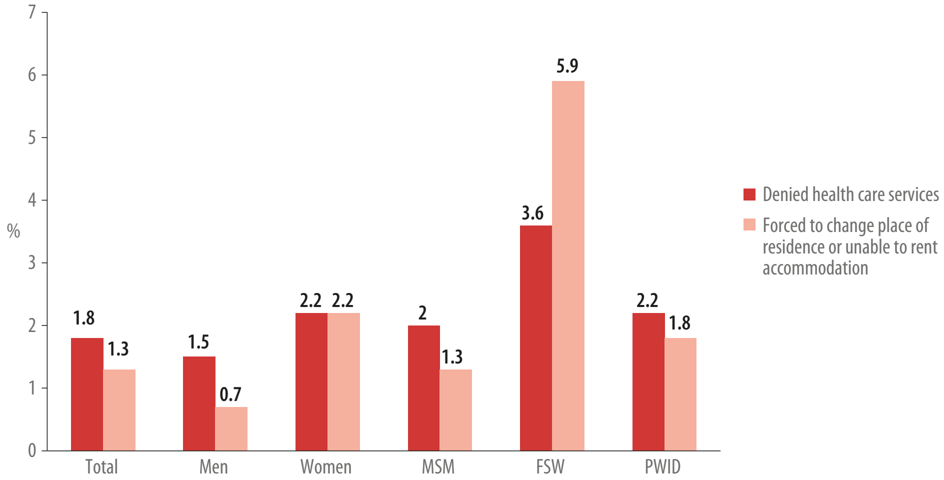
Giang was refused treatment for a cervical cyst when using her health insurance card for low-income people.



> “At first, the doctor said I needed to be hospitalized for surgery. Before the surgery, I told the doctor my status so that the surgical team could protect themselves and avoid transmission. The doctor immediately told me that the surgery was no longer necessary, and that I should wait until the cyst had broken, then come back. I think it was because I told them my HIV status, they tried to find a pretext to refuse me treatment.”

Case study: ***Giang is a former injecting drug user living in Hai Phong***

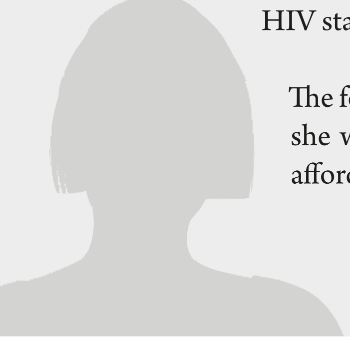
FIGURE 37:
Challenges in accessing health-care services and accommodation



Stable jobs and other sources of income are vital to ensuring livelihoods – the means of securing shelter, food, water, clothing, medicine and other necessities – and contribute to the ability of individuals to participate in and contribute to their community. However, the data show that 4.2% of the respondents had lost their job or source of income in the previous 12 months, with even higher rates among the key populations (9.5% of FSWs, 6.6% of MSM and 4.5% of PWID). Most of these incidents were attributed by respondents in part or in full to their HIV status. This is borne out by the data: there is a strong correlation between those respondents reporting that their employer knows their status and respondents losing their jobs. The percentage of people losing their jobs was higher among those whose employer knew their status (48.8%) than among those whose employer did not (11%).

In the past year, Khanh has lost four jobs due to her HIV status. Her longest-lasting job was as a cleaner for a guesthouse. She worked there for nearly two months before getting a fever and cough. The owner had heard gossip about her HIV status and was afraid: he said she should rest, and he would call her if he needed her. She was only paid for one of the months she worked, because of her poor health and the fact that the owner knew her status.

Khanh also worked for a garment company, but had to leave because the hours were not convenient for her drug regimen. She was only employed for a few days at her next job before her employer found out her HIV status and sacked her. Khanh believes this employer had her ID card, and the communal authorities confirmed her HIV status.



The fourth job was with an employer who knew Khanh's status when she was recruited, but the salary was too low for her to be able to afford the bus fare to her workplace.

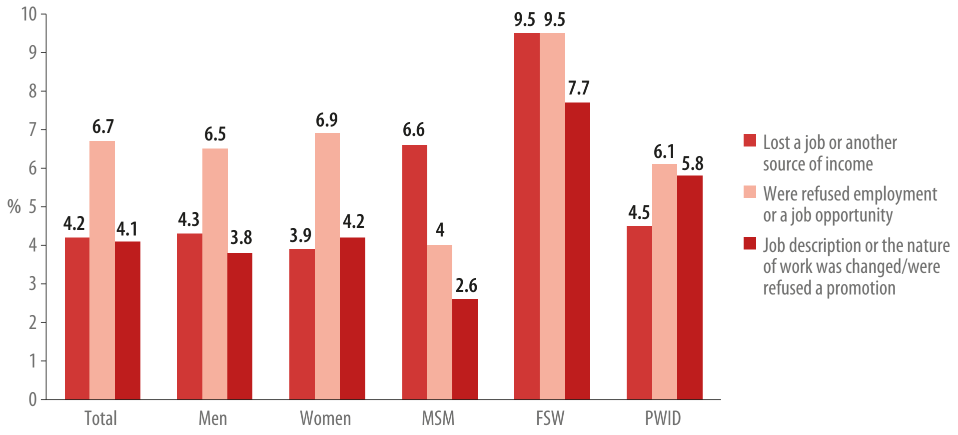
Case study: ***Khanh is a former injecting drug user and former sex worker living with HIV in Hai Phong***

Respondents also found it difficult to find a job, with 6.7% reporting being refused employment or a job opportunity in the previous 12 months; again, this percentage was higher among FSWs (9.5%).

After Quy found out her status, she has regularly been assaulted by clients and suffered stigma from her friends who are also sex workers. These friends have tried to humiliate her, gossiping about her HIV status and threatening her clients by telling them that having sex with her could mean being infected with HIV.

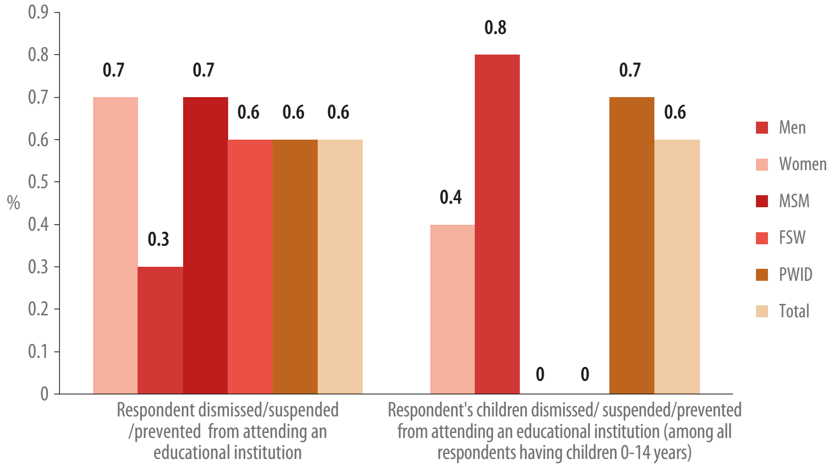
Case study: ***Quy is a sex worker living with HIV in Ha Noi***

FIGURE 38:
Challenges in accessing or maintaining employment



In contrast, few PLHIV seemed to have encountered difficulties relating to education: only 0.6% of the total sample reported being dismissed/suspended from, or prevented from attending, educational institutions in the past 12 months. Similarly, only 0.6% of respondents with a child/children under 14 years old reported that their child/children had been dismissed/suspended/preventing from attending school in the past 12 months.

FIGURE 39:
Challenges in accessing or remaining in education



h. Access to treatment

Respondents were asked whether they were currently undergoing antiretroviral therapy (ART) and receiving treatment for opportunistic infections (OI), and whether they thought they had access to ART and OI treatment, whether or not they were receiving it. The data show that the percentage of PLHIV who felt they could access ART (whether or not they were receiving it) was very high – over 97% of all respondents – and the percentage of PLHIV who could access OI treatment (whether or not they were receiving it) was over 88% of all respondents. In addition, 87% of all respondents were actually receiving ART and 46.2% were actually receiving OI treatment. This is much higher than the national ART coverage of 67.6% in 2013,[41] but it should be noted that the results may be biased towards high levels of treatment and access to treatment as most of the respondents were recruited at outpatient clinics (OPCs).

During the case study interviews, respondents also discussed their fears that ART might no longer be available for free in the future: many PLHIV will not be able to afford ART if they have to pay for it themselves. Currently, the free provision of ART is heavily subsidised by donors, but as these withdraw from Viet Nam alternative financing is being considered. The concerns expressed during the interviews echo those communicated at the consultations conducted with PLHIV for the development of Viet Nam's Investment Case, which does include provisions for providing ART free of charge under national health insurance.[42]

At the same time, despite these high levels of treatment coverage and perceived access to treatment, a very large percentage of respondents (60.1%) had not been able to discuss their HIV-related treatment with a health-care professional in the past 12 months. Only 16.6% of MSM had benefited from such a discussion.

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[41] Viet Nam Administration of AIDS Control (VAAC). *Viet Nam AIDS Response Progress Report.* 2014.

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

FIGURE 40:
Access to treatment, even if not currently receiving it

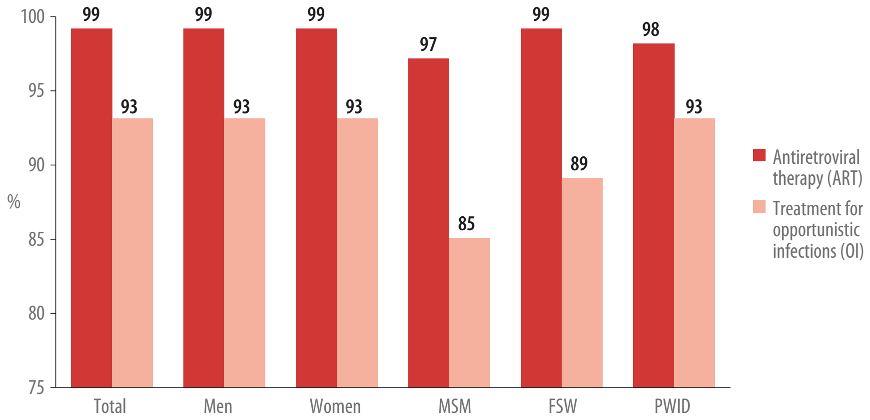
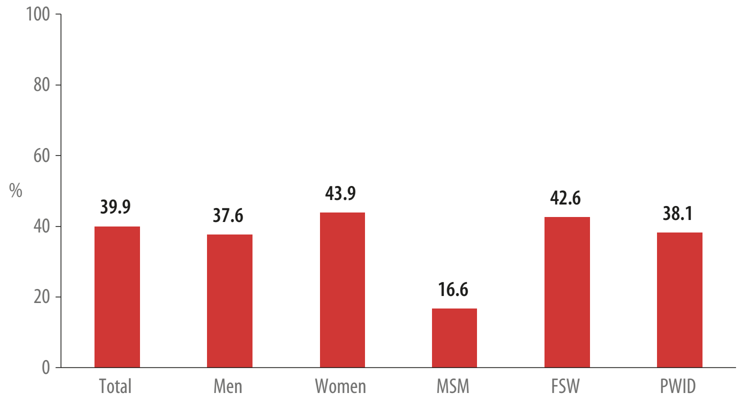


FIGURE 41:
Discussions with health-care professionals in the past 12 months about HIV-related treatment



i. The role of support groups and networks for PLHIV

Self-help groups and support networks for PLHIV in Viet Nam have long been involved in HIV-prevention activities and in providing support, care and treatment for PLHIV. Indeed, the Viet Nam Government's 2012 *National Strategy for HIV/AIDS Prevention and Control to 2020, with a vision to 2030* highlights the role of support groups and networks for PLHIV as part of multi-sectoral collaboration, community mobilization and human resources solutions to the challenges of the epidemic.

In order to determine the impact of such support groups and networks, a comparison exercise was undertaken as part of the Stigma Index data analysis. This exercise showed that these groups did have a positive impact on PLHIV, at least in certain areas. More PLHIV who had participated in support groups/networks had: disclosed their HIV status to their husband/wife/partner; heard of the Law on HIV; and read or discussed the contents of the Law on HIV than PLHIV who had not participated in support groups/networks.

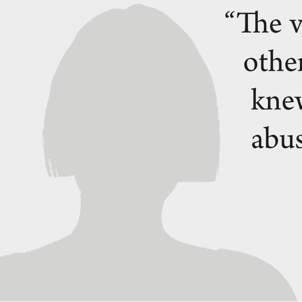
TABLE 4:
Role of support groups/networks for PLHIV

Index	% of PLHIV who participated in a support group/network	% of PLHIV who did NOT participate in a support group/network	P value
Had disclosed their HIV status to husband/wife/partner	66.3%	57.2%	<0.05
Had ever heard of the Law on HIV	84.1%	63.3%	<0.05
Had ever read or discussed the contents of the Law on HIV	56%	39%	<0.05

j. Double stigma and other vulnerabilities

"I often hear nasty comments such as: 'She's gay, she uses drugs; no wonder she got the disease'.

"I was once told off because I'd helped a child who had fallen down to stand up. The parents said their son could be infected because I'd touched him.



"The very worst thing that has happened is that I was sexually abused by other drug users when I was coming home late at night after work. They knew I also used drugs, and said that if I did not agree [to the sexual abuse] they would tell the police. So I had to keep quiet and accept it."

Case study: ***Nhung is a transgender woman who injects drugs living with HIV in Ho Chi Minh City***

It has already been suggested that people who are not only living with HIV but engage in risk behaviours that are highly stigmatized – injecting drug use, sex work and same-sex sexual activitiy – are at risk of double stigma. There may also be other factors that make PLHIV in Viet Nam more vulnerable to stigma and discrimination (such as gender, poverty or membership of an ethnic group). Additional analysis was therefore undertaken to investigate the extent of such double stigma.

The results of the survey as outlined above indicate that differences do exist between the stigma and discrimination experienced by PWID, FSWs and MSM and that experienced by other respondents. These include community/social stigma and discrimination; self-stigmatization; and difficulties in accessing education, employment and health services.

However, these results needed to be adjusted to take into account other differences between PWID/FSWs/MSM and the whole sample that may also affect stigma and discrimination and self-stigmatization: length of time living with HIV, age, gender, highest level of education, place of residence and average income.

Two composite indexes were therefore developed to investigate further the differences in stigma and discrimination experienced by PWID, FSWs and MSM and other factors affecting stigma and discrimination.[43]

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[43] For more information on methodology and the results of the analysis, please see Annex 1.

Community/social stigma and discrimination [44]

Multivariate linear regression was used to analyse double stigma among PWID, FSWs and MSM, using the responses to questions about community/social stigma and discrimination (see "Gossip, insults, harassment, assault and exclusion"), with adjustments for gender, age, education level, place of residence, years of living with HIV and average income.

It was found that MSM reported both more experiences of community/social stigma and discrimination than either PWID or FSWs, and more than other PLHIV. PWID and FSWs also experienced more stigma and discrimination than other PLHIV. This indicates that engaging in risk behaviours, particularly male same-sex sexual activity, does result in double stigma.

> "I often hear gossip about my gender, because I like to wear women's clothes. People often mock me and touch my body, thinking it's fun. If I wear the clothes I want to wear when I go to hospital or a health facility, the staff laugh at me and don't want to give me any treatment, so I don't go.
>
> "Once, I got a tingling feeling in my 'secret parts' and I went to a clinic that my friend recommended. That was when I found out I was HIV-positive. Of course I keep this confidential, because people look down on me already. If they find out my status, they will beat me."
>
> **Case study:** ***Sang is a transgender woman living with HIV in Ho Chi Minh City***

The analysis also found that two other factors can make PLHIV more vulnerable to community/social stigma and discrimination: gender (women more often experience this type of stigma and discrimination than men do); and education level (PLHIV who have no formal education experience more of this kind of stigma and discrimination than do PLHIV with higher education levels).

Self-stigmatization

Multivariate linear regression was also used to analyse double stigma relating to self-stigmatization, with the results again adjusted for gender, place of residence, age, educational level, length of time living with HIV diagnosis and average income.

In this analysis, too, MSM experienced the most self-stigmatization (with a self-stigmatization score[45] 3.4 points higher than PLHIV with no risky behaviours). FSWs also suffered more than others (with a self-stigmatization score 1.8 points higher), followed by PWID, who suffered more than PLHIV who did not engage in any risky behaviours.

In addition, the exercise showed that PLHIV living in rural areas suffered more self-stigmatization than PLHIV living in other areas; PLHIV with lower levels of education suffered more self-stigmatization than those with higher levels; and people who had been diagnosed within the past year suffered more self-stigmatization than people who were diagnosed in the more distant past.

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[44] "Experiences of stigma and discrimination created by other people"

[45] For a definition of this score, please see Annex 1.

3.3. Changes in stigma and discrimination between 2011 (Round 1) and 2014 (Round 2)

An important objective of the Stigma Index project is to identify and analyse any changes in stigma and discrimination over time. In Viet Nam, as described above and in Annex 1, changes in the sampling methodology (the selection and identification of respondents from key populations) between 2011 (Round 1) and 2014 (Round 2) have made comparisons between the two studies a challenge. The raw data cannot be directly compared. In order to establish whether there were any statistically significant changes over time, it was necessary to undertake adjustments to make the data comparable.

The first of these adjustments was to apply the Round 2 definition of key populations to the Round 1 data (please see the tables in Annex 1 for this data). This adjustment means that the values reported for each indicator will be different from the raw data values in the Round 1 report. The second adjustment was to use multiple logistic regression to control for the differences in sample characteristics over time; the odds ratio (OR) was calculated to determine whether any differences between Round 1 and Round 2 were statistically significant.[46]

a. Rights, laws and policies

The following four indicators were selected for comparison: (a) the percentage of PLHIV who had ever heard about Viet Nam's Law on HIV; (b) the percentage of PLHIV who had ever read or discussed the contents of the Law on HIV; (c) the percentage of PLHIV who had reported violations of their rights; and (d) the percentage of PLHIV who had sought legal redress after experiencing a violation of their rights.

The most important finding in this area was that significantly fewer people reported experiencing violations of their rights in the last 12 months, from 21.8% of the adjusted sample in Round 1 to 11.2% of the adjusted sample in Round 2.[47] The decrease was even larger among FSWs, from 41.1% in Round 1 to 16.6% [48] in Round 2, while among PWID the decrease was from 24% to 15.5%.[49]

In addition, the percentage of PWID who had heard of the Law on HIV rose from 61.9% in Round 1 to 69.6% in Round 2.[50] However, there was no statistically significant change among the total sample of PLHIV or among other groups for this indicator. There was also no significant change in the percentage of PLHIV who reported that they had read/discussed the contents of the Law on HIV.

The percentage of PLHIV who experienced rights violations and sought legal redress was slightly higher in Round 2, but the increase was not statistically significant because the number of PLHIV who sought legal redress was very small in both rounds.[51]

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[46] The odds ratio represents changes between the rounds. An OR of over 1 (>1) shows an increase, and an OR of less than 1 (<1) shows a decrease. Thus, an OR of 0.5 means that – for example – X was half as likely to happen in Round 2 than in Round 1; and OR of 1.5 means that X was 1.5 times more likely to happen in Round 2 than in Round 1.

[47] OR=0.4

[48] OR=0.2

[49] OR=0.6

[50] OR=1.4

[51] Note: there were 30 respondents in Round 1 who reported seeking legal redress, but did not report any rights violations. These responses were not included in the comparison

b. Testing and confidentiality among people diagnosed in the previous 12 months

For questions relating to HIV testing and the diagnosis of PLHIV, only the data from those respondents who had been diagnosed within the last 12 months were analysed.[52] This enabled a more accurate and reliable investigation of changes over time. However, as the number of recently diagnosed PLHIV in each samples was small, caution should be used when examining the results.

In Round 1, respondent confidence that their HIV-related medical records would be kept confidential was low. Although it decreased still further in Round 2,[53] the change was not statistically significant. Among MSM, confidence signficantly reduced from 75% in Round 1 to 25.5% in Round 2.[54]

There was a small but statistically insignificant improvement (from 71.8% to 80.4%) in the percentage of recently diagnosed PLHIV who said that they had received counselling before and after their HIV test. There was also a small but statistically insignificant decrease (from 15.3% to 7.7%) in the total number of PLHIV who had not taken a test voluntarily (those reporting coercive testing, testing undertaken under pressure from others and testing without their knowledge).[55]

c. Disclosure of HIV status among people diagnosed in the previous 12 months

Again, this comparison was restricted to respondents who were recently diagnosed, which again means that sample sizes were small and caution should be used when examining the results.

The analysis found that there was a change in the percentage of recently diagnosed PLHIV who reported disclosure without consent (from 35% to 18.5%) but it was not statistically significant. The decreases in the percentage of respondents reporting discriminatory reactions from their husband/wife/partner (from 8% to 6%) or from other adult family members (from 11% to 3.6%) were also statistically insignificant.

However, discriminatory reactions from friends, neighbours, colleagues and employers on first finding out the respondent's status was significantly lower, from 30.7% in Round 1 to 7.7% in Round 2 .[56] Among PWID, the decrease was even more marked: down from 31.9% to 4.4%.[57] There was no statistically significant reduction for these indicators among FSWs and MSM.

In addition, the analysis found that the percentage of recently diagnosed respondents disclosing their status to their husband/wife/partner reduced from 62% to 36.3%.[58] It decreased even further among MSM – from 60% reporting disclosure of status to a partner in Round 1 to 14.5% in Round 2.[59]

d. Community/social stigma and discrimination[60]

For the purposes of comparison, the data analysis was restricted to reported experiences of community/social stigma and discrimination that were attributed by respondents either wholly or in part to their HIV status (and not to "other reasons" or if the respondent was "not sure").

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[52] Those who selected "0-1 year" for the question "How long have you been living with HIV?" See Annex 1 for further information on the respondents.

[53] From 63.2% to 40.5% (a decrease of 22.7%).

[54] OR=0.1

[55] As the number of people reporting in each of these categories was extremely small, the results were combined.

[56] OR=0.2

[57] OR=0.1

[58] OR=0.5

[59] OR=0.2

[60] "Experiences of stigma and discrimination created by other people"

Changes in the total sample

In both rounds, the three most commonly reported types of HIV-related community/social stigma and discrimination among all categories of respondent were gossip, insults/verbal harassment/threats and sexual rejection. From Round 1 to Round 2 there was a statistically significant decrease in the percentage of all PLHIV who experienced gossip and sexual rejection related to their HIV status. The percentage of all respondents reporting gossip reduced from 28.9% in Round 1 to 19.3% in Round 2,[61] while the percentage of respondents reporting sexual rejection reduced from 6.2% to 2.6%.[62] There were no other statistically significant decreases in community/social stigma and discrimination among the whole sample of respondents.

Changes among PWID, FSWs and MSM

There were similar decreases among PWID specifically, with the percentage reporting gossip reducing from 31.6% in Round 1 to 25% in Round 2,[63] and the percentage reporting sexual rejection reducing from 6.1% to 2.9%.[64] There were no other statistically significant decreases in community/social stigma and discrimination among PWID.

In Round 1, FSWs reported the highest – and very high – rates of many forms community/social stigma and discrimination. The analysis shows significant decreases in instances of these forms of stigma and discrimination reported by FSWs in Round 2. The greatest decrease was in FSWs reporting gossip: from 39.3% in Round 1 to 20.1% in Round 2.[65] In addition, the percentage of FSWs reporting insults/verbal harassment/threats reduced from 19.6% to 7.7%;[66] the percentage of FSWs reporting being discriminated against by other PLHIV reduced from 12.9% to 1.2%;[67] the percentage of FSWs reporting psychological pressure or manipulation by a husband/partner reduced from 15.3% to 5.3%;[68] the percentage of FSWs reporting sexual rejection reduced from 15.3% to 5.3%;[69] and the percentage of FSWs reporting physical harassment and/ or threats reduced from 8% to 2.4%.[70] No statistically significant decreases were observed for FSWs in the other indicators for this category of stigma and discrimination.

Among MSM, the only statistically significant change was a reduction in the percentage who reported being subjected to psychological pressure by their partner in which their HIV status was used against them - from 6% to 1.3%.[71]

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[61] OR=0.73

[62] OR=0.48

[63] OR=0.73

[64] OR=0.48

[65] OR=0.36

[66] OR=0.3

[67] OR=0.07

[68] OR=0.3

[69] OR=0.3

[70] OR=0.2

[71] OR=0.2

e. Self-stigmatization

In order to assess changes between the two rounds, rather than analysing how many respondents did suffer from self-stigmatization, the percentage of respondents who did not report experiencing any negative emotions in the past 12 months because of their status; the percentage of respondents who did not report taking any decisions because of their HIV status in the past 12 months that might have a negative impact on their lives; and the percentage of respondents who did not report having feared community/social stigma and discrimination[72] in the past 12 months, (whether or not this had occurred).

Changes in the total sample

The analysis suggests that self-stigmatization among respondents as a whole decreased. The percentage of respondents who did not report experiencing any negative emotions rose from 26.5% in Round 1 to 32.9% in Round 2;[73] the percentage of respondents who did not report having taken any potentially harmful decisions rose from 14.1% to 30.1%;[74] and the percentage of respondents who had not feared community/social stigma and discrimination rose from 39% to 49.2%.[75]

Changes among PWID, FSWs and MSM

This reduction in self-stigmatization was not as great among the three key populations. In particular, there was no statistically significant increase in the percentage of PWID, MSM and FSWs who did not report experiencing negative emotions – including shame, guilt, blaming themselves, blaming others, low self-esteem, feeling they should be punished, and feeling suicidal.

However, there were a few statistically significant results among the key populations. The percentage of respondents who did not report having taken any potentially harmful decisions rose among PWID from 16.4% in Round 1 to 36.9% in Round 2[76] and among FSWs from 10.4% to 27.2%.[77] The percentage of respondents who did not report having community/social stigma and discrimination-related fears rose among PWID from 43.5% to 52.3%[78] and among MSM from 6% to 13.9%.[79]

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[72] Gossip; verbal insults/harassment/threats; physical harassment/threats; physical assault.

[73] OR=1.2

[74] OR=2.7

[75] OR=1.5

[76] OR=3.0

[77] OR=3.7

[78] OR=1.3

[79] OR=3.4

f. Access to employment and education

This comparison, focused on: (a) the percentage of respondents who were forced to relocate/had not been able to rent accommodation due to their HIV status in the past 12 months; (b) the percentage of respondents who had lost jobs/income sources due to their HIV status in the past 12 months; (c) the percentage of respondents who were dismissed or suspended from, or prevented from attending, an educational institution; and (d) the percentage of respondents who were refused employment or a job opportunity.; and (e) the percentage of respondents whose job description or nature of their work changed, or who were refused a promotion.

The analysis showed a statistically significant decrease in the percentage of all respondents reporting being forced to relocate or unable to rent accommodation due to their HIV status in the past 12 months, from 2.8% in Round 1 to 1.3% in Round 2.[80] There were no statistically significant changes for sub-groups of PLHIV. The very small changes in stigma and discrimination related to employment and education were insignificant among all groups of respondents.

g. Access to health-care services and treatment

The analysis showed that fewer respondents reported being denied health-care services in Round 2 than in Round 1, with a statistically significant decrease from 2.9% to 1.8%.[81]

There was no statistically significant change in the percentage of respondents who had been denied sexual and reproductive health care in the last 12 months, nor in the percentage of women who had been given ART to prevent mother-to-child transmission of HIV.

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[80] OR=0.47

[81] OR=0.6

IV. CONCLUSION

Decreases in stigma and discrimination

A comparison of the data from the two Stigma Indexes shows that there have been some positive changes with regard to the stigma and discrimination experienced by PLHIV in Viet Nam since 2011. Of particular note, fewer PLHIV – and particularly FSWs – reported having experienced rights violations within the 12 months prior to the survey date in 2014 than in 2011.

This overall reduction in rights violations was also reflected in more specific indicators of stigma and discrimination. There was a lower percentage of respondents reporting gossip in 2014, as well as a lower percentage of recently diagnosed PLHIV – particularly PWID – reporting discriminatory reactions from friends, neighbours, colleagues and employers when they first found out the respondent's status. In addition, there were significant reductions in the percentage of FSWs reporting gossip; insults/verbal harassment/threats; discrimination from other PLHIV; sexual rejection; psychological pressure from husband/partner; and physical harassment/threats.

Stigma and discrimination remain unacceptably high

Despite these positive results, the data also show that the incidence of many types of stigma and discrimination remain unacceptably high, and particularly so for PLHIV who also engage in transactional sex, injecting drug use and same-sex relationships. These results are in line with other recent findings on stigma and discrimination in Viet Nam: for example, a 2014 national household survey found that fewer than one-third of women in Viet Nam express accepting attitudes towards PLHIV.[82]

According to the Stigma Index, FSWs, other women living with HIV and PWID were most likely to have experienced violations of their rights as PLHIV. In addition, the vast majority of all respondents who reported such violations – 94% – had not sought legal redress. Many said they had been advised not to or that they had no confidence in the outcome. PWID were the least likely to seek legal redress; MSM were most likely to.

Gossip remained the most commonly reported form of stigma and discrimination, followed by insults and social exclusion. FSWs living with HIV and other women living with HIV were the most likely to report physical assault and verbal insults. FSWs, PWID and particularly MSM reported higher levels of both community/social stigma and discrimination and self-stigma (see below) than other respondents, indicating the existence of double stigma linked to risk behaviours as well as HIV status.

PLHIV also continue to encounter barriers to accessing and keeping employment, with no statistically significant improvements since 2011 in these areas. Respondents reported having lost their job or source of income, or having been refused employment or a job opportunity, in the previous 12 months. The percentage of people losing their jobs was much higher among those whose employer knew their HIV status than among those whose employer did not. These problems were even greater among key populations, particularly FSWs.

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[82] General Statistics Office and UNICEF. *Viet Nam Multiple Indicator Cluster Survey 2014, Key Findings.* 2014.

In addition, some respondents reported that they had been forced to relocate or unable to rent accommodation, or been denied health-care services in the past 12 months. Again, FSWs seemed particularly vulnerable. In contrast, very few respondents reported difficulties relating to accessing education for themselves or their children.

Quality and confidentiality of health care and HIV testing a concern

The Stigma Index revealed concerns about the quality and confidentiality of health care: many PLHIV reported not having been able to discuss their treatment with a health-care worker. Service delivery can be unfriendly and sometimes unethical. Of particular and ongoing concern is the fact that some respondents (especially PWID and recently diagnosed PLHIV) were coerced into testing, while others were tested without their knowledge.

In addition, there are very high rates of disclosure to others without the consent of the person involved, with over one-third of all respondents and nearly half of PWID reporting this. There was no statistically significant evidence that this has decreased since 2011, nor is there significant evidence of any improvement in respondent confidence in the health system's ability to keep their medical records and/or HIV status confidential. Recently diagnosed MSM have even less faith than other PLHIV that their results will be kept private.

Stigma and discrimination remain formidable barriers to ending AIDS

The Stigma Index results reveal formidable barriers to achieving Viet Nam's new "90-90-90" HIV testing and treatment targets and the global goal of ending AIDS by 2030. High levels of stigma and discrimination combined with low confidence in the confidentiality of HIV testing mean that many PLHIV only seek an HIV test after their immune systems become extremely weak and they develop symptoms of opportunistic infections: a considerable percentage of all groups of respondents reported taking a test because of suspected HIV-related symptoms. Testing only after symptoms appear results in the very late initiation of ART, which is dangerous for the health of the patient and, from a public health standpoint, fails to take advantage of the preventative benefits of antiretroviral treatment.

At the same time, respondents – particularly men – reported high rates of non-disclosure to partners. There were also very high rates of non-disclosure by FSWs to their clients and by PWID to their injecting drug partners. Such non-disclosure has clear implications for HIV prevention. It also suggests a significant fear of stigma and discrimination. Among recently diagnosed PLHIV, those interviewed in 2014 were much less likely to disclose their status to their husband/wife/partner than those interviewed in 2011.

Self-stigma

Over two-thirds of PLHIV continued to self-stigmatize, experiencing negative emotions relating to their HIV status and taking potentially harmful decisions. An alarming one in three MSM said they felt suicidal, and MSM and women were most likely to avoid seeking health care when they needed it.

However, a comparison of the 2011 and 2014 Stigma Index data suggests that self-stigmatization as a whole decreased: the percentage of respondents who did not report experiencing any negative emotions and that of respondents who did not report taking any potentially harmful decisions both increased.

Men who have sex with men

Throughout the Stigma Index data analysis, the results among MSM living with HIV stood out. Despite having significantly higher levels of education and income than other PLHIV, they also seem to suffer higher levels of stigma and discrimination, including discriminatory reactions from partners and family; familial and social exclusion; and self-stigmatization. In addition, a very large proportion of MSM had not disclosed their status to sexual partners and family, let alone others, with implications for both HIV prevention, and for support and health care for the MSM themselves. These higher levels of stigma and discrimination can almost certainly be linked to their sexual orientation, which amounts to double stigma due to both their HIV status and their sexuality.

MSM were also more likely to report issues with health care, including a lack of access. They had very low rates of talking to health-care workers and many also reported avoiding going to local clinics when they needed to because of self-stigma. Finally, MSM reported even less confidence in the confidentiality of their test results than other respondents, and much less than in 2011 (see above).

The MSM in the study were also younger and more recently diagnosed – possibly meaning they had not had as much time to initiate treatment, seek support and adapt to their status. These findings were in line with national epidemiological data that suggests the epidemic among MSM is newer and still growing, compared to older and more stable epidemics among PWID and FSWs.

Recommendations

The following recommendations provide tangible ways to address stigma and discrimination against PLHIV in Viet Nam, and some of the impacts of this stigma and discrimination. They arise out of the survey data and analysis and discussion with members of VNP+ and participants in the Stigma Index validation meeting.

Populations at higher risk of stigma and discrimination

Given their particular vulnerability to certain forms of stigma and discrimination, some groups of PLHIV need targeted interventions. FSWs and PWID living with HIV suffering from double stigma because of their HIV status and their risk behaviours, for example, need:

- Increased outreach activities at the grassroots level to provide support for individuals facing stigma and discrimination;
- Support for the formation and maintenance of self-help groups to help them connect and cooperate with harm-reduction and community-integration services;
- Community-level training about their rights to live free from stigma and discrimination and to have access to HIV, sexual and reproductive health care and other health services; and
- Meaningful involvement of FSW and PWID community leaders in the piloting of HIV service innovations and the adoption of lessons learned in national HIV service guidelines and policies.

FSWs living with HIV and other women living with HIV, who suffer higher levels of verbal abuse and/or harassment and physical assault, need:

- Awareness-raising programmes for FSWs living with HIV and women living with HIV on their rights and information on available support services;
- Measures to create an enabling environment for networks and groups to advocate for and provide support to female and transgender sex workers who are survivors of violence, including an online peer-support channel; and
- Comprehensive and integrated support services including a hotline, one-stop crisis centres and shelters where survivors can receive counselling, health care, voluntary and confidential HIV testing and services, as well as legal support.

MSM, given their isolation, high rates of stigma and discrimination and the challenges surrounding HIV testing and the quality of care, need:

- Behaviour change communication activities undertaken in collaboration with famous Vietnamese personalities, such as film actors, focused on supporting MSM living with HIV at the community level;
- Community monitoring surveys and mapping of quality, MSM-friendly testing and counselling and sexually transmitted infection (STI) and ART care and treatment services; and
- Further investigation and analysis into MSM as both a key population at risk of HIV and as targets of stigma and discrimination.

Testing, disclosure and confidentiality

Specific measures are also needed to increase the confidentiality of test results; health-care workers in particular need to ensure that results are not disclosed. This will help to reduce the fear of disclosure without consent and the risk of stigma and discrimination, and increase the likelihood that people will be tested early enough for the most effective outcomes early and maximization of the preventative benefits of treatment in line with the new 90-90-90 targets and Investment Case strategy.

Rights and legal support

Local authorities should work through the judiciary system to ensure compliance with the existing provisions under the Law on HIV (and other legal instruments) that provide protection for PLHIV, in particular regarding access to employment and education. Both educational measures that target the community and workplaces and the consistent application of legal sanctions should be used to increase implementation of the law.

In addition, State and non-state providers of legal aid should support PLHIV to seek legal redress when their rights are violated, in collaboration with self-help groups and networks of PLHIV.

Health care

The quality of health care for PLHIV, particularly interactions with health-care workers and particularly for MSM living with HIV, needs to be further improved. Education and training for health-care staff will be crucial and, again, self-help groups and networks of PLHIV have a role to play.

Health-care services and VNP+ member groups should establish a collaborative mechanism to refer and support PLHIV who have experienced stigma and discrimination at the hands of health-care staff.

Further research

More research is needed to further refine national understanding of stigma and discrimination and the development of anti-stigma laws and policies. Key areas highlighted in this report include stigma and discrimination suffered by MSM, FSWs, PWID and women living with HIV and stigma-related barriers to health and HIV service delivery.

In keeping with the global objective of the Stigma Index to track progress made regarding stigma and discrimination, another round of the Stigma Index should be conducted in four to five years.

V. ANNEXES

Annex 1: Methodology

This section provides more detail regarding the sampling methodology (the selection of respondents) for the Stigma Index, as well as the methodology used to analyse the data.

A. The Sampling Process

i. Systematic random sampling at outpatient clinics (OPCs)

A total of 1,072 PLHIV were selected for interviews using systematic random sampling. The following steps were followed:

Step 1: Provincial AIDS Centre (PAC) staff in each of the five survey provinces made a list of PLHIV who were clients at outpatient clinics (OPCs), screened the list using sampling criteria[83], and identified each person on the list with a code. The lists were provided to VNP+ data-collection coordinators in each province.

Step 2: VNP+ data-collection coordinators in the five survey provinces conducted systematic random sampling of the lists. The sampling fraction was calculated using the formula: $k = N/n$ (N: population; n: expected sample size). The first respondent was selected randomly in the list from 1 to N. The following respondent was in the order $i + 1k$; $i + 2k$; $i + 3k$ etc until the desired sample size was reached. The coordinators then sent the lists of randomly selected respondents to PAC staff.

Step 3: PAC staff added contact information to the lists of randomly selected respondents, and worked with OPC staff and/or peer educators to contact the respondents, briefly inform them about the research, obtain an oral agreement from respondents that they would participate in the survey, and finally formally invite qualified respondents to participate.

Step 4: After verifying all contact information, PAC staff provided the lists of confirmed interviewees to VNP+ data-collection coordinators and team leaders in each province. The team leaders passed on to the data-collection coordinators in their team the lists of respondents that they were responsible for interviewing.

Step 5: The VNP+ data-collection coordinators in each province contacted respondents to set up appointments for interview and briefly introduce the research.

ii. Snowball sampling of key populations (PWID, FSWs and MSM)

Snowball sampling of key populations took place in Ha Noi, Ho Chi Minh City and Can Tho only, to compensate for an under-representation of PWID, MSM and FSWs in the OPC populations interviewed there (this was not necessary in Dien Bien or Hai Phong).

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[83] Including that participants should OPC patients over the age of 18.

Step 1: VNP+ leaders/representatives/coordinators used sampling criteria[84] to screen the list of members of PLHIV self-help groups and retain those individuals who met the criteria. Each person on the list was assigned a unique identifying code.

Step 2: The VNP+ data-collection coordinators in each province randomly selected 10 people (10 codes) from the coded list and checked to ensure that these people had not already been selected for interview through the systematic random sampling method. The coordinators/leaders/representatives then contacted the selected candidates, briefly informed them about the research, invited them to participate in the survey and obtained their verbal agreement to be interviewed.

Step 3: The VNP+ data-collection coordinators in each province provided the list of the randomly selected 10 respondents to team leaders. The team leaders assigned interviewees to the interviewers in their team and the interviewers contacted the interviewees to make an interview appointment and briefly introduce the research.

Step 4: At the end of each interview, the interviewers asked the respondent to introduce them to two additional FSWs/PWID/MSM for interview. Step 4 was repeated until the desired sample size was reached.

B. Limitations

It is important for the reading of the Stigma Index survey findings in Viet Nam, and for the purpose of comparison with survey findings from other countries, to note the limitations of the survey as conducted in 2014. Some of these issues have also been covered in more detail elsewhere in this Annex and in the main report.

- The majority of respondents were selected from lists of OPC clients. This means that while the survey was representative of PLHIV in Viet Nam who know their status and have registered for services, the OPC sampling did not reach those who have been very recently diagnosed and have therefore not enrolled in treatment. It also excludes those who have not enrolled in treatment due to fear of stigma and discrimination.
- Although the use of snowball sampling went some way to addressing this bias, at least among key populations at higher risk, PLHIV who have completely withdrawn from their social networks due to self or peer stigma will still not have been included in the sample. This means that those who potentially experience the greatest degree of stigma and discrimination are not represented.
- The bias towards PLHIV who are registered at OPCs also means that the results regarding access to ART and OI treatment were positively skewed (reported real and perceived access to treatment was higher than the reported national treatment coverage). It may also mean that the figures regarding status disclosure, at least to health staff, are higher than in reality.
- It should be noted that the percentage of women living with HIV who had ever received prevention of mother-to-child transmission (PMTCT) services was calculated, and a comparison between Round 1 and Round 2 found an increase in women receiving PMTCT services. However, the analysis was not ultimately included in the report because: 1. women who were not pregnant and women who were not HIV-positive when they became pregnant could not be excluded from the denominator; and 2. the increase between Round 1 and Round 2 was in any case not statistically significant.

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[84] Respondents needed to be over 18 years of age and a female sex worker, man who has sex with men or person who injects drugs.

- For the analysis of changes between Round 1 and Round 2 relating to rights, laws and policies; testing and confidentiality; and disclosure of HIV status, only the data from recently diagnosed respondents (those who selected "0-1 year" for the question "how long have you been living with HIV?") were used. While this limitation of the sample served to minimize errors and confounding factors, but also meant that the samples analysed were very small – possibly too small – and potentially leading to unstable calculations.
- Finally, and perhaps most importantly, it is impossible to read the reports for Round 1 and Round 2 side by side for comparison. This is because in the Round 1 report, the key-population-related data was taken from the snowball sample only (and not from respondents in the OPC-sampled group who were also members of key populations). In Round 2, the data for analysis was taken from all respondents (in both the OPC and snowball samples) who identified as PWID, FSWs or MSM when completing the questionnaire.

For this reason, the data from Round 1 was reanalysed to include all people who identified as members of key populations to enable comparison, and a separate analysis comparing the two rounds was conducted. For more information on the reanalysis methodology, please see below.

C. Analysis

i. Identification of PWID, FSWs and MSM

In Round 1, the three key populations were identified by snowball sampling in three provinces only (PWID in Dien Bien; FSWs in Ha Noi; and MSM in Ho Chi Minh City), and only the snowball samples were used for the stratified analysis relating to PWID, FSWs and MSM. In Round 2, however, the identification of respondents belonging to these key populations was based on their responses to question 7, section 1 of the Stigma Index questionnaire ("Are you a member of or have you been a member of any of the following key populations?"):

- If the respondent was male and selected options 1 (men who have sex with men), 2 (gay or lesbian) or 3 (transgender) → the respondent was categorized as MSM.
- If the respondent was female and selected option 4 (sex worker) → the respondent was categorized as FSW.
- If the respondent selected option 5 (injecting drug user) for Q 7 → the respondent was categorized as PWID.

For the purposes of all the data and analysis in this report, the identification of MSM, PWID and FSWs was based on the Round 2 method (those who responded to question 7 as above). This necessitated a re-identification of Round 1 respondents from key populations, using this method, for the comparison between Round 1 and Round 2.

ii. Double stigma and other vulnerabilities

In order to investigate the extent of double stigma suffered by members of key populations, and other factors influencing vulnerability to HIV-related stigma and discrimination, two composite indexes were developed.

Community/social stigma and discrimination

The Stigma Index questionnaire contains 10 questions (Section 2A, questions 1-7 and 9-11) on "your experiences of stigma and discrimination created by other people" in the past 12 months, which covers community/social stigma and discrimination against PLHIV. The answers to these questions were coded as binary variables (the answer "never" was coded as 0, the answers "once", "a few times" and "often" were coded as 1) and added together to create an index. The higher the score, the greater the experience of community/social stigma and discrimination. The index was tested and found to be reliable.[85] The average score of the community/social stigma and discrimination index in 2014 was 0.5 (standard deviation was 1.1).

Multivariate linear regression (see Table 4) was used to analyse double stigma among MSM, FSWs and PWID, with adjustments for other factors such as gender, age, education level, place of residence, years of living with HIV and average income. The regression established not only that MSM report the highest levels of community/social stigma and discrimination, and that PWID and FSWs also report higher levels than other respondents, but that there are other risk factors (gender and education level) that increase this type of stigma and discrimination.

TABLE 5:
Risk factors for community/social stigma and discrimination

Risk factors	Coefficients	95% CI		P value
Being a man who has sex with men (MSM)	.56	.34	.78	.00
Being a female sex worker (FSW)	.31	.12	.50	.00
Being a person who injects drugs (PWID)	.35	.23	.48	.00
Being a woman (as opposed to a man)	.22	.09	.34	.00
Living in a rural area (as opposed to living in other areas)	-.11	-.26	.05	.19
Aged 25 to 40	.15	-.06	.36	.15
Aged over 40	.08	-.16	.31	.53
Having no formal education	.48	.16	.80	.00
Living with HIV for less than 1 year	.03	-.17	.23	.74
Average income level (unit: 1000 USD)	-.01	-.02	.01	.31

Self-stigmatization

The Stigma Index questionnaire also contains four questions on self-stigmatization in the past 12 months – "self stigma (the way you feel about yourself) and your fears)" (Section 2C). The questions cover 7 negative feelings, 10 decisions that might have a harmful impact on the respondent (in terms of family/social support, intimate relationships, employment, education and health) and 5 fears about real or possible community/social stigma and discrimination. The self-stigmatization index was calculated by adding together the scores of these 22 experiences (each worth 1 point). The higher the score, the greater the self-stigmatization by PLHIV. The index was tested and found to be reliable.[86] The average score for the self-stigmatization index in 2014 was 4.8 (the standard deviation was 3.6).

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[85] The measure of the internal consistency of the index was high: Cronbach's alpha = 0.71

[86] The measure of the internal consistency of the index was high: Cronbach's alpha = 0.79

Again, multivariate linear regression was used to analyse self-stigmatization (see Table 5), with adjustments for gender, place of residence, age, educational level, length of time living with HIV and average income. As with community/social stigma and discrimination, MSM had the highest levels of self-stigmatization, followed by FSWs and then PLHIV; all three key populations had higher levels than other respondents. The analysis also showed that living in a rural area, having no formal education and being recently diagnosed (living with HIV less than a year) were risk factors for self-stigmatization.

TABLE 6:
Risk factors for self-stigmatization

Risk factors	Coefficients	95% CI		P value
Being a man who has sex with men (MSM)	3.40	2.71	4.09	.00
Being a female sex worker (FSW)	1.82	1.22	2.42	.00
Being a person who injects drugs (PWID)	.54	.15	.94	.01
Being a woman	-.07	-.47	.32	.71
Living in a rural area	-.53	-1.03	-.03	.04
Aged 25 to 40	-.51	-1.17	.14	.13
Aged over 40	.04	-.70	.78	.91
Having no formal education	1.27	.27	2.28	.01
Living with HIV for less than 1 year	1.14	.50	1.80	.00
Average income level (unit: 1000 USD)	.02	-.02	.06	.31

iii. Changes in stigma and discrimination between Round 1 (2011) and Round 2 (2014) of the Stigma Index

An important objective of the Stigma Index project, worldwide and in Viet Nam, is to identify and analyse any changes in stigma and discrimination over time. However, as described above, there were changes in the identification of respondents from key populations between 2011 (Round 1) and 2014 (Round 2). This means that the results of each round (the raw data) cannot be directly compared. In order to establish whether there were any changes over time, therefore, it was necessary to conduct further analysis of the data.

For the comparison analysis, the data from both Round 1 and Round 2 were analysed for several new indicators (described further below) as well as for existing indicators. The relevant data for the following populations was analysed:

- the whole sample (all respondents sampled in both Round 1 and Round 2)
- the three key populations (PWID, FSWs and MSM)

As described above, in Round 1, these were identified by snowball sampling in three discrete locations (PWID in Dien Bien; FSWs in Ha Noi; and MSM in Ho Chi Minh City) only, while in Round 2, they were identified through respondent responses to the question “Are you a member of or have you been a member of any of the following key populations?” (Section 1, question 7). For the purposes of comparison, the data from Round 1 was reanalysed to capture all respondents (whether in the OPC or the snowball samples) who self-identified as PWID, FSWs or MSM (through responses to question 7, section 1).

Crosstabulation was used to create a joint frequency distribution of the data, which was then analysed using the chi-square value to identify statistically significant change. All indicators with statistically significant raw-data changes were then adjusted for the differences in the samples between Rounds 1 and 2, including age, gender, education level, place of residence, years of living with HIV and engagement in high-risk behaviour (such as injecting drug use, sex work and male same-sex sexual relations). These are all factors that could impact on both stigma and discrimination and self-stigmatization.

Multiple logistic regression was then used to calculate the odds ratio (OR) for differences between the two rounds relating to specific indicators, with adjustments for the above factors.

Note on reading the tables: Results in bold and with a * next to the adjusted OR are statistically significant.

a. Rights, laws and policies

The following four indicators were used for the comparison analysis: the percentage of PLHIV who had ever heard about Viet Nam's Law on HIV; the percentage of PLHIV who had ever read or discussed the contents of the Law on HIV; the percentage of PLHIV who had reported violations of their rights; and the percentage of PLHIV who had sought legal redress after experiencing a violation of their rights.

TABLE 7:
Changes in indicators relating to rights and laws (recently diagnosed respondents only)

	Indicator	Round 1	Round 2	Round 2 – Round 1	Adjusted OR
All	% of PLHIV who have ever heard about the Law on HIV	65.6	68.6	3.0	
	% of PLHIV who have ever read or discussed the contents of the Law on HIV	39.6	43.4	3.8*	
	% of PLHIV (including PWID, MSM and FSWs) who reported that their rights had been violated within the last 12 months	**21.8**	**11.2**	**10.6***	**0.4**
	% of PLHIV (including PWID, MSM and FSWs) who had sought legal redress after experiencing a violation of their rights	0.0	6.0	6.0	
MSM	% of MSM who have ever heard about the Law on HIV	56.4	62.3	5.9	
	% of MSM who have ever read or discussed the contents of the Law on HIV	33.8	26.5	-7.3	
	% of MSM who reported that their rights had been violated within the last 12 months	12.0	7.9	-4.1	
	% of MSM who had sought legal redress after experiencing a violation of their rights	0	2.6	2.6	

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▨ Statistically significant difference between Round 1 and Round 2

TABLE 7: continued
Changes in indicators relating to rights and laws (recently diagnosed respondents only)

	Indicator	Round 1	Round 2	Round 2 – Round 1	Adjusted OR
FSWs	% of FSWs who have ever heard about the Law on HIV	71.8	61.5	-10.3	
	% of FSWs who have ever read or discussed the contents of the Law on HIV	49.1	43.8	-5.3	
	% of FSWs who reported that their rights had been violated within the last 12 months	41.1	16.6	-24.5*	0.2
	% of FSWs who had sought legal redress after experiencing a violation of their rights	0.0	3.0	3.0	
PWID	% of PWID who have ever heard about the Law on HIV	61.9	69.6	7.7*	1.4
	% of PWID who have ever read or discussed contents of the Law on HIV	33.9	40.5	6.6*	
	% of PWID who reported that their rights had been violated within the last 12 months	24.0	15.5	-8.5*	0.6
	% of PWID who had sought legal redress after experiencing a violation of their rights	0	2.7	2.7	

▨ Statistically significant difference between Round 1 and Round 2

b. Testing and confidentiality among people diagnosed in the previous 12 months

For the purposes of comparison, the analysis was limited to people who were recently diagnosed – that is, those who were diagnosed HIV-positive within the previous 12 months (those who selected "0-1 year" for the question "How long have you been living with HIV?"). This limitation of the sample for analysis served to minimize errors and confounding factors.

- Among the whole sample, in Round 1 **163** people and in Round 2 **168** people were recently diagnosed.
- Among MSM, in Round 1 **20** people and in Round 2 **55** people were recently diagnosed.
- Among FSWs, in Round 1 **15** people and in Round 2 **21** people were recently diagnosed.
- Among PWID, in Round 1 **69** people and in Round 2 **45** people were recently diagnosed.

These samples of recently diagnosed people in both rounds and among all populations are small. This should be kept in mind when using the analysis presented in the table below, as the small sample size can lead to unstable percentage calculations and may mean that the samples are not sufficient to establish any differences between the two rounds.

TABLE 8:
Changes in voluntary counselling, testing and confidentiality among people who were diagnosed in the previous 12 months

	Indicator	Round 1	Round 2	Round 2 – Round 1	Adjusted OR
All	**% of PLHIV who did not take a test voluntarily [87]**	**15.3**	**7.7**	**-7.6**	
	% of PLHIV who received counselling before and after their HIV test	71.8	80.4	8.6	
	% of PLHIV who expressed confidence in the confidentiality of their HIV test result	**63.2**	**40.5**	**-22.7***	
MSM	% of MSM who did not take a test voluntarily [88]	0	12.7	12.7	
	% of MSM who received counselling before and after their HIV test	75	74.5	-0.5	
	% of MSM who expressed confidence in the confidentiality of their HIV test result	**75**	**25.5**	**-49.5***	**0.1**
FSWs	**% of FSWs who did not take a test voluntarily [89]**	**47.7**	**9.5**	**-37.2***	
	% of FSWs who received counselling before and after their HIV test	40	66.7	26.7	
	% of FSWs who expressed confidence in the confidentiality of their HIV test result	33.3	66.7	33.4	
PWID	% of PWID who did not take a test voluntarily [90]	13	6.7	-6.3	
	% of PWID who received counselling before and after their HIV test	76.8	86.7	9.9	
	% of PWID who expressed confidence in the confidentiality of their HIV test result	59.4	42.2	-17.2	

▨ Statistically significant difference between Round 1 and Round 2

c. Disclosure of HIV status among people diagnosed in the previous 12 months

The analysis of changes in disclosure of HIV status, and in reactions from husbands/wives/ partners, family members and neighbours/friends/colleagues when they first found out the respondents' HIV status, was also restricted to recently diagnosed respondents (see above).

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[87] This includes: the total number of PLHIV reporting coercive testing, testing undertaken under pressure from others and testing without the respondent's knowledge.

[88] See above

[89] See above

[90] See above

TABLE 9:

Changes in disclosure of HIV status among people diagnosed in the previous 12 months

	Indicator	Round 1	Round 2	Round 2 – Round 1	Adjusted OR
All	**% of PLHIV able to tell their husband/wife/partner**	**62**	**36.3**	**-25.7***	**0.5**
	% of PLHIV who had experienced disclosure without consent	35	18.5	-16.5*	
	% of PLHIV who had experienced a discriminatory first reaction from their husband/wife/partner	8	6	-2	
	% of PLHIV who had experienced a discriminatory first reaction from their adult family members	11	3.6	-7.4*	
	% of PLHIV who had experienced a discriminatory first reaction from their neighbours/friends/colleagues/ employers	**30.7**	**7.7**	**-23***	**0.2**
MSM	**% of MSM able to tell their husband/wife/partner**	**60**	**14.5**	**-45.5***	**0.2**
	% of MSM who had experienced disclosure without consent	30	12.7	-17.3	
	% of MSM who had experienced a discriminatory first reaction from their husband/wife/partner	0	7.3	7.3	
	% of MSM who had experienced a discriminatory first reaction from their adult family members	15	3.6	-11.4	
	% of MSM who had experienced a discriminatory first reaction from their neighbours/friends/colleagues/employers	25	7.3	-17.7	
FSWs	% of FSWs able to tell their husband/wife/partner	53.3	38.1	-15.2	
	% of FSWs who had experienced disclosure without consent	53.3	38.1	-15.2	
	% of FSWs who had experienced a discriminatory first reaction from their husband/wife/partner	0	9.5	9.5	
	% of FSWs who had experienced a discriminatory first reaction from their adult family members	6.7	4.8	-1.9	
	% of FSWs who had experienced a discriminatory first reaction from their neighbours/friends/colleagues/employers	53.3	14.3	-39*	
PWID	% of PWID able to tell their husband/wife/partner	68.1	44.4	-23.7*	
	% of PWID who had experienced disclosure without consent	42	22.2	-19.8	
	% of PWID who had experienced a discriminatory first reaction from their husband/wife/partner	10.1	4.4	-5.7	
	% of PWID who had experienced a discriminatory first reaction from their adult family members	11.6	2.2	-9.4	
	% of PWID who had experienced a discriminatory first reaction from their neighbours/friends/colleagues/ employers	**31.9**	**4.4**	**-27.5***	**0.1**

▨ Statistically significant difference between Round 1 and Round 2

d. Community/social stigma and discrimination

Section 2A of the Stigma Index questionnaire contains 10 questions on experiences of community/ social stigma and discrimination.[91] Respondents were asked to state whether these experiences were due to their HIV status; both their HIV status and other reasons; or other reasons. For the comparison of the two rounds, new indicators were developed to identify experiences that were attributed in whole or in part to respondents' HIV status. Tables 9 to 12 show changes in experiences of stigma and discrimination due to HIV status in the last 12 months among the whole sample, MSM, FSWs and PWID, organized from most commonly to least commonly experienced.

TABLE 10:
Changes in community/social stigma and discrimination due in whole or in part to HIV status experienced in the previous 12 months – all respondents

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% gossiped about	**28.9**	**19.3**	**-9.6**	**0.73***
% verbally insulted, harassed and/or threatened	6.3	3.6	-2.7	
% experienced sexual rejection	**6.2**	**2.6**	**-3.6**	**0.48***
% subjected to psychological pressure or manipulation by husband/wife/partner [92]	4.3	2.8	-1.5	
% discriminated against by other PLHIV	3.6	1.1	-2.5	
% excluded from social events/activities	2.6	2	-0.6	
% excluded from family activities	2.5	1.7	-0.8	
% physically harassed and/or threatened	1.6	0.9	-0.7	
% physically assaulted	1.2	0.8	-0.4	
% excluded from religious events or places of worship	0.8	0.6	-0.2	

▨ Statistically significant difference between Round 1 and Round 2

TABLE 11:
Changes in community/social stigma and discrimination due in whole or in part to HIV status experienced in the previous 12 months – MSM

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% gossiped about	22.6	15.2	-7.4	
% experienced sexual rejection	11.3	5.3	-6	
% verbally insulted, harassed and/or threatened	7.5	6	-1.5	
% subjected to psychological pressure or manipulation by husband/wife/partner [93]	**6**	**1.3**	**-4.7***	**0.2**
% discriminated against by other PLHIV	3	4	1	
% physically harassed and/or threatened	3	1.3	-1.7	
% excluded from family activities	1.5	5.3	3.8	
% of excluded from social events/activities	0.8	4	3.2	
% physically assaulted	0.8	0.7	-0.1	
% excluded from religious events or places of worship	0	0.7	0.7	

▨ Statistically significant difference between Round 1 and Round 2

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[91] "experiences of stigma and discrimination created by other people"

[92] "in which your HIV-positive status was used against you"

[93] "in which your HIV-positive status was used against you"

TABLE 12:
Changes in community/social stigma and discrimination due in whole or in part to HIV status experienced in the previous 12 months – FSWs

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% gossiped about	39.3	20.1	-19.2	0.36*
% verbally insulted, harassed and/or threatened	19.6	7.7	-11.9	0.3*
% subjected to psychological pressure or manipulation by husband/wife/partner [94]	15.3	5.3	-10	0.3*
% experienced sexual rejection	15.3	5.3	-10	0.3*
% discriminated against by other PLHIV	12.9	1.2	-11.7	0.07*
% being physically harassed and/or threatened	8	2.4	-5.6	0.2*
% of excluded from family activities	6.1	2.4	-3.7	
% physically assaulted	6.1	2.4	-3.7	
% excluded from social events/activities	3.1	3.6	0.5	
% excluded from religious events or places of worship	1.2	1.2	0	

▨ Statistically significant difference between Round 1 and Round 2

TABLE 13:
Changes in community/social stigma and discrimination due in whole or in part to HIV status experienced in the previous 12 months – PWID

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% gossiped about	31.6	25	-6.6*	0.73*
% experienced sexual rejection	6.1	2.9	-3.2	0.48*
% verbally insulted, harassed and/or threatened	3.6	4.7	1.1	
% subjected to psychological pressure or manipulation by husband/wife/partner [95]	3.6	3.4	-0.2	
% excluded from social events/activities	3.4	2.7	-0.7	
% excluded from family activities	3	1.3	-1.7	
% discriminated against by other PLHIV	2.6	1.8	-0.8	
% excluded from religious events or places of worship	0.9	0.5	-0.4	
% physically assaulted	0.4	0.7	0.3	
% physically harassed and/or threatened	0.3	0.9	0.6	

▨ Statistically significant difference between Round 1 and Round 2

e. Self-stigmatization

To assess changes in self-stigmatization between the two rounds, three new indicators were developed:

- Percentage of respondents who did NOT experience any negative feelings because of their HIV status in the past 12 months (those who answered "No" to all options in Question 1, Section 2C of the Stigma Index questionnaire).

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[94] "in which your HIV-positive status was used against you"

[95] "in which your HIV-positive status was used against you"

- Percentage of respondents who did NOT take any decisions that might have a negative impact on their lives because of their HIV status in the past 12 months (those who answered "No" to all options in Question 2, Section 2C of the Stigma Index questionnaire).
- Percentage of respondents who had NOT been worried about community/social stigma and discrimination (gossip; verbal insults, harassment and/or threats; physical harassment and/or threats; physical assault; and sexual rejection) due to their HIV status in the past 12 months (those who answered "No" to all options in Questions 3 and 4, Section 2C of the Stigma Index questionnaire).

TABLE 14:
Changes in self-stigmatization experienced in previous 12 months

	Indicator	Round 1	Round 2	Round 2 – Round 1	Adjusted OR
All	% reporting no negative feelings	26.5	32.9	6.4*	1.2*
	% reporting no potentially harmful decisions	14.1	30.1	16.0*	2.7*
	% reporting no fears of community/social stigma and discrimination	39.0	49.2	10.2*	1.5*
MSM	% reporting no negative feelings	17.3	11.3	-6.0	
	% reporting no potentially harmful decisions	2.3	7.3	5.0*	4.3
	% reporting no fears of community/social stigma and discrimination	6.0	13.9	7.9*	3.4*
FSWs	% reporting no negative feelings	31.9	28.4	-3.5	
	% reporting no potentially harmful decisions	10.4	27.2	16.8*	3.7*
	% reporting no fears of community/social stigma and discrimination	27.0	32.5	5.5	1.3
PWID	% reporting no negative feelings	17.5	23.7	6.2*	
	% reporting no potentially harmful decisions	16.4	36.9	20.5*	3.0*
	% reporting no fears of community/social stigma and discrimination	43.5	52.3	8.8*	1.3*

▨ Statistically significant difference between Round 1 and Round 2

f. Access to employment and education

To assess changes in difficulties due to HIV status in accessing employment and education, two new indicators were developed:

- The percentage of respondents who were forced to change their place of residence or unable to rent accommodation because of their HIV status (those who responded "once", "a few times" or "often" to Question 2a, section 2B AND who responded "because of your HIV status" or "both because of your HIV status and other reasons" to question 2b, section 2B of the Stigma Index questionnaire);
- The percentage of respondents who lost a job or another source of income due to their HIV status (those who responded "once", "a few times" or "often" to Question 1a, section 2B AND who responded "because of your HIV status" or "both because of your HIV status and other reasons" to question 1b, section 2B of the Stigma Index questionnaire).

TABLE 15:
Changes in challenges due in whole or in part due to HIV status when accessing employment and education in the last 12 months – all respondents

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% dismissed or suspended from, or prevented from attending, an educational institution	0.6	0.6	0	
% refused employment or a job opportunity	7.3	6.6	-0.7	
% lost a job or another source of income	4.6	4.2	-0.4	
% job description or nature of work changed/refused a promotion	4.6	4.1	-0.5	
% forced to change place of residence or unable to rent accommodation	**2.8**	**1.3**	**-1.5***	**0.47**

▨ Statistically significant difference between Round 1 and Round 2

TABLE 16:
Changes in challenges due in whole or in part due to HIV status when accessing employment and education in the last 12 months – MSM

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% dismissed or suspended from, or prevented from attending, an educational institution	0	0.7	-0.7	
% refused employment or a job opportunity	4.5	4	-0.5	
% lost a job or another source of income	3	6.6	3.6	
% job description or nature of work changed/refused a promotion	2.3	2.6	0.4	
% forced to change place of residence or unable to rent accommodation	1.5	1.3	-0.2	

TABLE 17:
Changes in challenges due in whole or in part due to HIV status when accessing employment and education in the last 12 months – FSWs

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% dismissed or suspended from, or prevented from attending, an educational institution	0.6	0.6	0	
% refused employment or a job opportunity	12.9	9.5	-3.4	
% job description or nature of work changed/refused a promotion	12.9	7.7	-5.2	
% forced to change place of residence or unable to rent accommodation	10.4	5.9	-4.5	
% lost a job or another source of income	9.8	9.5	-0.3	

TABLE 18:
Changes in challenges due in whole or in part due to HIV status when accessing employment and education in the last 12 months – PWID

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% dismissed or suspended from, or prevented from attending, an educational institution	0.6	0.5	-0.1	
% refused employment or a job opportunity	6.4	6.1	-0.3	
% lost a job or another source of income	4.6	4.5	-0.1	
% job description or nature of work changed/refused a promotion	3.8	5.8	2	
% forced to change place of residence or unable to rent accommodation	1.7	1.8	0.1	

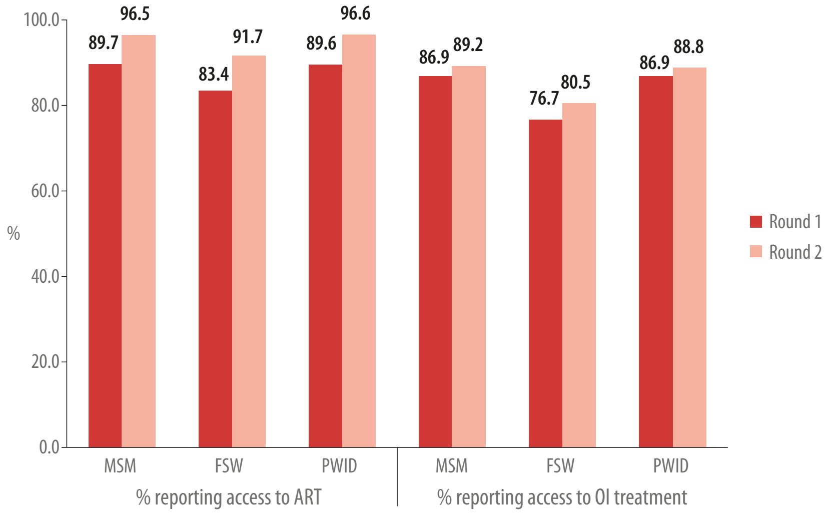
g. Access to health-care services and treatment

TABLE 19:
Changes in access to treatment and health services – all respondents

Indicator	Round 1	Round 2	Round 2 – Round 1	OR
% denied health-care services during the last 12 months	2.9	1.8	-1.1*	0.6
% denied sexual and reproductive health-care services during the last 12 months	1	1.3	0.3	
% access to antiretroviral therapy (ART), even if not currently receiving it	89.7	96.5	6.8*	3.1
% access to treatment of opportunistic infections (OI), even if not currently receiving it	86.9	89.2	2.3*	1.3
% women living with HIV who have ever been given ART to prevent mother-to-child transmission[96]	7.9	10	2.1*	

▨ Statistically significant difference between Round 1 and Round 2

FIGURE 42:
Changes in reported access to treatment (whether or not receiving it) – PWID, FSWs and MSM



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[96] Please note for this indicator, in 2014 there are problems with the denominator. Please see the "Limitations' section in Annex 1 for more information.

Annex 2: Source Data Tables

TABLE 1: Age distribution of PLHIV

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Aged from 18-19	38	3.9	7	1.1	13	8.6	4	2.4	16	2.9	45	2.8
Aged from 20-24	94	9.7	32	5.0	62	40.8	14	8.3	26	4.7	126	7.8
Aged from 25-29	143	14.7	123	19.2	58	38.2	40	23.7	64	11.5	269	16.6
Aged from 30-39	482	49.6	355	55.4	16	10.5	75	44.4	305	54.9	841	51.8
Aged from 40-49	184	18.9	116	18.1	2	1.3	33	19.5	126	22.7	303	18.7
Aged above 50	32	3.3	8	1.2	1	0.7	3	1.8	19	3.4	41	2.5
Total	**973**	**100**	**641**	**100**	**152**	**100**	**169**	**100**	**556**	**100**	**1625**	**100**

TABLE 2: Years of knowledge of HIV status

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
< 1 year	118	12.1	50	7.8	55	36.2	21	12.4	45	8.1	168	10.3
1-4 years	284	29.2	226	35.3	77	50.7	85	50.3	136	24.5	511	31.4
5-9 years	348	35.8	251	39.2	11	7.2	46	27.2	226	40.6	604	37.2
10-14 years	198	20.3	108	16.8	6	3.9	15	8.9	133	23.9	309	19.0
≥ 15 years	25	2.6	6	0.9	3	2.0	2	1.2	16	2.9	33	2.0
Total	**973**	**100**	**641**	**100**	**152**	**100**	**169**	**100**	**556**	**100**	**1625**	**100**

TABLE 3: Geographical distribution of PLHIV

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Rural area	112	11.5	101	15.8	13	8.6	16	9.5	72	13.0	214	13.2
Small town or village	144	14.8	87	13.6	11	7.2	23	13.6	79	14.3	232	14.3
Large town or city	715	73.6	452	70.6	128	84.2	130	76.9	403	72.7	1176	72.5
Total	**971**	**100**	**640**	**100**	**152**	**100**	**169**	**100**	**554**	**100**	**1622**	**100**

TABLE 4: Current relationship status

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Married or living with an intimate partner and husband/wife/partner is currently living in household	384	39.5	289	45.1	6	3.9	40	23.7	261	46.9	674	41.5
Married or living with an intimate partner and husband/wife/partner is living/working temporarily away from the household	20	2.1	20	3.1	2	1.3	11	6.5	9	1.6	41	2.5
In intimate relationship but not living together	73	7.5	41	6.4	20	13.2	22	13.0	42	7.6	115	7.1
Single	383	39.4	93	14.5	124	81.6	57	33.7	162	29.1	484	29.8
Divorced/separated	95	9.8	61	9.5	0	0.0	17	10.1	61	11.0	156	9.6
Widow/widower	18	1.8	137	21.4	0	0.0	22	13.0	21	3.8	155	9.5
Total	**973**	**100**	**641**	**400**	**152**	**100**	**169**	**100**	**556**	**100**	**1625**	**100**

TABLE 5: Respondents with one child or more

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Yes	428	44.0	439	68.8	8	5.3	86	50.9	286	51.6	870	53.7
No	544	56.0	199	31.2	144	94.7	83	49.1	268	48.4	751	46.3
Total	**973**	**100**	**641**	**100**	**152**	**100**	**169**	**100**	**556**	**100**	**1625**	**100**

TABLE 6: Respondents' children known to be HIV-positive

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Yes	19	4.4	37	8.4	0	0.0	1	1.2	13	4.5	57	6.6
No	409	95.6	401	91.6	8	0.0	84	98.8	273	95.5	812	93.4
Total	**428**	**100**	**438**	**100**	**8**	**100**	**85**	**100**	**286**	**100**	**869**	**100**

TABLE 7: Respondent self-identified category (multiple-answer question)

	Men		Women		Total	
	n	%	n	%	n	%
Men who have sex with men	146	15	0	0	154	9.5
Gay/lesbian	18	1.9	1	0.2	23	1.4
Transgender	0	0	0	0	5[97]	0.3

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[97] Please note that while 11 people identified as transgender in Part 1, Question 1 (where the options for "sex" were male, female and transgender), only 5 people identified as being or having been a member of the key population "transgender" in Part 1, Question 7.

TABLE 7: Respondent self-identified category (multiple-answer question)

	Men		Women		Total	
	n	%	n	%	n	%
Sex worker	4	0.4	169	26.4	174	10.7
Injecting drug user	447	46	107	16.7	556	34.2
Refugee or asylum seeker	2	0.2	1	0.2	3	0.2
Internally displaced person	16	1.6	5	0.8	21	1.3
Member of indigenous population	3	0.3	24	3.7	28	1.7
Migrant worker	3	0.3	6	0.9	10	0.6
Prisoner	19	2	4	0.6	23	1.4
None of the above	364	37.4	339	52.9	703	43.3

TABLE 8: Multiple risk behaviours among PWID, FSWs and MSM

	PWID		FSWs		MSM	
	n	%	n	%	n	%
Sex work	10	1.8	169	100	2	1.3
Male same-sex sexual activity	4	0.7	0	0	147	96.7
Injecting drug use	556	100	10	5.9	4	2.6

TABLE 9: Educational status

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
No formal education	17	1.8	28	4.4	1	0.7	6	3.6	12	2.2	46	2.8
Primary school	110	11.4	113	17.6	4	2.6	36	21.3	82	14.8	224	13.9
Secondary school (grade level 6-9)	327	33.8	257	40.1	8	5.3	70	41.4	222	40.1	586	36.2
High school (grade level 10-12)	339	35.1	204	31.8	65	42.8	54	32.0	187	33.8	546	33.8
Technical/college/university/ postgraduate	174	18.0	39	6.1	74	48.7	3	1.8	50	9.0	216	13.3
Total	**967**	**100**	**641**	**100**	**152**	**100**	**169**	**100**	**553**	**100**	**1618**	**100**

TABLE 10: Employment status

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Full-time employment (as an employee)	319	33.1	158	24.8	83	55.0	22	12.9	113	20.4	481	29.8
Part-time employment (as an employee)	146	15.1	82	12.9	20	13.2	12	7.1	88	15.9	228	14.1
Working full-time (self-employed)	108	11.2	74	11.6	9	6.0	27	15.9	67	12.1	183	11.3

TABLE 10: Employment status

	Men		Women		MSM		FSWs		PWID		Total	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Working part-time (self-employed)	174	18.0	224	35.1	15	9.9	94	55.3	127	23.0	404	25.0
Unemployed and not working at all	218	22.6	100	15.7	24	15.9	15	8.8	158	28.6	318	19.7
Total	**965**	**100**	**638**	**100**	**151**	**100**	**170**	**100**	**553**	**100**	**1614**	**100**

TABLE 11: Monthly household income levels (Vietnamese Dong)

	Men		Women		MSM		FSWs		PWID		Total	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
< 2.000.000	71	7.4	61	9.7	2	1.3	8	4.8	49	9.1	132	8.2
2.000.000 – 5.000.000	342	35.6	260	41.1	24	15.9	62	37.1	211	39.1	606	37.8
> 5.000.000	548	57.0	311	49.2	125	82.8	97	58.1	280	51.9	866	54.0
Total	**961**	**100**	**632**	**100**	**151**	**100**	**167**	**100**	**540**	**100**	**1604**	**100**

TABLE 12: Violation of respondents' rights

	Men		Women		MSM		FSWs		PWID		Total	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Yes	93	9.6	84	13.1	12	7.9	28	16.6	86	15.5	182	11.2
No	871	89.6	556	86.9	136	90.1	141	83.4	466	83.8	1433	88.3
Not sure	8	0.8	0	0.0	3	2.0	0	0.0	4	0.7	8	0.5
Total	**972**	**100**	**640**	**100**	**150**	**100**	**169**	**100**	**556**	**100**	**1623**	**100**

TABLE 13: Type of rights violations experienced by respondents

	Men		Women		MSM		FSWs		PWID		Total	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Right to education	0	0.0	0	0.0	1	8.3	0	0.0	0	0.0	0	0.0
Right to work	20	21.5	9	10.7	2	16.7	3	10.7	18	20.9	30	16.5
Right to privacy and confidentiality	57	61.3	51	60.7	9	75.0	13	46.4	54	62.8	113	62.1
Right to marry and have a family	4	4.3	2	2.4	1	8.3	1	3.6	5	5.8	7	3.8
Right to information and participation	2	2.2	0	0.0	0	0.0	0	0.0	2	2.3	2	1.1
Right to non-discrimination and freedom from stigma	61	65.6	62	73.8	7	58.3	24	85.7	60	69.8	125	68.7
Other	4	4.3	2	2.4	3	25.0	1	3.6	1	1.2	6	3.3
Total	**93**		**84**		**12**		**28**		**86**		**182**	

TABLE 14: Incidence of seeking legal redress for any abuse of rights

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Yes	6	6.5	4	4.8	3	25.0	2	7.1	3	3.5	11	6.0
No	87	93.5	80	95.2	9	75.0	26	92.9	83	96.5	171	94.0
Total	**93**	**100**	**84**	**100**	**12**	**100**	**28**	**100**	**86**	**100**	**182**	**100**

TABLE 15: Reason(s) for not trying to seek legal redress

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Insufficient financial resources to take action	3	8.3	1	5.6	3	33.3	0	0.0	3	9.4	5	8.6
Process of addressing the problem appeared too bureaucratic	2	5.6	0	0.0	2	22.2	0	0.0	0	0.0	2	3.4
Felt intimidated or scared to take action	1	2.8	0	0.0	0	0.0	0	0.0	2	6.3	4	6.9
Advised against taking action by someone else	7	19.4	7	38.9	3	33.3	1	25.0	7	21.9	15	25.9
No/little confidence that the outcome would be successful	9	25.0	5	27.8	3	33.3	1	25.0	8	25.0	14	24.1
None of the above	15	41.7	7	38.9	4	44.4	2	50.0	11	34.4	22	37.9
Total	**36**		**18**		**9**		**4**		**32**		**58**	

TABLE 16: Was the decision to be tested up to you?

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
I decided myself to have an HIV test	830	85.3	572	89.5	134	88.2	156	92.3	468	84.5	1410	86.9
I decided to go for the test, but under pressure from others	26	2.7	13	2.0	4	2.6	2	1.2	14	2.5	39	2.4
I was forced to take an HIV test	38	3.9	12	1.9	3	2.0	4	2.4	31	5.6	51	3.1
I was tested without my knowledge, I only found out after the test had been done	79	8.1	42	6.6	11	7.2	7	4.1	41	7.4	123	7.6
Total	**973**	**100**	**639**	**100**	**152**	**100**	**169**	**100**	**554**	**100**	**1623**	**100**

TABLE 17: Reasons given for HIV testing

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Employment	48	4.9	22	3.4	14	9.2	8	4.7	21	3.8	70	4.3
Pregnancy	0	0.0	54	8.5	0	0.0	9	5.3	6	1.1	54	3.3
Preparation for a marriage/ sexual relationship	20	2.1	5	0.8	6	3.9	0	0.0	10	1.8	26	1.6
Referred by a clinic for sexually transmitted infections	48	4.9	61	9.5	20	13.2	48	28.4	17	3.1	114	7.0
Referred due to suspected HIV-related symptoms	367	37.8	114	17.8	28	18.4	37	21.9	189	34.1	482	29.7
Husband/wife/partner/family member tested HIV-positive	46	4.7	131	20.5	10	6.6	10	5.9	47	8.5	177	10.9
Husband/wife/partner/family member got sick or died	29	3.0	124	19.4	0	0.0	13	7.7	23	4.2	153	9.4
I just wanted to know	290	29.8	106	16.6	74	48.7	42	24.9	148	26.7	398	24.5
Other	150	15.4	59	9.2	2	1.3	13	7.7	115	20.8	211	13.0
Total	**972**		**639**		**152**		**169**		**554**		**1622**	

TABLE 18: Disclosure of HIV status without consent

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Husband/wife/partner	18	2.5	11	2.1	4	3.4	1	0.8	8	1.9	30	2.4
Other adult family member(s)	42	4.4	28	4.6	14	9.6	3	1.9	21	3.9	71	4.5
Children in your family	26	3.7	14	2.8	4	3.4	3	2.7	19	4.7	41	3.4
Friends/neighbours	214	22.6	143	23.3	16	10.7	21	12.9	168	31.1	359	22.8
Other PLHIV	187	19.6	145	23.2	12	7.9	26	16.0	133	24.3	334	21.0
Colleagues	67	9.6	49	10.9	7	5.5	11	7.6	52	14.6	118	10.2
Employer(s)/boss(es)	41	7.2	21	6.4	5	4.3	6	7.8	33	11.8	62	6.8
Clients	33	5.3	33	7.7	2	1.7	4	2.7	31	9.5	66	6.2
Injecting drug partner(s)	94	19.7	11	8.6	4	13.3	3	11.1	96	19.0	106	17.4
Religious leaders	17	3.8	15	4.8	1	2.1	0	0.0	14	5.1	33	4.3
Community leaders	47	9.1	40	10.1	3	5.2	2	2.2	39	11.9	87	9.5
Health-care workers	90	9.8	67	10.9	13	11.6	7	4.5	82	15.1	158	10.2
Social workers/counsellors	73	7.8	63	10.3	8	5.4	7	4.5	69	12.9	137	8.7
Teachers	8	3.1	20	9.4	0	0.0	0	0.0	8	4.9	28	5.9
Government officials	5	2.5	1	0.7	0	0.0	0	0.0	4	3.1	6	1.7
The media	11	5.1	6	3.4	0	0.0	0	0.0	12	7.8	17	4.3

TABLE 19: Non-disclosure of HIV status

	Men		Women		MSM		FSWs		PWID		Total	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Husband/wife/partner	161	22.6	61	11.7	71	61.2	43	32.3	58	14.0	230	18.5
Other adult family member(s)	190	20.0	126	20.5	87	59.6	45	28.8	72	13.5	321	20.4
Children in your family	532	75.8	359	71.4	108	93.1	97	87.4	269	66.7	897	73.9
Friends/neighbours	649	68.5	402	65.4	126	84.0	125	76.7	312	57.8	1059	67.3
Other PLHIV	298	31.2	185	29.6	49	32.5	39	23.9	143	26.1	490	30.8
Colleagues	568	81.6	319	70.7	117	91.4	90	62.1	260	73.0	895	77.3
Employer(s)/boss(es)	489	85.9	276	84.4	109	93.2	66	85.7	226	81.0	774	85.5
Clients	566	91.7	375	87.4	117	96.7	133	91.1	282	86.2	951	90.0
Injecting drug partner(s)	157	32.8	79	61.7	24	80.0	13	48.1	168	33.3	237	38.9
Religious leaders	406	90.8	278	88.3	45	93.8	65	95.6	243	88.4	686	89.7
Community leaders	392	75.7	260	65.8	52	89.7	54	60.7	218	66.3	655	71.5
Health-care workers	63	6.9	29	4.7	18	16.1	6	3.8	14	2.6	93	6.0
Social workers/counsellors	79	8.4	70	11.4	14	9.4	23	14.7	31	5.8	151	9.6
Teachers	238	93.3	182	85.4	57	96.6	26	89.7	145	89.0	423	89.8
Government officials	192	96.5	149	97.4	39	100	27	96.4	124	95.4	344	96.9
The media	196	90.3	151	84.4	38	100	27	90.0	128	83.7	350	87.7

TABLE 20: Reactions of family members and community when they first found out the respondent's HIV status

		Men		Women		MSM		FSWs		PWID		Total	
		n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Husband/wife/partner	Discriminatory	37	5.9	12	2.5	11	15.5	3	2.9	21	5.4	49	4.4
	No difference	358	56.8	245	50.8	41	57.7	65	61.9	201	52.1	612	54.5
	Supportive	235	37.4	225	46.7	19	26.8	37	35.2	164	42.5	461	41.1
Other adult family member(s)	Discriminatory	58	7.0	41	8.1	12	14.0	8	6.8	45	9.3	100	7.4
	No difference	458	55.2	280	55.2	46	53.5	74	63.2	277	57.2	746	55.4
	Supportive	314	37.8	186	36.7	28	32.6	35	29.9	162	33.5	500	37.2
Children in your family	Discriminatory	7	2.0	4	1.8	3	8.1	2	5.3	4	1.8	12	2.1
	No difference	289	81.6	159	71.9	28	75.7	30	78.9	182	81.6	455	78.0
	Supportive	58	16.4	58	26.2	6	16.2	6	15.8	37	16.6	116	19.9
Friends/neighbours	Discriminatory	126	25.6	106	35.9	16	30.2	14	21.2	113	35.2	234	29.3
	No difference	341	69.3	175	59.3	32	60.4	47	71.2	194	60.4	525	65.8
	Supportive	25	5.1	14	4.7	5	9.4	5	7.6	14	4.4	39	4.9
Other PLHIV	Discriminatory	22	6.5	18	8.4	7	14.9	5	5.8	15	7.9	40	7.1
	No difference	294	87.0	167	77.7	37	78.7	64	74.4	158	83.2	471	83.7
	Supportive	22	6.5	30	14.0	3	6.4	17	19.8	17	8.9	52	9.2

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TABLE 20: Reactions of family members and community when they first found out the respondent's HIV status

		Men		Women		MSM		FSWs		PWID		Total	
		n	%	n	%	n	%	n	%	n	%	n	%
Colleagues	Discriminatory	22	6.5	18	8.4	7	14.9	5	5.8	15	7.9	40	7.1
	No difference	294	87.0	167	77.7	37	78.7	64	74.4	158	83.2	471	83.7
	Supportive	22	6.5	30	14.0	3	6.4	17	19.8	17	8.9	52	9.2
Employers/ boss(es)	Discriminatory	28	11.0	9	7.6	10	21.7	4	12.5	18	13.7	37	9.7
	No difference	214	83.9	96	81.4	33	71.7	24	75.0	108	82.4	317	83.4
	Supportive	13	5.1	13	11.0	3	6.5	4	12.5	5	3.8	26	6.8
Clients	Discriminatory	16	6.0	18	12.5	2	5.9	3	5.3	15	9.8	34	8.1
	No difference	239	89.8	114	79.2	29	85.3	49	86.0	131	85.6	363	86.4
	Supportive	11	4.1	12	8.3	3	8.8	5	8.8	7	4.6	23	5.5
Injecting drug partner(s)	Discriminatory	13	3.6	0	0.0	0	0.0	0	0.0	13	3.5	14	3.3
	No difference	281	77.2	47	82.5	12	92.3	11	68.8	288	77.8	331	77.9
	Supportive	70	19.2	10	17.5	1	7.7	5	31.2	69	18.6	80	18.8
Religious leaders	Discriminatory	4	3.3	0	0.0	3	21.4	0	0.0	1	1.4	5	2.4
	No difference	101	84.2	67	77.0	9	64.3	20	95.2	61	82.4	169	80.9
	Supportive	15	12.5	20	23.0	2	14.3	1	4.8	12	16.2	35	16.7
Community leaders	Discriminatory	4	1.9	2	1.1	3	20.0	0	0.0	1	0.6	6	1.5
	No difference	161	77.0	122	67.0	9	60.0	24	46.2	117	74.5	285	72.5
	Supportive	44	21.1	58	31.9	3	20.0	28	53.8	39	24.8	102	26.0
Health-care workers	Discriminatory	48	5.5	43	7.2	7	6.7	3	2.0	36	6.7	92	6.2
	No difference	600	69.0	402	67.6	93	88.6	110	72.8	389	72.8	1012	68.6
	Supportive	222	25.5	150	25.2	5	4.8	38	25.2	109	20.4	372	25.2
Social workers/ counsellors	Discriminatory	21	2.4	8	1.4	4	2.8	1	0.7	10	2.0	30	2.1
	No difference	627	71.6	430	75.7	110	76.4	114	80.3	404	79.7	1068	73.3
	Supportive	229	26.1	130	22.9	30	20.8	27	19.0	93	18.3	359	24.6
Teachers	Discriminatory	1	2.2	11	20.0	0	0.0	0	0.0	1	3.3	12	11.9
	No difference	38	84.4	44	80.0	12	75.0	8	100	27	90.0	83	82.2
	Supportive	6	13.3	0	0.0	4	25.0	0	0.0	2	6.7	6	5.9
Government officials	Discriminatory	2	6.1	0	0.0	0	0.0	0	0.0	2	11.8	2	3.6
	No difference	27	81.8	21	100	10	83.3	5	100	14	82.4	49	89.1
	Supportive	4	12.1	0	0.0	2	16.7	0	0.0	1	5.9	4	7.3
The media	Discriminatory	1	2.1	1	2.0	0	0.0	0	0.0	1	2.6	2	2.0
	No difference	42	87.5	44	88.0	9	81.8	6	75.0	32	84.2	87	87.9
	Supportive	5	10.4	5	10.0	2	18.2	2	25.0	5	13.2	10	10.1

TABLE 21: Experiences of stigma and discrimination in the last 12 months

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Excluded from social events or activities	26	2.7	16	2.5	8	5.3	7	4.1	16	2.9	42	2.6
Excluded from religious events or places of worship	11	1.1	5	0.8	4	2.6	3	1.8	5	0.9	16	1.0
Excluded from family activities	25	2.6	6	0.9	12	7.9	4	2.4	10	1.8	33	2.0
Being gossiped about	215	22.1	157	24.5	33	21.9	40	23.7	168	30.2	379	23.3
Verbally insulted, harassed and/or threatened	46	4.7	42	6.6	15	9.9	22	13.0	39	7.0	94	5.8
Physically harassed and/or threatened	9	0.9	17	2.7	5	3.3	11	6.5	7	1.3	30	1.8
Physically assaulted	10	1.0	18	2.8	3	2.0	11	6.5	8	1.4	29	1.8
Subjected to psychological pressure or manipulation by husband/wife/partner in which HIV status was used against respondent	22	2.2	22	3.5	2	1.3	9	5.3	19	3.4	45	2.8
Experienced sexual rejection	25	2.6	13	2.4	8	5.3	9	5.3	16	2.9	42	2.6
Discriminated against by other PLHIV	9	0.9	8	1.3	6	3.9	2	1.2	10	1.8	18	1.1

TABLE 22: Reasons for being gossiped about in the last 12 months

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Because of HIV status	101	47.2	93	59.6	15	45.5	14	35.0	66	39.5	195	51.7
Both because of HIV status and other reasons	28	13.1	15	9.6	9	27.3	3	7.5	22	13.2	48	12.7
For other reasons	74	34.6	41	26.3	8	24.2	20	50.0	72	43.1	116	30.8
Not sure why	11	5.1	7	4.5	1	3.0	3	7.5	7	4.2	18	4.8
Total	**214**	**100**	**156**	**100**	**33**	**100**	**40**	**100**	**167**	**100**	**377**	**100**

TABLE 23: Reasons for being verbally insulted, harassed and/or threatened in the last 12 months

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Because of HIV status	14	30.4	15	35.7	5	33.3	6	27.3	9	23.1	29	30.9
Both because of HIV status and other reasons	14	30.4	12	28.6	6	40.0	7	31.8	11	28.2	32	34.0
For other reasons	16	34.8	13	31.0	4	26.7	7	31.8	17	43.6	29	30.9
Not sure why	2	4.3	2	4.8	0	0.0	2	9.1	2	5.1	4	4.3
Total	**46**	**100**	**42**	**100**	**15**	**100**	**22**	**100**	**39**	**100**	**94**	**100**

TABLE 24: Reasons for being physically harassed and/or threatened in the last 12 months

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Because of HIV status	3	33.3	5	29.4	1	20.0	2	18.2	3	42.9	8	26.7
Both because of HIV status and other reasons	3	33.3	6	35.3	3	60.0	5	45.5	2	28.6	13	43.3
For other reasons	3	33.3	4	23.5	1	20.0	2	18.2	2	28.6	7	23.3
Not sure why	0	0.0	2	11.8	0	0.0	2	18.2	0	0.0	2	6.7
Total	**9**	**100**	**17**	**100**	**5**	**100**	**11**	**100**	**7**	**100**	**30**	**100**

TABLE 25: Reasons for being physically assaulted in the last 12 months

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Because of HIV status	3	30.0	4	22.2	0	0.0	3	27.3	1	12.5	7	24.1
Both because of HIV status and other reasons	4	40.0	10	55.6	2	66.7	7	63.6	3	37.5	15	51.7
For other reasons	2	20.0	4	22.2	1	33.3	1	9.1	3	37.5	6	20.7
Not sure why	1	10.0	0	0.0	0	0.0	0	0.0	1	12.5	1	3.4
Total	**10**	**100**	**18**	**100**	**3**	**100**	**11**	**100**	**8**	**100**	**29**	**100**

TABLE 26: Self-stigmatization

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
I feel ashamed	472	48.5	239	37.3	121	79.6	94	55.6	259	46.6	718	44.2
I feel guilty	477	49.0	181	28.2	98	64.5	83	49.1	282	50.7	663	40.8
I blame myself	545	56.0	249	38.8	76	50.0	94	55.6	355	63.8	797	49.1
I blame others	66	6.8	86	13.4	27	17.9	17	10.1	21	3.8	155	9.6
I have low self-esteem	271	27.9	185	28.9	31	20.4	48	28.4	204	36.7	456	28.1
I feel I should be punished	292	30.0	97	15.1	32	21.1	44	26.0	165	29.7	390	24.0
I feel suicidal	118	12.1	48	7.5	45	29.6	12	7.1	42	7.6	168	10.3

TABLE 27: Decisions taken as a result of respondent's HIV status in the last 12 months

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
I took the decision not to attend social activities/events	133	13.7	59	9.2	33	21.7	25	14.8	54	9.7	195	12.0
I have isolated myself from my family and/or friends	141	14.5	62	9.7	44	28.9	18	10.7	63	11.3	206	12.7
I took the decision to stop working	49	5.0	15	2.3	14	9.2	7	4.1	22	4.0	65	4.0
I decided not to apply for a job/work or for a promotion	92	9.5	44	6.9	29	19.1	13	7.7	43	7.7	137	8.4

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TABLE 27: Decisions taken as a result of respondent's HIV status in the last 12 months

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
I withdrew from education/ training or did not take up an opportunity for education/ training	62	6.4	28	4.4	11	7.2	16	9.5	21	3.8	91	5.6
I decided not to get married	319	32.8	216	33.8	105	69.1	71	42.0	144	25.9	542	33.4
I decided not to have sex	501	51.5	364	56.9	93	61.2	96	57.1	278	50.0	871	53.7
I decided not to have (more) children	162	16.6	93	14.5	50	32.9	28	16.6	68	12.2	259	15.9
I avoided going to a local clinic when I needed to	122	12.5	59	9.2	43	28.3	25	14.8	39	7.0	182	11.2
I avoided going to a hospital when I needed to	165	17.0	140	21.8	11	7.2	27	16.0	90	16.2	306	18.8

TABLE 28: Challenges due to HIV status in accessing accommodation, work, health and education in the last 12 months

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Forced to change place of residence or been unable to rent accommodation	7	0.7	14	2.2	2	1.3	10	5.9	10	1.8	21	1.3
Lost a job or another source of income	42	4.3	25	3.9	10	6.6	16	9.5	25	4.5	68	4.2
Were refused employment or a job opportunity because of HIV status	63	6.5	44	6.9	6	3.9	16	9.5	34	6.1	108	6.6
Job description or the nature of work was changed/were refused a promotion	37	3.8	27	4.2	4	2.6	13	7.7	32	5.8	66	4.1
Respondent has been dismissed or suspended from, or prevented from attending, an educational institution	7	0.7	2	0.3	1	0.7	1	0.6	3	0.6	9	0.6
Respondent's child/children has/have been dismissed or suspended from, or prevented from attending, an educational institution	2	0.4	3	0.8	0	0.0	0	0.0	2	0.7	5	0.6
Denied health-care services	15	1.5	14	2.2	3	2.0	6	3.6	12	2.2	29	1.8

TABLE 29: Respondents currently receiving treatment

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Antiretroviral therapy (ART)	838	86.2	573	89.8	108	71.1	129	76.3	495	89.4	1421	87.7
Treatment for opportunistic infections (OI)	492	50.7	251	39.3	63	41.4	54	32.0	267	48.2	749	46.2
Both ART and OI treatment	425	50.7	234	40.8	39	36.1	42	32.6	246	49.7	665	46.8

TABLE 30: Access to treatment, even if not currently receiving it

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Antiretroviral therapy (ART)	948	98.5	610	98.5	146	97.3	155	98.7	537	98.2	1568	98.5
Treatment for opportunistic infections (OI)	877	93.4	564	92.8	124	84.9	136	88.9	494	93.2	1450	93.1

TABLE 31: Respondent self-evaluation of current health status

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Excellent	8	0.8	3	0.5	2	1.3	1	0.6	3	0.5	11	0.7
Very good	55	5.7	30	4.7	8	5.3	7	4.1	21	3.8	86	5.3
Good	451	46.4	315	49.4	92	60.5	90	53.3	254	45.8	775	47.8
Fair	412	42.4	261	40.9	50	32.9	62	36.7	249	44.9	674	41.6
Poor	46	4.7	29	4.5	0	0.0	9	5.3	27	4.9	75	4.6
Total	**971**	**100**	**638**	**100**	**151**	**100**	**169**	**100**	**554**	**100**	**1620**	**100**

TABLE 32: Discussions with health-care professionals in the past 12 months about HIV-related treatment

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Yes	365	37.6	280	43.9	25	16.4	72	42.6	211	38.1	647	39.9
No	607	62.4	358	56.1	127	83.6	97	57.4	343	61.9	974	60.1
Total	**971**	**100**	**638**	**100**	**151**	**100**	**169**	**100**	**554**	**100**	**1620**	**100**

TABLE 33: Refusal to sexual and reproductive health care services

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Were refused family planning services	10	1.4	10	1.8	0	0.0	3	2.1	4	0.9	21	1.6
Were refused sexual and reproductive health services	10	1.3	10	1.8	2	1.4	4	2.6	6	1.3	21	1.5

TABLE 34: Advice from health professionals on reproductive options

	Men		Women		MSM		FSWs		PWID		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Received counselling on reproductive options since being diagnosed HIV-positive	448	49.1	391	64.2	25	19.2	106	64.6	267	50.6	842	55.0
Advised by a health professional not to have children since being diagnosed HIV-positive	212	23.3	186	30.0	5	3.8	48	29.1	120	22.7	400	26.0
Advised by a health professional to be sterilized since being diagnosed HIV-positive	12	1.4	16	2.6	1	0.8	3	1.8	4	0.8	29	1.9
Forced to accept the use of a method of contraception in order to receive antiretroviral therapy	12	1.4	24	3.9	0	0.0	7	4.3	9	1.7	37	2.5

Annex 3: Stigma Index Questionnaire

PEOPLE LIVING WITH HIV STIGMA INDEX QUESTIONNAIRE

Before starting the interview you need to:

1. Give the interviewee a copy of information sheet and allow him/her time to read it. If he/she is unable to read, you should read it out loud to him/her.
2. Give the interviewee a copy of the informed consent form and read this through with them. If they agree to be interviewed for the study, ask to complete the two forms. The interviewee will then need to sign two copies of the consent form, give the interviewee one of the signed copies and you keep the other one.

At the end of the interview, please answer the following questions:

Referrals and Follow-up

1. Did the interviewee need the referral information?

☐ Yes ☐ No

2. If yes, what kind(s) of referrals were made?

☐ Legal aid ☐ Support group
☐ Counselling ☐ Other

If the answer is "other", to where did you refer them?

....

....

....

3. What steps have you taken to assist the interviewee with accessing the above referrals? *(Tick more than one option if appropriate)*

☐ I provided the interviewee with sufficient information about the referrals
☐ I will send the necessary information to the interviewee
☐ Further follow-up is needed
☐ Please provide details about what you promised to assist the interviewee with regarding referrals after the interview:

....

....

....

4. Is this interviewee considered to be a potential candidate for a case study?

☐ Yes ☐ No

If yes, please explain why:

. . . .

. . . .

. . . .

Quality control procedures

Fill out this table only after your tasks* have been completed

	Name	**Signature**	**Date**
Interviewer			
Team leader			
Data entry 1			
Data entry 2			

***Tasks:**

- The interviewer must ensure that all sections of the questionnaire are completed fully and correctly, unless the interviewee does not want to answer certain questions – in this case it should be marked immediately alongside the relevant question(s).
- The team leader must check the questionnaire carefully and query any work that seems unclear with the interviewer. The quality check section on the last page of the questionnaire should be used to help the interviewer and team leader to complete these tasks.
- The two data-entry persons ("Data entry 1" and "Data entry 2") must enter all data from every questionnaire correctly and independently, following the procedures outlined in the User Guide.

II. PEOPLE LIVING WITH HIV STIGMA INDEX: QUESTIONNAIRE
(Please tick alongside the best answer)

Confidential and Anonymous

PART 1: Information about you (interviewee)

---

1. Sex

☐ Male
☐ Female
☐ Transgender

2. How old are you?

☐ Youth aged from 18 to 19
☐ Adult aged from 20 to 24
☐ Adult aged from 25 to 29
☐ Adult aged from 30 to 39
☐ Adult aged from 40 to 49
☐ Adult aged 50 years and above

3. How long have you been living with HIV? *(Tick one option only)*

☐ 0-1 year
☐ 1-4 years
☐ 5-9 years
☐ 10-14 years
☐ 15 years and above

4. Current relationship status *(Tick one option only)*

☐ Married or living with an intimate partner and husband/wife/partner is currently living in household
☐ Married or living with an intimate partner and husband/wife/partner is living/working temporarily away from the household
☐ In an intimate relationship but not living together
☐ Single *(→ go to question 6)*
☐ Divorced/separated *(→ go to question 6)*
☐ Widow/widower *(→ go to question 6)*

5. If you are currently in an intimate relationship, how long have you been involved with your husband/wife/partner?

☐ 0-1 year
☐ 1-4 years
☐ 5-9 years
☐ 10-14 years
☐ 15 years and above

6. At present, are you sexually active?

☐ Yes
☐ No

7. **Are you a member of or have you been a member of any of the following key populations?** *(Tick at least one option. Tick more than one if appropriate)*

☐ Men who have sex with men
☐ Gay or lesbian
☐ Transgender
☐ Sex worker
☐ Injecting drug user
☐ Refugee or asylum seeker
☐ Internally displaced person
☐ Member of indigenous population
☐ Migrant worker
☐ Prisoner
☐ I am not, and I have never been, a member of one of these populations

8. **Do you have any kind of physical disability?** *(excluding sickness related to HIV infections)*

☐ Yes ☐ No

If yes, please describe this physical disability:

....

....

....

9. **What is the highest level of formal education you have completed?***(Tick one option only)*

☐ No formal education
☐ Primary school
☐ Secondary school
☐ High school
☐ Technical college/University/Post-graduate

10. **Which one of these statements would best describe your current employment status?**

☐ Full-time employment (as an employee)
☐ Part-time employment (as an employee)
☐ Working full-time but not as an employee (self-employed)
☐ Working part-time (self-employed)
☐ Jobless and not working at all

11. **How many people are currently living in your household in each of these age groups?**

	Number of people
Children aged 0–14 years	
Youth aged 14–19 years	
Adults aged 20–24 years	
Adults aged 25–29 years	
Adults aged 30-39 years	
Adults aged 40-49 years	
Adults aged 50 years and above	

12. **How many of the children and young people living in your household were orphaned by AIDS?**

Number of children and young people orphaned by AIDS	

13. **Where is your household?** *(Tick one option only)*

☐ A rural area
☐ A village/small town
☐ A large town or city

14. **What was the average monthly income of your household in the last 12 months?** *(Provide figures in Vietnamese Dong)*

Average income of household over the last 12 months
For data capturers only: ....
Annual income in local currency: ....
Current exchange rate from local currency to US dollars: ....
Annual income in US dollars: ....

15. **In the last month, on how many days did any member of your household not have sufficient food to eat?**

Number of days	

PART 2A: Your experiences of stigma and dscrimination created by other people

1a. Within the last 12 months, how often have you been excluded from social events or activities (e.g. weddings, funerals, parties, clubs)? *(Tick one option only)*

☐ Never *(→ go to question 2a)* ☐ A few times
☐ Once ☐ Often

1b. If yes, what was the reason? *(Tick one option only)*

☐ Because of your HIV status
☐ For other reasons
☐ Both because of your HIV status and other reasons
☐ Not sure why

2a. Within the last 12 months, how often have you been excluded from religious events or places of worship? *(Tick one option only)*

☐ Never *(→ go to question 3a)* ☐ A few times
☐ Once ☐ Often

2b. If yes, what was the reason? *(Tick one option only)*

☐ Because of your HIV status
☐ For other reasons
☐ Both because of your HIV status and other reasons
☐ Not sure why

3a. Within the last 12 months, how often have you been excluded from family activities (such as cooking, eating together, and sleeping in the same room)? *(Tick one option only)*

☐ Never *(→ go to question 4a)* ☐ A few times
☐ Once ☐ Often

3b. If yes, what was the reason? *(Tick one option only)*

☐ Because of your HIV status
☐ For other reasons
☐ Both because of your HIV status and other reasons
☐ Not sure why

4a. Within the last 12 months, how often have you been aware of being gossiped about? *(Tick one option only)*

☐ Never *(→ go to question 5a)* ☐ A few times
☐ Once ☐ Often

4b. If yes, what was the reason? *(Tick one option only)*

☐ Because of your HIV status
☐ For other reasons
☐ Both because of your HIV status and other reasons
☐ Not sure why

5a. **Within the last 12 months, how often have you been verbally insulted, harassed and/or threatened?** *(Tick one option only)*

☐ Never *(→ go to question 6a)*
☐ Once
☐ A few times
☐ Often

5b. **If yes, what was the reason?** *(Tick one option only)*

☐ Because of your HIV status
☐ For other reasons
☐ Both because of your HIV status and other reasons
☐ Not sure why

6a. **Within the last 12 months, how often have you been physically harassed and/or threatened?** *(Tick one option only)*

☐ Never *(→ go to question 7a)*
☐ Once
☐ A few times
☐ Often

6b. **If yes, what was the reason?** *(Tick one option only)*

☐ Because of your HIV status
☐ For other reasons
☐ Both because of your HIV status and other reasons
☐ Not sure why

7a. **In the last 12 months, how often have you been physically assaulted?** *(Tick one option only)*

☐ Never *(→ go to question 8)*
☐ Once
☐ A few times
☐ Often

7b. **If yes, what was the reason?** *(Tick one option only)*

☐ Because of your HIV status
☐ For other reasons
☐ Both because of your HIV status and other reasons
☐ Not sure why

7c. **If yes, who physically assaulted you?** *(Tick one option only)*

☐ My husband/wife/partner
☐ Another member of the household
☐ A person or people outside the household whom I know
☐ A stranger

8. **In questions 1–7, if you experienced stigma and/or discrimination for any reasons other than your HIV status, please choose ONE of the reasons below that best explains why you felt you were stigmatized and/or discriminated against:** *(Tick one option only)*

☐ Sexual orientation (MSM, gay or lesbian, transgender)
☐ Sex worker
☐ Injecting drug user
☐ Refugee or asylum seeker

☐ Internally displaced person
☐ Member of an ethnic minority group
☐ Migrant worker
☐ Prisoner
☐ None of the above – other reasons

If your answer is "None of the above", please explain why you think you were stigmatized or discriminated against:

....

....

....

9. **Within the last 12 months, how often have you been subjected to psychological pressure or manipulation by your husband/wife or partner in which your HIV-positive status was used against you?** *(Tick one option only)*

☐ Never	☐ A few times
☐ Once	☐ Often

10. **Within the last 12 months, how often have you experienced sexual rejection because of your HIV-positive status?** *(Tick one option only)*

☐ Never	☐ A few times
☐ Once	☐ Often

11. **Within the last 12 months, how often have you been discriminated against by other people living with HIV?** *(Tick one option only)*

☐ Never	☐ A few times
☐ Once	☐ Often

12. **Within the last 12 months, how often has your wife/husband or partner, or any member(s) of your household, experienced discrimination because of your HIV-positive status?** *(Tick one option only)*

☐ Never	☐ A few times
☐ Once	☐ Often

13. **If, within the last 12 months, you have experienced any forms of stigma and/or discrimination related to HIV, what are the reasons?** *(Tick more than one option if there are multiple reasons)*

☐ People are afraid of being infected by me
☐ People don't understand how HIV is transmitted
☐ People are afraid of getting HIV from me through casual contact
☐ People think that having HIV is disgraceful and they should not be associated with me
☐ Religious beliefs or "moral" judgements
☐ People disapprove of my lifestyle or behaviour
☐ I look sick with HIV-associated symptoms
☐ I don't know why/I am not sure of the reason(s)

PART 2B: Access to work, health and education services

1a. In the last 12 months, how often have you been forced to change your place of residence or been unable to rent accommodation? *(Tick one option only)*

☐ Never (→ *go to question 2a)*	☐ A few times
☐ Once	☐ Often

1b. If yes, what was the reason? *(Tick one option only)*

- ☐ Because of your HIV status
- ☐ For other reasons
- ☐ Both because of your HIV status and other reasons
- ☐ Not sure why

If the interviewee has not had any income (from either formal employment or casual or part-time work) or has not been self-employed during the last 12 months, please go to question 5.

2a. Within the last 12 months, how often have you lost a job (if employed) or another source of income (if self-employed or an informal/casual worker)? *(Tick one option only)*

☐ Never (→ *go to question 3)*	☐ A few times
☐ Once	☐ Often

2b. If yes, what was the reason? *(Tick one option only)*

- ☐ Because of your HIV status
- ☐ For other reasons
- ☐ Both because of your HIV status and other reasons
- ☐ Not sure why

2c. If it was because of your HIV status (totally or partially), did you lose your work/income? *(Tick one option only)*

- ☐ Because of discrimination from your employer or co-workers
- ☐ Because you felt you had to stop working due to poor health
- ☐ Because of a combination of both discrimination and poor health
- ☐ Because of another reason

3. Within the last 12 months, have you been refused employment or a job opportunity because of your HIV status?

☐ Yes	☐ No

4a. Within the last 12 months, how often has your job description or the nature of your work changed, or how often have you been refused a promotion due to your HIV status?

☐ Never (→ *go to question 5)*	☐ A few times
☐ Once	☐ Often

4b. If yes, why did it happen? *(Tick one option only)*

☐ Because of discrimination from your employer or co-workers
☐ Because poor health prevented you from doing certain things
☐ Because of a combination of both discrimination and poor health
☐ Because of other reasons

5. Within the last 12 months, how often have you been dismissed, suspended or prevented from attending an educational institution because of your HIV status? *(Tick one option only)*

☐ Never
☐ Once
☐ A few times
☐ Often

6. In the last 12 months, how often has your child/children been dismissed, suspended or prevented from attending an educational institution because of your HIV status? *(Tick one option only)*

☐ Never
☐ Once
☐ A few times
☐ Often

7. Within the last 12 months, how often have you been denied health care services, including dental care, because of your HIV status? *(Tick one option only)*

☐ Never
☐ Once
☐ Not applicable
☐ A few times
☐ Often

8. In the last 12 months, have you been denied family planning services because of your HIV status? *(Tick one option only)*

☐ Yes
☐ No
☐ Not applicable

9. In the last 12 months, have you been denied sexual and reproductive health services because of your HIV status?

☐ Yes
☐ No
☐ Not applicable

PART 2C: Self stigma (the way you feel about yourself) and your fears

1. **Within the last 12 months, have you experienced with any of the following feelings because of your HIV status?** *(Tick one option for each category)*

I feel ashamed	Yes ☐	No ☐
I feel guilty	Yes ☐	No ☐
I blame myself	Yes ☐	No ☐
I blame others	Yes ☐	No ☐
I have low self-esteem	Yes ☐	No ☐
I feel I should be punished	Yes ☐	No ☐
I feel suicidal	Yes ☐	No ☐

2. **In the last 12 months, have you done any of the following things because of your HIV status?** *(Tick one option for each category)*

I took the decision not to attend social activities/events	Yes ☐	No ☐
I have isolated myself from my family and/or friends	Yes ☐	No ☐
I took the decision to stop working	Yes ☐	No ☐
I decided not to apply for a job/work or for a promotion	Yes ☐	No ☐
I withdrew from education/training or did not take up an opportunity for education/training	Yes ☐	No ☐
I decided not to get married	Yes ☐	No ☐
I decided not to have sex	Yes ☐	No ☐
I decided not to have (more) children	Yes ☐	No ☐
I avoided going to a local clinic when I needed to	Yes ☐	No ☐
I avoided going to a hospital when I needed to	Yes ☐	No ☐

3. **In the last 12 months, have you been worried about the following things happening to you – whether or not they have happened actually to you?**

Being gossiped about	Yes ☐	No ☐
Being verbally affronted, harrassed and/or threatened	Yes ☐	No ☐
Being physically harrassed and/or threatened	Yes ☐	No ☐
Being physically assaulted	Yes ☐	No ☐

4. **Within the last 12 months, have you been afraid that someone would not want to become your sexual partner because of your HIV-positive status?**

Yes ☐ No ☐

PART 2D: Rights, laws and policies

1a. Have you ever heard of the Declaration of Commitment on HIV/AIDS, which protects the rights of people living with HIV?

☐ Yes ☐ No *(→ go to question 2a)*

1b. If yes, have you ever read this document or discussed its contents?

☐ Yes ☐ No

2a. Have you ever heard of the *Law on HIV Prevention and Control,* which protects the rights of people living with HIV?

☐ Yes ☐ No *(→ go to question 3)*

2b. If yes, have you ever read or discussed the contents of the *Law on HIV Prevention and Control*?

☐ Yes ☐ No

3. In the last 12 months, have any of the following things happened to you because you are living with HIV? *(Tick more than one option if appropriate)*

☐ I was forced to submit to a medical/health procedure (including HIV testing)
☐ I was denied health insurance or life insurance because I am living with HIV
☐ I was arrested or taken to the court on a charge related to my HIV status
☐ I had to disclose my HIV status in order to enter another country
☐ I had to disclose my HIV status in order to apply for a residence permit or nationality
☐ I was detained, quarantined, isolated or segregated
☐ None of these things happened to me

4a. Within the last 12 months, have any of your rights as a person living with HIV been violated?

☐ Yes ☐ No *(→ go to PART 2E)*
☐ Not sure *(→ go to PART 2E)*

4a(i). If yes, which right(s) have been violated/abused?
(Tick more than one option if appropriate)

☐ Right to education
☐ Right to work
☐ Right to privacy and confidentiality
☐ Right to marry and have a family
☐ Right to information and participation
☐ Right to non-discrimination and freedom from stigma

☐ Other

If other, please specify

....

....

4b. If yes, have you tried to get legal redress for any abuse of your rights as a person living with HIV?

☐ Yes ☐ No *(→ go to Question 4e)*

☐ Not sure *(→ go to Question 4e)*

4c. Has this process begun in the last 12 months?

☐ Yes ☐ No

4d. What was the result?

☐ The matter has been dealt with

☐ The matter is still in the process of being dealt with

☐ Nothing happened/the matter was not dealt with

4.d(i). While seeking legal redress, did you contact a lawyer?

☐ Yes ☐ No

4d(ii). If yes, who did you contact for legal assistance?
(Tick more than one option if appropriate)

☐ HIV/AIDS legal clinic

☐ Provincial legal aid centre (Provincial Department of Justice)

☐ Centre for legal consultancy (Viet Nam Lawyers Association)

☐ Legal consultancy unit under social unions/associations (e.g. Women's/Labour Union)

☐ Private lawyer

☐ Other

4d(iii). What kind of assistance did the lawyer provide to you?
(Tick more than one option if appropriate)

☐ Legal advice

☐ Support in court proceedings

☐ Support in negotiations with authorities (in the form of representation)

☐ Other assistance

☐ I did not receive any services *(→ go to question 4d(vi))*

4d(iv). How would you describe the quality of the legal assistance you received?

☐ Very helpful

☐ Somewhat helpful

☐ Not helpful

4d(v). How much were you charged by the lawyer?

☐ Free service
☐ Less than 500,000 VND
☐ Between 500,000 and 5,000,000 VND
☐ More than 5,000,000 VND

4d(vi). What difficulties did you face in the process of seeking redress?
(Tick more than one option if appropriate)

☐ Difficulties in collecting evidence
☐ Limited access to authorities/court
☐ Limited collaboration from lawyers
☐ Costs were too high
☐ No collaboration from the community (e.g. witnesses)

4e. If the response to question 4b was NO or NOT SURE, what was the reason for not trying to get legal redress?

☐ Insufficient financial resources to take action
☐ Process of addressing the problem appeared too bureaucratic
☐ Felt intimidated or scared to take action
☐ Advised against taking action by someone else
☐ No/little confidence that the outcome would be successful
☐ None of the above

If "none of the above", please specify

....

....

....

5a. Have you tried to get a government employee(s) to take action against an abuse of your rights as a person living with HIV?

☐ Yes ☐ No *(→ go to question 6a)*

5b. Did this happen within the last 12 months?

☐ Yes ☐ No

5c. What were the results?

☐ The problem has been resolved
☐ The problem is still in the process of being dealt with
☐ Nothing happened/the problem is not resolved

6a. Have you tried to get a local or national party official to take action against an abuse of your rights as person living with HIV?

☐ Yes ☐ No *(→ go to PART 2E)*

6b. Did this happen within the last 12 months?

☐ Yes ☐ No

6c. What were the results?

☐ The problem has been resolved
☐ The problem is still in the process of being dealt with
☐ Nothing happened/the problem has not been resolved

7. To your knowledge, are any of the following legal services available to PLHIV in your district? *(answer yes/no for each)*

☐ HIV/AIDS legal clinics
☐ Provincial legal aid centre (Provincial Department of Justice)
☐ Centre for legal consultancy (Viet Nam Lawyers Association)
☐ Legal consultancy unit under social unions/associations (e.g. Women's/Labour Union)
☐ Private lawyers

8. How would you rate the accessibility of PLHIV to lawyers?

☐ Very accessible
☐ Accessible
☐ Limited accessibility
☐ Inaccessible

9. What are the main barriers to PLHIV accessing legal services? *(Tick more than one option if appropriate)*

☐ Cost
☐ Distance
☐ Lack of awareness/information about the service(s)
☐ Lack of trust of the support the service(s) can provide
☐ Fear of stigma and/or discrimination from lawyers
☐ Fear that your HIV status may be revealed to others
☐ Fear of stigma and/or discrimination from the community

PART 2E: Effecting change

1. Within the last 12 months, have you confronted, challenged or educated somebody who stigmatized or discriminated against you?

☐ Yes ☐ No

2a. Are you aware of any organizations and/or groups that you can ask for help if you experience stigma or discrimination?

☐ Yes ☐ No *(→ go to question 3)*

2b. If yes, which organizations or groups are you aware of?
(Tick more than one option if appropriate)

☐ Support group for people living with HIV
☐ Network of people living with HIV
☐ Local non-governmental organization
☐ Faith-based organization
☐ A lawyer
☐ A human rights group
☐ National non-governmental organization (NGO)
☐ National AIDS committee or council
☐ International non-governmental organization (NGO)
☐ United Nations agencies
☐ Other

....

....

....

2c. If the answer is "Other", please describe the organization or group you are referring to:

....

....

....

3. Have you ever asked for help from these organizations to resolve an issue of stigma and discrimination?

☐ Yes ☐ No

4. If you have tried to resolve issues of stigma and discrimination by yourself or with help from others, please describe what the problem was and how you or others have tried to resolve it.

4a. What was the issue of stigma and discrimination?

....

....

....

4b. If you were assisted by somebody else, who was it?

. . . .

. . . .

. . . .

4c. How did you (or others) try to resolve the issue of stigma and discrimination? (i.e. what were the specific activities that you and others tried to do?)

. . . .

. . . .

. . . .

5a. During the last 12 months, have you helped and supported other people living with HIV?

☐ Yes ☐ No

5b. If yes, what types of support did you provide to them?
(Tick more than one option if appropriate)

☐ Emotional support (e.g. counselling, sharing individual stories and experiences)
☐ Physical support (e.g. providing money or food, doing small jobs for them)
☐ Referring them to other services

6. Are you currently a member of a support group or network of people living with HIV?

☐ Yes ☐ No

7. During the last 12 months, have you served as a volunteer or employee in any support programmes or projects for people living with HIV (either government or NGO)?

☐ Yes ☐ No

8. During the last 12 months, have you participated in any process of developing legislation, policies or guidelines related to HIV?

☐ Yes ☐ No

9. Do you feel that you have the power to influence decisions in any of the following aspects: *(Tick at least one option. You can tick more than one, if relevant)*

☐ Legal and rights matters affecting people living with HIV
☐ Local government policies affecting people living with HIV
☐ Local projects intended to benefit people living with HIV
☐ National policies affecting people living with HIV
☐ National programmes/projects intended to benefit people living with HIV
☐ International agreement/treaties
☐ None of the above

10. **There are several organizations of people living with HIV working against stigma and discrimination. If one of these organizations asked you "What is the most important thing we need to do in order to address stigma and discrimination?" what would you recommend?** *(Tick one option only)*

☐ Advocating for the rights of people living with HIV
☐ Emotional, physical and referral support for people living with HIV
☐ Advocating for the rights of and/or providing support for marginalized groups (men who have sex with men, injecting drug users, sex workers)
☐ Educating people living with HIV on living with HIV (including treatment literacy)
☐ Raising the awareness and knowledge of society about AIDS

PART 3A: Testing/diagnosis

1. **Why were you tested for HIV?** *(Tick one or more option(s) as appropriate)*
   - ☐ Employment
   - ☐ Pregnancy
   - ☐ Preparation for a marriage/sexual relationship
   - ☐ Referred by a clinic for sexually transmitted infections
   - ☐ Referred due to suspected HIV-related symptoms (e.g. tuberculosis)
   - ☐ Wife/husband/partner/family member tested HIV-positive
   - ☐ Wife/husband/partner/family member got sick or died
   - ☐ I just wanted to know
   - ☐ Other reasons

   If "Other reasons", please specify the reason

   ....

   ....

   ....

2. **Was the decision to be tested up to you?** *(Tick one option only)*
   - ☐ Yes, I decided myself to have an HIV test (i.e. it was voluntary)
   - ☐ I decided to go for the test, but under pressure from others
   - ☐ I was forced to take an HIV test (coercion)
   - ☐ I was tested without my knowledge;
   - ☐ I only found out after the test had been done

3. **Did you receive counselling when you were tested for HIV?** *(Tick one option only)*
   - ☐ I received pre- and post-test counselling
   - ☐ I only received pre-test counselling
   - ☐ I only received post-test counselling
   - ☐ I did not receive any counselling when I had an HIV test

PART 3B: Disclosure and confidentiality

1. **For each of the following people or groups of people, please, describe how they were told about your HIV status for the first time, if they were told:** *(Tick your answer(s). Only tick more than one option in each line if your answer is different for different individuals)*

	I told them	Someone told them WITH my consent	Someone told them WITHOUT my consent	They do not know my status	Not applicable
Your husband/wife/partner	1	2	3	4	5
Other adult family members	1	2	3	4	5
Children in your family	1	2	3	4	5
Your neighbours/friends	1	2	3	4	5
Other people living with HIV	1	2	3	4	5
Your co-workers (colleagues)	1	2	3	4	5
Your employer(s)/boss(es)	1	2	3	4	5
Your clients	1	2	3	4	5
Injecting drug partners	1	2	3	4	5
Religious leaders	1	2	3	4	5
Community leaders	1	2	3	4	5
Health care workers	1	2	3	4	5
Social workers/counsellors	1	2	3	4	5
Teachers	1	2	3	4	5
Government officials	1	2	3	4	5
The media	1	2	3	4	5

2a. How often have you felt pressure from other people living with HIV or groups/networks of people living with HIV to disclose your HIV status?

☐ Often ☐ A few times
☐ Once ☐ Never

2b. How often have you felt pressure from people not living with HIV (e.g. family members, social workers, staff of non-governmental organizations) to disclose your HIV status?

☐ Often ☐ A few times
☐ Once ☐ Never

3. Has a professional health worker (e.g. medical doctor, nurse, counsellor, laboratory technician) told others about your HIV status without your consent?

☐ Yes ☐ Not sure
☐ No

4. How confidential do you think your medical records relating to your HIV status are? *(Tick one option only)*

☐ I am sure that my medical records will be kept completely confidential.
☐ I do not know if my medical records are confidential
☐ It is clear to me that my medical records are not being kept confidential

5. How would you describe the reactions of the following people (in general) when they were first knew about your HIV status ? *(Tick one option only for each category of people)*

	Very discriminatory	Discriminatory	No different	Supportive	Very Supportive	Not applicable
Your husband/wife/partner	1	2	3	4	5	6
Other adult family members	1	2	3	4	5	6
Children in your family	1	2	3	4	5	6
Your neighbours/friends	1	2	3	4	5	6
Other people living with HIV	1	2	3	4	5	6
Your co-workers (colleagues)	1	2	3	4	5	6

→

	Very discriminatory	Discriminatory	No different	Supportive	Very Supportive	Not applicable
Your employer(s)/ boss(es)	1	2	3	4	5	6
Your clients	1	2	3	4	5	6
Injecting drug partners	1	2	3	4	5	6
Religious leaders	1	2	3	4	5	6
Community leaders	1	2	3	4	5	6
Health care workers	1	2	3	4	5	6
Social workers/ counsellors	1	2	3	4	5	6
Teachers	1	2	3	4	5	6
Government officials	1	2	3	4	5	6
The media	1	2	3	4	5	6

6. **Did you find that the disclosure of your HIV status was an empowering experience?**
(Tick "not applicable" if you have not disclosed your HIV status)

☐ Yes
☐ No
☐ Not applicable

PART 3C: Treatment

1. **In general, how would you describe about your health status at this moment?** *(Tick one option only)*

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

2a. **Are you currently taking antiretroviral treatment?** *(Tick one option only)*

☐ Yes
☐ No

2b. **Are you able to access* antiretroviral treatment services, even if you are not on treatment at the moment ?** *(Tick one option only)*

☐ Yes
☐ No
☐ Do not know

* *Access in this question means that antiretroviral treatment services are available and free, or available and affordable for you.*

3a. **Are you taking any medication prevent or treat opportunistic infections?** *(Tick one option only)*

☐ Yes
☐ No

3b. **Have you been able to access* medication for opportunistic infections, even if you are currently not taking any of these medications?**

☐ Yes
☐ No
☐ Do not know

* *Access in this question means the treatment is available and free, or available and affordable for you.*

4. **Within the last 12 months, have you had a constructive discussion with a health care professional on the topic of your HIV-treatment options?**

☐ Yes
☐ No

5. **Within the last 12 months, have you had any constructive discussions with a health care professional on other subjects such as sexual health and reproductive health, sexual relationships, mental health, well-being and drug use etc.?**

☐ Yes
☐ No

PART 3D: Having children

<u>Questions 1-5 can be completed by both male and female interviewees</u>

1a. Have you got a child/children?

☐ Yes ☐ No

1b. If yes, are any of your children HIV-positive?

☐ Yes ☐ No

2. Since being diagnosed HIV-positive, have you ever had counselling about your reproductive options?

☐ Yes ☐ No
☐ Not applicable

3. Has a health professional advised you not to have a child since you were diagnosed HIV-positive?

☐ Yes ☐ No
☐ Not applicable

4. Has a health professional advised you to be sterilized since you were diagnosed HIV-positive?

☐ Yes ☐ No
☐ Not applicable

5. Have you been forced to accept the use of a method of contraception in order to be given antiretroviral treatment?

☐ Yes ☐ No
☐ Not applicable ☐ Do not know

<u>Questions 6 and 7 are only completed by female respondents.</u>

6. Within the last 12 months, has a health professional forced you to do anything related to the following because you are living with HIV?

	Yes	No	Not applicable
Termination of pregnancy (abortion)	1	2	3
Method of giving birth	1	2	3
Newborn baby feeding practices	1	2	3

7a. Have you ever been given antiretroviral treatment to prevent mother-to-child transmission of HIV? *(Tick one option only)*

☐ Yes, I have received this treatment
☐ No, I do not know about this treatment
☐ No, I was refused this treatment
☐ No, I did not access this treatment
☐ No, I was not HIV-positive when pregnant

7b. If yes, have you been provided with information about healthy pregnancy and safe motherhood as a component of the programme to prevent mother-to-child transmission of HIV?

☐ Yes ☐ No

PART 3E: Problems and Challenges

In your opinion, what are the MAIN PROBLEMS & CHALLENGES related to:

1. **Testing and diagnosis**

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2. **Disclosure and confidentiality about being HIV-positive**

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3. **Antiretroviral treatment**

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4. **Having children when you are HIV-positive**

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The interview ends here. Before completing the information on the quality check section with the interviewee, thank the inteviewees for their time working on the interview. After completing the quality check section, provide information for the referral and follow-up section at the beginning of the questionnaire and confirm any follow-up arrangements. Give the honorarium to the interviewees and thank them again.

After the interview, take some time to review the results of the interview that has just been completed: check again your notes taken during the interview to ensure that you had taken all the details you wanted and added any information if needed to your notes. Write down things that you want to discuss with or consult the team leader about.

Quality Checks

This section is designed to help the interviewers and team leader to check the quality of the completed questionnaire to ensure that it was done properly and completely.

However, you also need to use your own judgement to ensure that good work has been done. The team leader will check the answers of the interviewees when you return to the office.

The interviewer should answer the following points before the interview is closed, so that the interviewee can help you in answering the questions.

1. **Has the interviewee fully answered all the questions from Parts 1-3 of the questionnaire?**

   ☐ Yes ☐ No

   If No, specify which questions have not been answered and give the reasons why.

   ....

   ....

   ....

2. **Are the answers to the question 7 in Part 1 and question 8 in Part 2a (groups the interviewee has belonged to or does belong to) consistent?**

   ☐ Yes ☐ No

   If No, please explain why.

   ....

   ....

   ....

3. **Does the information provided in Part 1 (questions 14 and 15) seem credible? (e.g. is the level of household poverty consistent with the realities that the household did not have sufficient money to buy food, given the fact that some poor households could farm their own food?)**

   ☐ Yes ☐ No

   If there are differences, have you explored the reasons for them with the interviewee and written down these reasons in your notes?

   ☐ Yes ☐ No

4. **Has the front page of the questionnaire been completed?**

   ☐ Yes ☐ No

   The final part of the quality check can be completed by the interviewer after the interviewee has left, but before the interviewer leaves the interview location.

5. **Has the code of the questionnaire been written in the top right hand corner of each page?**

   ☐ Yes ☐ No

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