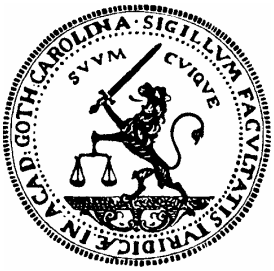

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The Human Right to Health
A Study of HIV/AIDS in Vietnam

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Contents

Summary

Although infectious diseases kill around 17 million people a year, some states spend less then one percent of their budget on health. The promotion and protection of health is a fundamental condition for well being and the possibility to leave a life in dignity. The world has now for 20 years been facing an extremely dangerous epidemic. In Vietnam the first HIV infection was reported in 1990 and today it is estimated that 292 930 persons are infected with HIV. The disease continues to spread with up to a 100 new people infected each day.

Experience in the fight against the HIV epidemic has showed that promotion and protection of human rights is of utmost importance in prevention the disease and reducing the impact of HIV. The human right to health is protected in a number of international legal instruments, including the ICCPR, the ICESCR, the CEDAW and the CRC. With a progressive interpretation as done by for example the ICESCR Committee in its general comments a rather good base for combating the disease could be found. Some obligations have an immediate character whereas others impose an obligation to take steps to the maximum of state parties' available resources. Vietnam is a state party to the above mentioned treaties.

Although international legal instruments can assist in the combat against HIV the ultimate effectiveness is dependent on measures taken by Governments to give effect to their international legal obligations. It took many years since the first reported disease in 1990 before Vietnam adopted any real substantial legal measures to combat HIV. A new National HIV Strategy was adopted in 2004 and later backed up by a new law on HIV in June 2006.The law on the Prevention and fight against HIV was a significant improvement and a piece of legislation compared to existing legislation in neighboring countries.

Nevertheless in terms of health programmes to aid PLHIV, as well as the actual implementation of the laws on a practical level, a great deal of work remains. The law still does not provide free treatment to large groups of the population and only around 20 percent of the population is covered by insurance. Most children above the age of 6 years stand without any protection. There is also a lack of provisions to address the prevention of sexual transmissions of HIV and the vulnerability of women and girls. In addition, more could be accomplished in order to address the stigma and discrimination against people living with HIV.

The most obvious shortcomings are to be found when looking at existing practices. The Vietnamese health care system is hierarchal and the lower district and commune levels don't have the capacity to provide high quality services. The salaries are low and as a result qualified doctors work in the higher sectors. People tend to avoid district and commune level health care facilities which make the central hospitals overcrowded. Private expenditure now accounts for 72 percent of all health spending in Vietnam. The 2006 world health report places Vietnam among the countries in the world with the highest out-of pocket spending on health in the world. The government of Vietnam has chosen to focus on high risk populations in order to combat the disease. In doing so other groups has been left out, mainly women. There is a great

threat that the disease will continue to spread in large numbers from high risk populations to the general public.

Preface

I want to thank my wonderful parents Karin and Krister Jonzon for their constant support and love without whom this thesis would ever have been written. I am also most grateful to Christina Vo for her bright inputs as well as for her patience and encouragement.

Johan Jonzon

Malmö, 5th of July, 2008

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Abbreviations

ACHR	African charter of human rights
ADB	the Asian Development Bank
AIDS/	acquired immunodeficiency syndrome
ARV	antiretroviral
ART	antiretroviral therapy
ASO	AIDS service organization
CBO	community-based organization
CEDAW	convention on the elimination of all forms of discrimination against women
CIS	commonwealth of independent states
CRC	convention on the rights of the child
DFID	the UK Department for International Development
ECHR	European convention on human rights
GDP	gross domestic product
GFATM	the Global Fund to fight IIDS, TB and Malaria
HIV	human immunodeficiency virus
HRC	human right council
HCMC	Ho Chi Mihn City
IBBS	Integrated Biological and Behavioral Surveillance report
ICCPR	international covenant on civil and political rights
ICESCR	international covenant on economic social and cultural rights
IEC	information, education and communication
IIDS	intensity disparities
IDU	injecting drugs users
IGO	with HIV
UDHR	universal intergovernmental organization
MOH	Ministry of Health
NGO	non-governmental organization
PEPFAR	President’s Emergency Plan for AIDS Relief
PLHIV	people living declaration of human rights
TB	tuberculosis
UN	united nations
VAAC	Viet Nam Administration of HIV/AIDS Control
VCT	voluntary counseling and testing
VND	Vietnam dong
WHO	world health organization

1 Introduction

1.1 Introduction to the Topic

"If we believe men have any personal rights at all as human beings, they have an absolute right to such a measure of good health as society and society alone is able to give to them."[1]

Infectious diseases are killing about 17 million people a year. Chronic diseases kill more than 24 million people a year – equal to almost half of all deaths worldwide.[2] Maternal deaths still occur at an unacceptably high rate and for many low-income countries, the majority of deaths still occur among children under the age of five.[3] Regarding environmental health, about three million deaths are estimated to result from air pollution each year. Estimates suggest that there are up to 160 million cases of occupational diseases worldwide each year, of which 30-40 percent may lead to chronic disease, and approximately 10 percent leading to permanent work disability.[4] Despite the alarming health statistics, some States spend less than one percent of their budget on health.[5] It is also observed that gains in health are not shared equally and that within countries health disparities have widened.[6] The promotion and protection of health is a very important condition for well being and a foundation for leading a dignified life.[7]

Within the scope of health and human rights, the author has chosen to focus on the right to health related to HIV because it is an imminent threat to human well-being and to the possibility of living a life in dignity. Practices and programmes that could rapidly improve life for people infected with HIV are available. Apart from the individuals who are suffering from the disease itself and potentially facing stigma and discrimination, the disease has a tremendous negative impact on the society as a whole. Children are left to grow up without any parents and large groups of the society lose an active part of its work force. Preventing HIV/AIDS can foster socioeconomic growth and development; it is known that poor health in many cases can lead to increased poverty.

This thesis focuses on HIV/AIDS in Vietnam because it is one of the most progressive countries in the region when it comes to HIV legislation and the country

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[1] This quotation is attributed to Aristotle by Von Wartburg, 1979, p. 112, first found in The Right to Health as a Human Rights in International Law, Birgit C.A. Toebes, 1999, page. 3.
[2] WHO, World Development Report 1996, p.1.
[3] WHO, Health for All: Origins and Renewal, Reflection on a changing world (draft), Geneva 1997.
[4] WHO, World Health Report 1997, pp. 13 and 65.
[5] World Bank, World Development Report 1995, pp. 180-181.
[6] WHO, Health for All: Origins and Renewal, Reflection on a changing world (draft), Geneva 1997.
[7] The Right to Health as a Human Rights in International Law, Birgit C.A. Toebes, 1999, page. 3

has significantly increased efforts to hinder further spread of the disease and its impact on Vietnam's socioeconomic development. Despite Vietnam's commitment to reduce the spread of the disease, there is still a need for imminent and increased action in order to halt the spread, improve the situation for PLHIV, and prevent future negative impact on the Vietnamese society and development.

Combating HIV/AIDS, malaria and other diseases is the sixth Millennium Development Goal, and its target is to halt and begin to reverse the spread of the disease by 2015.[8] The spread of HIV infections has been halted in the richer, developed regions of the world; however continues to spread with an increasing speed in many parts of the developing world. It is estimated that 39.5 million people were living with HIV by the end of 2006, which is an increase from 32.9 million in 2001. Some 14 million children have been orphaned by AIDS.[9] The worst situation is to be found in sub-Saharan Africa where 4.3 million people were newly infected with the virus in 2006 and the fastest rates of infection were to be found in Asia and the CIS. The number of people dying from AIDS has increased from 2.2 million in 2001 to 2.9 million in 2006. The main mode of transmission in the CIS countries and Asia is drug injection and the use of non-sterile equipment.[10] In Southern and South-Eastern Asia, people are most often infected through unprotected sex with sex workers. In recent years HIV outbreaks have become evident between men who have sex with men in Asia, in Cambodia, China, India, Nepal, Pakistan, Thailand and Vietnam.[11]

In order to effectively address and halt the spread of HIV/AIDS, the inequality between women and men must also be addressed as an increased number of girls and married women are being infected. At the present time, 48 percent of the people living with HIV in the world are women. [12] The young population, particularly young women, is vulnerable having the fastest rates of infection.[13]

Globally a number of interventions and programmes are in place to combat HIV/AIDS, as witnessed by the nearly 30-fold increase in HIV programmes in the course of the last decade.[14] Nevertheless the number of people receiving treatment continues to increase and it is estimated that 2 million people had access to ARV treatment in developing regions of the world in 2006. However, it should be mentioned that those treatment efforts only cover 28 percent of the estimated 7.1 million people in need of treatment. In the year of 2006 alone, 4.3 million people

[8] The Millennium Development Goals Report, Published by the United Nations Department of Economic and Social Affairs DESA - June 2007, p. 18.
[9] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS GENEVA SWITZERLAND, p. 5.
[10] The Millennium Development Goals Report, Published by the United Nations Department of Economic and Social Affairs DESA - June 2007, p. 18.
[11] The Millennium Development Goals Report, Published by the United Nations Department of Economic and Social Affairs DESA - June 2007, p. 18.
[12] The Millennium Development Goals Report, Published by the United Nations Department of Economic and Social Affairs DESA - June 2007, p. 19.
[13] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS GENEVA SWITZERLAND, p. 5.
[14] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS GENEVA SWITZERLAND, p. 5.

were newly infected, underscoring the imminent need to step up the efforts. [15] Stigma and discrimination towards PLHIV are discouraging a lot of people from taking HIV tests and disclosing their status to sexual partners.[16]

In Vietnam, the first case of HIV infection was reported in December 1990 in Ho Chi Minh City. By 1992, only 11 cases had been reported, but in 1993 there was a sharp increase in the number of reported cases.[17] Currently, there are approximately 292,930 people living with HIV/AIDS (up from 96,000 in 1999).[18] By the end of 2005, 56,600 Vietnamese people had lost their lives to AIDS.[19] The Ministry of Health estimates that between 18,000 and 39,000 people contract HIV every year – 50 to 100 new infections daily. The national HIV-prevalence rate among adults ages 15-49 was estimated to be 0.5 percent at the end of 2005.[20] Prevalence rates have, however, reached generalized levels (greater than 1 percent nationally) in several areas, including Ho Chi Minh City (1.25 percent), Quang Ninh (1.15 percent), and Hai Phong (1.15 percent).[21]

Over the years a number of international commitments and declarations have been adopted in order to strengthen the position of human rights in relation to HIV. The most important among these are: the Declaration of Commitment on HIV/AIDS; the Millennium Development Goals;[22] general comment 14 of the Committee on Economic, Social and Cultural Rights;[23] and the Commission on Human Rights resolutions on the right to the highest attainable standard of health[24] and access to medication.[25]

"All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of the States, regardless of political,

[15] The Millennium Development Goals Report, Published by the United Nations Department of Economic and Social Affairs DESA - June 2007, p. 19.
[16] The Millennium Development Goals Report, Published by the United Nations Department of Economic and Social Affairs DESA - June 2007, p. 19.
[17] Socialist Republic of Vietnam: Second country report on following up the implementation to the declaration of commitment on HIV/AIDS January 2003 – December 2005.
[18] Ministry of Health of Vietnam, Estimation and Projection of HIV/AIDS in Vietnam 2001-2005.
[19] Ibid.
[20] Joint United Nations Program on HIV/AIDS (UNAIUDS), 2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition, 485.
[21] Ministry of Health of Vietnam, Estimation and Projection of HIV/AIDS in Vietnam 2001-2005.
[22] United Nations Millennium Declaration, General Assembly resolution 55/2 of 8 September 2000.
[23] General comment 14 on the right to the highest attainable standard of health.
[24] Commission on Human Rights resolution 2002/31 of 22 April 2002.
[25] Commission on Human Rights resolutions 2002/33 and 2002/32 of 22 April 2002.

economic an cultural system, to promote and protect all human rights and fundamental freedoms."[26]

1.2 Subject and Aim

In this thesis, the author will examine how Vietnam is complying with its international obligation in regard to HIV by implementing relevant legislation and by materializing the rights in to practice. By placing the study in a broader national and international legal context, the author will analyze how Vietnam has succeeded in implementing its international obligations.

In the first step, the author intends to scrutinize which obligations follow from the relevant international conventions that Vietnam has ratified, including the Universal Declaration for Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic Social and Cultural rights and the Convention on the Elimination of All Forms of Discrimination Against Women. Secondly, the internal legislation as well as praxis in the field will then be examined in order to compare it with Vietnam's international obligations. As a third step, the actual implementation of Vietnam's national legislation will be scrutinized. The author aims at evaluating how Vietnam is fulfilling its obligations to protect PLHIV and prevent the spread in Vietnam. The right to health evokes both civil and political human rights as well as social, economic and cultural human rights.[27] The central focus of this thesis will be will be on social, economic and cultural rights.

1.3 Definitions and Delimitations

The right to health is a broad concept and I have chosen to focus only on HIV/AIDS (hereinafter referred to as HIV) because of how the disease undermines individual's prospect of living a life in dignity and because of the tremendous negative impact the HIV has on the society as a whole. As acknowledged above the right to health evokes both civil and social human rights. I'm bringing both of them up in this work but I will lay my emphasis on economic and social rights. I have chosen to focus on the most important legal instruments relevant for the right to health. There are a number of other treaties and other agreements that are relevant in regard to HIV aids but that has been left out because of restraints in time and space.

1.4 Method and Material

In order to scrutinize how Vietnam is complying with its commitment to combat HIV it has been necessary to examine Vietnam's international obligations. In addition, this framework needs to be compared with the existing legal structure and provisions in

[26] Vienna Declaration and Programme of Action, World Conference on Human Rights.
[27] WHO, Questions and Answers on Health and Human Rights, 2002, p. 10.

Vietnam. Even though national legislation might be in accordance with imposed international standards and obligations, it is necessary to look at the actual practice and the end result of those laws. To reach this goal, the author has compared the international and legal framework with the actual practices in regard to HIV carried out in Vietnam through interviews with representatives from NGOs and international organizations active in Vietnam. These qualitative interviews from various organizations have been examined to understand the current practice regarding HIV in Vietnam.

1.5 Disposition

Chapter 2 gives a historical and philosophical background the right to health. The existing legal regimes on the international level in regard to the right to health has been examined and then mainly UDHR, ICCPR, ICESCR; CEDAW. Since the ICESCR has a central role in regard to the right to health in this field, the focus has remained with this Covenant. Chapter 3 aims at examining if and how the imposed obligations are being incorporated into national legislation. Chapter 4 has examined what is actually being done in the field. Chapter 5 intends to conclude how Vietnam is fulfilling its international obligations to combat HIV aids combined with personal remarks.

2 The Right to Health in International Human Rights Law

2.1 Introduction

This thesis focuses on HIV/AIDS in Vietnam because it is one of the most progressive countries in the region when it comes to HIV legislation and the country has significantly increased efforts to hinder further spread of the disease and its impact on Vietnam's socioeconomic development. However more needs to be done in order to clarify and implement existing legal framework. Practices also need to be improved in order to combat the rapid spread of HIV. Clarify State obligations with regard to the right to health, which will be accomplished based on an interpretation of treaty texts that Vietnam has accessed. "The right to health as a Human Right in International Law" by Birgit C.A. Toebes has served as an important source of inspiration for this chapter.[28]

Experience in the fight against the HIV epidemic has showed that promotion and protection of human rights is of utmost importance in preventing the disease and reducing the impact of HIV and AIDS. There are no opposing objectives between the observance of human rights and public health care.[29] For example the human rights perspective could avoid discrimination and stigmatization and thus increase the number of people getting in contact with the public health care institutions. In the same way public health objectives could strengthen human rights by putting special emphasis on vulnerable groups in the society. The best result is obtained when both concepts are combined.[30]

Human rights law legally guarantees human rights, protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. They include what are known as civil, cultural, economic, political and social rights. Human rights are principally concerned with the relationship between the individual and the state.[31] Governmental obligations with regard to human rights fall under the principles of respect protect and fulfill. The obligation to fulfill contains obligations to facilitate, provide and promote. [32]

The human right to health is recognized in numerous different forms, such as the formulation of health polices, or implementation for health programmes developed by

[28] The Right to Health as Human Rights in International Law, Birgit C.A. Toebes, 1999 (Hereinafter referred to as Tobes).
[29] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS GENEVA SWITZERLAND, p. 77.
[30] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS GENEVA SWITZERLAND, p. 78.
[31] 25 Questions & Answers on Health and Human Rights, Health & Human Rights Publication Series Issue No. 1, July 2002.
[32] The right to the highest attainable standard of health, E/C.12/2000/4 (General Comments), 11/08/2000, para. 1.

the World Health Organization (WHO) or the adoption of specific legal instruments. Moreover, the right to health includes certain components, which are legally enforceable.[33]

Article 38 (1) of the Statute of the International Court of Justice is widely recognized as the most authoritative statement as to the sources of international law.[34]

"The Court, whose function is to decide in accordance with international law such disputes as are submitted to it, shall apply:

a) *international conventions, whether general or particular, establishing rules expressly recognized by the contesting States;*
b) *international custom, as evidence of a general practice accepted as law;*
c) *the general principles of law recognized by civilized nations;*
d) *subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law."*

As a consequence of Article 38 in the Statute this thesis will have its main focus on the international conventions relevant to the right to health.

A number of expert committees have been established under particular UN treaties.[35] Based on their experience with the state reporting procedure Committees also publish general comments[36] or general recommendations[37]. Decisions taken during the complaints procedures, together with these general comments and recommendations, constitute the main source of interpretation for the rights and other provisions contained in the respective treaties,[38] as a result, this thesis will elaborate upon them. The author's intention in this chapter is to describe both the international human right laws legislation regarding the right to health and also document the legislation that specifically refers to HIV.

Numerous charters and declarations, which specifically or generally recognize the human rights of people living with HIV, have been adopted at national and international conferences and meetings, see Annex 1. The most important commitments in recent days in relation to HIV/AIDS are the following:[39] the

[33] The right to the highest attainable standard of health, E/C.12/2000/4 (General Comments), 11/08/2000, para. 1.
[34] International law, Malcom n. Shaw, Cambridge University Press, fifth edition, 2003, p. 66 (hereinafter referred to as Shaw) and Principles of public international law, Brownlie, Oxford, Sixth Edition, 2003, p. 5.
[35] Shaw p. 289.
[36] Article 40(4) CCPR; article 19(3) CAT; Article 45(d) CRC.
[37] Article 19 CESCR; Article 9:82) CERD; Article 21(1) CEDAW.
[38] Introduction to the International l Human Rights Regime, Manfred Nowak, The Raoul Wallenberg's Institute Human Rights Library, 2003, p. 99.
[39] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS GENEVA SWITZERLAND, p. 11.

Declaration of Commitment on HIV/AIDS; the Millennium Development Goals;[40] general comment 14 of the Committee on Economic, Social and Cultural Rights;[41] and the Commission on Human Rights resolutions on the right to the highest attainable standard of health[42] and access to medication.[43]

Global initiatives to resolve, halt and reverse the epidemic continue to be strengthened. In the 2005 World Summit Outcome , world leaders committed to a massive scaling-up of HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it.[44]

2.2 The Universal Declaration of Human Rights

Article 25.1 of the UDHR affirms:

"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services."

UDHR is a progressive piece of document encompassing both the first generation of civil and political rights as well as the second generation of human rights (economic, social and cultural rights). In this way the declaration pre-empted the concept of interdependence and indivisibility of all human rights, which was not formally recognized until 1993, in the Vienna Declaration and Programme of Action. This is still a matter of controversy for most industrialized countries. Additionally the declaration states, in article 28 that: "everyone is entitled to a social and international order in which the rights and freedoms set fort in this Declaration can be fully realized". The UDHR is formally a resolution of the GA, and as such not binding under international law, but it still represents an authoritative interpretation for the term "human rights" in the UN Charter, an thus can be considered indirectly constituting international treaty law. No doubt some of its provisions, such as the prohibition of torture and slavery, today enjoy the status of customary international law, but it is still doubtful whether the Declaration as a whole can be considered as having achieved this status.[45]

As the right to health is mentioned in above quoted article 25.1 it has to be brought up in this thesis. It is though part of the second generation of human rights and hope

[40] United Nations Millennium Declaration, General Assembly resolution 55/2 of 8 September 2000.
[41] General comment 14 on the right to the highest attainable standard of health, adopted on 11 May 2000 (E/C.12/2000/4).
[42] Commission on Human Rights resolution 2002/31 of 22 April 2002.
[43] Commission on Human Rights resolutions 2002/33 and 2002/32 of 22 April 2002.
[44] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS GENEVA SWITZERLAND, p. 12.
[45] Introduction the International Human Rights Regime, Manfred Nowak, The Raoul Wallenberg's Institute Human Rights Library, 2003, p. 76.

could be expressed for that countries will regard it as a binding human right obligation and thus make sure the right to health and other social, cultural and economic rights constitute customary international law. It is according to the author currently hard to regard article 25 in UDHR as binding according to customary international law of today since a lack of opinio juris and state practice.

2.3 The International Covenant on Civil and Political Rights

Several of the Covenants articles address integral components of the right to health. These rights include the right to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedom of association, assembly and movement.[46]

Vietnam became a state party to the ICCPR through accession on the 24 September 1982. The ICCPR came into force upon receiving the necessary number of ratifications on the 23 March 1976.[47] Given that the Covenant has universal coverage it is probably the most important human rights treaty in the world and the author notes that it has been incorporated into the domestic law of many state parties.

The Covenant on Civil and Political Rights remains the most important international human rights treaty.[48] Until the present date 165 states have become a state party to the Covenant.[49] Similarly, the process recognizing the individual communications procedure under the first Optional Protocol is accelerating. Additionally the Covenant's provisions truly realizes in the daily practice of States Parties, booth in the actions and behaviour of State authorities and law enforcement officials, as well as in the day-to-day relations between private individuals.[50]

Art. 2(1) of the Covenant obligates the States Parties to respect all the Covenant's rights and to ensure them to all individual within their territory and subject to their jurisdiction. The ICCPR imposes not only negative obligations, in contrast to the obligation to respect Covenant rights, the obligation to ensure them is a positive duty, which is inherent not only in economic social and cultural rights but also in political and many civil rights. State Parties are obligated to take positive steps to give effect to these rights.[51] Article 2 requires that States Parties adopt legislative, judicial, administrative, educative and other appropriate measures in order to fulfill their legal

[46] General Comment No. 14, Para. 3.
[47] http://www.ohchr.org/english/bodies/ratification/4.htm (last visited 20 October 2007).
[48] CCPR Commentary, Manfred Nowak, Kehl am Rhein; Strasbourg; Arlington: Engel 1993, p. XXVIII.
[49] http://www.ohchr.org/english/bodies/ratification/4.htm (last visited 20 October 2007).
[50] CCPR Commentary, Manfred Nowak, Kehl am Rhein; Strasbourg; Arlington: Engel 1993, p. XXVIII.
[51] CCPR Commentary, Manfred Nowak, Kehl am Rhein; Strasbourg; Arlington: Engel 1993, p. 36-37.

obligations.[52] The article 2, paragraph 1, obligation to respect and ensure the rights recognized by in the Covenant has immediate effect for all States parties.[53] This is of course a central point as it makes it easier to establish a right or to point out a violation than if an article states progressive fulfillment. Although The Covenant in substance provides a broader scope of application than the ECHR or the ACHR, the international monitoring system compared to that of the two regional Conventions leaves a lot to be desired. Until today, The United Nations has not been able to decide on the establishment of an international court of human rights and the Human Rights Committee's decisions are not legally binding.[54]

2.3.1 The Right to Life Under ICCPR

Article 6 in the ICCPR might be the most important provision in regard to health since it guarantees the most fundamental right of al, namely to live. Without this right all other right must be deemed as irrelevant. Article 6 reads as follows.

1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

2. In countries which have not abolished the death penalty, sentence of death may be imposed only for the most serious crimes in accordance with the law in force at the time of the commission of the crime and not contrary to the provisions of the present Covenant and to the Convention on the Prevention and Punishment of the Crime of Genocide. This penalty can only be carried out pursuant to a final judgment rendered by a competent court.

3. When deprivation of life constitutes the crime of genocide, it is understood that nothing in this article shall authorize any State Party to the present Covenant to derogate in any way from any obligation assumed under the provisions of the Convention on the Prevention and Punishment of the Crime of Genocide.

4. Anyone sentenced to death shall have the right to seek pardon or commutation of the sentence. Amnesty, pardon or commutation of the sentence of death may be granted in all cases.

5. Sentence of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out on pregnant women.

6. Nothing in this article shall be invoked to delay or to prevent the abolition of capital punishment by any State Party to the present Covenant.

The Human Rights Committee has affirmed:

[52] HRC General comment number 31, 2004, para. 7.
[53] HRC General Comment number 31, 2004, para. 5.
[54] Introduction to the International Human Rights Regime, Manfred Nowak, The Raoul Wallenberg Institute Human Rights Library, p. 80.

"It is the supreme right from which no derogation is permitted even in time of public emergency which threatens life of the nation. However, the Committee has noted that quite often the information given concerning article 6 was limited to only one or other aspect of this right. It is a right which should not be interpreted narrowly."[55]

"Moreover, the Committee has noted that the right to life has been to often narrowly interpreted. The expression" inherent right to life" cannot properly be understood in restrictive manner, and the protection to this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics."[56]

2.3.2 Non-discrimination under ICCPR

Also article 3 becomes relevant in regard to the right to health as it imposes an obligation upon state parties not to discriminate against women while carrying out the rights in the Covenant. Article 3 reads as follows:

"The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant."

This is also complemented by a general non-discrimination clause in article 26 stating that:

"All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

The author notes that effective protection against discrimination must entail a right to effective remedy under the ICCPR.

2.4 The International Covenant on Economic, Social and Cultural Rights (ICESCR)

The right to health is generally considered to form part of the category of economic, social and cultural human rights.[57] And generally, economic, social and cultural rights

[55] HRC, General Comment 6, right to life, para. 1.
[56] HRC, General Comment, 6, para. 5.
[57] The Right to Health as a Human Right in International Law. Birgit C.A. Toebes, 1999, p. 5.

are distinguished form civil and political rights. Although it is often asserted that both sets of rights are interdependent, interrelated and of equal importance[58] as stated in the beginning of this thesis. But, in practice, particularly Western States and NGOs have tended to treat economic, social and cultural rights as if they were of less importance than civil and political rights.[59] Additionally economic, social and cultural rights, as opposed to civil and political rights, are often considered non-justicable, regarded rather as general directives for States than as rights.[60] Moreover, there are no effective complaints mechanisms to enforce these rights at the international level. All this implies that in practice, the two sets of rights do not have the same status and impact.[61]

Several reasons could be brought forward as an explanation. Economic, social and cultural rights are often criticized for being imprecise and given a programmatic format, thus not given immediate effect. Furthermore they imply financial commitments that could end being costly. It has, however, been correctly observed that civil and political rights shows quite some similarity in this regard.[62] Civil and political rights, as pointed out above, also give rise to positive obligations[63] that could lead to major financial implications.[64] Furthermore several civil and political rights are also ill-defined but have nevertheless been given meaning in practice.[65]

Article 12 in the Covenant spells out the specific right to health but the article has to be read in combination with article 2, 3 and 4 of the ICESCR in order to be correctly understood. Therefore an elaboration of these articles will now take place.

Article 2(1) in the Convention talks about the progressive realization of the provisions set forth in the Covenant:

1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

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[58] United Nations World conference on Human Rights, Vienna Declaration and Progamme of Action, UN Doc. A/CONF. 157/23, 12 July 1993, para. 5.
[59] Toebes, p. 6.
[60] Toebes, p. 6.
[61] Toebes, p.6.
[62] Toebes. p. 7.
[63] HRC, General comment No.
[64] Toebes, p. 7.
[65] Toebes, p. 6.

3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

Two very important documents for the interpretation of the ICESCR are the General Comment No. 3 of the ICESCR Committee and the Limburg Principles on the Implementation of the International Covenant on Economic Social and Cultural Rights, written by a number of international law experts in 1986.[66] It is important to notice the some rights in the ICESCR are to be "respected", "ensured" or "guaranteed" whereas others are to be "recognized". Toebes mentions a paper by Alston and Quinn[67], prepared for the Conference during which the Limburg Principles were drafted, where they argue that the obligation to recognize does not require such an immediate action as the notion "to ensure" and "to guarantee".[68]

During drafting procedure the term "to recognize" was chosen instead of "Everyone shall have the right…" in order to please countries that otherwise would have remained unwilling to ratify the convention. This is evidence in favor of Alston and Quinn's theory that "to guarantee" implies less state obligations in regard of the Covenant than other rights mention in combination with the above described attributes.[69]

Article 2(1) is essential for understanding of the Covenant since it establishes the general nature of the legal aspects. It has to be mentioned that article 2(1) obviously could be used as a scapegoat by state parties. There are difficulties in claiming state obligation when the Covenant uses terms like "take steps", to the maximum of its available resources" and "achieving progressively". On the same time it must be argued that the Convention shall imply some sort of obligation and it must increase with time and with augmented state resources. This has been discussed in ICESCR's general comment nr 3 and in the Limburg Principles.

The ICESCR Committee starts of its general comment by stating that even thought the Covenant talks about progressiveness and resources some immediate obligations could nevertheless be imposed. One such obligation is according to the Committee the principle of non-discrimination expressed in article 2(2) and 3.[70] The Committee further argues that the obligation to "take steps" must be done within a reasonable short period of time. The committee also states that measures should be deliberate, concrete and targeted.[71] The Committee also states that the Covenant imposes an obligation to act as swiftly as possible and as efficient as achievable in order to fulfill the Covenant.[72] Here Tobes notes that the Limburg principles requires even more stating that State parties should act immediately in order to realize the Covenant.[73] The author agrees with the latter statement since it would be very odd if the legal

[66] ICESCR Committee, General Comment No. 3, 1990, pp. 83-87 and Toebes p. 292.
[67] Working Paper prepared for the Limburg Conference, Alston and Quinn, 1987.
[68] Tobes p. 292.
[69] Tobes- p 293.
[70] ICESCR Committee, General Comment No. 3, 1990, para 1
[71] ICESCR Committee, General Comment No. 3, 1990, para 2.
[72] ICESCR Committee, General Comment No. 3, 1990, para. 9.
[73] Limburg Principles, 1987, para. 16, double check this reference my self.

outcome of the article two and the Covenant would be that a State could wait implementing its obligations. That would defeat the purpose of the Covenant and its language.

The Committee then moves on and discusses the concept of "core obligations" It is the Committee's view that a state party must at least fulfill some core obligations striving from the Covenant. This argument derives from the fact that the sole "raison d'etre" of the Covenant would otherwise be defeated.[74] According to Toebes this means in relation to the right to health an obligation to provide at least basic health services.

Another important statement in the general comment is the one in regard to the maximum available resources is that any retrogressive measures. It is said that "any deliberately retrogressive measures (…) would require the most care full consideration" and this is in the authors view a method of saying that in most cases no retrogressive measures could hardly be acceptable unless the state party faces exceptional circumstances.[75]

The ICESCR provides the most comprehensive article on the right to health in international human rights law.[76] The right to health is declared in article 12 of the ICESCR:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[77]

On the other hand it's also the case that an enumeration of four specific obligations are brought up in article 12 implying more obligations compared to similar provisions in the Covenant that do not spell out such steps. It is relevant in this thesis to repeat article 12.d) where it is spelled out that steps should be taken to achieve the full realization of the right to health including those necessary for the prevention, treatment and control of epidemic, endemic, occupational and other diseases. Aids

[74] ICESCR Committee, General Comment No. 3, para. 10.
[75] ICESCR Committee, General Comment No. 3 para. 9.
[76] General Comment No. 14, para. 2.
[77] http://www.unhchr.ch/html/menu3/b/a_cescr.htm (last visited 26 of October 2007).

falls under this category and is therefore especially underscored as a disease that is covered by the Article 12 in the Covenant.

There is also a general comment regarding the right to health, namely ICESCR Committee, General Comment No. 14. The ICESCR Committee ends its first paragraph in its general comment regarding the right to health stating that it includes components that are legally enforceable,[78] an important statement, especially in light of the criticism outlined above. The committee affirms that the right to health must be interpreted in a broad way, including underlying preconditions for a healthy life, such as the right to food, nutrition, housing, clean water, sanitation, safe and healthy working conditions and a healthy environment.[79] The right to health should be understood as an obligation to provide equal opportunities for people to enjoy the highest attainable standard of health.[80] As a result, in addition to above mentioned rights, the right to health should also encompass access to health related education, and the population should be invited in the decision-making process concerning health related issues affecting them.[81]

The right to health is, according to the CESCR, composed of four essential elements. Firstly, health services should be available. Secondly, they have to be accessible, which includes the concepts of non-discrimination and affordability. Thirdly, all health facilities must be respectful of medical ethics and culturally appropriate. Finally health facilities should provide good quality health care, meaning they should be scientifically and medically appropriate.[82]

In the Committee's general comment in regard to article 12. (d), it is stated, that everyone should have access to curative and rehabilitee as well as preventive health care. Appropriate treatment to prevalent diseases should be granted and essential drugs must be provided.[83]

2.4.1 In Case of a Violation of the ICESCR

If a lack of resources renders a State party unable to fulfill its obligations, the burden of proving that every effort has been made to use all available resources at hand in order to l its obligations. The Committee then states that a State party cannot under any circumstances justify non-compliance with the core obligations set out ion article 43, which are stated to be of a non-derogable character.[84] A violation could occur because of an omission of a State to take a measure laid out in the Covenant, inter alia taking steps or enforce relevant national legislation.[85] Examples of a violation of the obligation to fulfill could, according to the Committee, include a failure to adopt a

[78] CESCR, General Comment No. 14. para. 1.
[79] CESCR, General Commment No. 14, para. 4.
[80] CESCR, General Comment No. 14, para. 8.
[81] CESCR, General Comment No. 14, para. 11.
[82] CESCR, General Comment, No. 14, para. 12.
[83] CESCR, General Comment, No. 14, para. 17.
[84] CESCR, General Comment, No. 14, para 47.
[85] CESCR, General Comment, No. 14, para 49.

national health policy, insufficient expenditure or misallocation of public resources. It could also be about a failure to monitor the right the right to health at the national level or the unbalanced distribution of health facilities, a failure to adopt a gender-sensitive approach.[86]

2.4.2 Implementation at the National Level under ICESCR

First of all it is stated in the General Comment, that each State party has a certain margin of appreciation when deciding how to implement the Covenant. The Committee thought states that the Covenant clearly imposes a duty to implement a national strategy to ensure the enjoyment of the highest attainable standard of health. The plan should identify resources available to obtain the objectives spelled out.[87] The strategy must be based upon the principles of accountability, transparency and independence on the judiciary. It is stated in the General Comment that good governance is essential to the effective implementation of all human rights, including the right to health.[88] Moreover states should consider stating the national strategy in a framework law. This law should establish mechanisms for monitoring the implementation of the mention strategy.[89] Further on, State parties should identify relevant points of reference appropriate for the right to health in their strategies.[90]

Any individual or group should have access to effective judicial remedies at both national and international levels. Adequate reparation must be offered.[91] Incorporation of the right to health in national legislation is encouraged.[92] State parties also have an obligation to promote the work of human rights advocates.[93] Moreover there is an obligation to accept cooperation with the WHO.[94] The epidemic continues to confirm that the relationship between HIV and human rights is profound. Vulnerability to HIV infection and to its impact feeds on violations of human rights, including discrimination against women and violations which create and sustain poverty. In turn, HIV leads to human rights violations, such as further discrimination, and violence.[95] That is why an adoption of a so-called human rights based approach is encouraged, as “greatly facilitate implementation of the right to health”.[96]

[86] CESCR, General Comment, No. 14, para 52.
[87] CESCR, General Comment, No. 14, Para. 53.
[88] CESCR, General Comment, No. 14, Para. 55.
[89] CESCR, General Comment, No. 14, Para. 56.
[90] CESCR, General Comment, No. 14, Para. 57.
[91] CESCR, General Comment, No. 14, Para, 59.
[92] CESCR, General Comment, No. 14, Para, 60.
[93] CESCR, General Comment, No. 14, Para, 62.
[94] CESCR, General Comment, No. 14, Para, 63.
[95] International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version, UNAIDS GENEVA SWITZERLAND, p. 6.
[96] CESCR, General Comment NO. 14, Para. 64.

2.5 The CEDAW

In CEDAW one can find three different categories of rights. 1: The obligation "to ensure, accord or grant", 2 the obligation "to undertake to" and finally the obligation "to take all appropriate measures". The first category imposes an obligation to take immediate and clear steps and rights hereunder are justiciable. The second division imposes an obligation to take specific types of action and may there fore also be justiciable. Whereas the third category is not of such a character or it gives at least the state parties a large room for margin of appreciation.[97]

Article 12 in CEDAW states that:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

One could notice that the two different paragraphs belong to different categories according to the division outlined above. As a consequence the first provision should be classified to the category where the state party has a wider margin of appreciation. However, as opposed to other provisions using the language of "to take all appropriate measures" the term to ensure is included in this paragraph and it could therefore be argued that this provision is more likely to be justiciable meaning that it imposes a more precise legally binding character with and immediate character. The article is targeting the equality of the access and not as much the creating of health facilities as such. This means that the needs have to be decided upon objective criteria.[98]

2.6 The CRC

Vietnam became a state party to Convention on the Rights of the Child on the 28 February 1990. Children's right to health is protected in article 24 of the Convention:

"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

[97] Tobes p. 301.
[98] Tobes p. 302.

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries."

The committee on the rights of the child has in its general comment no 3 emphasized that the convention is taking a holistic approach in regard to the right to health. Although it is recognized that article 24 in the CRC is the most important provision for the protection of children in regard to HIV, also other articles are of utmost importance according to the committee. Among the rights underscored in this regards are the right to non-discrimination, the principle of the best interest of the child, the right to life, survival and development and the right to express views and have them taken into account. The committee is high lightening the special needs of children and some groups require special attentions such as children affected or orphaned by HIV, victims of sexual and economic exploitation and victims of violence and abuse.

2.7 Restrictions and limitations of International conventions under international human right law

Under international human rights law, States may impose restrictions on some rights, in narrowly defined circumstances, if such restrictions are necessary to achieve overriding goals, such as public health, the rights of others, morality, public order, the

general welfare in a democratic society and national security. Some rights are non-derogable and cannot be restricted under any circumstances.[99]

[99] International Guidelines on HIV/AIDS and Human Rights p. 81.

3 Existing legal regimes on the national level in Vietnam

3.1 Background

The HIV epidemic takes on different forms in different countries and thereby affecting certain sub-groups of the population. One possible mode of the spread of HIV could be through heterosexual transmission as in Southern Africa or by injecting drug use as in China. Each country should develop strategies and programs appropriate for its own epidemic, based on the most comprehensive information available about risk groups and targets for interventions in both prevention and care.[100]

Approximately 83 million people are living in the Socialist Republic of Vietnam.[101] Since the implementation extensive economic and social reforms known as (Doi Moi) in 1986[102], Vietnam's economy has grown at a rapid pace. In 2005, the gross domestic product (GDP) reached more than 52 billion dollar with an annul growth rate of 8.4 percent.[103]

The first case of HIV infection was reported in December 1990 in Ho Chi Minh City. By 1992, only 11 cases had been reported, but in 1993 there was a sharp increase.[104] Currently, there are approximately 292,930 people living with HIV/AIDS (up from 96,000 in 1999).[105] By the end of 2005, 56,600 Vietnamese people had lost their lives to AIDS.[106] The Ministry of Health estimates that between 18,000 and 39,000 people contract HIV every year – 50 to 100 new infections daily. The national HIV-prevalence rate among adults ages 15-49 was estimated to be 0.5 percent at the end of 2005.[107] Prevalence rates have, however, reached generalized levels (greater than 1

[100] A hidden HIV epidemic among women in Vietnam.
[101] World Bank report, available at: http://devdata.worldbank.org/AAG/vnm_aag.pdf.
[102] CARE international in Vietnam, Vietnamese Research Centre for Human Rights, and HO Chi Minh National Political Academy, International Law, National Policy and Legislation for the Prevention of HIV/AIDS and Protection of Human Rights of People Living with HIV/AIDS in Vietnam (November 2003), p. 7 (hereinafter referred to as Care international).
[103] Ibid.
[104] Socialist Republic of Vietnam: Second country report on following up the implementation to the declaration of commitment on HIV/AIDS January 2003 – December 2005.
[105] Ministry of Health of Vietnam, Estimation and Projection of HIV/AIDS in Vietnam 2001-2005.
[106] Ibid.
[107] Joint United Nations Program on HIV/AIDS (UNAIUDS), 2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition, 485.

percent nationally) in several areas, including Ho Chi Minh City (1.25 percent), Quang Ninh (1.15 percent), and Hai Phong (1.15 percent).[108]

HIV-prevalence rates are also significantly higher among groups at elevated risk. For example, the 2005 estimated national prevalence rate among injecting drug users was 33 percent, while other estimates have put it as high as 65 percent.[109] [110] The prevalence rate among sex workers is also high, with a national estimate of 16 percent, and rates of 20 to 30 percent in some provinces.[111] Limited surveillance data among men who have sex with men indicate a prevalence-rate range that is between 5 percent (Ho Chi Minh City) and 9 percent (Hanoi).[112]

The HIV/AIDS epidemic in Vietnam was initially largely driven by injection drug use and, to a lesser extent, by sex work. Recent evidence, however, suggest that HIV is spreading to the general population through the sexual networks of drug users and clients of sex workers. As a result, an increasing number of women are being infected with HIV. Women now account for a third of all new infections.[113][114]

3.2 Legal Framework

Although the Committee on Economic, Social and Cultural Rights can assist in the implementation of the Covenant from an international perspective, the ultimate effectiveness of this instrument is contingent on the measures taken by Governments to put into practice their international legal obligations. In this regard, the Committee has recognized the essential importance of the adoption by States of appropriate legislative measures and the provision of judicial remedies, indicating the very real legal nature of economic, social and cultural rights."[115]

The position of the Party and State regarding human rights has been reflected in the policies and laws of Vietnam. Human rights have been established and broadened, in both quantity and content, through the succeeding Constitutions of Vietnam of 1946, 1959, 1980 and 1992. The 1992 Constitution states in Article 50 that:

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[108] Ministry of Health of Vietnam, Estimation and Projection of HIV/AIDS in Vietnam 2001-2005.
[109] Ibid.
[110] Ministry of Health of Vietnam, results form HIVSTI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam 2005-2006 (2007).
[111] Ibid.
[112] Ibid.
[113] Ministry of Health of Vietnam, Estimation and Projection of HIV/AIDS in Vietnam 2001-2005 and interview with Asia Dong Phuong Nguyen, Programme Officer- Coordination, UNAIDS Viet Nam, autumn 2007.
[114] HIV/AIDS policy in Vietnam, A civil Society Perspective, Public Health Watch, Open Society Institute, New York, 2007.
[115] Fact Sheet No.16 (Rev.1), The Committee on Economic, Social and Cultural Rights, http://www.ohchr.org/english/about/publications/docs/fs16.htm (12 of 19).

"In the Socialist Republic of Vietnam, the rights of the human person in the political, civil, economic, cultural and social fields shall be protected, embodied in the citizen's rights and stipulated in the Constitution and law."

The Resolution of the ninth Party Congress in 2001 emphasized the precious value of human rights and reaffirmed the national responsibility to fulfill their international commitments on human rights. The Political Report of the ninth Party Congress specified the tasks of:

"... care for the human beings, protection of the legitimate rights and interests of all people; respect and implementation of international instruments on human rights that Vietnam has ratified or acceded to."

The author would like to note, however that Vietnam has received widespread criticism from the international community for serious breaches of civil and political rights, such as the freedom of expression and assembly. With this in mind, the above statements could be regarded as a rhetoric tool rather than actual commitments to safeguard human rights. It is also of utmost importance to take into consideration that Vietnam does not have an independent judiciary;Vietnam is ruled buy a one state party and each court is responsible for implicitly or explicitly taking the regime's views into consideration.

For a long period of time, Vietnam lacked appropriate HIV legislation. The National Assembly Ordinance on HIV was the highest legislative document to support the fight against HIV from 1995 to 2006.[116] Obvious shortcomings in the Ordinance included a lack of provision granting the right to treatment of people infected with HIV. In general any substantial practical provisions were lacking, such as needle-exchange programs, substance therapy or condom distribution and issues of confidentially were not addressed. The efforts were mostly limited to preventive measures such as disseminating information. [117]

In 2004, a National AIDS Strategy was adopted.[118] The ordinance could not back up the new strategy since it ranks lower than a law in terms of legislative power[119] and as a result Vietnam passed a new law on HIV in June 2006.[120] The Law on the Prevention of and Fight Against HIV/AIDS is a significant improvement over the ordinance and a very progressive piece of legislation in Vietnam and compared to neighboring countries.[121]

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[116] National Assembly of the Socialist Republic of Vietnam, Standing Committee, Ordinance of the Prevention and Control of HIV/AIDS, May 31, 1995.
[117] National Assembly of the Socialist Republic of Vietnam, Standing Committee, Ordinance of the Prevention and Control of HIV/AIDS, May 31, 1995.
[118] DECISION OF THE PRIME MINISTER approving the National Strategy on HIV/AIDS prevention and control in Viet Nam till 2010 with a vision to 2020, Ha Noi, 17 March 2004
[119] CARE international.
[120] LAW ON HIV/AIDS PREVENTION AND CONTROL, (No. 64/2006/QH11) (hereinafter called Law on HIV).
[121] Interview with Lecturer of Hanoi Law University, autumn 2007.

The law provides the following: HIV-infected people the right to live in integration with the society and not to be discriminated against and PLHIV are granted the right to enjoy medical treatment and health care. Programs of action should be formulated in order to control and prevent the disease.[122] The state has a responsibility to encourage domestic production of ARVs in order to reduce prices according to the law, as well as mobilize and coordinate cooperation for the fight against HIV.[123] The law is granting everyone the access to information and education about HIV and its particularities[124] and encourages family and employers to morally support persons infected with HIV.[125] Persons infected with HIV "shall be facilitated by the state to have access to ARVs" under suitable socio-economic conditions. However, the law only covers people infected by HIV in their work, pregnant women, children under six and people infected due to risk of medical technique that are granted ARVs free of charge.[126] At the same time it is also stated that HIV people shall be taken care of in their families and in governmental medical health care facilities.[127] Article 43 has an important provision stating that the state shall allocate an appropriate budget for HIV prevention and control. [128] The law obliges the state to cooperate with other nations and international organizations in the fight against HIV.[129]

The decree concerns a couple of the areas covered by the HIV prevention and control law. Among others implementation of harm reduction, management, distribution and use of HIV drugs and care for abandoned HIV infected children.[130] There are provisions on condoms and guidance on condom use.[131] The distribution and use of clean needles and syringes are covered[132] as well as treatment of addiction to opiate substances with substitution drugs.[133] The managements of HIV medicine are also stipulated in the decree.[134] Additional guidelines are needed to address additional issues and subsequently it may take years until the law on prevention and control of HIV is full in effect. The implementation of the decrees might be a complicated process and the outcome is yet to be seen.[135]

The full-scale rollout of harm reduction measures would represent a significant shift away from the forced rehabilitation of drug users in so called 06 centers, which will likely continue to exist as long as the government is committed to drug control. There is hope that the harm reduction interventions stipulated in the HIV/AIDS Law will be

[122] Law on HIV, Article 4.
[123] Law on HIV, Article 6.
[124] Law on HIV, Article 11.
[125] Law on HIV, Article 13.
[126] Law on HIV, Article 39.
[127] Law on HIV, Article 41.
[128] Law on HIV, Article 43.
[129] Law on HIV, Article 48.
[130] GOVERNMENT'S DECREE No. 108/2007/ND-CP OF JUNE 26, 2007, DETAILING THE IMPLEMENTATION OF A NUMBER OF ARTICLES OF THE LAW ON HIV/AIDS PREVENTION AND CONTROL Article 1.
[131] Law on HIV, Article 8.
[132] Law on HIV, Article 9.
[133] Law on HIV, Article 10.
[134] Law on HIV, Article 12.
[135] Care International, p. 22.

an integral component in the eventual phase-out of these rehabilitation centers and provide an opportunity for patients to safely and effectively reenter society."[136]

3.3 "HIV/AIDS Policy

The main policy document where Vietnams strategy to combat HIV is outlined is to be found in the National Strategy on HIV/AIDS prevention and control in Vietnam till 2010 with a vision to 2020 from 2004. It is firstly stated in the strategy plan that HIV is a threatening disease challenging individual's life, future generations and socio-economic developments. It is therefore stated that the fight against HIV must be a considered as a crucial matter of urgent concern. It is said that preventing HIV means an investment giving socio-economic benefits. It is further stated that stigma and discrimination against HIV infected shall be fought and that Vietnam rests committed to implement international agreements on HIV prevention and control which the country has signed or acceded to. The areas of priority is efforts to change behavior through information and communication, enforced harm reductions, intensified counselling, care and treatment and improved program management and monitoring activities.[137]

Specific objectives are outlined in the Strategy plan. The over all objective is to keep the infection rate under 0,3 percentage of the population by 2010 and then try to halt the disease. Some of the more specific objectives are to raise the knowledge about HIV transmission to 100 percent for people living in urban areas and to 80 percent for people living in the rural areas. To control the transmission from high risk groups from further spread to the rest of the society, this will manly be achieved through programmes for safe injections and condom use. The treatment for HIV infected people shall be scaled up to cover 90 percent of the adults and 100 percent of infected children and pregnant mothers. To improve the monitoring and surveillance to the HIV programs and all testing should be carried out on a voluntary basis.[138]

The main proposed solutions to reach the outlined objectives are to improve the leadership of the Party and the State when it comes to HIV prevention and control. All local administrations should take into account HIV when setting up there development plans. Special efforts should be put on integration of drugs and prostitution prevention and control programs into prevention of HIV transmission. All branches of the society should be encouraged to combat HIV including religious, charity and non governmental organizations. It is said that the legal framework should be improved and education of the actual provisions contained in the law should be carried out. Step up efforts to accelerate behavioral change information and education especially among high risk groups. The information as such should also be improved in order to be more relevant. Harm reduction innervations should be promoted including clean syringes and needles and condom use programs. The treatment and care for HIV infected people are said to be improved and community based care

[136] Ibid.
[137] National Strategy on HIV/AIDS prevention and control in Vietnam till 2010 with a vision to 2020, 2004, Article 1 paragraph 1 (hereinafter called National Strategy Plan).
[138] National Strategy Plan, Article 1 paragraph 2.

centers should be set up in order to enlighten infected people and their families and community in order to prevent further spread of HIV.[139]

Nine action programs are outlined in the strategy:

"1. Behavioral Change Information, Education and Communication Program in HIV/AIDS prevention and control in coordination whit the drug and prostitution prevention and control programs to prevent HIV/AIDS transmission.
2. HIV/AIDS Harm Reduction Intervention and Transmission Prevention Program.
3. Care and Support for HIV/AIDS-infected People Program.
4. HIV/AIDS Surveillance and Monitoring and Evaluation Program.
5. Access to HIV/AID Treatment Program.
6. Prevention of Mother-to-Child HIV/AIDS Transmission Program.
7. Sexually Transmitted Infections Management and Treatment Program.
8. Blood Transfusion Safety Program.
9. HIV/AIDS Prevention and Control Capacity and International Cooperation Enhancing Program."[140]

3.4 International Donor Assistance

The Central Government allocated 5 million US dollar on the AIDS programme in 2006 and has increased the number to 9.4 million in 2007. The local authorities are additionally responsible for bringing additional resources to the implementation programs, however there are no available data on how much local authorities have contributed with.[141]

At a first glance it looks like Vietnam has achieved very good results for a country with limited public resources calculated per capita GDP. Vietnam spends about 5-6 percent of GDP on health care but that includes even private expenditure. After a breakdown of the figures one can see that only one fourth of the overall resources put on the health sector emanates from public spending. This puts Vietnam as the second worst in the region. And when it comes to general government resources Vietnam spends only 6 percent on health care, and only less than one percent of is GDP allocated for current health resources. The high annual growth rate of the GDP, 7 percent, has made it easier for the public to pay from their own pocket, which has eased the situation a little bit but also helped the government neglecting an increased health budget.[142] Private expenditure now accounts for 72 percent of all health spending in Vietnam. The author notes that this must be considered a very poor achievement keeping in mind the general good economic development mentioned above. The 2006 World Health Report places Vietnam among the countries with the

[139] National Strategy Plan, Article 1 paragraph 4.
[140] National Strategy Plan Article 2.
[141]The third country report on the following up the implantation to the declaration of commitment on HIV and aids, Hanoi January 2008, p. 5.
[142]Susan Adam, Vietnam's Health Care System: A macroeconomic Perspective, paper prepared for the International Symposium on Health Care Systems in Asia, Hitotsubashi University, Tokyo, January 21-22, 2005. Available at: www.org/external/country/VNM/rr/sp/012105.pdf (accessed June 29, 2008).

highest out-of-pocket spending on health. A 2002 survey revealed that, for the poorest quintile, a single visit to a district hospital will cost more than 230 percent or the average annual nonfood budget per person, admission in a provincial hospital will cost nearly 45 percent of the household nonfood budget. The government has acknowledged that ill health and health care costs are among the primacy causes of poverty.[143]

The main founding however comes from international donors whom have contributed significantly to the AIDS founding in Vietnam. The international community contributed with 51.8 million dollar in 2006 compared to the above mentioned number of 5 million forms the Vietnamese government.[144] This should be compared to a total budget of 13 million form international donors in 2005. The main source of founding comes from the (US) President's Emergency Plan for AIDS Response (PEPFAR), the Global Fund to fight IIDS, TB and Malaria (GFATM), the UK Department for International Development (DFID), the Asian Development Bank (ADB) and the World Bank.[145]

It has to be kept in mind that the Vietnamese government' budget on 9.4 million dollar should cover implementation by 18 ministries and sectors with sub departments across 64 provinces. The result is that the budget is still fairly limited.[146] However together with the international donor assistance the lack of founds is no longer a critical problem for implementation of wide scale programs. The real challenge is now to ensure efficient use of the founds available and very importantly to build up local the local capacity when it comes to administration and health service facilities in order to appropriately manage the available founds. There must be an increased coordination between donors and the Vietnamese government and local authorities.[147] For example one third of the PEPFAR's budget was put on own management expenditures. There is a concern that only a small amount of the founds form international donors has been spent for real on the ground activities.[148] The reason behind why some international organizations spend their founds themselves is that local organizations do not have the capacity to mange the allocated money themselves.[149] As also elsewhere stated in this thesis it is absolutely crucial that Vietnam manages to build up its own local capacity to ensure that Vietnam could provide their own management in the future. Especially there is no guarantee that international donors will continue to contribute in the same way in the future. An additional problem is that some donors might have ideological reasons not to support

[143]IV/AIDS policy in Vietnam, A civil Society Perspective, Public Health Watch, Open Society Institute, New York, 2007, p. 18.
[144]The third country report on the following up the implantation to the declaration of commitment on HIV and aids, Hanoi January 2008, p. 6 (hereinafter referred to as Country report).
[145] Country report, p. 13.
[146] Country report p.13.
[147] Care International, p. 88 and Interview with Asia Dong Phuong Nguyen, Programme Officer- Coordination, UNAIDS Viet Nam, autumn 2007.
[148] Care International, 88.
[149] Care International, 88.

part of crucial HIV programs like support to drug users and sex workers. This is for example the case concerning PEPFAR.[150]

[150] Interview with UNAIDS Viet Nam, autumn 2007.

4 Existing practice on the national level in Vietnam

4.1 Health Sector Capacity

"Vietnam's health indicators are better than might be expected for a country at its stage of overall development, and they continue to improve at rates that equal or surpass those in most neighboring countries. In terms of life expectancy adjusted for years lost to disabilities, Vietnam ranks 116 among 191 members of the World Health Organization (WHO), not very different from much wealthier countries such as Greece and Brazil."[151]

Primary health care facilities offer preventive, ambulatory services and they are implementing a number of national health programs. As a result, in 2005 nearly all communes had health care facilities.[152] These measures have led to increased life expectancy at birth as well as in overall. The general life expectancy is now an average of above 71 years.[153]

Even though Vietnam has managed to improve its health care system, several difficult challenges are still very prominent. This is especially the case for HIV where the disease is now on the verge to spread from the most vulnerable groups to the general population.[154] The Vietnamese health care system is hierarchal (like the Russian model) with four different levels; national province, district and commune level. The system has difficulties in reaching out to the countryside, and particularly becomes problematic since the hospitals or health care facilities at the commune and even district level are not that well equipped. Many of them do not have the capacity to carry out testing. It is expensive and time consuming to travel to the provincial capitals.[155]

When it comes to allocation of budget for the purpose of health, at a first glance it seems like Vietnam has achieved very good results for a country with limited public resources calculated per capita GDP. Vietnam spends about 5-6 percent of GDP on health care but that includes private expenditures. After a breakdown of the figures, one can see that only one fourth of the overall resources put on the health sector emanates from public spending, which puts Vietnam as the second worst in the region. And when it comes to general government resources Vietnam spends only 6

[151] Susan Adam, Vietnam's Health Care System: A macroeconomic Perspective, paper prepared for the International Symposium on Health Care Systems in Asia, Hitotsubashi University, Tokyo, January 21-22, 2005. Available at: www.org/external/country/VNM/rr/sp/012105.pdf (accessed june 29, 2008).
[152] IV/AIDS policy in Vietnam, A civil Society Perspective, Public Health Watch, Open Society Institute, New York, 2007, p. 18
[153] IV/AIDS policy in Vietnam, A civil Society Perspective, Public Health Watch, Open Society Institute, New York, 2007, p. 18.
[154] Interview with UNAIDS Vietnam, autumn 2007.
[155] Interview with Management Board Member of a NGO in Vietnam, autumn 2007.

percent on health care, and only less than one percent of is GDP allocated for current health resources. The high annual growth rate of the GDP, 7 percent, has made it easier for the public to pay from their own pocket, which has eased the situation but also helped the government neglect an increased health budget.[156]

Private expenditure now accounts for 72 percent of all health spending in Vietnam. The 2006 World Health Report places Vietnam among the countries with the highest out-of-pocket spending on health. A 2002 survey revealed that, for the poorest quintile, a single visit to a district hospital will cost more than 230 percent or the average annual nonfood budget per person, admission in a provincial hospital will cost nearly 45 percent of the household nonfood budget. The government has acknowledged that ill health and health care costs are among the primacy causes of poverty.[157]

In general health system working well, the cost is partly covered by insurance but its only ca 20 percent of the population that is covered by insurance. All persons under the age of 6 are provided with free health care and the age of coverage is planned to be increased to the age of 16 sometime in the near future. Many health source cards. Farmer poor health insurance card.[158]

There is currently a system in place with emergency insurance for poor people in Vietnam. However, because the system is paying for part of the costs, it has been difficult to implement and also laborious to get the reduction. Less then 10 case in one hospital so in conclusion very few people get founded from this insurance.[159]

The primary health care system in Vietnam also faces a number of difficulties. Although facilities have been constructed, many of them do not have adequate equipment[160] and qualified doctors work in the higher sectors. The district and commune levels have a reputation for so doctors and clients try to avoid them. This makes the central hospitals overcrowded and it's not unusual with 8 persons sharing one bed according to an interview with a Management board member of a NGO in Vietnam. An additional problem is that the doctors that although are working at the district and communal level are not sufficient trained. It is common that they only have 3 years of training instead of 6 years as is required in order to become a fully educated doctor. This originates form very low salaries in the primary health care system.[161] As a result, approximately 80 percent of the public health care staff works in the private sector at the same time as in the public in order to supplement the low incomes. [162]

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[156]Susan Adam, Vietnam's Healt Care System: A macroeconomic Perspective, paper prepared for the International Symposium on Health Care Systems in Asia, Hitotsubashi University, Tokyo, January 21-22, 2005. Available at: www.org/external/country/VNM/rr/sp/012105.pdf (accessed june 29, 2008).
[157] Care International, p. 18.
[158] Interview with Management Board Member of a NGO in Vietnam, autumn 2007.
[159] Interview with Management Board Member of a NGO in Vietnam, autumn 2007.
[160] Care International, p. 18.
[161] Interview with Management Board Member of a NGO in Vietnam, autumn 2007.
[162] Care International, p. 18.

4.2 High risk populations

HIV is still largely concentrated among high risk populations such as drug users and female sex workers. The government's response has been to focus mainly on young male drug users.[163] The approach has been to create special residential rehabilitation centers, which could be likened to a prison, since the placement is mandatory. The prevalence of HIV among drug users is even greater within the centers than outside.[164] The problem is that drug users and sex workers are not only illegal, but they are also regarded as "social evils," and often results in creating stigma and discrimination around these so-called social evils. In 2006 the number of people detained in these centers undergoing compulsory rehabilitation was approximately 57 000 people. The rehabilitation method has not been successful and the overall number of drug users has increased form 69 000 in 1996 to 170 000 in 2005.[165]

According to the HIV/AIDS strategic plan 2006-2010, only 20 percent of the total allocated founds for HIV is allocated for harm reduction measures and only a small number of this amount is allocated for targeting sexual transmission.[166] Also among international organization there is a lack of funding for this category. Amongst the 58 international organizations working non HIV prevention, 32 of them are working only with drug users, nine with commercial sex workers and the rest are largely working with general campaigns for awareness.[167]

This concentration on a specific at risk population, namely injection drug users, has led to a situation where the other high risk group of female sex workers has not received sufficient attention and support. The same holds true for the general population of women in Vietnam. According to a study, the HIV transmission among women in Vietnam has been underestimated. This study fears that the reported data only represents 16 percent of the real number of infected women. There are estimations concluding that up to 83 000 women infected with HIV have not been discovered or taken care of by the health system. Most new infections among women could so far be detected from sexual relations with drug users.[168] But there is of course also transmission due to partners having unsafe sex with clients, husbands or lovers. Since the risk of transmission within this group is under recognized women are not getting tested and they are not aware of the risks, as a result they don't protect themselves or make sure that there partners are protected.

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[163] A hidden HIV epidemic among women in Vietnam, Thu Anh Nguyen, © 2008 Nguyen et al; licensee BioMed Central Ltd, http://www.biomedcentral.com/1471-2458/8/37, last acceded fifth of July 2008 (hereinafter called A hidden HIV epidemic among women in Vietnam).
[164] Interview with Programme Officer- Coordination, UNAIDS Viet Nam, autumn 2007.
[165] HIV/AIDS policy in Vietnam, A civil Society Perspective, Public Health Watch, Open Society Institute, New York, 2007, p. 15.
[166] Joint United Nations Program on HIV/AIDS (UNAIDS): HIV intervention map for Vietnam 2007. [http://unaids.org.vn/facts/map/index.htm]
[167] A hidden HIV epidemic among women in Vietnam.
[168] A hidden HIV epidemic among women in Vietnam.

Since Vietnam is in many ways neglecting care and treatment of a vulnerable subset of the population, as well as potentially underestimating the number of HIV cases, the country might face a state where the disease is spreading to the vast layers of the population.[169] It is therefore important to set up programs for prevention and care targeted at women because otherwise women will bear the virus and remain invisible until they become pregnant and then detected as HIV positive. An additional problem is that the programs working for an increased use of contraceptives and condoms has not proven to be that effective.[170]

4.3 Prevention, Information and education

Prevention, information and education are widely covered in the National AIDS strategy plan. Five of the nine areas where action is prioritized concern these IEC. Some of the areas are harm reduction, prevention of mother to child transmission, sexually transmitted infections and blood safety, see also chapter 3.3.[171] Most focus is put on harm reduction since the high prevalence among drug users and sex workers. As of early 2006, there were 53 testing centers in 40 provinces, serving 40,000 clients annually. Although it has to be mentioned that the programmes are not big enough and the efforts have to be increased.[172]

But still it's a remaining major problem with HIV is that a lot of people infected with the virus are not aware of it. In fact many of them are not even aware of the main ways of transmission. According to a interview with a Management board member from a NGO in Vietnam, a study form 2002, revealed that 95 percent of the population had heard about HIV but only 40-50 percent of the population could accurately describe the three ways of transmission. But the knowledge do increase, a more recent survey from 2007, showed that now 65 percent of the population could mention the three ways of transmission.[173]

According to the HIV/STI Integrated Biological and Behavioral Surveillance report (IBBS) carried out by the Vietnam Administration for of HIV/AIDS control, US disease center for control and the US Agency for International development a scale-up of VCT has been carried out during the last years. But in HCMC only one in five high risk groups could say that they had been HIV tested and that they knew the result. Over 75 percent of people living with HIV in the measured risk groups were not aware that they were living with HIV. A low number of sex workers reported receiving a condom in the past six months.[174] And among the younger population, during the fist time of sexual intercourse only 30 percent of the men wore a

[169] Interview with UNAIDS Vietnam, autumn 2007.
[170] A hidden HIV epidemic among women in Vietnam.
[171] National AIDS strategy plan.
[172] Care International.
[173] Interview with Management Board Member of a NGO in Vietnam, autumn 2007.
[174] HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam 2005 – 2006, p. 4 (hereinafter referred to as IBBS).

condom.[175] Between 56-97 percentage of the IDUs in the IBBS study's measured provinces reported that they had not received free needles during the last 6 months.[176]

According to a programme coordinator for a NGO in Vietnam the number of IDUs is rapidly increasing in the major cities and then also the risk of a rapid spread of the number of people infected. The situation becomes even more dangerous since the lack of proper rehabilitation.[177] As previously described the HIV prevalence is even higher within rehabilitation centers then outside them.

They authors of the IBBS concludes that VCT in general and for persons living with HIV needs to be improved immediately since the prevention coverage was unacceptably low in most provinces. Another major problem is that even though VCT might be available the majority of people, the persons living with HIV tends not to go and test themselves but the services are instead used by people who are not infected. The obvious reason behind is that people exposed to a high risk of infection is reluctant to know their status because of discrimination and a knowledge of a lack of available effective treatments.[178] The same finding were reached in the IBBS study where the authors concluded that the availability of ARV treatment most be increased so that people can see that there is a possibility living a healthy and productive life. The VCT also has to focus even more on high risk groups according to the IBBS study.[179]

The most threatening scenario now is that HIV will start to spread in large numbers through sexual transmission among the general population. This has not received enough attention.[180] Even though about two-thirds of all new infections now takes place outside high risk groups as drug users and sex workers.[181] A large number of resources must be put on targeting in particular the young population with messages about increased use of condoms as well as a lower number of sexual relations.[182]

4.4 Treatment

The government of Vietnam has decided to scale up treatment, care and support in regard to HIV in its National Action Plan on HIV/AIDS care and Treatment that was approved in 2006.[183] The national action plan stets as a goal that 70 percent of the adults and 100 percent of children who are eligible will receive ARV by the year of 2010. In order to be eligible one most be covered by one of the nine priority areas in the above mentioned National action plan on HIV/AIDS. MOH has received considerable support in order to achieve this goal from international donors such as Pepfar and GFATM during the two past years. According to the third country report

[175] Care international.
[176] IBBS, p. 4.
[177] Interview with UNFPA Vietnam, autumn 2007.
[178] Interview with UNFPA Vietnam, autumn 2007..
[179] IBBS, p. 45.
[180] Interview with Swedish NGO in Vietnam, autumn 2007.
[181] Care International, p. 102.
[182] Interview with Swedish NGO in Vietnam, autumn 2007.
[183] National action plan on HIV/AIDS care and support 2006.

on following up the implementation to the declaration of commitment on HIV and aids the government of Vietnam claims that ARV was available in all 64 provinces by the year of 2007 and this is accordingly a 5.7 folded increase compared to 2005. It is estimated in the report that 28.4 percent of the total number of people infected with HIV was undergoing ARV treatment at the third quarter of 2007. But it was only 15 percent of PLHV who received treatment for both HIV and TB.[184] In numbers this means that about 14 000 people were undergoing aids treatment by the beginning of 2008, compared to 4 000 in 2005.[185] Despite the increased amount of people receiving ARV it is obvious, compared with the previously mentioned number of about 300 000 infected people, that these measures must be scaled up immediately.

The government of Vietnam has increased it budget for ARV from 1 billion VND at the end of 1990 to 10 billion (about 650 000 dollar) VND in 2005.[186] This is still a very low number. This means that the main founding comes from international donors.[187] The pepfar is the largest donor with the Global found as the runner up. MOH stated that pepfar had given a total number of 5874 people ARV treatment in 2007and the same number for the Global found was 2 118 patients. Other major donors were the Esther project and the Clinton foundation. The government of Vietnam only bought ARVs enough to cover about 1500 patients.[188]

Although the international organizations tires to cooperate with VAAC in order to avoid overlapping and an effective distribution of resources this remains a crucial problems. The Vietnamese authorities lack the right ability to organize and distribute the resources given to them.[189] As a result access to treatment especially for people living in rural areas and for marginalized groups remains to be achieved. There is a lack of trained health care personnel and of monitoring systems. This is also a major barrier for scaling up the treatment programs. The government of Vietnam also tries to increase the production capacity of the local pharmaceutical industry in order to produce more and cheaper ARVs as well to negotiate for lower prizes from other drug distributors.[190]

Also persons not covered by the National action plan could be provided with free ARV treatment if certain clinical criteria are met. In provinces where major founding through international donors are available treatment will be given by a first to come basis. The criteria mean that the person in question must be tested for HIV and then register. The test requires that the patient undergoes a so called CD4 count test.[191] This process could be lengthily and it could also be a costly process since those tests are far from being available in all provinces.[192] The great challenges remains for

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[184] The third country report on following up the implementation to the declaration of commitment on hiv and aids reporting period: January 2006 – December 2007 Hanoi, January 2008.
[185] Care International, p. 160.
[186] Care International, p.105.
[187] Interview with UNFPA Vietnam, autumn 2007..
[188] Care International, p.105.
[189] Interview with UNICEF Vietnam, autumn 2007.
[190] Care International. 105.
[191] Care International, p. 154.
[192] Interview with Swedish NGO in Vietnam, autumn 2007.

people living in provinces not covered buy any international donors porgramme. Those provinces receive a very low amount of ARV form the government and it is normally impossible to undergo a test in those provinces. This means that persons wishing to under go a test must pay out of own pocket to cover expensive to travel to a major city. Since the revenues in rural areas are very low this is often a major burden for the person in question since an annual average income is only about 8 million dong (about 500 dollar). The ARV treatment also requires some sort of proof of residency this could be hard to prove for poor people being for example homeless or migrant workers.[193]

One obstacle for being able to scale up the treatment is the above mentioned problem with the lack of trained and also lack of motivated medical personnel. There is still a lot of stigma and discrimination against people living with HIV in Vietnam and as a result there is reluctance among medically schooled persons to work in this field.[194] An additional problem is that the private sector is not sufficiently overlooked. There have been reports indicating that ARVs have been distribution without any counseling, instructions or information about possible side effects. Another area for great concern is the high dependence on international donors. As previously stated donors like PEPFAR and the Global found stand for a large amount of the ARV treatment of today. It is likely that they will still stay in the country for a couple of years but keeping in mind Vietnam's rapid economic development it might not last for ever. It is there for a most imminent concern that Vietnam scale up its own budget allocations and health sector capacity and a national monitor system both for donors and for keeping track of the patients.[195]

[193] Care International, p 157.
[194] Interview with Management Board Member of a NGO in Vietnam, autumn 2007.
[195] Care International, p 160.

5 Conclusion

In the conclusion, the author intends to discuss how Vietnam is managing to uphold its international obligations in regard to the prevention and control of HIV.

Firstly, it is important to recognize Vietnam's accession to ICCPR, ICESCR, CEDAW and CRC since all four conventions impose far-reaching legal obligations. However, there is always a danger that international treaties are merely used as a rhetoric tool instead of leading to improved practices.

5.1 Vietnam's national legislation in comparison with its international legal obligations

Initially, Vietnam's response to HIV was slow with the first case of HIV reported in 1990 and appropriate strategic plans and polices not in place until 2004. In 2006, Vietnam adopted the Law on HIV/AIDS Prevention and Control. From 1995-2006 the highest legal document consisted of an ordinance which ranked low in the national legal order of Vietnam and could not be regarded as an appropriate response in regard to the threat posed by HIV. ICCPR, CEDAW and ICESCR all require state parties to take appropriate legal measures so that the rights contained in the aforementioned treaties are protected within the national legal order. Both ICCPR and CEDAW impose direct obligations, meaning that a state party has to fulfill the rights in those treaties from the day they become state parties. Some of the rights in ICESCR are also of a direct nature but mostly the state party is obliged to take steps to the maximum of its available resources. Vietnam did not implement an appropriate legal response to HIV until 16 years after the first reported case of HIV. In regard to ICCPR, CEDAW and ICESCR, this long time period must be deemed too slow. Therefore, Vietnam has consequently been in breach of its obligations to set up an appropriate legal framework regarding HIV.

However, it must first be recognized that once the law was in place, it must be considered as a significant improvement over the ordinance and as a progressive document compared with similar legislation in neighboring countries. The law prohibits discrimination against PLHIV and should therefore be in line with ICCPR and ICESCR. It is difficult to answer as well as out of the scope of this thesis to explicate the details of the anti discrimination clause. There is, for example, no decree following up the law on how to actually combat stigmatization and discrimination against PLHIV and a very general statement might not render an actual effect.

In addition, there is no general clause preventing discrimination against women. Vietnam should have an obligation to include an anti discrimination clause in its HIV legislation targeting discrimination against women. Particularly since the spread now is about to change nature with an increased and rapid infection rate among women. Such a general article would aim at fulfilling Vietnam's obligation in regard to the first paragraph in CEDAW's article 12. At the same time, Vietnam has put forth a great deal of effort fulfilling the second paragraph in the same article according to which "appropriate services in connection with pregnancy" in the field of healthcare

should be granted. Pregnant women are mentioned a number of times in the Law on HIV aids granting specific rights to pregnant women in all areas such the right to information, free counseling and testing as well as access to treatment.

It is stated in the Law on HIV that persons infected with HIV "shall be facilitated by the state to have access to ARVs" which by no means grants universal ARV treatment. In fact, only children under the age of 6 are guaranteed HIV treatment free of charge. The ICCPR impose an international legal obligation on Vietnam to respect the right to life. The HRC has stated in its general comments that this entails positive obligations and that all possible measures should be taken to increase life expectancy, especially to eliminate epidemics. It is a stretch to reach the conclusion that Vietnam has fulfilled this obligation when there are no provisions guaranteeing a universal access to ARV treatment; not even children above the age of 6 are guaranteed access to basic treatment including ARVs. The national legislation in regard to the ICESCR is of a more complex nature. Some parts of the Covenants obligations are of an immediate character such as discrimination. Most parts of the ICESCR; however, impose an obligation to take steps to the maximum of its available resources in order to progressively achieve the full realization of the rights outlined in the Covenant. This could hardly said to be fulfilled in regard to general access to ARV and treatment.

In regard to other pressing areas such as access to information and education about anti discrimination clauses and harm reduction, the Law on HIV must be seen as a progressive piece of legislation. There is, for example, a decree addressing issues such as the use of condoms and distribution of clean needles and syringes as well as treatment of addiction to opiate substances with substation drugs. This is quite progressive compared to the achievements in neighboring countries. Having such issues addressed in its legal framework, Vietnam does fulfill quite some of its obligations to safeguard the rights set out in IESCR in relation to HIV in its national legal order.

5.2 National practices in comparison with international legal obligations

If Vietnam has made significant achievements when it comes to legal implementation, a great deal of work still needs to be accomplished in terms of actual on the ground practices and program implementation.

It is of vital importance to mention that Vietnam does not have an independent judiciary. In the courts' rulings, they are explicitly or implicitly responsible for taking into account the opinions expressed by the one party regime. Therefore, it is very unlikely that a Vietnamese court would ever conclude that the state is in breach of its international obligations. Legal norms need to be backed by independent courts in order to give citizens sufficient protection.

One area of concern is the health sector capacity. Vietnam's hierarchical health system poses significant problems since the lower levels of the health care system are inadequate to meet the health demands of PLHIV. The health care facilities at the district and commune level are not sufficiently equipped nor do they have sufficient

personnel or fully trained personnel. The heavy burden then weighs on central hospitals. Additionally, poor people living in rural areas often cannot afford to travel to the central health care centers in the larger cities, and therefore do not receive the health care that they need. It is also very difficult for donor organizations to improve the situation because the have to focus on setting up facilities themselves instead of improving already existing centers. Without a functioning health sector capacity, all other measures might be in vain. For example, it may be futile to buy or have ARVs available, if the system for distribution and treatment is not in place. Again, as previously mentioned in this thesis, ICESCR obliges state parties to take steps to the maximum of its available resources. Setting up a system with basic health care facilities must be regarded as the first step in trying to fulfill any right to health. Vietnam can hardly be considered to have reached this target or ensured adequate health care treatment, thus must be considered in breach of ICESCR.

Focusing on high risk populations is necessary since the infection is much higher among people in these categories and a number of new people at risk to be infected with HIV are part of these high risk groups. The current measures taken by Vietnam can hardly be described as appropriate. The system which includes forced residential rehabilitation centers could be likened to a prison, since the placement is mandatory. People staying in those centers are regarded as social outlaws and they are not given appropriate treatment since the HIV prevalence is even higher within the center then outside them among sex workers and drug addicts. This system is not aligned with Vietnam's international legal obligations, and in particular Vietnam must said to be in breach of the right to free movement in ICCPR because of these programmes. Derogations from the rights in ICCPR are allowed under certain limited conditions. One such condition is restrictions in order to ensure public health. Although the provisions in ICCPR could be restricted because of reasons of public health they must still be proportionate, no other measures should be available and they must be efficient. None of these prerequisites are fulfilled in this case. The treatment in the rehabilitation centers is not efficient since the HIV prevalence amongst drug users within the centers is even higher than among the same group outside the centers.

Vietnam should stop regarding drug addicts and sex workers as social evils, which leads to stigma and discrimination. It is of course also an obvious breach against its own legislation prohibiting discrimination against people infected with as well as a breach of ICESCR on the same ground. Vietnam could also be in breach of its international obligations under CEDAW discrimination against women since there is no justifiable reason to keep female sex workers in the above mentioned centers. Instead, it must be considered as a particularly vulnerable group which should have extended protection and not the other way around.

Information and education about HIV/AIDS is another area of concern in regards to Vietnam's continued effort to provide adequate support, treatment and prevention. Despite their ongoing efforts and substantial international donor support, 35 percent of the population is unaware of the three main modes of transmission of HIV. The obstacles in reaching the large population are the size of the country with a large rural population which can oftentimes be difficult to reach. An additional problem is that people infected with HIV could be reluctant to get tested because of stigma and discrimination in the society as well as lack of ARV treatment. There are already signs that the main mode of transmission has changed from transmission via unclean

needles and sex workers to transmission through sexual intercourse between large groups of the population. Therefore, it is urgent that large information campaigns are set up in order to improve the knowledge among all groups in the society. Information should also form a natural part of primary education and detailed programmes should be implemented. While Vietnam has implemented large mass media campaigns, they have generally been insufficient to adequately educate and inform the 80 million people living in Vietnam. Vietnam has not maximized the use of resources for information, education and communication, which could be vital to reducing the spread of HIV in Vietnam.

Although Vietnam has scaled up its treatment for HIV infected people, a great deal remains to be accomplished. Approximately 28.4 percent of HIV infected people in Vietnam receive ARVs today. It is difficult and expensive to undergo testing and most people are not covered by health insurance. Therefore, it is oftentimes a matter of luck whether there is a donor organization present in the actual province where an HIV infected person in is living in order for the person to receive ARVs. The ICCPR imposes an immediate obligation upon any state party. Also positive measures are required meaning that the state party has to take actual action in order to fulfill its commitments. Each year 13 000 people are dying from HIV, however Vietnam has the funding to provide ARVs to a much larger extent. Vietnam has to take steps to the maximum of its available resources but still only a minority of HIV infected people is given basic ARV treatment. This should also be regarded in the light of Vietnam's extraordinary economic development for many years. The author therefore concludes that Vietnam must be in breach of its international obligation in regard to the right to health in ICCPR as well as in breach of article 12 of ICESR to combat infectious diseases.

Many of the aforementioned problems could be resolved if the local institutions and health sector were better organized, a national monitoring system was in place and questions regarding overlapping of donor activities were appropriately dealt with at the national level. With many international donors present in Vietnam with large budgets to spend on HIV/AIDS, there is not currently an issue in regards to funding. As mentioned previously, having an adequate and accessible health system, must be regarded as a basic first step to ensure the basic right to health for PLHIV. While Vietnam may have acceded to international conventions, they have still failed to set up an adequate health care system. Therefore, it must be considered a breach of article 12 in IESCR since no health related diseases could be fought without a functioning primary health care system.

It should be taken into consideration that Vietnam has experienced tremendous economic growth and development with an annual national growth of 7 percent, yet still only 9.4 million dollars are spent on the National HIV programme. Vietnam also has one of the largest out of the pocket based health care systems in the region. The ICESCR obliges state parties to take steps to maximize its available resources until the full realization of prevention, treatment and control of HIV is achieved. Vietnam ia in breach of this obligation since adequate funding is available, and yet the appropriate system is not in place for treatment. Many of the difficulties described could be addressed through organizational improvements.

5.3 Final remarks

Vietnam has made significant progress in terms of HIV legislation, and the government seems to understand the great threat of HIV for the individual as well as for the society as a whole. A new action plan has been adopted where viewpoints and stands are taken, objectives are outlined and methods to fulfill the objectives are described. National legislation has been adopted in order to give legal weight to the strategy plan. These are all considerable achievements in comparison with neighboring countries. Nevertheless, any legal norms need to be safeguarded by an independent judiciary in order to be fully upheld and the lack of such independent courts remains a major shortcoming in Vietnam. The legislative framework still has not improved on the ground practices and practical program implementation. Simple reforms, such as a monitoring system and an improvement of the primary health care system that could improve the situation considerably are left undone. Vietnam also heavily relies on international donors instead of taking its responsibility itself. Vietnam's international obligations are not to be judged in comparison to other countries but rather on Vietnam's own merits and actions. A lot remains to be done before Vietnam fulfils its own outspoken goal to implement and adhere to its international legal obligations in regard to the right to health and HIV control and prevention.

6 Annex 1

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