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ORIGINAL ARTICLE

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The evolution of HIV policy in Vietnam: from punitive control measures to a more rights-based approach

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***Aim*:** Policymaking in Vietnam has traditionally been the preserve of the political elite, not open to the scrutiny of those outside the Communist Party. This paper aims to analyse Vietnam's HIV policy development in order to describe and understand the policy content, policy-making processes, actors and obstacles to policy implementation.

***Methods*:** Nine policy documents on HIV were analysed and 17 key informant interviews were conducted in Hanoi and Quang Ninh Province, based on a predesigned interview guide. Framework analysis, a type of qualitative content analysis, was applied for data analysis.

***Results*:** Our main finding was that during the last two decades, developments in HIV policy in Vietnam were driven in a top-down way by the state organs, with support and resources coming from international agencies. Four major themes were identified: HIV policy content, the policy-making processes, the actors involved and human resources for policy implementation. Vietnam's HIV policy has evolved from one focused on punitive control measures to a more rights-based approach, encompassing harm reduction and payment of health insurance for medical costs of patients with HIV-related illness. Low salaries and staff reluctance to work with patients, many of whom are drug users and female sex workers, were described as the main barriers to low health staff motivation.

Conclusion: Health policy analysis approaches can be applied in a traditional one party state and can demonstrate how similar policy changes take place, as those found in pluralistic societies, but through more top-down and somewhat hidden processes. Enhanced participation of other actors, like civil society in the policy process, is likely to contribute to policy formulation and implementation that meets the diverse needs and concerns of its population.

Keywords: *policy analysis*; *health policy*; *HIV*; *Vietnam*; *health staff*

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Vietnam, with a population of approximately 86 million (1), has a concentrated HIV epidemic, with the highest HIV prevalence among injecting drug users, female sex workers and men who have sex with men (2). The first HIV case was reported in 1990 and the estimated total number of people living with HIV (PLWH) in 2010 is 254,000 (2). Adult HIV prevalence (age 15–49) is estimated at 0.44% (2). As in many countries in Asia (3) and Eastern Europe (4), the HIV epidemic in Vietnam appears to be a consequence of the social context: new drug trafficking routes, internal migration, increasing economic and urban-rural inequalities and the transition from smoking opium to the risky injection of heroin practices (5). Illicit drug use and sex work are not only illegal but also are both officially (in government policy and reports) and unofficially referred to as 'social evils' in Vietnam. Since the onset of the HIV epidemic in Vietnam, both drug users and

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sex workers have been seen as 'destroying the morale, creating bad effects on society's culture, public security and contributing to the spread of HIV' (6). Much of Vietnam's HIV prevention and control policy during the 1990s and early 2000s was based on mandatory HIV testing and the internment of drug users and sex workers and information campaigns that have linked HIV to these heavily stigmatised risk behaviours.

In 2006, the government of Vietnam passed an HIV law that promoted a more rights-based approach to HIV prevention and care, legalising harm reduction policies like needle and syringe exchange programs, and instituting medical insurance policies for PLWH. Vietnam had gone, within the span of 10 years, from being a country with one of the most punitive HIV policies to having a rights-based HIV policy that includes measures that many higher-income countries still struggle with, such as needle exchange and health insurance inclusions. In the case of Vietnam, as in other social and political contexts with a long history of single party governments such as countries from the former Soviet Union (7) and China (8–10), it is often unclear how policy has been formulated, who has been involved, what the relationships are between different actors and the effects that different policies have on each other (11). While difficulties in programme implementation are often described in the literature or in programme evaluations, they are rarely linked back to the policy-making process. Analyses of the processes of policy change and implementation should consider the roles, views and values of the front-line providers tasked with policy implementation (12, 13). Although HIV epidemics and consequent responses differ between and within countries, there are important cross-country lessons to share, particularly in terms of national policy processes. In a similar way, lessons from Vietnam may be of use for other settings and states in the region and beyond. This study describes the evolution of HIV policies in Vietnam from the mid-1990s to the late 2000s, focusing on the limited set of actors involved, the influences on them, and the processes that led to policy change. The paper also considers implementation issues, especially barriers due to human resource shortages.

Methods

Study setting

The study was conducted during 2007 in Hanoi, the capital of Vietnam, and Quang Ninh Province. Quang Ninh was selected because its HIV prevalence was among the top 10 provinces in Vietnam (14) and it also received extensive government and donor support. Given these conditions, we determined that this province would have comparatively good conditions for policy implementation and be an illustrative case study.

Study methodology

This study consisted of a document review, key informant interviews and applied Walt and Gilson's (1994) health policy triangle framework (15–17), which focuses on understanding the content of policy as inextricably connected to and affected by the policy-making process, the actors involved and the context. The framework was used in both planning and analysing the study, whereby, the document review and the analysis of key informant interviews situated the policy issues and content in relation to the actors, context and policy formulation processes. When conducting the interviews, respondents were encouraged to explore the reasons behind the policy changes, and consider the interests, roles and powers of the different actors. The study team consisted of three Vietnamese nationals, with backgrounds in medicine, pharmacy, public health and health policy, and three non-Vietnamese nationals familiar with the Vietnamese context with backgrounds in nursing, medicine and public health.

Selection of HIV policies

Prior to starting data collection for this study, the first author conducted six exploratory interviews with officials at the Vietnam Administration for AIDS Control (VAAC), the Communist Party Commission and the National Assembly's Department for Social Affairs to help shape the study focus, to identify relevant policy documents and potential key informants. During the formative research stage, policies listed in the Ministry of Health's Book on Legal Documentation on HIV (18) and on the website of UNAIDS Vietnam (http://www.unaids.org.vn) were reviewed (6). We selected all nine major HIV policy documents issued by the Party, National Assembly and Government for detailed study:

(1) Directive numbers 52 (1995) and 54 (2005) issued by the Communist Party Commission for Popularisation and Education.
(2) National Assembly's Ordinance (1995) and Law on HIV (2006).
(3) Government's Resolution numbers 05 on sex work control (1993) and 06 on drug use control (1993).
(4) Decree No. 34 (1996) and Decree 108 (2007) on guiding the implementation of the 1995 Ordinance and the 2006 Law on HIV.
(5) National HIV Strategy (2004).

Selection of key informants

Key informants who were likely to have insider knowledge and insights into the issues were selected purposively based on suggestions made during formative exploratory interviews. An eligible key informant was a person who was expected to be able to provide broad information or particular insights into the topic, and who had actively

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participated in and/or had current knowledge of HIV policy formation and implementation in Vietnam (19). Key informants came from a range of relevant statutory agencies and were selected with the aim of achieving a variety of perspectives and opinions. In total, 17 persons (2 women and 15 men) participated in these interviews. Respondents were officials from the Party Commission; the National Assembly's Department for Social Affairs; VAAC; Ministry of Health's Department of Legislation, Department of Personnel and Organization; and from Quang Ninh Provincial AIDS Centre (PAC) and the Provincial Health Department.

Data collection and procedures

The first author, a medical doctor by training with 20 years of work and interview experience in the health sector, conducted the interviews under conditions of privacy in the offices of the informants. Permission to tape the interviews was sought and granted by all key informants. The interviews were conducted in Vietnamese. To capitalise on the time available during the interviews, an interview guide was drafted, so that common issues would be raised with all or most respondents. The following issues were raised: respondents' experiences and opinions on HIV policy-making processes, the roles of different actors in contributing to or influencing the HIV policy process, the changes in and appropriateness of the HIV policy content, and respondents' views on anticipated or actual obstacles to policy implementation. Each interview lasted approximately 1 hour.

Data analysis

This study used framework analysis, which is a type of qualitative content analysis that summarises and classifies data in a thematic way in order to facilitate the policy- and practice-oriented application of findings (20). In this study, the first step of data analysis involved the first two authors' familiarisation with the data, through repeated reads of documents or interview transcripts. Then, thematic analysis was carried out, where a coding schema was developed. Codes were discussed between the first two authors and manually applied to the data systematically, a step referred to as 'indexing' (20). Lastly, relationships were looked at between the codes, both within individual documents and interviews, as well as across all data sources, in order to explore associations between the concepts, which we refer to here as themes. Themes were discussed and agreed on by all co-authors, and were based on the health policy triangle framework applied in this study (17).

Document review

We reviewed all nine HIV-related documents issued from 1993–2006 including Party directives, the National Assembly's Ordinance and Law, the Government Strategy and Plan for HIV: 1995–2006. Initially, the first two authors read all the documents from one agency (e.g. the Party directives) in order of issue so as to identify important changes in the contents. We used a similar approach with the National Assembly and the Government documents. Thereafter, we compared dates of issue and reviewed all the documents issued to try to understand whether changes in one policy document had influenced those issued subsequently. The document review provided information mainly on the content changes, sometimes on the actors, but rarely on how and why these changes happened.

Key informant interviews

Key informant interviews were important to provide insight into the reasons behind the changes, and to help to understand why, how and who influenced the changes in HIV policy in Vietnam. The tape-recorded interviews were transcribed verbatim in Vietnamese and then translated into English. Then, the interviews were read through several times by the first two authors to identify key messages of interviewees and to obtain a sense of the whole. The Vietnamese and English versions were reviewed and analysed side-by-side during the coding procedure to avoid misinterpretations of the full meaning of the texts.

Ethical consideration

Informants were given information about the study, informed that only their department and agency would be identified in relation to their quotes, and that they could withdraw from participation in the study at any time. Those agreeing to participate provided oral informed consent prior to beginning the interview.

Results

Four themes were identified based on the health policy triangle framework: HIV policy content, the policy-making processes, the actors involved, and human resources for policy implementation. These themes, while related, are presented separately for clarity of presentation. We felt that the policy-making context, which is an important element of the policy triangle framework, was theoretically present underlying all of the themes and that it was not possible to separate it out into a theme of its own. The findings are presented under each of the four themes with quotes from the key informants and reference to policy documents to illustrate each theme.

HIV policy content

AIDS, social evils and forced rehabilitation

The first phase of Vietnam's AIDS response was characterised by its closely linking HIV prevention and control to what has, in Vietnam, been referred to as

'social evils'. Therefore, campaigns to combat sex work and drug use were judged to be the most logical solutions to reduce the spread of HIV.

> Initially, leaders were afraid that revealing the information of this dangerous disease in the province would make the visitors scared. The public was confused about AIDS and social evils. National communication (prevention campaigns) often used the skull and crossbones to indicate AIDS. (Provincial Health Official)

In 1993, the Government issued *Resolution No. 05 on sex work control* (18), which stated that 'sex work is linked with the AIDS disaster', and therefore prescribed that 'female sex workers should be interned in rehabilitation centres for the treatment of sexually transmitted diseases and vocational training'. Another Government edict, *Resolution No. 06 on drug control*, which was also issued in 1993, prescribed that all drug users have compulsory detoxification in rehabilitation centres (18). In March 1995, the Party Commission issued *Directive No. 52 on HIV Prevention* (18) according to which 'HIV prevention is considered the country's top priority'. The Directive called for 'healthy and faithful lives avoiding drugs and prostitution' and further linked AIDS and social evils in prescribing that 'interventions should be integrated with the prevention of social evils: first, drug abuse and second, sex work. Police should make timely discoveries and punish drug traffickers, producers, users, brothel owners and decoys' (18).

Control of persons living with HIV and compulsory testing

In June 1996, the Government issued *Decree No. 34 on guiding the ordinance implementation* (18), which, besides defining roles and responsibilities of different ministries on the AIDS response, listed the responsibilities of PLWH and mandated that they inform their spouses of their HIV status. The Decree also prohibited PLWH from working in 'certain jobs' such as surgery or obstetrics. District health managers or higher-level authorities were given the authority to request that key populations at higher risk have HIV tests. This often meant that those who fell into the categories of drug users or sex workers were mandated by local authorities to test for HIV, and their results were kept and tracked by local authorities.

From detention and control to harm reduction and individual rights

The National Assembly's *Ordinance on HIV* (18) came into effect as of August 1, 1995 to ensure the confidentiality of PLWH and provided a counterbalance to the dominant coercive strategies focused on actual or suspected drug users or sex workers as well as PLWH. With this ordinance, it was prohibited to publicly share the name, age, address or photo of a PLWH. In March 2004, based on the commitments made to the Declaration of United Nations General Assembly Special Session on AIDS (UNGASS), the Government approved its *National HIV Strategy in Vietnam till 2010 with a vision to 2020* (6). This strategy adopted more specific goals, targets and defined three categories of actions to be taken: first, social solutions including effective leadership, multisectoral collaboration, community involvement and a practical legal framework; second, technical solutions including surveillance, voluntary testing, appropriate medical treatment and harm reduction interventions; and third, resource mobilisation and international collaboration. These included an action plan on prevention that focused on behaviour change communication; harm reduction including needle/syringe provision; prevention of mother-to-child transmission; voluntary counselling and testing for HIV; blood transfusion safety; and sexually transmitted infection management.

In November 2005, the Communist Party issued *Directive No. 54 on Strengthening Leadership on HIV prevention in new situation* (6). It instructed 'the concerned sectors to complete the consistent legal document system for the creation of a favourable legal environment and to issue policies for support and care for HIV-positive persons'. Mass media had mostly stopped giving negative information and images about AIDS with 'skulls and crossbones' (6). HIV/AIDS had slowly started to be de-linked from the social evils construct, encouraging society in general to develop more sympathy for PLWH.

> During the last few years, communication on HIV has reached the public. People understand causes and transmission of infection. Before, they were so scared of the disease, now they are more aware and do not isolate the infected people/. . ./Now HIV-positive persons get closer to the community. (Provincial Health Official)

The Law on HIV was adopted by the National Assembly in June 2006. It encouraged PLWH to participate in all social activities, including HIV prevention and also requested that the Government 'implement harm reduction interventions'. According to the Law, the state budget pays for antiretroviral drugs while health insurance pays for medical expenses. In 2009, following WHO's recommendations of 2006 on antiretroviral therapy (ART) for HIV infections in adults and adolescents, the Ministry of Health issued ART guidelines, according to which the cut-off levels for initiating the therapy include: (1) all patients with WHO clinical stage 4, (2) patients with clinical stage 3 and CD4 count under 350 cells/mm^3 and (3) patients with clinical stages 1, 2 with CD4 count of under 250 cells/mm^3 (21).

In June 2007, the Government issued Decree No. 108 with guidelines on implementation of harm reduction,

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antiretroviral treatment and the work of the PLWH as peer educators.

The policy-making process

Fig. 1 shows a timeline for the policy-making process in Vietnam, illustrating the major policy documents for the three main actors: Communist Party, National Assembly and the Government. Vietnam's HIV policy evolved considerably during the 12 years with HIV getting on to and staying on the agenda for several reasons. Firstly, despite all early control efforts, the epidemic continued to spread with new cases being reported from all the provinces. Secondly, the person who was responsible for developing the National HIV Strategy of 2004 was appointed as one of the leaders of the Party Commission to be in charge of health and HIV.

> I was the one who initiated development of the National Strategy and the new Party Directive/. . . / Our political system is that the Party takes the leadership, sets the directions, then the National Assembly will turn them into laws and the Government will make plans. (Party informant)

This was just one of the important links between the Party and the Government implementing bodies, with Party directives preceding most of the important Government legislation on HIV. Fig. 1 illustrates how many of Vietnam's important policies on HIV were first formulated and adopted during 1995–1996, and were later replaced by new policies in 2005–2006, along the lines of those reported above.

The Law on HIV reflected the change from traditional control measures to more internationally recognised measures and the policy development process illustrated the central role and capacity of the Party to bring about this change.

> The Ordinance has been implemented for over 12 years since 1995. Its implementation in provinces met many difficulties / . . . / We added new articles in the Law such as organizational set up, fights against stigma and discrimination, and harm reduction interventions, etc. It was necessary to have all these components to prevent the epidemic. (National Assembly informant)

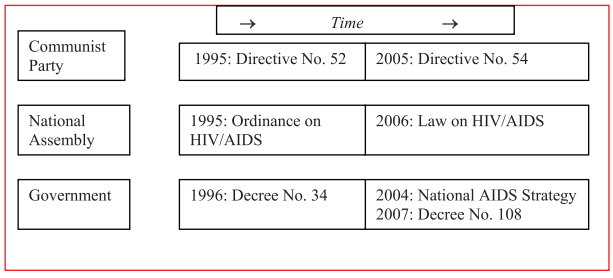


Fig. 1. Timeline of key HIV policies in Vietnam.

One informant reported that more direct experiences and evidence had been used in the policy-making process because of technical and financial support provided by international organisations.

> We received both financial and technical support from donors. We did not have any financial difficulties. We could do whatever we wanted. (Party informant)

This support, for example, enabled the Party Commission to organise scientific conferences and international study visits to provide evidence to convince sceptics within the Party of the effectiveness of harm reduction.

> We built up the Party Directive in a new way / . . . / very different from the previous one. We hired an external professional team to collect suggestions from localities, ministries, party leaders, national and international experts, and even infected people / . . . / We organised four scientific conferences on sensitive issues such as harm reduction, syringe exchange and condom distribution. (Party informant)

Implementation of harm reduction and health insurance for the patients were two of the most difficult and contentious topics during the debate on the Law on HIV at the National Assembly's sessions. The following response from a Ministry of Health informant revealed the problems that were encountered in ensuring coherent policies across different sectors – health and those responsible for enforcing pre-existing laws. It also shows that a process over time was required to bring about cross-sectoral policy change:

> The biggest difficulty was to reach agreement with other sectors, especially the Ministry of Public Security on harm reduction. We have to deliver clean syringes and needles for drug users. But if drug users were seen injecting each other they would be arrested by the police. Furthermore, the peer groups who deliver the syringes would also be arrested. So it was very difficult. Finally, the people understood that harm reduction is an intervention and not a kind of encouragement to drug addiction. (Ministry of Health informant)

The issue of health insurance for antiretroviral costs was also described as contentious between the Ministry of Health and the Ministry of Finance. It was seen as creating a very heavy burden on the economy and on health services.

A key event in 2006 was when the Law was passed, weighing heavily in the eyes of the central level key informants that the battles between Ministries had been won in favour of harm reduction interventions and mandated health insurance that would cover medical expenses for the PLWH. However, key informants at the provincial level were less sure how much influence the Law would have at the level of implementation. Key

informants at both central and provincial levels reflected that although provincial representatives were invited to participate in the policy-making process, in practice the process was mostly restricted to central governmental institutions.

The actors involved

Fig. 2 presents the actors involved in the HIV policy-making process in Vietnam. The main categories were the Communist Party, the National Assembly and the Ministry of Health. The Communist Party is the ruling party in Vietnam. Through its resolutions and directives, the Party provides the policy directions for all aspects of national life. The Party has several commissions; the Commission for Popularisation and Education is in charge of science, culture, education and health. The Commission formulated Directive No. 52 and Directive No. 54. The National Assembly has the power to make ordinances and laws and takes direction from Party Commissions. Its Committee of Social Affairs is responsible for the appraisal of ordinances and laws in health and social areas including the Ordinance on HIV in 1995 and the Law on HIV in 2006. The Ministry of Health is responsible for drafting legal documents such as ordinances and laws relating to the health sector, and then submits them to the National Assembly for approval. The Ministry is also in charge of developing health strategies and submitting them to the Government for approval.

The Party was described by two key informants as providing leadership and direction:

> Vietnam's political system is that the Party takes overall leadership on everything. The Party's directives and resolutions are concretized by the National Assembly into laws and ordinances. The Government turns them into strategies and plans. The Party raises the issues, the National Assembly brings out the solutions, and the Government implements. (Party informant)

Another key informant illustrated the power of each actor in the process:

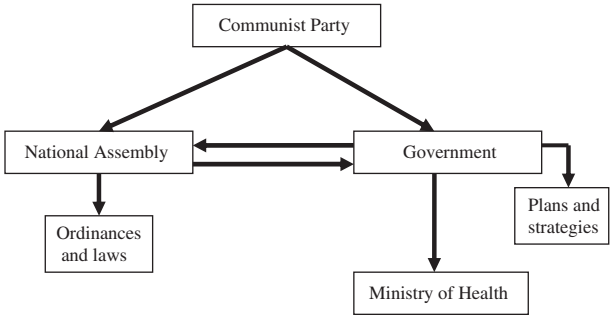


Fig. 2. Actors involved in the policy-making process in Vietnam.

> Communist Party is the ruling party in Vietnam. /. . ./For example, if people want to go from here to Ba Dinh, the Party directive is the headlight and the law is the road. No one is allowed to get out of the road/. . ./ how people go and what they do, they should follow the government strategy/. . . /It makes people go in the same direction. (Party informant)

Strong leadership from the Party was seen as particularly crucial in terms of spearheading and 'blessing' what many viewed as the more controversial changes related to moving away from the 'social evils' approach towards a more rights-based approach. Less controversial government policy changes in Vietnam were described by several key informants as not needing such heavy involvement or directive advice from the Party Commission.

Human resources for policy implementation

Many key informants highlighted the acute shortage of human resources as a barrier to the implementation of HIV policy in Vietnam. Before 2005, HIV prevention was mainly carried out by part-time staff in provincial preventive medicine centres. In order to increase the number of staff in terms of quantity and quality for successful implementation of the National HIV Strategy (22), in 2005 the Ministry of Health decided to establish Provincial AIDS Centres (PAC) under the Provincial Health Department, to be responsible for implementing HIV prevention (23). Still, the recruitment of staff at PACs has not been easy. Reasons for difficulties in recruiting were described as: (1) health staff preferred to work in curative care and in hospitals rather than in preventive care, (2) health staff preferred to work in areas other than HIV prevention because of the low salaries and incentives and (3) health staff are reluctant to work with drug users and sex workers because of the extreme social stigma associated with such groups.

> There are shortages of staff in terms of quantity and quality. New models of treatment and care take place even at district levels. Shortages of staff in districts are even more serious /. . . / AIDS Centres in many provinces have only 5 or 6 people. It was very difficult to recruit new staff /. . . / People said they prefer to work in hospitals to cure patients. Very few are willing to work in a preventive area, especially on AIDS. (VAAC Official)

Low incomes were reported as one of the main reasons for low work motivation. HIV prevention was considered as requiring less input from the medical professions and as having few career development advantages.

> Prevention deals with humanitarian issues like health education or public health. These programmes do not have much money. Therefore, staff don't have any other sources of income. Meanwhile a doctor just needs some hours working in private clinics and earns

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> as much as the monthly salary of preventive staff. (VAAC Official)

Another informant from the same organisation added:

> Income is just one of the concerns. Most medical fields are linked with improving professional expertise, for example if you are a doctor, the more you treat patients the more experience you would gain. Then you become a good doctor. But if you work on HIV prevention, what professional experience could you get after 10–15 years? (VAAC Official)

One informant suggested educating health staff to make them feel that their job is important and that it contributed to society, which might give them more job satisfaction and higher morale than they currently experienced:

> We should call for mercy and charity in each person /. . . / (so that) people feel they are devoting themselves to society. So they work wholeheartedly. (VAAC Official)

Peer educators

Many PLWH became more actively involved in the care of other patients, through starting to work as peer educators and distributing syringes and condoms, thereby becoming agents of change. They were even trained to become nursing assistants and received government salaries.

> Ministry of Health has approved the nine month training of these people in nursing schools in Ho Chi Minh City. After the training, they can work as nurses to take care of other patients. They will receive government salaries /. . . / this is a unique Vietnamese initiative /. . . / PLWH share well with each other about their emotions and feelings. They are not afraid of being infected. (VAAC Official)

However, more covert stigma continued to exist, as illustrated in the following quote from one key informant who saw a benefit from task-shifting to PLWH who would help reduce the risk of health staff becoming infected.

> PLWH can take care of each other. It is very good because they already have HIV so they are not afraid of being infected again when taking blood or dressing the wounds of other patients. So we can reduce staff working accidents. (VAAC Official)

Discussion

Unlike in more pluralist states, where positive changes often come from below, often from advocacy groups, the changes in Vietnam in societal attitudes to the HIV epidemic have largely reflected and been driven by top-down changes in policies. The focus in the early 1990s on control measures by enforcement forces such as police, investigation and courts has evolved over time to more social and technical solutions, mainly carried out by health and social workers and, increasingly, peer support from PLWH.

Our main finding was that during the last two decades, developments in HIV policy in Vietnam was driven in a top-down way by the state organs, with support and resources coming from international agencies. The earlier responses to HIV control policies, which were characterised by control and punitive measures, were replaced by more supportive and rights-based actions such as the implementation of harm reduction and health insurance for HIV-positive persons. These changes are in line with the optimal and most effective approaches to AIDS response in other countries.

In 2008, the Commission on AIDS in Asia pointed out that the Asian responses to HIV fit a predictable pattern: (1) the denial stage when responses are based on fear or denial, (2) the ad-hoc stage as countries introduce more interventions, though often not informed by solid evidence, (3) the informed stage when responses are improved and shaped by scientific evidence although problems of where to prioritise remain and (4) the mature stage when mature responses are achieved and governments deploy the necessary financial, human and institutional resources to achieve a sustainable and comprehensive response. It is easy to identify Vietnam's trajectory through the first three stages over this 12 year period. In the early and mid-1990s, Vietnam attempted to control the disease by isolating drug users and female sex workers in rehabilitation centres. Similar practices were implemented earlier in other countries, where PLWH were not even allowed entry into the country (8) or patients were kept in special hospitals (24). These approaches were manifested as the stage of denial and fear (3) where the emphasis was placed upon high risk groups rather than high risk behaviour (25). In recognition of punitive control measures that made cooperation between those at risk and the authorities almost impossible, Vietnam began to make significant changes to its national policies from the early 2000s, when the Government became aware of new and effective strategies including antiretroviral treatment, condom usage promotion, methadone use and the distribution of needles for injecting drug users. These strategies were the result of Vietnam having moved from a denial stage in 1996 to a more evidence-informed engagement stage by 2006 (3).

There are several reasons to explain the HIV policy changes in Vietnam during the period. First, the Party, National Assembly and the Government demonstrated enhanced political commitment and leadership in the area of HIV over time, likely as leaders realised that AIDS was a potential threat to people's health and life as well as the nation's development. Second, more accurate HIV information was provided to the public that started to influence society's views and norms, as well as policy.

Third, a scientific evidence-based approach was used to inform policymaking, and this made the introduction of measures such as harm reduction reasonable on scientific rather than moral grounds.

The policy-making process, as described by many key informants, was a top-down approach, through predetermined steps that were structured by Vietnam's administrative system. The process was not characterised by intensive discussions in society or at parliamentary level, as is often seen in more pluralistic countries (25, 26). The policy-making process was therefore driven by government institutions, with little or no involvement of local authorities and civil society organisations. This contrasts with studies from more pluralistic countries with a longer history of democracy, which have shown the active involvement of non-governmental organisations and sometimes PLWHs in policy formulation and implementation (26, 27).

Our study, firstly, throws some light on the importance of the Communist Party in the HIV policy-making process, in that it was central to precipitating change in other state institutions such as the National Assembly and the Government. In a country with one ruling political party like Vietnam, policies are strictly developed based on directions given by the ruling Communist Party. This is common practice in countries with similar political systems such as China (10), the former Soviet Union (28) or Cuba. In Cuba, the state applied a policy of coercive HIV testing for all pregnant women and for people with sexual transmitted diseases (29, 30). Those requiring antiretroviral treatment were required to attend a 6-week quarantine programme called 'Living with HIV' in closed sanatoria (31). Despite complaints about violating human rights in regards to this aggressive testing, sexual contact tracing, Cuba has the lowest HIV prevalence in the Caribbean region (30).

While the organs of power can appear to be like a 'black box' under communist political systems, the interviews suggest that individuals within the Party, the Government and the Ministry of Health, played a role in bringing about changes in attitudes that led to policy change. There was also evidence of at least one 'policy champion' who worked on drafting the National Strategy for HIV that was published in 2004 and then moved to work within the Party Commission, which issued Directives that changed the course of the country's response to HIV in 2005.

International agencies have played an important role in Vietnam in supporting the national HIV response: their financial assistance increased from US$8 million in 2002–2004 to US$52 million in 2006, representing 80–90% of total HIV funding (32). The support is used for HIV prevention, treatment and care as well as for surveys, studies and workshops that marshal the evidence for policy development (33). In this study there was evidence that study visits and workshops funded by international organisations for the Party Commission had significant influence in swaying their opinion about the acceptability of harm reduction.

Several factors act as HIV policy implementation obstacles in Vietnam including the need for improved salaries and more training opportunities for health staff; but strategies to improve staff work morale by valuing their work could help considerably to improve their work motivation. In order to meet the requirements of scale-up of antiretroviral therapy (ART) and to solve the problem of the shortage of health staff, some countries apply 'task-shifting', the delegation of medical and health services responsibilities from higher to lower cadres of health staff (34–36). Other countries promote the involvement of PLWH in the care of other patients (25, 27), and Vietnam has gone towards a policy of implementing similar strategies for HIV prevention and care. Their work could lessen the work load for health staff; however, the policy of using PLWH to provide supplementary supportive care should be closely monitored so that it doesn't reinforce the message that PLWH are too undesirable to be cared for by health staff and, therefore, require a supplementary care system.

Methodological consideration

The main difficulty in this study was in getting senior policymakers to agree to be formally interviewed, which is a common problem in policy studies that seek to record the views of civil servants. This was reflected in the short time allowed for interviews (as short as 30 to 45 min with some informants), and their generally cautious approach to answering questions. These made it difficult to get in-depth information on the roles of actors, how decisions were taken and how policy turning points took place. These difficulties have been encountered in other policy analysis studies (17). Sampling biases were not only likely, they were inevitable in a context where tradition dictated non-disclosure as the norm. It is likely that those actors who were favourable to the policy changes and who played (or saw themselves as playing) a role in the policy change process were more willing to be interviewed.

Conclusion

The results of the study show that Vietnam's HIV-related policies have converged towards internationally recognised approaches since the late 1990s. Rights-based approaches, such as policies of harm reduction interventions and health insurance eligibility for patients' medical costs, are now the norm. The policy-making process has been a top-down approach, controlled mainly by central state institutions with limited and passive involvement of

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provinces, civil society and persons living with HIV. The historical and political context dictated this to be the most feasible approach. While significant policy change took place in this top-down manner, the success of implementation needs to be assessed and evaluated.

Health policy analysis approaches can be applied in traditional one party states and can demonstrate how similar policy changes take place, as those found in pluralistic societies, but through more top-down and somewhat hidden processes. Enhanced participation of other actors in the policy process is more likely in the future, as Vietnam becomes more pluralist, and is likely to contribute to policy formulation and implementation that meets the diverse needs and concerns of its population.

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Conflict of interest

The authors have declared no conflict of interests.

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