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Policy analysis

Drug policy in Vietnam: A decade of change?

Thu Vuong[a,*], Robert Ali[b], Simon Baldwin[a], Stephen Mills[a]

[a] Family Health International (FHI), 7th floor, Hanoi Tourist Building, 18 Ly Thuong Kiet Street, Hanoi, Viet Nam
[b] University of Adelaide, Australia, North Terrace Campus, Adelaide, SA 5005, Australia

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ABSTRACT

Background: Driven by the rapid spread of HIV, Vietnam's response to drug use has undergone significant transformation in the past decade. This paper seeks to identify and analyse factors that prompted these changes and to investigate their impact on the lives of people who use drugs.
Method: This policy analysis is based on a review of Vietnamese Government documents, peer-reviewed publications and the authors' knowledge of and involvement in drug policy in Vietnam.
Results: The last decade has witnessed a progressive change in the mindset of political leaders in Vietnam around illicit drug use and HIV issues. This has led to adoption of evidence-based interventions and the evolution of drug policy that support the scale up of these interventions. However, HIV prevalence among drug users at 31.5% remains high due to limited access to effective interventions and impediments caused by the compulsory treatment centre system.
Conclusions: The twin epidemics of HIV and illicit drug use have commanded high-level political attention in Vietnam. Significant policy changes have allowed the implementation of HIV prevention and drug dependence treatment services. Nevertheless, inconsistencies between policies and a continued commitment to compulsory treatment centres remain as major impediments to the provision of effective services to drug users. It is critical that Vietnamese government agencies recognise the social and health consequences of policy conflicts and acknowledge the relative ineffectiveness of centre-based compulsory treatment. In order to facilitate practical changes, the roles of the three ministries directly charged with HIV and illicit drug use need to be harmonised to ensure common goals. The participation of civil society in the policymaking process should also be encouraged. Finally, stronger links between local evidence, policy and practice would increase the impact on HIV prevention and drug addiction treatment programming.

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Introduction

Vietnam has undergone rapid social and economic change since economic deregulation in 1986 (known as *Doi Moi*). National GPD rose from US$26.3 billion in 1986 to US$101 billion in 2010 (World Bank, 2011b). Health has improved and the population has grown to approximately 88 million people in 2011 (WHO, 2011).

Vietnam is located close to the Golden Triangle where much of the region's opium and amphetamines are produced (Nguyen, 1998; Nguyen et al., 2010) and since 1986 has experienced increasing urbanisation, exposure to globalised culture, and changing patterns of drug use. The production, trafficking and use of illicit drugs are important social issues for contemporary Vietnam (OSI, 2009). Over the past two decades there has been a shift away from opium smoking towards heroin injecting as well as the use of methamphetamine and other psychotropic substances (Reid, Devaney, & Baldwin, 2006).

Vietnam's response to drug use has historically focused on deterrence through punishment and supply-side measures (Hammett et al., 2008; Reid et al., 2006). The strong emphasis on supply reduction has led to significant reductions in domestic opium cultivation, from 12,199 hectares in 1992 to 32 hectares in 2004 (UNODC, 2005). However, and despite a substantial decline in opium cultivation, the use of heroin and amphetamines has increased dramatically (Nguyen & Scannapieco, 2008). The Ministry of Labour, Invalids and Social Affairs (MOLISA), the government body responsible for managing drug dependence treatment, estimates that in 2009 there were about 150,000 people nationwide using illicit drugs, including heroin, opium, synthetic drugs and cannabis (83% of whom injecting heroin) (MOLISA, 2010). MOLISA's figure probably underestimates the size of the population, especially if non-injecting drug users are included; other estimates suggest that there could be as many as 500,000 people who use illicit drugs in Vietnam (DEA, 2003).

Driven by the rapid spread of HIV among people who inject drugs, Vietnam's response to drug use has undergone a significant

* Corresponding author. Tel.: +84 4 3934 8560; fax: +84 4 3934 8650.
E-mail addresses: huongthu@fhi.org.vn, huongthuhanoi@gmail.com (T. Vuong).

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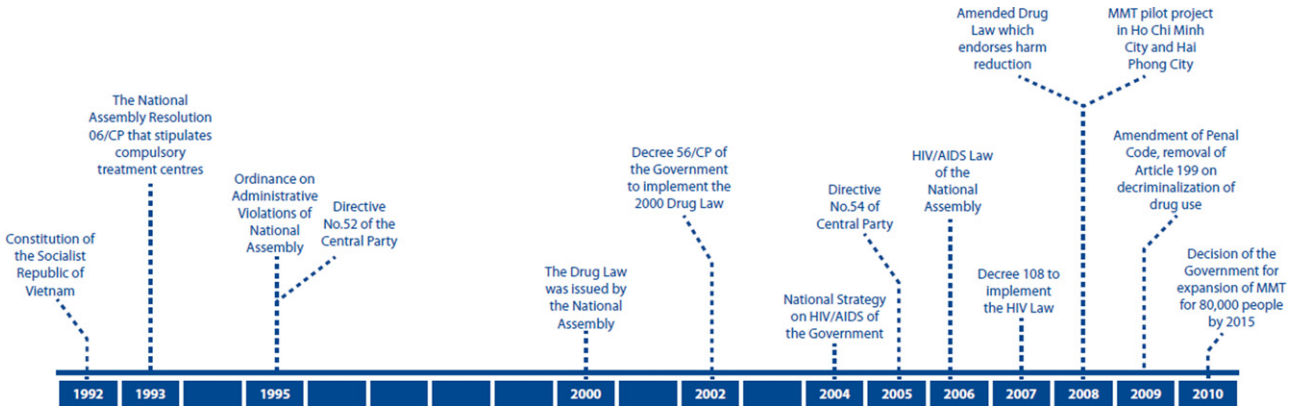

Fig. 1. Timeline of Vietnamese Government drug and HIV related policy, 1992–2010.

transformation in the past decade. This paper seeks to identify and analyse the factors that prompted these changes, as well as to describe the impact of these changes on the type of services that are available for people who use drugs in Vietnam. The paper also identifies inconsistencies embedded within the current policies and between the policies and practices and discusses how these continue to hinder effective public health responses for drug users. Finally, using examples from other countries, we propose a range of interventions for improving drug policy in Vietnam and offer lessons for other similarly situated developing countries.

Method

This analysis is based on Walt and Gilson's health policy framework (Walt & Gilson, 1994; Walt et al., 2008), which focuses on understanding health policy through understanding four interrelated factors: actors, content, context and process. Walt and Gilson (1994) argue that it is critical to understand the interplay between these factors and especially draws attention to the significant influence that policy actors play in the process of both policymaking and policy reform. Our analysis also employs a rights-based approach adopted by Nguyen et al. (2010), explores the reasons behind the policy change, and pays attention to the interests, roles and relative power of the different actors.

We conducted a review of Vietnamese Government documents and peer-reviewed publications, as well as calling on the authors' personal experience from working in the drug policy field in Vietnam. Specifically, reviewed documents include: (1) government policies and documents on illicit drug use and harm reduction programmes between 1992 and 2011 obtained from the Official Gazette of Vietnam, the largest database of legal documents in Vietnam, (2) English language studies of Vietnamese drug policy published in international peer-reviewed scientific journals between 1990 and 2010, and (3) programme documentation for drug treatment and harm reduction interventions supported by international and local organisations in Vietnam. Peer-reviewed journal articles were obtained through searching PubMed (Medline being a subset), EBSCO (Academic Search Premier) and Google Scholar databases. The search terms included Vietnam, drug policy, harm reduction, HIV law, and compulsory drug treatment. Respectively, 30 government policy documents were reviewed and 14 were selected for the analysis, 12 peer-reviewed articles (out of 29) were selected after review of titles and abstracts and 16 programme and evaluation reports/briefings were used. No primary data was collected for this analysis.

Fig. 1 shows the chronology of the key drug and HIV legal documents and related events that will be analysed in this paper.

Policymaking process in Vietnam

In Vietnam, as in other countries with a long history of single party governments such as the former Soviet Union (Rechel & McKee, 2009) and China (Hammett et al., 2008; Shen & Yu, 2005; Xue, 2005), it is often unclear how policy has been formulated, who has been involved, what the relationships are between different actors and the effects that different policies have on each other (Khuat, 2007). Policymaking in Vietnam has traditionally been the preserve of the political elite and not open to scrutiny from those outside the Communist Party (Nguyen et al., 2010). Mechanisms of drug policy change in Vietnam are somewhat similar to those found in pluralistic societies, but operate through a more top-down and hidden process (Nguyen et al., 2010).

The Socialist Republic of Vietnam is governed through a highly centralised system dominated by the Communist Party of Vietnam. The central role of the Communist Party of Vietnam is reaffirmed in the current Constitution. All Vietnamese political organisations are under Vietnamese Communist Party control. Through its resolutions and directives, the Party provides policy direction for all aspects of national life (Nguyen et al., 2010).

The National Assembly, according to the Constitution, is the highest representative body of the people and the only organisation with legislative powers. The National Assembly has authority over lawmaking, but is still subject to Communist Party direction (United States Government, 2011). The National Assembly is best described as the country's most representative body with its 493 deputies, elected by a majority system with nominations and endorsements sought from workplaces and local communities, for 5-year terms. The National Assembly is increasingly regarded as playing a more active and independent role in Vietnam's political life (Palmieri, 2010).

The Government is the executive of the National Assembly, the highest organ of state administration. It carries out overall management of the fulfilment of the political, economic, cultural, social, defence, security and external duties of the State. The Government ensures the effectiveness of the State apparatus from the Central Government to the grassroots and enforces respect for and implementation of the Constitution and the laws (Government of Vietnam, 2010a).

The Communist Party, the National Assembly and the Government are the three main policymaking actors for issues related to drugs and HIV in Vietnam (see Fig. 2). The Government is represented by the National Committee on HIV/AIDS, Drugs and Prostitution Prevention and Control (NCADP), which was established in 2000 and tasked with coordination of programmes for the prevention and control of HIV and drug use. The NCADP, chaired by one Deputy Prime Minister, is in charge of social affairs and consists

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Fig. 2. Actors involved in drug and HIV policymaking in Vietnam and the types of legal documents under their governance.

of 18 members from government agencies, some socio-political organisations (mass organisations like Women's Union), and professional organisations, and centrally run Government agencies.

The Communist Party has several commissions, one of which is the Commission for Popularization and Education that has responsibility for science, culture, education and health. The Commission formulated Directive No. 52 (1995) and Directive No. 54 (2005) which provide direction on HIV/AIDS issues for the country's leadership.

The National Assembly has the power to make resolutions, laws, ordinances, and codes and takes direction from the Party Commissions. Its Committee of Social Affairs is responsible for the appraisal of ordinances and laws in health and social areas. The MOH, MOLISA and MOPS draft legal documents relating to their particular interests in HIV/AIDS and drug use and submit them to the Government and/or National Assembly for endorsement. The ministries are also in charge of developing specific circulars for the operationalisation of Government's decrees. It is important to note that there is a difference in the lawmaking process of Vietnam when compared to democratic countries. In democratic countries, the Houses of the Parliament propose, draft and approve laws. In Vietnam, the ministries and the Government submit proposals for new or amended laws to the National Assembly for review and approval. Therefore, the content and emphasis of the law might be guided by the interests and incentives of the respective ministries.

Early illicit drug control strategy

Since the early 1990s, Vietnam's drug policy has focused specifically on the internment of drug users in compulsory treatment centres and information campaigns that have linked HIV to injecting (Nguyen et al., 2010). The primary philosophy that underpinned these early laws is demonstrated in Article 61 of the 1992 Constitution issued by the National Assembly, which stipulates "...the State provides for compulsory treatment of drug addiction and certain dangerous social diseases..." (The National Assembly of Vietnam, 1992, p. 11). The legal framework around drug control activities in general and drug treatment in particular in Vietnam has been strongly influenced by the direction given in the 1992 Constitution (MOLISA, 2010) and a philosophical commitment to the eradication of 'social evils'.

As is the case for many other countries, Vietnam's illicit drug treatment approach is strongly influenced by the Government's signature to the UN International Drug Conventions of 1961, 1971 and 1988 (which occurred in 1997). Each of these treaties encourages (and in some instances requires) criminal sanctions to be put in place at the national level (The Beckley Foundation, 2008). Many countries, including Vietnam, have adopted overly restrictive interpretations of these criminal sanctions, resulting in measures (such as detainment of drug users in compulsory centres for a period of 2–5 years without due process) that are well beyond the treaties' requirements (The Beckley Foundation, 2008).

Guided by the 1992 Constitution, in 1993 the National Assembly launched Resolution No. 06/CP (MOLISA, 2010) with measures focusing primarily on anti-drug information and education, supply reduction, interdiction and compulsory treatment of drug users. The Resolution defines rehabilitation treatment for citizens who use illegal drugs as "compulsory treatment as determined in article 29 of the Law for Protection of People" (National Assembly of Vietnam, 1993, p. 2).

Following Resolution No. 06/CP, activities related to drug treatment officially began in 1994 when there were only 55,445 registered drug users nationwide (MOLISA, 2010). At this time, most drug treatment activities were home-based and community-based and focused purely on detoxification and didactic moral teaching. In 1995, the National Assembly issued the Ordinance on Administrative Violations which states that people who use illegal drugs, if not successful with home or community-based drug addiction treatment, will be subject to administrative violations and to compulsory treatment for 3 months to 1 year (National Assembly of Vietnam, 1995). During the first 2 years of the implementation of the Resolution 06/CP there were only a few small compulsory centres in some richer cities with the capacity to house around 3000 people in total (MOLISA, 2010). However, as a result of the 1995 Ordinance on Administrative Violations, by the end of 2005 up to 80 compulsory centres with a total capacity of 55,000 people had been established; at this time Vietnam had 128,657 registered drug users (MOLISA, 2010). An increase in the number of drug users from 1994 to 2005 were reported since during this time MOLISA was spending significant resources on national scale surveys to get national data on number of illicit drug users for better drug treatment planning and budgeting (Nguyen Thi Van, personal communication, October 20, 2011). By June 2010 there were 129 treatment centres in Vietnam capable of housing approximately 70,000 drug users (MOLISA, 2010). The total reported number of (registered) drug users in Vietnam by June 2011 was 149,900 (Ministry of Public Security, 2011).

The rapid increase in the number of compulsory centres was partly driven by the 1995 Ordinance, but also by the economic gains to be realised by the managers of the centres from the cheap labour of the residents (OSI, 2009). A report by Human Rights Watch documenting human rights abuses in a number of the centres of South of Vietnam argues that there is an economic incentive in building and running treatment centres and the internment of drug users constitutes a self-reinforcing system that is not really interested in the wellbeing of drug users (Human Rights Watch, 2011).

The interplay between HIV and illicit drug use

The burden of illicit drug use on the health-care system in Vietnam is considerable. In 2006, 65% of all reported HIV cases in Vietnam were among people who injected drugs (WHO, 2009). The 2009 Integrated Biological and Behavioral Survey (IBBS) suggested that in some parts of Vietnam over half of all drug users were HIV positive (MOH, 2009). People who inject drugs in Vietnam

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are also disproportionally affected by Hepatitis B (80.9%) and C (74.1%) (Nakata et al., 1994; Quan et al., 2009) as well as premature death through opiate overdose which accounts for 27% of all causes of death among injecting heroin users (Bergenstrom et al., 2008; Quan et al., 2011).

It was not until 2005 that the Communist Party and the National Assembly became significantly and proactively involved in the drug and HIV policymaking process. Leaders of several Communist Party Commissions emerged as strong proponents of including harm reduction in the new HIV law. Communist Party organisations thus became forces for positive policy change in HIV prevention in Vietnam, in contrast to what had occurred in other Communist states. For example, Cuba and the Soviet Union adopted policies such as mass mandatory HIV testing and quarantine that violate human rights and are at odds with evidence-based public health policy (Hammett et al., 2008).

The 2005 Directive No. 54, which replaced Directive 52 of 1995, shows a remarkable shift in the mindset of the Communist Party. The old Directive called for "healthy and faithful lives avoiding drugs and prostitution" and further linked AIDS and social evils in prescribing that "interventions should be integrated with the prevention of social evils: drug use and sex work. Police should make timely discoveries and punish drug users, brothel owners and decoys" (The Communist Party of Vietnam, 1995, p. 3). The language in the new Directive shows that the Communist Party leaders realised the need to deal with drug use and HIV in a more coordinated and holistic approach. It calls for "the relevant government agencies to improve the legal documents to ensure consistency to facilitate more effective implementation of the HIV prevention programme" (The Communist Party of Vietnam, 2005, p. 3). This shift in thinking was critical since the Communist Party of Vietnam exerts political influence over all political organisations at both the national and the local levels. These political organisations have influences in budget allocation for various health programmes including HIV.

The National Assembly Social Affairs Commission embraced the Communist Party's new direction. It sponsored debates on the draft HIV Law at the 8th session of the Eleventh National Assembly convened in November 2005 (Government of Vietnam, 2010b). In 2008, it sponsored debate on the amendment of the Drug Law at the 3rd session of the Twelfth National Assembly (National Assembly of Vietnam, 2008a). Implementation of harm reduction was one of the most difficult and contentious topics during these debates, since many delegates envisaged problems in ensuring coherent policies across the sectors responsible for health and the enforcement of pre-existing laws (Government of Vietnam, 2010b).

Despite some controversy at the 2005 National Assembly, the Government assumed its executive role and, through a consultative process, developed Decree 108 in 2007 to guide the implementation of the HIV Law. Various groups, including people living with HIV and civil society organisations, were consulted about the draft Decree. Although it does not meet expectations of all the activists including people living with HIV and civil society organisations, the content of the Decree shows that some critical comments from the consultations were taken seriously (HAIVN, 2007). The Decree created a crucial legal corridor for the implementation of a harm reduction programme for drug users.

The processes of development of Vietnam's major legal documents on HIV and illicit drugs differ widely. For example, the story of the Vietnamese government's endorsement of harm reduction was comprised of two main subplots (Hammett et al., 2008). A team from Ministry of Health (MOH), with input from an informal working group of international organisations, drafted the 2004 National HIV/AIDS Strategy (which includes many mentions of harm reduction) and presented it to the Government for endorsement (Hammett et al., 2008). The process of developing and adopting the new HIV law in 2006 was very different as it involved greater receptiveness to open dialogue with stakeholders, including people living with HIV, international organisations, and NGOs (Hammett et al., 2008).

The role of civil society in shaping drug and HIV policies

Mass organisations – such as the Vietnam Women's Union – are referred to as one type of 'civil society' organisations in the national HIV/AIDS programme. Apart from funding from the Central Government, the Women's Union receives funding of approximately US$20,000 a year from the National Target HIV/AIDS Programme (Nguyen Thi Hoa Binh, personal communication, August 20, 2011) and are also included as representatives in the NCADP (Khuat, 2007; UNDP (United Nations Development Program), 2002). However, some civil society activists argue that these organisations are more governmental than civil as the government fully funds and staffs them. Civil society is a relatively new phenomenon in Vietnam, but such organisations have been growing rapidly in number, capacity, and scope. The Vietnam Civil Society Partnership Platform on AIDS (VCSPA), founded in October 2007, brings together formal and informal civil society organisations that share an interest in combating HIV. VCSPA has more than 200 member groups and organisations from all over Vietnam including people living with HIV (PLHIV), sex workers, drug users, sexual partners of drug users, men who have sex with men, transgender people, local NGOs and faith-based organisations, but not including mass organisations. While the involvement of civil society in social and political processes is still new, the government appears to be increasingly receptive to this development, particularly with respect to HIV/AIDS prevention and control (Khuat, 2007).

Nevertheless, with the exception of the development of the 2006 HIV Law and Decree 108, there is still little evidence of meaningful involvement of civil society in shaping drug and HIV policy in Vietnam. A study conducted by OSI found that few civil society respondents were aware of the content of the national drug control policy and their knowledge about drug addiction treatment was limited (OSI, 2009). Drug users were aware of legal provisions that directly affected them such as different drug-related convictions under the Penal Code and Drug Law, but were not involved in policy decisions in any way. Civil society has never been formally invited to take part in the development of drug control policies (OSI, 2009).

Existing inconsistencies in legal documents

From 1995 to mid-2006, the National Assembly Ordinance on HIV/AIDS (enacted 1995) was the highest-level legislative document supporting the national HIV/AIDS programme. It excluded provisions for harm reduction services for drug users as well as other critical interventions for HIV prevention such as safe sex education and HIV treatment.

When the National AIDS Strategy was adopted in 2004, the ordinance could not provide adequate support for the strategy's implementation (Government of Vietnam, 2010b). Ordinances rank lower than laws in terms of legislative power. So, for example, the ordinance could not provide sufficient legislative backing for the strategy's harm reduction interventions which conflicted with provisions in the 2000 Drug Control Law. To support the National AIDS Strategy more effectively, Vietnamese lawmakers decided to upgrade the Ordinance on HIV/AIDS into an HIV Law in 2006. This was the first piece of Vietnamese legislation approving harm reduction interventions and specifically mentions "the promotion of the use of condoms and sterile needles and syringes, treatment of opioid addiction by substitution. . .to prevent HIV transmission"

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(Article 2, Clause 15). This was a key event since the passing of the Law carried substantial weight with the central bureaucracy and it confirmed that harm reduction intervention advocates had won the battle between ministries. However, programme implementers at the provincial level were less sure of the Law's likely influence on implementation (Nguyen et al., 2010) due to conflicts with the 2000 Drug Law, which outlaws possession of needles and syringes and mandates centre-based compulsory drug treatment. The National Assembly subsequently realised they needed to amend the Drug Law to make it more consistent with the HIV Law. The Amended Drug Law (passed in June 2008) contains a section which has generic reference to harm reduction as defined in the Law on HIV; however, it did not resolve the other inconsistencies (Hammett et al., 2008). The revisions maintained the system of compulsory centres, with 2 years in a compulsory treatment centre if drug users refuse to undergo (or fail) family/community detoxification.

Through the influence of the international community, it has become a commonly held belief among many Vietnamese leaders that drug dependence is a chronic relapsing medical condition, not a crime (National Assembly of Vietnam, 2008b). This belief was manifested in the removal of Article 199 in the Penal Code in 2009 (National Assembly of Vietnam, 2009). The revision recognises people who are addicted to drugs as patients rather than criminals; this means illicit drug users should not be arrested and imprisoned for drug use. However, under the Ordinance on Administrative Violations, illicit drug use is still considered an administrative violation with illicit drug users subject to being sent to compulsory centres for 2 years. This means that even though illicit drug use has been decriminalised since 2009, there has been no difference in the way drug users are dealt with by the operational police and community leaders at the local level. In fact, informal group discussion with drug users in the field revealed that during "special days" to avoid being arrested by local police and put into the centres with longer term of detention and forced labour some drug users purposefully commit small crimes to be arrested to be put into short-term prison sentencing. In this regard, the Ordinance on Administrative Violations remains a significant barrier to the provision of effective HIV prevention and drug treatment services for drug users.

Harm reduction programmes

Despite policy-level inconsistencies and lack of coordination, small pilot harm reduction programmes focusing on peer education and needle and syringe programmes (NSPs) began in a number of provinces/cities in Vietnam as early as 1993 (Quan, Chung, & Abdul-Quader, 1998). Today, NSPs and methadone maintenance treatment (MMT) programmes are established in many provinces. These developments emphasise that while national policy has been stuck, local authorities have moved forward in introducing evidence-based programming with technical assistance and financial support from internationally funded projects.

Peer education/outreach programme to promote safer drug injection and safer sex behaviours

Vietnam's current National HIV Strategy, the Law on HIV and Decree 108 specifically support scaling up harm reduction interventions for drug users. MOH works with peer educators, PLHIV support groups and local police to provide harm reduction services to IDUs and female sex workers. By the end of 2009, there were 4585 peer educators (former and current IDUs and FSWs) participating in the harm reduction programme (VAAC, 2009). However, the majority of these positions are paid through funding from donor-funded projects. This poses a challenge for Vietnam over the next 5 years when donors will reduce their funding since Vietnam became a middle income country in 2010 (Palmieri, 2010).

The issuance of the 2006 HIV Law has brought about considerable expansion in services for drug users in Vietnam. The NSP expanded from 21 provinces/cities in 2005 to 42 provinces/cities by the end of June 2007 and 60 provinces/cities in 2009 (Government of Vietnam, 2010b). The average number of needles/syringes distributed per IDU per month (not including pharmacy network) increased from 2.4 in 2006 to 10.7 in 2007 (Government of Vietnam, 2008). The total number of needles/syringes distributed increased from two million in 2006 to 24 million in 2009 (VAAC, 2009). However, according to the 2009 IBBS data, only 17% of IDUs in 10 provinces were reached with prevention programmes (MOH, 2009). The definition of "reach" was access to any one type of HIV prevention service (VCT, NSP, condoms, HIV health education) during the past 12 months. Nevertheless, it is encouraging that the proportion of IDUs reporting using sterile injecting equipment is high, increasing from 89% in 2006 to 94% in 2009 (MOH, 2009). With the improved enabling environment, many drug users are able to buy sterile needles and syringes from their local pharmacies to practise safe injection behaviours (Pankonin, Higgs, Reid, & Aitken, 2008).

Methadone maintenance treatment programme

From 1997 to 2002, the National Mental Health Institute was permitted to carry out a small methadone maintenance pilot activity for the treatment of opiate addiction, with the funding from the National Programme for Illicit Drug Prevention and Control. Although the pilot only treated 68 patients, in 2005, an inter-ministerial specialist council, in reviewing the pilot results, recognised the positive impact of methadone use in reducing heroin injecting.

Regardless of the challenges posed by legal inconsistencies, the advocacy efforts of the international community and the willingness of certain political leaders (in particular former Deputy Prime Minister Mr. Truong Vinh Trong) enabled establishment of a legal framework for the introduction of a national pilot methadone programme, which began in Hai Phong and Ho Chi Minh City (HCMC) in May 2008. The initial legal framework included the 2006 HIV Law, Decree 108, and Decision No. 5073/2007 of the MOH that provided specific guidance on the implementation of the methadone pilot programme.

By September 2011, MMT services are provided in 9 provinces/cities with 30 clinics that enrol 4904 patients. A cohort study conducted by MOH found after 9 months of treatment extremely positive results (MOH, 2010a) in terms of reduced HIV risk, improved social and health status and crime reduction (MOH, 2010b). By the end of 2009, the pilot programme's success led the Government to scale up in other provinces, with the goal of providing MMT to 80,000 drug users by 2015 (MOH, 2010b).

Since 2010, some international organisations in Vietnam have encouraged MOLISA to run community-located, evidence-based drug treatment services. On 18 June 2011, the first MOLISA-run methadone treatment co-pay clinic was inaugurated in Hai Phong City. In this co-pay programme, the clients contribute VND240,000/month (~US$12), which represent about 30% of the running cost of the clinic (Nguyen Thi Diep, personal communication, October 20, 2011). Inclusion criteria for entry into the co-pay MMT programme are less strict when compared to the fully funded government clinics. By the end of September 2011, there were 130 patients in the co-pay programme. This is the first MMT clinic funded largely by the Vietnam Government. The opening of the Hai Phong co-pay clinic is a critical milestone that marks the official role for MOLISA in the national MMT programme implementation.

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Existing challenges

The 18-year battle waged by the Vietnamese Government against illicit drug use is beginning to be questioned due to its limited success. Many Vietnamese policymakers are realising that the massive law enforcement effort combined with preventive education and compulsory detainment will not eliminate the country's drug problems. In questioning the current approach, it is legitimate to ask how the Government's future commitments should be balanced and prioritised. Thus far, harm reduction interventions coverage is low (Mathers et al., 2008; World Bank, 2011a). Also, some national, provincial and local authorities continue to oppose harm reduction approaches and prefer a continued emphasis on law enforcement and compulsory incarceration (Hammett et al., 2007).

There is ongoing political commitment to compulsory treatment centres in Vietnam due to belief in the philosophy behind this approach as well as a variety of motivations and incentives for different government organisations. Specifically, The Government of Vietnam has made a commitment to being drug free (AIFOCOM, 2010) and wants to provide some visual proof of their commitment to a "drug free" Asia. In the meantime, the Government organisations who are tasked with responsibility to manage these compulsory centres have had budget increases from the National and/or local government (DSEP/MOLISA, 2007). This, along with profits made through commercial contracts signed by the centres (Human Rights Watch, 2011) provides an incentive for keeping the existing centres and building new ones. This ongoing commitment is also having a significant negative impact on harm reduction opportunities (OSI, 2009). Many drug users remain reluctant to access harm reduction services fearing detection by police and detention, thus increasing their risk of HIV exposure (Reid & Higgs, 2011). Rightly or wrongly, IDU believe that police are required to meet arrest quotas to keep compulsory treatment centres at capacity (Khuat Thi Hai Oanh, personal communication, April 28, 2010). Policing practice has also been shown to affect access to sterile injecting equipment. A study conducted in 2004 in Lang Son reported a drop in the number of needles and syringes distributed via peer educators and pharmacies during police crackdowns (Hammett et al., 2006).

Compulsory detainment is in itself doubly stigmatising. In addition to being identified to one's family and community as a drug user, the person must cope with the ongoing stigma of involuntary detention; these issues combine to make it difficult to find employment or even return to the community (Larney & Dolan, 2010). Compulsory centres may also be contributing to HIV transmission among people who use drugs even though HIV transmission in closed settings is very difficult to measure. Internationally, closed settings such as prisons and detention centres have been identified as sites of increased HIV risk (Small, Wood, Jürgens, & Kerr, 2005). Drug users in the centres continue to engage in risk behaviours including drug injecting and sex, albeit at a lower rate, but without access to sterile injecting equipment or condoms (Nguyen, Giang, Nguyen, & Wolffers, 2000). Hence, the likelihood of transmission of HIV and other blood-borne infections may in fact be higher in the centres than in the community. Gains made from introducing harm reduction interventions in the community may be undermined by higher risk behaviours in the centres, especially as internees may not even be aware of their infection status (Reid & Higgs, 2011).

The way forward

How can the policy, legislative and regulatory environments be harmonised? How can coordination across ministries and relevant sectors be improved so that drug addiction treatment and harm reduction programmes achieve their maximum positive effects in Vietnam?

Improved recognition of the consequences of policy conflicts

It is important for relevant Vietnamese Government agencies to recognise these policy tensions as problematic – for example, to consider the effects that crackdowns and mass incarceration of drug users may have on an HIV prevention programme. There is reportedly growing recognition of the problems brought about by the parallel pursuit of inconsistent supply control policies and harm reduction-based HIV prevention approaches. Government officials are now more willing to discuss and consider harmonising the overall policy environment and adopting strategies for reducing risk in environments frequented by drug users. It is critical for the international community to continue to work collaboratively and provide ongoing advocacy to ensure the Vietnamese Government pursues a consistent public health approach towards illicit drug use. A multisectoral dialogue could help advance this policy harmonisation through greater cross-sector coordination.

Harmonisation of the roles of MOH, MOLISA and MOPS

Transformation of the roles of MOLISA and MOPS with respect to interventions and responses towards people who use drugs is critical. These two sectors should be involved in service delivery in a way that is complementary to services and interventions that are currently managed by the MOH. A major obstacle is that drug addiction treatment and rehabilitation is the responsibility of MOLISA but prevention, treatment and care related to HIV/AIDS lies with MOH and inter-sectoral involvement has been superficial (Nguyen et al., 2010). This divided jurisdiction has resulted in difficulties in implementing broad-ranging prevention programmes for all drug users in Vietnam as well as many other similar country settings (Reid, Kamarulzaman, & Sran, 2007).

The leading role of the NCADP is critical in facilitating the alignment of the three implementing ministries. Lessons can be learnt from neighbouring countries like Malaysia where similar change processes have been undertaken. Malaysia in the past had a similar political interest in the compulsory treatment approach. However, since 2005, the introduction of harm reduction services as well as the more recent initiation of a process to transform compulsory centres for drug users into voluntary needs-based community services indicates that Malaysia's response to drug-related issues has become increasingly health focused (Tanguay, 2011). Policymakers of Vietnam could examine the practical changes in Malaysia that enabled them to transform compulsory centres into voluntary services facilities under a national drug dependence treatment strategy. This might provide guidance on how the roles and responsibilities of the MOH, MOLISA and MoPS could be complimentary rather than contradicting.

Enhanced participation of civil society and the affected community

Enhanced participation of civil society, the HIV-affected community, and other actors in the policy process is likely to contribute to policy formulation and implementation that meets the diverse needs and concerns of the population (Nguyen et al., 2010). Existing intervention programmes are largely run by government agencies; NGOs in Vietnam should be encouraged to actively participate in drug use and HIV intervention programmes. In drug addiction treatment and HIV intervention programmes NGOs have the advantage of being able to reach out to drug users without provoking fears of arrest or stigmatisation (Qian, Schumacher, Chen, & Ruan, 2006). Experiences from other countries have demonstrated that NGOs play an important role in drug treatment and HIV/AIDS

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interventions (Ainsworth, Beyrer, & Soucat, 2003; Paiva, Ayres, Buchalla, & Hearst, 2002). Stronger participation of civil society organisations would also resolve human resource shortages within government agencies and improve the coverage of service delivery.

Linking evidence to policy and practice

Evaluation of community-based drug addiction treatment and HIV prevention programmes must be undertaken and the results disseminated, especially to policymakers. One of the lessons of the Vietnamese experience is the value of scientific evidence for policy advocacy. Evidence can make a difference, particularly in countries that take pragmatic approaches to health problems (Hammett et al., 2008). Most of the evidence for the efficacy of community-based drug addiction treatment programmes and HIV interventions comes from developed countries, but well-designed evaluations of interventions in Asia will have a better chance to influence policy decisions. A synergistic approach involving research, policy development and service delivery is most likely to achieve positive results in drug addiction treatment programmes and HIV interventions in Vietnam (Hammett et al., 2007).

Conclusion

During the last decade, due to a change in the mindset of many Vietnamese political leaders, there has been a major shift in drug policy towards acceptance and implementation of harm reduction programmes. This change in policy has allowed evidence-based HIV prevention and drug addiction treatment services to be available for thousands of drug users. However, scaling up the response to drug use and HIV remains an enormous challenge. The persistence of tensions between drug control and harm reduction policy initiatives will continue to have a negative effect on programme implementation until a fully harmonised policy environment is established (Hammett et al., 2008). In the meantime, excessive reliance on law enforcement and forced detoxification will not solve the problems of illicit drug use or the spread of HIV among drug users (Hammett et al., 2008). The continuation of the system of compulsory centres for drug users hinders efforts to scale-up harm reduction services.

Resolving the tensions between drug control and harm reduction policies and the impediments to public health gains due to the continuance of the system of compulsory centres is complex. While the foundation for increased collaboration between the health sector and public security to address drug use and HIV issues exists at the national and some provincial levels, ongoing advocacy is required to ensure greater understanding between these sectors to allow complementary rather than conflicting practices towards drug users (Hughes & Stevens, 2007). With ongoing advocacy allied to appropriate education and training, the capacity of the Vietnamese Government and the broader community to adopt, support and promote measures to reduce HIV and other drug-related harms would be markedly strengthened (Reid & Aitken, 2009).

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