

Vietnam – United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific Baseline Assessment Dec 2006

ACRONYMS - VIETNAM

05 Centres	Compulsory Rehabilitation Centres for Sex Workers
06 Centres	Compulsory Rehabilitation Centres for Drug Users
ADB	Asia Development Bank
ARHP	Asia Regional HIV/AIDS Project
ARV	Antiretroviral
ASEAN	Association of Southeast Asian Nations
AusAID	Australian Agency for International Development
BCC	Behavioural Change and Communication
BI	Burnet Institute
CCSE	Centre Commission of Science and Education
CCIC	Central Commission Ideology and Culture
CPV	Communist Party of Vietnam
DANIDA	Danish International Development Agency
DFID	Department for International Development
DIC	Drop in Centre
DOLISA	Department of Labour, Invalid and Social Affairs
DSEP	Department for Social Evils Prevention (Viet Nam)
FHI	Family Health International
GF	Global Fund
HR	Harm Reduction
IDU	Injecting Drug User
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MIS	Management Information System
MMT	Methadone Maintenance Therapy
MOLISA	Ministry of Labour, Invalids and Social Affairs (Viet Nam)
MoH	Ministry of Health
MPS	Ministry of Public Security
NIHE	National Institute of Hygiene and Epidemiology
NSP	Needle and Syringe Program
PEPFAR	President's Emergency Plan for AIDS Relief
PLHA	People Living With HIV/AIDS
PE	Peer Education
SIDA	Swedish Agency for International Development Cooperation
SODC	Standing Office on Drugs Control of Vietnam
TWG	Technical Working Group
UNAIDS	Joint United Nations Program on HIV/AIDS

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UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime (formerly UNDCP)
VAAC	Viet Nam Administration HIV/AIDS Control
Viet Nam	Socialist Republic of Viet Nam
WB	World Bank
WHO	World Health Organization

1. National Program Support

	Ministry / Agency Responsible	Systems / Frameworks In Place (List Relevant Items)	
		Existing	Gaps
Political Commitment	<p>Ministry of Public Security (MPS) – Standing Office for Drug Control</p> <p>June 2000: National Committee for the Prevention and Control of AIDS, Drugs and Prostitution established. Headed by the Deputy PM and includes 19 member ministries including Ministry of Health (MOH) and MPS.</p>	<ul style="list-style-type: none"> • New Law on HIV/AIDS Prevention and Control effective January 1st 2007. 	<p>HR programs are largely donor funded and to date do not cover all 64 provinces.</p> <p>The Decree to accompany the HIV Law has not been finalised (this will provide the necessary information as to how to implement and understand the HIV Law).</p>
Donor Commitment	<p>World Bank, DFID, ADB, PEPFAR, Global Fund, Netherlands, AusAID, DANIDA</p>	<ul style="list-style-type: none"> • Vietnam Administration for AIDS Control (under MOH) is responsible for managing DFID, WB and GF funds. • WB and DIFD have undertaken joint planning sessions for 2007.¹ • AusAID ARHP has had limited activities in Vietnam. However, there has been capacity building work in 05/06 centres. • DANIDA has been funding work by UNODC in 3 north western provinces. 	<p>DFID 21 Provinces, PEPFAR 40 provinces, GF 20 provinces, ADB 15 provinces – there is overlap in these provinces so not all 64 provinces have HIV programs and not all HIV programs include harm reduction interventions. Harm reduction programs are in approximately 30 provinces – most are minor in coverage.</p>
Costed National Strategy	<p>Ministry of Health - Vietnam Administration for AIDS Control (VAAC)</p>	<ul style="list-style-type: none"> • MOH is currently working on the sixth draft of the Action Program on HIV/AIDS Harm Reduction Intervention and Transmission Prevention for 2006 - 2010 Period. This document is expected to be finalized by January 2007. This includes a budget which is primarily donor funded with a small national allocation. • As part of the National Harm Reduction Strategy VAAC will develop national guidelines for the implementation of HR programs including NSP and Peer Education. 	<p>Proposed national allocation for programming is approximately one third of total program costs and is dependent on ongoing donor commitment. A lack of funds among all the sectors to address the scale of drug use and HIV is a challenge.</p>

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Legal Environment		<ul style="list-style-type: none"> • Party to the 1961, 1971, and 1988 UN conventions. • UN Convention Against Transnational Organized Crime 2002.² • Signatory to ASEAN declaration for a drug-free ASEAN by 2015. • HR interventions for HIV prevention mandated in the HIV law include: IEC, Condoms, NSP, and drug treatment. • Law on HIV/AIDS Prevention and Control effective January 1st 2007 (includes harm reduction). 	<p>Methadone pilots have been delayed by the MOH though this may change in 2007. Key members of the HR TWG have been advocating for methadone pilots with the National Assembly.</p> <p>Possession of needles and syringes unlawful for those recorded as suspicious or IDU.</p>
Policy Environment	<p>Ministry of Health – Department of Health Legislation</p> <p>Ministry of Public Security – Standing Office for Drug Control</p> <p>National Committee for the Prevention and Control of AIDS, Drugs and Prostitution</p>	<ul style="list-style-type: none"> • Law on HIV/AIDS Prevention and Control effective January 1st 2007. • Law on Narcotic Drugs Prevention and Suppression 2001 – acknowledges drug use is a social problem and users should be viewed as needing assistance. • National Drug Control Action Plan 2001-2005 – aims to reduce number of drug users by 10-20% annually. National Drug Control Master Plan 2001-2010 supported by UNODC. 	<ul style="list-style-type: none"> • Drug users still targeted in some provinces and sent to 06 rehabilitation centres. • Delivering the HIV Law from the central government level to provincial and district authorities is identified as a challenge. • Interpretation of the HIV Law can vary at the district level as the head of each district in a Province may have a different perception of HIV risk in the community, resulting in differing responses.
M & E Systems/Research Capacity	National Institute of Hygiene and Epidemiology (NIHE)	<ul style="list-style-type: none"> • NIHE is assisting MOH to develop indicators for a single M&E system (supported by FHI, WHO, UNAIDS). • Will conduct the 2nd household survey in 2007 and will include questions on drug use.³ 	National Harm Reduction M & E framework has not been finalised.
Surveillance Systems	National Institute of Hygiene and Epidemiology (NIHE)	Sentinel surveillance for HIV managed by NIHE in 40 out of the 64 provinces.	No formal system for HR programs.

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<p>Multi-sectoral Involvement</p>	<p>CCSE, CCIC AusAID – ARHP</p>	<ul style="list-style-type: none"> • The ongoing development of Vietnam's 2006–2010 Socioeconomic Development Plan and the UN Development Assistance Framework 2006 - 2010 are strengthening the framework for coordination and mainstreaming of HIV/AIDS activities. • Donor coordination on HIV/AIDS – led by the Committee of Concerned Partners – was recently strengthened by additional meetings among the heads of agencies of the largest international supporters of the national AIDS response.⁴ • Asia Regional HIV/AIDS Project is working with Health and Public Security – activities in Vietnam have been limited to date. • Study tours hosted by Burnet Institute in September 2006 under the UNDP/SIDA project for the Central Commission of Science and Education and Ideology and Culture on multi-sectoral collaboration for the development of BCC materials may progress movements to address this issue. • The Vietnamese government has recognized the need for a multi-sectoral response to HIV/AIDS, and in March 2004 approved the first five-year National Strategy on HIV Prevention and Control.⁵ 	<ul style="list-style-type: none"> • Multi-sectoral collaboration and coordination of response among the various sectors is either poor or requires improvement. Tend to work vertically. • It is not clear how health and law enforcement will interact in the implementation of Harm Reduction programs mandated under the new HIV Law.¹ • The official linking of AIDS with two illegal activities in the National Committee for AIDS, Drugs and Prostitution Prevention and Control fosters a high level of HIV-related stigma and discrimination.
<p>Law enforcement involvement</p>	<p>Ministry of Public Security Ministry of Labour Invalids and Social Affairs (MOLISA) Standing Office on Drugs Control (SODC), General Department of Customs, Border Army and Maritime Police. C17, Department for Drug and Crime Prevention (operational police).</p>	<ul style="list-style-type: none"> • Law on Drug Control effective June 2001. • The death penalty may be imposed for those in possession of small amounts of heroin, cannabis or opium, but is rarely imposed. 	<p>Number of operational police receiving harm reduction education is not large.</p> <p>Enforcement – security regulations require police to detain those who are found in possession of or using drugs and commit them to a compulsory drug treatment centre for up to 5 years. Mandatory death sentences are imposed for those in possession of 600g or more of heroin.</p>

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Involvement of IDUs in Response		<p>There are a small number of PE based NSP programs. They have been piloted since 1993. Peer Educator Clubs act as localised network for project interventions.</p> <p>B93 clubs for those returning from forced rehabilitation centres have been established in many provinces.</p>	<p>No IDU network organisation in Vietnam though there are a number of government sanctioned HIV+ support groups (Ban Giup Ban – friend help friend) often made up of users/former users.</p>
Capacity building	MOH, WHO, AusAID - ARHP	<p>WHO acts as the in-house technical partner for the programs managed by MOH.</p> <p>Capacity building program in 05/06 Centres</p>	<p>Level of HR expertise is low. Requires intensive training/mentoring at province level with provincial officials expected to develop HR action plans and implement them.</p> <p>There is a lack of technical capacity, capacity building in general terms and/or the opportunity for professional development.</p>

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2. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers	
1. Political commitment	1.1 Stigma and Discrimination	Communist Party of Vietnam (CPV) Political Bureau	<ul style="list-style-type: none"> • CPV: Proposals to enhance the fight against HIV/AIDS will be submitted to the Political Bureau. The draft of a new directive on HIV/AIDS prevention to replace Directive No 52-CT/BBT has been re-adjusted for the sixth time and posted for input.¹⁷ • The statement was made at a seminar, “Fighting the stigmatization of and discrimination against HIV/AIDS patients,” in Hanoi on September 5. The seminar was held by the commission in coordination with the UN Development Programme (UNDP) and the Swedish International Development Agency (SIDA). • In the last few years, the Vietnamese state has begun creating a legal framework that is in accordance with international practice and traditional cultural characteristics which will fight the stigmatization and discrimination associated with HIV/AIDS.⁶ 	
2. Community commitment	2.1 Stigma identified as an ongoing challenge ⁷	Communist Party of Vietnam Political Bureau	None identified.	
	2.2 Social Evils Campaigns and Police Crackdowns			Public Security
	2.3 Re-integration of people back into communities after having been in 05 or 06 centres for up to 5 years			
3. Legislative / policy				
4. Comprehensive Services	4.1 Donor restrictions on program activities	PEPFAR		
	4.2 Poor access to ARV – in some cases ARV services are completely inaccessible to IDUs			

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5. Resources ⁸	5.1 High staff turnover 5.2 Overcommitted provincial staff 5.3 Dependent on donor funding; most programs run as pilots for up to 3 years ^{2,9} 5.3 Low salaries for government jobs. Difficulty in attracting/retaining staff ¹⁰		
6. Affected community involvement	6.1 Limited involvement		Recent Study tours to Australia for multi-sectoral policy development included representative of PLHA group reflecting an increased awareness of the importance of including the affected community in decision making and programming (groups from CCSE and CCIC to Burnet in 2006 focus on multi-sectoral responses and including targeting community in policy making). There are also a small number of groups of affected communities who are active in buying ARV from outside Vietnam – this has support of the POLICY project office in Hanoi.
7. Commodities	7.1 New Law on procurement may affect ability to arrange large scale centralised procurement for commodities including needles and syringes. ¹¹		Need further research on the impact of this law on commodities procurement. UNFPA has a centralised system for procurement of contraceptives, which may offer a solution for needles and syringes. ¹²
8. Scaling up plans			
9. Capacity Building	9.1 No		

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3. Program Implementation

Estimated IDU Population: 170,400 registered drug users, unofficial estimate 200,000-500,000²

Service Coverage: No estimates provided in available data

	Available Data Sources: 1. Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries 2003 (published June 2004) ¹⁸ 2. Mapping of HIV Interventions in Vietnam UNAIDS Secretariat (mapping of general HIV interventions not all specific for IDU) published November 2006 ¹⁹ 3. Burnet Institute (BI) Vietnam program data 2006 (BI works in cooperation with provincial government services)							NSP coverage (B/A)
	*Provincial Coverage (% or Avg)	NGOs (Number)	Govt. Health Services (Number)	# Clients Accessing Services	Needle / Syringe Distribution (Number) (B)	# Condoms Distributed	# of IEC Materials Distributed	
Outreach	Provinces where NGOs list programs targeting IDUs: Thanh Hoa, Bac Giang, Lang Son, Quang Ninh, Ha Noi, Ninh Binh, Binh Dinh, Can Tho	8/64 Provinces with NGO programs targeting IDU have outreach services covered by 9 NGOs.	BI works in Bac Giang and Thanh Hoa with the provincial HIV/AIDS Centres					
Drop-in Centres		Hanoi	BI programs Bac Giang, Thanh Hoa,					
VCT	75 sites			18250/year (2002)		250,000,000 (2002) across all services		
Linkage to HIV Care and Support								

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ARV Poor access to ARV – in some cases ARV services are completely inaccessible to IDUs. ¹³	16 provinces (25%), but not data specifically for IDU	11 NGOs and international organisations						
Primary Health Care								
Needle and Syringe Programs	2/64 provinces with NGO programs targeted toward IDU listed NSP services as a component activity.	6 NGOs + UNESCO	BI works in Bac Giang and Thanh Hoa with the provincial HIV/AIDS Centres to deliver NSP services					
Substitution Programs	None at the moment but 700 places have just been approved (expected to commence in early 2007, managed by FHI). ¹⁴							
Linkage to Rehabilitation and Detoxification								
Peer education programmes	6/64 Provinces with NGO programs targeting IDU have peer education services	9 NGOs	BI works in Bac Giang and Thanh Hoa with the provincial HIV/AIDS Centres					
Targeted IEC								
Plans for Scale Up								

*provinces listed where activities/programs occur, no accurate estimates for coverage available yet.

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Services in Closed Settings:**

Estimated Prisoner Population: 55,000 (mid-98, World Prison Population List, Home Office, UK Government (www.homeoffice.gov.uk), sixth edition, 2005)

Estimated % of Drug Offenders: Not available (Dolan, K. et al., Review of Injection Drug Users and HIV Infection in Prisons in Developing and Transitional Countries, August 2004)

Service	# of Clients Accessing Services
Voluntary Counselling and Testing	NA
Needle and Syringe Programs	NA
Peer Education Programs	NA
Substitution Maintenance	NA
Post-release Follow-up	NA
Primary Health Care	NA
Condoms	NA
Total	NA

Workforce

Estimated Required Workforce: **NA**

	Available Data						Standardised Training Programs in Place	Capacity Assessment (low/medium/high)
	Provincial Coverage (% or Avg)	NGOs (Staff No's)	Govt. Health Services (Staff No's)	Total	Current Workforce compared to Required Workforce (%)	% of Peers in Workforce		
Service Providers								
Plans for Scale Up								

4. Gap Analysis

Most programs only run as pilot projects and are dependent on donor funding. ARV provision, NSP, and outreach are all very limited, and methadone pilot programs have been delayed. No data is available on services in prisons.

There is as yet no framework for harm reduction M&E.

There is a lack of human capital and skills, with high staff turnover and low salaries adding to these problems. Capacity building for local staff is urgently required. Continuing stigma and discrimination should be addressed.

The possible conflicts between the new Law on HIV/AIDS Prevention and Control and drug control laws have not been explored. Likewise, the consequences of the new law on commodities procurement for the purchase of needles and syringes need to be researched. Police crackdowns on IDU are continuing.

5. Recommendations

Political and multi-sectoral commitment

There is a need to promote the concept of harm reduction to all appropriate government sectors, at all levels (Ministry of Health, Ministry of Public Security, Ministry of Labour, Invalids and Social Affairs (MOLISA), and Provincial level including Department of Health, Department of Public Security, Department of Labour, Invalids and Social Affairs, Youth Union and Women's Union).

M & E systems

A standardized reporting (national) system for harm reduction programs needs to be established. A new Management Information System (MIS) for harm reduction programs in Myanmar is currently being developed and is planned to be operating in 2007. This model should be considered for Vietnam.

A good monitoring system should be in place to keep track of the harm reduction activities implemented in confined settings and a linkage with the harm reduction activities in the community (or a referral system) should be established to ensure the continuum of services from within the confined settings and in the community if this is available.

A series of specific training programs on the fundamentals of monitoring and evaluation for all program management staff should be implemented to ensure a more efficient, effective, and economic harm reduction practice should be implemented.

Policy Environment

Highlight and promote a *comprehensive* package of harm reduction approaches and interventions among drug users.

Capacity building

Involve the broader health sector through training health care workers who work with drug users at selected provincial, district and commune levels on the fundamentals of harm reduction theory and practice.

Strengthen the technical capacity of the National Committee on HIV, Drugs and Prostitution to improve the linkages and coordination between the Ministry of Health, MOLISA and Ministry of Public Security, in order to improve planning of harm reduction responses and guide, implementing agencies on appropriate programmatic responses.

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