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Caught in the Middle: The Contested Politics of HIV/AIDS and Health Policy in Vietnam

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Introduction

Policymaking on HIV and AIDS, and its translation into potentially sustainable programs, is rife with contention within and between several fields of power (e.g. the political, economic, scientific, and cultural). Studies of policy formation have attempted to illustrate and dissect the policymaking process by identifying how stakeholders compete and collaborate to evaluate the saliency of issues, define the gamut of possible solutions, negotiate policy choices, and implement policy outcomes (Meier 1991). Because many developing countries only began to devise national plans to address the HIV epidemic in the mid to late 1990s, and only some have embarked on the process of implementation, the relatively few studies on HIV and AIDS policies in resource-constrained countries have focused on policy *formation*, and empirical work on *implementation* is scarce (Stover and Johnston 1999). The majority of the literature on policy and program implementation in the developing world is limited to the evaluation of prevention strategies and focuses heavily on behavioral change, although it recognizes the importance of structural barriers (AIDSCAP 1998; Lamptey et al. 2009). A number of studies have described national responses to the HIV epidemic (R. G. Parker et al. 2003; Berkman et al. 2005; He and Detels 2005; Nguyen Ha et al. 2010), and yet studies that explore the contexts that shape and are shaped by, the epidemic are still rare. This highlights the need for research that describes and analyzes both the formulation and the implementation processes of HIV policies in resource-constrained countries, and that takes into account the intricacies of interactions at both global and national levels.

Vietnam offers an important opportunity to analyze several dimensions of the ‘on-the-ground’ processes involved in HIV policy negotiation, formation, and implementation (Giang and Huong 2008). Vietnam represents one of the first national cases where PEPFAR is beginning used to decrease funding following a period of intense scale-up (The US President’s Emergency Plan for AIDS Relief 2011). Responsibility for funding is now being transferred to the national government and local implementing institutions. Looking at the Vietnamese case thus provides an opportunity to explore facilitators and barriers to scale-up

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and challenges to sustainability that are distinctive features of the national and local political environments and public health challenges in Vietnam, while also exploring the more general mechanisms through which global policy stakeholders influence political commitment, capacity building, and sustainability in national settings.

Vietnam may be among the first countries where substantial scale-down of donor funding for HIV and AIDS is taking place, but it is unlikely to be the last. It is vital therefore to consider what aspects of the Vietnamese story provide insight into processes of more general relevance, as well as to consider the implications of these events both specifically, for what might be learned that could enhance the Vietnamese response, as well as more generally, for the ways in which these questions speak to issues of health sovereignty and governance. Moreover, it has been argued that country-level analyses of HIV policy have largely overlooked the examination of concentrated epidemics, which may pose different challenges for effective responses compared to those faced by countries with generalized epidemics, and thus that the Vietnamese case offers important insights into the limitations of the very notion of a concentrated epidemic (Dworkin 2010).

In this paper, we describe the roles of the state, civil society and global policy stakeholders, offering insights to inform policy formation and implementation in other settings undergoing scale-up, as well as making an argument for the need for increased attention to sustainability. In particular, the Vietnamese case offers an opportunity to consider the effects of shifting global funding priorities on programmatic sustainability and the bureaucratic restructuring of HIV policy-making processes – questions which are relevant not just in Vietnam but also globally. In the first section, we briefly describe the evolution of HIV policy in Vietnam, grounding that history in the national context where since the late 1980s the country has opened itself to global market economy. In the second section, we examine the roles of international donors in shaping HIV policy in Vietnam, and offer critical insights into the power of global forces in aligning global interests and national concerns. National concerns, however, are not only the business of the state, especially when the opening of the country to global influences also means that the state (willingly or not) has given up some political space to the civil society interests jockeying for ever greater recognition. Such recent developments of civil society interests in relation to HIV and sexuality are the focus of the third section. In the fourth section, we argue that the sustainability of Vietnamese responses to the epidemic hinges at least in part on the further development of local capacity to conduct research that is meaningful for policy formulation and implementation, and that takes into account the multiple interests of various stakeholders in the increasingly crowded field of HIV policy in Vietnam.

The description and analysis of HIV and AIDS policies in Vietnam draws on multiple forms of evidence. In addition to secondary sources, our insights reflect over seven years of engagement with the Vietnamese HIV and AIDS research community as part of an NIH-funded social science research capacity building initiative (R24 HD056691; JSH, RGP and LMG). Perhaps most importantly, two of the authors have been centrally involved in the policy formation processes described here through their institutional locations as, respectively, a senior researcher at one of the nation's leading civil society organizations working in the area of health, inequalities, and HIV (LBD) and as a lead investigator in the

HIV research unit at Hanoi Medical University, the nation's flagship medical school (LMG). Furthermore, our observations about the relative role of international donors, the state and civil society in shaping Vietnamese HIV and AIDS policy reflect an implicit comparison with a very different set of conditions in Brazil, where one author (RGP) has been involved in both the formation and analysis of HIV and AIDS policy since the earliest years of the epidemic (Berkman et al. 2005; R. G. Parker 1987; R. G. Parker 1996; R. G. Parker 2000; R. G. Parker 2002; R. G. Parker 2003; R. G. Parker, Galvao, and Bessa 1999; R. G. Parker et al. 2003). That deep knowledge of a distinct set of circumstances, in which HIV and AIDS was a critical terrain for the formation of civil society during an era of significant political and economic transformation, provides a sensitizing framework to many elements of the narrative that follows.

The history of HIV policy in Vietnam

The first case of HIV in Vietnam was reported in 1990. The epidemic has not become generalized, as many had feared it would; rather, it has developed rapidly into many sub-epidemics, with significant variation in terms of geographic location and key populations affected. An overall HIV prevalence among the adult population (aged 15 to 49) at 0.45% masks significant concentrated epidemics among injecting drug users (IDUs), female sex workers (FSWs) and men who have sex with men (MSM) (Socialist Republic of Vietnam 2012). In terms of gender disaggregation, the epidemic has been concentrated among men, in large part because it has been driven by injection drug use, and yet recent decreases in sex ratio raise serious concerns about transmission from infected men to their wives and female partners (Lim, Tran, and Tran 2011). These epidemiological features have marked Vietnam as a prototypical example of a country with a concentrated epidemic.

At that same moment in 1990, the country had just embarked on a set of economic and social policies known as *Doi Moi* (Renovation), opening what had been a relatively isolated socialist country to global flows of capital, ideas, and people (see more description in the following sections). The epidemic exploded in the decade after *Doi Moi*, when widespread heroin use among young men and the growing visibility of prostitution became part of the experience of these social and economic transformations (Hien, Long, and Huan 2004; Vu, Hien, and Go 2009).

The significant shifts in policy responses to the epidemic over the past two decades reflect the rapidly changing political environment. In the early 1990s, when the first cases of AIDS were reported in the country, the state, equipped with limited alternatives, resorted to what it knew best – the Leninist mode of governance, characterized by exhortations directing state administrators to address the perceived linkages of HIV and AIDS to drug abuse and prostitution (Nguyen-Vo 2008). As early as 1995, a policy response came from the highest level in the form of a directive by the Party Central Committee to strengthen Party leadership in the prevention and control of AIDS (Socialist Republic of Vietnam 1995). Early responses framed HIV prevention as control of drug use and prostitution, known then as *tệ nạn xã hội* (social evils). Other policy documents enacted before or around the same time as that leadership directive included legislation to require the compulsory detention of drug users and female sex workers in special facilities (locally known as 06 and 05 center,

respectively) (Socialist Republic of Vietnam 1993). In 2000, the National Bureau of AIDS Control was abolished and its functions were merged with the National Committee for Prevention and Control of AIDS, Drug Use and Prostitution, confirming the emphasis on linking HIV prevention to the fight against social evils (*tệ nạn xã hội*).

The epidemic's second decade saw a number of major changes in the Vietnamese state response, including a 2004 comprehensive national strategy on HIV and AIDS with the ambitious goal of achieving a national prevalence below 0.3% by 2010, with no rise thereafter (Government of Vietnam 2004). In recent years, the state has enacted, supplemented, and amended numerous policies and legal documents, creating a stronger, more progressive and more consistent legal framework for prevention and control activities. For example, Instruction 54/CT-TW, issued in late 2005 by the Communist Party, confirmed HIV/AIDS prevention as an urgent and long-term goal, and stated that revision of the legal framework to better address the epidemic was needed. Most importantly, the 2006 Law on HIV/AIDS Prevention and Control then provided a foundation for a coordinated multi-sectoral response and for the protection of the rights of people living with HIV (Socialist Republic of Vietnam 2006). That was a key moment, with the state pivoting to acknowledge HIV as a socioeconomic and public health issue rather than a question of social evils. In 2007, the government issued the Decree 108/2007/ND/CP, which guided the implementation of the 2006 Law and includes harm reduction component. In 2012, the government included HIV/AIDS among the formal list of 'National Target Programs', committing significant resources to the response; notably, this National Health Target setting is largely internal to the state, and so the priority placed upon HIV and AIDS, in a policy process that includes neither international donors nor civil society, demonstrates substantial state commitment (at least for the moment) to HIV and AIDS. Government funding for HIV has doubled since the beginning of the 21st century, which together with funding from international donors makes HIV and AIDS one of the most amply-funded health priorities in Vietnam.

These policy and legal changes have reverberated across the country, leading to developments such as the formal networks of people living with HIV (described in greater detail below in the section on civil society) which have been founded and now reach beyond large cities such as Hanoi and Ho Chi Minh City (HCMC), and the featuring of many people living with HIV in both public events and national media. The higher prioritization and shift in orientation to HIV and AIDS was mirrored by a similar policy shift in relation to drug abuse that has taken place during the past two decades, opening up the possibility for addressing drug addiction with measures other than administrative detention or compulsory retention in drug detoxification centers (Vuong et al. 2011).

Health sovereignty and the role of international donors

The social and economic transformation that has taken place in Vietnam over the past three decades provides crucial context for the state responses to the epidemic described above. Initiated as a set of economic reforms, *Doi Moi* (or Renovation) has vastly increased not just economic but also social and cultural engagement with individuals and institutions outside of the country. This opening of the country to outside influences has transformed the social,

economic, and political landscape. The Gross Domestic Product increased tenfold over the following two decades, with the gap between rich and poor segments of the Vietnamese population growing even more quickly (Taylor 2004; United Nations Country Team Vietnam 2004). Vietnam became a full member of the Association of Southeast Asian Nations (ASEAN) in 1995, and has since signed many social and economic agreements with neighboring countries. The country joined the World Trade Organization (WTO) in 2006, and is negotiating with the US and eleven other countries to join the Trans-Pacific Partnership. Those economic and social reforms, however, have left the governing role of the Communist Party largely untouched. There have been improvements in terms of functioning and decision-making power in the National Assembly, but it remains weak, with nearly all of the National Assembly delegates also being Party members who are bound by an obligation to obey the Party's orders and pursue its priorities. A persistent central consideration in the National Assembly's deliberations is the impact of any potential policy change on the Party's legitimacy and grip on the society.

HIV policy transformation in Vietnam over the past decade must also be situated in the context of unprecedented global concern about, and commitment to addressing, the HIV epidemic. Unlike previous decades, the early 2000s saw the emergence of programs with global scope such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). In addition, other multilateral donors such as the World Bank and private philanthropies such as the Clinton Foundation and the Gates Foundation have been very active in funding the fight against HIV and AIDS in low and middle income countries. There have been some important differences among donors regarding their program emphasis. For example, World Bank programs focused on prevention while those of the Clinton Foundation concentrated on orphans and vulnerable children. PEPFAR has emphasized the need to support the involvement of civil society and promoted rights of at-risk groups, including MSM. Between 2002 and 2008, international assistance for HIV and AIDS from donor governments increased six-fold to more than \$ 7.7 billion US dollars, remaining at that level except for the year of 2010 during the global economic crisis (Kates et al. 2012). Thanks to this increased global commitment, countries devastated by the epidemic have seen rapid scale-up of HIV-related services, with millions of HIV positive people gaining access to once inaccessible ARVs and millions more infections having been prevented (El-Sadr et al. 2012). Such success has transformed the profile of the epidemic in many countries, especially those with generalized epidemics, halting the growing number of HIV-related deaths (e.g. in Rwanda, Tanzania) (Bendavid et al. 2012). Maintaining such success, however, is a major challenge for many countries that have depended on outside support and funding (Serieux et al. 2012).

Vietnam is a case in point. In less than a decade, total funding from various global agencies has quadrupled the annual expenditure per capita on HIV and AIDS (Vietnam Authority of AIDS Control and UNAIDS 2011) with more than 70% of national expenditure on AIDS coming from international sources. In the early years of the epidemic in Vietnam, the community of concerned donors (most notably UNDP, the Swedish International Development Agency [SIDA], and the Ford Foundation) played an especially important role in supporting small-scale programs. Then in 2004 Vietnam became the only Asian nation to receive support from PEPFAR. Since that time, PEPFAR has provided more than 500

million US dollars; in 2009–10, for example, PEPFAR paid for almost 50% of expenditures on AIDS in Vietnam. In addition, Vietnam received more than 160 million US dollars from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) since 2004, and more than 35 million US dollars from the World Bank. While Vietnamese Government funding for AIDS during the past decade increased manifold as compared to the 1990s, in 2009–2010 more than 70% of available funding still came from international sources (United Nations 2013). While typically international donors are interested in influencing government policies to create a more favorable environment for programs that they support directly, some (such as UNDP and PEPFAR) were (or have been) more involved than others (such as GFATM) in advocating for policy change.

Major changes in HIV and AIDS responses have resulted from international donors' funding and technical inputs. Notable examples include the afore-mentioned progressive law on AIDS passed by the National Assembly in 2006. This law, which provided the foundation for many programs and services that have since developed, was achieved with support from UNDP and USAID through the Health Policy Initiative, in which first the Futures Group (2005–2009) and then later Abt Associates (2008–2013) provided funding to Vietnamese organizations to support their contributions to the passage of the 2006 legal reform as well as the 2008 founding of the PLHIV Network (United States Agency for International Development 2013). Another example is the Methadone Maintenance Therapy (MMT) program, introduced as a pilot in 2008 in the two cities of Hai Phong and Ho Chi Minh and recently approved by the government for expansion to more than 40 provinces due to its highly successful outcomes, which was supported by PEPFAR through CDC, FHI360, SAMHSA and USAID. While the idea of introducing Methadone as an alternative to the 06 centers was introduced as early as 2004, many study visits and policy advocacy workshops – mostly sponsored by PEPFAR-supported agencies and its international partners (WHO for example) were necessary to secure the government approval which was granted in mid-2008 to open the pilot clinics. The approval of the Methadone program is the consequence of several factors, including the growing pressure from society in the context of government failure in addressing drug issues from both supply and demand ends, the growing awareness of the government of the advantages of the program compared to that of 06 centers, and sustained advocacy activities from both donors and civil societies. No less important is the visit of Deputy Prime Minister Truong Vinh Trong to Australia to learn about the country's methadone program success. Since then, PEPFAR-supported agencies have steadfastly provided support for the expansion of this program. They have directly or indirectly provided technical support for training and mentoring of clinical staff as well as financial support for procuring the medication and setting up clinics throughout the country.

The embrace of internationally agreed-upon best practices, however, is far from complete. Efforts to address stigma, for example, continue to coexist with relentless efforts to wipe out the “social evils” of drug use and sex work, and MSM are still forced to live in the shadows (Hammett et al. 2008; Le and Nguyen 2007; Montoya 2012; Nguyen et al. 2008; Vu, Hien, and Go 2009; Vuong et al. 2012). These challenges persist in the context of growing overall social vulnerability, as the social safety net has frayed and economic inequality has increased (Taylor 2004; United Nations Country Team Vietnam 2004). The case of drug treatment presents a telling example. While the expansion of Methadone program as well as

the transformation of 06 centers (compulsory detention centers for drug users) into voluntary drug treatment centers has been ratified by the national government, enormous resistance to transformational change exists in many corners. Any challenge to the existence of the 06 centers, for examples, must address the interests of provincial governments, which are a key stakeholder with direct responsibility for the management of such centers. Such centers in many provinces have provided those provincial governments both with a means to control local populations and with an important resource, in the form of the labor power of thousands of economically productive drug users. This is only one example of the resistance that exists to a shift towards voluntary drug treatment programs (Human Rights Watch 2011).

In light of the planned withdrawal of PEPFAR, the challenge of sustaining what has been achieved while also striving to address the substantial gaps in the response is enormous. With the goal of achieving sustainability, a number of initiatives have been taken up by the government and by external funding agencies. The government, for example, has recently developed the National Strategy for HIV/AIDS Prevention and Control for 2011 to 2020 with a vision to 2030 (Government of Vietnam 2012a), using processes of cross-sector consultation similar to those for the 2006 legislative change; the strategy features a heavy emphasis on scale-up to achieve universal access to services as well as on the development of alternative funding sources such as health insurance, public-private partnerships and user fees. The donors, especially PEPFAR, have issued contracts and grants that put more emphasis on capacity building for local institutions, including government, NGOs and CBOs, to shoulder future responsibilities. In PEPFAR's own description of its focus, there is a switch from provision of donor-funded services to provision of technical assistance for government-funded programs. Both the government and international donors are developing new, supposedly more cost-effective, models of services to meet the demand of programs in new contexts (Duong 2012).

Beyond the Vietnamese state and international donors: The growth of civil society

As mentioned above, one of the products of the HIV epidemic and the responses to it over the past two decades has been the growing legion of NGOs and CBOs involved in work related to HIV and AIDS. Internationally, there is a substantial literature on the response of social movements to the epidemic and particularly the conditions under which these movements emerge (Kippax et al. 2013; R. Parker 2011). Social movement organizations have been shown to have a dual role, serving as important service providers to PLHIV through community resource mobilization while also (at least potentially) acting as catalysts for social changes through their impact on social structures and the policy process (Petchey et al. 1998). The Vietnamese story provides examples of both types of activities.

Beginning from the late 1990s, the growing democratization caused by deeply rooted social transformations that followed the economic reforms of *Doi Moi* reduced the state's health sovereignty and introduced new actors, i.e. civil society organizations (CSOs), in various development and social spheres, particularly in the field of HIV and AIDS. This was made possible with change in government policies that for the first time sanctioned the

establishment of civil society organizations (Government of Vietnam 2002). International donors – most notably PEPFAR and the GFATM, which are the major funding sources for HIV/AIDS prevention in Vietnam – played a decisive role. One important objective of these donors has been to involve CSOs in the national responses to HIV and AIDS. For example, PEPFAR funded the Center for Community Health Research and Development (CCRD), a local NGO, to build capacity and promote the role of CBOs in the provision of HIV/AIDS related services at 9 target provinces from 2011–2016 (CCRD 2013). In a similar manner, the Global Fund (Round 9) funded three local NGOs, the Institute for Social Development Studies (ISDS), the Center for Community Health and Development (COHED), and the Life Center to establish 76 community-based organizations in 10 provinces to provide HIV prevention, care and treatment programs for over 15,000 PLHIV, 5,000 sexual partners of PLHIV and IDUs, and over 7,000 men who have sex with men (People's Representative 2013). Many international organizations, particularly the United Nations, also funded initiatives to encourage participation of CSOs. Indeed, AIDS has become the first area in Vietnam where operations of CSOs are found at the national scale, ranging from community-led programs to policy formulations. The 2006 passage of the Law on HIV/AIDS Prevention and Control was largely the result of a prolonged set of cross-sectoral consultations between the state, donors, and CSOs, including organizations of people living with HIV and AIDS. Initially, these consultations were primarily organized and supported by international donors, but with time the role of state agencies as protagonists, and their appreciation for the potential contributions of CSOs, has increased. CSOs also contribute to meeting the Vietnamese government's international commitments, particularly in the development of the 2007 and subsequent national reports to the United Nations (UNGASS reports) (Socialist Republic of Vietnam 2012). For the preparation of the 4th UNGASS Report in 2010, for example, over 2,000 people from 179 groups/networks/organizations (including 11 NGOs, 10 religious organizations, 107 self-help groups/networks of PLHIV, 23 vulnerable groups, and 28 community groups) participated in 8 workshops to provide consultation for the government and UNAIDS (UNAIDS 2011). In both cases, as well as in many other programs, international donors have been successful in engaging CSOs as a condition of their funding and technical support for the government.

Critically, HIV/AIDS activism in Vietnam has now developed into what can be termed a social movement, i.e. collective and sustained challenges based on common purpose and social solidarity among CSOs and other informal assemblies (Tarrow 1998). This phenomenon is unprecedented since, in general, collaborative activities among CSOs in Vietnam have been vanishingly rare. The state in practice has a policy to guide and manage CSOs as its extended hand, and in fact some simply function as branches of government organizations. HIV and AIDS have provided, in contrast, a unique opportunity in which interests of various stakeholders overlap, enabling the evolution of social movements. Initially this was limited to the area of HIV and AIDS, but it has since expanded, and there may be synergies with other processes also in motion that have challenged the authoritarian voice of the state in political and economic arenas. Perhaps the most compelling recent example of the broader political ramifications of the development of Vietnamese civil society was the recent open letter, signed by more than 300 prominent Vietnamese intellectuals, many of whom have played leadership roles in the formation of HIV and AIDS

policy, requesting a move away from a one-party system and state's respect of civic and political rights of citizens (Civil Society Forum 2013). While this is hardly attributable solely to the emergence of CSOs in the response to HIV and AIDS, it seems unquestionable that the successes in shaping national policy in that domain have helped create and legitimize a sector that a decade ago barely existed. CSOs have also actively promoted the legalization of marriage among the same-sex couples, taking the opportunity of the revision of the Law on Marriage and Family undertaken by the National Assembly (NA). Many National Assembly members are resistant to this change, and it seems unlikely that marriage equality will become law, although these same collective advocacy efforts on the part of CSOs will certainly result in the decriminalization of same-sex domestic partnerships. Just a few weeks before the reauthorization of the Law on Marriage and the Family in November 2013, prominent NGOs like ISDS, iSEE (Institute for Studies of Society, Economy and Environment) and CSAGA (Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents) launched an event in which several open letters, signed by over 3,000 individuals asking for same-sex marriage legalization, were sent to all 500 members of the National Assembly (The Dan 2013).

The emergence of social movements in relation to AIDS has taken shape through the interplay of four primary sets of factors. First, widespread and severe stigma and discrimination directed towards individuals living with HIV and AIDS on the part of both the state and society have forced marginalized PLHIV to connect with each other for mutual support, forming self-help groups and other informal assemblies across the country. By 2010, this included over 30 registered NGOs; 13 registered CBOs; 200 self-help groups of PLHIV; seven groups people who inject drugs (IDUs); one group of sex workers; five groups of sexual partners of sex workers; one group of sexual partners of PLHIV; 15 groups of MSM, and over 30 religious groups, all working on HIV and AIDS. The numbers continue to grow. By 2013, for example, there are already 23 groups of IDUs across 16 provinces, and 17 groups of sex workers.

Second, global actors have sought both to involve civil society in the national response to HIV and AIDS and to build capacity for their sustained engagement. USAID, for instance, has several projects administered by the Futures Group and Abt Associates to develop, strengthen, and support Vietnamese civil society advocates and networks to assume leadership in HIV and AIDS response. Recently, the organization provides up to 25 million dollars through the 5-year Pathways project to improve the sustainability of CSOs by developing organizational and technical capacity and governance systems, promoting models that achieve measurable results, increasing CSO participation in HIV and AIDS forums, and strengthening systems and platforms through which CSOs can contribute as valued participants in the national HIV and AIDS response.

Third, the influence of international donors is complemented by that of leading local NGOs (e.g. ISDS, CCRD, COHED, VICOMC) who, as suggested by the present narrative, have played perhaps the most decisive role in mobilizing social movements as a vehicle for addressing HIV. Led by ex-government officials, intellectuals, or activists who have a long experience of working with the state and remaining connected, these organizations actively strategize to enlarge the possibilities for public action by working through personal

relationships with key actors at the state level, finding informal allies, and building networks. Two notable examples of civil society alliances include the Vietnam Civil Society Platform on AIDS (VCSPA) and the Vietnam National Network of People Living with HIV/AIDS (VNP+). Established around 2010, these alliances have rapidly developed into nationwide networks that include hundreds of CSOs from most of provinces and cities across the country. VCSPA and VNP+ both employ comprehensive strategies to promote the rights of PLHIV and other social minority groups as well as civil society empowerment. Their organizational structure and governance have become increasingly formal with the establishment of national steering committee, regional and local representative offices, and working mechanism that combines both centralized and decentralized processes. VCSPA and VNP+ are well recognized by both the state and the international donors and have become strategic partners of these actors.

Last but not least, the danger of the epidemic itself has perhaps forced both the government and society to acknowledge the positive contributions of social movements to the national response, thus creating a certain legitimacy for their emergence. As publicly proclaimed by a government leader at a national conference organized by the National Committee for Prevention and Control of AIDS, Drugs and Prostitution, the Ministry of Health, and the Vietnam Union of Science and Technology Associations, “the participation of CSOs and CBOs is one of the most active, most important strategies in HIV/AIDS prevention in Vietnam”(Ngan Ha 2013).

Whether expected by the government or not, the consequences have extended far beyond the response to the epidemic. AIDS activism has moved beyond the area of HIV and AIDS to speak to other related critical social issues such as sexual diversity, gender equality, cultural identity, social inclusion, rights and social justice. Social movements on HIV and AIDS are now joined by mobilizations of previously invisible groups, such as those of gay, lesbian, and transgender minorities, CSWs, IDUs, and other assemblies of politicians, intellectuals, service providers, and interested individuals. Very recently, in August 2013 the first national network of MSM and transgender groups, called Vietnam MSM-TG, was established. The network has immediately received financial support from the Global Fund to expand and develop their organizations.

Social movements in the country are now also linked with parallel movements abroad. In August 2012, for instance, Pride parades¹ came to Vietnam under the name Viet Pride, a series of social activities including a bicycle rally, a film festival, and research presentations organized by LGBT communities in Vietnam. The event was organized in Hanoi, the capital, with wide participation of hundreds of LGBT individuals and groups as well as their supporters. Prominent on Viet Pride’s agenda was the promotion of sexual diversity and the empowerment of sexual minorities. The fact that police refrained from intervening, thus tacitly providing permission for these activities to take place, reflects the government’s changing view towards LGBT issues; in large part this is the product of tireless advocacy undertaken by CSOs during the last several consecutive years and consequent changes in

¹Pride parades are events organized in many countries by LGBT groups to celebrate their cultures and support the universality of human rights regardless of sexual orientation and gender identity.

public opinion. While international support was decisive in the successful organization of the Viet Pride 2012, which received support from UNDP and Goethe Institute, the leaders of this movement have envisioned different alternatives to assure the movement's sustainability. These include widening the resource base by approaching the private sector, including multi-national corporations, or individual contributions. They also planned their next move: Employment Equality was the focus of the Viet Pride 2013 (Rodgers 2013).

The growing power of civil society to shape the national response to HIV and health policy, however, has not gone unchallenged. Despite their officially-sanctioned existence, Vietnamese CSOs remain under strict control of the government due to fear about the political opposition that could emerge from a strong and responsive civil society. The government's concern is particularly strong since most of support for civil society comes from international donors who are exclusively "Western". Thus, unlike its counterparts in democratic countries, civil society in Vietnam cannot function as a separate sphere independent from the state, or as a counter-balance force against excessive state intrusion or misconduct. Instead, Vietnamese CSOs must (indeed, are legally required to) maintain relationships with state organizations through their formal registration with 'umbrella organizations' of the government assigned to supervise their activities. CSO's legal legitimacy depends on this operation as a hybrid form, somewhere between state and non-state organizations. The present political situation thus forces CSOs to maintain a fragile and sensitive balance between the demands of the state and of the public. The result has been a severely constrained autonomy in all areas of development, including HIV and health.

Furthermore, as international assistance is being substantially reduced and as the government and the national private sector are not traditional sources of funding, most CSOs face significant financial challenges that may limit their capacity to continue to realize their missions. Solutions presently being explored by CSOs in Vietnam include the development of social entrepreneurship, corporate social responsibility, voluntarism and an ongoing process of social change through which understandings of citizenship have been gradually redefined, with engagement in the process of policy formation and implementation reframed as acts that help constitute a modern nation and as individual assumption of the obligations associated with citizenship. The emergence of CSOs exemplifies how HIV has exposed hidden areas of social and political lives and challenged long-held beliefs and practices regarding relationships between state and society, individuals and communities, individuals and state, and citizenship. In this sense, confronting the HIV epidemic has contributed to this process of change, and how the state and society come to terms with these challenges will help to define the future of Vietnam in the next decades. Social movements will undoubtedly play a critical role in shaping the ways the country addresses these challenges.

The role of evidence in policy: knowledge-sovereignty as an element of health sovereignty

Policy may not be entirely or even mostly driven by evidence, and yet the capacity to independently define a national research agenda, and to produce the answers to critical questions, is without a doubt a vital element of health-sovereignty. One element of the sustainability of HIV and AIDS policy is the existence of local capacity to conduct rigorous

and critical research on the extent to which those policies do or do not address the local contours of the epidemic. A little noted but nonetheless key lesson from history of HIV and AIDS, therefore, is the importance of institutional investment in research development. Universally (and this has certainly been true in Vietnam as well) research on HIV and AIDS was initially impeded by the stigma and discrimination associated with the epidemic itself, with many of the early HIV researchers working in relative isolation, and often in marginalized institutional settings or capacities, so that building a meaningful scientific community for AIDS research (and especially for research on the social dimensions of the epidemic) was an ongoing challenge.

In the USA as well as in developing countries such as Brazil and South Africa, where significant, policy relevant bodies of social science research on the epidemic have been most successfully developed (Pouris and Pouris 2011), it is impossible to understand the productivity and contributions of committed individual researchers without also considering the institutional climate in which they work. NIH funding played a critical role in this regard in the United States, as did mechanisms aimed at building researcher communities such as the AIDS and Anthropology Research Group (AARG) and the Sociologists' AIDS Network, which were critical in supporting the early social science research response to the epidemic in the USA. The Brazilian Interdisciplinary AIDS Association (ABIA) or the Network for HIV/AIDS Research in Nigeria (NARN) have played a similar role in key developing countries, as have networks such as the AIDS and Reproductive Health Network (ARHN), the NIH-sponsored HIV Prevention Trials Network (HPTN) and the HIV Vaccine Trials Network (HVVN), or the International AIDS Society (IAS) at the global level. Without such mechanisms to build research communities, researchers remain isolated, and research findings fail to circulate; these networks have played a critical role in the research communities which have grown in many of the countries and regions most affected by HIV and AIDS. Vibrant research communities, in turn, have been crucially important in mobilizing more effective policy and social responses to the HIV epidemic: this has been clearly documented both in the case of Brazil's mobilization against on AIDS in the 1990s and early 2000s and in the case of South Africa's ability to overcome misguided policy leadership and reorient its response to the epidemic in the late 2000s and the early 2010s (Berkman et al. 2005; Pouris and Pouris 2011).

A further problem then, of the impending withdrawal of international donors, is the very limited Vietnamese capacity for generating the evidence necessary to inform the country's response to HIV and AIDS. In striking contrast to the strong emphasis on building clinical capacity as an element of sustainability (The US President's Emergency Plan for AIDS Relief 2011) PEPFAR's efforts have made no effective provision for capacity-building in relation to research infrastructure, and provide no support for strengthening the ability of the HIV and AIDS research community to develop critical, theory-driven, evidence-based science on the most important prevention, treatment and policy questions confronting the national response to the epidemic in Vietnam. Vietnamese research institutions that have been heavily supported by bilateral aid face challenges that parallel those faced by the state, in terms of seeking new funding sources to sustain and continue to build infrastructures that could not have emerged through Vietnamese efforts alone. The infrastructural weaknesses that characterize many universities (limited salary support for faculty, tightly-centralized yet

inefficient administration of resources, weak to non-existent research infrastructure) constituted major barriers to the development of HIV research capacity in Vietnam's state-run universities and research centers. The vast external funds that began to pour into the country within a relatively short period of time as the result of PEPFAR and similar Global Health Initiatives, perhaps ironically, created new human resource challenges, beyond even those noted in terms of clinical capacity (Friedman et al. 2006; Sumartojo 2000; Davis and Howden-Chapman 1996). The opportunities for external consultancies offered by well-funded, multi-lateral organizations have led to a kind of 'brain drain' from universities to the local and international NGOs that leapt at the opportunity to compete for donor funding (Vasquez et al. 2013).

The programmatic research that has been supported in parallel with the scale-up of HIV prevention, care and treatment in Vietnam has helped formulate and evaluate specific interventions and supported the national response to the epidemic, but it has two important shortcomings. First, it gives short shrift to underlying social processes as well as to changes outside program boundaries that may have significant impacts on the results. A more vibrant and critical community of social science researchers working on HIV and AIDS could play a vital role in ensuring that the Vietnamese response continues to take into account social dimensions of the epidemic. The development and relatively superficial evaluation of behavioral interventions, for example, does little to articulate the broader structural factors that shape risk or the barriers to adopting policies that might attenuate these risks. Second, the intense focus on program evaluation does not build local capacity to engage critically with the influx of ideas, blueprints and best practices, often presented as proven solutions and applied wholesale without any consideration of adaptation or even of appropriateness to the local context. The current social organization of AIDS research in Vietnam thus constitutes an additional set of barriers to building the local expertise necessary to explore adequately how policy makers, program managers, targeted beneficiaries and the broader Vietnamese society should adopt approaches to HIV and AIDS that have been built elsewhere. It is possible, however, that the new donor interest in "good evidence" (as measured by publications in peer-reviewed journals demonstrating that their investments have paid off) may have unintended (but in this case positive) impacts on the reward structure for academic productivity.

Furthermore, most program evaluations conducted within the context of large-scale GHIs failed to generate peer-reviewed publications; the occasional products of rigorous training for academic degrees and of international cooperation for research capacity building (Natividad, Fiereck, and Parker 2012; Chen et al. 2004; Kober and Van Damme 2004; System wide Effects of the Fund(SWEF) Research Network 2003; Hughes 2006) are the exception rather than the norm. In the case of Vietnam, an extensive review of international literature for HIV research from Vietnam during the period from 2005 to 2011 turned up little more than 200 articles in international peer-reviewed journals, with only a handful theoretically and/or methodologically rooted in social sciences (Ministry of Health-Vietnam 2012). This lack of more sophisticated social research capacity, together with the operations-research focus of most available research funding and the narrow focus on program evaluation in the limited research conducted by NGOs and INGOs, has severely constrained the extent to which it has been possible to answer important questions for policy formulation

and program implementation in Vietnam. Looking forward, one under-considered element in the sustainability of country HIV and AIDS programs facing the looming withdrawal of substantial donor funding may be the ways in which academic sector is or is not able to serve as an institutional context to train a new generation of social entrepreneurs, engage them in questions related to HIV and AIDS, and provide them with a set of enduring connections to independent intellectuals from around the world who are working under diverse conditions to press for a continued robust national response to HIV and AIDS.

Conclusion

There is no question that more work remains to be done to detail the contested terrain of HIV policy formation and implementation in Vietnam. A thick description of the effects of these parallel processes (i.e. increased national ownership and decreased global intervention) on scale-up could reveal the complexities of on-going challenges to public health systems, which are confronted by policy makers, front-line health care workers, CSOs, vulnerable populations, and people living with HIV. An even more in-depth country-level case study also has the potential to capture how global phenomena are affecting people and interventions on the ground. Equally important, no studies that we know of have taken into account political culture to uncover the intricacies of the ‘real-life’ decision-making in HIV policy processes.

The assessment of HIV scale-up in Vietnam by international donors has indicated a level of ‘readiness’ on the part of decentralizing health structures and delivery systems that (to them at least) justifies their withdrawal. Further work on the actual implementation of policies and the lived experience of health care managers, however, might reveal substantial further needs, such as for additional capacity building in the provision of culturally appropriate services, or support for increasing access to services for the most vulnerable populations. The fact that cultural factors, such as those that perpetuate systematic stigma and discrimination experienced by people living with HIV and AIDS, have not been taken into account sufficiently in studying or analyzing the process of scale-up or HIV policy formation and implementation more broadly (Rudolph et al. 2012) suggests that such work is extremely important. The sustainability of scale-up in Vietnam, as in other parts of the world, urgently requires attention to how “ownership” of the response to the HIV epidemic is mediated by the ideologies and cultures that affect commitment and accountability (Trapence et al. 2012), as well as greater exploration of the potential of ground-level community and social mobilization to overcome barriers that affect programmatic implementation and sustain programs over time.

The Vietnamese case also speaks to some of the more general questions raised by this special issue. Firstly, it clearly highlights the complex intersection between global institutions (ranging from binational and multinational agencies to private foundations) and local partners (ranging from the government at national to local levels and to emerging civil society). The power of global institutions is substantial, but we should not regard it as inexorable; the Vietnamese case suggests that the role of global institutions is particularly critical at junctures when the state is unsure – or when there is internal dissension – about how to respond to an emerging crisis. At the same time, however, the state is hardly passive.

The persistence, for example, of the 05 and 06 detention centers, despite the global opprobrium to which they have been subject, underlines the intense moral (and perhaps financial) interests within Vietnam that have ensured their continued existenceⁱ. The focus of the emerging sexual rights movement on employment rights is another instructive example, in which a political agenda with substantial international support is filtered through the local landscape of the possible: the right to work fits much more comfortably within existing ideas about obligation to kin groups and modern citizenship than would a focus on the right to love, not to mention the right to pleasure. The outcome of these long negotiation processes, involving multiple sectors and stakeholders at the global and national levels, have generally settled – perhaps not surprisingly – on outcomes deemed globally acceptable and nationally beneficial.

A second characteristic of these often protracted processes of negotiation that is of more general relevance is the way in which civil society organizations have creatively played alongside the state and the donor community in Vietnam's political space. They have tried to shape and influence these negotiations to the greatest extent possible, while simultaneously trying to extend the boundaries of the possible. This has included providing input and even influencing negotiations as much as opportunities have allowed. As a result, the policy or program outcome frequently fails to satisfy any party in the policy arena, creating a context of perpetually unsatisfied political interests and continued instability (or, seeing it differently, continued opportunity). A concrete example would be the incremental change in policy for introducing methadone maintenance treatment in Vietnam. While methadone was first tested as a treatment modality for heroin users in early 2000s and there were growing interests in mid 2000s, the first pilot program in two provinces was not sanctioned until 2008. It took another four years (until 2012) for the government to introduce a decree (Decree 96/2012) that allowed the expansion of methadone maintenance in the country (Government of Vietnam 2012b). While the government was boasting of this decree as a break-through in the policy agenda towards drug abuse, the donor community and those who are directly affected by this policy (including drug users and health care workers) felt that the decree left a great deal to be desired. The process has developed into one in which change is incremental and ongoing, rather than occurring in a way that might look like a substantial break from the past. The more contentious the issues of interest, the more incremental the changes in the policy outcomes have been. This raises the question for future policy research about whether this perpetual process of small improvements is the norm rather than exception, as well as about the circumstances under which more transformational change in public health policy might be possible.

The Vietnamese case also reminds us of the critical importance of timing for policy intervention. It is no coincidence that the HIV policy change in Vietnam did not begin to gather steam until the mid 2000s, despite international efforts dating back to the late 1990s. It is also not a coincidence that the LGBT civil society organizations made a number of significant breakthroughs in late 2000s and early 2010s, almost a decade after initial success

ⁱThe recent policy shift in China involving the abolition of the “re-education through labor” (Buckley 2013) system hints both at potential for future comparative work on the circumstances under which the world's few remaining one-party states respond to international pressure regarding policies that have been the subject of widespread criticism.

by CSOs in shaping HIV and AIDS policies. The insight to draw from this sequencing is not that the cumulative effects of change necessitate reaching a certain threshold for things to happen. That sort of determinist, mechanical view of the history of policy fails to take into account the historical and political context of change, including the ways in which conflict within the government agencies may have opened up new opportunities for civil society organizations to push for change. Questions that are relevant for future policy research include: What are historical, political and social factors that create an environment amenable to health policy change (without regime change)? What are factors that make change sustainable?

These issues of timing, in particular, may have important implications when compared with the experience of other countries that are experiencing similar process of scale-up – and in some instances, scale-down – in relation to HIV and AIDS or through other GHIs. Although Vietnam's unique social, cultural, political and economic circumstances necessarily mean that many aspects of its response to the HIV epidemic will necessarily have their own particular characteristics, the intense process of scale-up that has taken place in response to HIV in Vietnam, together with certain aspects of its size and scale, perhaps magnify the impact of scale-up in a number of important ways. This, in turn, may also offer important insights into the relationship between national authorities and international donors, between bilateral and multilateral as well as public and private donors, and between civil society and both government as well as donors. These insights have implications for other countries undergoing similar process in terms of the challenges that they may face, dilemmas that may emerge, conflicts and tensions that can be expected, and perhaps other questions as well. In addition, since it appears that scale-down, through the withdrawal of major donors and the curtailment of major initiatives, may be expected more rapidly in Vietnam than in some countries, the Vietnamese experience may offer insights for what can be expected elsewhere, albeit perhaps less quickly, as a result of almost inevitable changes in the funding and policy priorities of a notoriously rapidly changeable domain of health policy. By extension, precisely because the social, policy and programmatic response to HIV has so often been the trial run for innovations that have then later been expanded more broadly, frequently becoming normative approaches in global health more broadly, the careful investigation of cases such as the scale-up of HIV policies and programs, in Vietnam and elsewhere, can clearly provide important opportunities for extending and interrogating theoretical frameworks that may prove insightful in relation to a range of other major global health problems and initiatives.

A final point is about the unintentional ways in which health policies shape the social terrain. Scholarship on health policy has come to take the social into account as a matter of course, exploring the ways in which cultural framings, social institutions, historically-determined interest groups and entrenched patterns of inequality shape and constrain the formation of health policies. The Vietnamese case reminds us, however, of the importance of turning that around and examining how health policies shape the social terrain in areas far beyond health policy and population health. The unexpected consequences of HIV scale-up and donor involvement have included, for example, Hanoi Pride 2012, a public event which would hardly have been imaginable only a decade before. Nor should one be too celebratory about the valence of the unintentional; as noted above, there have been significant negative

consequences of scale-up in terms of the ways in which the structure of global funding has created disincentives for independent health scholarship (Vasquez et al. 2013). This final observation just underlines the critical nature of further work on the interplay between global actors, civil society, and the state in shaping health policy. It raises a set of questions that are vital not just for understanding what shapes the health of societies, but also for understanding broader questions about the processes of social change.

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