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ACRONYMS AND ABBREVIATIONS

ACSM	Advocacy – Communication – Social Mobilization
CBO	Community-Based Organization
CLM	Community Led Monitoring
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease
CSO	Civil Society Organization
CSS	Community Systems Strengthening
CST	Care, Support, and Treatment
DR-TB	Drug-Resistant Tuberculosis
DST	Drug Susceptibility Testing
GF	The Global Fund
ICESCR	International Covenant on Economic, Social And Cultural Rights
IRD	Interactive Research and Development Vietnam
KVP	Key And Vulnerable Populations
MDR-TB	Multi Drug-Resistant Tuberculosis
MOH	Ministry Of Health
NTP	National TB Program
OOP	Out Of Pocket
PAL	Practical Approach to Lung Health
PASTB	The Patient Support Foundation to End TB
PCDC	Provincial Centre for Disease Control
PLHIV	People Living With HIV
PPE	Personal Protective Equipment
PPM	Public-Private Mix
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SCDI	Centre for Supporting Community Development Initiatives
SES	Socioeconomic Status
STP	Stop TB Partnership
TB	Tuberculosis
TPT	TB Preventive Therapy
UN	The United Nations
VSTP	Vietnam Stop TB Partnership
WHO	World Health Organization

INTRODUCTION

The 2018 United Nations High-Level Meeting on TB contains commitments to address socioeconomic and gender-related barriers in TB response. As guided by the Stop TB Partnership Global Plan to End TB, conducting a TB CRG Assessment demonstrates Vietnam's commitment to achieving the UNHLM on TB targets and commitments.

This needs assessment has been developed as an effort to contribute to epidemic control, specifically by providing insight into areas in Vietnam's national TB program and TB-related policies that could be strengthened. Funded by the Global Fund, this needs assessment was commissioned by Vietnam's National TB Program and carried out by the Center for Supporting Community Development Initiatives (SCDI) with technical assistance from Stop TB Partnership (STP).

Through this assessment, Vietnam aims to address the persisting TB issues in line with the Global Fund (GF) vision of accelerating its TB program to achieve the 2030 TB targets, which have been adversely impacted by the COVID-19 pandemic. Acknowledging that certain factors affect one's vulnerability to TB and inequitable treatment, this needs assessment will assess the aforementioned factors and potential opportunities to strengthen the TB response.

Vietnam is committed to finding and treating all people with TB. As part of finding the missing people with TB, we must also understand the socioeconomic barriers that different people experience in accessing TB services.

QUALITATIVE DATA COLLECTION

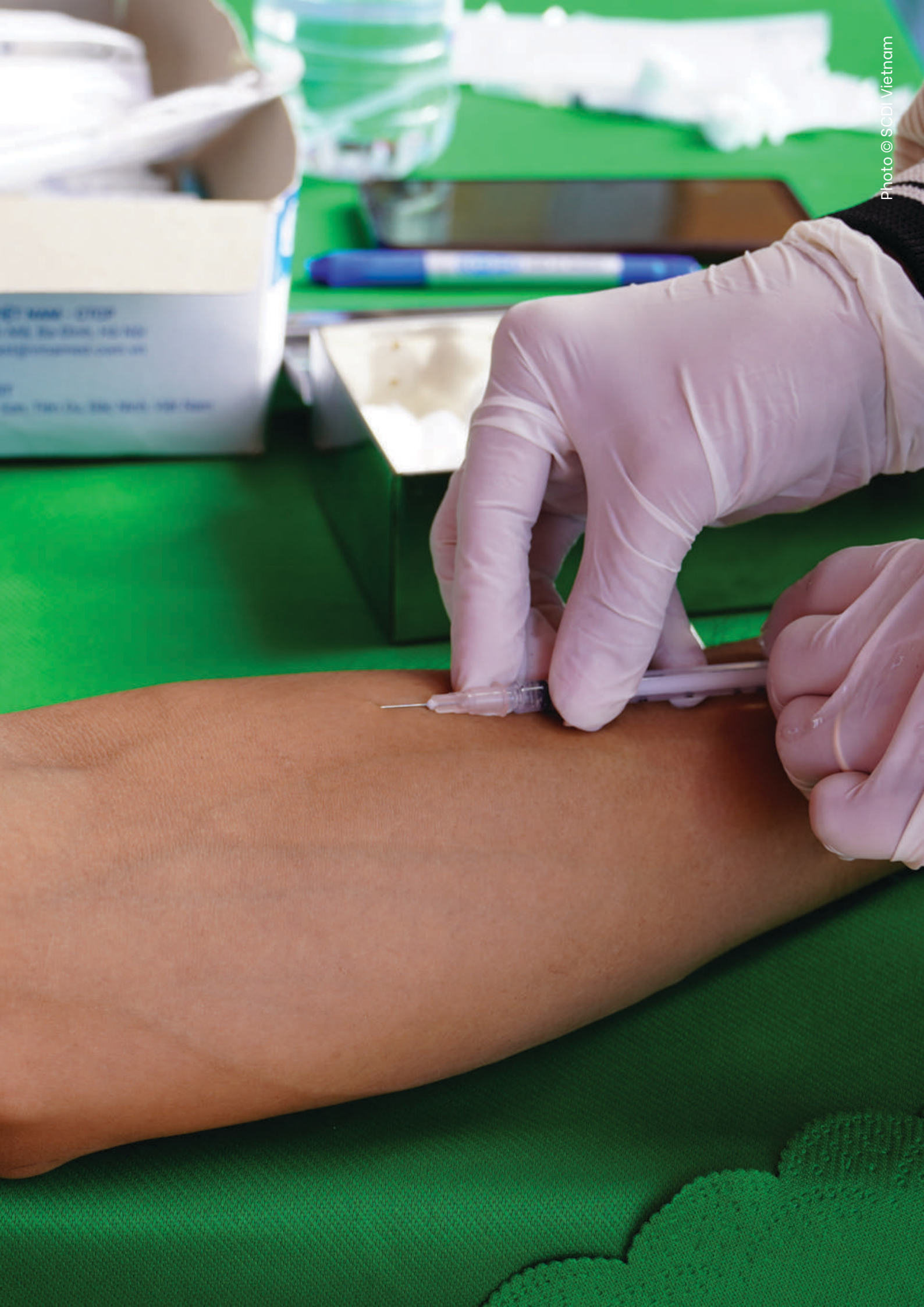
METHODOLOGY

To ensure the specificity and accuracy of the needs assessment, data is obtained through primary and secondary sources. This took the form of data from the National TB Program (NTP), in-depth interviews, and focus group discussions (FGD) for the primary source, which were analyzed and supported by secondary sources as listed in the bibliography section. Six focus group discussions and 41 in-depth interviews were conducted, with respondents ranging from TB program implementers, health workers, community members, key and vulnerable populations (KVP), and more. In addition to the aforementioned sources, this needs assessment also assessed policy documents, guidelines, and additional documents.

LIMITATION

Due to the novelty of several topics, such as TB-related stigma, there are limited resources that fully assessed the effectiveness of subgroup-specific stigma and stigma reduction interventions. Existing primary data used are only disaggregated by age and gender, not by key population (KP), hence providing little insight into the accessibility of TB services by KP groups.

Following the COVID-19 pandemic's outbreak, including the fourth wave (April 7, 2021), data collection and reporting for 2021 was delayed. Hence for the purpose of this needs assessment, the 2021 data will be compared to the data of approximately 10 months from the previous years.



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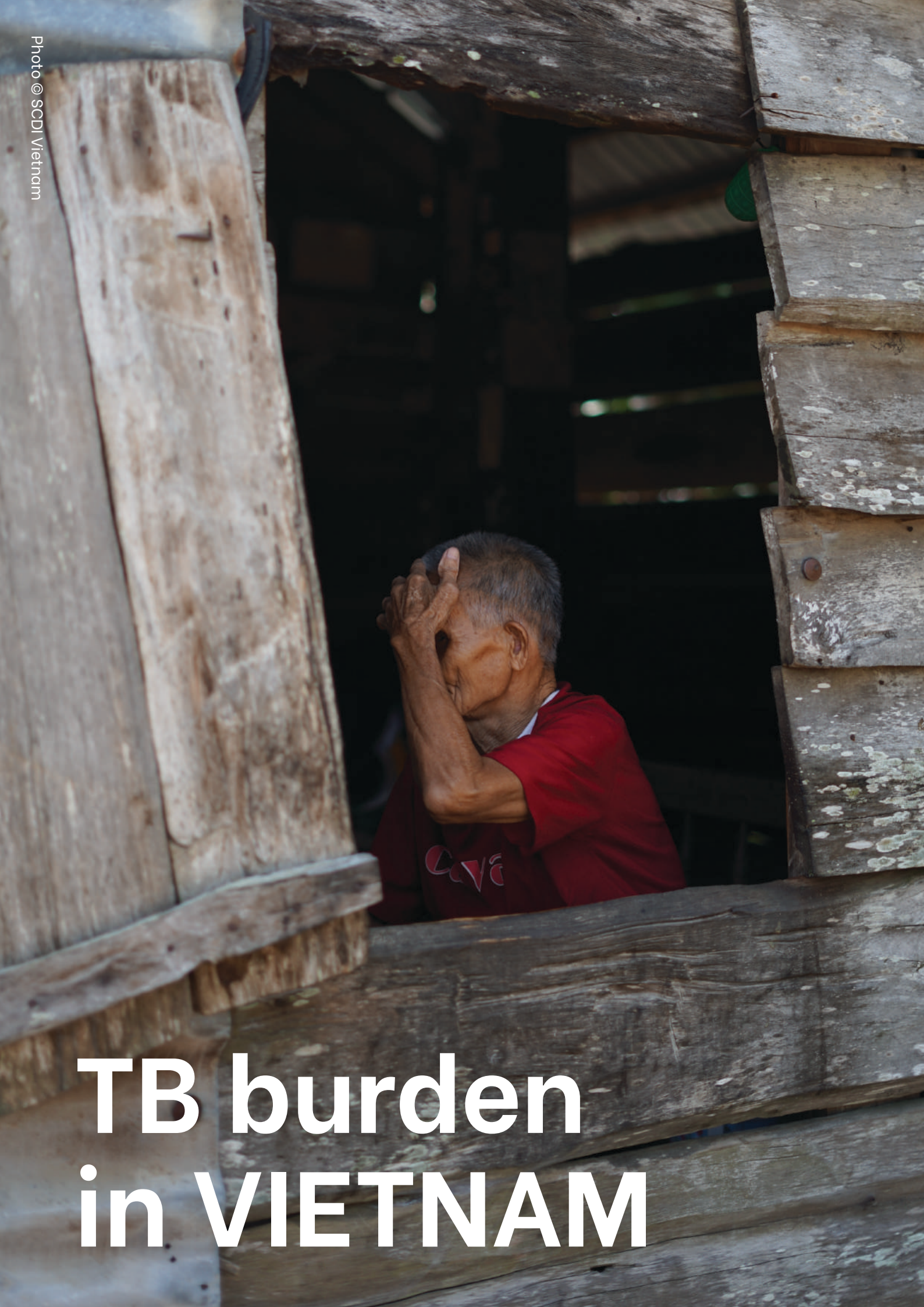

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TB burden in VIETNAM

BACKGROUND

TB Burden in Vietnam

Located at the heart of Southeast Asia, Vietnam is home to an estimated 98 million citizens. The country is considered a high TB and DR-TB burden country, though it has made tremendous efforts to address finding persons with TB over the last few years, which contributed to a decrease in incidence rate by 11%.[1]

Data from the National TB Program (NTP) reveals that from 2019-2021 there has been an estimated 2,000 incidence number found annually, with the number of males making up double to triple the number of females with TB (Appendix 2). The Southeast region has the highest number of persons with TB at 30,427, closely followed by the Mekong Delta region (25,728 persons) and Red River Delta region (17,724 persons). Among the ±98 million citizens, 169,000 developed TB in 2021 and 14,000 persons died due to infectious disease.[2]

In the same year, Nguyen et al. (2020) conducted a TB prevalence survey that showed 7.7% of the respondents (n=87,207) screened TB-positive, though each was followed up with additional testing.

Due to the distinctive nature of each region and province, the progress of TB programs differs across the nation. Data from NTP shows that there are huge differences between provinces when it comes to TB notification rate, ranging from 17 to 235/100,000 population. Regional differences are also pronounced, seeing a much higher rate in the South than in the rest of the country, but even within regions, provinces showed significantly different rates, pointing to room for improvement. There are correlations between the general notification rate with notification rate among children (moderate), and the older people (very strong). Provinces that do well in notification, in general, would do better in finding persons with TB among children and older people.

Missing persons with TB

According to the Global TB Report, in 2019, the total TB incidence is estimated to be 170,000 new (persons with TB) with an estimated rate of 176/100,000 population; the total of notified cases in the same year was around 102,000 with the notification rate of 106/100,000 population (WHO, 2020). Nearly 40% of persons with new and relapsed TB were missing. The prevalence survey in 2018 estimated bacterially confirmed pulmonary TB prevalence to be 322 per 100,000 population, with only 14% of person with TB identified in the survey having been on treatment while the others did not access any TB care (Nguyen et al., 2020). Although having different epidemiological meanings, these two sources of data both indicate that a significant proportion of persons with TB are being missed.

The outbreak of the COVID-19 pandemic further dampened the situation and progress towards achieving epidemic control in Vietnam. In 2021, the total TB incidence was estimated to be 172,000 persons with TB as reported in the Global TB Report (2021) by WHO, the notification number was estimated at 77,000 whilst the missing people with TB reached 56% of the total incidence. The same missing people with TB is also an issue with multi-drug resistant TB (MDR-TB), with WHO estimating that due to the increase over the years, there were 8,400 persons with MDR-TB in Vietnam in 2019. NTP reported that in 2017 only 41.5% of the estimated persons with MDR-TB were diagnosed and treated, among these only 52.6% were successfully

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[1] *Prime Minister. Decision to approve the National Strategy for Prevention and Control of TB to 2020 with a vision to 2030. Decision 374/QDD-TTg. 17 March 2014.*

[2] *https://dashboards.stoptb.org/country-profile.html*

treated and 15.8% had completed their treatment, that means over 70% of persons with MDR-TB are missed, either for not being found or having failed to complete the treatment. For a country with a high burden of MDR-TB, this is a cause for concern, added to the effects of the COVID-19 pandemic. Highland and mountainous provinces have a high number of missing people with TB, up to 80% of the estimated incidence. These provinces have limited available TB services with many barriers for people to access services.

Existing Systems

The National TB Program

The National TB Program is based on a government's vertical structure of TB facilities (TB centers, TB hospitals) existing at the national and provincial levels. At the district level, there are TB teams at district health centers. At the commune level, a commune health center's staff is designated to manage the TB program.

Decision 374/QD-TTg dated 17 March 2014 spells out the National Strategy for TB Prevention and Control, at the national level with the Ministry of Health being the focal governmental structure for the implementation of the TB Strategy. At provincial levels, People's Committees are in charge of establishing Steering Committees for TB Prevention and Control. In practice, National TB Program is managed by the National TB and Pulmonary Diseases Hospital while provincial programs are managed by designated provincial-level facilities; in most provinces, it is a provincial-level hospital that treats TB, and in a few provinces, it is the provincial Center for Disease Control. Notably, facilities that manage TB programs, at the national or provincial level have been upgraded to TB hospitals, with more beds and equipment, and to handle a larger scope of lung diseases.

Since 2006, the government started to pilot the so-called "hospital financial autonomy" policy. In 2021, the government's decree 60/ND-CP/2021 made it clear that all public hospitals should be financially autonomous. This would mean hospitals are responsible for their financial balance sheet; the government will no longer directly subsidize hospital expenses. Because of that, hospitals will rely on fees from services, whether to be paid out-of-pocket by persons with TB or by a third party such as health insurance or a donor.

To create more opportunities for staff's professional development and attract more diverse clients rather than only persons with pulmonary TB to bring better income to hospitals, there has been a movement to change the name of hospitals that treat TB from "TB hospital" to "TB & Pulmonary Diseases hospital" and to "Lung hospital". The national center of the National TB Program – The National TB Hospital is now known as the National Lung Hospital. In the same trend, many provincial TB hospitals have become Provincial Lung Hospitals. These hospitals expand their scope of services and invest in other health concerns, such as prevalent non-communicable illnesses (e.g. COPD, asthma, or lung cancer), which bring much more lucrative revenues. This movement is also an acknowledgment of the widespread stigma against TB and the eventual diversion of the attention and resources for TB programs within those hospitals. Although there are still TB departments/wards that treat TB and the Technical Supervisory Unit that oversees TB activities at lower levels of the health system, TB is no longer the only focus and not even a major business of some hospitals. TB program is losing its dedicated bodies and, as such, its integrity is affected.

Vietnam has adopted several ways to accelerate its NTP, as captured in the 2020 Step Up for TB report. One such method is by exchanging smear microscopy with Xpert MTB/RIF, and allowing chest X-ray to be used as pre-screening should resources be scarce.[3] Through the TB REACH campaign, the Stop TB Partnership

[3] *Step Up for TB, 20*

was also actively involved in ensuring that chest X-rays are accessible throughout the nation, knowing that access to health services or technology in certain areas is difficult. This aim was successfully carried out through SWEEP-TB, a project that funded mobile TB testing including chest x-rays, in partnership with Interactive Research and Development Vietnam (IRD), Friends for International Tuberculosis Relief (FIT), and authorities or stakeholders at the provincial level.

By 2020, Vietnam had 126 facilities that offer Gen-Xpert MTB/rifampicin (RIF), Truenat, TB-LAMP testing, and/or other RMD.[4] The RMD was required as the primary test for TB for at-risk groups and children. Specific to PLHIV, TB-LAM was expected to be implemented in the coming year(s). The drug susceptibility testing (DST) was already in place by that year with a total uptake of 44%.[5] National policies were already in support of the use of universal DST, RIF-resistance testing for persons diagnosed with TB, and follow-up testing for RIF-resistant TB. Several components that may be vital to integrate into the national policies are RIF and INH resistance testing for new on-treatment.

Though relatively rare, drug-resistant TB (DR-TB) presents more challenges for both people with TB and health providers. Additional measures need to be taken to successfully treat DR-TB. Hence, it may prove vital to integrate routine testing of persons undergoing TB treatment's sputum throughout the DR-TB treatment into national policies. As of 2020, Vietnam has yet to adopt the 2019 guidelines on DR-TB, as laid out by the World Health Organization (WHO).[6] Though shorter DR-TB regimens have been integrated into national policies, DR-TB treatment options such as longer or modified shorter all-oral regimens have yet to be adopted as well.

Overall, funding for TB program is mostly from external donors, with the most predominant funding originating from the Global Fund. In 2021, the government's funding for TB accounted for only 10% of the funding managed at the national level which is almost exclusively used for the procurement of first-line TB drugs. Meanwhile, at the provincial level, funding for TB services derives from national programs and local government allocations, which vary between provinces and tend to only be accessible later in the year. At the district and community levels, there are government-salaried staff to carry out regular services but almost no funding for other activities such as communication or active finding persons with TB. As health insurance now covers first-line TB drugs and all essential diagnostics and monitoring tests, with the Global Fund providing enough GeneXpert machines, current government-salaried staff can provide facility-based TB diagnosis and treatment. Therefore, funding from the Global Fund could be used for activities other than facility-based diagnosis and treatment.

In 2018, Vietnam experienced a change in the TB health system, particularly in the TB control unit.[7] Following the Prime Minister Decision No. 1745/QD-TTg dated 4/12/2019, a National Committee was formed to aid the country in realizing epidemic control.[8] Their duties include conducting research and developing national strategies for the program, as well as assisting the Prime Minister in overseeing and coordinating with relevant stakeholders to strengthen the NTP. Another strategy taken to accelerate treatment outcomes and epidemic control, the NTP has emphasized the importance of private sector engagement in the fight against TB. Using the public-private mix (PPM) model, the collaboration has shared efforts in the TB control program and presented new opportunities that would otherwise be difficult to achieve without multi-sectoral efforts.

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[4] *Ibid.*

[5] *Step up for TB – Dashboard – Diagnosing TB, pg. 50*

[6] *Step up for TB – Dashboard – Diagnosing TB, pg. 53*

[7] *Year End Report Review of NTP Performance in 2018 (pg. 11)*

[8] *Year End Report Review of NTP Performance in 2020 (pg. 71)*

As reiterated by the MOH in the Year-End Report Review of the National TB Control Program (2020), the NTP experienced several challenges in the implementation of the PPM model. One such challenge is the lack of (financial) support provided to health workers from private health facilities for recording and reporting people with TB to the NTP system.[9]

2020-2021 TB Program

Since the COVID-19 pandemic in 2020, Vietnam has seen a drastic shift in both the implementation and performance of its TB program. The sporadic nature of the pandemic caused sudden changes in health services, such as but not limited to the reallocation of health workers to the COVID-19 response and the shortage of supplies or delay in procurement of TB medicine, PPE, and equipment.[10] In addition, another concern was the sharp decrease in visits to health facilities caused by lockdown and isolation during the pandemic, as well as the fear of contracting COVID-19.

Although the country faced several challenges carrying out TB programs during the pandemic, most of the targets set for 2020 were still met, indicating that Vietnam is still on track to realizing TB control by 2030. Some of the most profound achievements are listed below:

1. Maintained and expanded TB control network, in which 76% of the provinces have established specialized TB facilities, such as Lung hospitals, TB and pulmonary disease hospitals. The remaining provinces, barring Phu Yen use their own TB control model, and have integrated into the Provincial Centre for Disease Control (PCDC);
2. Protected 100% of the target populations;
3. Detected over 100% of new and relapsed persons with TB and achieved over 91.7% of treatment success in both instances, with treatment success differing per province.[11]

Aside from services provided by the health facilities and the NTP, other forms of activities also played a key role in maintaining TB control during the pandemic. Examples include meetings, parades, and media appearances by the Vietnam Stop TB Partnership (VSTP) and the Patient Support Foundation to End TB (PASTB) campaign that raised nearly VND 1.3 billion in support of the TB program.

Among the list of challenges faced by the country, perhaps the most apparent one is the lingering effects the pandemic has had on the NTP. In its 2021 plan, the NTP has highlighted several areas that have been heavily affected by the pandemic and that require immediate attention, as listed below:

1. Persisting high TB and MDR-TB burden
2. Supply chain management of drugs and equipment, including PPE, was slowed
3. Healthcare system
    a. Public-private mix (PPM) could be maximized by providing support for health workers in private sectors to conduct recording and reporting into the NTP system
    b. Efforts to conduct prevention and tests for pediatrics with TB need to be accelerated and standardized throughout the provinces
    c. Hospitals faced multiple challenges due to the financial autonomy model, such as debt and a decreased number of visitors seeking health services during the pandemic
    d. The gap between provinces with specialized facilities and those without them caused differences in achievement and heightened burden per province

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[9] *Year End Report Review of NTP Performance in 2020 (pg. 10)*

[10] *Year End Report Review of NTP Performance in 2020 (pg. 6)*

[11] *Year End Report Review of NTP Performance in 2020 (pg. 9)*

4. Specific case management
    a. Programmatic management of drug-resistant TB (PMDT): treatment enrolment only increased by 1% (cumulative 75%) from 2019 and the success rate was at 71%
    b. TB program for prisoners faced persisting and new challenges

Since this reform towards a new type of health financing (financial autonomy), the country has seen a shift in the provision of health services, including in the TB sector. It was found that following the move towards financial autonomy, like other countries that have adopted this approach, the largest portion of health financing source comes from out-of-pocket (OOP).[12] Several achievements that were attained following the health reform are significant growth in hospital revenues, surge in investments in health facilities and equipment, expansion of services provided, reduction of costs, and more.[13] Meanwhile, other factors such as efficiency, costs of medicine, and disparity between one health facility to another are some of the challenges that need to be addressed to strengthen the healthcare system in Vietnam, especially following the 2020 national TB program evaluation.

Pursuant to international laws, Vietnam has also made significant efforts to fulfill prisoners' rights to healthcare. One such method is by providing periodic screening for 120,000 prisoners in 54 prisons across 44 provinces/cities.[14]

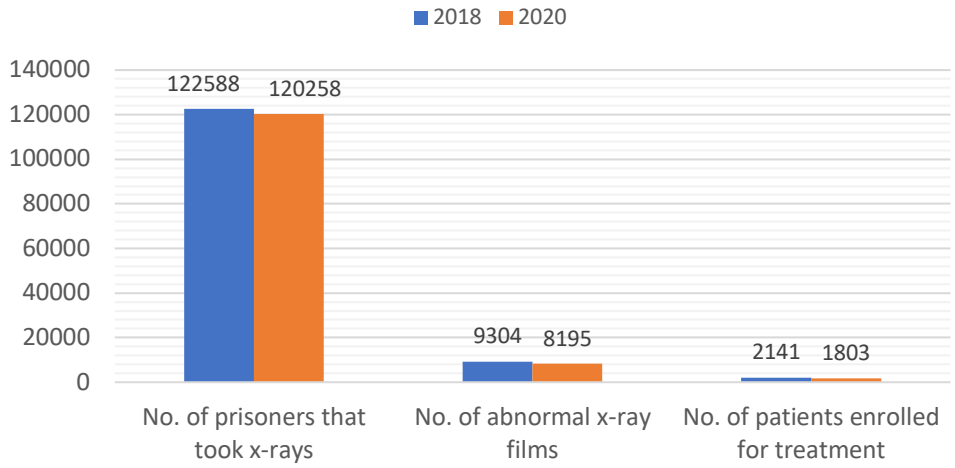

Figure 1. TB Screening and Treatment among Prisoners (2018 & 2020)[15]

In 2020, the aforementioned screening activities only began mid-year, with follow-up activities expected to be conducted in 2021. Nevertheless, there were only slim differences in the performance of screening and treatment enrollment for prisoners in 2020 compared to 2018.

The program, which was a fruitful partnership between the National Lung Hospital, the Police Department, the Department of Health – Ministry of Public Security, and provincial/district-level TB control units, faced

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[12] *World Bank, Lessons for Hospital Autonomy Implementation in Vietnam From International Experience (pg. 25)*

[13] *Ibid.*

[14] *Ministry of Health – The National Tuberculosis Control Program, Year-End Report Review of National TB Control Program in 2020 (pg. 33)*

[15] *Ministry of Health – The National Tuberculosis Control Program, Year-End Report Review of National TB Control Program in 2018 and 2020*

several challenges. Similar to the screening activities held in 2018, the program was mostly held outdoors and exposed prisoners to heat and discomfort. Following the pandemic, though, other issues also arose such as the inability of prisoners to get X-rays in prisons without (functioning) X-ray machines as well as delayed implementation in the central regions, partly caused by the oncoming flood. It was also reported that aspects such as human resources and their capacity to use TB detection and treatment equipment need to be increased.

In addition to screening and treatment, the NTP also held several training activities in collaboration with Department C10 – Ministry of Public Security. A total of 120 health workers in prisons in Ninh Binh, Nghe An, and Can Tho provinces were trained to detect, diagnose, and treat TB and MDR-TB, while peer educators for prisoners were also trained on similar materials.

Primary Focus of the 2021 TB Program and Its Implementation

Upon evaluating its performance in 2020, the following year, the NTP declared its primary objective and focus for its upcoming TB program. The annual review revealed successes and challenges faced by the NTP during the COVID-19 pandemic and became the basis for the reorientation and maintenance of its activities in 2021. The primary goal of the NTP by 2025 remains as follows:

1. To maximize the detection and treatment of TB in the community to prevent TB transmission;
2. To strengthen the detection and treatment of latent TB to prevent infections from becoming TB [16]

In addition to the acceleration of the reduction of TB/MDR-TB incidence and mortality as well as catastrophic costs incurred by affected families, additional series of activities have also been made to address specific concerns. This includes strengthening MDR-TB management, research activities, supply-chain management, NTP activities, information management, TB-HIV program, pediatric with TB management, latent TB, TB control network development, active finding persons with TB, PPM and PAL, laboratory system, ACSM, and plan development. The NTP not only aims to strengthen existing national/provincial health systems but also its partnership with relevant stakeholders.

However, in April 2021, following the development of the NTP target and report (March 2021), the fourth wave of the COVID-19 pandemic hit Vietnam and drastically affected its TB program operations. One such impact, which has been mentioned in the “Limitation” section of this document, was the missing and/or delayed reporting from the district- and province levels. [17] For this report, and per NTP method, the achievements of the TB program in 2021 will be compared to the 10-month achievements of 2020.

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[16] *Ministry of Health – The National Tuberculosis Control Program, Year-End Report Review of National TB Control Program in 2020, pg. 76*

[17] *Final Report Activities of the Tuberculosis Program 2021, NTP (pg. 14)*

Year	TB with bacterial evidence			TB without bacterial evidence	Extra-pulmonary TB	Unknown prehistory	Total
	New	Relapsed	Re-treatment				
10 months 2021	34,908	3,317	749	10,997	12,967	60	62,998
%	55.41	5.27	1.19	17.46	20.58	0.10	100
10 months 2020	43,893	3,924	999	16,551	16,956	45	82,368
%	53.29	4.76	1.21	20.09	20.59	0.05	100
Quantity Comparison	-8,985	-607	-250	-5,554	-3.989	15	-19,370
Rate Comparison %	2.12	0.50	-0.02	-2.64	0.00	0.04	0.00
Ratio/Quantity Comparison %	-20.47	-15.47	-25.03	-33.56	-23.53	33.33	-23.52

Table 1. Detection of person with TB in the first 10 months of 2020-2021[18]

Year		No. of person assessments	Treatment results					
			Cured	Treatment completion	Deceased	Failed	Unable to monitor	No assessments
9 months of 2020	No. of persons undergoing TB treatment	41,437	35,102	2,989	1,186	316	981	863
	%	100	84.7	7.2	2.9	0.8	2.4	2.1
9 months of 2019	No. of persons undergoing TB treatment	**43,123**	**36,800**	**2,673**	**1,217**	**359**	**1,148**	**926**
	%	100	85.3	6.2	2.8	0.8	2.7	2.1
Quantity comparison		**-1,686**	**-1,698**	**316**	**-31**	**-43**	**-167**	**-63**
Rate Comparison (%)		0	-0.6	1	0.1	0	-0.3	0
Ratio/Quantity Comparison (%)		-3.91	-4.61	11.82	-2.55	-11.98	-14.55	-6.80

Table 2. Treatment for a person with new and relapsed TB bacterial evidence[19]

On a national level, detection and treatment of persons with TB fell sharply in 2021, which is partly due to the effects of the fourth wave. Similar to previous years, there are differences in TB program achievement across the different provinces, all of which can be seen in the table summary below:

[18] *Ibid.*

[19] *Ibid.*

Scale/ Province	Description Note: detection data used is for 10 months of 2020 and 2021	Challenges
National	detection □ Case detection fell sharply in comparison to the previous year (Table 1) □ The number of persons newly diagnosed with TB with bacterial evidence decreased by 20.47% from 2020, whereas the total number of persons diagnosed with TB with bacterial evidence decreased by 20.16% (9,842) □ The number of persons diagnosed with TB without bacterial evidence fell even more drastically to 33.56% (5,554) □ Detection efforts for persons with new or relapsed TB (with or without bacterial evidence) in 2021 reached an estimated 50-52% of the annual target	□ Social isolation and restriction, which lasted longer than in 2020, proved to be a challenge in case detection and treatment □ TB detection rate fell from 84.33/100,000 population (2020) to 62.61/100,000 □ The number of persons with TB access to health services was significantly reduced, with some facilities facing a reduction of up to 50%
Southern	detection □ Detection of persons with TB decreased by 26% from 2020, with the most rapid decrease being attributed to the person (with TB) without bacterial evidence (-35.62%) □ The number of persons with pulmonary TB with bacteriological evidence decreased by 23.96%, which is the most decrease experienced by any of the three regions □ The ratio of persons with TB with bacterial evidence to the total number of persons with TB detected is 68.01%, which is the highest across the three regions □ Compared to 2020, the ratio of persons with TB without bacterial evidence to the number of persons detected decreased by 35.62% The number of admissions for undergoing TB treatment fell compared to 2020	□ Experienced the sharpest decrease in TB detection rate due to the region experiencing the highest number of persons with TB treated for COVID-19. This reoriented the health workers' focus to COVID-19 protocols. □ The detection of new cases also decreased rapidly, especially in Binh Duong (35.2%), Tay Ninh (30%), and Can Tho (27.1%) provinces, among others.
Central	detection □ Within the 10-month period, the number of persons with TB with bacterial evidence decreased by 1,008 cases whereas those without bacterial evidence decreased by 988 □ Similarly, the number of persons with new pulmonary TB with bacterial evidence	□ The Central region saw a 24.51% decrease in case detection compared to 2020. □ Quang Ngai (38.3%), Quang Binh (36%), and Phu Yen (33.1%)

	decreased by nearly 21% (959 cases) whilst the number of persons with extrapulmonary decreased by 364. □ The number of admissions for undergoing TB treatment did not decrease as much as in the Southern and Northern regions The Central region had the highest male/female ratio of new and relapsed persons with TB (2.74:1)	provinces saw a significant reduction in the ratio of new and relapsed cases with bacterial evidence to the total number of persons with TB Nearly 40% of targeted new cases were detected and nearly 45% of the entire detection target was met.
NORTHERN	DETECTION □ At 53.93%, the rate of persons with TB with bacterial evidence is still the lowest in the Northern region, though it did decrease by 11% compared to the previous year. The decrease in the number of cases was more significant among persons with TB without bacterial evidence (-30.47%) than among persons newly diagnosed with TB with bacterial evidence (-10.6%). □ The ratio of persons with TB without bacterial evidence to the total of diagnosed was 23.88% but decreased by 4.19% (2,207) from 2020 □ The Northern region had the highest proportion of extrapulmonary TB (22.18%) over the total number of persons with TB, akin to findings from 2020. The number of persons with extrapulmonary TB *did decrease* by 1,096 cases compared to 2020. □ Number of admissions for undergoing TB treatment fell compared to 2020	□ Some of the provinces that faced the most prominent decrease in the number of new and relapsing persons with TB with bacteriological evidence include Bac Giang (41.4%), Hung Yen (39.9%), Ha Nam (38.2%), etc. □ The Northern region reached an estimated 50% of its target for 2021 in terms of case detection

Table 3. Summary of TB program per province[20]

[20] *Ibid.*

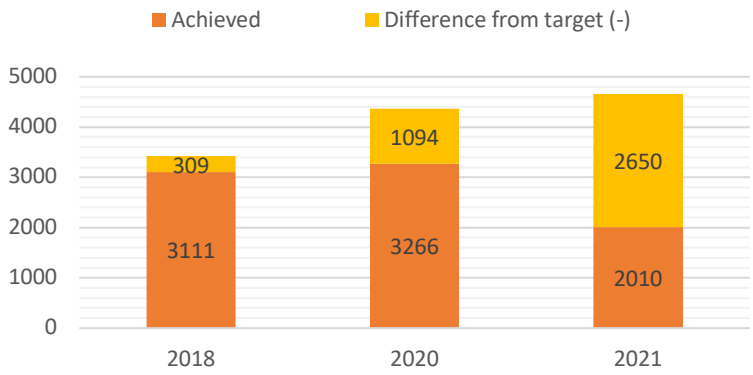

Figure 3. Admission of persons with MDR-TB

Due to the challenges faced during the COVID-19 pandemic, there was a sharp decrease in the number of admissions of persons with MDR-TB in 2021, which as shown in Figure 3 was recorded in the last 10 months.

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LAWS, GOVERNANCE AND SYSTEMS

The legal and institutional framework of a nation is tightly linked to its ability to implement health programs effectively. As such, similar to the rest of the world, Vietnam looks to international laws and guidelines as the foundation for its TB program.

INTERNATIONAL LAWS AND GUIDELINES

Ensuring health equity among key and vulnerable populations (KVP) is vital in healthcare programs such as TB. **The International Covenant on Economic, Social, and Cultural Rights (ICESCR), 1966,** mandates UN member states to adhere to several human rights concerns. Some of the integral rights that nationals and, to an extent non-nationals, have the right to are the right to self-determination, non-discrimination, equal opportunity and treatment, and more.[21] Concerning health programs, Article 12 delves into health rights that one is entitled to, including the right to enjoy the "*highest attainable standard of physical and mental health*." The ICESCR mandates State Parties to fulfill this through several means, including those related to infectious diseases, namely:

a. The improvement of all aspects of environmental and industrial hygiene;
b. The prevention, treatment, and control of epidemic, endemic, occupational, and other diseases;
c. The creation of conditions that would ensure all medical services and medical attention in the event of sickness (Article 12.2).

Following this Convention, people affected by TB and KVP have the right to gain equitable treatment, which should be made widely accessible, especially in the event of sickness. This indicates that health facilities or providers should have ample logistics and readiness to test and treat persons with TB. Recognizing that TB transmission is also caused by poor ventilation and other environmental factors, it can also be drawn that the same Convention highlights the importance of work environment and safety as part of TB prevention. The same right to quality healthcare and equitable treatment, including the safeguarding of the environment, also goes for specific KVPs such as but not limited to prisoners.

As part of its commitment to provide equal rights to prisoners, Vietnam signed and ratified **The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment (1984)** in 2013 and 2015, respectively. Pursuant to Article 16, Member States are required to prevent "acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in Article I," which alludes that prisoners have the right to equitable treatment, both in the non-discriminatory social norm and in the healthcare aspect.[22] As referenced both here and in **The United Nations Standard Minimum Rules for the Treatment of Prisoners**, prisoners must be given fair treatment, equitable healthcare of the same quality as healthcare services provided to society, and acceptable living environments. Whilst these factors retain

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[21] *The International Covenant on Economic, Social, and Cultural Rights (ICESCR), 1966*

[22] *"For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions." (Article 1, The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment)*

their dignity, they are also integral to both TB prevention and treatment, especially seeing as TB transmission is highly prevalent in prison settings.

> *"Healthcare services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis, and other infectious diseases, as well as for drug dependence"*
>
> *- The UN Standard Minimum Rules for the Treatment of Prisoners, Rule 24(2)*

EXISTING LEGAL FRAMEWORKS IN VIETNAM

In support of its commitment to end TB by 2030, Vietnam has several national laws and policy practices that are aligned with international laws and standards. The foundation of its fight against TB relies on the UN SDG goals, specifically goals number 3 (good health and well-being), 5 (gender equality), 10 (reduced inequalities), and 16 (peace, justice, and strong institutions).

Under Article 3 of Law number 03/2007/QH12 dated 21/11/2007, TB is defined as a highly infectious disease that can cause death (Group B). However, as stated in Article 5(4), the care, support, and treatment (CST) for people with pulmonary TB is not specifically described, which may pose a challenge in the standardization of CST for TB programs across provinces or health facilities. Similar to other diseases classified under Group B, treatment for TB is also not compulsory by law.[23] At the moment, Article 66 of the Law on Medical Examination and Treatment only mandates treatment for infectious diseases under Group A.

The cost of testing and treatment for persons with TB or DR-TB, among others, is covered in dedicated health facilities, as stated in the Law on Health Insurance and Circular no. 04/2016/TT-BYT (dated February 26, 2016, on prescribing tuberculosis diagnosis and treatment, and payment for covered healthcare services provided to people with tuberculosis). These TB service providers encompass facilities from the communal, district, provincial, and central levels. Persons with signs and symptoms suggestive of TB and persons with TB accessing services outside of these allocated health facilities will be transferred to the nearest available health facility.

In addition to their right to access and receive equitable health services, people with TB also have the right to confidentiality, which protects their health status and prevents potential stigma and discrimination against them.[24] Furthermore, the current policies in Vietnam also protect their right to be free from stigma and discrimination, although it does not state strategies to reduce stigma and discrimination.[25] Under the same law, people with TB and their family members are also entitled to information on TB prevention and control (Article 10), the standards of which are outlined in the next article, which states:

> *Requirements for information, education, and communication on TB prevention and control: Accurate, clear, easy to understand, practical, and timely; Appropriate to the target audience, cultural traditions, ethnic groups, social ethics, religions, beliefs, and customs.*[26]

It is here that the government and policymakers recognize differences in backgrounds and cultures across the country and urge public service providers and relevant stakeholders including those in the healthcare

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[23] Law No. 40/2009/QH12 dated on Nov. 23, 2009 Law on medical examination and treatment (Article 66)

[24] *Law No. 40/2009/QH12 dated on Nov. 23, 2009 Law on medical examination and treatment (Article 3)*

[25] *Law number 03/2007/QH12 dated 21/11/2007 on prevention and control of infectious diseases (Article 8)*

[26] *Law number 03/2007/QH12 dated 21/11/2007 on prevention and control of infectious diseases (Article 11)*

sector to cater to this diverse pool. People with TB and KVP, just like the rest of society, are also given autonomy to choose medical examination and treatment.[27]

Additional support for specific KVP is provided through various laws. One such example can be found in Article 29(2) of Law number 03/2007/QH12 (dated 21/11/2007), where vaccines and TB equipment are compulsory and free of charge for children and pregnant women.

To ensure that its people can access health services, Vietnam has taken positive steps towards providing universal health coverage (UHC). Its implementation today is largely based on the Law on Social Health Insurance (2014), which provides a list of those eligible exempt from paying for social health insurance, namely those of low socioeconomic households. The responsibility for ensuring their ability to access examination and treatment befalls several parties. In Article 22 (5), it is stated that "*…the insured living in island communes or island districts who go to the hospitals different from the registered hospital shall be paid for their medical examination and treatment expenditures at the commune hospitals, their inpatient treatment costs at the provincial and central hospital by the health insurance fund according to the benefit levels prescribed in Clause 1 (Law No. 46/2014/QH13 dated June 13, 2014, on Social Health Insurance).*" Similarly, the country also provides other forms of support such as monthly allowance for children and people living with HIV (PLHIV), for example.[28]

[27] Law No. 40/2009/QH12 dated on Nov. 23, 2009 Law on medical examination and treatment (Section 1. Rights of persons undergoing treatment, Article 10)

[28] Decree No. 136/2013/ND-CP stipulating social support policies for social protection subjects dated October 21, 2013

Adjustments to Legal Framework Post-COVID-19 Outbreak

In response to the COVID-19 outbreak and the continuously changing situation in Vietnam, the government issued several changes that would aid in TB control efforts.

- The Directive No. 07/BYT-CT dated July 15, 2021, which was issued by the Minister of Health, mandates TB examination and treatment to be covered by the Department of Health Insurance (HI).[29]
- This was shortly followed by Official Letter No. 6636/BYT-CV (August 14, 2021), which pushes for the consolidation of the organization of TB examination and treatment, all of which are covered by HI.
- The Official Letter No. 2079/BVPTU-DAPCL (September 6, 2021) of the Director of the National Lung Hospital which outlines the evaluation of TB treatment models at the province level and monitoring health facilities to meet the conditions for examination and treatment covered by HI

Social Contracting and the Role of Communities

The importance of communities in TB control program has been mentioned in several policies, including Decision No. 374/QD-TTg dated March 17, 2014, of the Prime Minister approving the National strategy on TB prevention and control to 2020 and vision to 2030 (Article 1.1.c). The clause provides a solution for the acceleration of TB prevention and treatment programs, namely to "*encourage the participation of communities and social organizations to support individuals with TB to use examination and treatment services*." With existing international guidelines, it is integral that national policies on TB are made with the targeted beneficiaries in mind. Although the current TB guidelines are regularly updated in accordance with international guidelines, they also have no mention of the role of communities and strategies to reduce stigma and discrimination.

As of 2021, there was still no social contracting with government funds in Vietnam, which affects the accessibility of TB services in regions with limited resources (e.g. provincial or district health facilities).[30] Should social contracting be made available, NGOs could play a vital role in the acceleration of epidemic control and improvement of services.

Policy and Governance Analysis

In 2021, the Stop TB Partnership with the support of USAID released its Governance of TB Programs report, where high TB-burden countries were analyzed based on various factors. In terms of its legal framework, Vietnam already showed exemplary practices, such as the integration of TB notification as a requisite in the national policies, which also entails routine monitoring of its progress.[31] Furthermore, policies surrounding social protection and human rights for TB are partially in place. In addition to social health insurance, people with TB in Vietnam are provided other forms of social protection, be it in the form of socioeconomic, psychosocial, health (nutrition), or other support. By law, people with TB are also entitled to rights to privacy, confidentiality, and equality (non-discrimination), as proven by the policy on the inclusion of human rights in national modules or guidelines. However, it is important to note that gender-related policies have yet to recognize or include genders other than male and female. This is partly because the gender equality

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[29] *2021 report, pg. 57*

[30] *Governance of TB Programmes, pg. 15*

[31] *Governance of TB Programmes, 24*[32] *Law No 73/2006/QH 11 on Gender Equality*

law has not been revised since 2006. At the moment, only the following articles/clauses from Law on Gender Equality are in place:

- *Article 3. Where an international treaty to which the Socialist Republic of Vietnam is one of the signatories contains provisions that differ from those of this law, the provisions set out in that international treaty shall be applied;*
- *Article 4. The gender equality goals are to eliminate gender discrimination, to create equal opportunities for men and women in socio-economic development and human resources development in order to reach substantial equality between men and women, and to establish and enhance cooperation and mutual assistance between men and women in all fields of social and family life; and,*
- *Clause 5. Measure to promote gender equality is the measure aimed at ensuring substantial gender equality, set forth by the state authorities in cases where there remains considerable imparity between men and women concerning the positions, roles, conditions, and opportunities for men and women to bring into play all their capacities and to enjoy the achievement of the development where the application of equal regulations for man and woman cannot remove this imparity. The measure to promote gender equality is to be implemented for a certain period of time and shall end when the gender equality goals have been achieved.*[32]

At the other end of the spectrum, more could be done to strengthen other areas of the policies, such as the inclusion of free DR-TB medicines in Vietnam's essential medicines list. Another aspect that should be addressed in the national policies is TB-related stigma. Though external factors such as the healthcare system or logistics available do affect end-beneficiaries' ability to access TB services, it is also commonly known that experience and/or fear of TB-related stigma and discrimination decreases one's inclination to seek tests or treatment. As such, it is important to tackle the issue throughout multiple layers, starting at the above-site level (policies) to the site level (health facility practices or community interventions).

The 2020 Step Up for TB Report provided an overview of Vietnam's TB-related policies, separated into five categories, which are diagnosis, treatment, models of care, prevention, and procurement.[33] A wide variety of indicators were used to determine the score for each category. For example, the diagnosis component analyzed policies related to RMD, urinary TB LAM, DST, and treatment monitoring. The results of this scoring system indicated that Vietnam's policies on TB treatment (50%), closely followed by TB diagnosis (44%) and procurement (43%), were the ones that met international standards or guidelines the most. Meanwhile, at just above 20% each, the report indicates that Vietnam's policies surrounding TB models of care and prevention require further attention.

During several in-depth interviews with key respondents, it was revealed that there is still a need to strengthen accessibility of the health services through the legal aspect, which leaves the country at a 21% uptake of TPT by 2020.

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[32] Law No 73/2006/QH 11 on Gender Equality

[33] Step up for TB – Dashboard – Diagnosing TB, pg. 49-63 [34] Stop TB Partnership (2020) Assessing TB Stigma[35] Long et al (1999)

PROVISIONS OF TB SERVICES

The WHO has long developed a guideline that outlines a minimum standard of care and approaches to TB services. Aside from the WHO guideline, several frameworks are widely used by nations in the implementation or evaluation of their health programs, one of the famous ones being the AAAQ framework.

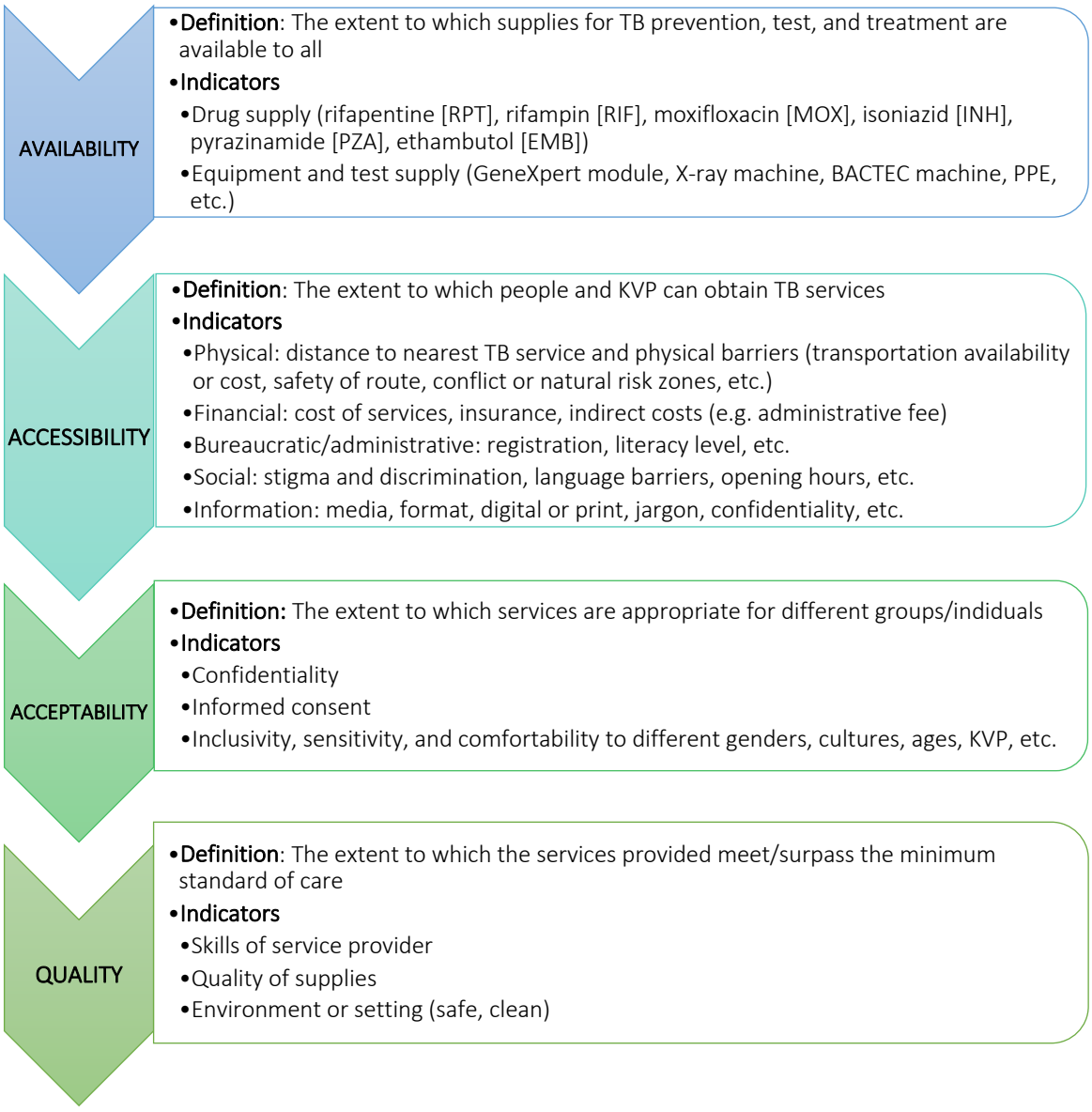

Figure 1. AAAQ Framework (UNICEF)

Conceptualized by the WHO, the following framework presents four aspects of health services that determine the success of a health program. This framework challenges the antiquated belief that service delivery should take a one-way top-down approach, by incorporating humanistic aspects. One widely used framework that promotes person-centered services is the human rights approach to the TB framework.

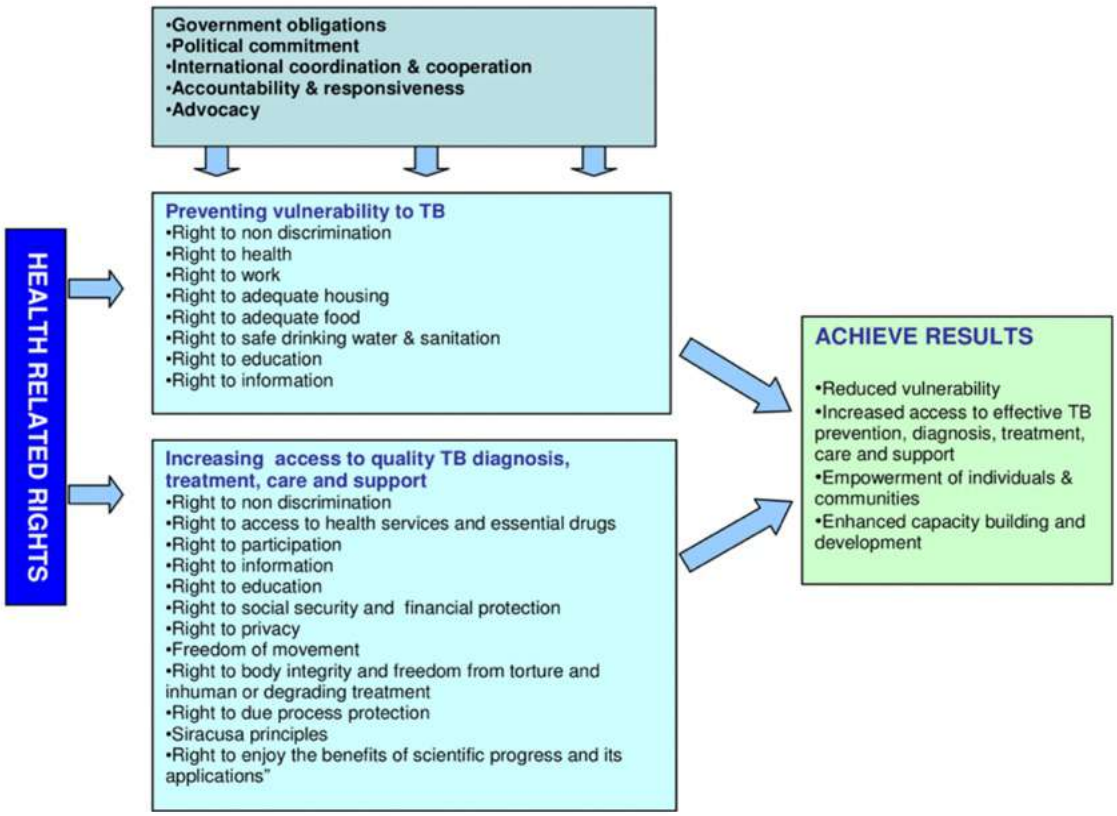

Figure 2. Human rights approach to TB framework[34]

As depicted in the figure above, there are two main health-related rights, namely, to prevent vulnerability to TB and to increase access to quality TB diagnosis, treatment, care, and support. By conducting multi-sectoral and multi-stakeholder collaborations to help fulfill the rights of people with TB under these two categories, epidemic control can be achieved.

The burden of TB management and control does not fully rest on the public health sector and government counterparts. It is also vital for other sectors, such as the private sector, to contribute and to be accountable for the program.

Public interest towards private healthcare providers, including private clinics, in the TB program remains high. Some of the most common reasons for individuals with TB to prefer private health services to public ones is due to the privacy and comfortability.[35] The growing interest to access private services and the scarcity of public health facilities that provide TB services are clear indications of the big opportunity for public-private mix (PPM). Endorsed by the WHO, PPM is an integrated approach to TB care and prevention that combines the efforts of both public and private sectors. A literature review of PPM pilot projects in India for TB control suggests that PPM can improve aspects of the healthcare sector that would otherwise be difficult to achieve, which in this case was the increase of case notification.[36]

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[34] *Stop TB Partnership (2020) Assessing TB Stigma*[35] *Long et al (1999)*

[35] *Long et al (1999)*

[36] *Dewan et al.*

KEY AND VULNERABLE POPULATIONS

As with other communicable diseases, several groups or demographics are vulnerable to TB or the effects of TB on their lives, such as its catastrophic cost. There are several factors commonly known to determine one's vulnerability to TB, namely socioeconomic, biological, and environmental factors.[37]

The Stop TB Partnership has named several key and vulnerable populations that should get special consideration or attention in the development and implementation of TB programs worldwide. These groups include prisoners, PLHIV, migrants/refugees/tribal populations, PWUD, health workers, children, people with diabetes, the urban poor, the elderly, and miners.

Vietnam conducted a prioritization exercise of TB KVPs. Through the prioritization tool, we looked at various socioeconomic barriers experienced by these different groups. Through that exercise, we identified the following 6 groups as prioritized KVPs

1. **Prisoners**. TB is highly prevalent among incarcerated people, including prisoners. A study by Coninx et al. (2000) shows that globally, prisoners are at high risk of TB. The rate of case notification of all forms of TB in prisons, as seen across eight different locations globally in the 90s, range from 2.4% to 7.2% (per 100,000), with an average of 5.3%.[38]

   In addition to the high prevalence of TB among prisoners, the closed setting of prison requires NTPs to pay close attention to strategies to prevent and treat individuals with TB in prisons.[39] This is due to the fact that prisoners' access to TB tests and treatment is limited in comparison to those not incarcerated by society.

   The notification rate among prisoners was at 1,642 per 100,000 in 2019. Over the years, the rate has been slightly reduced as the rate among the general population mildly declined, but consistently around 15 times more than that of the general population. Studies in other countries have shown that incarceration was associated with TB in urban populations. A study in Brazil found as many as 54% of Mycobacterium tuberculosis strains were related to strains from persons in prisons. TB control in prisons is critical for reducing disease prevalence. Annual TB screening is performed in all prisons of Vietnam and individuals infected with TB get their treatment if positive. However, treatment arrangements differ between prisons and depending on the existing facilities. Ex-prisoners report that persons diagnosed with TB staying in shared cells with 50 – 60 other inmates for the entire course of treatment. In addition to that, the transition of TB treatment from prison to post-prison is not always smooth. Instability in their post-prison lives and lack of support from local TB programs led to treatment discontinuation in many, including in people with XDR-TB.

   Many ex-prisoners are poor, ID-less, unregistered. That is on top of their vulnerability to TB. The assessment team met several ex-prisoners who have MDR or XDR-TB being refused treatment in TB hospitals since they didn't have ID paper or money for a cash deposit. Stigma and discrimination against ex-prisoners make it difficult for them to remake their ID, register for their residency, or access charitable or social welfare programs.

2. **People living with HIV.** Even with a relatively high level of ARV coverage among people living with HIV (PLHIV), TB remains the leading cause of death among people living with HIV in Vietnam. WHO estimates that TB incidence among PLHIV in 2019 was 5,500 people. For a population of 230,000 PLHIV, the TB incidence rate among this population is about 2,400 per 100,000, or almost 14 times higher than that of

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[37] *EquiTB*

[38] *Coninx et al. (2000), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117551/*

[39] *Coninx et al. (2000), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117551/*

the general population. Low coverage of TPT - TB Preventive Therapy (39% among people who were enrolled in HIV care in 2018) could partly explain the high incidence rate of TB among this population.

Although 86% of new and relapse persons with TB know their HIV status and 93% of PLHIV who had newly diagnosed or relapsed TB were on ARV, the treatment success rate among TB/HIV individuals was only 79% among PLHIV compared to 92% among HIV-negative individuals. TB among PLHIV, which represents only 3,3% of all persons with TB in Vietnam has a disproportionately high mortality with an estimate of 2,000 deaths, compared to 9,800 for all HIV-negative individuals, or 60 times difference. It is estimated that for every 3 persons with TB who are HIV positive, at least one person would die. Although PLHIV are supposed to be screened annually for TB, the service quality appears to be uneven according to persons with TB that we interviewed. In addition to that, challenges in the diagnosis of TB among PLHIV, many PLHIV enter TB care late, leading to a high mortality rate.

3. **Ethnic minority people.** With a few exceptions, provinces with higher ethnic minority population distribution see lower notification rate despite high rates shown in some surveys. In a Central Highland district, one community screening campaign in 2020 of 650 people in Chu Se district of Gia Lai province saw the number of persons with TB increase by over 50% in comparison to the previous year. In Lak district of Dak Lak province, a screening campaign in 2020 saw the number of notified cases increased 3 times compared to the year before. These demonstrated the severe lack of access to services in these areas and the need for community-based active finding of persons with TB.
4. **The undocumented (migrants etc.).** People without citizen's ID cards don't have access to any public programs, including public hospitals. Many TB hospitals refuse ID-less people. People not locally registered (e.g. mobile and poor migrants) are not considered for programs implemented by local agencies, including TB screening, and TB services at district and commune level. Many of them opt for self-treatment or cheap private services. Most of them are poor and live hand-to-mouth, forgetting the medication or drop-out of treatment is not uncommon. In addition to being vulnerable to TB infection, persons having TB who are migrants also showed poorer treatment outcomes than residents.[40] Several factors may have affected this, such as difficulty in seeking treatment due to lack of documentation or health insurance, language barriers that may inhibit one from understanding the procedures to get TB treatment, or frequent travels, among others. Predictors of poor treatment adherence among migrants include co-infection with HIV, older age, and prior TB infection. In comparison, treatment adherence was assumed to be good among migrants with direct or easy access, by distance and administration, to TB services such as DOTS.
5. **People who use drugs.** TB screening among people who use drugs in drug rehabilitation centers and among individuals on methadone treatment demonstrated that the TB burden among this population is more than 10 times higher than in the general population, at 1,180 per 100,000 in 2019. DRIVE study on 3,500 people who use drugs in Hai Phong found that the incidence rate of TB could be 10 – 30 times higher than that of the general population, and TB accounts for 22% of deaths among DRIVE participants. The crude mortality rate among study participants was 1,9% among HIV-negative and 4,3% among HIV-positive PWID, 3 to 7 times higher than 0,63% in the general population. TB accounts for one-third of deaths among HIV-positive and 8% among HIV-negative participants. People who use drugs have higher TB infection rates, including the MDR TB infection rate, they are less likely to access treatment, more likely to experience treatment failure and face more stigma and discrimination in TB services. However, when supported by CBOs, people who use drugs have good treatment uptake and completion.

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[40] Vo, L.N.Q., Codlin, A.J., Forse, R.J. et al. Tuberculosis among economic migrants: a cross-sectional study of the risk of poor treatment outcomes and impact of a treatment adherence intervention among temporary residents in an urban district in Ho Chi Minh City, Vietnam. BMC Infect Dis 20, 134 (2020). https://doi.org/10.1186/s12879-020-4865-7

6. **Children**. WHO estimated that, in 2019, there were around 8,000 children with TB but only 1,677 were notified. Children accounted for only 1.6% of total notified cases, ranging from 0.2 to 3.9% among 63 provinces. As many as 80% of children with TB were missing. Lack of engagement of pediatric services, limitation in contact screening, and slow pick-up in latent TB treatment among children are among the reasons.
7. **People who have existing conditions, including diabetes.** WHO estimates that persons with TB in Vietnam are also prevalent among people with malnutrition (29,000 persons), alcohol use disorder (18,000 people), and 4,200 with diabetes (4,200 persons) with no formal collaboration with programs in charge of these diseases. Similarly, collaborations between TB and geriatric, mental health, and reproductive health programs are not established.
8. **Poor people** Once diagnosed with TB, TB-related drugs and monitoring tests are free in facilities designated by the National TB Program. But everything else is not free; clinical consultations and tests before TB diagnosis are not free. Medications in support of TB treatment are not free. Evaluations of TB-related clinical conditions (liver, eyes, cardiovascular, diabetic…) are not free. Those are in addition to transportation, food, and accommodation costs for the individuals undergoing TB treatment and the accompanying family members, and in addition to their income lost.

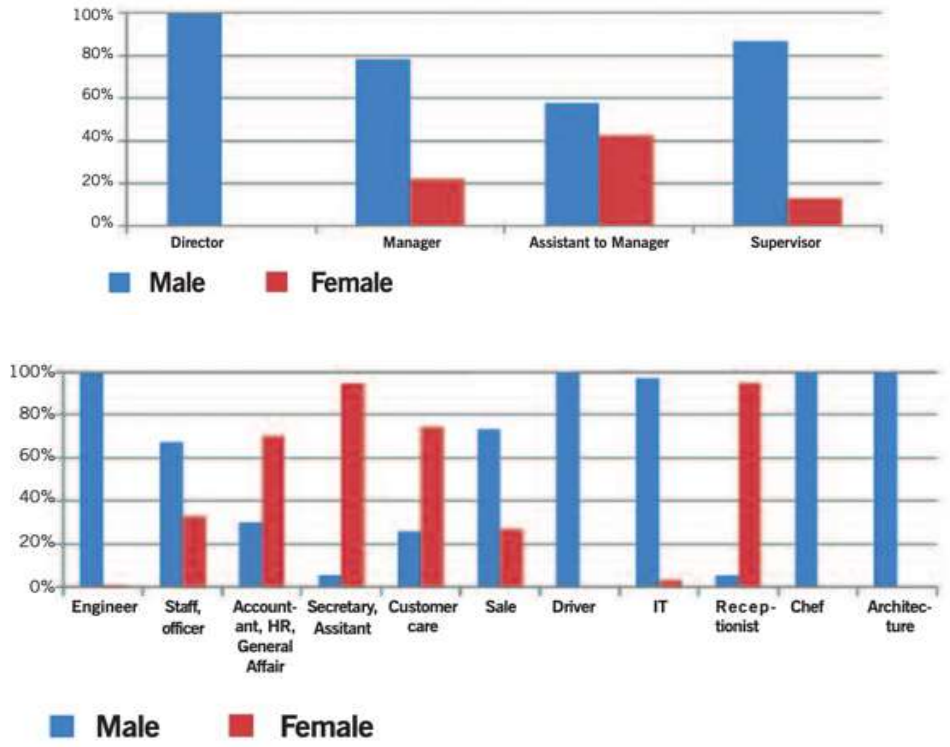
   The lucky poor who have an official poor or near-poor household book will have social health insurance fully cover essential medical services. Others who have regular health insurance still need to have money for co-payment. The unlucky ones who have no insurance would have to bear all those costs.

   Furthermore, since most poor people with early TB symptoms such as fever and cough would self-medicate or visit private practitioners to have easy access to medical care, many of the poor people would have spent most of their savings (if any) on these services, until it is obvious that their condition is not improved.
9. **Older people.** In general TB prevalence among older people (65 and plus) is more than double that of general population (689 vs. 322). However, there are large disparities between provinces, in some provinces this rate among the older people is lower than for the general population. Lack of information, resources, transportation, and care are among the reasons that prevent older people from accessing TB care.

Gender Disparity

Gender plays a huge factor in TB programs, as it indicates the disproportionate effect TB has on different genders. The male-to-female TB ratio worldwide in 2021 was recorded at approximately 2:1, which was significantly less than the 4:1 ratio found in the national prevalence survey.[41] The high TB incidence among men is partly caused by their dominance in the workforce, which exposes them to a higher possibility of contracting TB. According to ILO (2015), gender and perspective of gender roles strongly affect one's employability and position in a company/organization, for example.

[41] *https://www.who.int/news-room/fact-sheets/detail/tuberculosis*



Figures 3 and 4. Job position and title based on gender[42]

Economic empowerment for women and the promotion of gender equality in the workforce remain a challenge, all of which impact one's inclination or ability to access health services. Due to these explicitly or implicitly assumed gender roles, men's occupation also enables them to financially access TB treatment, unlike women who are at a more socioeconomic disadvantage. Specifically in Vietnam, women still make up for a large portion of the unpaid, lower-paid, or informal workforce.[43]

Current studies and policies worldwide focus on TB among men and women. TB among transgender or gender minorities lacks research globally and requires further attention.[44] This is especially urgent for gender minorities that face heightened burden due to other factors such as social inclusion or exclusion, SES, and other health conditions such as HIV or diabetes, etc. However, current available research and programs show that TB disproportionately affects gender minorities due to socioeconomic and other non-health factors. In 1998-2000, the TB Control Program of the Baltimore City Health Department (BCHD) in the US conducted contact tracing from four TB-positive individuals belonging to a transgender community, some of whom also tested HIV positive.[45] The contact tracing activity reveals the correlation between KVP and vulnerability to TB. Their backgrounds, KVP, and housing/occupation are also key determinants of their ability to access quality TB services. Not only are they at high risk of TB, but the BCHD also recognized that traditional public health means will not be as effective for this KVP group, which may be true for gender minorities in other geographic locations as well.

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[42] *ILO*

[43] *https://www.ilo.org/hanoi/Areasofwork/equality-and-discrimination/lang--en/index.htm*

[44] *Poteat et al. (2017), Epidemiology of HIV, Sexually Transmitted Infections, Viral Hepatitis, and Tuberculosis Among Incarcerated Transgender People: A Case of Limited Data*

[45] *https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4915a1.htm*

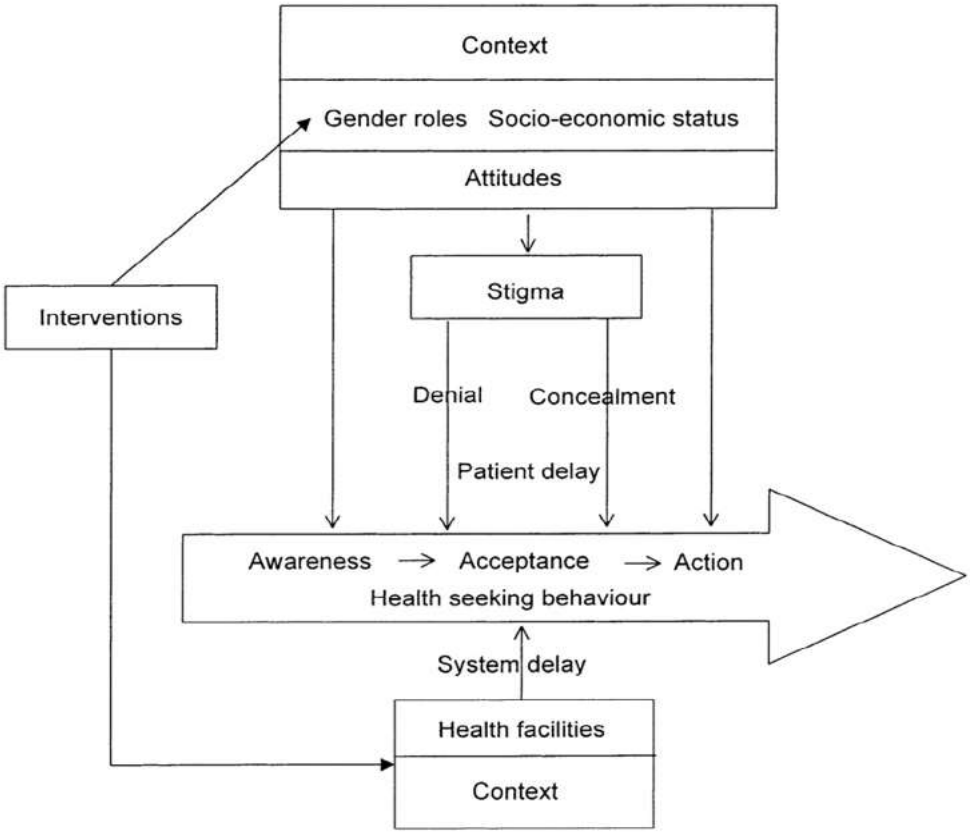

Figure 5. Contextual Influences on TB-related health-seeking behavior[46]

In a study by Johansson et al. (2000), it was found that several contextual factors affect health-seeking behavior related to TB, which include family structure and gender roles. Men might delay, deny, or conceal TB diagnosis due to fear of loss of income or financial stability. On the other hand, women's dependence on their husbands causes them to fear rejection from their spouse or society should they be diagnosed with TB. Women are also found to be more sensitive to implied behaviors of health workers and treated more inferiorly when seeking testing or treatment.

According to several studies, there is no significant difference in the time it takes for men or women to seek out TB services.[47] [48] However, women were found to have visited a higher number of healthcare providers compared to men (1.7 and 1.5 providers, P=0.02), but this might have been due to the providers themselves. Though the reason remains unclear, it was shown that the time it takes for women to get their diagnosis is slightly longer than for men, which indicates that health workers need to be more gender-sensitive whilst providing care.

[46] *Johansson et al. (2000)*

[47] *Long et al. (1999)*

[48] *Hoa et al. (2011)*

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Primary findings

PRIMARY FINDINGS

OVERVIEW: ACCESS TO CARE

Over the last few years, Vietnam's health sector has flourished and has become more equipped to handle TB-related issues. At the moment, the doctor-to-population ratio in Vietnam could be improved, especially the TB specialists. During an interview, a respondent revealed that counseling to persons undergoing treatment is still limited due to the limited number of health workers in TB healthcare centers.

> *"Only saying that I had TB, giving me some medicines then telling me to take them at the same time every day. That's all"*
>
> *Respondent 24, Hai Phong*

Currently, persons with TB symptoms tend to have to go through several layers of professionals before arriving at the TB center. For example, they may first go to the pharmacy to obtain over-the-counter medication, choose to go to the provincial or central hospital when their symptoms do not dissipate, and then go to the TB healthcare center.

> *"When I started to have some symptoms, I looked for reasons and treatment on the internet. I was not better. I went to hospitals (top hospitals in Hanoi). They did many tests to look for other diseases, but TB was. At that moment, if they had a doubt and had done some TB tests, I would not have had to wait for months for TB treatment. I think anyone with symptoms should be tested for TB"*
>
> *Respondent 34, Hanoi*

With regards to costs, not all active screening is currently covered by the health insurance scheme. As expressed by respondents during the in-depth interview, at such a high cost, local authorities would need to closely coordinate with the relevant healthcare system to ensure that end-beneficiaries can still access the service. This is further dampened by the fact that it may take several appointments with general practitioners and specialists before reaching the TB diagnosis, something that those of low SES may not have the privilege of.

Should one be diagnosed with TB and require inpatient treatment, they are required to pay a deposit fee, something that not all can afford. As for the medication itself, though anti-TB drugs are covered by health insurance, other adjuvant drugs are not.

> *"Having social health insurance or not, persons with TB still have to pay for a deposit before being admitted for TB treatment… They don't have daily meals properly where can they get 1M for advance payment"*
>
> *Respondent 1, Hai Duong*
>
> *"I did not have to pay for TB medicine. My doctor told me that TB medicine harms my liver a lot and I should take some medicine to help my liver. He prescript it for me. Social health insurance does not cover this, so I have to pay for it"*
>
> *Respondent 15, Hai Phong*

Though there are already primary healthcare centers available, with some offering TB tests and treatment, several end-beneficiaries still seek out tests and/or treatment from private health centers. This might be due to their trust in the latter or the convenience they receive in private facilities, even though end-beneficiaries would most likely need to pay higher fees.

PRIORITY POPULATIONS

Data on the prevalence and impact of TB on each KVP is not available as the national data is not disaggregated by KVP. However, based on the findings and performance of its KVP-specific programs, supported by secondary sources, one can induce the characteristics of the high-risk groups in Vietnam that require urgent attention.

For its 2022 program, the NTP has emphasized the expansion and implementation of TB services for high-risk groups. These groups include prisoners and those in detention camps, people taking Methadone in the community, the elderly, mental undergoing treatment people, people living in social protection centers, people with diabetes, and workers in high-risk industrial zones, among others.[49] Prisoners, people living in social protection centers, and workers are highly vulnerable to TB due to their environment and/or socioeconomic factors. Others such as PLHIV, people with diabetes, and the elderly, for example, are vulnerable to TB due to biological factors.

Of course, it is also important to address health workers' vulnerability to contracting TB, which the NTP hopes to reduce by provision of PPE.[50] The same approach is taken by the Department of Health and Department C10, Ministry of Public Security, which understand the importance of protecting prison officers from TB transmission as well.[51][52]

Several groups are most vulnerable to TB infection, which include people living with HIV (PLHIV), people who use drugs (PWUD), prisoners, the elderly, and people with existing medical conditions, among others. The general key and vulnerable populations (KVP) for TB come from low SES, which correlates to their perception of healthcare. Due to their inability to afford healthcare services and unwillingness to miss work for appointments, health is not their primary concern, making them less likely to seek TB tests or treatment. Their unwillingness or inability to seek TB services, in turn, may increase the rate of TB infections in the nation. As described by 3 out of 17 key respondents during the in-depth interviews, it is also not uncommon for persons with TB to somewhat self-diagnose and seek the most accessible treatment albeit ineffective. For example, they may opt to buy medicine at the pharmacy when showing symptoms and will only seek professional help when their condition worsens.

Aside from the general demographic, several KVP groups do not have identification and face heightened difficulties in accessing TB services. Since personal identification is required to buy health insurance, those without it are unable to register for one and will be more likely to opt out of testing or treatment due to the high fees.

Because health facilities and TB centers are limited in each province, those who reside far from a health facility have difficulty accessing (additional) appointments. This may be due to the high transportation costs and the time-consuming nature or frequency of visits, among others.

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[49] *2021 report, pg. 88*

[50] *2021 report*

[51] *2021 report, pg. 68*

[52] *2021 report, pg. 70*

Regarding the existing policies, it was recently found that there were still several groups ineligible for TB preventive treatment (TPT). This includes healthcare workers, miners or people with silicosis, migrants, people with diabetes, and those undergoing dialysis.[53] The exclusion of these groups will prove detrimental in ensuring TB control. As an example, a study by Vo et al. revealed that treatment outcomes among migrants are poorer than permanent residents, which strongly suggests a need for strengthened monitoring/tracing and treatment continuity among the vulnerable group.[54]

Prisoners

The COVID-19 pandemic has not only affected the supply chain and service delivery aspects of TB services but also exposed specific populations/KVPs to inequitable treatment.

In 2021, the NTP revealed that TB screening for prisoners in 26 out of 54 prisons has not been implemented due to challenges that arose after the COVID-19 outbreak.[55] Additionally, due to social distancing and travel restrictions, officers and soldiers had to stay in the unit. Pre-entry TB screening for prisoners was also postponed, similar to screening for Methadone users, the elderly, chronic mental individuals, workers, and miners.

Six prisons have conducted TB testing among prisoners whose reports have been captured in the preliminary results by the NTP, namely Ninh Khanh Prison, Ngoc Ly Prison, Tan Lap Prison, Phu Son 4 Prison, Prison No. 3, and Prison No.6. The data shows that the rate of abnormal film among prisoners who took X-rays range from 5% to 11.6%, with 100% of TB- and MDR-TB- positive individuals enrolled for treatment.

Stigma and Discrimination among KVPs

During the FGD and in-depth interview sessions, nearly half of the respondents claimed that stigma and discrimination are prevalent among certain KVPs although their TB treatment differs slightly.

In addition to getting little to no care, ex-prisoners and PWUD are often stigmatized by their own families and society. Similarly, undocumented, poor, and homeless people with TB are also ostracized from society.

Aside from society's perception towards ex-prisoners, PWUD, PLHIV, undocumented, and homeless people in general, they face heightened stigma and discrimination when or if they access health services such as TB services.

Stigma can also manifest differently across genders.

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[53] *Step Up for TB Report (2020), pg. 60*

[54] *Vo, L.N.Q., Codlin, A.J., Forse, R.J. et al. Tuberculosis among economic migrants: a cross-sectional study of the risk of poor treatment outcomes and impact of a treatment adherence intervention among temporary residents in an urban district in Ho Chi Minh City, Vietnam. BMC Infect Dis 20, 134 (2020). https://doi.org/10.1186/s12879-020-4865-7*

[55] *Final Report: Activities of the Tuberculosis Program 2021, pg. 39*

GENDER AND TB

The COVID-19 pandemic's effects were felt disproportionately across different KVPs and genders. In the first 10 months of 2021, it was noted that the male/female ratio of new and relapsed individuals was 2.45:1, which showed a decrease compared to the previous years.[56] At 2.74:1, the male/female ratio of persons with TB in the Central region was highest among the three regions, whilst the other two regions had an estimated 2.5:1. Several possible causes could have resulted in this outcome. Whilst TB transmission among men may have decreased, it may also imply that case detection among men is not optimal, especially among certain KVPs such as prisoners and migrants. Though the reported cases do show a higher prevalence among men, women are also affected by TB in other aspects.

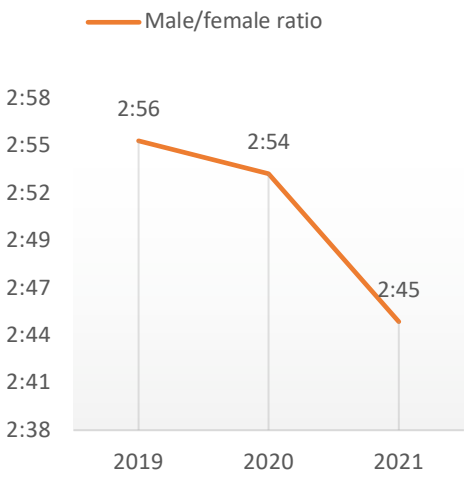

Figure 6. Distribution of new and relapsed TB cases by sex

During a series of FGDs and in-depth interviews with health workers, CBO members, and persons affected by TB, it was revealed that there were differences in perception regarding gender roles and their correlation with TB (Appendix 2). Out of 4 FGDs and 13 interview sessions, respondents from four sessions resounded a belief that women are more attuned to their and their family's health whilst six sessions revealed another common belief that women had better treatment adherence, partly due to their health-seeking behavior. Similar to the discovery made by Johansson et al., few respondents believe that men's hesitance to seek tests or treatment is due to the financial aspect, which might be due to the pressure that they have to take on the role of breadwinner. However, unprecedentedly, only one medical staff out of all the respondents during the 17 sessions assumed that men are more likely to access health services than women due to their financial ability to do so, be it due to better income, occupation, higher job opportunities, etc. Although this might imply that the majority of the respondents do not believe that one's occupation determines their willingness and/or ability to access health services, this finding may also imply that regardless of their ability to afford health services, men do not access health services as much as women. The latter of the two logics, which remains a possibility, may be caused by their inability/unwillingness to miss work,

It is important to note that the existing policies in Vietnam only address the two normative genders, namely males and females, regarding the TB program. As of now, there is not enough primary data to provide an in-depth analysis of the effects of TB among other genders, such as transwomen, transmen, non-binary individuals, and more. However, this is not to say that explicit and implicit gender roles, as well as other related factors such as SES and employability, do not impact these groups. Therefore, it is critical to collect data and disaggregate them based on not only biological sex but also gender identity and expression.

INVOLVEMENT OF TB SURVIVORS AND KVP IN THE NTP

To maximize its TB program performance, Vietnam continues to involve TB survivors and KVP in the implementation of its TB program.

[56] *NTP 2021, pg. 22*

Farmer's Union

For the past 11 years, the Global Fund Project for TB Prevention – Vietnam Farmers' Union has long contributed to TB management and control in the country. In 2020, it was reported that the dropout rate significantly decreased whilst the treatment success rate increased following the implementation of the Farmer's Association Model.[57]

During the COVID-19 pandemic, the Farmer's Union faced several challenges that hindered its activities but managed to soar in other aspects. In 2021, activities were carried out across 17 provinces and cities in several forms, namely:

- 51 models on "Farmers' TB Prevention" (district-level);
- 330 models on "Latent TB Management" (commune-level); and,
- 5 models on "Application of M-Health in TB Treatment."

The three models had specific purposes of their own, with the first on "Farmers' TB Prevention" being to reduce the risk of TB infection among farmers. Similar to other high-risk groups, the Union recognizes the importance of increasing farmers' knowledge on prevention, seeing as they are vulnerable to TB due to their workplace, living conditions, and/or geographical mobility. Capacity building is also given to families and close contacts of persons with TB through the "Latent TB Management" model. It is here that Union members encourage them to screen for LTB and to seek treatment if needed.

Whilst the first two models were efficient in increasing one's knowledge of TB prevention and management, the "Application of M-Health in TB Treatment" model was equally as fruitful. Following its activation in 5 districts/2 provinces last year, an estimated 150 received support messages that aided individuals undergoing TB treatment in adhering to treatment and preventing further transmission. Information is also provided to families as part of the Union's effort to ensure psychosocial support for persons with TB, which could boost treatment adherence.

Trainings were also conducted for members of Vietnam Farmers' Union as part of its prevention efforts. The Union has also conducted early detection of persons with TB with TB/LTB and conducted media campaigns to raise public awareness and eliminate TB-related stigma. The latter was conducted through partnerships with VTV1, Rural News, New Rural Magazine, and more.

Indicators*	2020	2021	% Change (2020-2021)
The number of people consulted and provided with information and knowledge on TB prevention	128,545	81,252	-37%
The number of people with signs and symptoms suggestive of TB mobilized for medical examination.	16,018	9,598	-40%
The number of visits to persons undergoing TB treatment at home.	1,236	13,500	992%
The number of newly diagnosed TB.	1,526	1,092	-28%
The number of persons with TB AFB (+)	824	983	19%

[57] *2020 Report, p. 49*

The number of individuals with TB under DOTS treatment.	1,569	1,134	-28%
The number of persons with extra-pulmonary TB.	231	109	-53%
The number of persons with TB/HIV.	27	48	78%
The number of persons with drug-resistant TB	77	60	-22%
The number of deaths from TB.	10	2	-80%

**Indicators are taken from the 2021 NTP report, all of which are similar to the 2020 indicators*

Table 4. Achievement of the 2020-2021 Farmer's Union TB Activities[58] [59]

The successes of the Farmers' Union project have won the trust of stakeholders such as local authorities, the health sector, and communities. The additional human resources also enabled improved monitoring of TB prevention and management activities.

The vast network and rapport that the Union has built cover gaps in the TB program that would otherwise be difficult to track. Seeing as TB vulnerability is driven by socioeconomic factors as well, the Union utilizes its resources to aid poor individuals undergoing TB treatment to seek treatment and still maintain their livelihoods or financial aid.

Prisoners

In 2021, the NTP provided specialized training that involved prisoners who survived TB and qualified or skilled prisoners, as depicted in the following table. The same method was used in the previous year.

Target audience	**Description**
1. Administrators of Phu Son 4 prison, Vinh Quang camp, and Quyet Tien prison (Unit staff and soldiers)	Three courses on TB detection, diagnosis, treatment, and management following release from prison and re-entry into society
2. Ninh Khanh prison, Yen Ha camp, and Hong Ca camp (Unit staff and soldiers)	Three courses on TB prevention and control
3. Inmates at 51 prison subdivisions	Peer communication and education session

Table 5. Training for prison settings

The resource persons, which in this case are prisoners who survived TB and qualified or skilled inmates, are then given the responsibility to aid in the screening of persons with potential TB at their respective prisons as well as to ensure that inmates adhere to their TB treatment. This not only improves monitoring of TB prevention and management in the aforementioned prisons but also improves communication with the peer prisoners.

[58] *2020 report, p. 49*

[59] *2021 report, p. 59*

DISCUSSION

Over the past two years, Vietnam has made significant progress toward fulfilling its target of epidemic control by 2030. Although several aspects of the TB program could not be maximized during the COVID-19 pandemic (e.g. delayed procurement, understaffed health facilities, etc.), most targets set by 2020 were still met by the NTP and significant contributions by partners such as the Stop TB Partnership and GF sub-grantees showed continued support and promise towards the fulfillment of this objective. However, in 2021, the fourth wave hit Vietnam and instilled adverse impacts. In response, many activities under the NTP including specific activities for high-risk populations were halted. The shortage in human resources and the shift to COVID-19 response also meant that the finding, recording, and reporting of persons with TB, as well as achievements by partners and stakeholders who contribute to the NTP, were significantly delayed.

As seen in both primary and secondary sources, several aspects of the TB control program remain a priority, such as strategies needed to address TB and missing people with TB among KVP. Involvement and sensitization of stakeholders both from within the healthcare sector and outside, one of which is the private sector, is another factor that needs to be strengthened in the upcoming program. Aside from these main concerns, however, the breakout of COVID-19 also emphasized factors in the current system that need to be strengthened, such as but not limited to the supply-chain management of drugs and equipment, human resources at health facilities, and the disparity between one health facility's and/or province's quality and capacity to the next.

PRIORITY POPULATIONS

The current national policies and health services are inclusive of prioritized populations, but there remain several groups that require more support, namely:

1. Homeless people with TB
2. PWUD
3. People with disability
4. Labor exporters
5. Ethnic minority groups
6. Elderly

These groups either do not have health insurance or compulsory documentation such as medical records, do not prioritize their health, or are unable to access TB services without additional support. Integrated, community-friendly, and person-centered services are required to improve treatment uptake, adherence, and perceptibility. TB services should be catered to the community's needs, something that could be improved through Community Systems Strengthening (CSS) efforts and meaningful involvement of the community. This could be done by involving KVP, CSOs, and the TB community in the development of national strategic plans, program reviews, and discussions with policymakers and relevant stakeholders.

In addition to KVP, gender also plays a key role in determining prevalence of TB and treatment success. As seen from both primary and secondary data, the disparity between perception, access, and treatment adherence among different genders was interesting to note. To quote examples during the in-depth interviews, there was a shared belief by a few respondents (1 respondent from a CBO and 4 health workers) that women cared about their health and their family's health more than men, which may correlate with the belief that they have better treatment adherence. An interesting finding was that only one out of 17 participants in the interview claimed that men make higher income compared to women hence their ability to access health services is better.

Stigma and Discrimination

Not only do KVP and end-beneficiaries face systematic barriers in accessing TB tests and medicine, but TB-related stigma and discrimination are still prominent worldwide. Hence, it is important to address the issue in multiple layers and to do so continuously. TB-related stigma and discrimination are often found in communities or settings that have low TB literacy, for example in families that have never been exposed to the issue or in non-TB polyclinics at health facilities. People infected by TB (and their families) reported isolation, avoidance, and denial of services. Many people infected by TB report being isolated in their families, prevented from seeing their children or even being abandoned. If known as having TB, many individuals with TB reported being reallocated at the workplace or losing their jobs. People whose work involves direct contact with other people such as customer service, restaurant staff, and sex workers are torn between the fear of guilt for infecting others with the fear of losing their job and their income.

Stigma, however, could also be internalized by the person with TB themselves. They also carry psychological, emotional, social, and economic burdens that take some time to accept. Because of that, it is understandable that many of them deny their potential TB infection and try to delay it until they experience dire symptoms. People with TB who are employed, primarily by companies/organizations/institutions that provide private health insurance, tend to not use social health insurance for their TB treatment because they fear that their employers may know about their diagnosis. They also often choose private clinics for the treatment, for fear of disclosure as most private clinics do not register their undergoing TB treatment persons in the public database.

Although stigma may persist among all persons with TB, it is vital to identify subgroups within that demographic, to identify heightened stigma or discrimination faced by different subgroups. Though the literature on TB-related stigma is limited, there are signs that there are differences in perception of TB and TB-related stigma among men and women. According to Courtright & Turner (2010), internalized stigma among women includes fear that TB diagnosis will exclude them from society and will hamper their marriage prospects.

In addition to gender-related issues, people living with HIV (PLHIV) and people who use drugs (PWUD) with TB often face stigma or discrimination from their families or close communities, as seen in the in-depth interview results. Another subgroup that faces heightened stigma and discrimination is homeless people with TB who tend to be shunned by society.

Community Involvement

The involvement of survivors and KVPs in TB programs has proven to be an effective method to address existing challenges in TB prevention and management among specific groups. One such activity is the involvement of prisoners who survived TB in several provinces. As seen in the AAAQ framework, many contextual factors affect one's health-seeking behaviors. The inclusion of survivors and KVP contribute to the "appropriateness" factor. For example, the jargon used by a fellow inmate or peer educator in a prison will be more relatable to prisoners who (are suggestive to) have TB. The peer educator's involvement or stance in the prison also increases the other prisoners' trust towards them, hence increasing their motivation to seek testing or adhere to their treatment.

RECOMMENDATIONS

Vietnam is committed to finding and treating all people with TB. As part of finding the missing people with TB, we must also understand the socioeconomic barriers that different people experience in accessing TB services.

In response to the findings from the needs assessment, four proposed recommendations could be used to address the existing gaps/barriers to Vietnam's TB response, namely:

I. To invest in strengthening community system that engages with populations vulnerable to TB to find missing people with TB and support treatment

Many factors inhibit one from accessing TB testing and treatment, most of which cannot be addressed with one-pronged solutions. Nevertheless, one of the aspects that could significantly address each concern is through community-friendly communication, which could be accomplished by investing in strengthening community systems. Following the GF Community System Strengthening framework, CSS could be done by strengthening the following areas. The CSS framework should be adopted to complement existing mechanisms, such as but not limited to existing legal and health frameworks.

- Enabling environment and advocacy
- Community networks, linkages, partnerships, and coordination
- Resources and capacity building
- Community activities and service delivery
- Organizational and leadership strengthening
- Monitoring, evaluation and planning
- Monitoring socioeconomic barriers to access

It may also be crucial to conduct community-led monitoring (CLM) across the different districts/provinces in Vietnam, as a means to gain community perspective on the current health services and on their needs that may have not been met. In recent years, CLM has proven as a successful platform to effectively strengthen health facilities to provide more person-centered services. Exemplars of CLM programs can be seen in South Africa's HIV programs.

II. To support networks of TB survivors who then can support people with signs or symptoms suggestive of TB and people receiving TB/LTB treatment in tackling stigma and discrimination.

As reiterated by Courtright & Turner (2010), there should be a systematic way to reduce TB-related stigma. It is first important to characterize the stigma and to identify the subgroups within the people receiving TB/LTB treatment demographic that face heightened stigma, be it external or internal. Once the identification process has been done, a tool to measure the aforementioned stigma would also be useful to determine the next course of action. This could take the form of continued CLM and/or surveys to seek a baseline of measurable stigma and discrimination against people with TB and people affected by TB, such as but not limited to families of people with TB.

Interventions for internal and external stigma should differ among these sub-groups, which can also be accomplished with the help of a community support network. This network can be developed from the existing VCTB. The network will provide information and timely personalized support to prevent and overcome self-stigma and stigma and tackle discrimination.

Last but not least, there should be legal systems in place to assist persons with TB who experience stigma. Legal and administrative remedies need to be understood and available for people affected by TB who suffer

stigma and discrimination. Community networks on TB should work on this in collaboration with legal institutions and lawyers.

III. To engage with National and Local Committees to End TB, and support their roles in TB response such as policy dialogues and consultations with community, social organizations, and service providers, oversight activities to TB programs and activities, and policy development in order to get enabling policy and needed investment for TB responses at all levels

In order to capture their voice and provide more person-centered care, it is vital to increase KVP and end-beneficiaries' capacity in this regard as well, which can be done through socialization or capacity-building activities.

From the legal perspective, although there are existing frameworks in Vietnam that can accelerate epidemic control, there are several gaps that should be addressed to maximize its progress. In recent years, there have been many literature/reports that could help shed light on which areas could be strengthened in Vietnam's national TB-related policies. Factors such as the roles of community, social contracting, and gender equality (including for genders outside of male and female) need to be addressed in policy dialogues. Fulfilling health equity and rights of KVP and people of all genders is detrimental and will contribute to the acceleration of TB control in Vietnam.

It is also important to prioritize TB KVPs and ensure the NSP has funding and M&E attached to delivering nuanced services to the needs of different KVPs.

IV. To organize gender sensitization activities for TB policymakers and program managers as well as implementers.

Gender plays an integral factor in TB programs, as it affects health service accessibility, perception of the disease, stigma and discrimination, and more. Gender-disaggregated data, along with KVP disaggregated data if available, should be used to navigate the direction of the NTP. Sensitization on gender-inclusive and gender-attuned TB services among different stakeholders, such as policymakers, program managers, peer outreach workers, and social workers at TB hospitals should be conducted. Specific to health workers, it is vital to sensitize TB staff at all levels so that they are sensitive to persons undergoing TB treatment of different genders and help to empower these persons to overcome gender stereotypes that affect their TB service-seeking behaviors and care. Additional activities may include gender empowerment interventions for people affected by TB and their families, support group discussions for male individuals undergoing TB treatment to encourage self-care and support group discussions for spouses and/or family members of female individuals undergoing TB treatment to instruct care.

In addition to sensitization activities, public awareness of gender issues in TB should also be raised. One such method is by highlighting harmful practices caused by gender stereotypes such as drinking and smoking among men or the perception of women as the primary (and better) caregivers. It is vital for such campaigns to provide accurate information about transmission and how to prevent it in the family, and the treatment process.

It is necessary to continue to foster privacy and confidentiality for people receiving TB-related services, especially in the treatment process and in the M&E system.

V. Integrating and institutionalizing TB CRG in Vietnam

To further strengthen Vietnam's efforts on TB CRG, a number of steps could be taken. These would include appointing a dedicated focal point on TB CRG in the NTP; ensuring there is a dedicated TB CRG Chapter in the TB National Strategic Plan and that TB CRG features in the NSP accompanied by costings and a related

M&E framework"; ensuring that there are dedicated interventions that focus on each of the prioritized TB KVPs (namely: prisoners, PLHIV, ethnic minority people; undocumented migrants; people who use drugs; children; people with diabetes; poor people; elderly); and, conduct TB CRG sensitization training across NTP partners at national and sub-national level.

Photo © SCDI Vietnam

CONCLUSION

There are already several healthcare and legal mechanisms that are in favor of advancing TB service uptake in Vietnam, though there are several aspects that could be maximized to further maximize TB control efforts. From a legal standpoint, Vietnam's current policies are in favor of international laws on the rights of people with TB. However, several aspects of the existing policies could be more specified, such as the management of stigma and discrimination cases and the inclusion of non-male/female genders in the law on gender equality. Additionally, the targeted KVP should be expanded in the strategic plan and policies, seeing as the current one is limited to some groups (PLHIV, persons in direct contact with the source of infection, especially children, people with chronic diseases, people with drug, alcohol, or tobacco addiction, and people on long-term immunosuppressive drugs) but leaves little attention to others (homeless people, migrants, ethnic minorities, elders, etc.).[60] Although its objectives and activities have addressed most concerns, the National strategic plan on TB has also yet to include the role of communities in TB program.

It is also important to recognize that end-beneficiaries or key and vulnerable populations may not have the same capacity or literacy level to understand legal or healthcare jargons or frameworks, unlike professionals in those fields. Even with the existence of treatment rights to clear information, the issue was still captured during the in-depth interviews in several sections, including the people's knowledge of relevant policies and their health literacy. Other than information, several barriers increase end-beneficiaries' reluctance or inability to seek TB treatment, most of which will need to be addressed to strengthen efforts for epidemic control. Upon analyzing the demographic of persons with TB prioritizing TB KVPs and ensuring the NSPs in Vietnam, it becomes evident that SES plays a huge factor in determining one's ability to access tests/treatment and to adhere to it. Factors such as distance to health facilities, ability to afford (multiple) appointments and treatment, ability to come to health facilities without other conflicting schedules or priorities (e.g. work or assumed family roles), and other social aspects need to be considered before further developing strategies to maximize the TB service uptake in Vietnam. Furthermore, due to the subjectivity and prismatic nature of each district/province, it would be more effective to cater said strategies to each area, the details of which will be discussed in the Recommendations section. Of course, last but not least, their health literacy and perception of the urgency of TB also play huge roles in determining one's initial willingness to seek test and treatment as well as their treatment adherence. This was repetitively brought up during the in-depth interviews, where for example 8 (47%) respondents stated that side effects of the treatment will reduce or entirely diminish their working capacity, a consideration that individuals who are working will consider prior to committing to treatment.

In addition to the in-depth interviews and internal reviews of national policies, the Step Up for TB Report (2020) could also be used as a tool to navigate future NTP development. The analysis of the five components (diagnosis, treatment, models of care, prevention, and procurement) reveals that while each component in the national policies could be further strengthened, more attention should be given to models of care and prevention (Step Up for TB). Though treatment initiation and decentralization showed partial progress, the main areas of concern for the models of care component involve the integration of person-centered care and social support in the national TB-related policies. Though person-centered care is difficult to standardize due to the subjectivity of each district/province and individuals undergoing TB treatment, a guideline or minimum standard should be set. To ensure that person-centered care has been implemented even in regions or sites with limited resources, it may be beneficial to seek end-beneficiaries' perception of TB services as well as to seek and meet the local community's needs. Although the current policies enable

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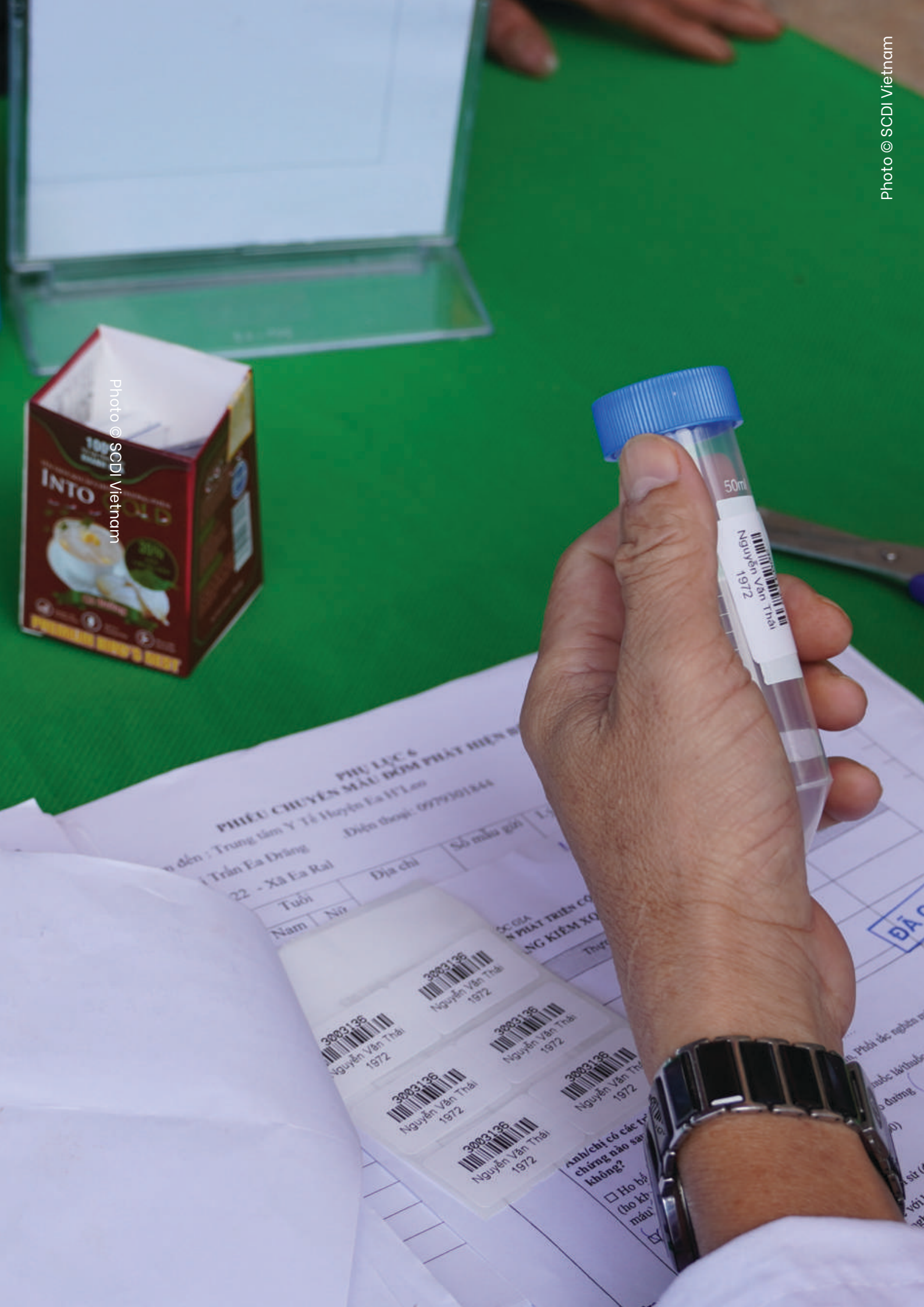
[60] *Decision 1314/QD-BYT Guidelines for diagnosis, treatment and prevention of TB - Quyết định 1314/QĐ-BYT Hướng dẫn chẩn đoán, điều trị và dự phòng bệnh lao*

persons undergoing TB treatment of low socioeconomic status (SES) to access said services, the administrative or procedural requirements to access free or affordable TB services should be further simplified. Another component that could be opportune is a partnership with the private sector, which as identified by the NTP in the 2020 program evaluation, required further support in recording and reporting, among others. By urging for a more active role from the private sector through the PPM mechanism, accessibility, and uptake of TB services will be heightened. Their involvement, however, is not the only type of innovation that will prove essential in the strengthening of TB programs in Vietnam. It is also with the help of the National TB Committee and local communities, through CSS or CLM, that the current health sector can capture community needs and see a sharp increase in testing and treatment uptakes, even among missing people with TB.



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Appendix I. Analysis by AAAQ Framework

Component	Description	Source(s)
Availability	□ According to the 2020 Year End Report (NTP), Vietnam experienced a **stockout of 1st line drugs** from 2016 to 2019, with varying degrees. More would have been procured in 2020 with additional funds, but there would be another stock out from July 2021 if the NTP budget plan approval was delayed. □ Following the outbreak of the fourth wave (April 7, 2021), there were additional concerns like reduced visits to health facilities and delayed procurement. It was reported that there was still a lack of first-line drugs and there is a high **risk of drug expiry** for the next year. The latter has resulted from the reduced rate of persons with DR-TB admissions. □ **Disbursement rate for second-line drugs was slower** in comparison to previous years. The shift in the situation following the fourth wave caused Vietnam to have to consider the situation for the next quantification round, which will prove difficult for second-line drugs especially seeing as they have short shelf life. □ **The procedure for drug procurement during the COVID-19 pandemic was simplified** following the issuance of Circular No. 13/2021/TT-BYT (Article 11) of the MOH dated September 16, 2021, which exempts the procurement of medical equipment and drugs for COVID-19 prevention and control from having to apply for MOH import licenses. □ To mitigate potential delays due to the impact of COVID-19 on the international supply chain, the **NTP has issued an early order for drugs** sourced from international suppliers. □ Drugs purchased from the health insurance fund have been allocated for 822 health facilities (across 705 districts), which implies that the winning pharmaceutical company would have to ensure that the supply chain runs smoothly. □ Concurrently, there is a need for software to aid the statistical reporting of drugs procured by the health insurance fund and a need to increase the number of human resources for the supply chain activities. □ In 2021, X-ray vehicles in several provinces/cities are not available but as of November, its bidding for 28 prisons has been approved by the Ministry of Health. In the previous year, it was reported that some prisons did not have a (functioning) X-ray machine, but COVID-19 made it difficult for prisoners to be moved outside to access the test.	NTP Report 2020, 2021
Accessibility	Physical □ Prisoners in several prisons that do not have (functioning) X-ray machines could not get screened at other facilities/prisons due to the	

	social distancing/restrictions imposed during the COVID-19 pandemic □ Those who tested TB-positive in the 6 prisons that have conducted testing activities were enrolled in treatment. However, the same could not be said for other prisons due to the lack of data and delayed testing activities in 2021.	
	Financial □ The cost of testing and treatment for TB and DR-TB, among others, is covered in dedicated health facilities	
	Bureaucratic/Administrative □ As relayed by respondents in the FGD and in-depth interviews, the administrative procedure for funded TB services is long and complicated, which seems to pose a challenge, especially for persons undergoing TB treatment of low SES	
	Social □ Delay, denial, and concealment of TB diagnosis is not uncommon among people infected with TB and society. Heightened stigma and discrimination are faced by socially disadvantaged, stigmatized, or excluded KVPs, such as PWUD and homeless people living with TB.	FGD and in-depth interview (Appendix 2)
	Information □ The government has set a policy in place to promote the spread of TB-related information that will fit and be understood by different target groups □ Explanation or information on TB-related policies and programs could be better catered to target groups. This is to address the belief that people still do not know of TB policies, as stated by respondents from the FGD and in-depth interviews.	Law number 03/2007/QH 12 dated 21/11/2007 on prevention and control of infectious diseases (Article 8) FGD and in-depth interview (Appendix 2)
Acceptability	**Confidentiality** □ Individuals undergoing TB treatment have the right to confidentiality, be it on health status, private information in medical records, etc. (Law No. 40/2009/QH12 dated Nov. 23, 2009, Law on medical examination and treatment, Article 3.2. and Section 1. Rights of Person with TB, Article 8.1.)	
	Informed Consent	

	□ By law, individuals undergoing TB treatment have the right to obtain full information, explanation, and counseling on their disease status, including results and risks of test and treatment (Section 1. Rights of a person with TB, Article 10.1) and the right to obtain their health history (Article 11) □ In relation to the clauses above, individuals undergoing TB treatment have the right to choose in medical examination and treatment (Article 10)	
	Cultural Sensitivity □ The importance of cultural sensitivity is recognized by law, as seen in Law number 03/2007/QH12 dated 21/11/2007 on prevention and control of infectious diseases, which states that people with TB, people with signs and symptoms suggestive of having TB, TB carriers, and family members have the right to information, education, and communication (IEC) on TB prevention and control (Article 10.2). As follows, the IEC must take into account several factors, including appropriateness for target audiences, cultural traditions, ethnic groups, social ethics, religions, beliefs, and customs (Article 11).	Law number 03/2007/QH 12 dated 21/11/2007 on prevention and control of infectious diseases (Luật Phòng, Chống bệnh truyền nhiễm số 03/2007/QH 12 ban hành năm 21/11/2007)
Quality	**Skills of Health Workers** □ The skills of health workers in prisons could be further improved	
	Supplies □ Several X-ray machines in health facilities and prisons have malfunctioned and procurement of new ones has been delayed due to the pandemic	
	Environment or setting □ Prisons in Vietnam are susceptible to drastic weather or disasters, such as extreme heat and floods, which either hinder the implementation of TB services or expose inmates to uncomfortable conditions	Final reports for 2018 and 2020

APPENDIX II. FGD & IN-DEPTH INTERVIEW: SUMMARY OF FINDINGS

SCDI conducted interviews with three groups: Health staff of district TB health care centers; members of CBO supporting people infected with TB in provinces; people infected with TB in provinces (including PLHIV, people who have been released from prison, the homeless, drug addiction treated persons). A total of 17 interviews, including 4 group discussions and 13 in-depth interviews shared the difficulties faced by the medical system, people infected with TB, and their families as follows:

About policies:

1. There are policies to support poor individuals undergoing TB treatment, but accessing these Funds requires complicated procedures *(7/17 interviews mentioned, including 1 by medical staff; 3 by CBO; 2 by persons undergoing TB treatment).*
2. Difficulties in the transition to health insurance payment *(2/17 interviews mentioned, including 2 by medical staff)*
3. Policy on PPM is in place, but the actual connection between the public-private health system is not clear *(1/17 interviews mentioned, including 1 by medical staff)*.
4. People do not understand the policies to support people infected with TB *(2/17 interviews mentioned including 2 by CBO)*.

About active screening:

1. Screening costs are expensive, requiring close coordination of local authorities and the entire health system *(1/17 mentioned interviews included 1 by medical staff).*
2. The people's knowledge about health is still limited, so it takes a long time for the media to mobilize them to participate in the screening event *(3/17 interviews mentioned including 3 by health workers).*

Access to examination and diagnosis services:

1. Persons infected with TB are poor, therefore health is not their concern *(7/17 interviews mentioned, including 3 by persons with TB, 3 by CBOs, and 1 by medical staff).*
2. Persons infected with TB have subjective psychology. When they cough and spit, they go to the pharmacy to buy medicine. Not until the symptoms worsen that they go to see the doctors *(3/17 interviews mentioned, including 1 by medical staff, 2 by CBOs)*.
3. Persons undergoing TB treatment who don't have identity cards cannot buy health insurance *(3/17 interviews mentioned, including 2 by persons with TB, and 1 by medical staff)*.
4. Persons infected with TB don't have money and don't want to spend a working day going to the doctor's *(2/17 interviews mentioned, including 2 by medical staff)*.
5. To diagnose TB, persons with TB symptoms must go around a circle before reaching the right TB-specialist health care center, which costs a lot of money: From the Pharmacy → Provincial Hospital/Central Hospital → District TB Health Care Center *(4/17 interviews mentioned, including 3 by medical staff and 1 by person with TB)*.
6. Individuals undergoing TB treatment have to return to the health care facility at least twice for a definitive diagnosis of TB. The transportation costs are high for people living far from the health facility → Hesitation of going to the health care center *(6/17 interviews mentioned include 4 by medical staff, 1 by CBO, 1 by a person with TB).*
7. Persons undergoing TB treatment are afraid of being stigmatized and self-stigmatized *(1/17 interviews mentioned, including 1 by medical staff).*
8. Counselling to individuals undergoing TB treatment is still limited due to the shortage of staff in district TB health care centers *(1/17 interviews mentioned, including 1 by medical staff).*

During treatment process:

1. In addition to TB, individuals undergoing TB treatment bear the economic burden of many other underlying diseases that are not covered by health insurance *(3/17 interviews mentioned include 3 articles by persons with TB).*
2. Some individuals undergoing TB treatment have health insurance but still receive private treatment services due to their distrust of the primary health care facilities → Expensive private treatment costs *(3/17 interviews mentioned, including 1 by CBO; and 2 by medical staff).*
3. When individuals must undergo TB inpatient treatment, they are required to make a cash deposit, but they have no money for the deposit *(5/ 17 interviews mentioned, including 1 by CBO; and 4 by persons with TB).*
4. Anti-TB drugs are covered by health insurance, but other adjuvant drugs must be purchased from outside *(11/17 interviews mentioned, including 5 by persons with TB; 2 by CBOs; 4 by medical staff).*
5. Side effects of anti-TB drugs causing reduction or loss of working capacity *(8/17 interviews mentioned, including 5 by persons with TB, and 3 by CBOs).*
6. Persons infected with TB who are on Methadone face drug interactions and have to increase the dose of Methadone *(4/17 interviews mentioned, including 2 by medical staff; and 2 by CBOs).*
7. Many individuals undergoing TB treatment don't have a means of transport and, therefore, have to ask someone to carry them to get medicine *(1/17 interviews mentioned, including 1 by a person with TB)*
8. Persons infected with TB who use drugs, have HIV, are homeless, or constantly migrating are those that are difficult to manage and quit treatment easily. *(10/17 interviews mentioned, including 7 by medical staff, and 3 by CBOs).*
9. Some individuals undergo TB treatment for a while and see no symptoms, so they quit the treatment *(1/17 interviews mentioned, including 1 by a person with TB).*

Groups with few opportunities to access screening services and treatment support:

1. The homeless (no family, doesn't care about health, doesn't have health insurance…);
2. Drug users (do not prefer interacting with local health workers, never take the initiative in terms of health);
3. People with disability, amputation, glass bone, spinal injury accident...;
4. Labor exporters who return to Vietnam do not bring medical records so they cannot continue to receive treatment;
5. Ethnic minority people;
6. The elderly who are not cared for by their children.

Differences between genders:

1. Women care more about their health and families *(4/17 interviews mentioned, including 1 by CBO; 3 by medical staff).*
2. Females have better adherence to treatment *(6/17 interviews mentioned, including 2 by CBOs; 4 by medical staff).*
3. Men put the burden of money on their health *(2/17 interviews mentioned, including 1 by medical staff).*
4. Men have better incomes than women, so they are more likely to access health services than women *(1/17 interviews mentioned, including 1 by medical staff).*

Stigma and Discrimination:

1. TB/HIV co-infected persons or TB-infected persons who use drugs are stigmatized by their families and society, they receive little attention and care. For persons infected with TB who are homeless, people are often shunned. These groups that go to the doctor are often looked at, talked about, and avoided *(7/17 interviews mentioned, including 3 by CBOs; 2 by persons with TB; 2 by medical staff).*

Appendix III. FGD & In-depth Interview: List of Guiding Questions

1. Comment on the implementation of commitments, and policies.
2. Describe the service-seeking pathway of a person with suggestive TB signs and symptoms.
3. Describe the pathway of people who participate in an active finding person with TB project.
4. List expenses for diagnosis, treatment, and sources of payment (based on a person with TB's pathways).
5. Describe a "typical" person infected by TB – age, sex, socioeconomic characteristics, ethnic background, places of living, and status of health insurance.
6. Name groups that have a high risk of getting TB.
7. List people who have fewer opportunities for accessing to screening, diagnosis, treatment, treatment adherence support, and nutrition support.
8. Who are the individuals undergoing TB treatment more likely to be stigmatized by health workers and others?
9. Who are the persons with TB considered "challenging" for staff? Reason?
   (Probe: person with TB's attitudes; Adherence; Success rate; Ability to pay; Staff's reluctance to accept due to social perception…).
10. Challenges to access, diagnosis, treatment, and care for persons undergoing TB treatment who are:

- People who use drugs;
- Sex workers;
- MSM;
- Transgender;
- People living with HIV.

11. Describe the differences between female and male individuals undergoing TB treatment.
12. Understanding about sexual orientations and gender identities.
13. Understanding about rights of persons at high risk of TB and persons with TB.
14. Experiences in working with community support groups.

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