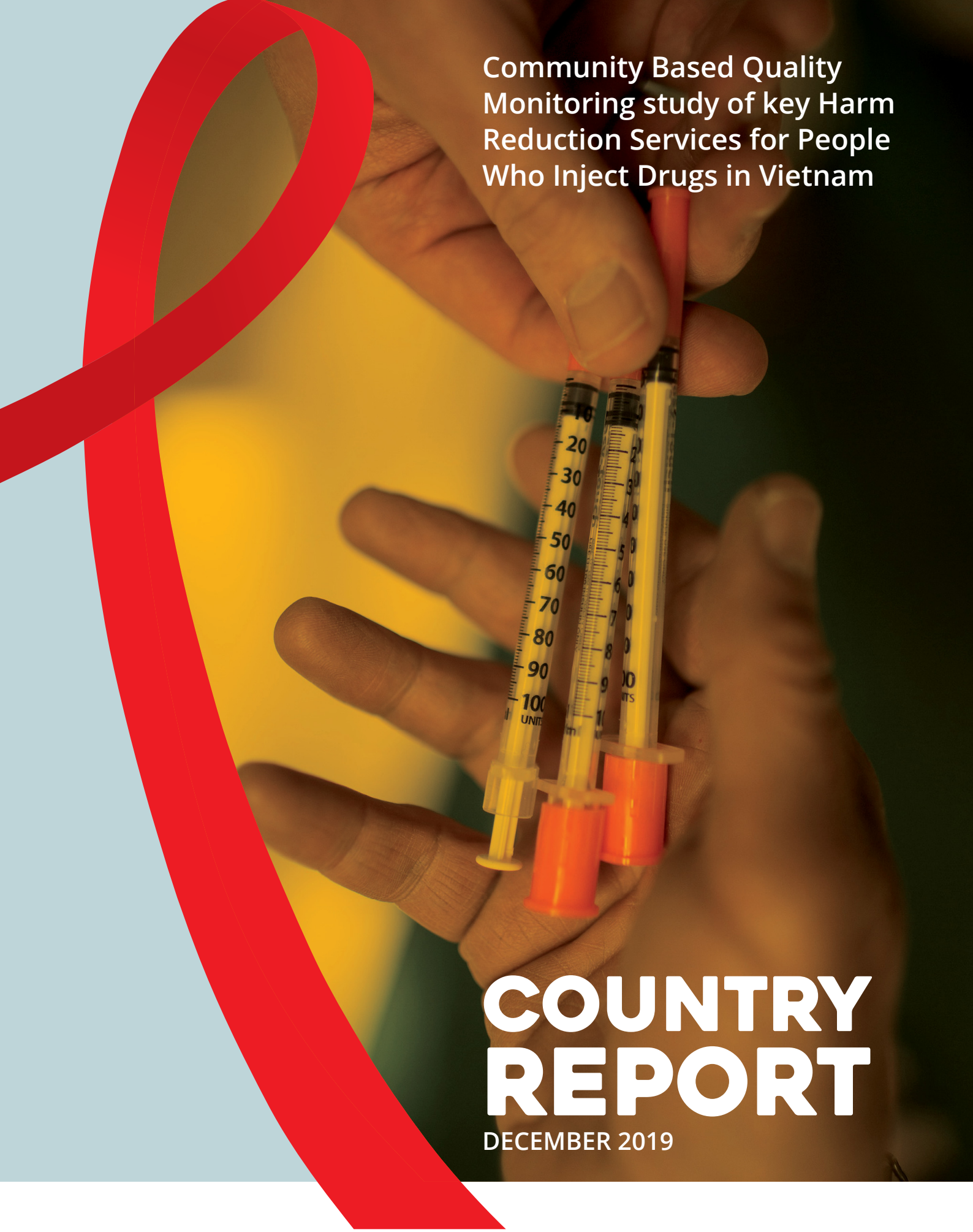

Community Based Quality Monitoring study of key Harm Reduction Services for People Who Inject Drugs in Vietnam

COUNTRY REPORT

DECEMBER 2019

VNPUD SCDI Develop Together ANPUD 10th Anniversary KPRA Key Population Research & Advocacy Project Save the Children

Community Based Quality Monitoring study of key Harm Reduction and other healthcare services for People Who Inject drugs in Vietnam.

This report presents a detailed description, methodology, and findings of the Community Based Quality Monitoring study. This study is the first of its kind in the region, designed, implemented, and analyzed in a peer-to-peer approach and model. The study presents information on the quality of Needle Exchange Services, Opioid Substitution Therapy Services, HIV testing, ART services, and the treatment of Hepatitis C, B, and TB infection. This study has also looked at the current linkage to essential HIV and other healthcare services for people who inject drugs in Vietnam.

The study has been designed and conceived by ANPUD with the active participation and the support from our partners in Vietnam. ANPUD appreciates the support from the data collectors and the community groups who directly and indirectly supported the implementation of this study.

This study is funded by The Global Fund To Fight AIDS, Tuberculosis, and Malaria under the program title: Key Population Research & Advocacy project and managed by Save the Children International, Nepal as the Principal Recipient.

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This final report was prepared by VNPUD which will contribute to the regional report to provide an overall picture of Harm Reduction services namely the provision of NSP and OST in four countries. Thank you to SCDI's coordinator for supporting, connecting the CBQM Study team members and coordinating project activities.

In solidarity,

Pham Thi Minh
Chief
VNPUD Steering Committee

ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ANPUD	Asian Network of People who Use Drugs
ART	Anti-Retroviral Therapy
ATS	Amphetamine Type Stimulants
CBO	Community Based organization
CBQM	Community Based Quality Monitoring
CCM	Country Coordinating Mechanisms
FO	Facility Observation
FGD	Focus Group Discussion
FSW	Female Sex Workers
GF	Global Fund
HCMC	Ho Chi Minh City, Vietnam
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance Study
IBBS	Integrated Bio-Behavioral Survey
IEC	Information Education Communication
ISDS	Institute for Social Development Studies
KII	Key Information Interview
KPRA	Key Population Research & Advocacy
LR	Literature Review
MMT	Methadone maintenance treatment
MoH	Ministry of Health
MOLISA	Ministry of Labor, Invalids and Social Affairs
MSM	Men who have Sex with Men
NGO	Non-Government Organization
NSP	Needle Syringe Exchange Program
ORW	Out Reach Worker
OST	Opioid Substitution Therapy
PE	Peer Educator
PUD	People who Use Drugs
PWID	People Who Inject Drugs
SCDI	Center for Supporting Community Development Initiatives
SR	Sub Recipient
TB	Tuberculosis
TI	Targeted Intervention
VAAC	Vietnam Administration of HIV/AIDS Control
VNPUD	Vietnam Network of People who Use Drugs
VUSTA	Vietnam Union of Science and Technology Associations

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CHAPTER 1

INTRODUCTION

Study Background

Due to social and biomedical advances, the responses to HIV have yielded remarkable results. There are better, improved tools for screening, diagnostics, and treatment of HIV. Community responses to HIV are also established as the cornerstone of effective, equitable and sustainable programmes. They play a critical role in demanding and delivering services, supporting health systems and reach those most vulnerable to HIV where state facilities cannot.

Communities are increasingly involved in monitoring access and quality of HIV treatment, care, and support services. They can act as barometers in their watchdog role, tracking what works and what does not, from a local, contextualized perspective. Communities give a voice to those who need services, provide feedback as to whether policies and programmes are working and suggest how they can be improved. As service recipients, they are best positioned to evaluate the programs and provide critical feedback to HIV and Health programs

Asian Network of People who Use Drugs (ANPUD) is a regional network of people who use drugs established to address the obstacles faced by the people who use drugs and their families in Asia. The core belief behind the formation of ANPUD is that people who use drugs living in countries of the region coming together with a unified voice can have a greater impact ensuring that the community enjoy equal human rights and opportunities for a better quality of life. ANPUD believes that drug use as a health issue (and not a law and order issue) can work more effectively towards creating a better environment for people who use drugs and their communities, building from within the

community.

One of the components of the KPRA grant is to use national PUD networks to monitor the quality of services related to NSP, OST and linkage to care for people who inject drugs in Cambodia, Indonesia, Nepal, and Vietnam. This study is designed as a part of community monitoring of quality aspect of the grant. This study is funded by the Global Fund and managed in part by SCF Nepal and HIV Alliance India.

Study Rationale

The following are the rationale of the community quality monitoring of key HIV prevention services for PUD in Cambodia, Indonesia, Nepal and Vietnam study:

1) There is a need to better understand the quality of the key HIV prevention services provided to people who use drugs in the study countries. There is an opportunity to encourage programs in the study countries to focus on monitoring and improving the quality of services provided and not limit themselves in only reporting coverage.
2) Communities of people who use drugs feel that services are partially provided and there is a room for improvement in the quality of services provided. They believe that there is too much focus on coverage while often times comprehensiveness and quality of those services are not prioritized.
3) Donors, specifically the Global Fund is increasingly interested in the community-centric monitoring of the quality of programs they fund. The people that are the recipients of the services will be extra eyes and ears on the ground to help ensure that the programs are delivered according to expected standards.

These avenues are new to the Asian region and therefore ANPUD has taken leadership in designing and delivering a community-led quality monitoring study, which will pave a way towards a national and regional level dialogue particularly on the quality of the services provided alongside the improving access.

Country Context

The HIV epidemic in the country is concentrated in a number of key populations. Predominant are female sex workers (FSW), men who have sex with men (MSM) and people who inject drugs (PWID). Other vulnerable people include women whose partners are living with HIV, those who use Amphetamine Type Stimulants (ATS), clients of sex workers, adolescents and internal migrants. Many of these populations overlap. HIV infection has been identified in all of the 63 provinces and cities in Vietnam. The total known number of PLHIV in Vietnam is 208,392, and 93.040 are AIDS patients (2018) . The transmission rate among PWID and FSW has been stabilizing and decreasing from 2004 to 2017 (around 10% and 3%). However, the report from Vietnam Administration on AIDS Control (VAAC) 2018 showed that the transmission rate is rising again with 14% among PWID and 3.7% among FSW.

As indicated above, the distribution of HIV cases largely follows the geographical distributions of the three high-risk population groups, (FSW, MSM, PWID) who are heavily concentrated in urban centres but can also be found in some rural communities. Thus, over 70% are found in the three major cities in Vietnam; 15% are in Ho Chi Minh City (HCMC), 12% are in Ha Noi and 2% are in Can Tho. These account for 32% of the total high-risk populations. HIV cases are also concentrated in the northern, northwest mountainous provinces (e.g. Dien Bien, Son La), the mountainous districts of Nghe An and Thanh Hoa, southwest (Mekong Delta), and southeast provinces.

Vietnam is the first country in Asia to endorse the UNAIDS target of 90-90-90, and is

making concerted plans to reach this target (90% will know their HIV status, 90% will receive ART and 90% will experience viral suppression) and to end the HIV epidemic by 2030.

HIV/AIDS control measures began in 1995 when the Standing Committee of National Assembly adopted an ordinance on HIV/AIDS prevention and control, which provided the legal framework for HIV/AIDS prevention efforts in Vietnam. Vietnam's response is coordinated and directed by the high level National Committee on AIDS, Drugs and Prostitution Prevention and Control, which was established in 2000. The Deputy Prime minister chairs the Committee. The three most prominent ministries to contribute to the AIDS response are the Ministry of Health's VAAC (Vietnam Administration for HIV AIDS Control), the Ministry of Public Security and the Ministry of Labor, Invalids and Social Affairs (MOLISA). The New Strategy on HIV/AIDS Prevention and Control 2020, with a vision to 2030 was approved in May 2012 and was written in consultation with government ministries, civil society, the UN in Vietnam and other international partners. It contains ambitious targets that adhere to the UN Political Declaration on HIV AIDS, which were agreed in the UN General Assembly in June 2011 to 'Intensifying our Efforts to Eliminate HIV AIDS'. The government is actively developing mechanisms to ensure sustainable funding for the response, addressing the imminent withdrawal of funding from international donors by significantly increasing national funding.

Study Objectives

The broader objective of this study is to build evidence for advocacy for improved quality of HIV prevention and care services for People Who Inject Drugs (PWID) in Cambodia, Indonesia, Nepal and Vietnam. The study also aims to expand community-based monitoring in South and South East Asia, moving it out of that which is just related to donor programs and starting to monitor national programs and local services. The evidence generated from the study is expected to help to reshape policy, address bottlenecks and provide an important feedback mechanism for the improvement of the quality of HIV prevention, care, and support programs for the people who inject drugs. The following are specific objectives of the CBQM study:

1) To improve understanding of policy position, program strategies, legal barriers, and the stage of implementation of harm reduction services for people who inject drugs in Cambodia, Indonesia, Nepal, and Vietnam
2) To improve understanding of the perceived quality of harm reduction services among service users (PWID) in Cambodia, Indonesia, Nepal and Vietnam
3) To explore the status and function of referral services lifesaving care like provision of ART, management of TB, and Treatment Hepatitis C and B.

Expected outcomes of the study

The following outcomes are expected from the CBQM Study:

Outcome 1

Consolidated report on HIV prevention and care program, legal environment and types of services provided to PWID in Cambodia, Indonesia, Nepal and Vietnam along with country-specific profile and a regional consolidation on HIV prevention and care program, legal environment and types of services provided to PWID in Cambodia, Indonesia, Nepal and Vietnam. The report will include the perceived quality of harm reduction services among service users (PWID).

Outcome 2

A study report each from each study country which will incorporate the policy position, program strategies, legal barriers and implementation of harm reduction services and perceived quality of harm reduction services among service users (PWID) in Cambodia, Indonesia, Nepal, and Vietnam.

CHAPTER 2

LITERATURE REVIEW

Initially, the study was conceptualized to be carried out in two stages. The first stage was a comprehensive situational analysis of HIV epidemic among people who use drugs, the current response in terms of programs, specifically harm reduction services and legal environment relating to drug use in the study countries. A national team each was proposed to conduct these analyses and prepare a national review report, on the basis of which, a community level survey was going to be designed. This plan was subsequently narrowed in scope and a regional desk review limiting to internet review HIV situation, legal environment and coverage of harm reduction services. Some of the proposed activities were shifted to stage two. The following approaches were taken for this desk review:

Online search and review of documents

During this stage, national strategic plans, national drug policy documents, size estimation/projection reports, Integrated bio-behavioral survey reports, Global AIDS monitoring reports, UNGASS country progress reports, national guidelines on harm reduction and in OST etc. from each of the study countries were reviewed.

Similarly, the regional and global reports on HIV and Drug use, international guidelines on Harm Reduction, WHO technical guidance, IBBS, and other CBQM Study guidelines, document on study design, sampling and CBQM Study ethics etc. were also reviewed.

In-country checklists

A checklist of 102 questions was prepared and sent to the country team for more in-depth information on the HIV epidemic, HIV program among drug users and other information. The first segment included the demographic data, estimation of population etc. The second segment of the checklist was the data on HIV prevalence, prevalence of hepatitis c virus infection, and other information behavioral information. The following section is on coverage of harm reduction services in the study countries.

The subsequent sections included a short description of the model used for needle and syringe programming, a note on the quality of services provided, participation of the PWID community in NSP. Model of OST, the model of HIV testing services, access to ART, TB treatment etc.

The last segment of the checklist also included the official position of VNPUD on certain important but ignored issues like provision of treatment of tuberculosis diseases and Hepatitis C virus infection, the involvement of PUD in national programs, and provision of Harm reduction services in prison and detention centers.

HIV epidemic in Vietnam

HIV in Vietnam remains a concentrated epidemic, with high HIV prevalence among FSW, MSM, and PWID, however PWID remain to be the main drivers for the HIV epidemic in Vietnam. PWID reported multiple risks including sharing of needles and syringes, sexual intercourse with FSW and inconsistent condom use. The activity of sharing needles and syringes showed a decreasing trend over time among people who inject drugs in most provinces but the numbers remain at a high level. According to the Integrated Behavioral Surveillance (HSS+2016) issued by the MOH, the incidence of HIV infection was 11.5% among PWID. The HIV epidemic, in the recent times, appears to have significantly decreased or stabilized among PWID in most provinces, despite the high prevalence and geographical diversity of the epidemic.

According to the statistics of the Ministry of Public Security, by the end of 2017, there were 222,582 registered PUD in the country, of which 67.5% were living in the community, 13.5% were in compulsory centers and 19% were in detention facilities, educational institutions and reform schools. ATS use is increasing in all provinces/cities of the country. It is estimated that the rate of ATS use is about 60-70% among PUD. According to an estimate of the VUSTA project - The Global Fund project on AIDS, the country is estimated to have 225,000 PWID.[iii]

Hanoi and Ho Chi Minh City are the two cities with the highest number of PUD in the country. At present, there are 12,800 PUD in Hanoi and 21,712 PUD in Ho Chi Minh City with management records. Therefore, harm reduction activities have been implemented quite thoroughly in these two cities. The number of CBOs involved in harm reduction intervention for PUD was quite high with seven (7) CBOs in HCMC and six (6) CBOs in Hanoi.

The time-lag between the data generated at the community level and it being analyzed, published and reviewed is an excess of 2 years in this region. A set of national review questionnaire was developed to collect peripheral level data. There was an extensive set of questions related to HIV and Drug use program in the region. The questionnaire also included an update on key harm reduction indicators at the country level. The data is presented in separate sections in this report. The following table is the summary is the most updated (and available) key epidemic indicators from the desk review.

Table 1: Key HIV and Drug Use related Indicators, Vietnam

SN	Indicators	Total	Remarks Source/data year
1	Total population	92,695,100 [iv]	2016 Male - 45,705,600 Female - 46,989,500
2	National HIV prevalence among adult population	0.4% [v]	UNAIDS
3	Estimated no of PLHIV	208,371[vi]	2017
4	The proportion of PLHIV who are PWID	9.53% [vii]	2016
5	Estimated number of opioid-dependent people (if available)	NA	Data on a number of registered drug users are available: 222.582 . The number includes people who use other kinds of drugs.
6	Estimated number of opioid-dependent people who inject drugs	NA	On National reports, the only term was used by governmental agencies are “Drug Addicts” – they don’t differentiate people who use drugs and people who inject drugs.
7	The proportion of MSM who reported using drugs (any drug/ indicate injecting users, if available)	7.1% [x]	Data on the number of registered drug users are available: 2768 The number includes people who use other kinds of drugs.
8	Proportion of sex workers who reported using drugs (any drug/ indicate injecting users, if available)	NA	
9	The proportion of transgender persons who reported using drugs (any drug/ indicate injecting users, if available)	NA	
10	HIV prevalence among PWID	9.53%[3]	
11	HIV prevalence among PUD	NA	
12	HCV prevalence among PWID	60%[x]	2013 IBBS sampled from 9 provinces (Dien Bien, Yen Bai, Quang Ninh, Ha Noi, Hai Phong, Nghe An, Can Tho, An Giang and HCMC)
13	HCV prevalence among PUD	NA	No reports
14	Proportion of PWID who have been tested for HIV	75%[xi]	
15	Total PWID who know their HIV status and are on ART	NA	
16	Choice of drugs		85% inject opiates (Ministry of Public Security). Increasing use of ATS, generally not injected, ATS use has been linked to high-risk sex while ‘high’ potential for HIV infection. It has been reported that the use of ATS has yearly increased since 2003 in several areas bordering Cambodia having exceeded heroin use. [xii]

Policy environment and legal provisions in Vietnam

The HIV epidemic from its start has been concentrated among PWID in Vietnam. The National Strategy on HIV/AIDS Prevention and Control till 2020 with a vision to 2030, the 2012-2015 National Target Programme on HIV/AIDS Prevention and Control, and a comprehensive set of implementing decrees and technical guidelines have been established. Under the directives of the National Committee and with the support of the international community, VAAC guides Provincial AIDS Centres and works with related sectors and organizations to coordinate and implement the national HIV programme from central to local level.

There has been a significant decline in HIV prevalence among PWID thanks to targeted harm-reduction interventions. By the end of 2013, the percentage of PWID among those who reported using sterile injecting equipment during the last time they injected was 97.3%. In addition, the methadone maintenance therapy (MMT) programme had been expanded to 92 sites in 32 provinces serving 18,000 PWID.

The National Strategy on HIV/AIDS Prevention and Control in Vietnam with a Vision sets the objective to reduce 50% transmission amongst PWID by 2020 using policy reform, harm reduction, and community mobilization as the key strategies. Vietnam's Strategy on Preventing, Combating and Controlling Drug Abuse acknowledges the importance of drug treatment and harm reduction.

Legal provisions that are relevant to the use of drugs

Vietnam instituted the 2006 HIV/AIDS Law which includes comprehensive harm reduction measures, but these are unevenly accepted and inadequately implemented. The 2006 HIV/AIDS Law describes 'harm reduction intervention measures' as including education, mobilization, the encouragement of the use of condoms and clean needles and syringes, substitution therapy and other harm reduction in order to facilitate safe behaviors to prevent HIV transmission (Article 2.15). The Law was passed by the National Assembly of Vietnam, the highest level of government. The following year, Decree 108 [7], which provides details for the implementation of the 2006 HIV/AIDS Law, was passed 'at the proposal of the Minister for Health'; Article 22 states that the Minister for Health is responsible for implementing the Decree.

There is a legal requirement for police not to impede the work of registered NSP outreach workers. The 2007 HIV/AIDS Decree makes it legal to establish NSP with the involvement of ORW/PE and formalizes the role of outreach workers through a card system and requires the Ministry of Health and Ministry of Public Security to liaise in relation to their work. If these workers carry an official card, police will not arrest them.

Drug Rehabilitation Renovation Plan developed by the MOLISA recognizes drug addiction as a chronic condition and resolves to replace the compulsory systems by a voluntary, community and residential-based and evidence-based drug treatment system, reducing the proportion of drug users sent to compulsory centers from 80% in 2013 to 6% in 2020.

The current 'Law on Handling Administrative Violations' regulates only "people addicted to drugs," which means people can only be fined or applied other sanctioned when an authority (doctors) determines that they are drug dependent. However, the MOLISA is currently discussing whether people who are caught using should be sanctioned as this would be easier for the law enforcement to implement. The amendment of this law is under progress and will be voted to approve in the next National Assembly meeting in October, 2020. The revision of the Drug Control Law is due in 2021. There is a dialogue of putting an article on addiction treatment and addiction prevention in the law.

The National Strategy for HIV/AIDS Prevention and Control, 2010-2020, includes the activity: "Pilot the harm reduction intervention programs (condoms, OST) in prisons". There is no legal or policy framework for the provision of NSP in prison. A pilot OST programme exists in one prison (UNODC, 2016). Condoms are available for family conjugal visits ('happy rooms') in some prisons.

Access to HIV services in prisons is supported by Decree 96/2007/QD-Tag of the Prime Minister, which includes a requirement for provision of HIV treatment to prisoners. Article 4 states that 'HIV-infected persons shall be given access to ART through their

family, organizations, individuals, programs or projects approved by competent agencies. The National HIV/AIDS Strategy, 2010-2020, includes the objective of "Increasing HIV testing and counseling promoting HIV/AIDS treatment for patients in detention camps and prisons".

Access to TB services in prisons is supported by the Ministry of Health, Guideline on TB control in Prisons and Correctional Institutions 2007. The National TB Programme has established TB units in all prisons.

Diversion

Drug use is an administrative offense under the Law on Handling Administrative Violations 2012, article 96.

The 2012 Law on Handling Administrative Violations puts in place a court process that ultimately decides who will be sent to compulsory treatment centers (unlike before where drug users can be sent to compulsory centers just with procession or history of drug use). New procedures established by this law requiring district court judicial order commenced 2014. Administrative penalties include detention for up to 2 years. Implementing this law, however, is problematic; no clear guidelines are given, and the court and judges are often "lost" as to what to do with a case. For a first drug use offense, an order for the measure of education in ward, commune, district town is made. However, the offender must be closely supervised. For further offenses, compulsory administrative detention is applicable.

Possession of drugs over threshold quantities is a criminal offense punishable with imprisonment or death e.g. Opium resin, marijuana resin weighing five kilograms or more; heroin or cocaine weighing one hundred grams or more; Marijuana leaves, flower or coca leaves weighing seventy-five kilograms or more; other narcotic substances in solid form weighing three hundred grams or more or in liquid form measuring seven hundred and fifty milliliters or more: Penal Code 1999, Article 194 (to be replaced in 2017 by Penal Code 2015 Law No 100/2015/QH13), Law on Combating Drugs 2000. Law on Combating drugs 2000, Article 13 gives police the power to order medical examinations and requires people to comply with directions.

Law on Combating Drugs 2000 provides Article 26. Families of drug users have the responsibility to report their use to the local administrations. Article 26.1. Drug users have the responsibility to Declare by themselves the state of their drug use to the agencies or organizations where they have worked or the administrations of the localities where they have resided and register by themselves for forms of detoxification.

Review of Harm Reduction services in Vietnam

A Comprehensive Package of interventions for the prevention, treatment and care of HIV among PWID has been endorsed by WHO, UNAIDS, UNODC, the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, the Global Fund and PEPFAR[xiii]. The 2012 revision of the WHO, UNODC, and UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for PWID, recommends that countries make available a comprehensive package of services for this population. The package includes:

1. Needle and syringe programmes (NSPs) including management of abscess and overdose management
2. Opioid substitution therapy (OST) and other evidence-based drug dependence

treatment
3. HIV testing and counseling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for PWID and their sexual partners
7. Targeted information, education, and communication (IEC) for PWID and their sexual partners
8. Prevention, vaccination, diagnosis, and treatment for viral hepatitis
9. Prevention, diagnosis, and treatment of tuberculosis (TB).

Based on global evidence, the first four interventions are particularly effective in preventing new HIV infections among PWID. However, while coverage of life-saving HIV prevention services, such as NSP and OST has been increasing, the pace of scale-up in most countries currently remains slow, resulting in a failure to reach the optimal levels of coverage to have a population-level impact.

Current status of the implementation of the comprehensive package is discussed in the following sections:

Provision of Needles and Syringes

In 2017, 27 million needles and syringes were distributed to 126,000 PWID in 53 provinces and 21 million condoms reached 58,000 injecting drug users in 50 provinces in Vietnam[xiv]. Harm reduction interventions implemented by the Global Fund since 2011 has significantly contributed to reducing HIV prevalence PWID. The HSS+ 2016 showed that the use of shared needles and syringes on the past month was only 11.4%, but the percentage of PWID who do not use condoms regularly when having sex with FSWs was very high at 44.9%[xv].

The following table includes country level data collected.

Table 2: Key indicators for needle syringe programming in the Vietnam

Indicators	Vietnam
Percentage of people who inject drugs reporting using sterile injecting equipment the last time they injected	95.6
Number of syringes distributed per person who injects drugs per year by needle and syringe program	62
Program coverage of NSP at the national level	NA
The proportion of PWID who reported meeting an ORW/PE from NSP in the past month	NA
The proportion of drug users reported purchasing syringes from pharmacies	NA
Instances of overdose reported deaths/naloxone treatment provided	NA

Provision of opioid substitution therapy (OST)

Methadone program in Vietnam was piloted in 2008 in Hai Phong and Ho Chi Minh city and then have expanded in other cities and provinces. The number of patients increased from 1,735 of 6 treatment centers in 2009 to 53,627 in 310 treatment centers in 63 provinces by December 2017. The Government of Vietnam in 2017, introduced a new information management software that enabled people who need treatment to have more flexible access to a methadone treatment program. However, many PWID is unable to access the services as the service centers have filled their new patient quota forcing patients to go the health facilities further in their location. Patients have presented themselves to receive the service every day resulting in a limited choice of livelihoods and other practical problems.

Table 3: Key indicators for OST Program in Vietnam

Indicators	Vietnam
Percentage of people who inject drugs receiving opioid substitution therapy	54.39%
Percentage of Individuals receiving maintenance OST continuously for at least 6 months	NA

Uptake of HIV testing and counseling (HTC)

Increasing uptake of HIV testing and counseling is a cornerstone of HIV prevention program among PWID. Low uptake to HIV testing has been a consistent challenge. The HIV testing uptake rate has been low in Vietnam (39%) with a larger population of PWID.

Table 4: Uptake of HIV testing and counseling (HTC) in Vietnam

Indicators	Vietnam
Percentage of PWID who tested for HIV in the past 12 months, or who know their current HIV status	30.3%
Percentage of PWID ever tested for HIV	24%

Provision of Anti-retroviral therapy(ART)

The general progress in the country for scaling up access to treatment for all in need is indicative however, the proportion of PWID amongst PLHIV currently on treatment is generally low. There is lack of adequate information on the current uptake of ART among PWID.

Table 5: Provision of Anti-retroviral therapy (ART) in Vietnam

Indicators	Vietnam
Antiretroviral therapy coverage among PWID living with HIV	47%
Percentage of PWID living with HIV is known to be on antiretroviral therapy 12 months after starting the treatment	NA
Percentage of PWID who report experiences of HIV-related discrimination in a healthcare setting	NA

IEC and provision of condoms

As part of the National strategy, consistent and correct usage of condoms is promoted. Condoms are distributed to PWID via outreach workers model. Outreach activities include condom promotion through prevention education and condom demonstration.

IEC strategies and materials used have remained the same over the decade. They are not specific needs of subgroups e.g. women who use drugs, female partners of PWID, Prison populations and young drug users with a specific focus on GBV and SRHR services. Messaging and mediums often directly or indirectly contribute to the increases stigma of PUD through the negative portrayal of drugs and drug use. Drug use info (multiple substances, drug interactions), HBV, HCV, TB, ATS use, legal aid, young people and drug use, women who use drugs etc is missing from the current IEC strategies.

Table 6: Access to Information, Condom and STI screening in Vietnam

Indicators	Vietnam
Number of people who inject drugs reached with individual and/or small group–level HIV prevention interventions designed for the target population and number of needles or syringes distributed to people who inject drugs	NA
Percentage of people who inject drugs reporting using a condom the last time they had sexual intercourse	59%
The percent of PWID who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	44.9%

PWID screened or treated for STIs services targeting PWID	NA

Prevention and treatment of HCV

It is estimated that up to 87 million people are currently living with HCV in this region and that it is responsible for more than 50% of all HCV-related mortality worldwide . In recent years, with the availability of more effective medicines, diagnoses and treatment of Hepatitis C specifically among people who are also living with HIV has received more attention. There is an effort to ensure that all prioritized high risk and vulnerable populations including PWID are covered with free diagnostics and treatment with DAAs.

Table 7: Key HCV, HBV indicators from Vietnam

Indicators	Vietnam
Proportion of PWID who are screened for HCV	NA
The proportion of PWID who are screened for HBV	NA
The proportion of people coinfected with HIV and HCV starting HCV treatment	NA

Prevention and treatment of TB

Due to social, environmental and biological factors PWID are at an increased risk of developing TB diseases. There is an overlap between countries where the HIV epidemic is mainly driven by injecting drug use and countries with some of the highest rates of multidrug-resistant tuberculosis Currently, PWID receive basic information on TB and accompanied to government TB facilities for screening. Screening and treatment for TB through Government hospitals offer free but there is no program that specifically addresses the increased risk of TB among PWID in Vietnam.

CHAPTER 3

METHODOLOGY

The CBQM study in Vietnam employed mixed methods. The quantitative arm was achieved through the community-based survey. The quantitative arm included FGD, KII, and FO at selected sites and respondents. The entire methodology was to review the efficacy of PWID interventions and assess the quality aspect of harm reduction program at the country level. Besides that, Literature review is also used as a separated source of information for the qualitative report.

Facility Observation

Selection of facilities came by recommendations from VNPUD taking into consideration the two (2) methadone centers that has the largest number of patients. Two biggest CBOs were also selected who were providing harm reduction services namely NSP, condoms, IEC, referral packages for the community in selected areas in Hanoi and HCMC.

Focus Group Discussion

FGDs were conducted to collect information on the quality of two main service components: NSP and OST. The total number of FGDs was discussed and agreed among the country team. Sic (06) FGDs were organized, in which 04 discussions were about methadone programs and 02 discussions were about NSP. All the discussions were evenly divided between the two cities Hanoi and Ho Chi Minh.

The selection criteria for FGD participants

1) is currently a PWID/using methadone; 2) above 18 years old, 3) have been using the

harm reduction services (free needles and syringes from CBO or attending methadone treatment) for the past 12 months.

All the six (06) focus group discussions were in café's where the PUD community generally congregate. All standards as per the CBQM Study protocol for conducting FGD was followed viz location selection, privacy, confidentiality, and comfort for PUD. All the participants were comfortable and confident to share their opinions. Guided questions were used during the FGDs.

Key Informant Interviews

KII participants were selected based on the service provider groups, with geographical considerations to ensure representation from the two CBQM Study sites. The selection of KII participants was discussed and agreed after consulting with the VNPUD Coordinating Committee. More specifically, respondents included 13 persons from the following organizations:

- Coordinating managers of VUSTA Project and Global Fund Project of VAAC
- 02 NGO representatives, which are SR from Global Fund-VUSTA project: one is Life Center in Ho Chi Minh City and one is ISDS Center in Hanoi.
- Leader of Provincial AIDS Control (PAC) Ho Chi Minh City
- Representatives from two Methadone centers in Hanoi and Ho Chi Minh City
- Representatives from PUD CBOs in Hanoi and Ho Chi Minh City

All key informant participants were contacted through emails and official documents to ensure their participation to the study and the appropriate interviewing time. The location of the interviews was mostly in KII's work space or offices based on their suggestions. The representatives from two NGOs were interviewed in quiet café's.

Semi-structured interview questionnaire was administered to collect qualitative information and details about the harm reduction services. For both FGDs and KIIs, the CBQM Study team used the data analysis method including the following steps: 1) analyzing documents to determine the main topic and sub-topics; 2) Data encrypt; 3) search for typical information; 4) Analysis and explanation from each information group.

Community Based Survey

The sample size for community survey was calculated based on the proportion of history of utilization of HIV testing for the recruitment through a snowball method. The study recruited 325 respondents based on the eligibility criteria. There were 205 interviewees in HCMV and 120 in Hanoi.

Sample size was determined using proportionate sampling method with error allowance of 0.05% and a target of 220.000 PWID for Vietnam. The sample size was then distributed based on geographical caseload estimated by National AIDS Program. Thereafter, a snow-ball sampling technique was used to enroll study respondents with seeds recommending their peers to the study. Since the purpose of the study is to evaluate the quality of services provided for PWUD, the criteria is quite clear to recruit the service users. In order to have a full representation of the community population, we set out the proportion of Methadone patients (30%), MSM-TG (10%), Female Sex Workers (10%), Female IDU (10%) and remaining is Male PWID. The categories can be overlapping. The data collectors chose the seeds from each sub-group to make sure to reach the study target. The data collectors were also assigned with different areas in the two cities (each data collectors were in charge of one or two locations) to reduce the risk that they recruit the same participant. Data collection was carried out between 13th May 2019 and 30th July 2019.

A structured questionnaire was used to collect data. There were 09 sections and an interview in an average took 60 minutes to complete. A total of 07 data collectors were recruited and trained for field data collection.

Ethical clearance for CBQM Study was received on 19th November 2018 from the ISDS.

Before each KII, the respondents were provided with complete information on the study and the purpose of the interview. All KII with consent of participants were audio recorded in accordance with the standard procedure employed for the KII. All the recorded audios were transcribed.

Before each FGDs or questionnaire interview, participants were provided with standard information about the study, the purpose of the study and the content of group discussion. Six (06) group discussions were audio recorded with 100% consent from participants.

CHAPTER 4

RESULTS (QUALITATIVE)

Findings from KIIs

The following section of the report summarizes the key findings from selected officials from the government department and CBOs. The aim of KII was to gather perspective of key officials on the national harm reduction program in Vietnam.

> In general, they (PUD Community) don't really care about the communication documents... you making them hold a piece of paper to read is difficult."

KII, CBO leader, HCMC

> Coordination between the group and local authority is really smooth. The group operates at the district level then surely half the district knows the name "Cat trang". There are some seminars where the group was invited, we shared our opinions in front of the whole district"

KII, CBO Hanoi

> They asked me to be a representative to voice my opinions for the community, but having participated in so many meetings, I still can't voice my opinions... they pick someone who can speak and how much can you speak."

KII, CBO Team Leader, HCMC

> To those sisters who work in that field, we need to dig deep, tell them clearly about safe sex. In the project, we have a team who specializes in providing safer sexual techniques, in order to guide them on techniques to achieve sexual pleasure but still be safe."

KII, CBO in Hanoi – 1/2019

> Why it is difficult? Firstly, it is difficult to manage because it is an addictive drug. We are proposing to change into a pill like other developed countries. But we don't use tablet form in the treatment immediately. The main treatment is still syrup, the pill is only given to pilot. For example, you use the syrup as usual, but when you go somewhere with your family, the facility provides you the pills to make it convenient for you."

KII – PAC, HCMC

> There are too many words they (community) won't read. If they don't understand anything they will ask. Direct consultation is easier, communication is nothing new, mostly still old documents from projects, the information is changing a lot."

KII, CBO Representative, Hanoi

> The center also wanted to improve the clinic's quality so we do the examination right away, even if there are only 2-3 people, we would start the dosage immediately."

KII, MMT center, HCMC

> During the preparation of the concept note for harm reduction program, drug users actively participated, contributing very well to the content of the project. During the project development, a technical draft was sent to the community groups/CBOs/ Networks to contribute."

KII – Leader, VUSTA project

> From my point of view, if patient can take methadone home, I will be more leisurely and it helps to reduce my work load but I have to think about whether the patient drink or not?... They don't drink fully their dosage and then blame me... it should be in the form of tablet"

KII – MMT facility, HCMC

> We focus on treatment so that patients do not die, such as patients in prison, patients without insurance cards because they cannot access ART drugs, if they do not have drugs and they will die. Because Vietnam has increased 10,000 patients each year, we prioritize to maintain treatment so that they do not die. It seems that many KPs have been able to equip themselves, according to my opinion. They understand the important of using clean needle and syringe, so they bought needle and syringe. So we do not need to spend a lot of money to invest on that. In terms of Methadone, the Government has already supported provision"

KII – Representative, VAAC

> Currently, Methadone is paid by Vietnam government, we just worry about needle-syringe and condom. We cannot subsidize forever; we need to move strategically. At the long-term, we need to encourage them to buy themselves. The Global Fund may decide no more distribution of needle-syringe and condom"

KII- representative, VUSTA

> when they (clients) enter the treatment program, they sometimes forgot the medicine, so you have to set the alarm for them and call to remind them" ... "Yes, we support the clients on re-examination and treatment adherence" "if they call for support, we need to pick up the phone or call them back if we are busy."

KII - CBO head, Hanoi

> I have a pressure with the target of 3% positive, very pressure, especially with those who drop-out of treatment"

KII - CBO head, Hanoi

Some more statements from KII respondents

- CBOs always try to provide comprehensive services to PWID community, therefore they have many activities and great initiatives to implement the strategy to encourage safe sex behaviors for their clients. This is present in the technical guidelines by VUSTA project.
- After receiving needle and syringes from local medical centers, CBOs distribute to clients based on needs, distributed mostly through ORW/PE.
- The needle & syringe supply source is quite stable and there has never been a stock out.
- There are various mechanisms to receive client's feedbacks on NSP, it is done through direct outreach occasions, group communication or clients can call or contact with outreach workers to give feedbacks on supplies.

- All CBOs apply a general outreach strategy for all clients, they do not have specific strategies for different groups.
- Transportation is a great barrier in approaching services for clients because the majority of clients are living in poverty. Therefore, outreach workers often have to go with or give clients a ride when they refer clients to other services.
- Field workers, beside team leaders and community leads, should be trained on overdose because they are the ones who are often present at hot spots.
- The time of travel, transportation between clients' house to the treatment center is not a big barrier to clients to go to the centers for daily dose.
- Methadone supply source for centers is sufficient, none of the centers had shortage or slow supply situations.
- The majority of staff at methadone centers participated in technical training courses and were instructed on how to work with PWID.
- MMT centers do not have a particular feedback mechanism. If patients have any opinions, they can directly comment or meet with the centers' leader to discuss.
- All of them expressed their concern about the use of meth-amphetamines (ATS) among drug users while VAAC and VUSTA project do not have any intervention for this group. However, VAAC is in the process developing guidelines on ATS use.

Findings from FGDs

The following section of the report summarizes the key findings from FGDs conducted with PWID who were end users of NSP and OST. The aim of FGD was to gather perspective of end users on the quality of the harm reduction services for PWID namely the specific NSP and OST components.

> The outreach workers are "very friendly and do not discriminate", "all my information is kept confidential", "I feel very safe while talking with ORW/PE"

FGD response on NSP, HCMC

> They (ORW/PE) understand us. It's easier to talk to them"

FGD response on NSP, Hanoi

> Years ago, when there was no needle distributing, there was a lot of needle sharing. Since this program, it decreased transmitting of HIV by a lot."

FGD response on NSP, HCMC

> Once I saw a garbage truck pass by and I dumped all of them away because their heads were too brittle, they broke so I had to throw all away. After giving feedback to 'Life', they came down with the producers ... bringing out 02 to compare. There were 17 groups and some reached a common opinion that they couldn't use them... It is already difficult to buy the stuff, but then when you put it in you lose it. After that, the producers changed, changed into the later needle batch. Even though they're not the red-headed ones of the pharmacies but they're still better than the firsts."

FGD response on the quality of NSP, HCMC

> This VIP is not as good as the NUMBER 1 (the yellowy one), the other has more lubricant than the VIP and it is harder to rip. However, in general, this one's quality is still pretty stable."

FGD response on condoms, Hanoi

> They usually come during the beginning phase, maybe about the first 3 months. Every one or two weeks, they would ask: How's the drug? Do you feel better? Do you think you spend less money now..."

FGD response on MMT, Hanoi

> I work at an office where they ask me to come at 7 am but the centers are open only at 7:30 am for meds so it's really inconvenient"

FGD response on MMT, Hanoi

> If I work in the morning then I need to be at the office at 7 am, but the centers close at 11 am, we only go on lunch break at 11:30 am or 12 pm. So, I have to quit the whole morning."

FGD response on MMT, Hanoi

> All the people around know about us; it's like that one place for that one group of people, just one look and you know it's the addict."

FGD response on MMT, HCMC

> Actually, I have been taking methadone for more than a year. I find this methadone program really good. I could decrease my drug use and now, I don't use drugs anymore. For the first few months of taking methadone I still used drugs, but now I don't use anymore and I find my thoughts much clearer. I don't have to worry everyday about getting money to for drugs"

FGD response on MMT, Hanoi

> I'll tell you this but us addicts are all patients with no health to work like others. There are people with health to work but it's 50-50. 50% have jobs but only the healthy ones have jobs but like us who aren't healthy, the jobs aren't suitable to us too, when the time comes, we have to struggle for the fees"

FGD response on MMT, HCMC

> I'm taking MMT at 09 Hospital, they are open until 10:30 am but whenever I'm late for even a little bit, I have to beg them. It's difficult if you come at 11 am, they are closed for sure even if the employees are still there."

FGD response on MMT, Hanoi

> Meds time is from 1:30 pm to 4 pm, so impossible for factory workers to take those. It's really difficult if you're working because recently, they changed methadone time to 7 am, but there is no one and they still start working at 7:30 am."

FGD response on MMT, HCMC

Some more statements from FGD respondents

- Needle & syringes and condoms are distributed based on our needs and our meeting with outreach workers.
- It is not compulsory for us to return used needles and syringes in exchange for new ones.
- Distilled water is also distributed along with needles & syringes, but is not used by many of us.
- Sometimes the police stops to search us. We may get into trouble if syringes are found on us.
- Some of us still buy syringes in pharmacies because the number of free syringes does not meet our needs.
- Referral services are good especially the fast HIV testing service by outreach workers.
- The procedure to get MMT is very simple and convenient but difficult to those without identification papers it is compulsory to have a supporter from family or friends.
- The first barrier is difficulty in travelling. The second barrier is difficulty in finding a stable job
- The location of the MMT centers is quite convenient, but not really private to PWID.

CHAPTER 5

RESULTS (QUANTITATIVE)

Place of enrollment

The field data collectors were responsible for data collection. These data collector were members of VNPUD. The place of enrollment for conducting interviews were mostly in the community that includes: park, coffee shop, tea shop etc. All of these places were in close proximity to the OST and NSP sites, hot spots and health service centers.

Table 8 – Place of enrollment

Variable	Total number	%
Community	119	36.7%
Hospital	0	0
Health Services Center	204	63%
Self-help group	1	0.3%
Others	0	0

Socio demographics

The study sample of 325, ranging in the age groups of 18-59 years (Table 9 below). The mean age of study respondents is 35.21 years. Most of participants were between the age group of 25-44 years (88.2%) and the remaining were between the age group of 18-24 years (3.8%). A recent research in Vietnam reveals that it is difficult in reaching out to PWID in the age group of 18-24 years. Another possible reason is that people of this age group prefer ATS over injectable drugs. 75% participants were males, 22.1% females and 2.8% were transgender. 56.7% of the study respondents were single,

divorced or separated. Only 30.2% were married and currently living with their spouse/ partner. Majority of the study respondents 50.5% completed secondary education, only 24.6% graduated from high school, 20% just finished primary education and 3% of them were illiterate. A total of 97.3% participants were from large towns or cities. 90.1% of participants identified themselves to be heterosexual, 8.3% gay and 2.5% as bisexual. 11.7% of participants claimed to have exchanged or sell sex for money or drugs.

Table 9 – Socio-demographics of study sample

Variable	Total number	%
Age (n=325)		
18-24	10	3.8%
25-34	148	45.2%
35-44	139	42.7%
45 and above	28	8.6%
Gender		
Male	244	75.1%
Female	72	22.1%
Transgender	9	2.8%
Marital status		
Married or cohabitating and husband/wife/ partner is currently living in a household	98	30.2%
Married or cohabitating but husband/wife/ partner is temporarily living/ working away from the household.	15	4.6%
In a relationship but not living together	19	5.9%
Single	126	38.8%
Divorced/separated	58	17.9%
Widow/widower	8	2.5%
Education		
Illiterate	3	0.9%
Primary completed	65	20%
Secondary completed	164	50.5%
Higher secondary completed	80	24.6%
College level or higher	12	3.7%
Geographical location		
A rural area	0	
A small town or village	9	2.7%
A large town or city	315	97.3%
Self-identified sexual identity		
Gay/homosexual/lesbian	27	8.3%
Bisexual	8	2.5%
Straight/Heterosexual	293	90.1%
Ever exchanged or sell sex for money/drugs	38	11.7%

Income and household size

Most of participants have a steady source of income: 77.2% were self-employed (n=194) and 14.8% worked for others. Approximately 24.7% participants were unemployed. Average income of the respondent group was 267 USD/month (equivalent to 6,157,000 VND).

Household size of the study participants averaged 4 people, including one child under 14 years and one youngster between 15-24 years. Average income of each household is approximately 652 USD/month (equivalent to 15,000,000 VND).

Table 10 – Income and household size

Variable	Total number	%
Have means to earn money/income (n=325)	251	77.2%
Present Job		
Office employee		
Self-employed	194	59.9%
Employed, salaried, work for others	48	14.8%
Unemployed	50	24.7%
Others	9	2.8%
Household size		
Total	4	
Children (0 – 14 yrs)	1	
Youth (15 – 24 yrs)	1	
Average monthly household income	652 USD	

History of utilization of NSP

A high proportion (87.3%) of study participants regularly used NSP services. NSP service centers in Vietnam are mainly implemented by CBOs that makes it easier to reach out to PWID in the communities. 99% participants answered that they had ever met ORW/PE and 88.2% among them met ORW/PE in the past 4 weeks either in the community or at the NSP service center.

Among the clients who came to NSP, 199 persons (63.6%) shared that ORW/PE have talked about safer injecting and HIV during the last meeting (in the last 30 days).

Services utilized by PWID were: NSP (97.7%), HIV testing (93.3%), education on safer injecting practices (87.9%), free condom provision (84.4%) and education about client's partner on HIV prevention (70,5%).

Services that has not been utilized by participants are: TB diagnosis and treatment (51 participants), STI diagnosis and treatment (64 participants). The reason for not availing these services is mainly because it is provided in health facilities. The ORW/PE provided information and referred PWID to health facilities for diagnosis and treatment of TB and STI.

Table 11 – History of utilization of NSP

Variable	Total number	%
Used the services of NSP (n=325)	275	87.3%
Used the services of a NSP site/drop-in center in the last four (4) weeks (n=315)	275	87.3%
Ever met an ORW/PE from an NSP service center (n=313)	312	99%
Ever met an ORW/PE from the NSP service center in the last 4 weeks (n=313)	276	88.2%
Duration that the ORW/PE talked about safe injecting and HIV (n=313)		
In the last 30 days	199	63.6%
In the last 3 months	90	28.8%
In the past year	17	5.4%
Longer than a year ago	4	1.3%

Variable	Total number	%
Utilization of NSP services		
Needle and Syringe exchange	308	97.7%
Condoms	266	84.4%
Opioid substitution therapy	112	34.5%
Abscess management	66	21%
Education on safer injecting practices	277	87.9%
Education about your sexual partner on HIV prevention	222	70.5%
Education on overdose prevention	232	73.7%
HIV testing	294	93.3%
STI diagnosis and treatment	64	20.3%
ART services	81	25.7%
Tuberculosis diagnosis and treatment	51	16.2%
Diagnosis and treatment of Hepatitis C Virus infection	133	42.2%
Others	0	

Access and appropriateness of NSP services

The study respondents were comfortable and confident to take the initiative to visit CBO sites or meet with ORW/PE in the field to avail commodities. If PWID clients were not able to reach out to ORW/PE, then they would actively follow-up. The FGD results showed that the frequency of outreach meeting between clients and ORW/PE was quite frequent, most of them would meet ORW/PE several times a month, some PWID met ORW/PE every day or even 2-3 times per week.

Most of the study respondents (n=314) thought that the opening and closing time of NSP sites were appropriate for them. 39.5% participants reported that they received needle/ syringe directly from the ORW/PE. Only a few respondents reported that the opening and closing hours were not suitable for them. When asked "what is your preferred opening and closing hours for NSP sites?", only 14 participants responded. Accordingly, 7 respondents wanted the NSP site to open between 7am-9:30 am and the remaining preferred 10-11am. Expected closing time was 23.00-23.30hrs (11 respondents).

Table 12 – Access and appropriateness of NSP services

Variable	Total number	%
Appropriateness of the opening hours (n=314)	151	48%
Preferred opening and closing hours (n=14)		
From 7.00-9.30 AM	7	50%
From 10.00-11.00 AM	7	50%
To 20.00-21.00 PM	2	14.3%
To 23.00 PM-23.30PM	11	78.5%
Sufficiency of syringes (n=314)	202	64.1%
Sufficient- No of Syringes received /week	202	64.1%
Insufficient- - No of Syringes received/week	76	23.9%
Neither easy, nor difficult	36	11.5%
Reasons for dissatisfaction (n=21)		
The size of syringe is smaller (than I need)	2	9.5%
The size of syringe is bigger	1	4.8%
The size of needle is smaller	4	19%
The size of needle is bigger (than I need)	3	14.3%

Variable	Total number	%
Because it is not reusable	17	81%
Other Low-dead space syringes (LDSS)	9	42.9%
Refused clean syringes due to shortage (n=315)	38	12.1%
Ease of going to NSP site (n=309)		
Yes, it is quite easy	208	67.3%
No, it is quite cumbersome	35	11.3%
No, I don't go to a NSP site	56	16.1%
Ease of returning the used syringes (n=314)		
Yes, it is quite easy	49	15.6%
No, it is quite cumbersome	42	13.4%
No, No, I don't have to return the used needle/syringes	213	67.8%
Average money spent in buying syringe from pharmacy		
Per Day	9,000 VND (0.4 USD)	
Per Week	38,000 (1.7 USD)	
Average time taken to go to a NSP site (per visit)	13 minutes	
Average cost to go to NSP site (per visit)	10,000 VND (0.5 USD)	
Average waiting time to meet an outreach worker	10 minutes	

Table 12 shows that, 64.1% respondents received sufficient number of clean needles and syringes that as per their need with an average of about 15 needle/syringe per week. 23.9% (n=76) claimed that they were not satisfied with the number of clean needles and syringes they were receiving and expected to receive 25 per week. When asked about the reasons on their dissatisfaction on the quality of needles and syringes, only 21 participants responded. A total of 17 respondents (81%) gave a strong reason that the given needles/syringes are not reusable and 42.9% low-dead space syringes. 24.8% of participants reported that they had not received clean needles/syringes because of a shortage.

For those who availed needles/syringes from distribution sites (243), 208 respondents (85.6%) responded that they could easily go to these service outlets. As participants were not required to return used needles/syringes, only 91/314 participants were returning after use. 49 respondents said they could easily return it and 42 respondents said it was very difficult for them.

The cost for travelling from home to NSP sites/CBOs is not considered a barrier because most of respondents shared that it doesn't cost them anything to travel. Even the ones who have to pay for travelling cost, the amount is minimal: USD 0.5. If participants have to buy needles/syringes at a pharmacy, it would cost about USD 0.4/day and USD 1.7/ week. The average time taken for clients to go to the NSP site was about 13 minutes with an average cost of USD 0.5. They would have to wait for about 10 minutes to meet ORW/ PE.

Perceived Quality of the NSP services

In NSP sites, condoms were always available when needed. 90.8% of participants said they could get condoms from the ORW/PE when needed. 97.5% shared that they were provided with information on HIV testing and 80.3% said that they were provided information on HBV and HCV from ORW/PE. 291/325 participants said that they learned something new from the outreach workers at NSP sites. When going to the NSP sites,

many participants were afraid of being arrested by the police (61%).

A total of 69.5% study participants felt being treated with respect. Only 125 (39.7%) respondents felt that they were able to openly speak up with the staffs at the NSP site.

Table 13 – Perceived Quality of the NSP services

Variable	Total number	%
Availability of condoms when needed	286	90.8%
Offered information on HIV testing	307	97.5%
offered information on Hepatitis B & C	253	80.3%
Learned anything new from the ORW/PE	291	92.4%
Scared of police arrest while traveling to NSP site	192	61%
Feel that the health workers/staff at the NSP site treat you with respect and dignity	219	69.5%
Able to speak up to the health worker/staff of the NSP site	125	39.7%

Chart 1 – How difficult is it in getting clean needles and syringes?

Most participants shared that it was easy for them to get clean needles and syringes when needed. Only a very few participants: 8 respondents (2.6%) said that it was difficult for them. We have tried to correlate this variable with other variables such as educational level, age and current job but could not detect any association.

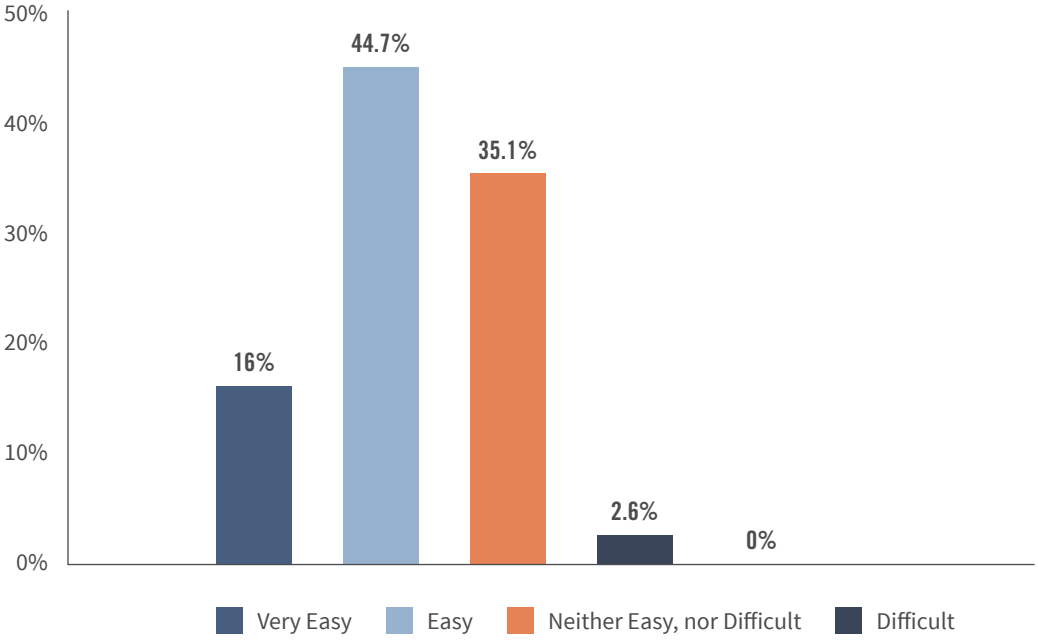


Chart 2 - Satisfaction with the information provided on safer drug use and safer sex

Most of participants said that they were very satisfied / satisfied with the level of information on safe drug use and safer sex provided to them. The below (chart 3) shows the correlation between education and the level of satisfaction by the study respondents.

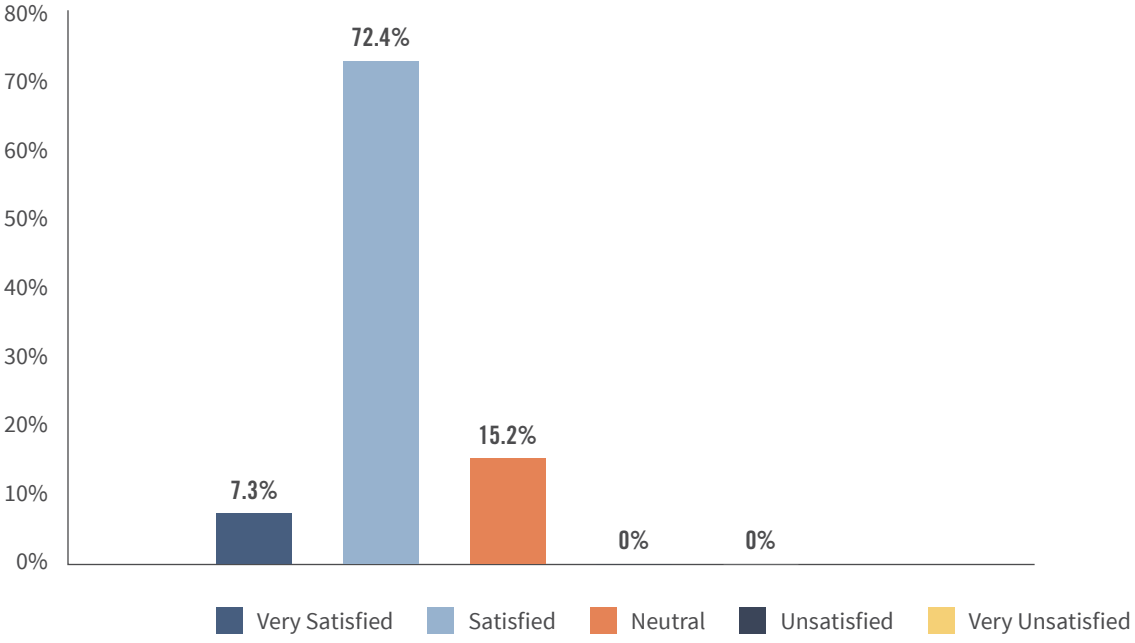
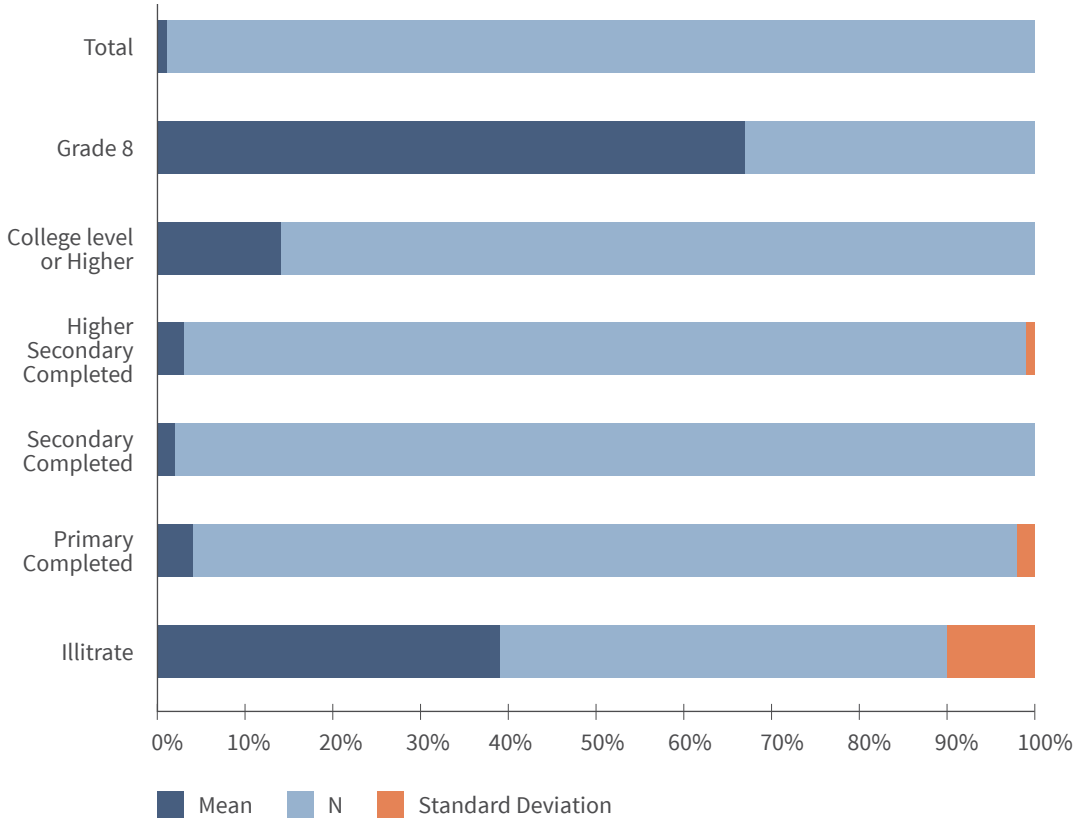


Chart 3 – Satisfaction with provided information on safe drug use, safe sex and education



When rating of the quality of NSP services, in the below chart 4, it can be seen that most of the answers were very good and good. Nobody chose the answer “very poor”. It is only 1 respondent who said that the NSP service was poor.

Chart 4 – Rating the quality of NSP services

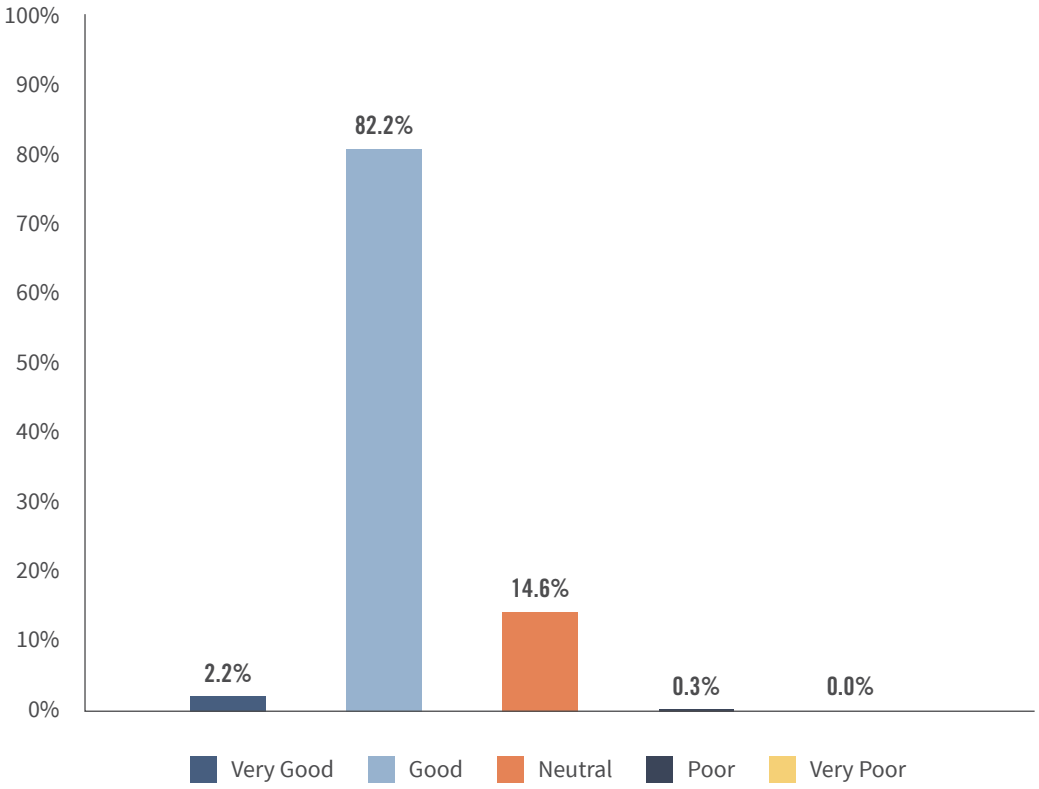
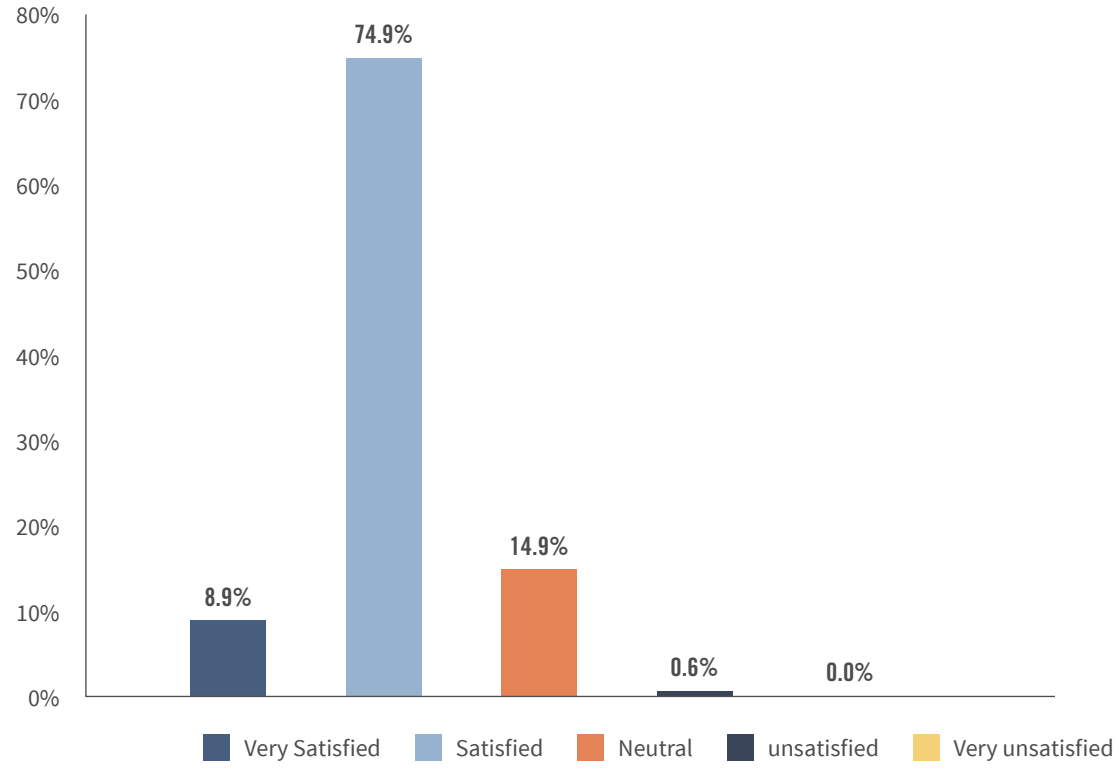
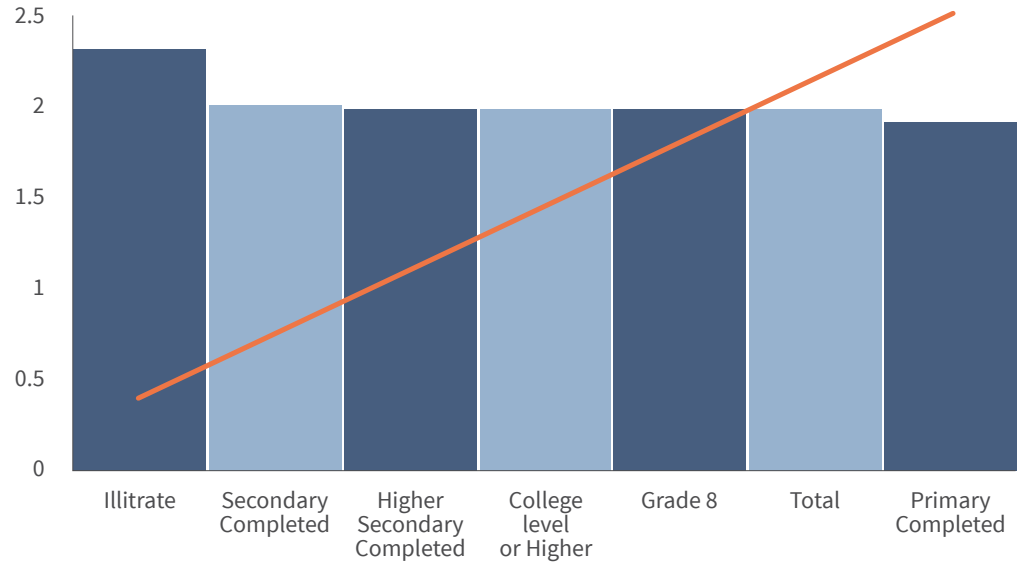


Chart 5 – Overall Satisfaction with the overall quality of NSP services



There is a correlation between satisfaction with NSP service quality and participant's education in Chart 6 below.

Chart 6 – Satisfaction with the overall quality of NSP services and education of the participant



Utilization of drug treatment services

Among 324 respondents, approximately 280 (86.4%) respondents said that they had received drug treatment services. The average number of times that they were treated was 2 (median = 2). The last time the participant was in drug treatment program about 24 months ago. The main types of drug treatment were Drug-free outpatient (53.9%) and Methadone outpatient (37.4%), no one had been treated with Buprenorphine/suboxone or inpatient methadone services.

Table 14 – Utilization of Drug Treatment Services

Variable	Total number	%
Received any drug treatment service (DTS)	280	86.4%
Average number of times admitted to DTS (n=279)	2.5 times	
Average time since the last admission to DTS	24 months	
Type of service received		
Drug-free inpatient	5	1.8%
Drug-free outpatient	151	53.9%
Methadone inpatient	0	
Methadone outpatient	105	37.5%
Buprenorphine inpatient	0	
Buprenorphine outpatient	0	
Other	51	18.1%
Source of payment (n=105)		
Paid from my pocket	62	59%
Family paid for it	43	40.9%
Covered by insurance/government/Global fund support	0	
Subsidy from other sources	1	0.1%
Detailed assessment of current substance use before enrollment (n=105)	103	98.1%
Helpful to have take-home OST (n=105)	91	86.7%
Yes	90	98.9%

Variable	Total number	%
Yes, it is already allowed	1	1.1%
No	11	10.5%
Reasons why take-home OST will be helpful (multiple choice)		
Distance and time	49	66.2%
Travel cost	56	59.6%
Takes work hours	60	63.8%
Uneasy of finding job due to OST hours	79	84%
Confidentiality	40	42.6%
Fear of arrest	22	21%
Others	0	
Received adherence counselling and behavior changes while on OST	105	100%
Missed OST dose because of stock out	0	0
Average number of doses missed due to shortage in last 12 months	0	
Offered a HIV test while on OST services	102	97.1%

Out of 104 PWID who had to pay for their drug treatment, 59% paid by their own pocket and 40.9% were paid by their families. No one was supported through social health insurance/government/Global fund support.

98.1% respondents (n=105) were assessed by a medical staff at the OST site to confirm substance use before starting OST treatment. When asked whether it would be helpful if OST dosage could taken home, only a small number: 11 respondents disagreed. Majority of the participants suggested take home dosage to be very useful. The main reason being that, (66.2%) had to travel too far to get OST dosage every day and had to spend a lot of time, (84%) felt that it was difficult to find job due to OST site timings, (63.8%) clients felt that they get late for work. Approximately, 21% said that they wanted to take home was because they were afraid of being arrested.

Also according to Table 14, 100% of the participants in the OST program received counseling by the healthcare staffs on adherence to treatment and behavior change. They never experienced stock out and therefore none of them missed their OST dose.

Satisfaction with the OST services

Table 15 - General Satisfaction

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
The OST services is perfect (n=104)	6/6%	50/48%	48/46%	0	0
I am dissatisfied with some things about OST services (n=104)	2/1.9%	41/39.4%	29/27.9%	32/30.8%	0

Overall, OST was considered perfect service as 54% of participants agreeing with this opinion. However, 30.8% said that some services still need to be improved.

Table 17 - Technical Quality of OST services

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
My OST services has everything needed (n=104)	5/4.8%	**57/54.8%**	42/40.4%	0	0
The providers carefully check everything when check and examining me. (n=104)	15/14.4%	**82/78.8%**	7/6.7%	0	0
Sometimes health care providers make me wonder if their approach to treatment is correct (n=104)	3/2.9%	20/19.2%	43/41.3%	**38/36.5%**	0
I have some doubts about the ability of the health care providers (n=104)		13/12.5%	54/51.9%	**37/35.6%**	0

Most clients responded that OST has met their needs. Majority of the participants felt that they are treated well by healthcare providers. However a small proportion of clients disagreed and doubted the ability of the health care providers and wondered if their approach to treatment has been correct.

Table 18 - Interpersonal Manner of health care providers at OST site

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Health care providers at OST site act too businesslike and impersonal toward me (the client) (n=104)	3/2.9%	16/15.4%	45/43.3%	**40/38.5%**	
My health care provider at the OST site treats me in a very friendly and courteous manner. (n=104)	5/4.8%	**47/45.2%**	49/47.1%	3/2.9%	

38.5% respondents disagreed with the negative statement about the health care provider at OST site. They said the health staff at the OST site treated them very friendly and polite (50%).

According to table 19, Health care providers have done a good job of explaining the reason for availing OST services (41.3% strongly agree and 54.8% agree)

Table 19 - Communication at OST services between the health care providers and the clients

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Health care providers are good about explaining the reason for availing OST services (n=104)	**43/41.3%**	**57/54.8%**	4/3.8%	0	0
Health care providers at OST site sometimes ignore what I tell them (n=104)	4/3.8%	24/23.1%	42/40.4%	**34/32.7%**	0

Table 20 - Financial Aspects

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
I feel confident that I can get OST services I need without being setback financially (n=104)	0	**36/34.6%**	48/46.2%	15/14.4%	0
I have to pay for more of my OST costs than I can afford (n=104)	1/1%	8/7.7%	44/42.3%	**51/49%**	0

About one-third (34.6%) of the respondents felt confident that they could afford the cost of OST without being setback financially. This was in line with 49% who disagreed with the statement that they have to pay for OST services more than they could afford.

According to table 21 below, 53.8% participants chose the option “disagree” stating that health care providers in OST services sometimes hurry to much while attending to them. However, they also disagree with the opinion that the health staff spent a lot of time with patients.

Table 21 - Time Spent with Doctor

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Those who provide OST services sometimes hurry too much when they treat me. (n=104)	0	4/3.8%	44/42.3%	**56/53.8%**	0
Health care providers at the OST site usually spend plenty of time with me.(n=104)	0	21/20.2%	43/41.3%	39/37.5%	1/1%

Table 22 - Accessibility and Convenience

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
I have easy access to the doctors I need (n=104)	**2/1.9%**	**43/41.3%**	43/41.3%	16/15.4%	
I find it hard to get an appointment for OST service right away (n=104)	1/1%	29/27.9%	42/40.4%	28.8%30	2/1.9%
I am able to get OST whenever I need it (n=104)	0	9/8.7%	33/31.7%	17/16.3%	45/43.3
Where I get OST, people have to wait too long for enrollment. (n=104)	2/1.9%	23/22.1%	65/62.5%	14/13.5%	0

Most respondents felt that making appointments with the treating doctor at the OST site was not difficult, but agreed with the statement that if clients wanted to access to OST services, they had to wait too long for enrollment.

One common point that was observed on the satisfaction with OST was 40%-60% respondents chose the “uncertain” option. This is indicative that there were certain underlying factors in the quality of OST services that made them think so.

Quality of Rehabilitation services

According to the results in Table 23, 90% of the respondents have ever been into a residential rehabilitation service. Majority (59.7%) of the respondents were involuntarily referred by police and only 1.2% were referred voluntarily. The percentage referred by family 31.2%. Very few (6.3%) were self-referrals through NSP services.

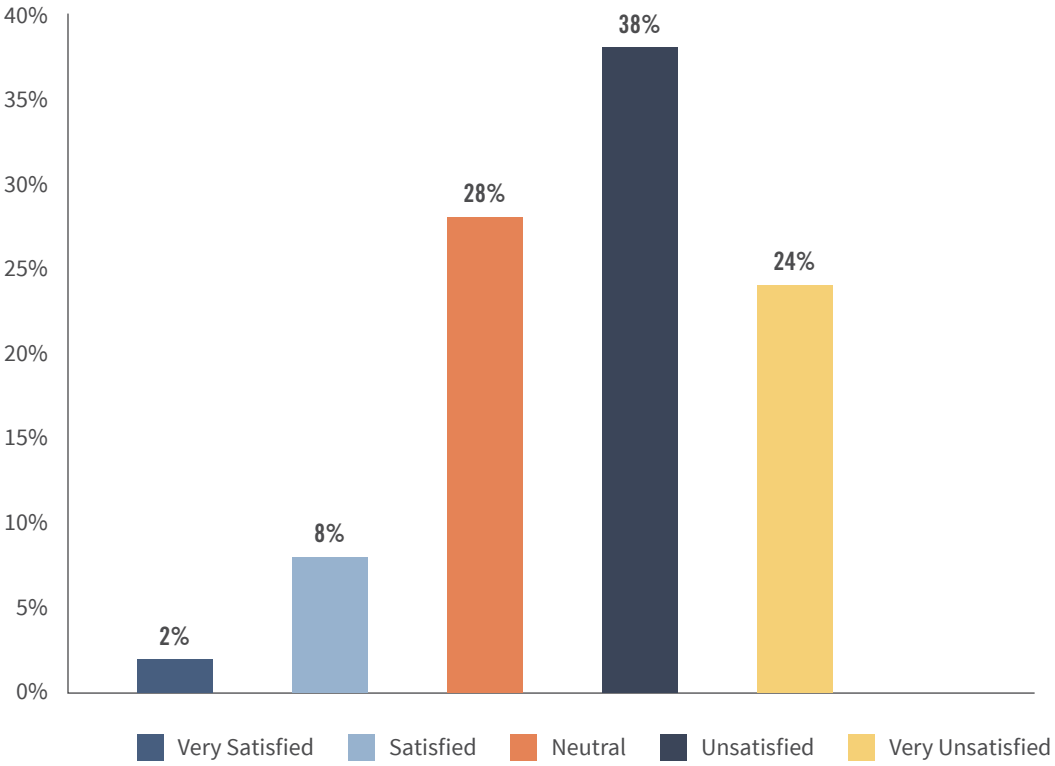
Majority of the respondents (83.8%) have undergone residential rehabilitation services, followed by another 55.3% who have undergone detoxification without any drug and further 52% who have undergone cold turkey without medicine.

Table 23 – Quality of rehabilitation services

Variable	Total number	%
Ever been into a residential rehabilitation service (n=281)	253	90%
Point of referral to the rehab service (last visit) (n=253)		
Self-referral	16	6.3%
Family-referral	79	31.2%
Involuntary police referral	151	59.7%
Voluntary police referral	3	1.2%
Referred through NSP	3	1.2%
Referred through OST	0	0
Medical referral	0	
Type of rehabilitation service visited (n=253)		
Outpatient counseling	7	2.7%
Self-help group	16	6.3%
Detoxification w/methadone	5	2%
Maintenance w/methadone	8	3.2%
Detoxification w/buprenorphine	0	
Maintenance w/ buprenorphine	0	
Detoxification w/other drugs	66	26.1%
Detoxification with no drug	140	55.3%
Residential rehabilitation	212	83.8%
Helped for cold turkey without medicine	129	52%
Forced to undergo cold turkey by others without treatment	67	26.5%
Others	0	
Average cost of rehabilitation service	236 USD (5,427,000 VND)	
Cost burden (n=105)		
Self-pay	15	14.3%
Paid by family	86	81.9%
Free Treatment	0	
Covered by insurance	1	1%
Paid by government/donor	0	
Detained against consent	169	66.8%
Experience physical violence and of abuse	164	64.8%
Had to do forced work	166	65.6%

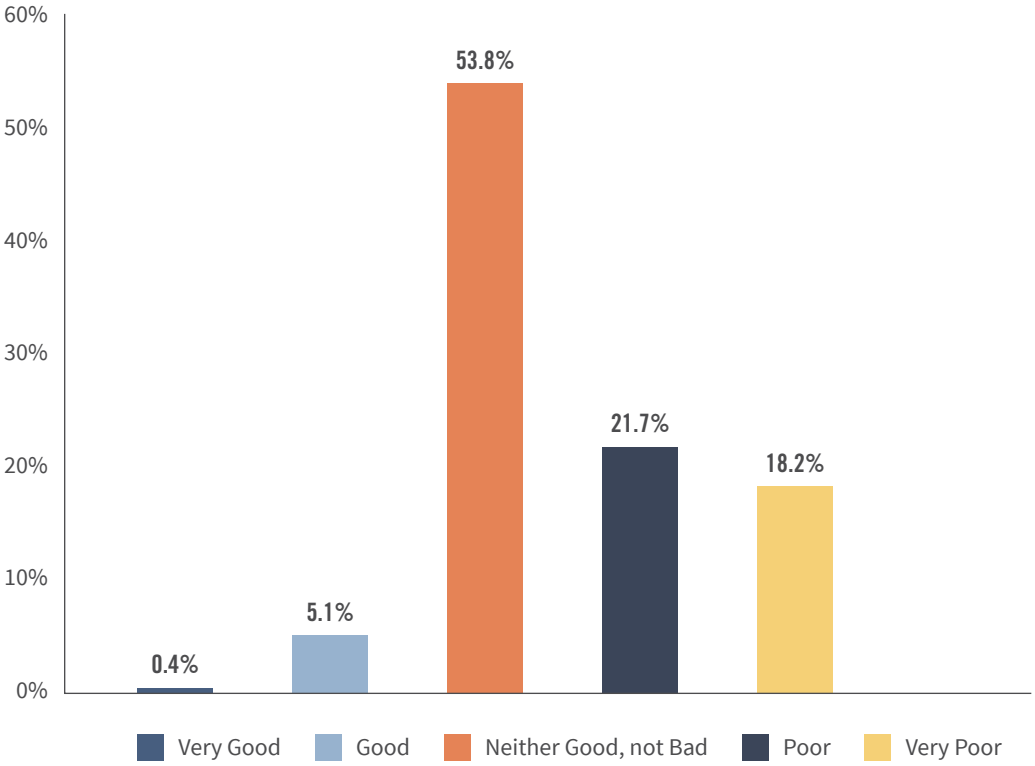
An average cost of drug treatment according to the respondents is USD 236/- and majority (81.9%) treatment cost were paid by the family. One case reported that the cost was paid through health insurance. Only 15/105 respondents paid for this expense by themselves. The percentage of participants who reported being detained for longer time than they wanted, physically abused as well as forced to work in rehabilitation centers was quite high: over 60%.

Chart 7 – Satisfied with last rehabilitation service received



Out of 253 respondents, 62% were dissatisfied with the last rehabilitation service. To assess the overall quality of the rehabilitation center services the responses were poor quality (21.7%) and very poor quality (18.2%).

Chart 8 – The overall quality of the drug treatment rehabilitation center



Overdose Prevention

About one third (114/325) respondents have experienced a drug overdose to the point where they lost consciousness. The frequency of overdose was 1-5 times (82.1%), more than 10 times (5.1%) in a period of more than a year (51.3%). Approximately 23% respondents experienced their last overdose between 7-30 days prior to the study. Naloxone is available in Vietnam but only (2.8%) 7 ORW/PE carry Naloxone with them. 23.7% respondents said that avail Naloxone from outreach workers during times of need. None of the participant knew the cost and the procurement channel.

Table 24 – Overdose prevention

Variable	Total number	%
History of overdose (ever) (n=325)	114	35.1%
Frequency of overdose (ever)		
None	3	2.6%
1-5 times	96	82.1%
5-10 times	11	9.4%
More than 10	6	5.1%
The last time when overdosed		
Within 7 days		
Between 7 and 30 days	4	3.5%
Between 1 and 6 months	26	23%
Between 6 and 12 months	22	19.5%
More than a year ago	58	51.3%
Source of naloxone when needed		
Outreach worker	77	23.7%
service center/ hospital/OST/NSP	7	2.2%
Take-away naloxone	0	
Naloxone unavailable in the area	45	13.9%
Naloxone available with educators/outreach workers	**7**	2.8%
Average personal cost of Naloxone when not available (USD)	**NA**	

Linkage to HIV testing and ART

97.2% respondents knew the HIV testing services in their localities. 85.9% respondents felt comfortable availing the HIV testing services. HIV testing rate was very high 96.9% among the respondents. (*This result is consistent with the result of VUSTA project in 2019, whereby the number of PWID in 15 project provinces have accessed to harm reduction/ prevention program which is provided by CBOs is 26,782 PWID*). The number of PWID who have been tested for HIV and know the result is 22,680 PWID (accounting for 85%).

The reasons why nine (9) respondents did not test were: i) they were afraid of receiving positive results (4), ii) they thought that there was not at risk of HIV infection (3) and iii) they did not have time for testing(2). *According to the technical guideline of VUSTA project, PWID is recommended to go for HIV testing every 6 months. In this study, average duration since the last HIV test was between 7-12 months.*

Table 25 shows that those who encourage PWID for HIV testing were PE of the NSP site (73%), followed by the OST counselor (21.9%). Only 3.1% went for testing by themselves. Up to 26 participants were forced to HIV test and 7 others reported that they were forced to test due to mandatory requirements (job requirements, overseas travel, hospitalization etc). The main HIV testing and counseling sites were based in NGO/CBO 62.2%.

Table 25 – Linkage to HIV testing

Variable	Total number	%
Knowledge of the location of HIV test	316	97.2%
Feel comfortable using the testing service	279	85.9%
Ever been tested for HIV	315	96.9%
Reasons for no test		
Not at risk	3	27.3%
Fear of a positive result	4	36.4%
No money	0	
No time	1	9.1%
Stigma by health care workers	0	
Others		
Average Duration since the last HIV test	Between 7-12 months ago	
Point of referral for the last test		
ORW/PE - NSP site	230	73%
OST site counselor	69	21.9%
Medical doctor	1	0.3%
For foreign employment	0	
Self-decision	10	3.1%
Other	4	1.3%
Ever coerced for a HIV test	26	8.3%
Ever HIV tested as a part of mandatory requirement	7	2.2%
Place for the last HIV test		
NGO/CBO testing center	196	62.2%
Private hospital/health clinic	14	4.4%
Government hospital	4	1.3%
Outreach/mobile testing	34	10.8%
Rehab center/OST site	63	20%
Other	2	0.6%

77/83 respondents who shared their HIV positive results were also connected with ART and CD4 testing centres. The time taken to start ART was, “within a week: 40.2% and “Between 1 week and 30 days”: 40.2%.

Table 26 – Linkage to ARV treatment

Variable	Total number	%
Result of the last HIV test		
Positive	83	26.3%
Negative	222	70.5%
Unclear, neither negative nor positive	1	0.3%
Did not receive the result	2	0.6%
Ever had a CD4 cell count (n=90)	77	85.6%
Ever been on ARV (n=90)	77	85.6%
Time taken to start ARV		
Within a week	33	40.2%
Between 1 week and 30 days	33	40.2%
1-3 months	5	6.1%
More than 3 months- less than a year	3	3.7%

Variable	Total number	%
More than a year	3	3.7%
Reasons for never starting ARV		
CD4 still high	3	10.3%
CD4 count unknown	0	
In a waiting list	0	
Advised by doctors too early to start	0	
Advised by doctors as a current user can't be on ARV	0	
Other	3	10.3%
Reasons for never starting ARV		
CD4 still high	3/10.3%	
CD4 count unknown	0	10.3%
In a waiting list	0	
Advised by doctors too early to start	0	
Advised by doctors as a current user can't be on ARV	0	
Other	3/10.3%	10.3%

Linkages to Hepatitis B and C, and Tuberculosis diagnosis and treatment

The number of participants receiving information on hepatitis C was higher than hepatitis B. Their main source of information was through outreach services (76.2%), and OST services (17.1%). The number of participants tested for HCV (48%) was also higher than those tested for HBV (34.5%). Most of participants were tested for Hepatitis C in the past 5 years.

Out of 93 participants who were positive with hepatitis C, only 9 were treated and 5 of them said the cost of treatment was within their ability to pay. 6/9 respondents received treatment from support of NGOs and private donors, only 3 participants paid for the expense by themselves.

The percentage of participants that has ever been diagnosed for TB was not high: 7.5% (n=24) and 7 participants have had TB infection more than once. 16 participants (88.9%) had completed TB treatment.

Table 27 – Linkages to Hepatitis B, C, Tuberculosis diagnosis and treatment

Variable	Total number	%
Ever received information on Viral Hepatitis B	**181**	55.7%
Ever received information on Viral Hepatitis C	**250**	76.9%
Source of such information		
Outreach setting	192	76.2%
NSP site	9	3.6%
OST clinic	43	17.1%
Doctor at the hospital	5	2%
Social media, internet or TV	0	
Others	2	0.8%
Ever been tested for Hepatitis B	112	34.5%
Ever received Hepatitis B vaccine	47	14.5%
Ever been tested for Hepatitis C	156	48%
The most recent Hepatitis C test		

Variable	Total number	%
Less than a year ago	69	44.2%
1-5 years ago,	85	54.5%
More than 5 years ago	2	1.3%
Hepatitis C test result		
Positive	93	59.6%
Negative	55	35.3%
Don't know	7	4.5%
Received treatment for Hepatitis C infection? (Merge yes and currently)	9	9%
Consider treatment affordable	5	33%
Source of treatment		
Government	0	
NGO	4	26.7%
Private donors	2	13.3%
Self-purchase	3	20%
Ever diagnosed with TB disease	**24/7.5%**	7.5%
Completed the TB treatment (Merge 1 and 2)	16/88.9%	88.9%
Ever diagnosed with TB infection more than once	7/41.2%	41.2%

A total of 23 participants were treated for HCV, 52.3% of these said that, in general they were satisfied with the Hep C treatment. For participants who had TB treatment, most of them were satisfied with the treatment (chart 10)

Chart 9 – Satisfaction with the overall Hep C treatment

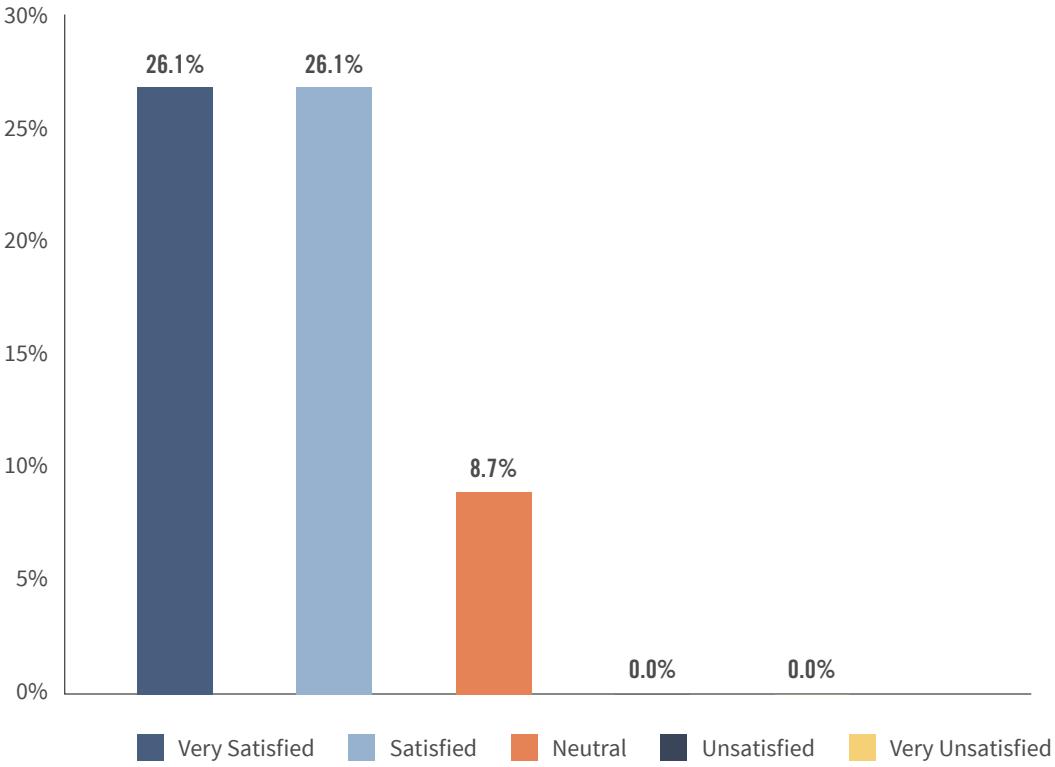
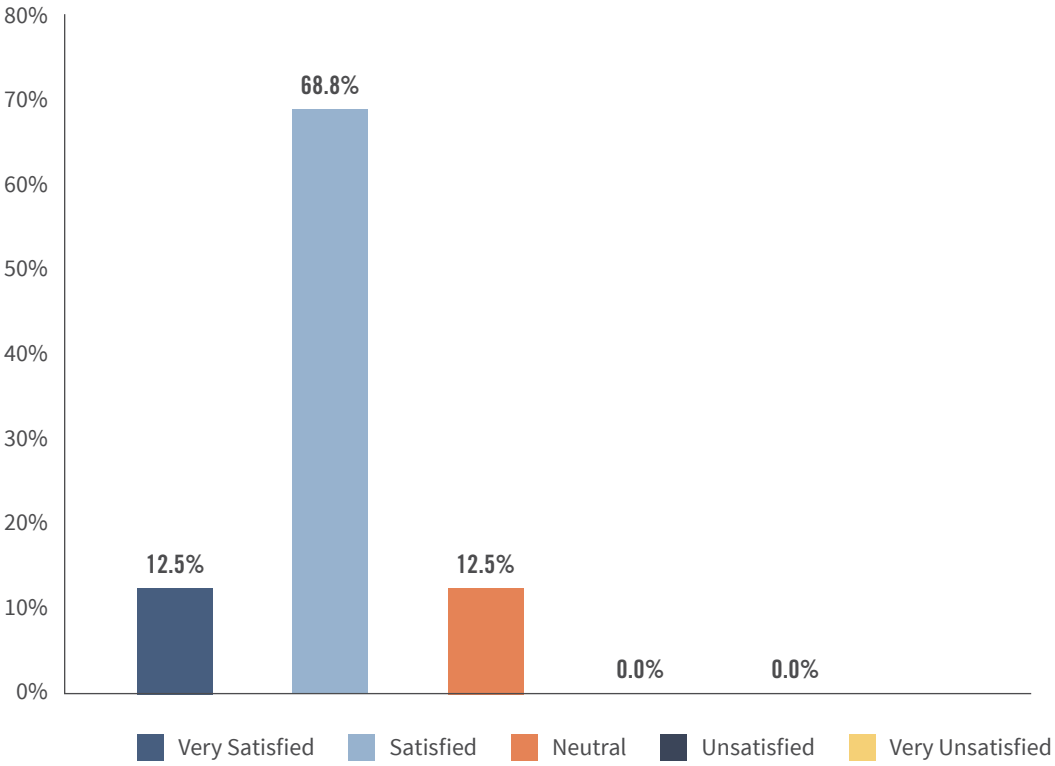


Chart 10 - Satisfaction with the TB treatment



Fear, Stigma and Discrimination

As per the data below (Table 28), respondents have largely experienced stigma and discrimination from families, ORW/PE, health workers. Being a PUD they still experience it but the percentage is not high. The various experiences of respondents in the last 6 months were: verbal abuse (16.6%), Physically harassed or hurt (19.4%) and arrested (6.5%). The fear in seeking health services among respondents was primarily concerned with confidentiality issues.

Table 28 – Fear, stigma and discrimination

Variable	Total number	%
Told others that you use/inject drugs (multiple choice question)		
No one	2	0.6%
Partner/spouse	141	43.4%
Family	246	75.7%
Friends/acquaintances who inject drugs	317	97.5%
Friends/acquaintances who do not inject drugs	65	20%
Healthcare providers	92	28.3%
Other	29	8.9%
Excluded from family activities		
Yes, in the last 6 months	55	16.6%
Yes, but not in the last 6 months	73	22.5%
Afraid to seek health services because of confidentiality concern		
Yes, in the last 6 months	27	8.3%
Yes, but not in the last 6 months	75	23.1%
Scolded because of drug use		

Variable	Total number	%
Yes, in the last 6 months	86	26.5%
Yes, but not in the last 6 months	104	32%
Physically harassed or hurt because of drug use		
Yes, in the last 6 months	63	19.4%
Yes, but not in the last 6 months	81	24.9%
Felt insulted by the health workers while receiving OST services		
Yes, in the last 6 months	1	0.3%
Yes, but not in the last 6 months	22	6.8%
Felt insulted by an ORW/PE while receiving NSP services		
Yes, in the last 6 months	0	
Yes, but not in the last 6 months	2	0.6%
Felt insulted by the health workers while visiting NSP service centers		
Yes, in the last 6 months	1	0.3%
Yes, but not in the last 6 months	3	0.9%
Believe that the medical records are kept confidentially at the NSP site (combine 1,2)	88	27.1%
Felt that the medical records are not kept confidentially at the OST site (combine 1,2) Arrested because of drug use	20	6.2%
Yes, in the last 6 months	21	6.5%
Yes, but not in the last 6 months	9	2.8%
Total number of imprisonment / incarcerations the year prior to interview		
Once	26	81.3%
Two or more times	4	12.5%
Used drugs or injected to get high while in prison		
Yes, oral drugs only	0	
Yes, injected drugs	2	6.3%
Received OST while incarcerated		
Yes	0	0
No, did not access it	2	6.5%
No, was not available	21	67.7%

Table 28, 29 and 30 presents the correlation between stigma and discrimination with accessibility to HIV, HBV, HCV and TB testing and treatment.

- There is a correlation between experiences of being scolded because of being drug users, insulted by the ORW/PE. All of these respondents have been tested for HIV, HBV, HCV and some were receiving ART.
- There is a correlation between stigma experiences such as being scolded or insulted and their fear that their medical report was not kept confidentially.

CHAPTER 6

DISCUSSION

Quality of NSP service

Study respondents, in general, are satisfied with the Harm Reduction program in Vietnam. They felt that it is an effective approach that helps PWID decrease the risks related to sharing of needles & syringes to prevent the transmission of HIV and other blood borne disease. NSP services are accessible, available and friendly.

The study found limited involvement of PUD in planning, management, implementation and monitoring of NSP at the local, provincial, national level. PUD representatives disclosed that they did not have a 'voice' when they report their feedback on harm reduction services during CCM meetings. Their concerns are heard but not acknowledged. Moreover, PUD are not involved in the national bidding process of procurement of needles & syringes.

ORW/PE play an important role on providing NSP services and a vast majority of study respondents were satisfied with ORW/PE services due to their friendly, not judgmental, non-discriminating behaviors. All interactions between clients and ORW/PE were rated as confidential and safe.

The stockout situation is rare and only one incident happened two years ago where needles & syringes were not made available to PWID. Otherwise clients have easy access to service delivery points and to field workers during times of need.

The cost for travelling from home to NSP sites is not considered a barrier. However, the FGD findings shows transportation a barrier as majority of clients live in poverty.

Therefore, ORW/PE provide field based services and often escort while referring them to other services.

Clients still purchase syringes from pharmacies because the number of free syringes does not meet their needs. However, according to them, only 1ml syringes are better with small dead space at pharmacies, while the 3ml syringes does not have a lot of difference. The price varies between 2,000 and 5,000 VND/each (0.1–0.25 US dollar). During the night, price of a syringe can go up to 15,000 to 20,000 VND/each (0.7–1 US dollar) costing around 0.4 USD/day and 1.7 USD/week.

Distilled water is distributed along with NSP package, but not used by all clients. Reasons for this includes: i) Distilled water is stored in glass vials, which is inconvenient to carry around; ii) PWID clients in the Northern region often use other additives such as Novo (Novocain: a drug used in arrhythmia, vasodilation), "sen" (sleeping pills) or "Phen" (usually referred as "Western meds") to increase the high. Therefore, they may refuse or not using distilled water. The distilled water distribution for the next phase of Global Fund project in Vietnam needs to be considered.

PWID still fear of being arrested by the police if caught with needles and syringes, so drugs are mostly used at home or private places and very few participants used at hot spots.

Information about HIV, hepatitis B, C, safe injecting and safe sex is provided through outreach. According to the respondents, the information is helpful to them.

No specific guidelines for groups of MSM or transgender who inject drugs. CBOs encourage safe sex behaviors such as: to evaluate the risk as well as demand for supply (condom) for needy clients; assigning appropriate outreach workers to reach MSM and TG. Referrals to LGBT groups; introducing MSM clients to subsidized condoms and lubricants services. Special focus on reaching out to female PUD during specific times, as some of them are busy with sex work, therefore they need specific information and essential support and referrals.

IEC materials were not readily available, the content was poor and not updated.

NSP is not available in prison and judicial custody even though some respondents shared that they have injected in the prison. It is highly likely that in the short term, it will not be possible to implement NSP at these settings due to Vietnam government's strict view on this issue.

One third of participants experienced overdose and 46% of these overdosed within 12 months. This indicates that overdose is still a big issue. Naloxone is not available in medical facilities. Naloxone is unknown among the drug using community in Vietnam. With the support of SCDI, VNNPUD members were trained on overdose and naloxone has been provided to community based organizations along with detailed guideline. Naloxone still remains obscure and difficult to access.

Quality of OST service

MMT is provided under the OST program in Vietnam. The target set out in the National Strategy for HIV/AIDS Prevention till 2020 is 80,000 PUD on MMT and only 54,255 (67%) were availing these services till 2018. Currently there is only methadone treatment is available at nationwide so the clients have no opportunities to choose between these therapies . OST with Suboxone has been evaluated as inappropriate after a pilot study. Buprenorphine pilot study started in May 2019 in 3 provinces Dien Bien, Son La and Nghe An. Then, it will be prioritized to expand in mountainous provinces before

expanding to the whole country.

PWID have to submit a treatment request form prepare with one of the four documents: i) identity card; ii) passport; iii) birth certificate; iv) household registration book) for enrolment to OST. These not having these documents find it difficult in accessing OST.

Stopping MMT and discontinuing OST services is quite common. The main reasons where OST patients used drugs again; i) they wanted to stop dependency on methadone, ii) patients forced to go into compulsory treatment centers, iii) switching to ATS, iv) not satisfied with the daily treatment, and v) compulsory escort of a family member/guardian .

The barriers for access to MMT program have been noted from the findings of this study include:

- Timings of MMT sites is not suitable.
- Difficulty in finding a stable job.
- Daily travel time and
- Daily transportation cost.

There was a strong recommendation to the take home OST solution and helpful to overcome barriers in treatment and help adherence to OST.

Stock out of medicines and supplies was not recorded during this study.

The attitude of staff and doctors at OST services is evaluated as appropriate, friendly, not judgmental or discriminating. The counselling and support is appropriate.

OST services do pay attention to gender component, but not comprehensively. Even though the participants said that there is no discrimination based on gender or sexuality, it is easier to see that gender sensitivity is still not considered.

The involvement of PUD in planning, management, implementation and monitoring of the OST program is still limited. Even though at the national level, VNPUD representatives are very active in reflecting issues related to the OST program but at the provincial level, the OST centers do not have a particular feedback mechanism. Even though the patients know how to give the feedback such as direct meeting with the doctor or the leader of the centers or writing opinions in the letter box but not sure that whether they have a voice in the MMT program.

All MMT centers has a referral system to refer to HIV testing and treatment, hepatitis B/C screening. Based on the results, patients will be referred to other services. However, some participants still reflected that they were not referred to any other services besides methadone treatment.

Other services that patients need such as employment introduction services or legal consultation remain unavailable.

OST was not available while participants were incarcerated. The article 8 Decree 90 Decree 90/2016/ND-CP issued on 1/7/2016 regulating the treatment of opioid addiction with substitution drugs has mentioned about the procedure for drug users in the prison, compulsory treatment center, detention center, reform school, compulsory educational institution. In the fact, OST is not available in these settings, except for selected compulsory treatment centers.

Access to HIV testing and treatment, Hepatitis B, C and TB testing and treatment

ORW/PE play an important role in providing HIV community testing service, providing information on Hepatitis B, C and TB, referring to ARV treatment as well as Hepatitis B, C and TB testing and treatment.

The HIV testing rate of participants was very high as well as on ART. CBOs plays an important role in linking PWID to ART, and ensuring treatment adherence.

There are no specific projects on Hep C but CBOs are providing information and linking PUD clients to Hep C testing and treatment, if needed.

While the uptake of ART is high, the rate of testing and treatment for Hepatitis C and Tuberculosis is low. The reason for this situation is hepatitis C testing and treatment are not really accessible to PUD. Hepatitis C viral load testing is only available in large cities. Hepatitis C DAAs are only partially covered by health insurance, making it difficult for most PUD to access treatment. Access to testing and treatment for tuberculosis is accessible to patients in the MMT program because of their regular tests.

Fear, Stigma and discrimination

As mentioned above, the PEs of CBOs are trained to work with the PWID when they start to provide harm reduction services for clients. Similarly, staff at methadone centers participated in technical training courses and were instructed on how to work with PUD. However, interviewed methadone centers do not have a specific strategy to ensure non-discrimination or these strategies were not shared in the KIIs.

According to KIIs, staff have been guided to work towards eliminating stigma against PWID, they also coordinate with medical centers to organize training courses for medical staff to decrease stigma.

About two thirds of the study participants were scared of police arrest while traveling to NSP sites. During FGDs in HCMC, the participants shared that at times they were searched by the police face trouble in case of needles and syringes are found in their possession. To help clients to avoid such problems, PEs do not distribute needles & syringes in large quantities, only enough to use for few days.

CHAPTER 7

CONCLUSION

Clients are satisfied with NSP services due to its accessibility, availability and friendliness with active participation ORW/PE.

Clean needles and syringes and condoms are always available and easy to access. The quality of needles and syringes is appropriate and meet the need of PWID.

The areas that need to be improved or changed are: capacity building for PEs, development of IEC material as well as strengthening the involvement of PUD in planning, management, implementation and monitoring of NSP.

Overdose is a big issue among PWID. Even though there is enough knowledge and information on naloxone but due to legal barriers, it was only was piloted and not deployed throughout the country.

The main OST service is methadone. Suboxone was stopped after pilot time because the end users felt it as inappropriate while Buprenorphine has started to be piloted in three mountainous provinces of Vietnam.

The procedure of OST program is easy, simple and convenient with PWID. The attitude of staff and doctors at OST services is considered as appropriate, friendly, not judgmental and non-discriminating. Doctors and medical staff spend enough time with patients when needed.

MMT program in Vietnam is co-payment and the government covers most of expense but the cost of MMT is a financial burden for PWID who do not have stable job or have bad

health.

There are many barriers for PWID in the OST program: the opening hours are not appropriate, difficulty in travelling, difficulty in finding a stable job and travel time and transportation.,

The areas that need to be improved are: increasing gender sensitivity in the OST program, enhancing the involvement of PUD in planning, management, implementation and monitoring of OST.

Both NSP and OST services are not available in close settings such as prison.

Police plays main role in referring the PWID to the residential rehabilitation service. Violence still happens in these places.

HIV testing service is available, accessible and provided primarily by community testing services that is implemented by CBOs. Therefore, the rate of HIV testing among PWID is high. The linkage with ART is efficient.

The number of PWID who are referred to Hepatitis B, C and TB testing and treatment is low.

PWID is still stigmatized and discriminated in some services, which affects their access to health services when needed (such as hepatitis B, C, Tuberculosis, STIs etc). This also prevents them from disclosing their drug use status and fear about confidentiality of their personal information at services sites.

CHAPTER 8

CHALLENGES AND RECOMMENDATIONS

Challenges

The study participants had other schedules so the discussion process usually happened for only limited timing of 90 mins, even though there were many topics that needed to be discussed. Therefore, there are some subjects that were not covered enough such as: overdose, feedback mechanism or PWID opinions, PWID role in the program etc.

Some participants had to take care of their children so they brought the children to the FGDs. The moderator asked the café owner for help with babysitting during the FGD process.

It would have been ideal if we could conduct KIIs with representatives of all methadone centers and NSP services in Hanoi and HCMC to obtain detailed information about these two CBQM Study sites. However, because of the financial situation and time constraints, we had to select limited respondents for KII. The selection of respondents may not provide a comprehensive view as expected. However, in the process of collecting feedback from different parties, we will continue to modify and include comments if available from all sides.

Among KII selected for interview there is no ORW/PE, so the peer approach aspect has not been described in detail in this report.

The study team interviewed the Global Fund project coordinator - Health Project, VAAC

but she answered that the interview contents are her personal opinions and does not represent her Department. However, we still included these ideas in the report, although it may not be considered as an official VAAC statement.

KIIs from VAAC and VUSTA project didn't comment much on the effectiveness and quality of services for drug users because they thought that it was very difficult to evaluate the effectiveness without CBQM Study or evaluation. Therefore, the content of these two sections has very little information from KIIs.

In the process of facility observation as well as NSP services, the CBQM Studier could not collect documented evidences from the representatives of state centers. Therefore, the evaluation results are mainly from the CBQM Study team's observation.

Challenges with the data collection and the study

Due to the time and personal limitation, there are some points to be noted in this study:

- Study locations are Hanoi and HCMC, where many CBOs are implementing harm reduction interventions, the sample size is too small, so the findings/results for the CBQM Study in these two cities does not adequately represent the situation of PWID in Vietnam.
- Convenient random sampling method with a minimum percentage of sample characteristics such as gender identification and sexual orientation, sex workers, MMT etc can lead to the fact that the data collectors tend to recruit PWID who are convenient for them. Therefore, the study could not reach other PWID who were not members/clients of CBOs.
- The capacity of the community data collectors can affect the information collection even though they were trained and supported by the country team.

Recommendations for policy makers

- Reviewing and revising the MMT guideline to enable access of MMT to PWID who lack personal documentation.
- Pilot the take-home OST model.
- Promoting the implementation of voluntary drug treatment services.
- Evaluating the effectiveness of overdose through pilot programmes
- Developing implementation guideline on overdose management with involvement and participation of PUD community members.
- Creating a diverse feedback mechanism to enable CBO to reflect their issues and challenges in the implementation of relevant policies relevant to harm reduction.

National program

- VUSTA and VAAC should have a plan to ensure the sustainability of the needle and syringe program before the completion of GF support.
- VUSTA and VAAC needs to assess gender mainstreaming in interventions and then they can have adjustments to provide adequate and appropriate services for different customer groups.
- Organizations which are working in the field of drugs and HIV to support the community system in improving capacity through knowledge and skills to build a strong community system and effective support system.
- Organizations working in the field of drugs and HIV should enhance the voice and meaningful participation of drug users in CCM and all processes of Global Fund programs at all levels: design, implementation to monitoring and evaluation.
- VUSTA and VAAC projects to work with Ministry of Health and donors to develop more communication materials, while supporting the development of communication

materials with community participation.

For VNPUD

- VNPUD network to continue sharing knowledge and skills on overdose management, and provide trainings to CBOs.
- VNPUD and other CBOs, along with NGOs, need to advocate for Naloxone to be used legally and widely by community outreach workers.
- VNPUD and CBOs need to advocate for PUD without legal identification papers to be able to access methadone treatment.

ANNEXES

Ethical approval

Viện Nghiên cứu Phát triển Xã hội – Institute for Social Development Studies

LETTER OF APPROVAL

- Based on the Decision No. 468/TC-LHH of VUSTA on 27th May 2002 of the Vietnam Union for Science and Technology Associations on the establishment of the Institute for Social Development Studies.
- Based on the Decision No. 295/PT-XH dated on May 9th 2008 by the Director of the Institute for Social Development Studies (ISDS) on the establishment of the ISDS Internal Review Board for reviewing of ethical issues in human subject research;
- Based on the results of the appraisal meeting of the ISDS Internal Review Board on 19 November 2018

INSTITUTE FOR SOCIAL DEVELOPMENT STUDIES
INTERNAL REVIEW BOARD IN HUMAN SUBJECT RESEARCH
Approves the ethical issues of the following research

Research title: Community-based quality monitoring study of Harm Reduction and HIV related health services for people who inject drugs (PWID) in Cambodia, Indonesia, Nepal, India, Thailand and Vietnam

Funding source: The Global Fund to Fight AIDS, Tuberculosis and Malaria through Save the Children International Nepal as Principal Recipient

PI of the research: Sushil K. Koirala and Francis Joseph

Research Institution: Asia Network of People who Use Drugs (ANPUD) and Center for Supporting Community Development Initiatives (SCDI), Vietnam Network of People who Use Drugs (VNPUD)

Site for research: Hanoi and Ho Chi Minh city

Research period: July 2018 to June 2020

The approval expires on: 30 June 2020

Attached documents:

1) Research proposal

2) Survey questionnaire

3) Handbook for national research team

4) Handbook for national data collectors

5) CV of principal investigator

IRB Secretary | **IRB Chair**

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ii People who inject drug in Vietnam: An update on HIV epidemic, risk behavior, and coverage of intervention service.

iii The concept note of the VUSTA project – The Global Fund Project on HIV/AIDS for the period from 2018-2020

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xi Summary Report Implementation of Vusta Project in the stage 2015 – 9/2017.

xii Reported in: James Windle (2015) A slow March from Social Evil to Harm Reduction: Drug and drug policy in Vietnam, Foreign Policy at Brooklings

xiii Implementing comprehensive HIV and HCV programmes with people who inject drugs. Practical Guidance for collaborative interventions (the “PWIDIT”)

xiv Report of the MoH in the workshop “Intervention for the drug users in the new situation” – Hai Phong, June/2018. Vietnam

xv ibid

xvi Nick Walsh1 , Nicolas Durier, Giten Khwairakpam, Annette H Sohn, Ying-Ru Lo1 The hepatitis C treatment revolution: how to avoid Asia missing out. Journal of Virus Eradication 2015; 1

xvii World Health Organization. UNAIDS and UN Office of Drugs and Crime Policy Guidelines for Collaborative TB and HIV Services for Injecting and Other Drug Users - An Integrated Approach. 2008

xviii Decision No. 3140/QD-BYT of the Minister of Health on August 30, 2010, on guiding substitution treatment for opioid addiction with methadone.

xix The article 10 in the Decree 90 has mentioned about conditions for stopping the treatment for patients who are on the OST program. Accordingly, patients can terminate when they want to stop or they will be removed from their treatment by the facility in following cases: 1) for patients who do not comply with professional procedures for treatment from two times within 6 months; 2) for patients who have positive result when testing with opioids substances from 2 times within 12 months after reaching the maintenance dose; 3) for patients who have positive result when testing with other drugs; 4) for patients who acts of infringing upon the property of individuals or organizations; property, health, honor, dignity of citizens and foreigners; violation of social order and safety.