



VNP+

YOUNG KEY POPULATIONS AND YOUNG PEOPLE
LIVING WITH HIV AND AIDS IN VIETNAM

Hanoi, November 2015

Table of Contents

1. Rational	3
1.1. Objectives of the assessment	3
1.2. Intended audiences	3
2. Literature review	4
2.1. Young key populations and young people living with HIV in Vietnam	4
2.1.1. Vietnam at a glance	4
2.1.2. Young key populations and young people living with HIV	5
2.3. HIV/AIDS situation among the youth	11
2.3.1. Distribution	11
2.3.2. Transmission route	13
2.3.3. Knowledge of HIV/AIDS	13
2.3.4. Stigma and discrimination	13
2.3.5. Responses from the Government	13
2.4. Other social issues	16
2.4.1. Access to education	16
2.4.2. Access to employment	17
2.4.3. Access to protection from exploitation	19
2.4.4. Access to opportunity for healthy lifestyles	19
3. Methods	20
3.1. Research design and qualitative approach	20
3.2. Ethical issues	20
3.3. Limitation	20
4. Main findings	21
4.1. Knowledge of HIV/AIDS and STIs	21
4.2. Stigma and Discrimination	21
4.3. National policies	22
4.4. Information-Communication-Education interventions	22
4.5. Harm reduction interventions	23
4.6. Voluntary counseling and testing	24

4.7. Treatment and cares	24
5. Conclusions and Recommendations	25
Appendixes	27
Appendix A – Project guidelines	28
Appendix B – References	31
Appendix C – Questionnaires.....	33

1. Rational

The aim of the program is to create enabling and empowering environment in the selected countries to enhance the engagement of young key populations in the Global Fund processes at country level, with following specific objectives: (i) To synthesize and generate strategic information in relation to HIV and young people to inform the National Strategic Plan review and Investment Cases; (ii) Ensure youth partners have the skills and knowledge to influence the country dialogue for adequately resourced HIV responses for young people; and (iii) Ensure programmes funded through the NFM targeting young people are designed and implemented in full partnership with young people to ensure programmes are effective.

The program is implemented in 5 Asian countries, including Cambodia, Nepal, Pakistan, Philippines, and Vietnam.

An action plan with three main activities was developed to obtain the above objectives. The first activity is a rapid national assessment of young key populations and young people living with HIV and AIDS in the countries. Findings and recommendations of the study and the standard toolkit developed by Youth LEAD will be used to facilitate in-country capacity development trainings on Global Fund and New Funding Model for young people. The follow up advocacy activities will be planned during the final day of the training. The activities will be planned based on the status of the country in-relation to concept note submission.

As part of the program activities, a rapid national assessment of young key populations and young people living with HIV and AIDS was conducted in Vietnam

Objectives of the assessment

- What are the HIV prevention and treatment, sexual reproductive health and other social needs of young key populations and young people living with HIV? The study should differentiate the young key populations based on the country.
- How have the national HIV response addressed the above-mentioned needs of young people?
- How many young people populations and young people living with HIV are recorded by the existing data and literatures?

1.1. Intended audiences

Firstly, this report aims to support Youth lead to facilitate in-country capacity development trainings on Global Fund and New Funding Model for young people. Therefore, in-country staffs of the program are the initial targeted audiences.

The second targeted group of audience is policy makers. The findings and recommendations from this report may suggest them in designing policies appropriate to young key populations.

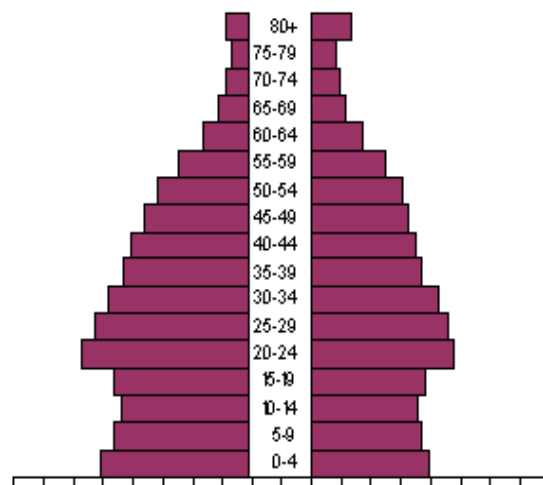
2. Literature review

2.1. Young key populations and young people living with HIV in Vietnam

2.1.1. Vietnam at a glance

Vietnam population by 2014 is estimated at 90.7 million people¹, of which up to 27.7% is youth population². The country is now close to the end of the demographic transition, when the “youth bulge” is reaching the age of entering to the labour market. It means that Vietnam has the largest workforce ever, with 52.2 million and a large part of it is young people. This is considered a good opportunity for the country to improve its national products; therefore it requires a strong focus from the Government to the demographic dividend and utilizes the opportunity.

Figure 1: % Population structure by age group in 2014³



There is not much difference between number of male and female youth. Currently male youth accounts for 50.9% and female youth accounts for 49.1%. However, the sex ratio in youth population is likely to increase in the recent years, from 102.4 male/100 female in 2010 to 103.2 male/100 female in 2013. This is implied by the traditional taboo of son preference⁴.

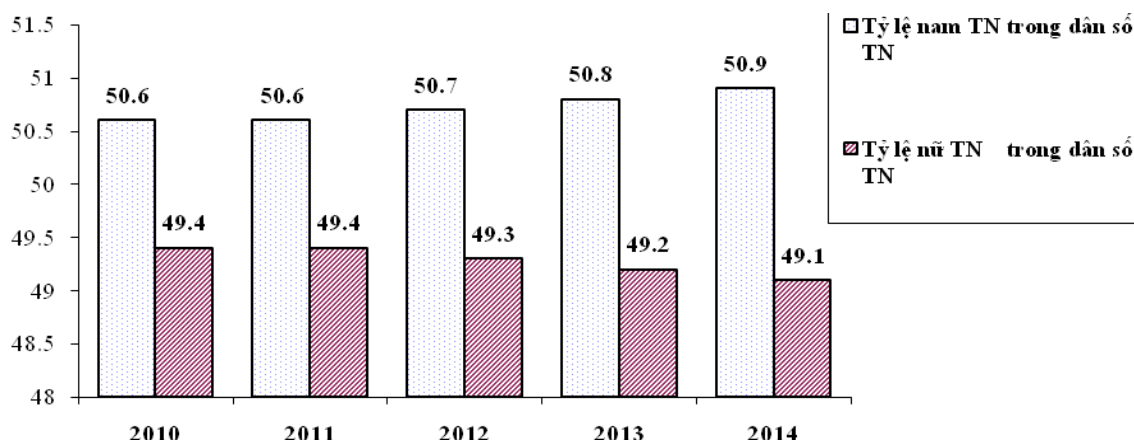
¹ GSO: <http://gso.gov.vn/default.aspx?tabid=714>

² GSO, Survey Assessment of Vietnamese Youth, 2015

³ GSO, Statistical yearbook, 2014

⁴ UNFPA, Sex Imbalances at birth in Vietnam 2014: Recent trends, factors, and variations, 2015

Figure 2: % male versus female youth by year



Over 2/3 of youth population is living in the rural area. While the number of young people is large and they are considered as key contributors to the productivity and sustainable economic development of Viet Nam, there are a number of factors that may increase their vulnerabilities.

2.1.2. Young key populations and young people living with HIV

Why we need to focus on young people?

The Different Types of AIDS Epidemics with Young People at Their Centre which was jointly commissioned by UNICEF, UNAIDS, and WHO in 2002 indicated four key reasons contribute to the vulnerability of the young people with regards to SRH and HIV:

- Young people have sex: Sexual activity usually begins in adolescence.
- Young people lack of information: Awareness of HIV and STIs is a crucial tool of prevention. However, young people usually lack of information, or quality of awareness is not high.
- Girls are vulnerable: though in general, there are more men positive with HIV than women, adolescent girls are at very high risk of getting infected, especially with STIs.
- Many young people are at especially high risk: vulnerable groups of young people who are forced to live on the social and economic margins of society have even less access to information, skills, services and support than young people normally do. Those groups include migrants, ethnic minority people, or people living in hard-to-reach areas.

What are young key populations?

“Young key populations” specifically refer to young people aged 15 to 24 years who are members of key populations, such as young people living with HIV, young gay men and other men who have sex with men, young transgender people, young people who inject drugs and young people

(18 years and older) who sell sex. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response⁵.

2.2. Sexual reproductive health among the young people

Young people tend to have higher risk of sexually transmitted infections and unwanted pregnancy. According to SAVY2, young people are becoming sexually active earlier than before. This tendency for more young people to engage in pre-marital and unprotected sex and get married later highlights the need for reproductive health services and information, including sexuality education and contraceptives.

Child marriage is a marriage involving a person under 18 years old. In Vietnam, the MICS 2014 indicated that 11.2% women between 20-49 were married or in union before 18, of which 0.9% from 15-19 years of age were married or in union before 15). The UN's 2014 Discussion paper on GBV cites the work of Duvvury who found in a large 2012 study an overall national CM rate of 16%⁶. Most of child marriage cases are in the ethnic minority groups (Hmong, Dao, etc.). Marrying at a very young age doubles young women's health risks in remote and mountainous areas because of their age and because they have poorer access to health services compared with women in other regions of the country⁷.

Early childbearing is not a high profile issue in Vietnam. According to the MICS 2014, only 4.7% women age 20-24 years who had at least one live birth before age 18. However, it is likely to be a disparity among regions. Early childbearing rate may be higher in the ethnic minority groups and in the communities who live in remote areas as a consequence of the child marriage issue.

Use of contraceptive. Whilst the contraceptive prevalence rate is quite high in general (77.2%), there is a disparity among age groups. The rate is high among the groups between 30-49 (70.5%-87.7%), but rather low in the group 20-24 (56.5%) and only about 1/3 in the group 15-19⁸. However, this rate statistics only reveals the situation of women 15-49 who are married and might be underestimated in reality.

⁵ UNAIDS, Terminology Guidelines, 2015

⁶ UN, op. cit., 2014 at p18

⁷ NCPFP. 1999. Vietnam Demographic and Health Survey, 1997

⁸ MOH. Health statistical yearbook 2013.

Table 1: Contraceptive Prevalence by Age Group 2011-2013
CONTRACEPTIVE PREVALENCE RATE BY AGE GROUP
2011 - 2013

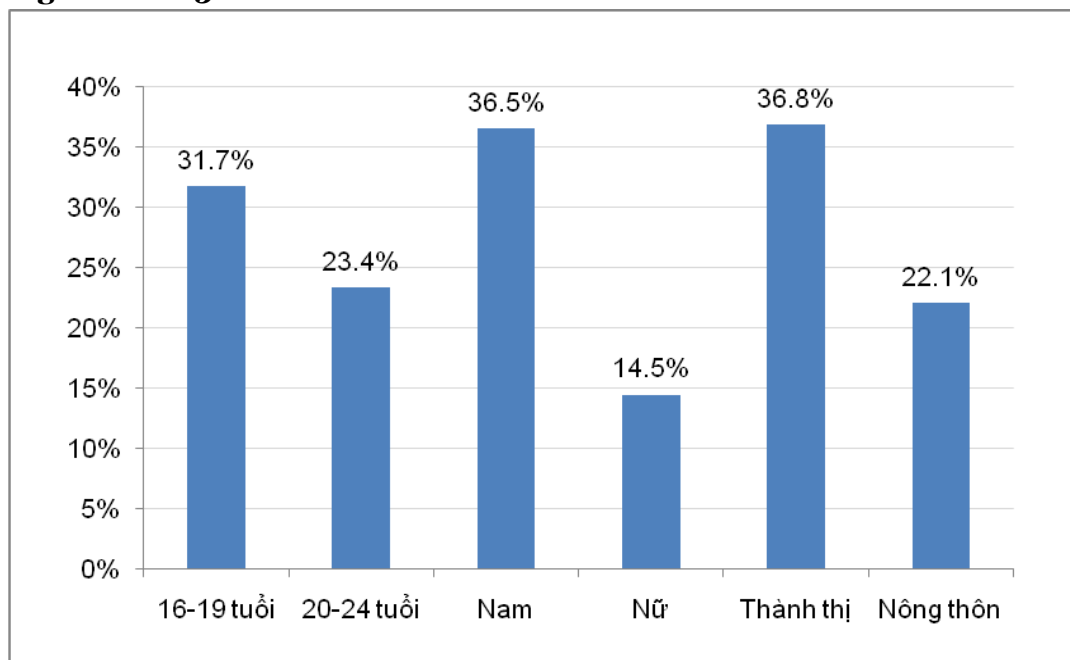
Nhóm tuổi - Age group	Tỷ lệ thực hiện KHHGD - CPR			Trđ: BP hiện đại - In which: modern methods		
	2011	2012	2013	2011	2012	2013
Tổng số - Total	78.2	76.2	77.2	68.6	66.6	67.0
15-19	29.2	32.4	34.7	25.2	28.0	29.7
20-24	55.9	53.2	56.5	48.7	46.1	48.7
25-29	72.1	68.2	70.5	64.2	60.1	61.8
30-34	83.8	80.5	81.4	74.6	71.3	71.8
35-39	88.8	87.5	88.0	78.4	77.2	77.3
40-44	88.4	87.7	88.0	76.5	75.7	75.4
45-49	76.5	75.6	74.4	65.4	64.6	62.8

Ghi chú- Note: Điều tra biến động dân cư & KHHGD 1/4/2012 của TCTK - Survey on Migration and family planning 1/4/2012 of GSO

Condoms are a critical component in a comprehensive and sustainable approach to the prevention of HIV and other sexually transmitted infections (STIs) and are effective for preventing unintended pregnancies⁹. However, the number of young people using condom during the first sex is significantly low in Vietnam, as presented in the following figure.

⁹ UNFPA, WHO and UNAIDS. Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy, 2015.

Figure 3: % use condom in the first sex¹⁰



The figure shows that proportion of female young people using condom during the first sex is much lower than that in the male young people group. There is also a big gap between urban and rural area in this indicator. However, it seems positive that the younger group 16-19 tends to use condom in the first sex more than the older one.

Unmet needs for contraception among youth and adolescence is a real concern. The below table presents the unmet need for contraception by age group and marital status based on results of MICS 2011.

¹⁰ GSO, Survey Assessment of Vietnamese Youth, 2010

Table 2: Unmet needs for RH and HIV services from MICS data, 2012

age group	Percentage with unmet need for contraception			Number of unweighted cases		
	Married	Unmarried	Total	Married	Unmarried	Total
15-19	30.5	35.4	31.4	130	39	169
20-24	19.0	34.6	19.7	777	43	820
25-29	10.3	25.1	10.7	1440	53	1493
30-34	7.7	28.8	8.4	1521	59	1580
35-39	7.4	8.0	7.5	1458	57	1515
40-44	10.3	17.6	10.6	1420	69	1489

Source: UNFPA. Unmet needs for RH and HIV services from MICS data, 2012.

The table indicates that the unmet need for the age 25-44 is much lower (7.4%-10.3%) than the need of the younger groups (34.6%-35.4%). For unmarried women the unmet need for ages 35–39 years is significantly lower (8.0%) than unmet need in the two youngest age groups (at 35.4% and 34.6% for women aged 15–19 and 20–24, respectively).

The unmet need may derive to **unwanted pregnancy and abortion**. In Vietnam, abortion rate is a high profile issue, with up to 17.45 voluntary abortions per 100 live births according to the Health statistics 2013. The Ministry of Health also reported that there were abortion case is 332,212 in 2013. However, abortion rate is always on controversial and many scientists argue that the real rate is much higher. According to the Vietnam Family Planning Association estimation, there are about 1.2-1.6 million abortion cases nationwide every year, of which 20% are adolescence. The rate is underestimated in private health institutes¹¹.

Sexually Transmitted Disease is a big burden for Vietnam as a low middle income country. STDs are often under-diagnosed and untreated in low income countries because of lack of knowledge and/or lack of health care facilities¹². In 2013, there were over 220,000, mostly among the group 15-49 according to statistics of the Ministry of Health. There is no data available disaggregated for young people group age.

¹¹ www.vinafpa.org.vn

¹² Lan et al. Lack of knowledge about sexually transmitted infections among women in North rural Vietnam, 2009.

Table 3: STIs with Predominally Sexual Mode of Transition by Age groups & Sex

**CÁC BỆNH LÂY TRUYỀN QUA ĐƯỜNG TÌNH DỤC PHÂN THEO TUỔI GIỚI NĂM 2013 -
INFECTION WITH PREDOMINALLY SEXUAL MODE OF TRANSITION BY AGE GROUP &
SEX**

	Tổng số <i>Total</i>	Giang mai <i>Syphilis</i>	Lậu - <i>Gonorrhoea</i>	Hoa liễu khác - <i>Other venereal</i>	HIV/AIDS
Tổng số - Total	220,918	1,755	4,122	206,813	8,228
Trong đó nữ - <i>In which female</i>	181,826	625	880	177,317	3,004
Dưới 15 tuổi - Under 15 years old	2,813	96	16	2,486	215
Trong đó nữ - <i>In which female</i>	1,853	17	7	1,714	115
15 - 49 tuổi - years old	214,951	1,609	4,043	201,548	7,751
Trong đó nữ - <i>In which female</i>	177,243	589	846	172,997	2,811
>=50 tuổi - years old	7,123	48	188	6,625	262
Trong đó nữ - <i>in which female</i>	6,067	14	27	5,948	78

Nguồn : Viện Da liễu

Source : National institute of Dermato-Venerreology

Lack of information and effective comprehensive sexuality education (CSE) is considered the main cause of the high profile issue of SRH in Vietnam. CSE is essential to deal with lack of understanding by children and adolescents of reproductive health rights, sexuality, vulnerabilities, life skills, and gender equality¹³. Despite a lot of efforts by different donors and the Government, there is a big concern of both quality of the curriculum developed and the reluctance of teachers and some parents to use the learning, and a failure to follow through on implementation because of claims of having an overly full curriculum¹⁴.

Response of the Government. Although estimates of the incidence of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) are high, the prevention and treatment of RTIs and STIs at the local level is still limited. Presently, there is a lack of nationally and sub- nationally representative data on RTIs/STIs. Moreover, no plan at the national level has been developed to meet people's increasing demands on RTIs/STIs prevention and treatment.

¹³ See CEDAW Committee recommendation in concluding observations on Government report, 24 July 2015

¹⁴ UNFPA. Quick Assessment on Situation of Population and Development in Vietnam, 2015

Due to the impact of shrinking of funding, quality of sexual and reproductive health services has decreased significantly. Stigma still exists in health facilities that provide these kind of services. Female sex workers are not aware of how to protect themselves from STIs¹⁵.

Recently, the Government has conducted a national workshop to review the SRH and family planning situation and identify priorities for the post 2015 period. The workshop emphasized 4 key SRH issues of young people, including: (i) unsafe sex; (ii) unintended pregnancy and unsafe abortion; (iii) unmet needs of information, knowledge, and contraception; and (iv) SRH of vulnerable groups including migrants, ethnic minority groups, and workers. 3 other issues among young people that also need to be prioritized in the next years including (i) high prevalence rate of HIV/STIs; (ii) gender equality/gender based violence; and (iii) sufficient budget and programs toward unmarried young people.

Provision of information; Provision of services; Policy development in functional government agencies; Coordination mechanism; Mobilization of participants; Budget allocation; and Initiatives Design are 7 recommended actions to the Government to address the SRH issues among young people.

2.3. HIV/AIDS situation among the youth

HIV epidemic has been spreading in Vietnam since the first case detected in 1994. By 2014, there was 226,819 HIV infected cases reported nationwide (among those number of AIDS cases was 71,050). HIV/AIDS has covered 63/63 provinces, in almost districts of the country¹⁶. Thanks to the huge efforts of the Government and different stakeholders, the number of infected cases tends to decline in the last few years, but still at high level. However, there is a concern of under detection since the Vietnam HIV/AIDS Estimates and Projections 2011-2015 estimated that there would be 256,000 PLHIV in Vietnam.

The most updated IBBS 3¹⁷ indicates that about 10-30% of PWID; 7-20% street-based sex workers (SSW); 30-50% venue based sex workers (VSW); and up to 50-80% MSM are under 25 years old. Unfortunately, further data disaggregated by gender and by most at risk populations are not available.

2.3.1. Distribution

Distribution by age.

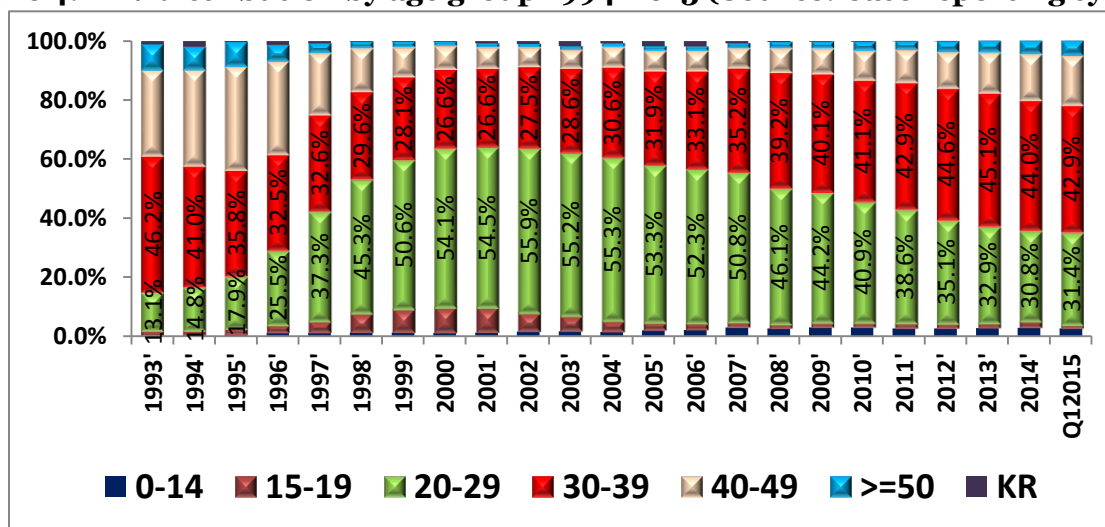
Most of PLHIV are in the age from 20 to 39. The proportion of reported cases in the age group 20-29 tends to decline in the recent years (30.8% in 2014) but still remains high. The following chart presents the distribution of HIV reported cases by age.

¹⁵ GARPR 2014

¹⁶ Vietnam national HIV response report, 2015.

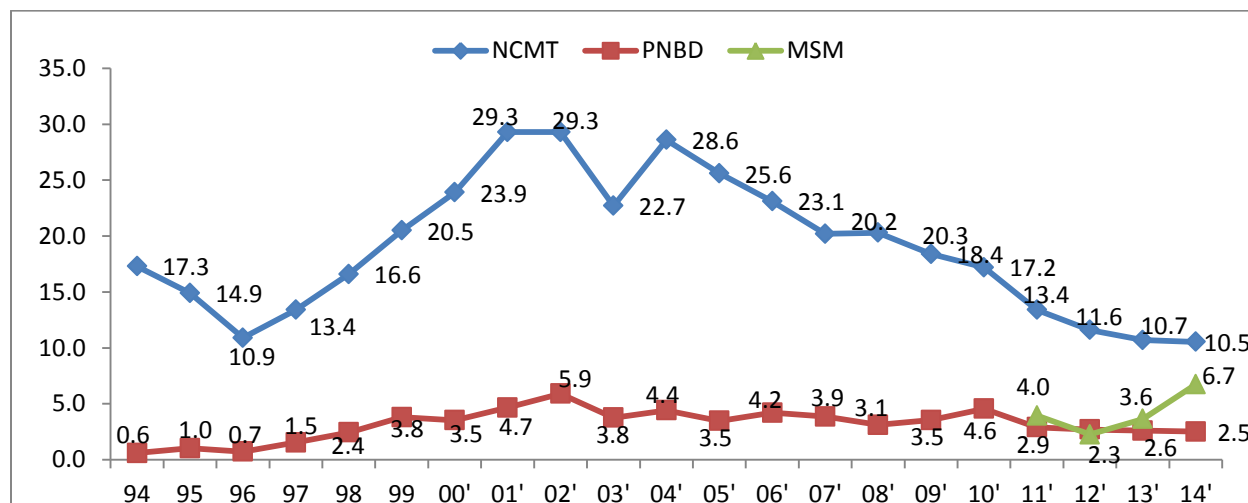
¹⁷ Will be published soon

Figure 4: HIV distribution by age group 1994-2013 (Source: Case reporting system)



Distribution by key populations. The epidemic in Viet Nam is comprised of many sub-epidemics across the country and remains concentrated primarily among three populations defined by high levels of HIV-transmission risk behaviors: people who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSW). Whilst injecting drug use is the leading contributor to the transmission, prevalence among PWID tends to slightly reduced in the recent years. Notably, the prevalence is significantly increasing among MSM group (3.6% in 2013 to 6.7% in 2014).

Figure 5: HIV prevalence among PWID, FSW, MSM 1994-2013 (Source: HSS)



Distribution by gender. There is a rise in HIV infected case among women. According to projection¹⁸, the HIV positive sex ratio is 2.9 by 2015. This indicates that there is a rise in HIV prevalence among women, and there is an increasing number of cases of transmission from

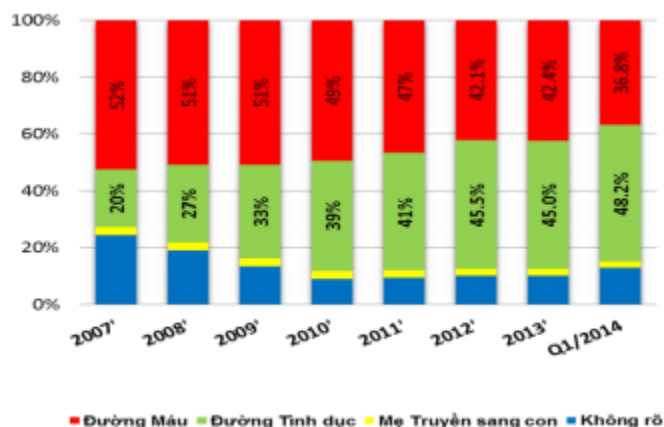
¹⁸ MOH. Vietnam HIV/AIDS Estimates and Projections 2011-2015, 2013.

men, especially men at high risk such as IDUs and clients of sex workers to their wives and partners.

2.3.2. Transmission route.

The proportion of PLHIV who was infected through sexual transmission route has been increased; in 2014, this accounted for 47.9% of all reported cases; following by infection via blood transmission route – 37.5% and MTCT – 3%; 12% of reported cases are unknown of transmission route.

Figure 6: HIV Prevalence by Transmission Routes and Years



2.3.3. Knowledge of HIV/AIDS.

While most of women in reproductive age have heard of AIDS (94.5%), only half of young people correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission¹⁹. Knowledge of mother to child transmission (PMTCT) is also very limited among women at reproductive age. Only 46.8% were able to identify 3 means of PMTCT correctly.

2.3.4. Stigma and discrimination.

The Stigma Index Study conducted in 2014 revealed a positive changes with regards to stigma and discrimination toward PLHIV since 2011 with 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 2011²⁰. However, despite the brighter picture, there remains unacceptably high incidence of stigma and discrimination particularly so for PLHIV who also engage in transactional sex, injecting drug use and same-sex relationships.

2.3.5. Responses from the Government.

Communication. Information-Education-Communication and Behavior Change Communication play important role to combat HIV epidemic. The communication activities

¹⁹ MICS 2014

²⁰ VNP+. Stigma Index, 2014

have been implemented by different line ministries²¹, mass organizations²², CSOs, and private sectors. Thanks to all of the efforts, the communication activities have helped to raise awareness of the people²³, and reduction in prevalence among young groups (15-29).

Harm reduction. The National Strategy on HIV/AIDS Prevention and Control through 2020 with a vision to 2030 emphasized the role and the need of scaling up harm reduction activities²⁴. Comprehensive Condom Program, Needle and Syringe Program, and Methadone Maintenance Treatment will need to be expanded further in implementation in order to pursue the ambitious targets of the Government.

The Comprehensive Condom Program had covered 57/63 provinces by 2012 according to the VAAC report 2014. However, there still remain gaps and fluctuations in results of the program. The HSS+25 and IBBS 2013²⁶ data from 26 provinces indicates that 72.9% of SWs reported having received free condoms in the last month. According to the HSS+ and IBBS 2013 data, 92% of sex workers used a condom with their most recent client. The same data source suggests that 66.4% of men reporting the use of a condom the last time they had anal sex with a male partner, and 41.2% of people who inject drugs who report the use of a condom at last sexual intercourse.

The main source of HIV transmission in Vietnam is through needle sharing. Therefore the Needle and Syringe Program is critical in preventing PWID from HIV infection. The average of needle and syringe delivered to a PWID increased from 140 NS/PWID in 2011 to 180 in 2012, however this figure reduce to 76 NS/PWID in 2014²⁷. There are plans to expand the NSP, with new needles and syringes being distributed for free through peer educators, VCT and OPC sites, and fixed site boxes and at subsidized rates through pharmacies participating in pilot social marketing initiatives.

The Methadone Maintenance Program has achieved outstanding outcome since it first piloted in 2008 in Vietnam. The number of MMT patients and MMT sites sharply increase over time. By 2014, over 25,000 patients have engaged in the program, and the program has expanded from 7 sites in 2009 to 134 sites in 2014. MMT programs have contributed to the reduction of new infections among IDUs. A few studies reveal that almost no new infections occurred among MMT clients.^{28,29,30} Quality of life of the MMT patient has improved remarkably over the treatment course, and highest in the psychological domain and in the first three months.**Error!**

²¹ Ministry of Education and Training, Ministry of Labor, Invalid and Social Affairs, Ministry of Home Affairs, Ministry of Transportation, Ministry of Construction, Ministry of Culture, Sport and Tourism, Ministry of Agriculture and Rural Development, Ministry of Justice

²² Fatherland Fronts and its members

²³ As indicated in the MICS 2014

²⁴ Decision 608/QĐ-TTg dated 25 May 2012

²⁵ VAAC (2014). HSS+ 2013 report.

²⁶ National Institute of Hygiene and Epidemiology (2014). HIV/RTI Integrated biological and behavioral surveillance (IBBS) in Vietnam. Results from round III 2013 and Trends across three rounds (2005-2009-2013) of surveys.

²⁷ GARPR 2014.

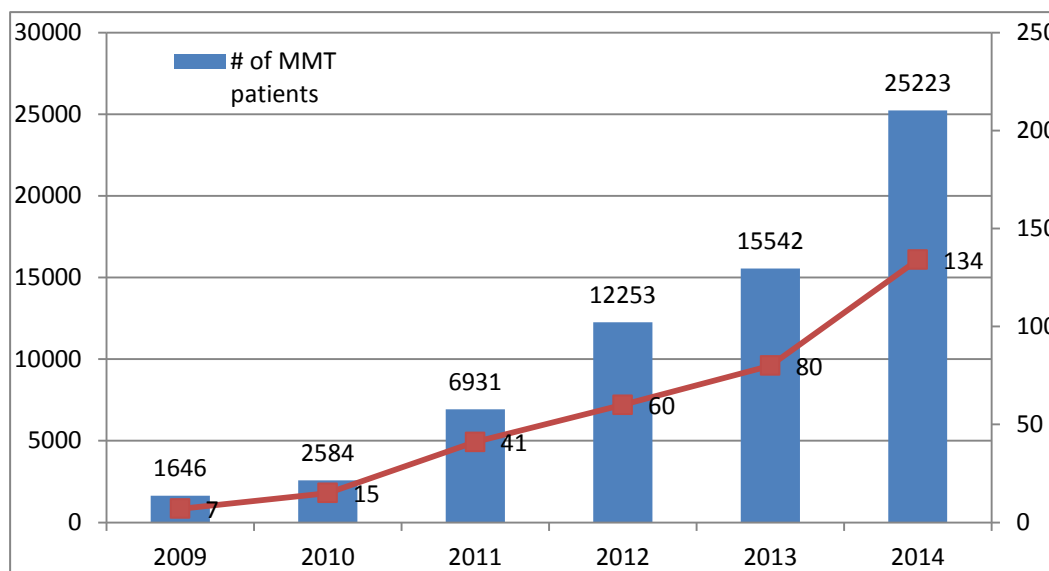
²⁸ T. L. Nguyen, D. M. Pham, T. M. T. Nguyen, et al. (2010). "Summary of the major findings from an evaluation of the pilot methadone maintenance therapy program in Viet Nam," *Journal of Practice Medicine*, Viet Nam Ministry of Health, vol. 742-743, pp. 332-334 (The collection of Research on HIV/AIDS, 2006-2010).

²⁹ Hoang BY et al. (2013). Evaluation of MMT program in Thanh Hoa during May 2011 – May 2012. Abstract at National AIDS Conference.

³⁰ Ho QT et. al. (2013). Evaluation of MMT program in Phu Tho during 2012-2013. Abstract at National AIDS Conference.

Bookmark not defined.^{31,32} The level of anxiety or depressive disorders dropped from 80% to 10% after nine months of treatment.³³ Additionally, MMT largely improved QALYs of PLHIV who are on treatment.³⁴

Figure 7: Number of MMT patients and MMT sites by year (Source: National HIV Response report, 2015)



Vocational Counseling and Testing. The number of VCT sites and VCT clients increasing from 157 sites in 2005 to 244 sites in 2008, 256 sites in 2009, 317 sites in 2011, 485 sites in 2013, and reduce to 270 sites in 2014. The number of people who received VCT services during 2014 was 612,007, which indicates a slight increase in comparison to that in 2013 (569,061 people). This scale-up of HIV testing has allowed many individuals to learn their status, whether HIV positive or negative.

According to surveys conducted between 2004-2014 the percentage of key populations at higher risk who received a HIV test in the last 12 months and knew the results has increased from around 10% in 2004 to 30-40% in 2014 (GARPRs).³⁵

Surveillance and M&E. M&E system is crucial to combat the HIV pandemic effectively and efficiently. The HIV/AIDS surveillance system has been established since 1987 in Vietnam. Till now, there are 40 provinces participating in the annual sentinel surveillance system. Some

³¹ Nguyen T.N et. al. (2011). Preliminary success from evaluation of a pilot program results in scaling up a MMT in Viet Nam.

³² Ha NTT (2010). The effect of methadone maintenance treatment in improvement of quality of life for heroin users in Hai Phong, Vietnam. The 4th International Conference on Reproductive Health and Social Sciences Research. Bangkok, Thailand, 2010.

³³ T. H. Nguyen, et al., “Impact of methadone on mental health, quality of life and social integration of injecting drug users in Viet Nam,” Journal of Practice Medicine, Viet Nam Ministry of Health, vol. 742-743, 2010, (The collection of Research on HIV/AIDS, 2006–2010).

³⁴ Tran XB et. al. (2012). Cost-effectiveness of MMT for HIV-positive drug users in Viet Nam. AIDS Care. 2012, 24(3):283-90.

³⁵ GARPR 2, 3, 4, 5 and 6.

provinces have implemented the integrated biological and behavioral surveillance and STI. Additionally, the case reporting system has been established to track on number of HIV cases nationwide.

After approving the new National Strategy in 2012, the Government has developed a multi-layer M&E system from central down to district level to measure impacts of the intervention. Additionally, there is a national M&E working group established and coordinated by the VAAC.

Treatment and Cares. The number of patients on ART has increased from just 500 in 2004 to 93,298 by the end of 2014, including 88,740 adults and 4,558 children. ART coverage also increased to 67.6% in 2013 (66.0% in adults and 78.1% in children), against current eligibility criteria per national guidelines (CD4<350 cells/ml³ in adults). Overall, adherence to treatment appears is high, and this is reflected in the high rates of virological suppression among patients on treatment, documented at over 90% at 24 months.

PMTCT. PMTCT program has achievement significant outcomes. HIV testing coverage for pregnant women increased from 8.2% in 2006 to nearly 50% in 2013-2014. In 2014, 48.7% of an estimated 1.7 million pregnant women who delivered had an HIV test. In 2014, out of an estimated 3,000 pregnant women diagnosed as HIV-positive during pregnancy, 1,733 mothers and 1,854 infants received ARV prophylaxis.

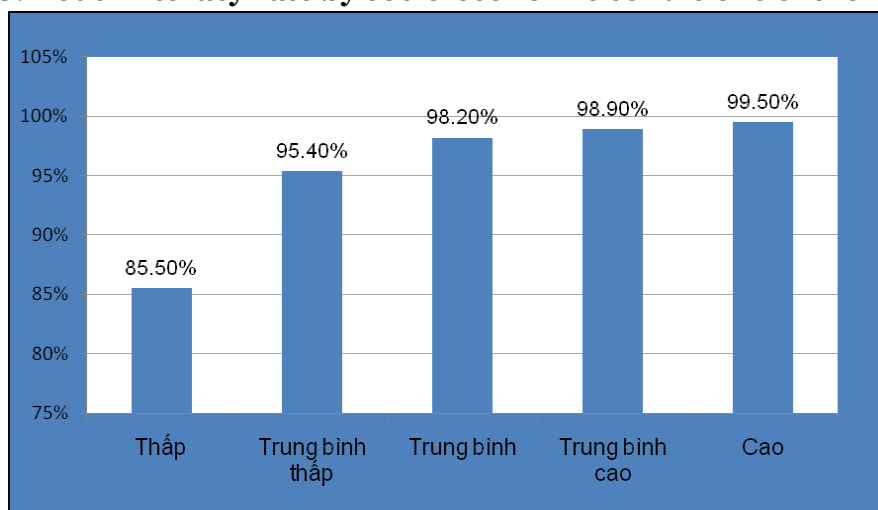
2.4. Other social issues

2.4.1. Access to education

Thanks to the big effort of the Government in the last decades, Vietnam has fulfilled universal primary education. By 2014, there was no significance difference between literacy rate and education attainment across all educational levels between males and females³⁶. However, there is a deep rooted disparity remain in the poorest and the most vulnerable young people are left behind their peers in term of access to and completion of schooling.

³⁶ Country Report, Achieving the Millennium Development Goals of Vietnam, 2015

Figure 8: Youth literacy rate by socio-economic conditions of the families³⁷



In addition, persons with disabilities (PWD) have difficulties at school e.g. because of disability-unfriendly school infrastructure and teachers' lack of skills to teach PWD. Youth PWD experience greater disadvantages in education. The youth literacy rate, i.e. the literacy rate of people aged 15 to 24 years, of PWOD is significantly higher than that of PWD (97.1 per cent vs. 69.1 per cent). Further, comparison of youth population with the general adult population shows that literacy rate of the youth PWOD is higher than that of adult PWOD population, while the literacy rate of youth PWD is lower than that of adult PWD³⁸. Young people living with HIV/AIDS also struggle to access education due to discrimination³⁹.

Vietnam is facing a severe imbalance in upper secondary education. Up to 80% people from 15 to above are enrolled in higher education institutes (colleges and universities). It leads to the inevitable consequence of the imbalance between supply and demand in the labour market, where graduates do not have appropriate knowledge and skills to meet labour market needs⁴⁰.

2.4.2. Access to employment

By the quarter II of 2015, there are about 70.8 million people from 15 to above, of which the percentage of young people in the labour force is significant. The following chart presents the percentage of young people in the labour force by age and rural/urban area by quarter II 2015.

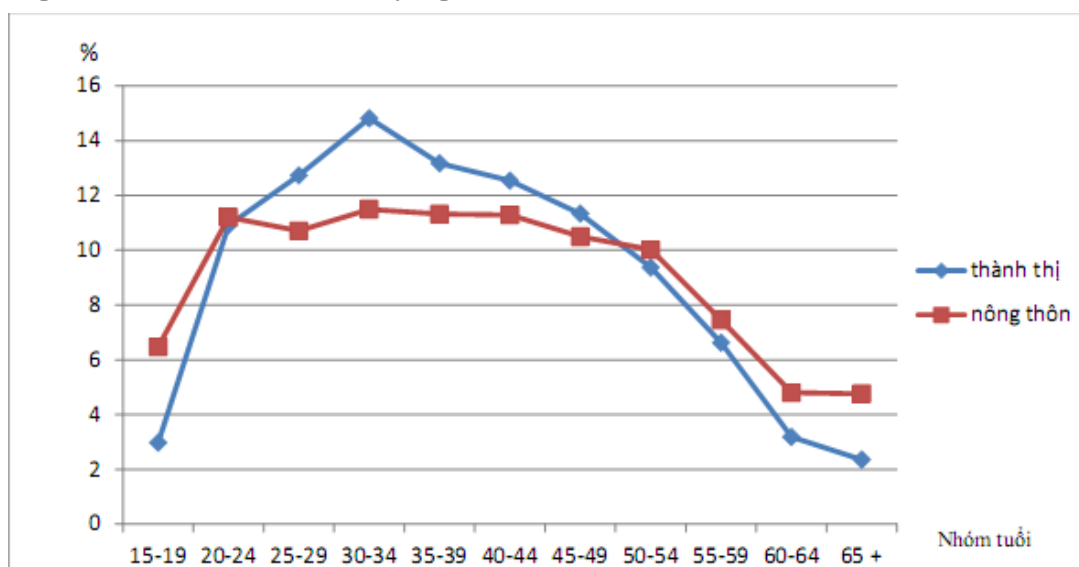
³⁷ GSO. Population and Housing Census, 2009

³⁸ UNFPA, People with Disabilities in Vietnam, Key Findings from the 2009 Vietnam Population and Housing Census, 2011

³⁹ United Nations Vietnam, Brief on Young People 2012-2016

⁴⁰ WB HEP2 Project, Higher Education Master Plan, 2012

Figure 9: % labour force by age and rural/urban area in Quarter II 2015⁴¹



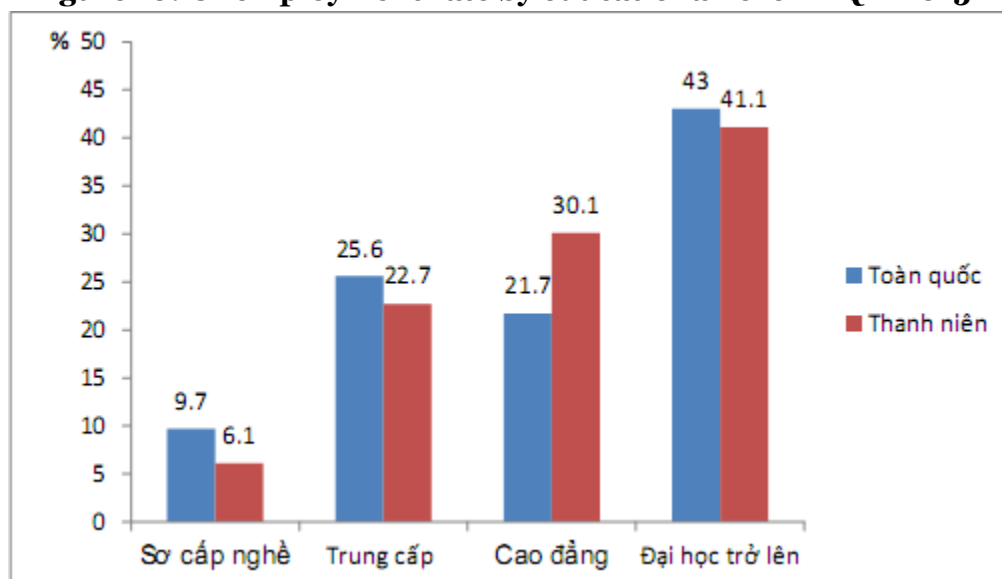
The above figure reflects the fact that most of young people in urban areas participate to the labour market later but leave earlier than their peers in the rural areas, due to the typical characteristics of the rural employment.

By QII 2015, there are about 890,000 people underemployed and 1.17 million people unemployed nationwide. Young people are considered one of the most vulnerable groups in the labour market. In the quarter II of 2015, up to 50.3% young people from 15-24 unemployed. Notably, unemployment rate is lower in the urban area than in the rural area (45.1% versus 54.9%) according to GSO. This is explained by more educational opportunities for young people in the urban area to the rural areas. Besides, about 27.1% among underemployed people are youth from 15-24.

As mentioned above, the mismatching in the labour market supply and demand leads to high unemployment rate in this group. There is a high possibility that the higher educational degree a person earns, the higher chance he/she is unemployed.

⁴¹ GSO, Employment survey Quarter II, 2015

Figure 10: Unemployment rate by educational level in QII 2015⁴²



2.4.3. Access to protection from exploitation

Internal migration flows have grown in volume and complexity in the recent years with a vast majority migrating for economic reasons and majority being young women⁴³. Migration can lead to disengagement from family and friends, as well as ineligibility for public services due to registration requirements. Though Vietnam ratified the ILO Convention on the Worst Forms of Child Labour in 1999, according to the Vietnam Multiple Indicator Cluster Survey 2014, up to 16.4% children age 5-17 years who are involved in child labour. Street children and young people who are separated from family care are especially at risk of economic and sexual exploitation.

2.4.4. Access to opportunity for healthy lifestyles

Young people who are healthy and happy tend to be better equipped to contribute to their communities as young citizens despite the major shifts occurring in the world they are about to inherit⁴⁴. However, injuries have become the main cause of death or disability for young people in Vietnam. According to World Health Organization, most of those killed or injured on the roads in Vietnam are young adults – in fact, road traffic crashes are the leading cause of death for those aged 15 to 29 years⁴⁵.

Vietnam is also one of the countries with the biggest number of cigarette smoker. The proportion of young smokers in the age group 16-19 was 18.2% and in the 20-24 age group was 33%. The average age for the first time the young smokers in the age group 16-24 was 17.4% (standard deviation = 2.5). The proportion of young ever drunk alcohol in the age group 16-19

⁴² GSO, Employment survey Quarter II, 2015

⁴³ United Nations Vietnam, Brief on Young People 2012-2016

⁴⁴ The Education of Young People: A Statement at the Dawn of the 21st Century, 2000

⁴⁵ http://www.who.int/violence_injury_prevention/road_traffic/countrywork/rs10_vietnam_en.pdf

was 41.7% and in the 20-24 age group was 58.1%. The average age for the first time, drunk youth in the age group 16-24 was 17.2% (standard deviation = 2.6)⁴⁶.

Substance use becomes more and more complicated and tends to increase in the recent years. By end of June 2011, there are about 149,900 drug users nationwide⁴⁷, of which 70% are under 30. According to the results of Survey Assessment of Vietnamese Youth, the proportion of young people who ever used drug (marihuana, ecstasy, crystal, and heroin) is 0.4% in the both two groups from 16-19 and 20-24. The average of first drug used by young people is 19.1 years (standard deviation = 2.3). However, this figure may be much higher in reality due to the sensitivity of the issue.

3. Methods

3.1. Research design and qualitative approach

In order to obtain the information required, different methods were applied to collect the necessary data, taking care of both the need to gather comprehensive information and to triangulate findings from one method using the others. The tools include: Desk review; In-depth interview; and Focus group discussion.

These are by no means the only tools that would be useful in such a study and those which are proposed here would have to be adapted to any particular situation. They are intended to give a sense of what information can be obtained by using different tools and how diverse issues can be looked at from multiple angles.

Interviews and group discussions were made with two groups of informants: young PLHIV and policy makers/implementers. We conducted totally 42 in-depth interviews and groups discussions in 7 provinces (5 in-depth interviews and 1 group discussion in each one).

3.2. Ethical issues

Free and informed consent was obtained from all participants in the study. Interviewees were advised that they were free to end the interview at any time. Participants were not asked their names, addresses or any other identifying information, to ensure privacy and confidentiality. All data sets are kept in a secure office accessible only to the research team.

3.3. Limitation

All respondents who were PLHIV were clients of OPCs or beneficiaries of international funded projects. They had participated in a number of trainings and therefore their knowledge of HIV/AIDS and STIs may be better than ones in community.

There was no young most at risk people without HIV among the respondents. This may limit the findings of how HIV prevention and treatment, sexual reproductive health and other social needs of young key populations and young people living with HIV are different. Lesson learns therefore may be harnessed.

⁴⁶ GSO, Survey Assessment of Vietnamese Youth, 2015

⁴⁷ MOLISA, Report on drug rehabilitation in Vietnam (No. 69/BC-LĐTBXH, dated 8 September 2011)

4. Main findings

4.1. Knowledge of HIV/AIDS and STIs

Most of respondents who were PLHIV had good knowledge of HIV/AIDS. They could verify the routes of transmission correctly. However, a number of respondents did not know about risk behaviors *“Honestly I have no idea of safe sex”*– shared by a young PLHIV. Notably, many of them had not heard about STIs given the fact that they had participated in counseling sessions or awareness raising trainings as part of OPCs or projects’ activities.

Both PLHIV group and policy maker and intervention implementer group shared the opinion that young people tend to have sex at earlier age while they did not have sufficient knowledge of SRH. *“...but girls are quite easy in accepting boys, they don’t ask to use condom*

“Maybe never or maybe I heard but it dropped out of my head as I had no interest”
– shared by a young PLHIV

while boys don’t like condom” – a young PLHIV.

“Many people were so shocked when they knew they got pregnant or STIs, but still they never learn the lesson” – a PLHIV

SRH was educated in schools, from secondary level to university level; however, all of respondents (from both groups) said that the curriculums were *“so boring and not deep enough”* which made students were not interested in. At home, parents were reluctant to share information on SRH to avoid *“teaching the dog to bark”*⁴⁸.

Young people were shy and reluctant to share about SRH, especially ones living in the rural areas where lacked of SRH services, especially for male.

Unsafe sex usually led to unwanted pregnancy and unsafe abortion. There were girls at 12-13 health clinics for abortion according to a doctor. A PLHIV also reported to know a friend who quit school due to unwanted pregnancy.

4.2. Stigma and Discrimination

Stigma and discrimination situation was thought to be *“less serious than before”* but still remain high. Stigma tends to be *“sophisticated”* in clinics and hospitals. PLHIV may be refused of service provision but *“hard to get evidence”* as health staffs usually refereed them to other places. Services for them were reported *“not friendly”* in many cases. They claimed to have to answer screening questions when they came to get HIV test, however the way that health staffs raised questions was not friendly and many of them did not come back.

“...but very hard to get evidence, it’s kind of sophisticated stigma. If we’re stigmatized, we can seek for legal support but in fact we scare of being disclosed, so usually people do not access to that kind of service” – a young PLHIV

PWD and SWs seems to be stigmatized more, according to

⁴⁸ Original in Vietnamese: Vẽ đường cho hươu chạy

PLHIV respondents, because of their risk behaviors: “...we want to be good people but everyone against us” – shared by a PLHIV.

Confidentiality was a concern of a number of respondents. They worried that their identities were disclosed when they got services from OPCs. Worrying of being disclosed may harness PLHIV to access services. This finding very much aligns with the recent Round 2 Stigma Index study.

Self-stigma is still a problem to PLHIV. Many of them shared that they did not want to hear about HIV which reminded them their HIV positive status.

4.3. National policies

Currently, policies are designed by key populations and not yet by age groups. According to the respondents, there were advantages policies for example a policy that enabled MSM to received treatment early, hence reduced risks among communities. However, there were policies that harness effectiveness of HIV/AIDS programs, for example a policy that gave penalty to sex workers and using condom as evidence. Another policy that was thought to constraint testing services, which required people under 16 to have parents or caregivers to accompany to get HIV test. While it is evident that there are more and more young people with risk behaviors, and most of them did not want to disclose to families, the policy was said to be “double edge knife”. Strangely, while none of the respondent could name this policy, it was only mentioned in Ho Chi Minh City, and Hai Phong respondents confirmed they did not have alike policy. This shows a difference in policy implementation among different provinces.

There is a gap between policy and implementation. A number of HIV/AIDS program implementers shared that policies were not clear, and they had to wait for circulars and guidelines after laws were issued to translate into reality.

“...everyone wants favorable policies to their specific needs. But from the government’s perspective, we need a balance in resource allocation. People need to be self-responsible for their actions. Families need to be responsible for their children’s awareness of SRH, not just the “society” in general” – a policy implementer

While most of PLHIV expressed their recommendations of more favorable policies for young key populations, policy makers and implementers had another point of view. In the context of sinking funds and more and more organizations gradually stepped out of the countries.

“...doctor asked so loudly that people outside the room could hear. He asked if I used condom when I had sex” – shared by a SW with HIV

4.3.1. Information-Communication-Education interventions

IEC was considered crucial in HIV/AIDS interventions. All of respondents could name a

certain number of IEC activities carried out by district authorities, schools, provincial aid committees, HIV/AIDS programs or projects, or through mass media. However, most of them said that the activities were limited.

IEC activities were said to target to public in general and designed in specific to young people. As young people and especially young key people, information and intervention approach should be adapted to fit their needs. IEC activities for MSM were not effective according to both PLHIV group and policy maker and implementer group.

HIV prevention communication activities were in place but targeted to PLHIV while people without HIV but committed risk behaviors should be the right ones to target to.

SRH information was designed to target to women only whilst men also wanted to learn. Some of them therefore sought information in health clinics or centers; however many of them were *“shy or worried people may misunderstand”* to come there.

“...they only can change other’s behaviors if they deeply understand their audience” – a PLHIV

As mentioned above, SRH trainings are integrated in schools, mostly in secondary and high schools. However, the trainings were said to be *“boring”* and not relevant to young people. There were a number of universities which implemented communication activities on SRH; however the effectiveness was limited due to constraints of budget and human resource.

IEC activities were not implemented regularly. Based on available budgets, the activities were said to be *“on and off”*. Activities were relied on availability of different programs’ budget, therefore they were *“intensive in a certain time and then we don’t see much”*. Both PLHIV group and policy maker/implementer groups shared the opinion of IEC activities should be *“continuous”, “in a long-run”, “better coverage”, and “better integrated with health checking activities and schools”*.

4.4. Harm reduction interventions

MMT program was highly appreciated by respondents who were IDU. Methadone was said to be helpful to quit drugs. However, it was not easy for them to access MMT programs. *“MMT program is available but as many people already joined, it’s not easy to be admitted. We have to pay to be in, but I don’t afford”* – a PLHIV. This finding was found in 3 cases of PLHIV who were IDU in different interviews. Besides, a number of respondents expressed their worry not being able to pay for methadone in the recent future when international donors withdrew from Vietnam.

“We do want to quit but it’s so challenging” – a PLHIV.

Needle and syringe and Condom programs. These two programs were only mentioned by a few respondents who were PLHIV. Three of them presented the needs of free needle and

syringe program, and only one case thought that free condom program was important to prevent HIV/AIDS. Unfortunately, the interviewers did not have chance to explore further the rationale behind.

4.5. Voluntary counseling and testing

As mentioned, people under 16 in Ho Chi Minh City must have parents or caregivers to accompany to take HIV test. This regulation was not found in any other cities that this study. The regulation was said to hinder people under 16 to get the test, and therefore diluted effectiveness of HIV/AIDS programs.

It is interesting to find that clients tended to stick with the first staff that they approached. Even after being tested and counseled, and referred to OPCs for treatment purpose, they tended to return to the first approached staff whenever they had any concern relating to both mental and physical health. This suggests that initial counseling is important in maintaining and keeping track clients, and there should be a close collaboration between VCT and treatment services.

4.6. Treatment and cares

While the adherence to treatment was high in general, a number of program implementers reported that following up young people especially people under 18 was difficult as they rarely disclose their real contact information.

A number of respondents who were PLHIV also expressed their need of receiving ARV at earlier phase (when $CD4 < 250$).

Linkage between VCT and treatment and care services is important to PLHIV because some of them felt “abandoned” when they were referred to OPCs to receive treatment. This strengthens the above recommendation of collaboration between the two services.

4.7. M&E systems

As a result of the policies which were not designed specifically by age groups, data of PLHIV were collected to fill in the M&E system as a pool, but not disaggregated by age groups without request. There're a number of reasons behind: (i) it's not a must in the M&E system; and (ii) information by group age was not accurate as a concern of project implementers. *“We need independent study because 1 person may get services from different places provided by different organizations”* – shared by a project implementer.

4.8. Health insurance

The new policy that allowed PLHIV to cover health expenses was highly appreciated. However it was reported that many people could not buy health insurance as only whole family package was available. However, not all members in a family wanted to buy health insurance and harnessed PLHIV to have their own insurance card. Besides, some poor and difficult families were not afford the insurance fee and needed support.

4.9. Other social needs

4.9.1. Employment and vocational training

Most of respondents said that employment was crucial to their life and without jobs, they hardly lived healthy. Vocational training hence was important to them. Many of PLHIV expressed their need of free vocational training and job finding support. Micro-credit was also a need as an important impact to boost their careers.

4.9.2. Life skills

Young key people tend to be more disadvantaged in life skills to young people in general. Both project implementers and PLHIV shared that they needed to learn life skills including communication skills to be more confident and self-esteem improvement. Communication skill was considered important especially with SWs to better negotiate with their clients to use condom.

4.9.3. Mental support

Usually mental health was supported by community based outreach (CBO) workers, while physical health support was provided by clinics/projects. Young key people seem more comfortable with their CBO workers as “...most of community workers are like us, some of them are not but they never stigmatize” and “they are easier to approach than doctors because they have too many clients” – shared by a PLHIV. Mental health support is important to young key people as expressed by many PLHIV respondents. However, most of CBO workers do not have coaching skills. It was reported that only Hoa Cat Tuong self-help group in Ho Chi Minh City provided mental health support by a voluntary psychologist.

4.9.4. Legal support

The need for legal support is considerably high among young key populations as a vulnerable group. They usually need legal support especially for the cases relating to stigma and discrimination. However, most of them are not affordable to pay legal fee, and services for key populations in general are still limited. Besides, as mentioned above, they worry of being disclose in disputes, therefore they rarely seek for this kind of support.

5. Conclusions and Recommendations

- ❖ Interventions are currently designed to address different key populations. To enhance effectiveness of the programs, interventions should also be designed to fit to age groups, and young key populations should be focused. To do this, the M&E system should be disaggregated by age groups to provide evidences for the policies and interventions.
- ❖ IEC is crucial in preventing HIV/AIDS and STIs. IEC activities are not sufficiently comprehensive, effective, and continuous. A long term IEC strategy for young people in general and young key people in specific should be prioritized. For young people in general, information on SRH and HIV/AIDS should be provided through mass media

or integrated in schools. For young key populations, IEC activities should focus on MSM group especially. The activities should be adapted to fit different groups of young people rather than being designed as a uniform for all. And in overall, there should be a comprehensive IEC strategy for young people in a long term and continuous basis.

- ❖ MMT program is highly appreciated by PLHIV to live healthy; however it is difficult to be admitted to the program. Hence, it is recommended that MMT program is expanded, and requirements to be admitted should be transparent to IDUs.
- ❖ Review and revise policies that may harness effectiveness of HIV/AIDS program, for example regulation of having parents or caregivers to accompany people under 16 to get HIV test, or taking condom as evidence to give penalty to sex workers.
- ❖ Health insurance is now available to PLHIV and highly appreciated. It will be more effective if the policy is more flexible so that PLHIV are able to buy single card instead of whole family package which is impossible in many cases.
- ❖ Stigma and discrimination remains high in both way of being stigmatized or discriminated, and self-stigma. People with risk behaviors seem to be stigmatized more seriously. They need to be trained of Law on HIV Prevention and Control to be aware of their rights. Legal support activities should be enhanced, and life skill training should be provided to support them to improve their self-esteem.
- ❖ Mental support and counseling services are significant to young key people and PLHIV because of their vulnerability status. Initial counseling is important in maintaining and keeping track clients, and there should be a close collaboration between VCT and treatment services.
- ❖ In the context of constraint resources, self-sustaining is vital to young key people and PLHIV. Vocational training and Income generation activities should be promoted to support them to improve their livelihood and to be independent.
- ❖ Since most of young key people and PLHIV who are working for HIV/AIDS programs/projects are built capacities in different areas, they should be mobilized when the programs/projects are handed over to the Government. Extra trainings with need assessment are needed to provide to help them to do the job. Interventions for young people by young people are therefore highly recommended.

Appendixes

Appendix A – Project guidelines

Project title: Making the money work for young people in the HIV response
Funded by: Robert Carr Network Fund
Managed by: Youth LEAD




Implementing countries: Cambodia, Nepal, Pakistan, Philippines and Vietnam

PROJECT IMPLEMENTATION GUIDELINE

The implementation guideline aims to facilitate understand the implementation modality of the project for the implementing partners of the project for better result. The guide does not aim to limit the innovativeness and flexibility of the country partners but have basic and common understanding on the objectives of the project.

Project Objectives

The aim of the program is to create enabling and empowering environment in the selected countries to enhance the engagement of young key populations in the Global Fund processes at country level, with following specific objectives

1. To synthesize and generate strategic information in relation to HIV and young people to inform the National Strategic Plan review and Investment Cases
2. Ensure youth partners have the skills and knowledge to influence the country dialogue for adequately resourced HIV responses for young people
3. Ensure programmes funded through the NFM targeting young people are designed and implemented in full partnership with young people to ensure programmes are effective. 

Project Activities

S.N.	Project activities	Guideline for implementation	Objective and linkage in the project
1	Rapid national assessment of young key populations and young people living with HIV and AIDS in the countries	<p>The rapid assessment, most probably, will be the first activity to be completed before or along with the training. The key questions to the assessment are</p> <ul style="list-style-type: none"> - What are the HIV prevention and treatment, sexual reproductive health and other social needs of young key populations and young people living with HIV? The study should differentiate the young key populations based on the country. - How have the national HIV response addressed the above-mentioned needs of young people? - How many young people populations and young people living with HIV are recorded by the existing data and literatures? <p>Proposed methodology (not limited to)</p> <ul style="list-style-type: none"> - Literature review - Survey (monkey survey, manual survey) - Focus group discussion - In-depth interviews - Key information interview <p><i>Reference: Young Key Population at Higher Risk of HIV in Asia and the Pacific: Making the case with Strategic Information, 2013 (UNICEF, UNESCO, UNFPA and UNAIDS).</i></p>	<p>Fulfill the objective 1 of the project.</p> <p>The trained young people from second activities will utilize this document as the advocacy tool to lobby with different stakeholders after the training.</p>
2	In-country capacity development trainings on Global Fund and New Funding Model for young people	<p>The in-country training will be implemented after the regional training planned on March 2015 in Bangkok. The partner will be trained based on the standard toolkit developed by Youth LEAD with support of UNAIDS Geneva for three days. The participants then have to roll out the training in the country based on its context.</p> <p>The training will be of three days and Youth LEAD will provide technical support during the training.</p> <p>The country partner can translate the toolkit in their local language.</p>	Fulfill the objective 2.
3	Follow up activities (advocacy activities)	The follow up advocacy activities will be planned during the final day of the training. The activities will be planned based on the status of the country in-relation to concept note submission. The categories and status of the countries could be	Fulfill the objective 3

		<ul style="list-style-type: none"> - Country dialogue for concept note and submission of the concept note - Re-submission of the concept note - Approval of the concept note and preparation for the implementation - Grant implementation - Call of EoI for SR - CCM election, reform etc 	
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Budget preparation

Each country will be provided with budget ceiling and indicative budget allocation for each activity, while country has the flexibility to develop the budget based on the context and need without exceeding the ceiling.

The budget and work-plan should be prepared and send to gaj@youth-lead.org

The other details will be provided through the agreement.

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Appendix C – Questionnaires

Câu hỏi phỏng vấn đối với PLHIV/Questionnaire for Young PLHIV:

Thông tin chung/Personal Information:

1. Bạn cho biết hiện bao nhiêu tuổi? (Lưu ý tuổi mụ)/*How old are you? (Ask interviewees about their year of birth because Vietnamese people usually use the age according to Lunar Calendar)*
Giới tính của bạn? (Giải thích về giới tính sinh học và giới tính người trả lời tự xác định)/*What is your sexual orientation and Gender Identification (SOGI) (Explain carefully about SOGI then let interviewees self-identify)*
2. Công việc của bạn là gì? /*Vị trí hiện tại của bạn tại tổ chức/ cơ quan là gì?*
Which position are you assuming in your organization? Hành vi nguy cơ của bạn?/*If you don't mind, can I ask you about the reason why you get HIV infection? Since when? Have you still doing it (high risk behaviors)*
3. Địa bàn thường trú? *Where is your current settlement?*

Câu hỏi cụ thể/ Questions for data collection:

4. Bạn có thể nêu lên 3 vấn đề nổi cộm của các nhóm thanh niên có nguy cơ cao và thanh niên sống chung với HIV hiện có những nhu cầu gì? (gợi ý: vấn đề về thông tin, về dịch vụ, về chính sách, ... yêu cầu cụ thể thông tin gì? Dịch vụ gì? Chính sách gì? ...)(Nên hỏi lần lượt từng nhu cầu, tránh bị lẫn lộn)/*Do you know what are the top 3 issues that young key affected population and Young PLHIV facing?*
5. Nếu bạn là Bộ trưởng bộ Y tế: Bạn sẽ làm gì để Dự phòng HIV cho giới trẻ và người có HIV trẻ tuổi?/*If you are given an opportunity to talk to your Minister of Health, what would you ask in terms of: (a) HIV and AIDS prevention, (b) supporting the young key populations including YPLHIV*
6. Bạn sẽ làm gì để Điều trị HIV cho người có HIV trẻ tuổi?/*In your opinion, how is the accessibility to HIV treatment among PLHIV? Among yPLHIV? What could be done? to strengthen treatment accessibility for Young PLHIV?*
7. Bạn có nhận xét gì về vấn đề Sức khỏe sinh sản tình dục của giới trẻ và người có HIV trẻ tuổi hiện nay?
 - How is the sexual life of youth and yPLHIV? How about reproductive health? Probe for issues: early sex, unsafe sex, abortion, harassment, contraception, transgender, sexual transmitted infections, etc)
 - Do you think youth in general and yPLHIV in particularly know how to protect themselves to have good sexual and reproductive health? Why yes and why no?
 - Where do youth and PLHIV have access to information about sexual and reproductive health? What do you think about the quality of information on sexual and reproductive health that is available in Vietnam?
 - Have you ever been informed about sexual and reproductive health services? Have you ever used and what is your opinion about its quality?
 - What should be done to improve the quality of these services
8. Bạn có kể ra những nhu cầu khác của những người trẻ tuổi và người sống với HIV trẻ tuổi không? (gợi ý: hỗ trợ xã hội, dạy nghề, hướng nghiệp, sức khỏe tâm thần, ...)

Is there any other issues with regards to youth and yPLHIV? Is there any other needs that we have not discussed about? What are they?

9. Theo bạn thì những rào cản nào đã khiến cho những người trẻ tuổi và người sống với HIV trẻ tuổi khó khăn trong việc tiếp cận những dịch vụ về Dự phòng và Điều trị HIV, Sức khỏe Sinh sản Tình dục, và các nhu cầu xã hội khác kể trên?

In your personal opinion, which barriers YKP and YPLHIV are now facing in protecting them from HIV infection? Or if already infected, having a:

- better health?
- Better sexual life?
- Job?
- Respect from others?
- Better quality of life?
- Any other wish?
-

10. Bạn có thể kể ra những hoạt động can thiệp cho giới trẻ đặc biệt là người có HIV trẻ tuổi giai đoạn gần đây là những hoạt động gì phổ biến không? Theo bạn thì những can thiệp về HIV này đã giải quyết những nhu cầu của giới trẻ được đề cập ở trên như thế nào?

Do you know any recent outstanding interventions for young people, specially for young PLHIV? How could those interventions impact to mentioned demands of young people?

11. Khi nói về lĩnh vực HIV/AIDS hiện nay thì đứng ở khía cạnh là người trẻ tuổi và/ hoặc người đang làm việc hỗ trợ những người trẻ tuổi và/ hoặc người sống với HIV trẻ tuổi, bạn mong muốn có sự thay đổi tốt hơn về những vấn đề gì cho giới trẻ?

To be a young person/supporter/YPLHIV talking about HIV/AIDS movement, what should be done to enhance the comprehensive changes that young people looking forward?

Câu hỏi phỏng vấn đối với nhóm các nhà thực hiện/hoạch định chính sách:

Questionnaire for implementers/ policy makers

1. Tuổi/*Age*
2. Vị trí công việc/*Occupation and position*
3. Các dịch vụ dự phòng HIV cho giới trẻ hiện bao gồm những dịch vụ gì? Ông/bà có nhận xét gì về dịch vụ dự phòng HIV/AIDS cho giới trẻ hiện nay? Bài học kinh nghiệm? Nếu được toàn quyền quyết định, ông/bà sẽ làm gì để nâng cao chất lượng dịch vụ dự phòng cho người trẻ tuổi?/*What are the current HIV prevention services? Could you please provide some comments on HIV/AIDS prevention service for young people nowadays. If you were the decision maker, what would you do to improve quality of prevention service for young people.*
4. Các dịch vụ điều trị HIV cho giới trẻ hiện bao gồm những dịch vụ gì? Ông/bà có nhận xét gì về dịch vụ điều trị HIV cho nhóm người trẻ tuổi sống chung với HIV hiện nay? Bài học kinh nghiệm? Nếu được toàn quyền quyết định, ông/bà sẽ làm gì để nâng cao chất lượng dịch vụ điều trị cho người trẻ tuổi?/*What are the HIV treatment services for young people? Could you please provide some comments on HIV/AIDS treatment service for young people? Any lesson learned from that? If being a*

- decision maker, what would you do to improve the quality of treatment service for young people.*
5. *Tương tự với SKSS và các vấn đề xã hội (hỗ trợ xã hội, cải thiện sinh kế, sức khỏe tâm thần...)/The same question with SRHR and other social intervention (social protection, livelihood, mental health...)*
 6. *Cần phải đẩy mạnh ưu tiên ở những hoạt động can thiệp gì cho giới trẻ và NCH trẻ tuổi nữa?/Which intervention should be enhanced for YKAP and YPLHIV*
 7. *Ông/bà có biết bao nhiêu % dân số Việt Nam thuộc nhóm giới trẻ không? (độ tuổi từ 18 – 30). Theo ông/bà chúng ta có số liệu về nhóm này ko?/Do you know how is the percentage among Vietnam population belong to the Youth? (from 18 to 30 years old). Do you know any data on this population.*
 8. *Ông/bà có biết có bao nhiêu người có HIV trẻ tuổi không? (độ tuổi từ 18 – 30). Theo ông/bà số liệu về nhóm người có HIV trẻ tuổi này ở nước ta như thế nào?/Do you know how many young people (relatively) are now living with HIV? (18 – 30 years old). How is the database for this population?*
 9. *Khi nói về lĩnh vực HIV/AIDS hiện nay thì đứng ở khía cạnh là người đang làm việc hỗ trợ những người trẻ tuổi và/ hoặc người sống với HIV trẻ tuổi, ông/bà mong muốn có sự thay đổi tốt hơn về những vấn đề gì cho giới trẻ?/Being a supporter for young people/YKP and YPLHIV talking about HIV/AIDS movement, which activities should we improve to enhance comprehensive intervention for these populations.*
 10. *Ông/bà muốn bổ sung thông tin gì cho chúng tôi không?/Any further comment, advise, additional information you want to distribute us.*
Xin cảm ơn/Thank in advance.