

Terminal Evaluation Report

Technical Assistance to Treatment and Rehabilitation at
Institutional and Community Level

Project VIE/H68

and

Drug Abuse and HIV Prevention among Ethnic Minorities in
Northwest Viet Nam

Project VNM/J04

Thematic areas: Drug Demand Reduction and HIV/AIDS

Viet Nam

Report of the Evaluators:

Dr. Kim Hoffman

(kim@kimhoffmanconsulting.com)

And

Arie Rahadi, MPH

(arie.rahadi@gmail.com)

UNITED NATIONS OFFICE ON DRUGS AND CRIME

HA NOI

LIST OF ACRONYMS

| | |
|---------|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ATS | Amphetamine Type Stimulant |
| AUSAID | Australian Agency for International Development |
| CCDU | Compulsory Centers for Drug Users |
| CEM | Committee for Ethnic Minorities |
| CLP | Core Learning Partners |
| COVIE | Country Office of Viet Nam |
| COW | Community Outreach Work/Worker |
| DOH | Department of Health |
| DOLISA | Department of Labour, Invalids, and Social Affairs |
| DSEP | Department for Social Evils' Prevention |
| FGD | Focus Group Discussions |
| FHI | Family Health International |
| GOV | Government of Viet Nam |
| HCT | HIV Counselling and Testing |
| HIV | Human Immunodeficiency Virus |
| IDU | Injecting Drug Use/User |
| IEU | Independent Evaluation Unit |
| IEC | Information, Education, Communication |
| Lux-Dev | Luxembourg Development |
| M&E | Monitoring and Evaluation |
| MMT | Methadone Maintenance Treatment |
| MOH | Ministry of Health |
| MOLISA | Ministry of Labour, Invalids, and Social Affairs |
| MSC | Most Significant Change |
| NSP | Needle Syringe Program |
| PAC | Provincial AIDS Committee |
| PSIP | Peer Supply Information Point |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| PLWH | People Living with HIV/AIDS |
| PMU | Project Management Unit |
| SAMHSA | Substance Abuse and Mental Health Services Administration |

| | |
|-------|--|
| SDSEP | Sub-Department of Social Evils Prevention |
| SIDA | Swedish International Development Cooperation Agency |
| STI | Sexually Transmitted Infections |
| TPR | Tri-Partite Review |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counselling and Testing |

Disclaimer

Independent Project Evaluations are scheduled and managed by the project managers and conducted by external independent evaluators. The role of the Independent Evaluation Unit (IEU) in relation to independent project evaluations is one of quality assurance and support throughout the evaluation process, but IEU does not directly participate in or undertake independent project evaluations. It is, however, the responsibility of IEU to respond to the commitment of the United Nations Evaluation Group (UNEG) in professionalizing the evaluation function and promoting a culture of evaluation within UNODC for the purposes of accountability and continuous learning and improvement.

Due to the disbandment of the Independent Evaluation Unit (IEU) and the shortage of resources following its reinstatement, the IEU has been limited in its capacity to perform these functions for independent project evaluations to the degree anticipated. As a result, some independent evaluation reports posted may not be in full compliance with all IEU or UNEG guidelines. However, in order to support a transparent and learning environment, all evaluations received during this period have been posted and as an on-going process, IEU has begun re-implementing quality assurance processes and instituting guidelines for independent project evaluations as of January 2011.

TABLE OF CONTENTS

| | |
|--|------------|
| LIST OF ACRONYMS | I |
| TABLE OF CONTENTS | III |
| SUMMARY MATRIX | IV |
| EXECUTIVE SUMMARY | V |
| CHAPTER 1: INTRODUCTION | 1 |
| 1.1. BACKGROUND AND CONTEXT | 1 |
| 1.2. METHODOLOGY | 7 |
| 1.3. LIMITATIONS | 8 |
| CHAPTER 2: EVALUATION FINDINGS | 10 |
| 2.1. PROJECT CONCEPT AND DESIGN | 10 |
| 2.2. RELEVANCE | 12 |
| 2.3. EFFICIENCY | 13 |
| 2.4. PARTNERSHIPS AND COOPERATION | 19 |
| 2.5. EFFECTIVENESS | 20 |
| 2.6. IMPACTS | 22 |
| 2.7. SUSTAINABILITY | 27 |
| CHAPTER 3: CONCLUSIONS | 30 |
| CHAPTER 4: RECOMMENDATIONS | 33 |
| CHAPTER 5: LESSONS LEARNED | 37 |
| | |
| LIST OF ANNEXES | |
| ANNEX 1: Field Visits and Data Collection Schedule | 41 |
| ANNEX 2: Interview and Focus Group Semi-Structured Interview Questions | 43 |
| ANNEX 3: List of Interview and Focus Group Participants | 45 |
| ANNEX 4: Documents Reviewed | 49 |
| ANNEX 5: References | 51 |

SUMMARY MATRIX

Below is the table summarizing the main findings, supporting information, and the recommended actions for the VIE/H68 and VNM/J04 projects. The matrix was organized to underscore findings that are particular for each project in addition to those that are shared among the two projects.

TABLE 1. Summary matrix of VIE/H68 and VNM/J04 findings

| Problems and issues identified | Supporting evidences | Recommendations |
|--|--|--|
| <i>VIE/H68: Technical Assistance to Treatment and Rehabilitation at Institutional and Community Level</i> | | |
| 1. Unable to assess patient outcomes | Absence of patient monitoring data | A robust monitoring component during sustainability efforts by Viet Nam Government |
| 2. Lack of sustained professionalization of the treatment staff | Field reports, especially staff interviews | Improvement of mentorship and coaching by Viet Nam Government and by UNODC for future projects |
| 3. Dearth of mental health training | Field reports, specially staff respondent interviews | Addition of mental health components into future trainings by UNODC and Viet Nam Government. |
| 4. Increasing use of amphetamine-type stimulants in some sites | Field reports from Central and Northern provinces. | Education for trainees about ATS into future trainings by UNODC and Viet Nam Government |
| <i>VNM/J04: Drug Abuse and HIV Prevention among Ethnic Minorities in Northwest Vietnam</i> | | |
| 1. Altered project focus deviating from the original scaling-up goal | - Revision Documents - Project Progress Reports - Field reports | Full-support extension of no less than two years to reinvigorate project achievements by UNODC |
| 2. Weak relapse monitoring system biased towards reporting low rates | -Field reports -Absence of baseline behavioural data on drug use | - Immediately initiating a baseline study by UNODC and GOV partners - Allocation of ample resources for systematic monitoring & evaluation |
| 3. Critical role of a specialist agent in the microfinance management | - Field reports | Integration with the GOV project with short-term assistance from a specialist organization, facilitated by UNODC |
| <i>Joint Findings</i> | | |
| 1. Uncertain prospect of sustainability upon project termination | -Field report -Project Progress Reports indicating declining outputs. | - Incorporation of technical and financial sustainability indicators by Viet Nam Government - Promotion of multi-sectoral involvement in the project central management |

| | | |
|---|---------------|---|
| 2. Need for strengthened collaboration among related projects | Field reports | Promotion and assistance for creation of drug use and HIV Master plans in project sites by UNODC, Viet Nam Government and other relevant partners |
|---|---------------|---|

EXECUTIVE SUMMARY

This report was commissioned by the United Nations Office on Drugs and Crime (UNODC) for the purpose of the terminal evaluation of the Projects: *Technical Assistance to Treatment and Rehabilitation at Institutional and Community Level* and *Drug Abuse and HIV Prevention among Ethnic Minorities in Northwest Viet Nam*, hereafter referred to by project reference numbers VIE/H68 and VNM/J04 respectively.

The VIE/H68 project addresses the need to improve and further develop a range of HIV prevention and drug abuse treatment services for drug users in 10 provinces in Viet Nam. The project has a duration of just under six years, from June 2006 to February 2012 and is a collaboration between the Ministry of Labour Invalids and Social Affairs (MOLISA) and the United Nations Office on Drugs and Crime (UNODC). The project includes HIV/AIDS prevention, as well as community-based and residential treatment and rehabilitation.

Similarly, VNM/J04 project represents an expansionary phase of comprehensive drug demand reduction encompassing community drug treatment, harm reduction, and socioeconomic mitigation for ethnic minorities in 48 communes of four North-western provinces of Viet Nam, with the Committee for Ethnic Minorities (CEM) as the main national counterpart to the commissioning body UNODC.

This terminal evaluation report documents findings, key recommendations, and best practices; produced from the synthesis of on-site data and project reports collected during the field visit mission from 22nd November to 6th December 2011 by independent evaluators, Dr. Kim Hoffman (Team Leader) and Arie Rahadi, MPH. During the evaluation period a total of 38 recorded interview sessions involving 96 respondents representing stakeholders of both projects were conducted.

The VIE/H68 project was designed to improve the quality and effectiveness of rehabilitation efforts by relevant government authorities, namely the Ministry of Labour, Invalids and Social Affairs (MOLISA), the Department of Social Evil Prevention (DSEP) as well as the sub-DSEP offices via technical assistance and capacity building. The evaluator found measurable progress towards the achievement of project outcomes as reported by project counterparts and beneficiaries. Specifically, the project has been successful in raising skills and knowledge of the national counterparts, trainees and beneficiaries on drug treatment and harm reduction through extensive trainings in 10 provinces. An absence of longitudinal behavioural or epidemiological data precluded systematic measurement of effectiveness at the patient level, such as reduced relapse rates, despite the reported acceptability, high participation, and quality management of the project.

Significant progress towards achievement of the stated outcomes was reported for VNM/J04, and this report draws attention to the present challenges related to developing and managing

an intervention package for hard-to-reach minority population in remote geographies. Of all programs, peer outreach and microcredit program were highlighted as the most significant contributions for project beneficiaries. Similar to the findings of VIE/H68, true biological and behavioural effects remain inconclusive in the absence of systematic data and credible methodology for reporting relapse, while alternate project focus in the extension period is likely counterproductive to the scaling-up efforts developed earlier as per original project design.

The report highlights priority areas of improvement for both projects. The prospect of project sustainability, particularly the extent of local financing capacity, in the face of complete termination is unclear and will likely vary by province for both projects. It is also important to note that both projects have multi-stakeholders, either administratively or sectorally, in implementation. Strengthened collaboration across sectors will improve future project outcomes.

Turning to individual projects, the unclear mission of the community-based counselling centers in VIE/H68 – whether counselling is aimed at both treatment-seeking individuals and post-treatment patients or only the latter group – raises concern on the issue of building a robust continuum of substance abuse treatment and care in Viet Nam. Future implementation should prioritize access to counselling service along the care continuum as well as systematized referral to counselling clinics and other care in the home region of the patient. Higher incorporation of family support during treatment is also warranted.

For VNM/J04, the report notes a low expenditure rate of 50% in the first extension year (2010) due to a major delay in funding disbursement in the last quarter, corresponding to the project reorientation to support the piloted methadone maintenance treatment (MMT) in Dien Bien province as the consequence of changed donors composition to single funding by PEPFAR. Inconsistent design brought potential reversal to the initial goal of expanded drug demand reduction programs. The reorientation caused a dramatic drop in the number of peer outreach workers in the first half of 2011 and will likely be followed by declining harm reduction outputs without a new outreach innovation or adequate resource allocation. Although high provincial commitment will sustain the presence of the project, the issue will lead to suboptimal implementation particularly in the new project sites. Moreover, the highly segmented target group of this project demands extended scaling-up efforts to reinvigorate project achievements.

Recommendations to address these issues were formulated. For both projects, at minimum a rapid drug use behavioural assessment in project sites whose results can serve as a baseline for any continuing phases warrants immediate attention. By extension, systematic reporting of behavioural data should be prioritized in the projects' monitoring and evaluation infrastructure for evaluation purpose. These steps will guarantee that project design and priorities are evidence-based with verified results. In implementation, securing full support of the related sectors that own specialized resources will improve the prospect of sustainability and expanding multi-sectoral involvement in the project management is another recommendation.

Specific recommendations for VIE/H68 are as follows: First, a robust monitoring component capturing sustainability efforts, including a cost-effectiveness evaluation to determine proper allocation of funds, to be carried out by the Viet Nam Government in cooperation with UNODC. Second, continuing to increase the professionalization of the treatment staff and improving mentorship or coaching of the trainees. This can occur via collaboration between Viet Nam Government and UNODC trainers. The quality and sustainability of the technical skills is dependent on their receiving continued support and training beyond the initial training; and this can occur via sponsored training within the project or at a specialized institution such as university. Third, expanding the training curriculum to address mental health issues and non-opioid drug use is of importance, responding to mental disorders associated with addiction and the increasing trend of amphetamine-type stimulants use in the Northern and Central provinces. This can be addressed in future projects by UNODC or by the Viet Nam government during VIE/H68 sustainability efforts.

With regard to VNM/J04, formulated recommendations comprise the following areas: First, there is a need for a consistent project design in the extended period of no less than 24 months. The focus is recommended to be on standardizing project performance across provinces, while explicitly monitoring the achievement of the technical and financial project sustainability. Second, since health workforce is shared between outreach and other unrelated activities, expanding the number of trained village-based health workers will mainstream HIV prevention in other health programs such as maternal and child health – a condition that improves efficiency gain in the health sector. Third, it is recommended that the microfinance program be integrated into the existing Government project to improve management and ownership. Finally, incorporating a special discussion on the ethnic minority special population in the local Master plans, or assisting in their creation where unavailable, is essential to raise the priority of this target group in the national response to drug abuse and HIV-AIDS.

A lesson learned regarding VIE/H68 concerned the strong association between the community based treatment and the sub-DSEP centers. It is possible that some voluntary drug users were reluctant to engage in treatment for fear of being officially registered as a drug user. The lessons learned from VNM/J04 center on the alignment of the goal of sustainable implementation with measurable activities to resolve the inevitable short-termism perspective in formulating project design.

In formulating evaluation findings and recommendations, the report acknowledged major research limitations, which, among all, include: a predetermined selection of representative site visits and respondents, potential biases in the data quoted from various reports for which the evaluators had no involvement in data collection and analysis, and potential loss in the richness of qualitative data arising from language translation as the evaluators do not speak Vietnamese and all responses were filtered through an interpreter.

CHAPTER 1: INTRODUCTION

1.1. BACKGROUND AND CONTEXT

A trend of increased injection drug abuse, and its associated HIV-AIDS transmission, has been observed in Viet Nam. Heroin is the most popular drug of choice although amphetamine-type stimulants (ATS) use seems to be on the rise in parts of the country. It is estimated that almost half of registered drug users are aged 18-25 and 94% are male.¹ It is estimated that drug related crimes are increasing, as well as the stigmatization of drug addicts. Drug users, even those in recovery, often suffer alienation from their community.

The HIV-AIDS epidemic in Viet Nam is characterized by an increase in HIV prevalence among high risk groups and is mostly transmitted through drug injection. Moreover, injecting drug users account for over 60% of the total HIV infection cases in the country. Although the general population and drug users increasingly understand that sharing needles is one way of acquiring HIV, a challenge has been how to translate this knowledge into action, and into the changes that diminish high risk behaviours.

Viet Nam has a compulsory treatment system with both institutional and community based modalities. Treatment is provided via these two systems under the administration of the Ministry of Labour, Invalids and Social Affairs. In 2000, the National Assembly adopted the Law on Narcotic Prevention and Suppression, reflected in three important decrees: the first (1996) promulgated the medical treatment of drug users; the second (2002) stipulated rehabilitation regimens for drug addicts consigned to compulsory treatment; and the third (2002) stipulated the organization of the family or community based rehabilitation. These regulations provide the background and context for the UNODC initiatives reflected in this report.

In the 1990s the Government of Viet Nam (GOV) launched a massive poppy eradication campaign in the region and over a decade the campaign achieved substantial reduction to less than one percent of the total area of land previously used for poppy cultivation. This supply-side intervention did little to address the demand for drugs, which continued unabated. Consequently the region has seen increased drug trafficking with rapid transition to injecting to adapt to the supply-induced price increase for drugs. About one-third of the nation's drug dependent individuals reside in the highland region² with 30 percent HIV prevalence among the injecting drug users (IDU) subpopulation.³ Harsh terrain and underdevelopment present major challenges to attempts at delivering effective interventions in the region.

The challenges related to delivering an intervention package for hard-to-reach communities underline the significance of highly segmented programs in the national response to drug abuse as ethnic minorities are often underrepresented in their access to health and other care.

¹ UNODC (n.d.a)

² Nguyen, V. T. and Scannapleco, M. (2008)

³ Ministry of Health – Viet Nam Administration of HIV/AIDS Control (2009)

1.1.1 VIE/H68, Technical Assistance to Treatment and Rehabilitation at Institutional and Community Level

The VIE/H68 project addresses the need to improve and further develop a range of HIV prevention and drug abuse treatment services for drug users in 10 provinces in Viet Nam. This includes HIV/AIDS prevention, as well as community-based and residential treatment and rehabilitation. The project document was signed in September 2005 by the Ministry of Labour Invalids and Social Affairs (MOLISA) and UNODC in light of the urgent need to improve drug treatment, prevention, and rehabilitation services in Viet Nam. The project has duration of 5.8 years (June 2006 to February 2012) with a budget of USD 1 649 800. The original project document had the budget of USD 1 649 800. Due to major funding shortfall, the project was launched in June 2006 on a reduced scale with the initial funds of USD 494 400. This amount was raised to USD 551 500 in July 2006 after AUSAID made a contribution via IDI project. A third project revision was proposed in November 2007 following a budget increase up to USD 768 900 and the project reinstated project output 4 on service delivery. It also extended the project duration. In November 2008, the project secured further funds from Luxembourg and a fourth project revision for USD 1,168,900 was proposed to expand geographical coverage and to further extend the duration.

The fifth project revision was proposed to incorporate additional funding of USD 480 900 received in July 2009 from Luxembourg. This covered the remaining budget shortfall (USD 1 649 800). The sixth project revision was proposed to implement the remaining activities which were delayed in 2010. It is aimed to extend the project for six months from January to June 2011. The seventh project revision is proposed to extend the project duration for another eight months from July 2011 to February 2012. The extension will allow time for UNODC to organize the final project evaluation, Tri-Partite Review (TPR) meeting and to come up with the follow-up technical assistance program.

This project addressed the need to improve and further develop a range of substance abuse services and HIV services in community based as well as residential rehabilitation within the compulsory centers for drug users (CCDU). The overall goal of the project is to assist Viet Nam reduce drug abuse and related health and social consequences by improving the effectiveness treatment. The project promoted capacity building for community-based and institutional staff through training events and in-service training. The project also sought to strengthen linkages between community-based and institutional drug abuse treatment services, such that patients could receive counselling in their respective communities.

The overall priorities for the project included:

1. **Greater availability of drug abuse treatment.** Studies have shown that patients participating in treatment decrease their drug abuse. Moreover, the longer patients stay in care, the less likely they are to relapse. The goal of this project was to reach the substance abusing population and make treatment services more readily available to them.
2. **Linked services.** This project sought to link different treatment modalities such that a continuum of care could be offered for individuals given their varied stages and needs.

For example, HIV/AIDS prevention services could function as a segue to referral to drug abuse counselling and treatment in the community.

3. **Capacity building.** Research has shown that improved knowledge of state of the art treatment approaches can improve attitudes among rehabilitation professionals and are critical to reducing relapse rates.

Project activities were designed to help the Viet Nam Government achieve their objectives of developing and implementing new or enhanced drug demand reduction strategies and programs in line with the Declaration on the Guiding Principles of Drug Demand Reduction. The objectives of the project are to achieve significant and measurable results in reducing the demand for illicit drugs through the two following outcomes: 1) Improved effectiveness of drug abuse treatment services; 2) Reduced adverse health and social consequences of drug abuse, including successful prevention of transmission of HIV and other blood-borne infection.

The intended beneficiaries of the project include drug dependent people, especially injection drug users and their families; professionals working on drug abuse treatment and HIV prevention; HIV/AIDS prevention and drug treatment institutions; and Government and non-governmental organizations. Increased numbers of staff with knowledge about effective treatment programs, satisfaction with training, cultural relevance, and increased number of quality treatment services, such as counselling, are the indicators used to measure the results.

The source for the information imparted to trainees is derived and adapted from Turning Point, Australia. International practitioners were engaged to deliver on the job training to VIE/H68 drug counsellor trainees via five manuals covering the following topics:

1. Ethical counsellor/client relationships
2. Client management including care plans
3. Evidence based approaches and best practices
4. Cognitive behavioural therapy training
5. Relapse prevention

To measure project impacts, the following five outputs were outlined:

1. Analysis of situation and mapping of existing services;
2. Functional national and local coordination groups on drug abuse treatment and HIV-AIDS;
3. A critical mass of expertise anchored in practice in each of the targeted service delivery centers;
4. Diversified HIV prevention and drug abuse treatment services in project target areas;
5. Responsibilities transferred to national counterparts and experiences acquired systematized and lessons learned disseminated through UNODC publication, its web site and expert networking.

1.1.2 VNM/J04, Drug Abuse and HIV Prevention among Ethnic Minorities in Northwest Viet Nam

The third phase of the project *Drug Abuse and HIV Prevention among Ethnic Minorities in Northwest Viet Nam*, referred to by its phase code as VNM/J04, is a scaling-up initiative to the previous phases VIE/B85 (2002-2004) and VIE/H61 (2004-2006). The VNM/J04 commenced in January 2008 and will terminate in March 2012, which includes a 27-month extension period. The project provides a comprehensive intervention package in drug demand reduction for hard-to-reach minority populations in four highland provinces in Northwest Viet Nam, namely Lao Cai, Yen Bai, Dien Bien, and Son La, that are among the poorest in the country. In this region, non-Kinh (non-Vietnamese) ethnicity accounted for 70 – 83 percent of the population, with Thai, Hmong, and Dao ethnic groups, whose long tradition of opium use and cultivation has been well documented, representing a sizable share of the total ethnic minority population.⁴ Drug use is therefore epidemic in this region. Official estimates recorded drug use prevalence as high as one per hundred population, which is twice the rates found in urban areas.

In the shared execution arrangement of the project, UNODC and the Committee for Ethnic Minorities (CEM) exercise full responsibility of all international funds and all Government-provided resources contributed financially and in-kind respectively. UNODC and CEM also jointly provide technical and policy guidance for the implementation of the project. All managerial aspects of the project are administered through the management structure comprising of a central-level Project Management Unit (PMU) and four provincial PMUs for each project province. This structure extends to commune-level steering boards in charge of program operations with representatives from program managers or other local stakeholders.

As of November 2011, VNM/J04 has expanded access to drug demand reduction intervention previously developed in 45 communes across four provinces, compared to 13 communes in three provinces, excepting Yen Bai, at the end tenure of VIE/H61. Similar to its predecessor VNM/J04 focused on establishing the local capacity for comprehensive drug demand reduction including drug treatment and harm reduction and is comprised of the following programs; all of which were considered and tried in the preceding phases, and reincorporated into the design of VNM/J04:

1. Peer outreach or **Peer Supply Information Points (PSIP)** or Peer Information Supply Points (PISP). Headquartered at the commune health center, this refers to outreach of drug users and the general population to promote knowledge of HIV risks and adoption of safer behaviours among drug users through information, education, and counselling activities by outreach workers and voluntary participation of knowledgeable community members.

Implementation sites: all provinces.

2. **Community-based drug treatment center.** Free short-course treatment center situated at home or in commune facilities (*e.g.* school, health center) mainly for non-

⁴ Rapin, A-J. and Eligh, J. (2003)

medically assisted detoxification in ≤ 30 days duration. Entry is on a voluntary basis but can be recommended for drug users who were identified and reported to authorities by community members. This center provides extra access to detoxification as the Government program, with designated facilities known as 05 and 06 centers, has low-income eligibility and seasonal intake due to high demand for drug treatment.

Implementation sites: all provinces except Son La.

3. **Relapse prevention with Aftercare Clubs.** Modelled after the Government aftercare program known as B93 Club the program operates at the commune level with the total membership of 540 drug users in all provinces or approximately 5 – 15 members per commune. As the successive care to the center, the program aims to maintain abstinence of its club members through weekly meetings whereby therapeutic experience sharing and supervision of abstinence by observation or occasional urinalysis are conducted.

Implementation sites: all provinces.

4. **Harm reduction.** Distribution of clean needles and syringes and condoms to prevent use of contaminated needles. A larger volume is distributed through peer outreach workers or anonymously through a vending box at the health station in Lao Cai and Dien Bien than by attendance at the PSIP. In outreach clean needles and syringes are distributed in exchange with the used ones, with a weekly distribution rate of 5 – 7 pieces per IDU.⁵

Implementation sites: all provinces except in Son La which began implementation only in 2009 due to resistance from the local authorities.

5. **Microfinance program.** A socioeconomic mitigation program for households affected by drug abuse or HIV infection which distributes capital loans for small-scale business and promotes savings among spouses of post-treatment drug users.⁶ Members are divided into small groups of 5-6 people who are collectively responsible for member's default and hold regular meetings to assist in business proposal writing and monitor individual loan utilization and repayments. The amount of monthly compulsory saving for each member is VND 10 000,⁷ whereas the average annual loan is VND 1.2 – 1.5 million per household.

Implementation sites: all provinces except Son La. The program is managed and supervised by Entrepreneur Du Monde in Dien Bien and by local counterparts with UNODC in all other provinces.

VNM/J04 has received a multi-funding budget of USD 1 819 011 for a total duration of 51 months until its termination in March 2012. This amount was contributed by USAID/PEPFAR (USA), Lux-Dev (Luxembourg), SIDA (Sweden), and AusAID (Australia), excluding the GOV's in-kind contributions equivalent to USD 73 000 in 2007 exchange rate.

⁵ Field observation reports.

⁶ See UNODC (2007).

⁷ VNM-J04 (n.d.).

Funding for program operational costs has stopped as per July 2011, and the project has thereafter been in its eight-month non-cost extension period until termination.

Three project revisions extended the project duration from the originally planned 24 months with a 32 percent budget increase secured for the entire extension period. The first project revision in 2010 reoriented the project in its linkage with the UNODC Regional Framework (Thematic Area 2 Health and Development) from sub-program 4: Drug demand reduction to sub-program 5: HIV/AIDS, with special focus on the capacity building for harm reduction and local HIV/AIDS response.

The second revision coincided with the change in donor composition to single funding by PEPFAR since the last quarter of 2010 and shifted the project focus geographically to Dien Bien to align it with the piloted methadone maintenance treatment (MMT) program in the province. The final revision extended the project up to March 2012 with no extra committed funding to settle the transfer of the pending funding. As a result, program supports as envisaged in the original design were maintained up to the third quarter of 2010.

1.1.3 Purpose and Scope of the Evaluation

The evaluation was commissioned by UNODC to provide an independent assessment of project results and to demonstrate the extent to which these contributed to achievement of the project objectives. Based on the evaluation findings, recommendations reflecting the lessons learned from the implementation of the project were formulated to provide a strategic direction for improvements in design, management, and setting up of new priorities that fully meet the needs of Viet Nam in the follow-up assistance. In so doing, the evaluation also sought the views and feedback from the donors funding the project as well as from the Core Learning Partners (CLP).

The evaluation was a comprehensive assessment of both projects covering five out of 10 provinces of VIE/H68 (3 in the North: Lao Cai, Hai Phong and Thanh Hoa; 1 in Central Vietnam: Da Nang; and 1 in the South: An Giang), and six communes in the four VNM/J04 provinces (Lao Cai: Ta Van and Muong Hum; Yen Bai: Cat Thinh and Son Thinh; Dien Bien: Muong Phan and Na Nhan; and Son La: Tuan Chau and Phong Lai). The Evaluation aimed to assess the project in its entirety encompassing the following areas:

- | | |
|---------------------------------|-------------------|
| 1. Project concept and design | 5. Impact |
| 2. Relevance | 6. Effectiveness |
| 3. Efficiency | 7. Sustainability |
| 4. Partnerships and cooperation | |

External evaluators (KH, the Evaluation Team Leader, and AR, Evaluation Team Member, were individually contracted for the VIE/H68 and VNM/J04 evaluations respectively. During site visits, the evaluators were accompanied by a core team of the UNODC Project Assistant and a translator. In each province a support team comprising provincial Project Field Officers, PPMU members, and program managers in each commune joined the evaluation process and formed the entire evaluation entourage.

1.2. METHODOLOGY

The evaluation was carried out in three distinct phases which were inception phase, site visits and data collection, and report synthesis. The entire evaluation process adhered to the standards and guidelines set forth by the United Nations. In the Inception Phase, a review of project-produced documents in the desk study was conducted and subsequently an Inception Report describing background and proposed evaluation methodologies including evaluation instruments was submitted to the UNODC, revised, and cleared by the Independent Evaluation Unit (IEU). Revisions had no major impact on the proposed methodologies and were directed at the integration between the VIE/H68 and VNM/J04 evaluations.

Interviews and discussions with various project stakeholders were conducted and relevant documents retrieved. In the final phase, the draft Evaluation Report was submitted to UNODC and revised in close cooperation with major stakeholders before receiving clearance from the IEU. The effort committed to the evaluation was 28 days for both projects as per the terms of reference, including the primary data collection period between 22nd November and 6th December 2011 (see **Annex 1** for field visit schedules).

A comprehensive participatory evaluation methodology was conducted to assess the results of the projects against the stated objectives. A set of data collection instruments including the semi-structured interview/discussion questionnaires and informed consent forms, all with Vietnamese translation, were utilized. A summary list of questionnaires is provided in **Annex 2**. Document analysis, interview, focus group discussion (FGD), and field observation were the main data collection methods. Details of respondents interviewed, with names of project beneficiaries concealed, are outlined in **Annex 3**. All scheduled site visits were met and primary qualitative data were triangulated with secondary data assembled from project-produced documents and other research.

For qualitative data a total of 98 respondents (VIE/H68: $n = 22$; VNM/J04: $n = 78$; 20% female and 2 shared respondents) comprising local counterparts, program implementers, project beneficiaries, and international agencies who met the eligibility criteria of age (≥ 18 years), and voluntary participation (signed informed consent) were available for the overall 38 recorded group interview and discussion sessions. The median duration of project participation was three years (range: 1 – 4 years). Of these respondents, 27 (35%) were project beneficiaries of ex- and current drug users ($n = 15$), affected spouses ($n = 10$), and affected community members ($n = 2$).

Additionally, two respondents representing the Project donors (USAID/PEPFAR) were jointly interviewed outside the scheduled sessions and this was unrecorded. One representative provided written responses on the debriefing report via email communication at a later date.

Interview/discussion sessions not exceeding 90 minutes were conducted in a variety of settings including Government offices and beneficiary homes. Only respondents of interest and the core field visit team were allowed in each session. Throughout each session, responses in Vietnamese were translated to English and audio-recorded. Saturation of

qualitative themes was sufficiently achieved during the data collection period. The proposed methods were adjusted to accommodate the presenting field situations and stakeholders' schedules with the major change being the use of group interviews rather than the proposed individual in-depth interviews. Furthermore, a few project beneficiaries were unable to read or supply written information on the respondent characteristic and informed consent forms due to illiteracy ($n = 3$) and hand injury ($n = 1$). For these respondents all writing process was delegated to another, able respondent or a member of the core field visit team with prior approval. One-page summary transcripts for each recorded session are available upon request.

During the evaluation period a total of six and seven relevant project documents for VIE/H68 and VNM/J04 respectively, including Project Progress Reports and Program Handbooks, were reviewed. These documents are listed in **Annex 4**.

The findings in this report are structured thematically by the evaluation area with each organized by the project in order to highlight distinct priority sub-areas of each project, acknowledging that individual projects differed by their aims. Commonalities and joint findings are also presented. Sections on conclusions, recommendations, and best practices are drawn for each project.

1.3. LIMITATIONS

In a number of focus group discussions (FGD), sessions respondents belonging to different stakeholder groups were assembled to avoid missing those who were not able to fully participate at their scheduled. Consequently response bias or social desirability concerns could not be excluded. All qualitative responses during interview and FGD sessions went through English translation. As a result, some contextual meaning and data could have been lost in the process.

Attempts to minimize bias and maintain the validity of the evaluation results included data triangulation from multiple data collection methods and sources, sampling frame representative of all major stakeholder groups, the application of selection criteria for interview and FGD respondents, and the checking of the evaluation's preliminary findings with the use of stakeholders' feedback prior to report final submission. It should be noted that the predetermined visited sites were purposively selected and assumed to be representative of the 'typical' project implementation.

One major concern in the evaluation was the absence of a rigorous design that would allow comparison between the intervention and non-intervention (control) sites for a systematic impact assessment as this type of evaluation design was not instituted in the Project Document. Likewise, it was not possible to apply such a design in the evaluation period given the available resources. Furthermore, the unavailability of some project reports and information on epidemiological outcomes limited the amount of data that could be used in triangulation, for which relevant information reported in the interviews and FGDs were substituted where possible. Lastly, the evaluators had limited means to ascertain the quality of the secondary data used in the analysis. What was done in terms of data verification was to

check the procedure of data collection and reporting with the relevant stakeholders during site visits. The evaluation placed a priority for credible datasets and cautionary notes were given for potentially biased secondary data incorporated in this report.

CHAPTER 2: EVALUATION FINDINGS

2.1. PROJECT CONCEPT AND DESIGN

2.1.1 VIE/H68

Overall, the evaluators found the VIE/H68 project concept and design to be mostly adequate, although some respondents reported areas where the design of the manuals could have been improved by the inclusion of additional mental health concepts and non-opioid drug treatment instruction (see *Effectiveness*, below). Respondents indicated that the training concepts and capacity building were well received and the manuals were appropriate. The information in the manuals was considered to be highly relevant and of high quality and the overall project management appears to have been good. One issue that is outside the scope of the actual capacity building trainings but nonetheless relevant to the project concept is the “setting”; i.e., these capacity building trainings were implemented within a drug treatment system that is largely compulsory; in particular, the compulsory centers for drug users (CCDUs). Given the recent concerns about human rights violations in these centers, the setting for the project activities is considered controversial and likely outside the mission of the United Nations. These issues will be discussed and decided at higher levels over the coming months. Despite the compulsory nature of the setting, there is evidence that the project did achieve its overall goals of educating staff and improving treatment for patients.

Components of the implementation could have been strengthened. For example, respondents reported that an improvement would have been more on-going involvement and support from the project experts/master trainers after the initial trainings. A comment heard repeatedly was that though the trainers were doing their best to convey the lessons in the manuals at their respective sites, the quality of the trainings were higher with VIE/H68 staff, Department of Social Evils Prevention (DSEP), and international staff. Also, they indicated that “international experts” are generally “more eagerly received” by project staff. As a result, there was a dilution of knowledge/expertise over the project period. Moreover, not all recipients of trainings were trained in all five manuals. The traditional Training of the Trainers (TOT) model may not sufficient at this point in Viet Nam, given the current their lack drug treatment expertise on the part of the pool of staff. Perhaps with more intensive and on-going training of the trainers over the entire project period, the TOT model would be sufficient.

2.1.2 VNM/J04

Compared to the preceding VIE/H61,⁸ the current phase has no district-level representatives in the management structure and retained all but supply reduction program to focus on drug demand reduction. The project was later refocused to address the residual gap in the local implementation capacity, consolidate activities, and expedite the transfer of implementation responsibility to the provincial authorities in the 27-month extension period since 2010. This major change has the following ramifications:

⁸ Trees (2005) and Schuffan (2006).

1. Given the lengthened extension period (>24 months) and its narrowed focus, first programmatically and then geographically as well, the clarity of the project's overall goal could have been improved had it treated the extension sub-phase as a separate project rather than as an ad hoc increment in which results from the previous sub-phase had not been verified in an evaluation.
2. While project revisions were aimed at strengthening the implementation capacity, project supports were increasingly scaled down to mainly training for law enforcement and other local stakeholders, without much consideration on how implementation in the previous sub-phase could be maintained both financially and technically.

The need for a new project design was acknowledged with the first revision in the early 2010 but not realized due fairly to the unanticipated, further revision taking place later in the year that altered donor composition. This design inconsistency painted a contradictory picture between the initial expansionary goal and the higher resource concentration on a distinct set of activities in the extension sub-phase (duration: 24 vs. 27 months, average monthly budget: USD 32,723 vs. USD 38,283 for the expansionary and extension sub-phases respectively). Without a new project design, the assumption that the original Project Document would adapt well to future conditions far beyond its stated duration had a limited basis.

From the perspective of UNODC, the prospect of long-term planning with extended funding commitment is limited by the fact that, in contrast to bilateral agreements, as a multilateral entity UNODC provides no direct project funding, which has to be externally sourced from international donors. Consequently there is a separation of project planning from funding commitment in the design formulation, which explains the short-term duration of each phase and the project-based approach with less regard on the long-term, sustainable project outcomes.

Seen from this perspective, it is therefore important to explicitly incorporate indicators to monitor the progress of project transferability to the local stakeholders. The following are examples of transferability indicators that can be adopted in the future project design:

1. Financial transferability: [gradual] percentage of harm reduction supplies (*e.g.* syringes, condoms) procured using provincial funds at the end of the first and second year respectively; [number of] additional POWs budgeted and deployed annually.
2. Managerial transferability: creation of the provincial master plan for drug demand reduction and HIV prevention and care by the end of the project term.

Another issue related to the project indicators are impressive targets of some indicator items that should have received solid substantiation for its potential disagreement with the established evidence. These indicators are: (a) relapse of 40 percent or less for local treatment program participants after one year; and (b) a reduction in current drug abuse in project areas of 70 percent of baseline after two years. The rate at which the targeted use reduction was set was directly derived from the biannual country commitment of UNODC,⁹ supported by the

⁹ UNODC (n.d.b).

evaluation results of VIE/H61,¹⁰ but appeared to underestimate the time lag to the intended behavioural effects commonly seen in drug use interventions.

Lessons learned related to project expansion were executed proportionally to the amount of funding secured. Priority for timely provision of quality baseline information, however, has been a persistent recommendation since the VIE/B85 phase with unresolved constraints in data collection and analysis (see *Efficiency*, below).¹¹ The recommendation for an extension to the community supply reduction program was excluded with negative implications for its performance in the current phase. The recommendation of a single evaluation covering the entire duration was followed without considering the lengthened extension period and its altered focus.

2.2. RELEVANCE

2.2.1 VIE/H68

All respondents indicated that the trainings were highly relevant to them and the treatment population. The respondents reported an eagerness to learn about the topics covered in the manuals. One indicator they provided for this was that they had seen an improvement in the relationship between trained staff and beneficiaries – the staff were taking the lessons to heart and had an increased sense empathy and a feeling of collaboration in recovery with the patients. Patients reported this improvement also. The weakness in relevance for VIE/H68 can be found in Lao Cai, where about 30% of the beneficiaries are part of minority populations and do not speak Vietnamese. The training materials were not translated and there is a language/cultural gap between the Vietnamese staff and the minority groups so VIE/H68 was not applied to these populations. Thus, it is impossible to report if the counselling techniques would have been relevant for those groups.

Respondents in the Northern provinces indicated that the training materials would have been slightly more relevant for their patient populations if the trainings had included information on ATS abuse. Apparently, treatment providers have seen a substantial increase in ATS use in some regions and they are greatly concerned about the impact on individuals and communities. They expressed a deep interest in learning more about these drugs and how to help their patients.

2.2.2 VNM/J04

As stated in the Project Document the design of the project strongly corresponded to the country's priorities in comprehensive demand reduction as evident in the linkage between the

¹⁰ Trees (2005) and Schuffan (2006). The mid-term evaluation report of VIE/H61 recorded a lower project relapse rate of 12 percent, which was said to have been “verified with random drug use screening and reporting from peers.” (p. 23). It is not known if this suggested urinalysis was conducted on a random sample of treated drug users *regardless* of their participation in the Aftercare Club. A study by Department of Labor, Invalids, and Social Affairs (2007) highlights that Aftercare Clubs discourages participation of relapsed drug users (selection bias) due to the widespread stigmatization of drug use as one of ‘social evils’; and Aftercare reporting was the primary method for monitoring the progress of drug use reduction in the current phase.

¹¹ Ranklin, S. (2003); Trees (2005); Schuffan (2006).

project objectives and those in the regulatory framework.¹² Moreover, the combination of high specificity of the target population and its comprehensive scope of intervention is the central underpinning of the VNM/J04 that distinguishes the project from others. While a range harm reduction or drug treatment projects do exist in project sites, differences in the delivery mode, operational areas, and activities hardly signify efforts duplication. For example:

1. In Son La and Yen Bai, international agencies such as the World Bank, the Global Fund (Round 9), and Life GAP are implementing harm reduction and IEC interventions in the districts where VNM/J04 operations are not present.
2. The community-based drug treatment in Yen Bai and Lao Cai takes in some of the excess demand for detoxification due to the limited capacity of the Government-funded centers.
3. In Dien Bien and Lao Cai the project's harm reduction program was reoriented to support the PEPFAR-funded MMT programming and in Muong Phan commune the main outreach delivery strategy for needle and syringe exchange of VNM/J04 complements the fixed-site modality at village health stations by another project.¹³

As for the microfinance program, overlapping efforts are likely. In Yen Bai, for instance, the existing poverty reduction programs disburse loans in the form of cattle (the Bank of Social Policies) or are targeted at the general poor (the World Bank) as opposed to the additional criterion of being a member of a household affected by drug use or HIV under the microfinance program of VNM/J04. This situation may create incentive for multiple receipt of financial assistance with implications on fair distribution of such assistance.

2.3. EFFICIENCY

2.3.1 VIE/H68

Project Inputs

In order to understand the efficiency of the VIE/H68 project, the project manager of the VIE/H68 project at MOLISA responded to questions from the evaluators about project implementation in written format. He indicated that “despite the difficulties in mobilizing resources for the project, UNODC completed the commitments of funding for the project as stated in the project document through both funding for the project sites and providing technical experts.” He also reported that the main activities, especially the training and technology transfer, should be prolonged due to the need for more time to implement the activities.

¹² UNODC (2007). Laws and regulations stressing the relevance of the VNM/J04 activities included those on drug use demand reduction (The National Drug Control Masterplan for 2010; The Prime Ministerial Decision 61/2000/QD-TTg; Government Decree 20/ND/CP superseded by Government Decree 132/2004/ND-CP; Government Decree 56/ND/CP dated 15 May 2002), those on HIV-AIDS prevention (Prime Ministerial Directive 02/2003/CT-TTg; The National Strategy on HIV/AIDS Prevention and Control to 2010 with a Vision to 2020; Law on Prevention and Control of HIV/AIDS 64/2006/QH11), and those pertaining to socioeconomic mitigation for the target communities (Prime Minister's Comprehensive Poverty Reduction and Growth Strategy 2685/VPCP-QHQT; Government's Hunger Eradication and Poverty Reduction Programme for Especially Difficult Communes 135/1998/QD-TTg dated 31 July 1998).

¹³ Interviews and FGDs with local stakeholders.

A strength of the VIE/H68 program is that it is “suited to the characteristics of Vietnamese culture, so all project activities are supported highly by project sites and communities”. A weakness of the project was that “Due to the knowledge of officers and professionals involved in the project (project beneficiaries) are limited, their knowledge gained from the project trainings is not enough so in the process of applying, the way they do still seemed based on administrative management element rather than social services delivery.” When asked about implementation of the project, the respondent reported: “IEC activity of project VIE/H68 is an important activities, to help communities access to the project, to encourage community participation and enhance the sustainability of the project. Due to lack of coordination in the period of developing/formulation of the Project Document so there is limitation to the IEC results.” The limited relationship between the VIE/H68 international coordinator and the project management unit “is considered to be the main reason leading to some limitations of project results and effectiveness”. With regard to the quality of the training, the respondent reported that UNODC trainers “do not have enough time to understand reality in Vietnam (both cognitive ability, educational level, ability to participate in TOT training workshops). So only some 30% of the project sites reported activities of case management proven positive signals (Lao Cai, Hai Phong and Thanh Hoa provinces).” He also indicated that communication and networking between the counseling sites and the centers are “well well maintained both in the community and the center. Out of them, Hai Phong, Lao Cai, Thanh Hoa and Phu Tho are project sites with good practices. This is an important factor in helping to reduce the gap between the drug treatment center and the community through counseling activities both in the community center and home to the drug users as well as their family.”

Project Outputs

The main objective of the VIE/H68 project is to assist the Vietnamese Government to achieve significant and measurable results in reducing the demand for illicit drugs through the following outcomes:

1. Improved effectiveness of drug abuse treatment services;
2. Reduced adverse health and social consequences of drug abuse, including successful prevention of transmission of HIV and other blood-borne infection.

These outcomes were generally achieved through the following five outputs:

Output 1: Analysis of situation and mapping of existing services;

The analysis of the drug dependence problems and the training and capacity building needs of the staff were congruent with the aims of this project’s goals. Two areas could have been improved: 1) failure to take into account and translate the materials for the approximately 1/3 of the population in Lao Cai province that does not speak Vietnamese. In the future, this dynamic should be taken into account and the appropriate services rendered in the relevant languages. 2) The northern and central regions reported that the project primarily focused on heroin and opium, while they have seen a significant increase in amphetamines.

Output 2: Functional national and local coordination groups on drug abuse treatment and HIV/AIDS;

There was a fair amount of variability related to Output 2 across provinces. Overall, local coordination seemed relatively high between the sub-DSEP offices and the treatment sites. In the case of Da Nang, the offices were in the same building, and some staff were overlapping.

Output 3: A critical mass of expertise anchored in practice in each of the targeted service delivery centers;

Although the idea of “critical mass” is a fuzzy notion and was not quantified as a specific benchmark in the project document, it appears that a significant number of professionals were adequately trained at each of the sites.

Output 4: Diversified HIV prevention and drug abuse treatment services in project target areas;

This output has been achieved, as service capacity has been increased in all provinces visited. Moreover, the VIE/H68 project manager informed the evaluators that he has seen improvement on this output: the project has helped sites review problems on rehabilitation and after-care management and learn how to improve service delivery. He also indicated that the project has helped drug users understand their responsibilities to their families and communities and actively participate fully in treatment programs.

Output 5: Responsibilities transferred to national counterparts and experiences acquired systemized and lessons learned disseminated through UNODC publication, its website and expert networking.

This output is a “work in progress”. There were mixed reviews as to whether the responsibilities for VIE/H68 would be transferred to national counterparts. This mainly seemed to be due to budget and time constraints of MOLISA and DSEP staff. Project information can be found at: http://www.unodc.org/eastasiaandpacific/en/Projects/2006_01/rehabilitation.html. This final evaluation report will be posted on the website.

2.3.2 VNM/J04

Project Inputs

Interviewed PMUs generally described the project’s management structure and backstopping as efficient. The structure allows flexibility and representation of lower administrative levels (*e.g.* commune, district) in the higher managerial hierarchy (*e.g.* provincial PMU) and of inter-sectoral stakeholders.¹⁴ A smooth flow of decision-making was expressed despite the reported occasional administrative bottlenecks such as small delays in funding disbursement or central management directives. The roles PMUs including the liaisons Project Field Officers in delivering high-quality supervision, technical assistance, and backstopping were also well acknowledged. Scheduled coordination and review meetings and monitoring visits as per agreed workplans were met and became a strategic medium of knowledge sharing and task delegation.

¹⁴ FGD with the Yen Bai Provincial PMU.

The committed inputs including human resource were provided in a timely and transparent manner and reflected competence required by the project as per the terms of reference for each position.¹⁵ Project management teams at the provincial and commune levels comprise the Government officials representing DOLISA, Prevention HIV/AIDS Center (PAC), Peoples' Committee, and other relevant executive agencies, as well as official community organizations such as the Women's Committee and the Youth Committee, assisted by dedicated support staff. Effective mechanism of task delegation has been in place and this allows consistent monitoring of project activities when conflicting schedules arise. Budget allocations were deemed proportional, with grants to local stakeholders eliminated in the later extension phase possibly with an aim to transfer project responsibility to provincial partners.¹⁶ This type of effort to increase project ownership requires additional strategies to nurture the local financing capacity and coordination among international donors to avoid selective implementation based on project incentives.

Looking at the actual fund disbursements, the total expenditure rates were approximately 50 percent and 62 percent of the planned figures for the 2010 fiscal year and the first semester of 2011 respectively due to revised project deliverables in the last quarter of 2010 and the rescheduling of capacity building exercises to the last semester of 2011 and early 2012.¹⁷

Project Outputs

In this terminal evaluation the project was expected to produce all the stated outputs throughout the entire expansionary sub-phase (2008-2009) and in the extension sub-phase (2010-November 2011). The following describes project outputs and their achievements in each sub-phase.

A. Expansionary Sub-phase (2008-2009)¹⁸

Output 1: A surveillance report assessing baseline HIV risk behavior in conjunction with companion biological data is produced for project sites and distributed;

Attempts and preparation to conduct a baseline survey were repeatedly captured during interviews, and these included data collection training and coordination meetings with relevant agencies and the Ministry of Health (MOH), the main party to execute the 2007 National Behavioural and Biological Surveillance Survey that was expected to cover project sites through the allocated UNODC contribution. Poor coordination was identified as the likely reason for low representation of project sites and the unavailability of disaggregated results down to the commune level in the completed survey.¹⁹

Output 2: Community-based drug abuse and HIV prevention and intervention programs are developed and implemented.

¹⁵ UNODC (2007) and field observation reports.

¹⁶ *Ibid.* 13.

¹⁷ UNODC (2010a) and UNODC (2011a): VNM/J04 Annual Progress Report 2010 and VNM/J04 Semi-Annual Progress Report 2011.

¹⁸ *Ibid.* 12.

¹⁹ Interview with PEPFAR representatives.

Project reports and interviews with PMUs indicate that harm reduction intervention has been developed and established in 14 new communes, totaling to 27 communes at the end of the expansionary sub-phase as per the project original design. Of all four provinces, only Son La experienced a significant delay in the implementation up to 2009 due to the initial resistance from local authorities.²⁰ This number was further expanded to incorporate 18 new communes in Dien Bien in the extension sub-phase that the total number of communes was 45 in 2011.

Output 3: Community-based drug abuse and relapse prevention facilities and programs developed and implemented.

These programs are available in all provinces except Son La for the reason stated earlier. Community management of the microfinance program, with considerable involvement of the Women's Committee, exists in all implementing provinces.

Output 4: Community-based policing support programs developed and implemented.

Although stated, the original Project Document has no description of the policing support programs. Neither were relevant project activities reflected in the evaluation due to the unavailability of Progress Reports in the 2008–2010 period and the fact that no police officers participated in the interviews during the site visits. The evaluation could not determine the extent to which this particular output was produced in the expansionary sub-phase.

Output 5: Terminal evaluation to assess the effectiveness of prevention, treatment, and relapse prevention activities, and to elicit lessons learned, presented, and published.

This report forms the terminal evaluation of VNM/J04. There was no evaluation for the original duration in the 2008-2009 period, which could have addressed information gaps pertaining to the results of the expansionary sub-phase and the flow in design between the two sub-phases.

*B. Extension Sub-phase (2010-March 2012)*²¹

Output 1.1: Police, health, and drug dependence staff at provincial and local levels sensitized to harm reduction approaches.

Basic, advanced, refresher training, and training of trainers (TOT) courses, as well as domestic study visits were conducted for health staff, provincial project staff, POWs, and police officers. Corresponding to the immediate training effect of improved knowledge as measured by pre- and post-test results,²² interviewed project stakeholders reported a substantial increase in their understanding of harm reduction principles. This finding agreed with accounts from POWs and drug user project beneficiaries who reported ease of access to harm reduction services and the supportive attitude of law enforcement in project sites.²³

²⁰ Interview with Son La provincial PMU.

²¹ UNODC (n.d.c), UNODC (2010b), and UNODC (2011b): VNM J04 – Project Revision Documents for 2010 and 2011.

²² UNODC (2010a).

²³ *Ibid.* 13.

Output 1.2: Normative guidance provided to build capacity and support for harm reduction across a range of sectors.

Technical guidance and training has been provided for high-ranked officials of the DOLISA and PACs. Additional capacity building exercises through study visits to Ho Chi Minh City were conducted in 2010 for health staff to adopt the success of the existing harm reduction modalities and to prepare the establishment of MMT clinics in their localities.²⁴

Output 2.1: Support provided to the development of community capacity to participate in the development, implementation and management of programs focused on people who use drugs and people who live with HIV-AIDS.

A series of community-level advocacy and consultation meetings on MMT for officials and representatives at all administrative levels were organized in four project provinces in 2010. In 2011 a seminar on drugs and HIV-AIDS responses for 10 countries was held in Viet Nam and attended by 25 law enforcement and public health agencies representing project sites who as a result were kept abreast of the contemporary issues in developing effective interventions for drug abuse such as the role of law enforcement, HIV treatment and care in the penitentiary setting, overdose prevention, and role of the criminal justice system in facilitating drug treatment.²⁵

Output 2.2: Technical guidance provided to provinces and districts to support implementation of local harm reduction programming for IDU.

The 2010 Annual Progress Report states that training on basic HIV/AIDS prevention with focus on behaviour change communication was conducted for 45 participants comprising PAC and DOLISA officials, as well as health staff.²⁶ Harm reduction supplies (*i.e.* syringes, condoms, safe disposal boxes, IEC materials) were consistently allocated to project communes for outreach. The result of these capacity building efforts was evident in the expansion of outreach activities in 18 new communes in Dien Bien province by the end of 2010 and the completion of PISP establishment in 11 remaining communes in the second quarter of 2011.²⁷

Output 3.1: Technical assistance provided to support collection, analysis, and reporting of data on drug use and HIV.

In 2010 the project supported and completed a study on the social characteristics of local drug users and drug use, and HIV trends among ethnic minorities in Northwest Viet Nam. It is expected that study findings will be used by the local authorities to inform policy making.²⁸

²⁴ *Ibid.* 22.

²⁵ *Ibid.* 17.

²⁶ *Ibid.* 24.

²⁷ UNODC (2011a)

²⁸ *Ibid.* 22.

2.4. PARTNERSHIPS AND COOPERATION

2.4.1 VIE/H68

It is clear that DSEP, sub-DSEP and staff at the project sites desire a continued relationship with UNODC and would like for VIE/H68 or other capacity building projects to remain on-going. The project site staff indicated they would continue to use the counselling techniques after the project ends. One of the outcomes of interest for this project is whether there is a sense that national counterparts would continue to provide technical assistance and capacity building at the close of VIE/H68; the reports on this are mixed. Some respondents felt that national agencies would intervene and continue doing trainings with them while others felt that they would not.

2.4.2 VNM/J04

There has been an agreeable level of cooperation among key stakeholders in project sites, with respondents emphasizing how this was beneficial to minimize efforts duplications among related projects and strengthen the provincial response in drug abuse reduction and HIV prevention in the province. Responses to key questions exploring this evaluation aspect demonstrate a positive development in technical collaboration in some project sites:

1. In Dien Bien, in which the project was intended to support the establishment of MMT program, there were examples of joint training courses at the province level, with funding from UNODC and trainers contributed by Family Health International 360 (FHI 360), or at the community level.
2. In Son La the PMU reported experience sharing of achievements from related projects in regular coordination meetings.
3. Strategic partnership with Entrepreneur du Monde in microfinance management in Dien Bien has increased members' compliance to savings procedure, with positive implications on program liquidity for future sustainability.²⁹

The evaluation draws attention to the multifaceted intervention areas of the project in drug abuse reduction and HIV prevention which the project has integrated with a considerable success through joint management with a single main counterpart CEM. The evaluation considers multi-sectoral involvement in the project central management will broaden project access to technical expertise, strategic engagement with other projects, and financing prospect.

2.4.3 International Agencies

We dedicated this special sub-section to emphasize the importance of coordination among international agencies or their sponsored activities, particularly because our interviewed respondents represented the funding agency for VNM/J04 and shared the priority areas in drug treatment that VIE/H68 evaluation addresses.

²⁹ *Ibid.* 13.

Coordination with International Agencies³⁰

Representatives from USAID and PEPFAR were asked about their opinions of the VIE/H68 and VNM/J04 project. The respondents indicated that they had not been included, informed or consulted on these projects. Moreover, the PEPFAR representative indicated that there was little connection or collaboration between the UNODC efforts and his agency. He indicated that this was a weakness of both UNODC and PEPFAR to coordinate and leverage out joint activities with MOLISA and DOLISA. Both respondents were discouraged at the lack of coordination between UNODC, PEPFAR and USAID, given that they all have the same objectives. This is not a responsibility of UNODC alone – all parties must act together.

The need to address the nexus between drug use and HIV is vital. There is a great need for collaboration of UNODC activities as it relates to drug demand reduction with a focus on HIV. The PEPFAR respondent indicated that generally this coordination is sorely lacking on the PEPFAR side although his agency and Treatnet staff have made efforts to include staff from each others' organizations on the work and activities. For example, Treatnet has included Substance Abuse and Mental Health Services Administration (SAMHSA) in meetings and site visits. Also, PEPFAR-CDC has included the Treatnet regional representative on the MOLISA Advisory Committee for the project on community based treatment.

Both respondents indicated that there are potential opportunities for duplication, competition and complimentary activities. All of the projects have as a component the development of curriculum and training materials. However, rather than collaborate on the development or use existing curriculum, the agencies continually finance the development of these materials. Rather than developing multiple curriculums on the same topic, agencies should coordinate to be using ones that have already been developed. There are multiple trainings that take place and often for the same audiences, goals and purpose. It was noted that recently there has been an improvement in the communication between international agencies and they have started working more closely. With regard to sustainability of the projects, the respondents did not feel that it was likely that the government of Viet Nam would be picking up the program supports for the elements of VIE/H68 or VNM/J04.

2.5. EFFECTIVENESS

2.5.1 VIE/H68

The respondents indicated that the project was generally effective, but that in addition to the implementation issues mentioned above, the project would have been more effective if the sites had had an opportunity to talk with each other, do site visits, and share info/lessons learned. The local project counterparts felt that despite the trainings their expertise was still lacking and they needed additional support from others in the field, so that they could gain additional knowledge from others' experiences.

Across provinces, the respondents indicated that they felt their capacity would have been improved and the counselling techniques more effective if they had also been provided some

³⁰ *Ibid.* 19.

training in “psychology”. These staff members are recognizing the high rates of co-morbid mental health disorders in their patients. Overall, respondents indicated that the VIE/H68 project was effective and had obtained its objectives.

2.5.2 VNM/J04

While it is difficult to measure the overall effect of the project, the evaluation determined that reasonable positive progress towards attainment of the stated objectives has been made as can be seen from the increasing trend in project outputs and its early manifestation in the forms of reduced HIV transmission among IDUs and the general improvement in well-being for affected households. According to respondents, peer outreach and microfinance loans are programs whose contributions are most strongly felt. Improved community’s awareness of the harms of drug use and HIV risks, reduced stigma and discrimination towards drug use and PLWH, and applied HIV preventive measures through the use of condoms and clean syringes were among the recurrent themes in the interview and discussion sessions, notably in a majority of the visited sites that were new additions to the current phase.

High project participation testifies high program acceptability and effective resolution to some of the constraints in harm reduction implementation. For instance, a total of 32 000 high-risk individuals have been reached and educated on HIV prevention, and 42 percent ($n = 427$) of those reached in the first semester of 2011 had HIV or sexually transmitted infections (STI) tests, representing a four-fold increase relative to the same period in the previous year. Total monthly supply distribution for condoms and clean syringes in the last 18 months reached 10 100 and 14 800 respectively, with one-third increase of needle and syringe exchange volume in the first semester of 2011 compared to the same period in the previous year.³¹

Another success area is the UNODC-supported skills building exercises and training that received high appreciation from respondents for their perceived high quality and have been instrumental in developing implementation and management capacity for local partners based on the international best practices. These activities have drawn attention of local partners to the contemporary policy debates in the treatment of drug users as well as set new priorities for expansion of harm reduction services by promoting access to MMT and creation of enabling policy environment through multi-sectoral cooperation, which all have been incorporated in the extension phase of the project albeit mostly concentrated in Dien Bien province.

Achievements in drug use reduction component (*i.e.* community-based drug treatment and relapse prevention) cannot be ascertained in the present evaluation as there were systematic barriers to data triangulation which rendered assessment of the overall performance of this component problematic, if not impossible, despite the reported high outputs. These barriers included ambiguous case definition for relapse, its measurement, and the general drug treatment situation that draws uncertainty as to its adherence to the medically and ethically acceptable standards, coupled with incomplete data. More importantly, the evaluation draws attention to the potential gaps in the implementation of the community-based drug treatment

³¹ *Ibid.* 17.

caused by the shifting or project priorities in the extension phase. Rarely did respondents in the implementing sites reflect on achievements of this program, while those who did – the Lao Cai PMU and the project steering board in Na Nhan commune in Dien Bien – suggest mixed findings on the effectiveness of the project’s drug use reduction component.

It appears that the present focus on harm reduction frequently reported in the interview sessions has relegated the priority of the drug use reduction component, as is suggested by the absence of reporting of the community drug treatment in the Project Progress Reports covering the 2010—July 2011 period.³² Given these considerations, the question regarding the success of the drug use reduction component remains inconclusive and there is a broader question of sustainability of the entire existing programs in the face of changing project orientation or project termination which has recently become more evident with the reduction in the supply of POWs.

2.6. IMPACTS

2.6.1 VIE/H68

Due to the variability between provinces and the richness of the responses of the respondents, the impacts of the VIE/H68 project will be reported by province:

Lao Cai: The Lao Cai Province center houses about 230 male patients. The director of education reports that because of VIE/H68 there have been fewer relapses of patients because *“counselling helps them understand the harmful effects of drug use”*. He made several recommendations, such as there should be psychology and communication training included in the manuals: *“knowledge is one thing but communication is another”*. He expressed that he wished there had been more specific information on counselling techniques for women. He has this interest because the center has a plan to set up a separate portion for women. He also stressed that staff must be provided more knowledge and kept abreast of the newest developments, specifically, new drugs that are emerging in their province such as ATS.

The director of the counselling clinic reported that VIE/H68 has been effective in improving drug abuse treatment services by way of the counselling training they have received and that it has been diffused to treatment staff at the clinic and throughout the 17 communities. The counselling center staff reported that “thousands” of patients have been counselled after the inception of VIE/H68. Other activities that he is involved with within the framework of VIE/H68 include the provision of clean needles, assistance with rehabilitation, and the formation of a post treatment “club”. In this aftercare group, the former drug users have a chance to hang out together, eat, and share experiences. In this club they *“meet together a once a month, exchange opinions, talk about family situations, changes in life, who has found a new job or gotten married.”* It also sounded like this was a place where attendees could network about employment opportunities. A recommendation would be that if possible, the aftercare group should occur more often (perhaps weekly) and group counselling should be offered as a part of the “club” by one of the trained counsellors. The respondent brought up a very important point that it takes time to change what could be called the “hearts and minds”

³² *Ibid.*

of the population toward drug users. Community outreach and education would be an important component of any future projects so that stigmatization is reduced and individuals feel free to seek treatment. Two beneficiaries were interviewed, and both reported gaining knowledge as a result of the counselling. One reported he had received *“very good counselling for rehabilitation and how to prevent relapse but the most important that the individual must try to avoid HIV”*. One of the issues that the beneficiaries seemed concerned about was employment opportunities after discharge. This is obviously beyond the scope of VIE/H68 but brings up the issue of how being a registered former drug user impacts employment and what kinds of policies could be enacted to reduce barriers.

Thanh Hoa: Thanh Hoa province center has 600 drug users who are treated between 1 and 2 years. Part of their treatment includes detoxification. Similar to remarks made in Lao Cai, it was suggested that there be more trainings on mental health disorders and also women. The sub-DSEP office has been highly involved with the VIE/H68 project. The staff expert reported that he has attended four training courses and is now a trainer to other staff. With regard to how many individuals had been trained aside from himself, he reported that all the counsellors, the 5 leaders from sub-DSEP and staff from communes. He had no knowledge of the number of staff trained in the communes. When asked how the project could be improved, he reported that the project was very good but in the future he would like to see more information on relapse prevention as well as an emphasis on public education to decrease stigmatization. Also, he would like to see a similar model to that of J71/Treatnet set up throughout the province. When asked what he particularly liked about J71, he reported that it is a *“comprehensive model for support and treatment, mobilizing all the people in the fight against drug abuse, raising awareness on the part of the communities, mobilizing all levels of the governments.”* J71 also helps in *“coordinating the support services, for example vocation training, creating jobs, regular contact between his staff and the beneficiaries after treatment (aftercare).”* At present, there doesn’t seem to be a lot of overlap between J71 and VIE/H68 – they are operating as independent projects. With regard to the beneficiaries, two respondents were interviewed – one male, one female. The male respondent was very familiar with VIE/H68, knew it by name, and its objectives. He reported that since he has received counselling, he has seen an *“improvement in himself and his behaviour and has better relations with peers.”* When asked for examples, he replied that he has an improvement in *“perceptions”* and that *“addiction is due to lack of knowledge and now he understands and he has improved himself.”* When asked if he knew of after care programs he could utilize after he was released from Thanh Hoa, he indicated that he knew that the government had an aftercare program but that it dispensed methadone and he does not wish to use methadone. The female respondent did not know the VIE/H68 project by name but indicated that she does receive counselling and that it has improved her understandings of drug use and in particular, how HIV is transmitted.

Hai Phong: In addition to the CCDU in Hai Phong, the province also has a counselling clinic that is connected to a methadone clinic. They began to dispense methadone in June of this year. The size of the community based staff/methadone staff has increased from 16 to 31 in the last year. Both the counselling and methadone centers are supported by the VIE/H68

project and the staff overlap with each other. Of those 31 staff, 12 people have received some VIE/H68 training but not everyone has received training on all five modules. When asked what the reason was that not all had received training, the respondent indicated that most of the staff are newcomers since this March, so they did not have the opportunity. However, the staff work between both the counselling and methadone clinics so VIE/H68 counselling techniques are being used at the methadone clinic. There has been an interruption of VIE/H68 training activities and they have not received any trainings in the past year. At the sub-DSEP office, there are 20 staff in addition to 70 staff in the communities. The director of the sub-DSEP office indicated that they receive training every month in “education in drug abuse prevention” including the VIE/H68 capacity training materials. There are 5,300 registered drug users in Hai Phong province but he reports that the real numbers are much greater of course. This province has adopted three models of drug control: 1) 2200 beneficiaries are represented in four centers (including the one we visited) 2) community based treatment which is currently treating 300 beneficiaries and 3) methadone maintenance. The respondent reported: *When a person is drug addicted, first they must go through the CBT treatment first, no methadone, to gain knowledge first.*” The respondent reported that VIE/H68 trainings had been initiated in all three levels. ATS seems to be increasingly used in this province and the sub-DSEP office indicated that it would have been helpful had the VIE/H68 trainings had more information about ATS. When asked if he felt VIE/H68 had had a meaningful improvement on his work, he replied that it had and there had been a very positive reduction in drug addiction and HIV transmissions. *“In the past, if you saw a person who relapsed, you will be angry but now it is different -you give them advice to keep coming back to treatment again and again.” We believe that drug addiction is like any other illness including tuberculosis and diabetes but if you want to get better you must try yourself*”. The director of the provincial center indicated that trainings like VIE/H68 are necessary because technical assistance and counselling training are new to Vietnam. His only concern with the program was that there had been no activities in the past year. Additionally, he felt that the project would have been improved had there been more *“meetings and exchange of experience between this center and others and especially foreign centers”*. When asked if VIE/H68 had reduced the health and social consequences of drug use, he replied that *“Within the framework of the VIE/H68 they have records for all the counselling to thousands of patients”*. When asked if those records had shown that the patients’ outcomes had improved since the introduction of VIE/H68, he indicated that there had been three categories of improvement: 1) staff improved their capacity to provide better service 2) counsellors were able to work with patients’ families to help raise awareness and help them change their *“understanding and behaviour”* and 3) attitudes were changing in the community because as each of his patients is released to the community, they are able to *“educate those around them”*.

Da Nang: In Da Nang there are 1,546 registered drug users in the province, two methadone clinics and one small counselling center (only two counsellors). The sub-DSEP office and the counselling clinic are operating in the same building. Both the director of the sub-DSEP office and one of the counsellors were interviewed. VIE/H68 activities came to an end earlier this year so the director has not received any direct training (he was hired in February of this

year) although there has been a transfer of knowledge from the counselling staff to him about the project. While VIE/H68 was in full operation, all DSEP staff received some kind of training. The respondent indicated that more emphasis should be made on aftercare activities: *“The effectiveness of the drug treatment rests upon the aftercare activities”*. The respondent indicated that within Da Nang province there are 26 after care clubs but *“most people in charge are doing part time work and the conditions for these activities to be carried out are limited”*. When asked if the clubs were officially connected with the counselling center, he indicated that they were not really related – that the counselling center is responsible only for the work they do at the center: *“The activities of the counselling center include counselling in the choice of forms of abstinence, counselling in aftercare, counsel families and assist with psychology problems and provide counselling in relapse.”* A recommendation would that linkages to these clubs be strengthened, and if possible, trained counselling staff attend to provide group counselling, and info disseminated to patients about when/where the clubs meet. The respondent indicated that the community based counsellors begin connecting with the families of an individual who is about to be released from the CCDU to provide them counselling. They also provide counselling to the individual before they leave, by telephone. The director of the CCDU was interviewed and he indicated there are 310 patients at his center. There are 6 staff who have received training but some have received multiple trainings. There is a mechanism for the transfer of knowledge from those staff who have received direct trainings: so far there have been two training courses of 25 participants each. The director of the center indicated that the trainings had been helpful and improved the capacity of the staff. When asked about coordination with the sub-DSEP office for after care, the director indicated that one month before the patient is allowed to leave, they give info to the families and also adopt a program of education counselling in relapse prevention and also *“how to behave in the communities social reintegration”*.

An Giang: This is a relatively small, remote province with over 1000 registered drug users including nearly 580 in compulsory treatment centers. There are no methadone clinics here yet although the sub-DSEP office reported that one will be opened next year. There are two counselling clinics and two CCDUs. One CCDU was visited but the other was 50 kilometres away. The sub-DSEP office reported that 90% are compulsory while the director of the CCDU reported that only 16 of 544 patients (3%) are voluntary. Similar to Da Nang, the emphasis of the counselling center seemed to be on aftercare, rather than pre CCDU treatment, although the sub-DSEP office reported that some counselling is offered during the detoxification period which usually occurs at home. This province seems to have a strong public education component via mass media newspapers, radio, posters and loudspeakers. When asked about the relevance and effectiveness of the trainings, the sub-DSEP office and the director of the center indicated that they were pleased with the trainings. Specifically, I was curious about the need for additional information about other drugs apart from heroin and opium and they reported that in this province, information about ATS was not really needed; that they had seen a small increase but it was not really being seen in their population and considered a “wealthy” drug. The respondents reported reduced health and social consequences in those treated, because *“now he knows how to make safe injections, how to avoid relapse and there have been reductions in health consequences”*. Improvements that

could have been made to the trainings would have been to have more info on “psychology” and that a psychologist involved in the trainings would have been helpful.

2.6.2 VNM/J04

In the absence of systematic, epidemiological data on drug, it is difficult to extrapolate whether the project’s community-based drug treatment and relapse prevention programs have generated the intended reductions of at least 70 percent and 60 percent for current drug use and relapse rates respectively. Information on the rate of access to community-based drug treatment center collected from interviews indicates an annual enrolment rate of 40—80 individual drug users in the visited sites. The mixed opinions of the treatment effectiveness notwithstanding,³³ this figure corresponds favourably to the targeted access rate of 60 percent given the estimated average of 70—105 known drug users residing in each commune.³⁴

For harm reduction, the 2010 Annual Progress Report cited a major reduction in needle sharing rates of 42 percent and 33 percent respectively for Lao Cai and Dien Bien provinces. It is rather likely that a similar reduction also occurred in the other project sites considering the greater accessibility of harm reduction services for IDUs as measured by the increasing trend in the distribution volume of needle and syringe exchange in the extension period.³⁵ During site visits there were early indications that high access rate to harm reduction was directly contributing to the achievement of the project outcome in reduction of HIV prevalence among IDUs. For example, program implementers in Na Nhan commune in Dien Bien province reported zero HIV seropositive rates among the 33 IDUs participating in voluntary counselling and testing (VCT) throughout 2011.³⁶

The project offers a comprehensive intervention package in drug demand reduction that specifically targets ethnic minorities residing in the remote areas of Northwest Viet Nam with long history of drug use. This high segmentation has become the key competency that distinguishes the project from all other similar efforts in drug demand reduction and HIV prevention among drug users. Interviewed stakeholders expressed high appreciation of the project’s pioneering contribution in raising the awareness of the local communities to the harms of drug abuse and HIV risks, as well as in broadening access to drug treatment and effective HIV prevention methods. Importantly, the community active participation in project activities helped reduce stigma and discrimination against drug users or PLWH.³⁷

Interviewed local stakeholders shared the increasing need for project expansion both geographically, as in the greater territorial coverage, and programmatically, as in the requests for MMT to be available in their localities. At the organizational level, project implementers have taken up initiatives such as internal training and routine discussions to ensure

³³ Lao Cai has consistently reported the high effectiveness of the community-based drug treatment since the previous phase. The other implementing sites, on the other hand, did not subscribe to such a conclusion because of the lack of comparable prospective data (Yen Bai) or the consistently high rates of post-treatment relapse regardless of the receipt of project support (Dien Bien, which received support for this programme only in the VIE/H61 phase). This point emphasizes the need for systematic reporting of relapse.

³⁴ *Ibid.* 13.

³⁵ *Ibid.* 22.

³⁶ Interview with Na Nhan commune project steering board.

³⁷ *Ibid.* 22.

knowledge transfer. During the latter stage of the extension period, reorientation of priorities has brought the project under close cooperation with the PEPFAR-funded MMT programming in Dien Bien at the expense of long-term implications on the performance of the established drug demand reduction programs particularly in the other project sites. With the total number of POWs in four provinces falling by more than half to 68 in early 2011 due to the reduction in the scope of project activities, it is reasonable to expect lower output levels in the remaining period and after full termination in March 2012.³⁸ Past implementation demonstrated that project activities could be maintained at a limited level in the two-year transition period (2007—2008) between the termination of VIE/H61 and the commencement of VNM/J04.³⁹ The wider scale of the current phase, however, presents a major challenge as regards the readiness of the local funding capacity to sustain the project optimally.

2.7. SUSTAINABILITY

2.7.1 VIE/H68

In general, respondents indicated that staff with the responsibility sustain VIE/H68 changes have been made aware of the benefits of the trainings and will not be going back to previous approaches. For example, although there was doubt regarding the transfer of responsibilities to the national government, individuals at all levels indicated that they would continue with their activities, even without support from UNODC or the government. There was a certain amount of variability by province:

Lao Cai: The Sub-DSEP director indicated that though the VIE/H68 project had been effective, the scope of the project is relatively small compared to the needs of the community. He would like to see that the national counterparts take responsibility for the continued support and funding of this project and its objectives. The local governments have very limited funds so he feels it is important to have the support of the national government. A plan is in place to ask for support but it doesn't seem to be known at this time what the outcome will be.

Evaluator's estimation of the value of including this province in the future: Lao Cai seems to be fairly advanced and "fertile ground" for further trainings/UNODC involvement.

Thanh Hoa: Over the course of the project, 30 people including the drug users and core staff have received trainings and transferred knowledge to the rest of the drug users. Most of the users who receive training under VIE/H68 have completed treatment and those people are now in charge of disseminating knowledge to other users and the staff. The director's observation is that the staff trainers' performance is not as effective as those done by VIE/H68 specialists but in the organization, the counselling treatment has been adopted and knowledge has been transferred under the framework and as directed by the VIE/H68 project and there will likely be a high degree of sustainability.

Evaluator's estimation of the value of including this province in the future: there is evidence that this would be a good province to continue to work with given their interest in capacity

³⁸ *Ibid.* 27.

³⁹ *Ibid.* 13.

building and a progressive environment (availability of methadone clinics). They have only been involved since 2009 but have widely trained staff. Additionally, it has trained peer-based mentors.

Hai Phong: The director of the provincial center indicated that trainings are necessary because technical assistance and counselling training are new to Vietnam. He indicated that the staff were eager to learn and that knowledge from the trainings were incorporated into their treatment processes and would continue to be so.

Evaluator's estimation of the value of including this province in the future: It was reported that the municipal Government is amenable to progressive drug laws and changes. There is an ongoing review to plan for next year's activities. This would be a good province to continue working with.

Da Nang: VIE/H68 activities came to an end earlier this year so the director has not received any direct training (he was hired in February of this year) although there has been a transfer of knowledge from the counselling staff to him about the project and he intends to sustain the techniques learned. While VIE/H68 was in full operation, all DSEP staff received some kind of training and this knowledge appears to be sustained.

Evaluator's estimation of the value of including this province in the future: from the appearance of the counselling clinic/sub-DSEP office vs. the CCDU, this province is obviously putting more emphasis and funds into CCDU rather than community based components. If this province is considered for future projects, there should be more oversight and resources/support than might be needed in a province like Hai Phong. Also, it would be advisable for the counselling center to be located in a separate building from sub-DSEP: it was reported that there was reluctance on the part of prospective clients to come to the clinic because of potential repercussions with being identified by DSEP. Also, although there seems to be a strong linkage between the community-based center and the CCDU, the counselling clinic needs to strengthen its "pre treatment" component as they seem to be focusing primarily on aftercare of former CCDU patients.

An Giang: Project staff in An Giang indicated that although capacity building gains would be sustained, they were concerned about the future. It was reported that the government might step in to continue with the technical assistance/capacity building, but "*without support of the project they might have a problem in getting knowledge about new developments in treatment.*"

2.7.2 VNM/J04

Interviewed respondents at all levels expressed confidence with the prospect of independent implementation of drug demand reduction activities in their localities even if UNODC decided to terminate all the project supports without future continuation. Although it is difficult to measure, the degree of sustainability accomplished in this final stage of the project is likely to vary by province, with the following findings:

1. **Lao Cai:** Experience in the two-year transition period between the termination of VIE/H61 and the commencement of VNM/J04 demonstrated that all implementation activities could be maintained in the absence of UNODC support although lower implementation rates due to funding constraints were likely in this period.
2. **Dien Bien:** The province has received significant national and international attention for its expanded harm reduction services with the piloted MMT programming in which VNM/J04 has played a significant supporting role. The creation of the provincial masterplan on HIV control has helped coordinate disparate project activities by different funders.
3. **Yen Bai:** The managerial structure has representation from lower administration in each succeeding hierarchy level to ensure that community needs are effectively communicated to the decision makers. Greater representation of the health sector and systematized project implementation guidelines were two suggestions from the PMU.
4. **Son La:** Delayed implementation of harm reduction and the decision to exclusively support the Government drug treatment centers are key concerns likely affecting the provincial response in drug demand reduction as different from the other provinces.⁴⁰

The evaluation underlined the high level of knowledge retention and transfer among the provincial project staff by the virtue of the provincial policies aspiring to high specialization for the Government agencies. On the whole, achievement of sustainability is more pronounced for implementation capacity and progressively less for managerial and funding capacities in order. Project management skills were frequently cited as ones that should receive more improvement in the future, whereas a series of TOT was seen as a strategic move towards community empowerment in drug demand reduction. Organizational and provincial scale initiatives in skills building exercises, whether in formal training or otherwise, were reported in the interview sessions; and standardizing the quality of these exercises while acknowledging provincial variations in the priority skills is of strategic importance for future project implementation.

One major concern in the way of sustainability is the lack of stability in implementation due to the project reorientation that was likely to reverse expansionary efforts developed earlier in the limited two-year duration, especially for the new project sites. The extent of this reversal remains unknown pending the 2011 Annual Project Progress Reports, although earlier analysis suggests that the drug use reduction component was likely to be most affected. Present findings point to the indication that project-determined priorities took precedence of the intervention needs. In retrospect the project has witnessed how the non-incorporation of the recommended anonymous community reporting in supply reduction into the current design has drastically reduced its importance despite its evaluated early success.⁴¹ There is a strong need for an analysis of the performance gaps and further actions to reinvigorate as well as standardize project achievements.

⁴⁰ *Ibid.* 16.

⁴¹ FGD with Lao Cai provincial PMU.

CHAPTER 3: CONCLUSIONS

3.1. VIE/H68

Treatment staff seems to come from all walks of life and though they have a sincere interest in helping drug abusers, there is a general lack of education and knowledge in their background. As a result of the work of UNODC and other projects, there is now an improvement in the pool of staff to draw from. A recommendation is to try to identify those staff who seem to have the most interest in drug abuse treatment, have performed best on the pre/post training evaluations, and continue working with them to develop their skills. A method that could be adopted is the “coaching” system that is in the US literature. The Network for the Improvement of Addiction Treatment (NIATx) has used this model successfully (please see www.niatx.net for more info). The weakness of the coaching system is that the interactions between the coach and trainee must be routinized – there are opportunities for gaps if the expectations about amount/duration/quality of contact is not specified and adhered to. The interactions should be consistent, not just “as needed” or left to the trainee to express doubts as they may not want to show their lack of knowledge to their coach.

The project was relevant and culturally appropriate, but somewhat limited in scope. A recommendation for future projects concerns the integration of mental health training to participants. Co-occurring psychiatric and substance abuse prevalence rates are very high and the treatment of the two disorders should be integrated, not separate, and should be a collaborative process between the treatment team and the patient. The respondents were quite clear on this aspect – more mental health training is needed to attend to the needs of their patients and better prepare them for integration to society and to avoid relapse.

A recurring theme from respondents regarding capacity building is the need for refresher training on harm reduction for all project implementers and acquisition of project management and organizational skills for PPMU members and program managers. Additionally, domestic and overseas study trips were proposed for comparison of HIV and drug abuse response/situations. One important suggestion in this regard is that by CEM whereby a “Project Review Workshop” is to be conducted that best practices and lessons learned can be shared among the participating stakeholders. Along this line, it is advisable that project review at the provincial level be performed prior to this Review Workshop so participants representing each province will bring the provincial results for effective discussion in the forum. It is hoped that the documented results of this Review Workshop will serve as guidelines of best practices for future implementation of similar programs or harm reduction in the country.

Lastly, it was found that there was a general lack of coordination between international agencies and donors. Networking with other agencies ensures a higher degree of participation from other sectors, organizations, and national counterparts – especially PEPFAR, USAID and the Ministry of Health. Multiple funding entries have been shown to have caused lack of coordination and fragmented response as every funder runs activities

independently of the others. Another common theme as regards implementation of VNM/J04 is the lack of stability and possibly a coordination problem, both due to change of the Project Coordinator. This reservation was shared by provinces and international agencies.

The VIE/H68 project would have benefitted from more on-going external monitoring. A model might be something similar to Treatnet II where there are external evaluators going into the project sites to collect data on the trainings, number of staff trained, satisfaction with trainings, changes in attitudes etc. These individuals are nationals but independent to UNODC. This mechanism might be helpful for future projects. Additionally, a relatively small sum seems to have been allocated to each project site. Given the total budget for this project, one has to wonder if more of the funds should have been targeted to the sites. An external auditor for future projects might be helpful, as well as a cost effectiveness analysis.

3.2. VNM/J04

The scaling up VNM/J04 phase represented a culmination of comprehensive drug demand reduction strategies for ethnic minority communities in highland areas. Constant efforts building on previous achievements in this highly targeted population have developed the competency of UNODC and local stakeholders in this often overlooked segment in the international development of drug abuse interventions. The report presented evaluation findings on the design, managerial, and technical aspects of the project in entirety. Design inconsistency rooted in what appeared to be the inherent limitation in securing long-term funding commitment on the part of UNODC, deviating the project from its expansionary goal and more into the technical capacity building for local stakeholders, and the evaluation highlighted this issue as the project's main weakness. Within the methodological constraints of the current evaluation, reasonable findings suggesting that the project's drug demand reduction intervention is generating the expected results can be determined to a certain extent.

The organizational structure of the project promoted participation from local stakeholders at all but district level, marking the distinction from the previous phase without much effect on timely information flow and decision making. Variations in program choice and duration of implementation likely caused disproportionate outputs production across provinces. In Lao Cai and Yen Bai, consistent implementation of all the programs appeared to have a positive effect on the critical mass of technical expertise and the latter's PMU was on a steep learning curve, having introduced the project only in this phase. In Dien Bien the project has been refocused to support the piloting of MMT in the province, while early opposition to harm reduction in Son La excluded outputs of this program in the first two years of implementation. Reporting bias precluded adequate assessment of the drug use reduction component, which remains inconclusive at best. Reorientation of project priorities in the extension sub-phase had focused on training activities with considerably less attention on field-level implementation and the delayed funding disbursements rescheduled high-cost training sessions to the terminal stage of the project, which made implementation rates appear low.

Outreach and microfinance loans were two programs that received highest appreciation from local stakeholders for raising awareness of the communities to the harms of drug use and HIV

risks and diversifying the economic role of the affected households particularly women. Outreach was key behind the high distribution of harm reduction supplies and there were early indications of HIV reduction in some project sites due to this expanded access. These findings stemmed from triangulation of all-site data and interview results in the visited communes, with a majority participating in the project only in this phase. Taken together, it could be argued that project impacts that began to materialize would not hold equivalently in the future as the project was shifting away from its expansionary goal both programmatically and geographically.

The evaluation draws attention to the constraints identified. Some of the constraints either had minor impact on implementation or had been resolved as the project drew its course. Identified areas of improvement include a greater multi-sectoral participation, intensified strategic partnership, evidence-based indicators development, systematized outcomes monitoring and reporting procedures, and the health system strengthening for drug use reduction and HIV prevention to improve project ownership. On an inter-project scale, there is a risk to differential implementation due to variations in the amounts of institutional grants or similar economic incentives for implementers among projects.

In retrospect, the combination of wide project scope and the specificity of target population has made VNM/J04 a highly relevant intervention. The project should be extended to reinvigorate project achievements likely to have diminished in the extension sub-phase and standardize performance across project sites, while paying greater attention to local ownership and sustainability. It is expected that the project can complete the process of transfer of responsibility to the local stakeholders in the next phase.

CHAPTER 4: RECOMMENDATIONS

4.1. VIE/H68

Overall, the evaluators make four recommendations:

1. A robust monitoring component during sustainability efforts, including a cost effectiveness evaluation to determine proper allocation of funds by Viet Nam Government in concert with UNODC.
2. Increased professionalization of the treatment staff and improved mentorship or coaching of the trainees. The quality and sustainability of the technical skills acquired by the trainees is dependent on their receiving continued support and training beyond the initial training. This can be accomplished in the current project by Viet Nam Government and by UNODC for future projects.
3. The addition of mental health components into future trainings; respondents repeatedly mentioned the dire mental circumstances of the patients and their wish for better meeting those needs. This can be accomplished in the current project by Viet Nam Government and by UNODC for future projects.
4. Additional education to trainees about other drugs beside heroin. The respondents in the central and northern provinces specifically noted an increase in ATS use. This can be accomplished in the current project by Viet Nam Government and by UNODC for future projects.

Other considerations include:

4.1.1. Design and Management

The issue of working with CCDUs is controversial. Given the recent concerns about human rights violations in these centers, the design of the project being carried out within the CCDUs is likely outside the mission of the United Nations. From the perspective of the evaluators of this project, there does seem to be evidence that UNODC trainings are “changing hearts and minds” of the management and staff. For future design and management, withholding funds to “voluntary only” project sites is a carrot that the UN could leverage. **A recommendation would be to encourage the treatment centers to include voluntary subjects only.** Discussion with staff about this topic usually came up after the end of the interviews so it was not recorded but the general sense is that the Vietnamese people value their current system and feel it is the appropriate method. While on mission, we learned of some private treatment clinics with excellent reputations. Perhaps their voluntary approach to treatment could be emulated used as an example of how voluntary treatment can work for the Vietnamese people. Additionally, some of their methods could be incorporated into future UNODC projects.

Clarify the role of the counselling centers and make sure it is consistent across provinces and in line with national laws. The mandate of all individuals having access to community based treatment should be consistent across provinces and should also be the UNODC expectation when working with the centers. When consulting an MD who has done work in methadone clinics in Viet Nam, he mentioned that there is a tension for drug users about

whether or not to seek counselling because once they do, they become registered as a drug user, and then they are “easy pickings” for the police who have quotas to fill for the CCDUs. A recommendation that would be that the Viet Nam government allow individuals to seek treatment in the community based centers without having to register as a drug abuser. Registration as a drug abuser has severe implications for individuals, their families, their status in the community, as well as their employment opportunities; the design and implementation of the registration of drug abusers should be examined. The clarification of the role of the counselling centers naturally leads to the next issue of building a robust continuum of care in Viet Nam.

4.1.2. Programmatic Considerations

Continuum of care. Counselling in the community, not just MMT, should be available to individuals, even if they have not received CCDU treatment. In Da Nang and An Giang, staff seemed to focus on aftercare and those relationships were strong between the counselling center and the CCDU but pre-CCDU treatment counselling was limited to referring individuals to the “right” CCDU. In the future, it should be clear that individuals can access counselling prior to or instead of CCDU treatment and that there is a clear process for referral to the counselling clinics as well as information about after care clubs in the home region of the patient. Also, it would be recommended for future ventures that the system for incorporating the families of the patients into counselling be routinized.

4.2. VNM/J04

4.2.1. Design and Management

An extended implementation phase of at least 24 months, the normal duration of one project cycle for the project, is required to reinvigorate and standardize achievements across project sites. This period ideally excludes extra time required for preparation in instituting the corresponding support infrastructure, which includes expansion in membership of central PMU and the strengthening of long-term provincial strategies in comprehensive drug demand reduction.

Building on the mid-term recommendation for VIE/H61, the cross-cutting role of CEM in handling all matters pertaining to the well-being of ethnic minorities should be matched by sectoral supports from concerned ministries. To this objective the evaluation underlines consideration for **future inclusion of the related sectors** such as MOH, MOLISA, and others in the project central management with shared, sectoral responsibilities to support the coordinating function of CEM as mandated by the 2008 Decree on Regulations on Functions, Powers, and Organizational Structure for Ethnic Minorities.⁴² It is expected that this synergy would bring together a multi-sectoral response and extra resources required to address the problems of drug use and HIV infection in ethnic minority populations.

At the provincial level, guidance and assistance from UNODC to **reinforce provincial masterplans** concerning drug demand reduction and HIV prevention or creation of one if not

⁴² The Decree No. 60/2008/ND-CP dated May 9, 2008 states that the function of CEM ranges from “development of laws to implementation of the programmes, their monitoring and acting as inter-agency of different ministries of Viet Nam and liaisoning with international agencies.”

available should be prioritized in the transition period or early in the new phase. These strategies document specific priorities including resource planning in the direction of attaining the long-term, national objectives in comprehensive drug demand reduction, with a special discussion on ethnic minority target group. Future project design will therefore reflect a degree of customization according to local priority needs, which findings indicate to likely vary by average implementation length of all programs with Lao Cai and Dien Bien in the advanced group and the rest in the other. More importantly, from the perspective of local stakeholders this step can promote stability in implementation and encourage continued, concerted efforts by multiple donors in implementation sites in the event of one project's termination or modification.

Project ownership is another challenge area that should be explicitly attempted in future implementation. Local funding capacity has become a key area that UNODC should initiate in the future. Regressive funding, whereby the committed external funding falls increasingly in proportion to substitution by local financing or in-kind contributions, has gained popularity among bilateral donors to stimulate the local financing capacity; and a similar scheme aimed increasing the Government's in-kind contributions to immediately replaceable cost items may be possible within the short project cycle. Prior agreement on the share of increase and cost items of interest ensues with the agreed substituted proportion of goods or services reflected in the similar indicators previously shown.

4.2.2. Programmatic Considerations

Of particular interest is the drug use reduction component of the project whose results could not be ascertained in the present evaluation. The evaluation proposes **a review of the drug use reduction component** by the CLP, possibly as a special discussion at the TPR meeting, to refine relapse case definition, set achievable indicators based on the established evidence, and advise on the effective monitoring system for reporting relapse-prevention.

What is important in developing the measurement methodology is the acknowledgement that relapse is a recurring episode and that abstinence is seen as 'delay' to subsequent use; such that relapse can only be effectively measured in **a well-designed prospective study** involving a representative sample of treated drug users as opposed to an output-oriented reporting system prone to sampling bias, that is – those who decided to remain being Aftercare Club participants were those likely to maintain abstinence. While such a study may not be possible given the resource constraint, a before-after behavioural survey depicting drug use prevalence can serve as a proxy for a similar construct of relapse.

The importance of such a study for outcomes measurement of both drug use reduction and harm reduction components has been stressed in this report, and it is therefore recommended that UNODC ensure logistics and all coordination activities for **effective, immediate execution of the survey**. In a broader context of monitoring and evaluation, adequate resource for systematic reporting, data collection and analysis must be secured.

High voluntary participation might well be expected to have occurred in outreach but tends to be excluded from regular reporting, and the corresponding outreach quality cannot be

expected to be equal to that of POWs. One possible idea is for UNODC to **systematize the function of voluntary outreach in the community setting**, taking advantage of the qualified trainers or train family members. This proposed system will likely normalize the talk of ‘social evils’ at the household level, there is a considerable risk of resistance from the local community or officials, and prior feasibility study is warranted. The application of this system entails change to the traditional role of POWs to one of ‘community organizing’ with less frequency of POW contacts in the indicator for outreach.

Alternatively, by promoting **higher participation of the health sector**, MOH in particular, which controls health resource allocation, the project can benefit from additions to the health care workforce, who can be assigned to outreach. According to the interviewed POWs this generic role of the public health care staff allows the mainstreaming of HIV prevention in other health programs such as maternal and child health, thus expanding the project target audience while promoting efficiency in the health sector.⁴³

The evaluation also recommends that UNODC expedite the **integration of the microfinance program with the existing Government-run poverty reduction projects** in the region such as the Bank of Social Policies that also operates a microfinance scheme for the general poor, with provision of technical assistance by a specialist organization. The eligibility criteria for receiving households should be reconsidered with a view on the trade-off between the retaining the extra criterion of being affected by drug use or HIV for poor households and lifting it to allow broader beneficiary groups. Future role of UNODC will be limited to ensuring initial liquidity, which may involve reimbursing lost savings and bad loans, and participating in selection of the partner organization.

4.2.3. Gender and Human Rights

There is also a potential for UNODC to stress its role in these areas. For gender, the microfinance program has contributed to women’s empowerment. However, less is known about sex disparity in access to services and health outcomes. Presenting participation outputs grouped by sex in official reports can readily draw attention to emerging sex disparity in program access. Additionally, a study exploring experiences of ethnic minority female drug users can address the knowledge gap in this area.

The issues of human rights are gaining increasing importance in drug policy discussion whose integration has shifted the central theme of ‘harm reduction’, emphasizing individual responsibilities for well-being, to ‘harm production’, with structural determinants of drug-related adverse consequences as its focus.⁴⁴ While human rights have been incorporated in the training content for law enforcement and other officials, the evaluation considers educating ethnic minority drug users, PLWH, and community members on the human rights-based approach to health care can be advantageous to the community advocacy for greater access to health care and stigma elimination.

⁴³ Interviews with Phong Lai commune steering board and project beneficiaries.

⁴⁴ Rhodes, Singer, and Bourgois *et al* (2005).

CHAPTER 5: LESSONS LEARNED

5.1. VIE/H68

Project Concept, Design, and Management

It is clear that the project concept was well designed although management was variable across the provinces. There are two areas where the design could have been improved, namely, by integrating additional mental health training as well as ATS information into the manuals. Additionally, due to the strong association between the community based treatment centers and the sub-DSEP centers – sometimes located in the same building - it is possible that some voluntary drug users were reluctant to engage in treatment, fearing that they would be recorded as a drug user (which comes with a host of concerns for the individual and their families).

Implementation

There is little doubt that VIE/H68 has implemented capacity building interventions that are relevant to this context. Staff have been trained in a set of skills that they are utilizing to good effect. An implementation issue that was not addressed, however, was the translation of the VIE/H68 documents for the minority groups in Lao Cai. Future projects in this province should consider this a lesson learned and ensure that all documents are properly translated.

Monitoring and Evaluation

The monitoring of the outcomes of drug users treated at VIE/H68 sites is an area that needs to be addressed. Recording keeping could be strengthened, as well as monitoring the contact between families and the center sites. Future projects should integrate a routine monitoring component, so that patient outcomes can be examined.

5.2. VNM/J04

Project Concept, Design, and Management

Stability in project direction with sufficient implementation duration is essential to nurture local management and implementation capacity, particularly since the initial goal is the scaling-up of the existing drug demand reduction interventions whose feasibility have been successfully tested in the previous phases. Design inconsistency poses a high risk of reversal to the accumulated expansionary efforts despite, perhaps, reasonable achievements in the shifted priorities.

In formulating a follow-up action to the above drawback, the **institutional boundary** of the planning agency should be adequately acknowledged. The evaluation draws attention to the project design mechanism of multilateral agencies like UNODC which treats project planning independently of the funding commitment – a characteristic that subjects implementation to the ‘short-termism’ perspective. Long-term implementation risks funding-induced modifications by which time the project has yet to achieve its critical mass for its initial goal.

Project sustainability needs to be built into the design, particularly in regards to the financing capacity of the local partners in anticipation of project termination. Along the

similar line, the evaluation emphasizes multi-sectoral representation in the project management team to broaden the scope of strategic partnership in the direction of sustainability.

Implementation

VNM/J04 implementation represents **a comprehensive service model** that has high value when applied in remote, isolated geographies where poverty and institutional neglect contribute to the poor health and socioeconomic outcomes of the populations.

Socioeconomic mitigation is the programmatic area often neglected that has been well integrated into the project's intervention package with consistent success. This area extends the core competency of UNODC rooted in its historical role in drug demand and supply reduction activities that within the implementation of VNM/J04, a strategic partnership with a specialist organization could improve its functioning.

Intensive outreach, the first point of contact to health and social services for many drug users, has resulted in high voluntary participation from the community in knowledge promotion activities for HIV risk groups, thus expanding the outreach base. Additionally, the generic role of health workers allows integration of relevant elements of drug demand reduction such as HIV prevention with other health programs.

Joint partnership with a specialist organization, as the implementation experience in Dien Bien has demonstrated, can be an effective management strategy for ancillary programs within the extended competency areas of the commissioning agency and is particularly well suited to catalyze the process of managerial know-how transfer to local partners.

Monitoring and Evaluation

Systematic data collection, analysis, and reporting system for relapse, the ultimate effectiveness measure for drug use reduction interventions, should be prioritized in future implementation. Given that drug use remains highly stigmatized in Viet Nam, the evaluation acknowledges the high potential for social desirability reporting and selection bias within the present output-oriented monitoring system and that epidemiological measurement in a prospective study is expected to overcome these analytical problems. Methodologically valid data should be available to assist efforts in project evaluation in order to produce generalizable results.

ANNEXES

ANNEX 1: Field Visits and Data Collection Schedule

VNM/J04

22 November (Ha Noi)

09.00-12.00 : Finalizing evaluation
14.00-16.00 : Interview with CEM
20.00-06.00 : Travel to Lao Cai town by train

23 November (Lao Cai)

08.30-09.00 : Travel to Sub-DSEP Office
09.25-11.00 : FGD with Lao Cai PMU
11.00-13.00 : Travel to Ta Van commune
13.00-13.50 : Lunch in Ta Van commune
13.50-14.20 : Interview with beneficiaries
14.40-15.10 : Interview with program managers
15.10-17.40 : Travel to Muong Hum commune
17.40-18.15 : FGD with
Overnight stay in Lao Cai town

24 November (Yen Bai)

08.00-15.00 : Travel to Yen Bai town
15.25-17.15 : FGD with Yen Bai PMU
Overnight stay in Yen Bai town

25 November (Yen Bai)

08.00-09.30 : Travel to Cat Thinh commune
09.55-11.00 : FGD with beneficiaries
11.30-12.30 : FGD with commune steering board
12.30-13.30 : Lunch in Cat Thinh commune
13.30-14.50 : Travel to Son Thinh commune
14.50-15.55 : FGD with project beneficiaries
16.25-17.10 : FGD with commune steering board
17.10- : Travel to Ha Noi for the weekend

28 November (Dien Bien)

08.30-11.15 : Travel and flight to Dien Bien city
15.15-16.35 : FGD with Dien Bien PMU

29 November (Dien Bien)

08.30-09.00 : Travel to Muong Phan commune
09.25-10.45 : Interview with
10.55-11.05 : Interview with sister organization
11.10-11.50 : FGD with commune steering
11.50-12.20 : Visit to commune health station
12.20-13.20 : Lunch in Muong Phan commune
13.20-14.30 : Travel to Na Nhan commune
14.55-16.20 : FGD with beneficiary/steering
16.20-17.00 : Visit to commune health station

VNM/J04

Overnight stay in Dien Bien city

30 November (Son La)

08.05-08.20 : Interview with FHI 360 in Dien

08.30-15.00 : Travel to Son La town

15.20-16.30 : FGD with Son La PMU

Overnight stay in Son La town

1 December (Son La)

08.00-08.30 : Travel to Tuan Chau commune

08.30-09.00 : Visit to commune health station

09.10-09.55 : FGD with beneficiary/steering

10.00-14.00 : Travel to Phong Lai commune

14.20-15.20 : FGD with beneficiary/steering

15-20- : Travel to Ha Noi

2 December (Ha Noi)

13.00 : Arrive in Ha Noi

13.00-17.00 : Preparation of debriefing report

5 December (Ha Noi)

08.00-17.00 : Preparation of debriefing report

19.00-21.00 : Dinner and interview with PEPFAR

6 December (Ha Noi)

09.00-12.30 : Debriefing at UNODC office

Notes:

CEM = Community for Ethnic Minorities

FGD = Focus group discussion

Sub-DSEP = Sub-Department of Social Evils Prevention

PEPFAR = United States President's Emergency Plan for AIDS Relief

PMU = Project Management Unit

UNODC = United Nations Office on Drugs and Crime

ANNEX 2: Interview and Focus Group Semi-Structured Interview Questions

Project Concept and Design

- Did the project match the local priorities in addressing the problem of drug abuse?
- What were the problems with past implementation that the project now successfully resolved?
- How did any changes to the project management structure positively or negatively influence the current implementation?
- How could the project design have been improved in order to produce better outcomes?
- Were the set targets and objectives reasonable given the project inputs?

Implementation

- In what ways did the project make a wider impact?
- What difficulties did the project encounter in its implementation?
- Were all planned activities executed in a timely manner?
- Was the managerial and implementation capacity of the local partners adequate to run the project effectively?
- How did monitoring and evaluation assist to improve the decision making related to project implementation at the central, provincial, and commune levels?
- What project areas or programs were executed to full extent and how did these differ from the others?

Outputs, Indicators, and Impacts

- Did the produced outputs contribute to an observable impact at the population level?
- What programs or activities that should have received more focus but did not and why?
- What was the project's most significant achievement and how did this relate to the project goals of reduction in drug use and HIV transmission?
- To what extent has the project resolved the problems of drug use and HIV infection in the region, province, or commune?
- What were any indirect consequences of the project?
- What measures did the project take to ensure that deliverables were efficiently produced?
- What were the gaps in management and implementation that could likely cause lower-than-expected performance?
- How did the project contribute to other similar efforts by the Government or other international agencies?

Relevance

- To what extent was the project in line with the national and local strategies in drug demand reduction?
- How did the project engage with the ethnic minorities in planning and execution of activities?
- Did the project complement, duplicate, or compete with other efforts from UNODC, the Government and other partners in the region?

Effectiveness and Efficiency

- Did the project make sufficient progress towards achievement of its stated objectives?
- What were the ‘missing elements’ from previous implementation that were likely to affect the project’s achievements either positively or negatively?
- Were there any underperforming programs?
- Was the technical and managerial support from the central management team provided according to the presenting problems and local needs?
- What was the quality of human resource inputs contributed to the project?
- Were project outputs produced proportionally to the given inputs?

Sustainability

- Can all the project activities be sustained independently upon the complete support termination?
- What measures have been taken to retain the existing skills in drug demand reduction?
- What would be the greatest challenge to sustainability? And what strategies have been developed to overcome this challenge?
- What were the local initiatives to sustain the existing programs and integrate them with other projects by the Government?
- Have policies, strategies in drug demand reduction or HIV prevention been in place?

Partnership, Cooperation and Coordination

- To what extent was the coordination between central and province project teams and between province and commune project teams reflected in decision making?
- To what extent did the project develop relationship and cooperate with similar projects by the Government or other international agencies?
- Did the project allocate sufficient activities in order to engender effective cooperation and concerted response in drug demand reduction?
- Are there challenges in developing strategic partnership across sectors or projects?

ANNEX 3: List of Interview and Focus Group Participants

| Project Capacity | Organization/sub-group or program | Name (Project title/organization title) | Sex | Length of participation (years) |
|-----------------------------|-----------------------------------|--|-----|---------------------------------|
| VIE/H68 | | | | |
| I. National Agencies | 1. DSEP, Ha Noi | Mr. Quynh (H68 Project Coordinator) | M | |
| II. Implementers | | | | |
| <i>1. Lao Cai</i> | | | | |
| Beneficiaries | 1. CCDU | | M | 1 |
| | 2. CCDU | | M | 1 |
| PMU | 3. SDSEP | Nguyen Tuong Long (Director/Head) | M | 3 |
| | 4. Counselling | Luong Duc Thuoc (Director/Head) | M | 6 |
| | 5. CCDU | Nguyen Thi Phuong Thang (Counselor) | F | 3 |
| | 6. CCDU | Tran Van Thien (Chief Counselor) | M | 6 |
| <i>2. An Giang</i> | | | | |
| Beneficiaries | 1. CCDU | | M | 2 |
| | 2. CCDU | | F | 1 |
| PMU | 3. SDSEP | Tran Xuan Loc (Director/Head) | M | 6 |
| | 4. CCDU | Phan Phat Nhung (Director/Head) | M | 6 |
| <i>3. Da Nang</i> | | | | |
| PMU | 1. SDSEP | Le Minh Hung (Director) | F | 1 |
| | 2. Counselling | Nguyen Cong Thanh (Deputy Head Education) | M | 4 |
| <i>4. Thanh Hoa</i> | | | | |
| Beneficiaries | 1. CCDU | | F | 1 |
| | 2. CCDU | | M | 1 |
| PMU | 3. SDSEP | Vu Huy Vuong (Expert) | M | 2 |
| | 4. CCDU | Nguyen Dao Duc (Head of Counseling) | M | 3 |
| <i>5. Hai Phong</i> | | | | |
| | 1. SDSEP | Nguyen Duc Phan (Director) | M | 6 |
| | 2. Counselling | Nguyen Thanh Giang (Deputy Director) | M | 6 |
| | 3. CCDU | Nguyne Quang Toan (Director) | M | 6 |
| III. Intl. Agencies | | | | |
| | 1. USAID-PEPFAR | Kevin Mulvey (Substance Abuse Treatment) | M | |
| | 2. USAID | Nguyen Thi Minh Huong (Drug Treatment) | F | |
| I. Central PMU | | | | |
| | 1. CEM | Lo Giang Pao (Director/Director) | M | 3 |
| | 2. CEM | Akan Van Hung (- /Vice director) | M | 3 |
| | 3. DSEP | | | |
| <i>1. Lao Cai</i> | | | | |
| PMU | 1. SDSEP | Nguyen Toong Long (Director/Head) | M | 3 |
| | 2. SDSEP | Le Anh Hao (Member/Vice Head) | M | 2 |
| | 3. SDSEP | Quach Dng Jhanh (Member/Sub-Head) | M | 3 |
| <i>1.1. Ta Van</i> | | | | |

Independent Evaluation of VIE/H68 and VNM/J04
Terminal Evaluation Report Annex 3

| Project Capacity | Organization/sub-group or program | Name (Project title/organization title) | Sex | Length of participation (years) |
|-------------------------|--|--|------------|--|
| Beneficiaries | 4. DU | | M | 3 |
| | 5. Spouse | | F | 3 |
| Field Implementers | 6. Aftercare | Tan Lao Ta (- / Manager) | M | 2 |
| | 7. Microfinance | Tran Thi Net (- / Manager) | F | 3 |
| <i>1.2. Muong Hum</i> | | | | |
| Beneficiaries | 8. DU | | M | 2 |
| Field Implementers | 9. PSIP | Hoanj Thi Giang | F | 1 |
| 2. Yen Bai | | | | |
| PMU | 1. PAC | Tsien Bich An (Director/Director) | F | 4 |
| | 2. SDSEP | Nguyen Van An (Vice Director/Director) | M | 3 |
| | 3. SDSEP | Pham Xuan Teung (Member/Vice Director) | M | 3 |
| | 4. DOLISA | Lunh Vanh Menh (Member/Vice Director) | M | 3 |
| | 5. SDSEP | Nguyen Ninh Nguyet (Member/ -) | F | 3 |
| <i>2.1. Cat Thinh</i> | | | | |
| Beneficiaries | 6. DU | | M | 2 |
| | 7. DU | | M | 3 |
| | 8. Spouse | | F | 3 |
| | 9. Spouse | | F | 3 |
| | 10. Spouse | | F | 2 |
| CPSB | 11. People's | Nguyen Thi Huong (Director/Director) | F | 3 |
| | 12. Women's | Pham Van Tien (Vice Director/Director) | M | 3 |
| | 13. PSIP | Vu Ngoc Dai (Member/Manager) | M | 3 |
| | 14. Aftercare | Hoang Thi Nam (Vice Director/Manager) | F | 3 |
| | 15. - | Ha Thi Thin (Member/Officer) | F | 2 |
| | 16. Microfinance | Nguyen Thi Bien (Member/Manager) | F | 3 |
| <i>2.2. Son Thinh</i> | | | | |
| Beneficiaries | 17. DU | | M | 3 |
| | 18. DU | | M | 1 |
| | 19. DU | | M | 2 |
| | 20. DU | | M | 3 |
| | 21. Spouse | | F | 3 |
| | 22. Spouse | | F | 3 |
| | 23. Spouse | | F | 3 |
| CPSB | 24. - | Hea Chey Cien (Director/Director) | F | 3 |
| | 25. - | Vu Thi Ngga (Vice Director/Director) | F | 3 |
| | 26. - | Le Iki Hong Van (Member/Manager) | F | 3 |
| | 27. - | Vu Thi Thu (Member, Manager) | F | 3 |
| 3. Dien Bien | | | | |
| PMU | 1. SDSEP | Le Minh Bon (Director/Director) | M | 4 |
| | 2. PAC | Hoang Xuan Chien (Vice Director/Director) | M | 2 |
| | 3. SDSEP | Vu Thui Luong (Member/Officer) | F | 2 |

Independent Evaluation of VIE/H68 and VNM/J04
Terminal Evaluation Report Annex 3

| Project Capacity | Organization/sub-group or program | Name (Project title/organization title) | Sex | Length of participation (years) |
|-------------------------|--|--|------------|--|
| | 4. PAC | CAO Quinh Hanh (Member/Officer) | F | 3 |
| | 5. SDSEP | Tran Viet Quan (Member/Officer) | M | 3 |
| 3.1. Muong Phan | | | | |
| Beneficiaries | 6. DU | | M | 4 |
| | 7. DU | | M | 3 |
| | 8. Spouse | | F | 1 |
| | 9. Spouse | | F | 1 |
| | 10. Spouse | | F | 1 |
| | 11. Comm. Member | | F | 1 |
| | 12. Comm. Member | | F | 1 |
| Field implementers | 13. PSIP | Lo Van Pan (- /Manager) | M | 3 |
| | 14. PSIP | Vung Van Pan (- /Officer) | M | 3 |
| | 15. PSIP | Vi Van Than (- /Officer) | M | 3 |
| CPSB | 16. - | Tran Van Bon (Director/Director) | M | 3 |
| | 17. - | Vung Van Pan (Vice Director/Director) | M | 2 |
| Sister program | 18. Microfinance | Lu Jhi Yin (- /Manager) | F | 2 |
| | 19. Microfinance | Lu Van Hui (- /Manager) | M | 2 |
| 3.2. Na Nhan | | | | |
| Beneficiaries | 20. DU | | M | 2 |
| | 21. DU | | M | 2 |
| CPSB | 22. PSIP | Liong Thi Thuy (Member/Manager) | M | 2 |
| | 23. - | Nuo A Hu (Member/Officer) | F | 2 |
| | 24. - | Quang Van Son (Director/Director) | M | 2 |
| 4. Son La | | | | |
| PMU | 1. SDSEP | Pham Van Vy (Director/Director) | M | 4 |
| | 2. SDSEP | Tran Thanh Binh (Vice Director/ -) | M | 1 |
| | 3. SDSEP | Dinh Van Xung (Member/ -) | M | 4 |
| 4.1. Tuan Chai | | | | |
| Beneficiaries | 4. DU | | M | 2 |
| | 5. DU | | M | - |
| CPMB | 6. Health center | Lu van Toau (Director/Manager) | | |
| | 7. PSIP | Ca Van Quy (Member/Staff) | M | 3 |
| | 8. PSIP | Ca Van Hoa (Member/Staff) | M | 3 |
| 4.2. Phong Lai | | | | |
| Beneficiaries | 9. DU | | M | 2 |
| CPSB | 10. Health center | Ti Nah Canh (Director/Manager) | M | 3 |
| | 11. PSIP | Nguyen Arom Ban (Member/Staff) | M | 2 |
| | 12. PSIP | Ca Van Hia | M | 3 |

Independent Evaluation of VIE/H68 and VNM/J04
Terminal Evaluation Report Annex 3

| Project Capacity | Organization/sub-group or program | Name (Project title/organization title) | Sex | Length of participation (years) |
|---------------------------|-----------------------------------|--|-----|---------------------------------|
| IV. Intl. Agencies | | | | |
| | 1. FHI 360 | Tran The Tranh Hu (Project Officer) | F | 2 |
| | 2. USAID-PEPFAR | Kevin Mulvey (Substance Abuse Treatment) | M | |
| | 3. USAID | Nguyễn Thị Minh Hương (Drug Treatment) | F | |
| Total: | | 98 | | |

Notes:

- | | |
|---|---|
| <ul style="list-style-type: none"> * = Interviewed for both VIE/H68 and VNM/J04 CCDU = Compulsory Centers for Drug Users CEM = Committee for Ethnic Minorities PMU = Project Management Unit CPSB = Commune Project Steering Board DU = Drug User | <ul style="list-style-type: none"> FHI 360 = Family Health International 360 PAC = Provincial AIDS Committee PEPFAR = U.S. President's Emergency Plan for AIDS Relief PISP = Peer Supply Information Point SDSEP = Sub-Department of Social Evils Prevention USAID = United States Agency for International Development |
|---|---|

ANNEX 4: Documents Reviewed

VIE/H68

1. Project Document ADVIEH68: Technical Assistance to Treatment and Rehabilitation at Institutional and Community Level
2. Midterm Evaluation Report AD/VIE/H68 Technical Assistance to Treatment and Rehabilitation at Institutional and Community Level
3. Training Report: Training for Enhancing Drug Addiction Counseling at Institutional and Community Level in Seven Provinces/Cities
4. Mission Reports
5. Clinical and Client Management for Drug Services
6. H68 Training Manuals, composed by Turning Point Australia

VNM/J04

1. 2010 Annual Progress Report
2. Project Document VNMJ04: Drug Abuse and HIV Prevention among Ethnic Minorities in Northwest Viet Nam – Extension to VIEH61
3. Project Revision: January 2008-December 2010
4. Project Revision: December 2007-July 2011
5. Project Revision: December 2007-March 2012
6. Semi-Annual Progress Report (SAPR): January-June 2011
7. VNM-J04 Management and Administration Handbook: Microfinance Program

ANNEX 5: References

- Department of Labor, Invalids, and Social Affairs (DOLISA) (2007). *Hanoi B93 Clubs Evaluation*. Ha Noi: DOLISA.
- Government of Viet Nam (2008). *Decree No. 60/2008/ND-CP of May 9, 2008, Defining the Functions, Tasks, Rights and Organization of Committee for Ethnic Minorities*. Ha Noi: Viet Nam Law and Legal Forum, Government of Viet Nam.
- Ministry of Health – Viet Nam Administration of HIV/AIDS Control (2009). *Viet Nam HIV/AIDS Estimates and Projections 2007-2012*. Family Health International, Ha Noi.
- Nguyen, V. T. and Scannapleco, M. (2008). Drug Abuse in Vietnam: A Critical Review of the Literature and Implications for Future Research. *Addiction*, 101(1), pp. 535—543.
- Rapin, A-J. and Eligh, J. (2003). *Ethnic Minorities, Drug Use & Harm in the Highlands of Northern Vietnam: A Contextual Analysis of the Situation in Six Communes from Son La, Lai Chau, and Lao Cai.*, UNODC and DENIDA, Ha Noi.
- Ranklin, S. (2003). *Mid-term Evaluation Report: AD/VIE/01/B85: Drug Abuse Prevention among Ethnic Minorities in Vietnam*. UNODC, Vienna.
- Rhodes, T., Singer, M., Bourgois, P., Friedman, S. R., and Strathdee, S. A. (2005). The Social Structural Production of HIV among Injecting Drug Users. *Social Science & Medicine*, 61(5), pp. 1026-1044.
- Schuffan, C. (2006). *Terminal Evaluation Report: Drug Abuse Prevention among Ethnic Minorities in Viet Nam, Project Number: AD/VIE/H61*. October 20, 2006, Ha Noi: UNODC.
- Trees, D. (2005). *Mid-Term Evaluation Report: Drug Abuse Prevention among Ethnic Minorities in Viet Nam, Project VIEH61*. Ha Noi: UNODC.
- UNODC (2007). *Project Document VNMJ04: Drug Abuse and HIV Prevention among Ethnic Minorities in Northwest Viet Nam – Extension to VIEH61*. Ha Noi: UNODC.
- UNODC (2010a). *VNM/J04 Annual Progress Report 2010*. Ha Noi: UNODC.
- UNODC (2010b). *Project Revision*. Ha Noi: UNODC.
- UNODC (2011a). *VNM/J04 Semi-Annual Progress Report 2011*. Ha Noi: UNODC.
- UNODC (2011b). *Project Revision*. Ha Noi: UNODC.
- UNODC (n.d.a). *Viet Nam: Map No. 4635 United Nations*. Vienna: UNODC. Retrieved from http://www.unodc.org/docs/treatment/CoPro/Web_Viet_Nam.pdf, on 16 December 2011.
- UNODC (n.d.b). *Strategic Program Framework 2005-2007: Viet Nam*. Unedited, Ha Noi: UNODC. Retrieved from http://www.unodc.org/pdf/Vietnam/strategic_program_framework_vietnam.pdf, on 17 December 2011.
- UNODC (n.d.c). *VNM J04 – Project Revision*. Ha Noi: UNODC.
- VNM-J04 (n.d.). *Management and Administration Handbook: Microfinance Program*.

