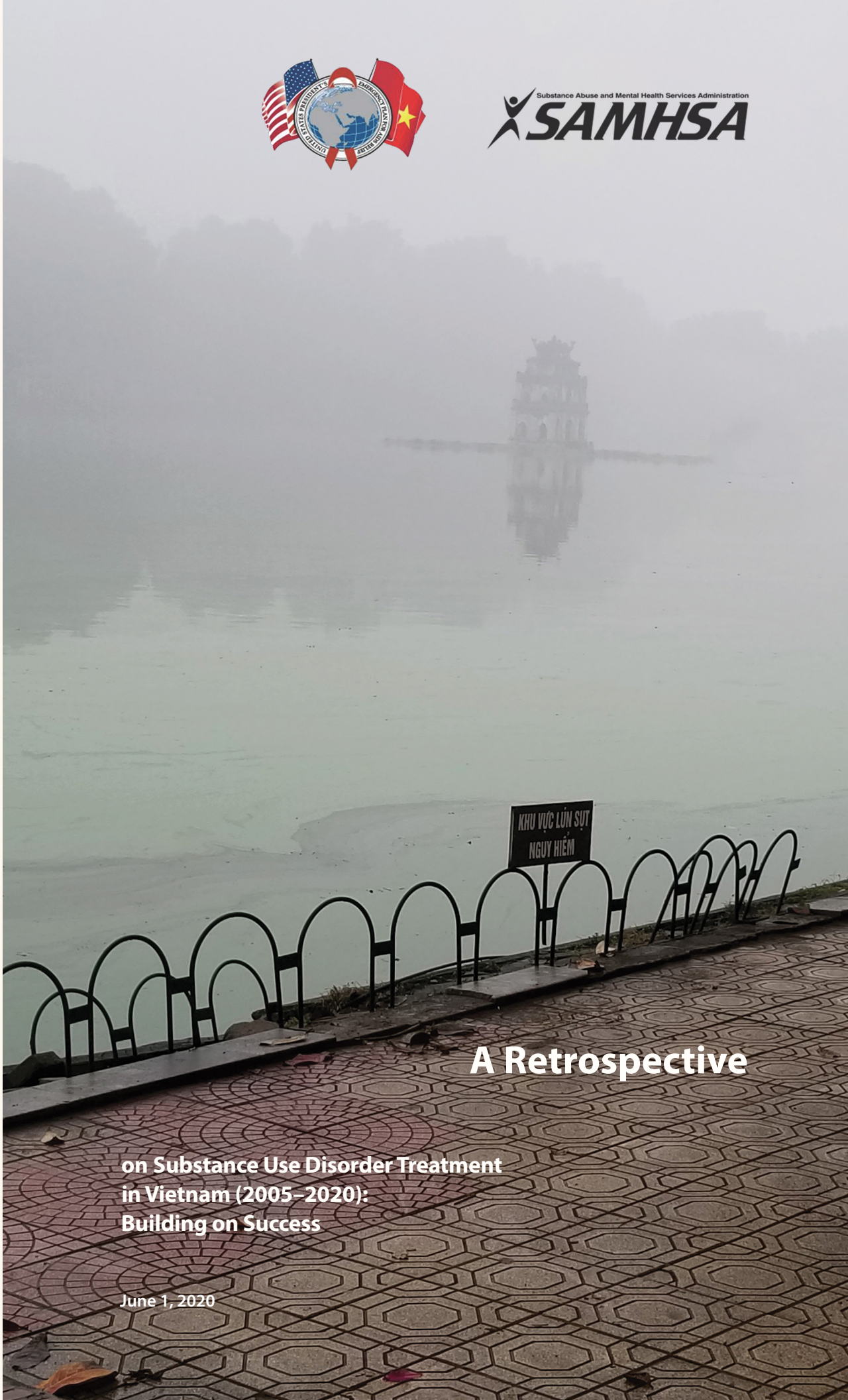


# A Retrospective

## on Substance Use Disorder Treatment in Vietnam (2005–2020): Building on Success

June 1, 2020

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The views expressed in this report do not necessarily reflect the views of SAMHSA/PEPFAR Vietnam, the US Department of Health and Human Services, or any other participating US or Vietnamese governmental agency or participating partner organization. The views expressed are the sole responsibility of the author.

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Victor Capoccia, PhD
Vineyard Haven, Massachusetts

April 15, 2020

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# Executive Summary

## Introduction

This report describes changes in Vietnam's approach to the treatment of substance use disorders (SUDs) during the period from October 2005 to February 2020. It tells the story of changes made in what constitutes treatment; opportunities unrealized for additional improvements; and opportunities that lie ahead to both sustain the changes made and continue the development toward a Vietnam-specific SUD-treatment system that joins the strengths of Vietnamese culture and values with the strengths of evidence-based SUD interventions.

The story of a 15-year period of change in approach to SUD in Vietnam is multi-layered. It includes changes in the legal and policy frameworks of the Government of Vietnam (GVN), changes in programs for GVN administrative agencies, significant investment of international governmental resources and technical expertise, engagement with non-governmental organizations (NGOs) and other implementing partners, and, not the least, changes in behavior and an extension of trust by tens of thousands of patients and their families across Vietnam's 63 provinces.

The magnitude of change in this period is embodied, on one hand, by a father in Hoa Binh province who, in 2010, drove approximately 100 kilometers to Hanoi weekly to purchase medication that would help his son's addiction and allow him to avoid being placed in a compulsory rehabilitation center, and, on the other hand, by a 2019 case of a woman in recovery who worked proudly and relentlessly in an eastern province to recruit two addicted brothers into a community-based methadone treatment program that also includes assessment and brief counseling for methamphetamine users.

## Methodology and Limits

The report is based on qualitative research that includes a structured interview discussion guide employed with a purposive sample of 64 respondents; 47 were associated with GVN, PEPFAR in Vietnam, or other implementing partners or were technical experts who have worked in Vietnam, and at least 17 were patients and family members. (See Appendix A: Discussion Guide for SAMHSA/PEPFAR Structured, Open-ended Interviews; Appendix B: Interview Requests [Vietnamese and English Versions] and Appendix C: Interview Respondent List.) In addition, information was reviewed and cited from a targeted selection of what is now a voluminous amount of published peer-reviewed and non-peer-reviewed report literature focused on HIV/AIDS and SUD in Vietnam.

## The Vietnam Context of SUD Treatment Development

A basic understanding of four elements of the context that is Vietnam is essential to understanding this report.

First, Vietnam is a rapidly growing "middle income"country (see https://www.worldbank.org/en/country/vietnam/overview). Practically, this means that public investment is focused primarily on economic and social development for basic needs; given the choice between investing in roads, housing, and schools or dedicating resources to mental health and SUD treatment, the former will usually take priority.

Second, the Government of Vietnam is integrated with a single political party, the Communist Party. The practical implication of this fact is the need to have party understanding and support for any structural change to the current social order.

Third, the strength and role of the family, as well as the local community, are ubiquitous in every person's life. Families and local-community norms are the leverage points for each member's economic, social, and community life. Finally, as in most places in the world, despite public declaration to the contrary, social stigma attaches to people who use drugs, especially those who use heroin andor methamphetamine.

## What Happened: Changes from 2005 to 2020

In the words of international expert Dr. Richard Rawson: "The work in Vietnam was the most productive of any international effort I have seen; it has saved lives and built capacity. It is a model for how the United States can assist other countries".

To the extent that this quoted statement is valid, the report discusses:

- GVN policy that states that SUD is a health condition, not a social evil, and that presents a "renovation plan"to transform compulsory rehabilitation centers for drug users to voluntary centers, hosting a range of evidence-based, medication-assisted treatment and clinical services.
- Data on the scale-up of methadone maintenance treatment (MMT) clinics from six pilot centers in Ho Chi Minh City, Haiphong, and Hanoi to more than 300 clinics serving 53,000 patients in all 63 provinces, the responsibility for which is fully assumed by GVN.
- Human resource capacity expansion that includes three HIV–Addiction Technology Training Center (VH-ATTC) initiatives and approximately 6,700 personnel trained in MMT, among them over 2,016 trained in contingency management, behavior modification, motivational interviewing, and related evidence-based clinical practices.
- The approach or process used to achieve these changes, and how the changes came about.

## What Might Have Happened: Opportunities Not Realized 2005–2020

This report also discusses unrealized opportunities throughout this period, such as:

- The reliance on the singular lens of human immunodeficiency virus infection/acquired immune deficiency syndrome (HIV/AIDS) mitigation to define SUD intervention, which led to the equation of SUD with opiate use disorder (OUD) and a treatment response based solely on medication.
- GVN policy that reinforced the equation of SUD and OUD by ceding methadone-based interventions largely to the Ministry of Health (MOH) and retaining other interventions to broader SUD in the Ministry of Labor, Invalids, and Social Affairs (MOLISA).
- The absence of an encompassing approach to SUD treatment to address the rise of amphetamine-type stimulants (ATSs) and the absence of a single, highly effective methadone-like intervention for ATS users, which underscores the shortcomings of a siloed, HIV/AIDS–driven SUD system and leaves the use of compulsory rehabilitation centers as a default response to non-heroin substance use.

In the words of another key respondent, "The focus on HIV as a lens for SUD with a 'methadone only' solution reinforced the bifurcated response to SUD in Vietnam".

## Looking Beyond 2020: Sustaining Success and Taking Next Steps

The report presents two dimensions for future consideration. The first looks at *how to sustain the positive changes that have been made and avoid default to past solutions* when faced with new complex issues, such as the use of ATSs or whatever new substances emerge in the future. Examples of achievements to be sustained include:

- The widespread use of medication to address heroin use.
- The values and core principles of the Prime Minister's 2013 Renovation Plan.
- The importance of engaging the strengths embodied in the cultural values of the Vietnamese family and ties to local community
- Training and support for the emerging behavioral health workforce, supported initially by FHI 360 and Vietnam Administration of HIV/AIDS Control (VAAC) and later by the three HIV-ATTCs in Vietnam.
- Support for Vietnamese leadership to sustain this work.

The second dimension of future consideration suggests a series of *steps that lead to a Vietnam-centric SUD treatment system* that is more closely aligned with the principles expressed in the Prime Minister's 2013 Renovation Plan. Examples of these steps include:

- A pilot community-based center of SUD treatment excellence, managed by MOH through a cooperative agreement with MOLISA.
- A feasibility analysis of the costs of expanding social health insurance coverage to include SUD treatment.
- Development of standards and responsibilities to expand the number and role of peer recovery support personnel.
- Incorporation of diversion and possible drug court models into a center of excellence pilot.
- An analysis of the SUD treatment needs of and available resources for women.
- A plan for a workforce development pipeline to deliver, manage, evaluate, and build knowledge for SUD treatment in the future.

The report notes the current presence of most of the core elements of a com-prehensive SUD treatment system in Vietnam. It aalso observes that each program element of a potential continuum of care is independently offered as a stand-alone service, managed by distinct levels and administrative units of government.

The goal of achieving a comprehensive and integrated system of SUD, mental health, and general medical care is within reach in Vietnam. Building on changes that occurred in the last 15 years, achieving the goal requires recalibration of administrative and protocol barriers that inhibit patient flow across services; continued development of a skilled and credentialed Vietnamese workforce; and Vietnamese and other leaders' willingness to invest and persevere in system changes that understand and respond directly to patient SUD treatment needs.

# Introduction

The first case of human immunodeficiency virus infection (HIV/AIDS) was reported in Vietnam in 1990, and by 2003, the estimated prevalence of HIV/AIDS in Vietnam ranged from 0.2 to 0.8%, involving somewhere between 110,000 and 350,000 people[1]. Further understanding at that time indicated that injection-drug use (IDU) was a major vector for the spread of HIV/AIDS. Up to one-third of the 156,000 registered intravenous drug users[2] were infected with HIV/AIDS[3]. While the Government of Vietnam (GVN) mounted efforts to address the spread of HIV/AIDS[4], the bi-lateral agreement between the governments of Vietnam and the United States that introduced the US President's Emergency Plan for AIDS Relief (PEPFAR) in 2004 marked the beginning of a more comprehensive effort to both prevent the spread of and treat existing HIV/AIDS among the Vietnamese population[5].

PEPFAR is coordinated by the PEPFAR Coordinators Office, with oversight by the Office of Global AIDS Coordination of the State Department, and includes other US government agencies, such as the Centers for Disease Control and Prevention (CDC), the US Department of Defense, and the US Agency for International Development (USAID).

Because of the strong relationship between HIV/AIDS and people who inject drugs (PWID), PEPFAR incorporated prevention and treatment approaches to IDU as a key strategy to reduce HIV/AIDS[6]. In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) joined the PEPFAR team in Vietnam[7]. SAMHSA employed technical expertise and program experience with SUD prevention, treatment, and recovery, along with PEPFAR's programs, which emphasized the use of medication-assisted treatment as an HIV/AIDS prevention intervention[8]. Beginning in 1993, the approach to addressing substance misuse in Vietnam was based on a view of addiction as a "social evil,"and drug users were sent to compulsory rehabilitation and re-education centers[9]. By 2008, the combination of international pressure to close the compulsory rehabilitation centers and the intergovernmental agreement with PEPFAR introduced the option of a community- and evidence-based approach to SUD treatment as an intervention to control HIV/AIDS spread in Vietnam.

In 2019, SAMHSA headquarters served notice that it would focus its resources on domestic priorities and no longer participate in PEPFAR, effective September 30, 2020[10]. This report on changes in SUD treatment in Vietnam can be viewed as one section of a road map that covers a journey, the starting point of which is arbitrary and the final destination unknown. The section of the map represented by this report is the road traveled by SAMHSA in the company of many others. The marker points on this section of the road map were created by many past and current partners associated with SAMHSA/Vietnam. The changes described in this period of time were not all created or caused by SAMHSA, but almost all have an association with SAMHSA's presence and participation throughout this time.

The 15-year period of SAMHSA's involvement with PEPFAR in Vietnam is a multi-faceted story—on one hand, of a dramatic scale-up of treatment for heroin and declarations by the government that addiction is a health condition, and, on the other, of the persistence of the stigma attached to drug use, and the response to it, as a deviant behavior associated with distinct substances (e.g., heroin or methamphetamine) rather than an addiction disorder, a bio-psycho- social health condition.

This report has three goals:

- To provide an overview of the development and current status of SUD treatment in Vietnam.
- To identify opportunities for change throughout that period that were unrealized.
- To identify and describe approaches to maintain and continue the development of SUD treatment services in Vietnam.

Dr. Dennis McCarty, another international expert, summarizes the approach during the 15-year period described in this report: "By a strong system of methadone maintenance treatment (MMT), a temporary shift away from 'compulsory rehabilitation centers,' and a corresponding need to use strong family and community supports to build a comprehensive system of care, because there is always a new drug that will come along".

## NOTES

**1.** Joint United Nations Programme on HIV and AIDS, Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Viet Nam, 2004, http//data.unaids.org/publications/fact-sheets01/vietnam_en.pdf; World Health Organization, Summary Country Profile for HIV/AIDS Treatment Scale-up, Viet Nam, December 2005.

**2.** Nguyen Van Minh, Le Duc Hien, and Tran Xuan Nhat, United National Office on Drugs and Crime, "Drug Abuse and Drug Dependence Treatment Situation, 2008, https://www.unodc.org/docs/treatment/CoPro/Web_Viet_Nam.pdf.

**3.** Nguyen Tran Hien, Nguyen Thanh Long, and Trinh Quan Huan (2004), "HIV/AIDS epidemics in Vietnam: Evolution and responses,"AIDS Education and Prevention 16, "HIV/AIDS in Asia,"pp. 137–154, https://doi.org/10.1521/aeap.16.3.5.137.35527.

**4.** Pham Nguyen Ha[1,2*], Anastasia Pharris[1], Nguyen Thanh Huong[3], Nguyen Thi Kim Chuc[2], Ruairi Brugha[4], and Anna Thorson[1], "The evolution of HIV policy in Vietnam: From punitive control measures to a more rights-based approach,"Global Health Action 3:1, 2010, doi: 10.3402/gha.v3i0.4625.

**5.** Anthony Fauci and Robert W. Eisinger, "15 Years and Counting the Lives Saved,"New England Journal of Medicine 378, January 25, 2018, pp. 314-316, doi: 1056/NEJMp1714773PEPFAR.

**6.** The U.S. President's Emergency Plan for AIDS Relief Comprehensive HIV Prevention for People Who Inject Drugs, Revised Guidance, 2010.

**7.** See Appendix D: SAMHSA/Vietnam Directors and Technical Leads.

**8.** Committee on the Outcome and Impact Evaluation of Global HIV/AIDS Programs Implemented Under the Lantos-Hyde Act of 2008; Board on Global Health; Board on Children, Youth, and Families; Institute of Medicine, "Evaluation of PEPFAR,"Washington, DC: National Academies Press (US), June 27, 2013.

**9.** There are multiple naming conventions employed in literature and in interviews for the centers established in 1993 by the National Assembly–launched Resolution 06/CP (MOLISA, 2010), whose purpose focused primarily on anti-drug information and education, supply reduction, interdiction, and compulsory treatment of drug users. Most common references to the centers include: "06 centers,""compulsory detention centers,""compulsory treatment centers,"and "compulsory rehabilitation centers". This report will follow the naming convention referenced by a respondent in a revision of Resolution 06/CP—"compulsory rehabilitation centers"—with the understanding that the centers did not begin to include evidence-based treatments until 2008.

**10.** US Department of State, "COP 2020 Planning Level Letter/Part 2,"January16, 2020 (UNCLASSIFIED), p. 10.

# Methodology and Limits

This report is a qualitative analysis presented as a retrospective narrative with implications for future actions. It is based on three sources of information. First, structured interviews were conducted using a discussion guide, with a purposive sample of 29 Vietnamese national experts from GVN, PEPFAR, and Vietnam-based NGOs; 18 international advisors and experts, including international staff from PEPFAR in Vietnam; and a minimum of 17 patients and family members[11]. Interviews were not recorded verbatim, but extensive notes were taken throughout each conversation. Respondents were told that statements would not be attributed without explicit permission. Interviews in Vietnam that required translation were, in all but one instance, conducted through the same Vietnamese- and English-speaking associate. All 53 Vietnam-based interviews were scheduled through SAMHSA/PEPFAR or the Center for Supporting Community Development Initiatives (SCDI) office, and included both English and Vietnamese versions of a letter of introduction, a brief description of the purpose of the interview, and the interview guide.

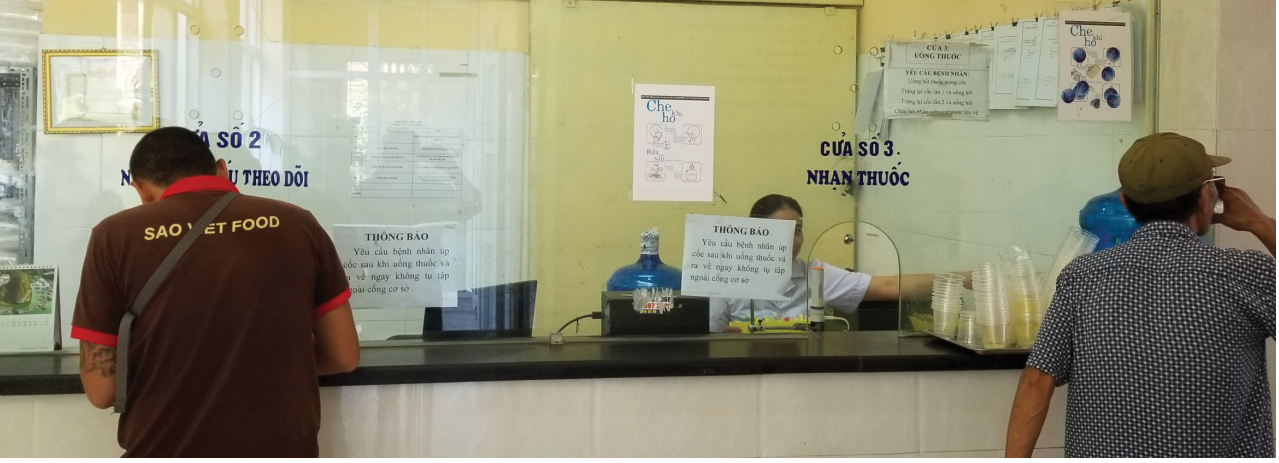
The second data source comprises peer-reviewed literature; GVN official documents, many of which are translated; technical reports issued by the World Health Organization (WHO), the Joint United Nations Programme on HIV and AIDS (UNAIDS), and the United Nations Office on Drugs and Crime (UNODC); PEPFAR guidance documents; and PEPFAR newsletters. No systematic software or keyword analysis was used to review this vast trove of written documents. Rather, written material was used as a reference, supplement to, and confirmation or questioning of interview data. Primary source documents are listed in the "Bibliography and Resources"section of this report.

The third source of report data is derived from the author's visits to directly observe as well as talk to patients in two outpatient MMT clinics; one voluntary (former rehabilitation) center; and three peer recovery support group settings.

The report is limited by information based on primary qualitative and secondary quantitative data. Both types of data are from purposive, not randomized sources. There were no comparative examples or controls involved in the research. A further limitation is found in the lack of precision in and the opaque nature of data reported from local to national levels by multiple GVN agencies. It is not uncommon to find data quoted and/or reported in written form that varies slightly and lacks reference to or documentation of data sources or means of production. One reason for the data discrepancy regarding SUD prevalence is that some government data track people who are registered users, a category that requires a formal process that many drug users avoid. The reported numbers are further complicated by the division of responsibility for SUD programs among the Ministry of Labor, Invalids, and Social Affairs (MOLISA), the Ministry of Health (MOH), and the Ministry of Public Security (MOPS). The analysis is finally limited by the cultural, language, and experience differences inherent in research conducted by a non-native person.

**NOTES**

**11** See Appendix A: Discussion Guide for SAMHSA/PEPFAR Structured, Open-ended Interviews; Appendix B: Interview Requests (Vietnamese and English Versions); and Appendix C: Interview Respondent List.




Patients at a Ministry of Health methadone maintenance treatment clinic.

# The Vietnam Context of SUD Treatment Development

An accurate understanding of both the changes in SUD treatment in Vietnam and opportunities for further development requires a basic familiarity with the context in which past changes occurred and future change will occur. “Context"represents the influences on changes in the social, cultural, political, and practical environment that extend from the very local to a national scale. Several overlapping contextual circumstances defined the development of an approach to treatment of SUD between 2005 and the present in Vietnam.

The first defining context noted by almost all respondents was that SUD treatment was introduced as an intervention in the effort to reverse the spread of HIV/AIDS, and not as an intervention in its own right to address addiction. For PEPFAR, the rationale for introducing SUD treatment was that IDU was a major vector for the spread of HIV/AIDS in Vietnam. For GVN, the rationale was that upward of 40% of drug users in compulsory rehabilitation centers were HIV-infected, and almost all returned to IDU upon release from the centers. Since 2005, the GVN approach to mitigating HIV/AIDS has been highly successful and well documented in other research[12].

The second defining context is the fact that Vietnam is a constitutionally based socialist republic governed by a 498-member National Assembly that elects a president and a prime minister, and is based on a constitution infused with the social and economic principles of the Communist Party of Vietnam[13]. The practical implication of Vietnam’s form of government is that decision making is highly centralized through a political structure that extends from the granular level of the commune through districts and provinces to the national level. As a result, for example, once the decision was made to approve the use of methadone to treat IDU, the barriers to implement the decision nationally were mainly operational, not so much political or ideological. The inverse implication is that no approach is executed until government approval is secured.

Another critical contextual dimension is Vietnam's economic status. The World Bank describes Vietnam as a remarkable case of economic and social development, transitioning in 1986 with *Doi Moi* ("Renewal") from one of "the world's poorest countries"to a rapidly developing and promising "lower middle-income"nation in 2019[14]. The transformation includes favorable rates of educational access; basic health insurance; reductions in poverty; growth of employment; water, transportation, and related infrastructure investment; and a favorable position in the global economy. The signs of development in Hanoi and the surrounding provinces—new factories, new highways, new sections of the city, cars, hotels, commercial and residential structures—are palpable to any visitor. The country's economic success to date has not been without costs; the most obvious is environmental degradation. Less obvious costs, typical of a developing country, are the lower priority given to quality-of-life investments—in this case, in mental health and addiction-prevention and-treatment capacity, which become second or third choices when determining where to spend scarce resources.

The context of drug use in Vietnam, like that of many countries in the world, evolved along a continuum that has ranged from traditionally being considered a moral failing or criminal behavior (a social evil) to today being viewed as a treatable health condition. The "social evil"perspective in Vietnam led, in the 1990s, to the development of compulsory rehabilitation centers that held registered drug users—initially for six months, and later for two years or sometimes indeterminate time periods. A midpoint on this continuum was reached in 2013, when the prime minister approved a Drug Rehabilitation Renovation Plan to reduce the number of compulsory rehabilitation centers and strengthen voluntary, community-based treatment opportunities. Most respondents reported that the number of center occupants initially declined after 2013, as the number of MMT clinics and enrollments increased; however, the decline was reversed in 2016 due to an increase in the use of amphetamine-type stimulants (ATSs)[15]. The continued reliance on compulsory rehabilitation centers as a means to address addiction in Vietnam is relevant because the GVN expenditures that support those centers directly competes with the support needed to develop community-and evidenced-based addiction treatment. The future risk is that centers will become a "default solution"to the growing ATS problem in Vietnam, absent either a single (methadone-like) and highly effective intervention to ATS use or negative pressure from human rights–related international governments and organizations.

As they considered the context in which continued development will occur, respondents suggested the importance of a number of small but nevertheless essential elements in the initiation, testing, and eventual spread of MMT clinics to stem HIV. The MMT scale-up process included:

The MMT scale-up process included:

- Multiple *site visits* to other countries and models of service delivery.
- The initiation and concurrent evaluation of three *pilot projects* for *MMT*.
- *Donor investment* in the pilot projects.
- Clarity about the *effectiveness* of the pilot sites.
- The eventual *scale-up* of the MMT clinic approach.
- Eventual *GVN ownership* of the current operation of some 300 clinics across the all 63 provinces.

The MMT clinic case example highlights the fact that GVN is generally not an "early adopter"; is willing to engage in controlled pilot projects; likes to share the financial cost of new interventions with donors until the interventions are proven effective; and takes pride in the role of enlightened steward of knowledge. These are perhaps small, and obvious, but nevertheless important points to bear in mind in planning for future development.

**NOTES**

**12.** Pham Nguyen Ha, et al., "The evolution of HIV policy in Vietnam".

**13.** Embassy of the Socialist Republic of Vietnam in the United States of America, http://vietnamembassy-usa.org/vietnam/politics/government-structure.

**14.** World Bank, "The World Bank in Vietnam,"April 2020, https://www.worldbank.org/en/country/vietnam/overview; Anja Baum, "Vietnam's Development Success Story and the Unfinished SDG Agenda, "International Monetary Fund Working Paper, February 14, 2020.

**15.** See Appendix E: Occupancy of Compulsory Rehabilitation Centers Established by Resolution 06/CP (1993), 2012–2020.

# What Happened: Changes from 2005 to 2020

The peer leader smiled when asked to talk about a recent case that illustrated the ongoing work of the seven peers meeting around the conference table. A story unfolded of two brothers addicted to heroin and also using amphetamines—one with a compromised liver due to hepatitis C, both distrustful of the consequences of their drug use if local authorities should become involved, and both causing hardship to their family. The peer-outreach worker's home visits and follow-up phone calls were ignored and unanswered by the brothers over a two-month period. The worker persisted, waiting until evening on several occasions to encounter and talk with the brothers. The worker reached out to the family and connected with a sister who supported the effort to reach her brothers.

After close to four months of persistent outreach, one of the brothers appeared and met with the peer leader. That connection began a process that led to the overcoming of his fear of enrolling in an MMT clinic and his intake at the clinic; the engagement of the second brother; and the employment of both with jobs in construction. This story illustrates the role of persistence, family strength, and peer outreach to support access to SUD treatment.

The story also can serve to illustrate the arc of SUD development in Vietnam, which occurred in three distinct periods[16] between 2005 and 2020. *In 2005, the period of building relationships, foundation principles*, and pilot testing, the brothers were more likely to have been directed to a compulsory rehabilitation center than to get into evidence-based treatment, as MMT was nascent in Vietnam and SUD peer outreach had not begun. *By 2012, the period of renovation, expansion, and challenges to success*, there were new MMT programs and the initial use of outreach workers, and the brothers would have been more likely to find treatment, as the country adopted goals to enroll as many as 40% of those engaged in IDU, according to WHO's recommendations, into community-based rather than institutional care. This period saw a shift from punitive control measures to a more rights- and evidence-based approach, such as harm reduction, medication-assisted treatment, and public subsidy of costs. And in more recent times, *starting in 2016, a period of building capacity, maintenance of effort, and looking ahead*, the brothers, with continued ATS use, will face a crossroad between the default use of compulsory rehabilitation centers and potential for care in integrated, community health clinics that incorporate evidence-based clinical interventions for SUD treatment with primary care.

*The arc of SUD development in Vietnam, between 2005 and 2020, reflected three phases: a period of building relationships, foundation principles, and pilot testing; a period of renovation, expansion, and challenges to success; and, a period of building capacity, maintenance of effort, and looking to the future.*

### Period I: Building Relationship, Foundation Principles, and Pilot Testing (2005–2012)

The brothers in the story above would most likely not have found or been led to treatment for their SUD during this initial period—not because of a lack of activity and interest during this time, but because, with the ramp-up of PEPFAR, the SUD efforts in this period focused on building relationships, sharing knowledge, gaining trust, and piloting proof-of-concept interventions that fit Vietnam's political/cultural context. The brothers would most likely have been identified on multiple occasions by local law enforcement, brought before their local commune people's committee on at least two occasions, and, assuming they continued their drug use, been sent to a compulsory rehabilitation center. Centers were authorized in the 1993 Resolution 06/CP to "reeducate, punish, and rehabilitate"drug users[17]. The consistent failure of these centers to achieve two of their three purposes, along with the economic and family costs and international disapproval, provided a context for the community-based initiatives that were started in this era and that have been expanded to the present time.

Vietnam identified its first HIV/AIDS cases early in the 1990s. The number of cases grew throughout the decade, from thousands to more than 10,000 new cases annually by the year 2000[18], when there were an estimated 160,000 people living with HIV/AIDS. At the same time, Vietnam experienced a parallel increase in the number of PWID, reflecting the availability of heroin and other opiates that replaced the smoking of opium. IDU accounted for more than half (53%)

of HIV/AIDS infections[19]. While for this report there were no reasonably available estimates of PWID prevalence for the same period (1990–2000), there were an estimated 170,400 registered drug users in Vietnam in 2004[20]. By 2012, there were an estimated 208,866 people living with HIV/AIDS[21] and 171,000 registered drug users, 85% of whom used heroin[22].

As referenced in the "Methodology and Limits"section of this report (above), SUD prevalence estimates are probably underestimated because they reflect registered users of primarily illegal drugs, make no reference to alcohol, and are tracked by three different government ministries for different purposes. According to a Brookings report and based on the UNODC World Drug Report of 2014, it is reasonable to estimate that, worldwide, 0.53 percent of persons between 14 and 64 years of age have used an opiate[23]. This translates to an estimate of 335,990 drug users in this period in Vietnam.

By 2005–2006, all GVN and supporting partners realized that flattening the trajectory of the rise of HIV/AIDS infections was dependent on decreasing transmission associated with PWID. A multi-faceted response—coordinated by PEPFAR/SAMHSA, GVN, and VAAC, assisted by a wide range of partners, such as FHI 360 and SCDI—led to what was characterized as a "model of international cooperation and coordination to save lives and build capacity". SCDI's role involved both advocacy and harm-reduction activities as they worked with people with HIV/AIDS and with SUD. FHI 360's role involved the development of standards and protocols to guide the development of evidence-based SUD treatment interventions, and support for a cadre of international experts to train and provide guidance for the development of SUD clinics by GVN's MOH and MOLISA. Respondents consistently referenced the following components of success:

- Leaders in SAMHSA/PEPFAR who *listened to and took into account cultural and political qualities* when developing programs.
- Key GVN persons from different ministries, as well as the umbrella Office of Government (OOG) and prime minister's office, who became *champions for policy change and development*.
- PEPFAR/CDC/USAID support that focused on the SUD issue with resources, in tandem with HIV/AIDS testing and anti-retroviral interventions.
- *Investment* of financial resources and technical expertise from international partners, as noted in Appendix F: International Partners and Funders.
- International support for a focus on *research and workforce development* based at Hanoi Medical University (HMU).
- The strategic use of *international site visits, and initiation of proof-of-concept pilot* projects.

According to respondents, key to the process for developing SUD treatment protocols and services was the time taken by SAMHSA staff to l*isten, understand, and build trust* with Vietnamese government officials; Karl White in 2005–2008 and Kevin Mulvey in 2008–2014 were mentioned in particular. The "listening"function, while not confined to SAMHSA staff, had four components: informal communication and association with local officials; employing qualified Vietnamese nationals in positions of responsibility (all PEPFAR components employ Vietnamese nationals in positions of responsibility); bringing to Vietnam international targeted subject matter experts in advisory/educational capacities (Richard Rawson, Walter Ling, Elinore McCance-Katz, Robert Ali, and Don Des Jarlais were advisors throughout this period); and exposing key Vietnamese officials to evidence-based models of care, especially in other Southeast Asian localities (e.g., study tours of MMT programs were sponsored by various partners in Hong Kong, Australia, the United States, and Kuala Lumpur).

Tracking the relevant content of specific *laws, decrees, directives, and strategies* (each has a distinct legal meaning in Vietnam; they are differentially created by combinations of National Assembly, executive, and administrative bodies) that represent SUD treatment policy throughout this period is frequently identified as challenging in the literature[24], and as a practical matter, it is beyond the scope of the research for this report. The literature and the respondents, however, offer the consistent appraisal that drug policy simultaneously shifted from and retained elements of one of the world's toughest policies, focused on criminal sanctions, to a more science-based policy focused on health and reducing threats to health. Both criminal-sanction and health-status SUD policy elements now coexist in Vietnam, as in many other parts of the world today. The appearance of GVN policy that views SUD in a health context was driven by the HIV/AIDS epidemic and was embodied in the National Strategy on HIV/AIDS of 2004; Directive/CP 54 in 2005; the National Assembly HIV/AIDS Law of 2006 (revised in 2009 and 2012); the decriminalization of drug use in the penal code (Article 199) in 2008–2009; and the Drug Rehabilitation Renovation Plan of 2013, which will be discussed in the next section.

While HIV/AIDS mitigation remained the impetus, relationship- and trust-building and changing policy developments provided the context for the initiation of harm-reduction and medication programs throughout this period. Harm reduction focused primarily on HIV testing and the distribution of condoms and clean needles. Six pilot methadone OUD treatment clinics were established, three in Ho Chi Minh City and three in Haiphong in 2008, followed in 2010 by a pilot for a third type in Hanoi. The six original clinics served a total of 1,200 patients, for whom follow-up research indicated strong retention and improved health and HIV/AIDS–status outcomes[25]. The pilots were models of international cooperation between GVN, PEPFAR, and others. PEPFAR provided the preponderance of direct support for operating the pilots. SAMHSA, with FHI 360, provided the technical assistance and workforce development dimensions of the pilots; and other international partners, including United Kingdom Aid, the WHO, and the Global Fund, supported research and implementation activities. Given the pilots' positive results, the Vietnamese government took, progressively, more active ownership through MOH and MOLISA, expanding MMT clinics to 41 sites serving 7,000 patients in 2011 and 60 sites serving 12,253 patients in 2012.

According to respondents, the remarkable shift in policy and expansion of MMT programs was well supported by key GVN officials at several levels who *championed* the development and expansion of community- and evidenced-based SUD treatment. Referenced leaders included, but were not limited to:

- HE Truong Vinh Trong, the former Deputy Prime Minister, who approved the methadone pilot and directed all sectors to collaborate in the implementation starting in 2007.
- Dr. Hoang Van Ke, former Vice Chairman of the People's Committee of Haiphong City. Dr. Ke volunteered to lead the methadone pilot in his city and directed all provincial sectors in its implementation. He now sponsors recovery support staff to work with methadone patients.
- Mr. Nguyen Trong Dam, former Vice Minister of MOLISA, who directed implementation of the transformation plan. This plan, together with the MMT program, helped improve the system of treatment and recovery. He also approved the implementation of MMT in voluntary treatment centers.
- Dr. Le Minh Giang, Assistant Professor and Founder of the Center for Research and Training on HIV/AIDS (CREATA) and coordinator of the Vietnam HIV–Addiction Technology Transfer Center (VHATTC) at Hanoi Medical University (HMU). He led a SAMHSA–funded capacity-building project to provide training and mentoring for the MMT program.
- Dr. Do Van Dung, Director of VHATTC at the University of Medicine and Pharmacy in Ho Chi Minh City (UMP). He led SUD–treatment capacity-building activities and facilitated strong collaboration with NGOs, community-based organizations (CBOs), and government agencies in the south of Vietnam.
- Dr. Doan Huu Bay, Vice Director of the Department of Science and Cultural Affairs of the Office of the Government, who coordinated implementation of the medication-assisted treatment and transformation plan between GVN health and civil-society agencies.
- Dr. Nguyen Cuu Duc, Acting Vice Director of the Department of Science and Cultural Affairs of the Office of Government, who advocated for capacity building for SUD treatment.
- Dr. Nguyen Thanh Long, Vice Minister of Health, who directed the procedures and protocols needed to pilot and bring MMT clinics to scale.

In addition to GVN officials, there were notable local champions for developing evidence and community-based SUD treatment in the nascent Vietnamese NGO sector and in key units of PEPFAR in Vietnam. Those referenced by respondents included but were not limited to:

- Dr. Khuat Thi Hai Oanh, Founder and Executive Director of the Center for Supporting Community Development Initiatives (SCDI), a key advocate for the renovation plan and a community representative partner, as well as an implementing partner of community-based pilot initiatives like Community Addiction Treatment Sites (CATSs) in Vietnam.
- Dr. Nguyen To Nhu, former FHI 360 Deputy Country Director for Vietnam, who worked closely with MOH to develop and implement quality guidelines and standards for MMT pilots, and who supported the required staff training and mentoring until the VHATTCs debuted in 2015.
- Dr. Nguyen Thi Minh Ngoc, HIV Care and Treatment Team lead, USAID/PEPFAR, who since 2005 has worked with NGOs, technical experts, and all GVN ministries to deliver testing, treatment, and harm-reduction and prevention interventions to patients across Vietnam.
- Dr Hoang Nam Thai, Care and Treatment Officer, CDC Vietnam, US Embassy, Hanoi, Vietnam. Dr.

Thai worked with FHI 360, drafting policies and guidance, and building capacity for the medication-assisted treatment program.

- Dr. Vu Huy Hoang, former Public Health Specialist, now Country Director of SAMHSA/Vietnam, who provided, coordinated, and sustains the technical assistance needed by SUD treatment components in Vietnam.

- Ms. Nong Thi Thuong, SAMHSA/PEPFAR Deputy Program Manager; she managed implementing partners who provide technical assistance for and direct SUD treatment services.

Champions throughout this era essentially legitimized the shift from the perspective of addiction as a moral and behavioral failure to the view that it is a treatable health condition. The champions referenced through this period encouraged evidence- and community-based SUD treatment through a variety of roles that included:

- Authorizing and directing actions.
- Advocating and mobilizing support for actions.
- Providing technical and strategic advice to execute actions.
- Making resources available to support actions.
- Making connections between people who needed to act.

At the same time that new policies and pilot programs were emerging, resources were also invested in *capacity building* with a view to the future. Hanoi Medical University's Center for Training and Research on Substance Abuse–HIV (CREATA), led by Dr. Le Minh Giang, began its focus on HIV in the mid-1990s and celebrated its 25th anniversary in 2020. During that period of time, the Center has engaged more than 6,200 health professionals from 48 provinces in training programs related to SUD and HIV; had six staff members enter international PhD research programs; participated in or authored more than 50 peer-reviewed journal articles; and received funding for more than 10 competitively reviewed research projects. Faculty at UMP, led by Dr. Do Van Dung, also engaged in training, coordination, and research throughout this time. For example, UMP provided more than 50 courses, at basic and advanced levels, for Ho Chi Minh City and the southern provinces; engaged the departments of public health, psychiatry, and family medicine in the SUD efforts; and collaborated with international partners such as the Bureau for International Narcotics and Law Enforcement and UNODC to pilot interventions for ATS users and women. The investments in locally initiated and conducted research led to results used by local policy makers to make decisions. Local research is also a source of justifiable pride that Vietnam is a contributor to, as well as beneficiary of, the body of evidence-based SUD intervention knowledge.

The same benefits accrue to investments in workforce development. Training existing health-care providers to deliver care that meets recognized quality standards shows an immediate return in program effectiveness, while supporting doctoral-level education in both domestic and international institutions assures that locally conducted research will be available to inform future policy decisions.

Capacity building in the form of both research and training was heavily supported by PEPFAR throughout this initial period. Contracts with international entities, such as Abt Associates, FHI International, and the University of Minnesota Medical School, led to contributions from expert advisors, such as Ted Hammett, PhD, of Abt, who participated in many research initiatives funded by the National Institute on Drug Abuse (NIDA), Peter Banys MD of FHI International, and Gavin Bart, MD, who mentored and monitored hundreds of MMT medical staff for the period of initiation and expansion to the present.

## Period II: 2012–2016: Renovation, Expansion, and Challenges to Success

The brothers described earlier would have had a significantly better chance of finding treatment for their heroin addiction through the early part of this period. The start of this period was one of optimism: policy changes effectively declared drug use a health condition, not a crime (though the criminal law remained "on the books"); pilot MMT clinics and harm-reduction practices provided the evidence needed to move to full implementation; GVN assumed total responsibility for MMT clinics; the rates of HIV/AIDS infection declined; and the numbers of drug users remanded to compulsory rehabilitation declined, while enrollment in MMT clinics increased. A change in circumstances later in this period might have diminished the brothers' opportunity to actually enter into treatment. The growing use of ATS, for which there existed no intervention as direct and simple as the one methadone provided for heroin, led to an increased use of compulsory rehabilitation, after three years of enrollment decline.

The *most significant policy development throughout this period is embodied in the Drug Rehabilitation Renovation Plan*[26], approved by Prime Minister Nguyen Tan Dung in 2013. Technical work on the Renovation Plan was carried out in 2011 and 2012, and incorporated best practices put forward by GVN agencies and UMP; Vietnam-based NGOs (e.g., SCDI and FHI 360); and international partners


The Rehabilitation Center # 5 of Hanoi City

(e.g., UNAIDS and UNODC, WHO, the governments of Australia and France, and PEPFAR advisors). The plan envisioned community-based voluntary SUD treatment interventions, grounded in research evidence and integrated with relevant health and social support services. These services were to be delivered in part through the renovated network of compulsory rehabilitation centers and managed cooperatively by MOH and MOLISA.

The *second significant policy development through this period is the planned transition of PEPFAR in Vietnam financial, administrative, and technical responsibility for HIV/AIDS care and treatment services to GVN*[27] At its inception by the US Congress in 2003 as a global emergency response to HIV/AIDS, PEPFAR was designed to have three phases. The first was direct financing and operations of testing, prevention, and treatment services; the second was building capacity of the host government to perform these functions; and the third was a transition of these functions to the host government, a process that continues today.

*The need to accelerate the development of a skilled workforce for expanded MMT services*, as well as for the integrated community-based health clinics envisioned in the Renovation Plan, was answered as SAMHSA/Vietnam introduced the US-based Addiction Technology Transfer Center (ATTC) model to international PEPFAR settings. In 2011, a pilot Vietnam HIV-ATTC (VHATTC) was organized at HMU, and a Cooperative Agreement Announcement was released to support a second pilot in 2015 at UPM[28]. A third VHATTC was funded in the next year at the University of Labor and Social Affairs (ULSA), which is associated with MOLISA. Together, the three Vietnam-based VHATTCs provide training, in both direct form and through online linked educational programs, to peer-led outreach workers; MMT staff at local MOH– and Department of Social Vices Protection (DSVP)–operated clinics; and physicians, nurses, and counseling professionals. By 2018, the VHATTCs reported training more than 5,100 individuals in 249 clinics[29]. The VHATTCs are supported by an interagency agreement transferring PEPFAR funds to SAMHSA and a cooperative agreement with University of California, Los Angeles, Integrated Substance Abuse Programs to fund, manage, and provide technical oversight and support to the three programs. The VHATTCs have become the primary vehicles that provide the capacity building required for SUD treatment in Vietnam for GVN and donors including PEPFAR, the Global Fund, and others.

The ramp-up and nationwide spread of MMT clinics reflects the intent of the Renovation Plan and represents the major programmatic change through this period. From a starting point of 60 clinics serving almost 13,000 patients in 2012[30], the access to methadone grew to a reported 19,000 patients in 103 MMT clinics in 2014[31], and finally in 2016 to more than 53,000 patients in 336 clinics. The impact of the renovation plan was visible in visits to three distinct clinics in September 2019.

The *first visit* was an MMT clinic in Hanoi, operated by MOH, that opened in 2012 with 140 patients. Currently, 550 almost all male patients (women represent fewer than 10% of that total) come to the clinic daily for medication. Two nurse counselors, one who joined at its inception, work in this clinic and see an average of 20 patients each day. Liquid medication is dispensed from a calibrated, hand-pumped container. Discussion with six patients at the clinic, whose enrollment ranged from one to seven years, highlighted their pride at being able to work and support their families; their referral to the clinic through friends; and their observation of the recent improvement among clinic staff in their respect for patients. Patients also referenced an increase in ATS use among peers, and the benefits of peer outreach as this clinic, which is also a research site for the Drug Use and Blood-Borne Infections in Vietnam (DRIVE) pilot project, which targets ATS.

The *second* visit was to a center operated by MOLISA and the DSVP that was established in 2007 and transitioned in 2015 from a compulsory to a voluntary inpatient and outpatient treatment facility. At the time, this center housed just under 300 inpatient residents and 120 outpatients in the MMT clinic. The inpatient population had an average length of stay of six months that began with a 15-day detoxification period, followed by a daily schedule involving work/vocational experience, group counseling, and recreation time. The

cost of care was shared by GVN (70%) and families (30%). Almost 25% of patients were also using ATS. The outpatient MMT clinic followed the same protocols described for the MOH clinic above.

The *third* visit was also to a MOLISA/DSVP MMT clinic started in 2011 and currently serving 400 MMT patients. In 2015, this clinic entered a partnership with the National Alliance of Methadone Advocates, a US-based advocacy organization and the Vietnam Union of Science and Technology (VUSTA) in Haiphong to include an innovative methadone patient recovery-support pilot demonstration. The peer recovery support program, called medication-assisted recovery support, organizes teams of peers in recovery who reach out to PWID at the community level. The recovery model has been championed and supported by Dr. Hoang Van Ke, the recipient of the Nyswander-Dole Award by the American Association for the Treatment of Opioid Dependence, for his extraordinary work establishing the methadone and recovery-support initiatives.

In 2015, a pilot CATS in Bac Giang Province that closely reflected the intent of the prime minister's Renovation Plan was organized by SCDI upon an invitation by the chair of the National Committee on AIDS, Drugs, and Prostitution, with technical and financial support of the Asia Action for Harm Reduction project, the French Embassy, the Open Society Foundations, and SAMHSA[32]. At its core, the CATS initiative is distinctive because treatment is voluntary and driven by evidence-based guidelines. Components include detoxification, peer outreach, medication-based treatments, counseling, referral connections to related health services, and referral and connection to social-support services—e.g., employment and housing. The pilot started in one province and within the year expanded to two additional provinces.

Another pilot, Buprenorphine/Naloxone to Reduce Addiction and Improve HIV Outcomes in Vietnam (BRAVO), initiated in 2014, is based on a randomized controlled trial study that compares the impact of buprenorphine and naloxone (suboxone) with methadone on viral loads of HIV patients who inject drugs. While this study looks at the use of an alternative to methadone for drug treatment, its primary outcome measure is an HIV/AIDS status indicator. Nevertheless, this and an earlier NIDA funded study represent the introduction of buprenorphine to address opiate addiction in Vietnam.

In summary, this period of time was one of optimism due to the dramatic expansion of MMT clinics and policy espousing addiction as a health concern, despite simultaneously foreshadowing more restrictive responses to the looming growth of ATS use.

## Period III: 2016–2020: Building Capacity, Maintenance of Effort, and Looking Ahead

It was in this third period that the brothers agreed to enter treatment after initial resistance, as is common with the disease of addiction, because of the skill and persistence over many months of the dedicated peer recovery support outreach worker from the Lighthouse group, a CBO operated by SCDI. The worker is one of a dozen peer-outreach staff, available because the pilots of the previous period demonstrated efficacy and supported by the skills training provided by the ULSA Addiction Technology Transfer Center. The brothers, as this story was told in 2020, were employed in construction, connected with family, and still engaged in treatment.

Replicating the apparent success of the brothers has become more challenging as ATS has gained in popularity and prevalence, particularly among younger drug users. According to UNODC, there were more than 223,000 registered drug users in Vietnam in 2018, a growth from the estimated 175,000 registered users in 2013. Heroin continued to be the most prevalent drug of choice throughout 2019, representing more than two-thirds of total users, but ATS was used by more than two-thirds of the newly registered drug users, an increase from about 22% ATS use among newly registered users in 2013[33].

This changing use pattern is significant because to this point, the system to address drug use in Vietnam was built first to operate in the context of HIV/AIDS services, and second to address the use of one substance only, heroin/opiates. While ATS clearly impacts HIV/AIDS, especially among men who have sex with men (MSM) and sex workers, its use extends beyond those populations and is comorbid with mental health conditions as well as social dysfunctions.

In 2018, HIV/AIDS remained the

SAMHSA staff visited and provided technical assistance to a Methadone clinic

context for 316 MMT programs in all 63 provinces/cities providing treatment for 52,677 patients, which is 65% of the national target assigned by the prime minister in the Decision No.1008/QĐ-TTg[34]. By 2017, the expansion of MMT clinics reflected several new policy changes. For example, GVN took more direct ownership of the financial and administrative support needed to maintain clinic operations; a system of cost-sharing fees was instituted between patient and the government (the equivalent of a co-pay in the amount of 10,000 dong per day (the equivalent, at that point, of a little less than $0.50 per day); a patient at a local MMT clinic was no longer required to "register"with local authorities to be an "eligible patient,"though it is reported that this policy change is unevenly executed across all clinics; and finally, GVN invested in less-costly local/Vietnam-produced methadone[35].

The national target established in 2015 was 80,000 patients in MMT programs, or less than half of the estimated registered primarily heroin drug users in 2015. When asked about the difference between 2018 enrollment and the established target, respondents' answers followed two themes: The first was that retention in MMT clinics was an issue, so actual numbers of OUD patients who had been engaged in MMT interventions was closer to the target, but some had dropped out. The second theme was that clinic administrative practices, including daily dispensing, co-pays, enrollment limits of 250 patients in some clinics, and staff attitude together discouraged entry into and retention in MMT clinics[36]. Research that pioneers the introduction of buprenorphine to Vietnam is designed in part to provide an alternative medication that reduces these barriers and improves retention in treatment[37]. The BRAVO study offers an important alternative for medication-based treatment for opiates, especially for those whose access to MMT clinics is limited by distance and related factors.

Meanwhile, concern for the increased use of ATS, absent a single locus of responsibility for comprehensive SUD prevention and treatment, led to divergent responses driven by the user's drug of choice, opiates or ATS, rather than the more encompassing notion of SUD or substance use addiction. One response is to address ATS use in psychiatric hospitals. ATS is the primary drug of choice by patients hospitalized in the National Institute of Mental Health hospital, according to one respondent. A second response views ATS use as deviant behavior, monitored by local public safety officers and addressed by referral to compulsory rehabilitation centers. Another response by PEPFAR, in collaboration with MOH's Vietnam Administration of HIV/AIDS Control (VAAC), prioritizes ATS use by MSM and transgender people. To meet their HIV/AIDS targets, PEPFAR employs a combination of case-finding, HIV viral load suppression, and harm-reduction strategies to address the increased risk of ATS use for HIV/AIDS transmission. Case finding, testing, and tracking are accomplished through the community-based organizations that employ peer recovery outreach workers. And harm reduction, in this case, prioritizes the use of pre-exposure prophylaxis and condoms[38]. The use of peer-outreach workers with PWID is also a prominent feature of research projects, such as DRIVE, which seeks to reach both ATS and heroin users to reduce HIV risk in Haiphong[39].

Another pilot, Recovery Plus, started in 2018 through a cooperative effort of GVN/OOG/MOLISA and PEPFAR/SAMHSA, and implemented by SCDI, focuses on diverting drug users (ATS and opiate) from compulsory rehabilitation centers. More than 200 patients from four districts in Hanoi and Ho Chi Minh City were diverted from compulsory rehabilitation by participation in HIV/AIDS and community-based drug treatment services. In the Recovery Plus pilots, SCDI conducts training workshops for local police, judges, and peoples' committees involved in the administrative processes of referral to compulsory rehabilitation centers. The pilot employs community-based peer-outreach staff to refer drug users to HIV/AIDS testing, MMT, employment, and commune health centers[40].
GVN, MOLISA, the Supreme Peoples Court, MOH, and OOG are also involved in early stages of planning to test a drug court alternative to the incarceration model in Vietnam. SAMHSA's Center for Criminal Justice provided critical initial support for this model. The current prime minister, Nguyen Xuan Phuc, visited a US-based drug court in 2013 and observed pretrial proceedings, treatment planning and implementation, alternative sentencing, and monitoring functions. With the support of the Colombo Plan, the State Department's Bureau for International Narcotics and Law Enforcement invited the US-based National Association of Drug Court Professionals to facilitate a training and planning meeting for Vietnam[41]. The workshop, held in October 2019, was attended by court officials, the staff of public health centers, social workers, and relevant staff members from the Nam Tu Liem and Long Bien districts. Follow-up steps will be dependent on availability of resources to support the pilot.

In the fall of 2019, SAMHSA/Vietnam, in collaboration with the SAMHSA South East Asia HIV Addiction Technology Transfer Center, organized a study tour for a delegation from Vietnam (including representatives of the prime minister's office, the National Assembly, and related ministries, NGOs, and academic institutions) to Chiang Mai and Chiang Rai, Thailand[42]. Over seven years (2010–2017), Thailand had reviewed and reformed their drug laws and added community- and evidence-based voluntary approaches to their compulsory treatment options.

Laws were revised and practices implemented that adopted UNODC's community-based drug treatment and care approach; one result was to reform the Thai health-care system to include SUDs. The site visit covered several elements of the SUD system, including a psychiatric hospital for methamphetamine patients experiencing psychosis, a community-based health center that incorporates SUD care, medication-based treatment services, and prevention programs. The visit also included exposure to services that address poly-substance addiction that are delivered by volunteer village health workers at sub-district-level health centers and district hospitals that together deliver evidence-based treatment interventions, such as behavioral intervention; motivational interviewing; cognitive behavioral therapy; screening, brief intervention, and referral to treatment (SBIRT); and the MATRIX model of care.

Research like BRAVO and DRIVE, pilots like CATS and Recovery Plus, and, potentially, drug courts all represent incremental steps advancing the 2013 Renovation Plan to deemphasize the use of compulsory rehabilitation centers in favor of evidence-based, community-based resources to treat drug addiction[43]. Unfortunately, at the same time, several respondents noted that social and political attitudes toward drug users, especially with the rise in ATS use, was regressing to the old view of SUD as criminal behavior. Data that track actual changes in the population of compulsory rehabilitation centers between the enactment of the Renovation Plan in 2013 and the present day are challenging to identify. Data supplied by MOLISA between 2012 and 2020, exhibited in Appendix E: Occupancy of Compulsory Rehabilitation Centers Established by Resolution 06/CP (1993), 2012–2020, appears to confirm reports from respondents that reliance on compulsory rehabilitation centers declined as the drug-treatment Renovation Plan was initially implemented and has returned to pre–Renovation Plan levels in recent times.

The resurgence of the perspective that drug use is a crime is reinforced by available information regarding the National Assembly's current consideration of revisions to the law—specifically, amending and supplementing a number of articles of the Law on Handling Administrative Violations no.15/2012/QH13. Respondents expressed concern that the proposed changes in Sections 89 through 104 of the Administrative Violations law would result in more, not fewer persons with SUD consigned to compulsory rehabilitation. One analysis of this law supports that perspective, based on changes that "widen the net"by reducing the age of offenders, reducing the time for adjudication of the suspected violation, and broadening the type of violation subject to sanction[44].

An incremental approach to reforming SUD treatment has occurred in many countries, including the United States. Steps toward developing an integrated, evidence-based, community-level SUD treatment system are followed by pauses that take the form of uneven implementation of sound policy or steps back that reinforce a perspective that drug addiction is a criminal behavior best addressed by sanctions. As noted by respondents, *the scale-up of MMT* to a point where it has reached more than 50,000 patients, the declaration that *drug addiction is a disease*, not a "social evil,"adoption of *voluntary detoxification* procedures, promulgation of *the Renovation Plan* (that integrates SUD treatment in a continuum of care delivered by local health center services), development of knowledge through Vietnam-based and-led research, and education of thousands of health-related staff in skills for evidence-based SUD treatment—these advances constitute progress that is remarkable in scope and significance. The impacts of these achievements are, however, diluted by the diffusion of responsibility for SUD among multiple governmental agencies, which sometimes results in conflicting approaches; by an approach that focuses on one drug of choice at a time, not addiction; and by resources that are less abundant and efficient than needed, as they are allocated across several agencies with variant approaches.

Peer recovery support members of the Lighthouse Group describe their experiences.

## NOTES

**16.** While there are three identifiable phases, or periods, of SUD treatment services in Vietnam between 2005 and 2020, the phases are representative for the dates that define them and are porous or somewhat overlapping, as most social change is incremental in occurrence, not dichotomous in appearance.

**17.** L. M. Giang, L. B. Ngoc, V. H. Hoang, K. Mulvey, and R. A. Rawson, "Substance use disorders and HIV in Vietnam since Doi Moi (Renovation): An overview,"Journal of Food and Drug Analysis 21:4, 2013, pp. S42–S45, doi:10.1016/j.jfda.2013.09.032.

**18.** World Health Organization, "Joint review of the health sector response to HIV in Viet Nam 2014,"p.5, fig. 4, https://iris.wpro.who.int/handle/10665.1/12787.

**19.** Ministry of Health, Vietnam Administration of HIV/AIDS Control, "Vietnam HIV and AIDS Country Profile,"May 11, 2009, http://vaac.gov.vn/en-us/solieu/Detail/VIETNAM-HIV-and-AIDS-Country-Profile.

**20.** United Nations Office on Drugs and Crime, Strategic Programme Framework, Viet Nam 2005–2007, https://www.unodc.org/pdf/vietnam/strategic_programme_framework_vietnam.pdf p.3.

**21.** L. M. Giang et al., "Substance use disorders and HIV in Vietnam since Doi Moi (Renovation)".

**22.** Tam T. M. Nguyen, Long T. Nguyen, Manh D. Pham, Hoang H. Vu, and Kevin P. Mulvey, "Methadone maintenance therapy in Vietnam: An overview and scaling-up plan,"Advances in Preventive Medicine, 2012, article ID 732484, p. 1, https://doi.org/10.1155/2012/732484.

**23**. James Windle, "A slow march from social evil to harm reduction: Drugs and drug policy in Vietnam,"Foreign policy brief, Brookings Institution, 2018, p.3, https://www.brookings.edu/wp-content/uploads/2016/07/WindleVietnam-final.pdf.

**24.** The challenges include division of responsibility among three different ministries; policies from different sources and times that conflict; and an uneven process of executing policy at provincial, district, and commune levels. See, e.g., T. Vuong et al., "Drug policy in Vietnam: A decade of change?"International Journal on Drug Policy 23:4, July 2012, doi:10.1016/j.drugpo.2011.11.005; International Drug Policy Consortium, "Drug Policy in Asia: Challenges, Opportunities, and Prospects,"2013, Vietnam, p.52, http://fileserver.idpc.net/library/IDPC-report-drug-policy-in-South-East-Asia.pdf; James Windle, "A slow march from social evil to harm reduction,"p.5.

**25.** Tam T. M. Nguyen et al., "Methadone maintenance therapy in Vietnam,"p.1.

**26.** Pascal Tanguay, Claudia Stoicescu, and Catherine Cook, "Community-based drug treatment models for people who use drugs: Six experiences on creating alternatives to compulsory detention centres in Asia,"London: Harm Reduction International, 2015, p.53, https://www.hri.global/files/2015/10/19/Community_based_drug_treatment_models_for_people_who_use_drugs.pdf; T. M. Hammett, N. T. Trang, K.T.H. Oanh, et al., "The relationship between health policy and public health interventions: A case study of the DRIVE project to 'end' the HIV epidemic among people who inject drugs in Haiphong, Vietnam,"Journal of Public Health Policy 39, 217–230 (2018), https://doi.org/10.1057/s41271-017-0115-7; Prime Minister of Vietnam, Decision No. 2187/QD-TTg.

**27.** PEPFAR, Country Operational Plan, Vietnam, COP 2019, Strategic Direction Summary, April 12, 2019, p.3, https://www.state.gov/wp-content/uploads/2019/09/Vietnam_COP19-Strategic-Directional-Summary_public.pdf.

**28.** Substance Abuse and Mental Health Services Administration, "Cooperative Agreement to Support the Establishment of a Southeast Asia Regional HIV Addiction Technology Transfer Center (ATTC),"https://www.samhsa.gov/grants/grant-announcements/ti-16-004.

**29.** Hoang Vu, MD, "Integrating substance use and mental health screening into HIV clinical care: Lessons from Vietnam and the Southeast Asia region,"PEPFAR Annual Meeting, Durban, South Africa, July 18, 2016.

**30.** Tam T. M. Nguyen et al., "Methadone maintenance therapy in Vietnam".

**31.** World Health Organization, Western Pacific Region, "Joint review of the health sector response to HIV in Viet Nam 2014,"p. 20, https://iris.wpro.who.int/bitstream/handle/10665.1/12787/9789290617426_eng.pdf?ua=1.

**32.** Pascal Tanguay et al., "Community-based drug treatment models for people who use drugs,"p.54.

**33.** United Nations Office on Drugs and Crime, Global SMART Programme, "Synthetic drugs in East and South-East Asia: Trends and patterns of amphetamine-type stimulants and new psychoactive substances,"March 2019, p.72, figs. 1, 2, and 3, https://www.unodc.org/documents/southeastasiaandpacific//Publications/2019/2019_The_Challenge_of_Synthetic_Drugs_in_East_and_SEA.pdf.

**34.** Ministry of Health, Socialist Republic of Viet Nam, "Report on Reviewing 10 Years of Methadone Maintenance Therapy (MMT) Implementation,"Report to the Prime Minister, no. /BC-BYT, Hanoi, 2018 (a translated GVN document the author reviewed in Microsoft Word).

**35.** Ibid.

**36.** Nguyen Thu Trang, Ngoc Luong Anh, Carole Chauvin, Jonathan Feelemyer, Nicolas Nagot, Don Des Jarlais, and Marie Jauffret-Roustide, "Struggling to achieve a 'normal life': A qualitative study of Vietnamese methadone patients,"International Journal on Drug Policy 68, April 2019, p.19, https://www.researchgate.net/publication/332464317_Struggling_to_achieve_a_'normal_life'_A_qualitative_study_of_Vietnamese_methadone_patients.

**37.** Todd Korthuis, MD, Buprenorphine/naloxone to Reduce Addiction and Improve HIV Outcomes in Vietnam (BRAVO), presentation at HMU CREATA-H 25th anniversary workshop, February 2020.

**38.** PEPFAR, Country Operational Plan Vietnam, COP 2019, Strategic Direction Summary, April 12, 2019, p.22.

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**41.**US Embassy & Consulate in Vietnam, "Drug Treatment Court: A New Approach for Vietnam in Treatment for Drug Addicts,"Hanoi, October 11, 2018, https://vn.usembassy.gov/drug-treatment-court-a-new-approach-for-vietnam-in-treatment-for-drug-addicts/.

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**43.** T. M. Hammett, N. T. Trang, K.T.H. Oanh, et al., "The relationship between health policy and public health interventions".

**44.** Jay Jordens, "Commentary, Administrative Violations Law,"unpublished article, and personal correspondence related to it, April 2020.

# What Might Have Happened: Opportunities Not Realized 2005–2019

Because no system is perfect, it is legitimate to wonder what additional changes might have helped reach the brothers earlier had they occurred through this 15-year period. Were other opportunities available in this period that were not realized that might serve as guidance for future developments? Could the brothers have been reached earlier? Might their family members and neighbors have been engaged in different roles? Might peers in recovery have engaged them earlier? Thinking about opportunities not realized is not a question about failure or blame; rather, focusing on missed opportunities is about learning from experience that benefits others and minimizing future missed opportunities.

The question of missed opportunity was part of the standard interview guidance for all international and Vietnamese domestic interviews. Not surprisingly, the most consistent response to the question, in the words of a prominent Vietnamese leader was, "We focused on HIV/AIDS [as a condition], not on drug use disorders [as a co-occurring condition]". This point was made in many different forms. Some referenced the missed opportunity as the sole reliance on methadone; others, as the sole reliance on HIV/AID sero-prevalence and viral-load measures as indicators of success. The reality in this period is that the mobilization of international and domestic expert financial, therapeutic, and related resources developed a system that stemmed the threat of HIV/AIDS and that made MMT available to up to one-third of registered drug users with opiate-based disorders, but not a system that addressed the bio-psycho-social dimensions of SUDs.

There are several correlates of the singular focus on HIV/AIDS. For example, alcohol consumption, largely unrecognized or discussed in the context of the SUD treatment system, has doubled between 2003 and 2010[45]. The disease burden of excessive alcohol use in Vietnam received the highest possible score for alcohol-attributable years of life lost, a metric that encompasses liver cirrhosis, road traffic crashes, and the prevalence of alcohol use disorders and alcohol dependence[46]. The extent to which alcohol is overlooked as other than a social commodity was underscored during a meeting of people in recovery, when one member opened a bag and pulled out a beer to accompany the food that was customarily served. Most recently, in 2020, a new standard of "zero tolerance"for alcohol use while driving was adopted in Vietnam, the impact of which is unknown at this time. Perhaps the opportunity to develop an SUD system in its own right that addresses multiple substances—from alcohol, tobacco, and marijuana to methamphetamines and opiates, among others—was unrealizable in 2005, when the direction was set by international partners and GVN to focus exclusively on HIV/AIDS prevalence.

The next most referenced opportunity was the uneven follow-through on the 2013 Renovation Plan. The plan put forward strong principles on which to build a community- and evidenced-based intervention system for SUDs that would be integrated into the far-reaching Vietnamese commune-based health system. A combination of changing political circumstances, dispersed responsibility for follow-through, and multi-layered/level of governance in Vietnam together account for the reality that there was "no grand plan by government"to implement renovation, in the words of one respondent. Perhaps the clearest manifestation of this missed opportunity is the continuing role played by compulsory rehabilitation centers in the Vietnamese response to drug use. While some centers have made changes by incorporating voluntary MMT and detoxification programs, that is not the norm for center operations. The reality is that, like other countries', close settings, such as prisons, the current 112 compulsory rehabilitation centers represent a significant economic investment in terms of employment and infrastructure in both urban and rural Vietnam. It was also reported that center occupancy is driven in part by financially incented quotas for local police to refer residents with "defined behaviors"to the local commune review system that determines consignment to a center.

The need for coordination and communication among international partners and donors and between this collective and GVN was referenced as an opportunity. Throughout this period (2005–2020), there were a minimum of 15 international government- and philanthropy-sponsored technical and financial aid initiatives in Vietnam. In addition, there were many technical "experts"in country, working on a variety of independent projects. Coordinated effort and communication from that number of international bodies, representing a significant financial investment, was not leveraged either to advocate for reform or, programmatically, to develop a coherent SUD system.

The strength and attachments that Vietnamese people have to family and to local communities are noteworthy, and often mentioned in the literature

and in our interviews. These qualities, while relevant in local communes, are not as fully employed or engaged by the SUD system at higher levels. The Vietnamese family's ability to leverage members to get help, monitor patient compliance with treatment protocols, and connect patients to social supports that sustain recovery contains immense, unique potential in a Vietnamese SUD treatment system.

A consistent observation in the five site visits was the under-representation of women among patients and recovery support peers. This observation is reinforced by the fact that most reports and publications that contain data on SUD have limited references or breakdowns by gender. The exception is the category of female sex workers when discussing HIV/AIDS-related drug use. When asked about this, respondents elaborated on two themes: one was that women's substance misuse was primarily an issue with female sex workers; the other was that Vietnamese women culturally do not use substances. One (female) respondent strongly disagreed with these themes, asserting that stigma and oversight together left women in Vietnam an underserved class in terms of SUDs. Available literature that focuses on the prevalence of addiction disorders in Vietnam reports very low rates of female alcohol disorders (less than 0.5%) and generally discusses women's drug use in the context of HIV/AIDS prevalence. No reports were identified for this project that quantify women's use of methamphetamines. If, in fact, the prevalence of SUD is unusually low among women in Vietnam today, it is difficult to imagine that prevalence will not increase in tandem with economic growth and prosperity.

Social health insurance (SHI) has been available to provide access to inpatient and outpatient health services to people in Vietnam in a variety of forms since the 1970s, in a transition from what was effectively a national health service. The SHI program has gaps, like most plans; one was that it did not cover services available from other third-party sponsors. Given the fact that most HIV/AIDS testing, prevention, and pharmaceuticals (e.g., antiretroviral drugs) were paid for by international donors, especially PEPFAR and the Global Fund, only 30–40% of people with HIV/AIDS were covered by SHI in 2014[47]. In 2014, recognizing the transition of PEPFAR from a provider of direct care to a provider of capacity-building and technical assistance, GVN, through MOH–VAAC, the Ministry of Finance, and the Vietnam Social Security, with assistance from the USAID Health Finance and Governance project, began a detailed analysis of the costs and strategies required to expand SHI coverage to include all unenrolled patients and fill any service gaps[48]. Again, the effort focused on HIV/AIDS and did not include insurance coverage for SUD services for people with SUD and/or comorbid HIV/AIDS diagnoses.

Each of the opportunities noted, for the most part, were unrealized because of combinations of programmatic, economic, political, or knowledge limitations at a given moment in time. The consequences of opportunities missed during this period may entail social or other costs, but they in no way diminish the achievements of the period. In short, an unrealized opportunity is still an opportunity.

**NOTES**

**45**. Martha Lincoln, "Alcohol and drinking cultures in Vietnam: A review,"*Drug and Alcohol Dependence* 159 (2016), pp. 1–8, doi:10.1016/j.drugalcdep.2015.10.030

**46**. World Health Organization, Vladimir Poznyak and Dag Rekve, eds., "Global Status Report on Alcohol and Health 2014,"https://www.who.int/substance_abuse/publications/alcohol_2014/en/.

**47**. Nazzareno Todini, Theodore M. Hammett, and Robert Fryatt, "Integrating HIV/AIDS in Vietnam's Social Health Insurance Scheme: Experience and Lessons from the Health Finance and Governance Project, 2014–2017,"*Health Systems & Reform* 4:2 (2018), pp. 114–124, doi: 10.1080/23288604.2018.1440346; US Embassy & Consulate in Vietnam, "U.S. and Vietnam Celebrate First Patients Receiving Antiretrovirals Covered by Social Health Insurance,"Hanoi, March 8, 2019, https://vn.usembassy.gov/20190308_first-patients-receiving-antiretrovirals-covered-by-social-health-insurance/.

**48**. Duong Cong Thanh, National Institute of Hygiene and Epidemiology, Department of HIV/AIDS, "An assessment of enrollment in and use of social health insurance for the care and treatment of people living with HIV,"September 2015, https://www.researchgate.net/publication/315891118_Social_health_insurance_and_people_living_with_HIV_in_Vietnam_An_assessment_of_enrollment_in_and_use_of_social_health_insurance_for_the_care_and_treatment_of_people_living_with_HIV.

# Looking Beyond 2020: Sustaining Success and Taking Next Steps

Given the success of the past 15 years and the absence of SAMHSA, the opportunity looking forward is to sustain the changes that continue to be effective in SUD treatment and to determine new SUD services to be added, given the current and foreseeable needs. Addressing these concerns will be essential to continued improvement in a variety of Vietnam's health outcomes, especially those chronic illnesses, such as diabetes, hypertension, HIV/AIDS, and asthma, that are associated with addiction. The interview guide used with respondents posed these concerns. The author has combined respondents' answers with data and observations in the available literature, all filtered through the author's observations and experience, to offer the following suggestions for sustaining and initiating efforts that will effectively serve Vietnam residents with SUD diagnoses and improve health in Vietnam.

## Sustaining Effective Achievements

The *introduction, acceptance, and widespread use of medication*—specifically methadone and, more recently, buprenorphine—to treat OUDs is a change that must be continued. GVN, to its credit, has effectively taken ownership of the production and distribution of methadone and established goals for access that could reach as many as 50% of opiate-dependent residents. Further adoption of buprenorphine, beyond the current pilot, especially in rural and other difficult-to-access areas, would hasten the achievement of those goals. Continued success is also achieved by consideration of the use of additional medications, such as naltrexone, or its injectable form, Vivitrol, for alcohol dependence, as well as new medications as they are developed, tested, and introduced to treat SUDs.

The *values and core principles inherent in the 2013 Renovation Plan* deserve to be maintained and realized. The decree that recognizes addiction as a disease/health condition and abandons the view of addiction as a "social evil"is not only a milestone, but an essential quality to build what is proposed as an evidence-based, community-oriented addiction treatment system integrated into local health clinics. While there is much yet to do to realize this plan, attention is needed to prevent regressing from these principles and defaulting to interventions that have proven to be ineffective in the past. This concern has been expressed, specifically, with proposed changes being considered by the National Assembly to Sections 89 through 104 of the Administrative Violations law, as discussed earlier.

The combined *strength of the Vietnamese family, and local community bonds and identification* are hallmarks of Vietnam life and culture. Strong family and local community values are a foundation for educational development, civic engagement, economic well-being, and cultural activity. These strengths are under-utilized resources to the continued development of a Vietnam-specific system for addressing SUD. The potential to expand family ties to leverage support and monitor treatment is unlimited. Similarly, the bonds and identification among and between members of local communities can also be expanded to perform these same leveraging, supporting, and monitoring functions. Unfortunately, the forces of rapid economic development and accompanying urbanization can dilute the strength of these bonds. The challenge, therefore, is the continued incorporation and expansion of these strengths into Vietnam's SUD system while they remain strong and before they diminish.

The beginnings of a *skilled and educated workforce*—physicians, nurses, counselors, researchers, and administrators—was accelerated by the three VHATTCs introduced in 2011. At this point, thousands of Vietnamese professionals have been trained by externally supported programs and are employed delivering SUD interventions. The status and effectiveness of these and future dedicated employees would be elevated by creating clear pathways to achieving educational standards and credentials needed by the workforce to deliver evidence-based SUD (and mental health) care.

*Advocacy* to decrease stigma and introduce new interventions, from harm reduction to medication-assisted treatment, was a critical part of the development of SUD treatment in Vietnam. Respondents noted that local civic and NGOs, as well as international partners, shaped messages, introduced evidence-based approaches and provided public support for policy makers to make needed changes. The advocacy function provides needed technical and evidence-based input to policy making, where, for example, the current review of the Administrative Violations laws provides an opportunity to reinforce the view of addiction as a health condition and avoid the perception of "social evil".

More than one respondent noted that the future development of SUD

treatment must be *Vietnamese-led*. This point is crucial; the withdrawal of SAMHSA, the transition of PEPFAR's role to capacity building and technical assistance, and time limitations on the commitment of philanthropic and other international grants—all these underscore the importance of the locus of responsibility being held by GVN ministries and associated partners. Fortunately, there exists a cadre of strong and capable leaders, both inside and in partnership with GVN, to assure that sustaining existing and initiating future change is Vietnamese-centered. Some of these leaders have played critical roles in "bridging"the transfer of knowledge and resources across cultural boundaries to advance the development of an SUD system. Examples of these resources include, but are not limited to, Dr. Bay, Dr. Duc in GVN; Dr. Oanh of SCDI; Dr. Nhu, the FHI360's former Associate Director; Dr. Giang, a key figure in medical education and Vietnamese-led research and knowledge development, along with Dr. Dung and Ms. Vi, who trained more than 8,000 health-care professionals between 2015 and 2020; Dr. Ngoc of USAID; Dr. Thai of the CDC; and Dr. Hoang and Ms. Thuong, who led SAMHSA/PEPFAR initiatives and pilot programs. These are but a few key professionals; they are representative of many other leaders.

## Next Steps

Along with sustaining the directions noted above, there are important next steps to be taken. Interviews with respondents, review of the literature, and the author's observations, filtered through experience, suggest a number of steps that will be important to advance development of a comprehensive SUD system in the future, and to avoid defaulting to less-effective control mechanisms to address current and emerging forms of addiction disorders. The suggested next steps meet one or more of the following criteria:

- They build on existing programs or resources.
- They are achievable with existing capacity and resources.
- They lend themselves to potential philanthropic or external donor criteria (i.e., they have a beginning and an end, and their impact will be measurable).
- They are suggested by several respondents and/or flow from current evaluations or research.

The recommendations are offered in brief summary form, so that detailed proposals can be developed by Vietnam-led stakeholders and supporting partners as appropriate.

Vietnam is ready to develop a five-year Substance Use Disorder Treatment Center of Excellence pilot program that includes a continuum of inpatient, medically managed detoxification; variable-length-of-stay residential rehabilitation; day treatment; outpatient; and support services. The pilot should be based in a community and be an integral part of the local community health center. Interventions, such as SBIRT, all proven medications, clinical therapies (e.g., motivational interviewing and contingency management), recovery support, and peer support should be based in science and delivered by specifically trained and certified professional staff. Patient participation should be voluntary. The pilot would be managed, through a cooperative agreement between MOLISA and MOH, by MOH. The pilot would be a center of excellence for SUD integrated health care in Vietnam. The center of excellence would be planned by a work group involving all relevant stakeholders and include a formal evaluation component. The basic elements of this pilot currently exist in various stages of development, with diverse geographic and administrative accountability in Vietnam. Elements of this pilot have been experienced in an UNODC/Treatment visit to community-based treatment centers in Malaysia (July 2012) and the earlier referenced SAMHSA/PEPFAR visit to Chiang Mai (2019). Elements of the pilot are also contained in the CATS model and described in the workshop led by Professor Dennis McCarty (Oregon Health and Science University), where all elements of an integrated, evidence- and community-based model were discussed in the summer of 2019.

Part and parcel of the community-based pilot and the cooperative agreement is a complementary pilot that transforms a limited number of MOLISA/DSVP–managed compulsory rehabilitation centers into voluntary, variable-length-of-stay residential treatment and rehabilitation programs, staffed by personnel credentialed in SUD treatment. Residential-based program content would include medical assessment and care, as well as individual counseling, peer recovery support group, and daily living and work skill development. Entry to the residential program would be based on a treatment plan established at the community clinic level or as a step down from short-term medically managed detoxification. Exit from the program would be guided by the individual treatment plan developed jointly by clinician and patient decisions.

GVN, using the model employed with HIV/AIDS SHI coverage, might convene an intergovernmental work group and again engage support of the USAID Health Finance and Governance project to conduct an *analysis* of the relative costs of direct funding versus the cost of *insurance coverage for SUD services* associated with the center of excellence pilot. Currently, GVN pays for all administrative, operating, capital, and consumable medication expenses for 50,000+ MMT patients, as well as 112 compulsory rehabilita-

tion centers. The analysis might also incorporate the potential for cost offsets and positive health outcomes that SUD treatment has on chronic illness (e.g., diabetes, hypertension) care. The flexibility inherent in SHI coverage of SUD is ultimately supportive of a system that matches a patient's severity and context with appropriate intervention(s)—in essence, a patient-centered treatment plan that holds greater promise for recovery.

Several examples of the use of *peer recovery support workers* were seen over the last 15 years. While respondents generally made positive reference to the work performed by CBOs or peer-outreach workers, their presence is targeted largely to research projects, and their focus is on specific time-limited tasks; that is, they are not employed full-time. To fully realize the potential of peer recovery support workers, a scope of *standard responsibility and an accompanying skill-certification process* are needed. A broad-based work group initiated by any of a number of parties (e.g., employing organizations, academic institutions, or associations of peer workers) might be formed to develop standards and a scope of work, as well as a certification process to assure that further engagement of peer recovery support personnel involves functions that have demonstrated effectiveness, as well as providing a career path that supports workers and families.

In recent years, GVN has shown interest in drug court and diversion programs. Both make the most sense when they are part of a continuum of care, as referenced in the center of excellence pilot described above, and when they are used in non-violent criminal matters, where SUD is a secondary factor to the criminal matter. It is important that drug courts and diversion program operations avoid the assumption that addiction is a crime, the remedy of which is punishment or the threat thereof. In addition to advocacy through the National Assembly, engagement of judicial judges, leaders, and staff from the judicial sector will be critical to ensure this distinction. Under circumstances when the program is dealing with non-violent criminal behavior and addiction is a corollary to that behavior, pursuit of both the *diversion and drug court models could be considered as an element of the continuum in the pilot* center of excellence. In that case, the GVN judicial system would also become a party to the cooperative agreement noted above.

The question of the *potential under-representation of women* as patients in SUD treatment was raised in the previous section. The available literature and interviews offer possible explanations, such as that in Vietnamese culture women do not use substances or that SUD is mainly a problem for female sex workers, but most literature offers a limited understanding of women's use of alcohol, ATS, as well as opiates, hallucinatory tobacco, and other substances. Two simultaneous approaches would offer deeper insight into this question. The first is "to build it, and see if they come"—that is, to add a distinct women's services component, including a women and children's residential treatment component to the center of excellence pilot. Separate women-centered services have proven effective in western cultural contexts, which may or may not apply in Vietnam. The second approach is to commission an academic research institution to conduct a targeted and grass-roots-oriented survey of women's substance-use practices and patterns; this could be accomplished through commune-level health-service centers. The consequence of relying on current practice and assumptions regarding the prevalence of SUD in women—especially as there are signs that younger, more mobile generations of women are entering the workforce and thus are being separated from their traditional family and community structures—is that women will remain underserved. A secondary consequence is that the prevalence of related health conditions (HIV/AIDS, sexually transmitted diseases, and other chronic illness) as well as social/economic costs to the family will escalate.

Last, but critical to sustain and to expand the SUD treatment system, is an *educated and credentialed behavioral health workforce*. A workforce pipeline is essential to support evidence-based SUD treatment that begins at the secondary education level and moves through graduate professional degrees in fields that include clinical specialties of social work and psychology; medical specialties in behavioral health for physicians, nurses, psychiatrists, and pharmacists; and policy, research, and administrative specialties that focus on financing, management, program development, research, and evaluation. Along with development of this professional pipeline, there must also be training for appropriate support personnel, including peer recovery personnel and administrative support. The existing VHATTC academic centers (at HMU, UMP, and ULSA)—in combination with actions by the Ministry of Education and with the support of MOH and MOLISA, and technical support from implementing partners—can develop a plan that includes but is not limited to projections of the numbers of professionals needed by specialty and degree level; the knowledge and skill specifications required at different levels of care and for different functions; a capacity inventory of faculty and courses currently available and needed in public and private educational institutions at the secondary, college, and graduate levels; and some discussion and estimation of the investment of money and time required to achieve an educated, credentialed behavioral health workforce.

# Conclusion


There are many perspectives that capture the past 15 years of development of SUD treatment in Vietnam. One is reflected in a Vietnamese proverb, *Có công mài sắt, có ngày nên kim*; roughly translated, it means "Perseverance grinds iron into needles"; it is a declaration of the virtue of perseverance. The story of the past 15 years is not a tale of superheroes, but rather the combined accounts of many committed people who were determined and who persevered to improve the well-being of people with SUDs. It is the story of a father who persevered in seeking medication for his son; the story of a deputy prime minister and his allies, determined to advocate for an experiment to use a previously shunned medication to treat heroin addiction and reduce the spread of HIV/AIDS; the story of US Government specialists who consistently listened and understood another culture before suggesting solutions; the stories of many generous international governments and private philanthropies that continued to invest in a dimension of change; the story of many Vietnamese professionals from academia, government, and NGOs who played roles as "bridgers"between technical expertise in addiction science and Vietnam's unique systems and culture; and many hundreds of other stories of families and patients who sought help to return to their families, communities, and jobs.

These stories, collectively, tell us how change happened in Vietnam. They illustrate the importance of:

- Understanding and accommodating *cultural and political context*.
- *Local leadership, "champions"*who stand up for and support change.
- *Governmental policies* that align with and provide context for change.
- *Technical and scientific knowledge* relevant to change.
- *Human and financial resources* to conduct and support change.
- *Public and private institutional capacity* to manage and deliver change.
- *Committed and skilled professionals*, local and otherwise, who ultimately deliver service.

These are the elements that made a difference between 2005 and 2020 in Vietnam.

Another perspective views the past 15 years of development as a milestone and opportunity to recalibrate SUD treatment in Vietnam. Contemporary SUD treatment came to Vietnam in 2005 as an intervention to stem the spread of HIV/AIDS. The 2005 WHO Country Report estimated 263,000 people with HIV/AIDS, of whom 50%

*The resources for developing an SUD system of care consistent with the excellent principles outlined in the 2013 Renovation Plan largely exist: commune-level health clinics, MMT clinics, pilot projects, beds for longer-term interventions, academic institutions educating clinicians and conducting research, and GVN policy that recognizes addiction as a health condition, not a crime. The missing piece from this picture is a clear locus of accountability and responsibility for linking, managing, and amplifying these now-distinct pieces into a unified system of care.*


Conference Presenters: 25th Anniversary Meeting of HMU Center for Research and Training on HIV/AIDS (CREATA).

were PWID. Conversely, 34% of drug users were infected with HIV/AIDS. The response to control HIV and manage AIDS, described in earlier sections, was nothing short of dramatic, and it was successful. Drug treatment, combined with testing, anti-retroviral therapy, and now case finding, have essentially brought HIV/AIDS to a point where it is a preventable and manageable chronic health condition. SUD treatment, because it was designed to contain HIV/AIDS, exists primarily to address opiate use, in the context of clinics whose primary function is anti-retroviral therapy; it is managed by at least two distinct GVN agencies; and it remains separate from the compulsory rehabilitation centers that are used more frequently for people who use ATS. As it exists, the SUD-treatment resources are not designed to address the growing prevalence of ATS, which among young people has surpassed heroin use. Nor has it recognized addiction to alcohol (except in the mental health hospitals), which, as in most countries, is the substance on which there is most dependence and which in Vietnam has unaccounted-for social and economic costs. SUD treatment in Vietnam was not originally designed to address the health condition that is bio-pyscho-social addiction to alcohol, opiates, hallucinogenic, amphetamine-type, or tobacco and related substances.

Many of the respondents interviewed for this review expressed an awareness that the time is opportune in Vietnam to recalibrate the resources that exist and to develop an SUD system of care that is integrated with the health system and consistent with the excellent principles outlined in the 2013 Renovation Plan. The pieces of this integrated, community-based system largely exist, albeit in distinct forms. There are distinct: c*ommune-level health clinics* in all local communities; *MMT clinics* in all 63 provinces; *pilot projects* demonstrating the efficacy of peer outreach, buprenorphine, interpersonal clinical therapies, and integrated care; beds, although without therapeutic support, when *longer-term interventions* are needed; *academic institutions* at HMU, ULSA, and UMP educating clinicians and conducting research; and *GVN policy that recognizes addiction as a health condition, not a crime*.

The piece that is missing from this picture is a clear locus of accountability and responsibility for linking, managing, and amplifying these now-distinct pieces into a unified system of care. A locus of responsibility for addiction is needed that parallels the authority and functions of the VAAC in MOH. Inattention to this perspective—while ATS use spreads among the young, alcohol continues to extract its price, and the next "drug of choice"looms on the horizon—risks reversion to the default reliance on compulsory rehabilitation centers, a strategy known mainly for its failure to manage addiction and its disproportionate cost to lower-income populations. The opportunity to recalibrate, by harnessing the potential power of linking these services and pursuing pilots and directions described in the "Next Steps"section, offers Vietnam a behavioral health service that is on par with the economic transformation that brings security and satisfaction to the people of Vietnam.

One very wise and experienced respondent, offered another proverb in response to the question of how change happens: *Con có khóc, mẹ mới cho bú* roughly translates as, "The mother feeds the child when it cries"or "If you don't ask, you don't get". Recalibration offers needed nourishment to address the discomfort of people in Vietnam, who suffer from many different types of substance use disorder.

# Timeline: Policy, Data, Pilots, and Other Events, 1990–2020

| YEAR | POLICY | DATA | PILOT | OTHER EVENT |
|---|---|---|---|---|
| 1990 | | | | First case of HIV/AIDS |
| 1993 | Resolution 06/CP | | | |
| 1995 | | | First methadone research trial at Vietnam National Institute of Mental Health | CREATA HMU founded |
| 2000 | National Committee for HIV/AIDS Control; Committee 50 established by Prime Minister | | | |
| 2003 | | HIV/AIDS= 110,000–350,000 cases<br><br>PWID = 156,000 cases | | |
| 2004 | USA/GVN bi-lateral PEPFAR agreement<br><br>GVN National Strategy on HIV/AIDS<br><br>GVN states that SUD is a health condition | | | Karl White, SAMHSA Advisor |
| 2005 | Vietnam Administration for HIV/AIDS Control (VAAC) established in MOH | | | SAMHSA coop agreement with PEPFAR |

| YEAR | POLICY | DATA | PILOT | OTHER EVENT |
|---|---|---|---|---|
| 2007 | Methadone pilots approved by Deputy Prime Minister Trong | | | |
| 2008 | GVN Article 199, decriminalization of drug use | | Methadone pilots in Haiphong, HCMC with 950 patients | Kevin Mulvey, SAMHSA Advisor |
| 2011 | | 41 MMT clinics with 7,000 patients<br><br>121 compulsory centers with 40,000 residents | First VHATTC pilot in Vietnam established at HMU | |
| 2012 | | 209,000 people with HIV/AIDS<br><br>171,000 people registered as drug users<br><br>60 MMT clinics with 12,253 patients<br><br>35,400 residents in compulsory centers | | ATS use increases and spreads |
| 2013 | Drug Rehabilitation Renovation Plan approved by Prime Minister Dung | | | |
| 2014 | | 103 MMT clinics with 19,000 patients<br><br>24,000 residents in compulsory centers | Second VHATTC established at HCMC UMP<br><br>Buprenorphine pilot research (BRAVO) | |

| YEAR | POLICY | DATA | PILOT | OTHER EVENT |
|---|---|---|---|---|
| 2015 | Some compulsory centers add voluntary components | 17,361 residents in compulsory centers | Medication-assisted recovery support peer outreach in Haiphong<br><br>CATS SCDI Community Treatment | Kenneth Robertson, SAMHSA Advisor |
| 2016 | | | | Humberto Carvalho, SAMHSA Advisor |
| 2017 | | 32,600 residents in compulsory centers | Third VHATTC established at ULSA | Nadine Rogers, SAMHSA Advisor |
| 2018 | | More than 5,100 staff in 249 MMT clinics trained through ATTCs<br><br>223,000 registered drug users<br><br>336 MMT clinics in 63 provinces with 53,000+ patients<br><br>36,300 residents in compulsory centers | Drug court workshop for GVN officials<br><br>Recovery Plus diversion initiated/SCDI | More than 2/3 of newly registered drug users choose ATS |
| 2019 | National Assembly begins review of Drug Control Law<br><br>SAMHSA provides notice of termination of participation with PEPFAR | 38,200 residents in compulsory centers | SEA ATTC conducts Chiang Mai, Thailand, study tour for GVN | Hoang Vu, SAMHSA Country Director |
| 2020 | PEPFAR focus on HIV/AIDS risk for ATS users, MSM, female sex workers case finding | | | SAMHSA/SCDI/VHATTC sustainability meetings |

# Abbreviations

| | |
|---|---|
| ART | Anti-retroviral therapy |
| ATS | Amphetamine-type stimulants |
| ATTC | Addiction Technology Transfer Center |
| BRAVO | Buprenorphine/naloxone to Reduce Addiction and Improve HIV Outcomes in Vietnam |
| CATS | Community Addiction Treatment Site |
| CBO | Community-based organization |
| CDC | Centers for Disease Control and Prevention |
| CREATA | Center for Research and Training on HIV/AIDS |
| DRIVE | Drug Use and Blood-Borne Infections in Vietnam |
| DSVP | Department of Social Vices Protection |
| GVN | Government of Vietnam |
| HIV/AIDS | Human immunodeficiency virus infection/acquired immune deficiency syndrome |
| HIV-ATTC | HIV–Addiction Technology Training Center |
| HMU | Hanoi Medical University |
| IDU | Injection drug use |
| MMT | Methadone maintenance treatment |
| MOH | Ministry of Health |
| MOLISA | Ministry of Labor, Invalids, and Social Affairs |
| MOPS | Ministry of Public Security |
| MSM | Men who have sex with men |
| NGO | Non–governmental organization |
| NIDA | National Institute on Drug Abuse |
| OOG | Office of Government |
| OUD | Opiate use disorder |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PWID | People who inject drugs |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SBIRT | Screening, brief intervention, and referral to treatment |
| SCDI | Center for Supporting Community Development Initiatives |
| SHI | Social health insurance |
| SUD | Substance use disorder |
| ULSA | University of Labor and Social Affairs |
| UMP | University of Medicine and Pharmacy of Ho Chi Minh City |
| UNAIDS | Joint United Nations Programme on HIV and AIDS |
| UNODC | United Nations Office of Drugs and Crime |
| USAID | United States Agency for International Development |
| VAAC | Vietnam Administration of HIV/AIDS Control (part of MOH) |
| VHATTC | Vietnam HIV–Addiction Technology Transfer Center |
| VUSTA | Vietnam Union of Science and Technology |
| WHO | World Health Organization |

# Appendices

## **Appendix A:** Discussion Guide for SAMHSA/PEPFAR Structured, Open-Ended Interviews

The purpose of this interview is to provide one source of data, among several others needed, to prepare a *Retrospective and Sustainability Plan* for the period 2005–2019 of SAMHSA/PEPFAR engagement as PEPFAR partner to promote evidence- and community-based drug treatment and reduce the spread and risk of HIV/AIDS associated with drug use in Vietnam.

These questions are intended to guide discussion with key participants in the SAMHSA/PEPFAR Vietnam initiative to build community- and evidence-based drug treatment capacity in Vietnam as a strategy to reduce risk and transmission of HIV/AIDS.

Thank you for your time in considering and discussing these questions. Information that you provide will be collated and aggregated with responses of other respondents. *No specific attribution will be made to an individual without their prior, explicit consent*.

Information is sought re: SAMHSA/PEPFAR involvement between 2006 and 2019; this experience is divided between three periods of time: 2006–2012, 2012–2015, and 2015–2019.

1. Please discuss, from your perspective and experience, what you see as the (two or three) major contributions/roles played by SAMHSA/PEPFAR in Vietnam within or over the time frames of this 13-year retrospective.

2. Please describe, from your experience and or your knowledge of primary sources, the (three to five?) major changes that have occurred in Vietnam re: the development of community/evidence-based drug treatment in Vietnam within or over this 13-year retrospective.

3. Please describe, from your perspective and experience, any unrealized opportunities for change and expansion of community/evidence-based drug treatment in Vietnam within or over this 13-year retrospective.

4. Please identify any empirical published or report-form analysis that captures data, stories, or other documentation that illustrate or represent the contributions, changes, or opportunities missed or yet to be taken in the growth of community- and evidence-based drug treatment in Vietnam within or over this 13-year retrospective.

5. Please identify any key Vietnamese and American persons in governmental, NGO, or other roles who have essential knowledge required to tell the SAMHSA/PEPFAR story in Vietnam within or over this 13-year retrospective.

6. Please discuss your thoughts on the approaches and opportunities available, and the prospects of those opportunities to sustain and grow the community- and evidence-based drug treatment resources that exist today in Vietnam over the next 5-year period.

## **Appendix B:** Interview Requests (Vietnamese and English Versions)

*Vietnamese Version*

*Hà Nội, ngày 05 tháng 02 năm 2020*

*Về việc: Đánh giá về hỗ trợ kỹ thuật của SAMHSA và các đối tác về Điều trị nghiện.*

Kính thưa: **TS. Hoàng Đình Cảnh**
**Phó Cục trưởng Cục Phòng, chống HIV/AIDS, Bộ Y tế**

Thưa TS. Hoàng Đình Cảnh,

Thay mặt Cục Quản lý Các Dịch vụ Điều trị Nghiện và Sức khoẻ Tâm thần (SAMHSA), tôi xin gửi tới Bác sĩ lời chào trân trọng.

SAMHSA đánh giá cao sự hỗ trợ và hợp tác của Bác sĩ và Quý cơ quan trong công tác nâng cao chất lượng điều trị nghiện và phòng chống HIV/AIDS trong 15 năm qua. Chúng tôi có kế hoạch phối hợp cùng Trung tâm Hỗ trợ Sáng Kiến Phát triển Cộng đồng (SCDI) để thực hiện một đánh giá nhằm ghi nhận những thành quả chung của chúng ta, đồng thời tổng hợp các cơ hội để duy trì các hoạt động về điều trị nghiện cho Việt Nam trong thời gian tới. Công việc này sẽ do Tiến sĩ Victor Capoccia, cố vấn kỹ thuật thực hiện. Tiến sĩ Victor dự kiến sẽ đến Việt Nam từ ngày 3/2 -23/2/2020 để gặp và trao đổi với các cơ quan đối tác có liên quan. Tiến sĩ mong được gặp và làm việc với Bác sĩ:

+ Thời gian: 09:00 – 10:00, Thứ tư ngày 19/02/2020
+ Địa điểm: Cục Phòng, chống HIV/AIDS
+ Thành phần dự kiến: Tiến sỹ Victor Capoccia cùng đại diện của SAMHSA và SCDI.

Tôi xin gửi kèm thông tin giới thiệu về Tiến sỹ Victor và nội dung dự kiến trao đổi trong buổi họp. Nếu Bác sĩ cần thêm thông tin, xin vui lòng liên hệ với Cô Nguyễn Thị Thuỳ Linh, Trợ lý Chương trình của SAMHSA theo số điện thoại 0969220291 hoặc email NguyenLTT@state.gov.

Trân trọng cảm ơn Bác sĩ và Quý cơ quan về sự hợp tác!

Kính thư,

Bs. Ths Vũ Huy Hoàng
Giám đốc SAMHSA Việt Nam
Đại sứ quán Hoa Kỳ tại Hà Nội.

*English Version*

October 21, 2019

As you are aware, SAMHSA's role in PEPFAR in Vietnam has been to provide mentoring, training, and technical assistance, as well as policy advocacy to develop an evidence- and community-based substance use disorder treatment capacity that reduces the risk and spread of HIV through injection drug use.

The Vietnam SAMHSA office has commissioned a two-pronged report that captures results of these roles between 2006 and 2019, and that identifies sustainable approaches for future expansion and maintenance of evidence- and community-based drug treatment in Vietnam.

Because of your experience and contribution to SAMHSA's work in Vietnam, your knowledge is essential to preparing this report. I am asking for an opportunity to hear your perspective and thoughts on a number of questions that essentially seek to capture: the type and amount of change that occurred in Vietnam during this period; opportunities that may have passed by during this period; and specific ideas that assure the maintenance and further development of community- and evidence-based drug treatment programs in Vietnam.

Attached is a discussion guide for our conversation. The guide is intended to be flexible to adapt to your specific knowledge and experience with SAMHSA's work through the 2006–2019 period.

Please respond to this outreach, indicating your willingness to contribute to this effort and at least two dates after November 5, 2019, and the time that you would be available for a 30- to 60-minute-telephone conversation.

Your contribution to this work is essential and appreciated in advance. I look forward to hearing your thoughts... and catching up.

Thank you, and best wishes,

Victor Capoccia, PhD
Consultant/Advisor

cc: Dr. Hoang Vu, Ms. Thuong Nong

Attachment: Interview Guide

## **Appendix C:** Interview Respondent List

The list below identifies US-based respondents involved in direct technical or oversight responsibilities for the role that SAMHSA/PEPFAR Vietnam played through the period 2005–2020.

Dr. Gavin Bart, MD, PhD, Professor of Medicine, University of Minnesota
Dr. Mady Chalk, PhD, Consultant, Chalk Group (former SAMHSA/CSAT)
Dr. Theodore Hammett, PhD, former Chief of Party at Health Finance and Governance Project, Abt Associates
Dr. Kimberly Johnson, PhD, Associate Professor, University of South Florida (former SAMHSA/CSAT)
Dr. Todd Korthuis, MD, PhD, Associate Professor, Oregon Health and Science University Medical School
Ms. Laurie Krom, MS, Director, ATTC Coordinating Office, University of Missouri
Dr. Sherrie Larkins, PhD, Director, International Training, University of California, Los Angeles; Integrated Substance Abuse Programs
Mr. Robert Lubran, MS, MPA, (ret.) SAMHSA/Division of Pharmacology
Dr. Dennis McCarty, PhD, Professor Emeritus, Oregon Health and Science University
Dr. Richard Rawson PhD, Professor Emeritus, University of California, Los Angeles; Department of Psychiatry
Mr. Daniel Wolfe, Director, International Harm Reduction Development, Open Society Foundations

The following list identifies Vietnam-based international and Vietnamese national respondents from PEPFAR, GVN, and NGOs who were involved in direct policy, management, and operating responsibilities through the period 2005–2020.

### PEPFAR Team

Mr. Mark Troger, PEPFAR Country Coordinator
Dr. John Blandford, Country Director, CDC
Ms. Paula Morgan, Deputy Country Director, CDC
Ms. Ritu Singh, Director, Office of Health, USAID
Dr. Phung Thi Phuong Mai, Program Manager, DOD
Ms. Nguyen Thi Minh Huong, HIV/AIDS Prevention Specialist, USAID
Dr. Ramona Bhatia, Chief Medical Advisor, CDC
Dr. Nguyen Thi Minh Ngoc, HIV/AIDS Care and Treatment Team Lead, USAID
Dr. Hoang Nam Thai, Care and Treatment Officer, CDC
Dr. Vu Huy Hoang, Country Director, SAMHSA
Ms. Nong Thi Thuong, Deputy Program Manager, SAMHSA
Dr. Kevin Mulvey, Southeast Asia Regional Director, SAMHSA

### Government of Vietnam

Dr. Nguyen Doan Phuong, Director, NIMH
Dr. Le Minh Giang, Coordinator of VHATTC, HMU
Dr. Nguyen Thu Trang, Training Coordinator, VHATTC, HMU
Dr. Do Van Dung, Director, VHATTC, UMP
Ms. Nguyen Thi Tuong Vi, Coordinator, VHATTC, UMP
Ms. Nguyen Thi Hoai Thu, Coordinator, ULSA
Dr. Nguyen Trung Hai, Trainer, ULSA
Dr. Nguyen Thi Minh Tam, Head of Harm Reduction Department, VAAC
Dr. Do Huu Thuy, Head of Communication Section, VAAC
Dr. Nguyen Cuu Duc, Acting Deputy Director, Department for Science, Education, Culture, and Social Affairs, Office of Government
Dr. Doan Huu Bay, Deputy Director General, Department for Science, Education,
Culture, and Social Affairs, Office of Government
Dr. Hoang Van Ke, Chairman of Vietnam Union of Science and Technology Haiphong, VUSTA staff, and peer leader of medication-assisted recovery support program in Haiphong
Dr. Do Van Khanh, Deputy Director of DSVP, MOLISA
Dr. Phung Quang Thuc, Director of DSVP

### Other Government Entities and Non-governmental Organizations

Ms. Marie-Odile Omond, Country Director, UNAIDS
Dr. Nguyen Thanh Cuong, Program Officer, UNODC
Ms. Nguyen Phuong Lan, Program Officer, UNODC
Dr. Nguyen To Nhu, former FHI 360 Associate Director
Ds. Khuat Thi Hai Oanh, Executive Director, SCDI
Ms. Do Thi Ninh Xuan, Technical Advisor, SCDI
Ms. Pham Thi Hanh Van, Coordinator, SCDI
Ms. Nguyen Quynh Trang, Program Manager, SCDI
Ms. Pham Thi Minh, Head of Executive Board, Viet Nam Network of People Who Use Drugs (VNPUD)
CBOs supporting DRIVE study in Haiphong (7)
Peers in medication-assisted recovery program Haiphong) (6)
Peers in Haiphong who received ULSA support
Patients in-site visits (14)

## **Appendix D:** SAMHSA/Vietnam Directors and Technical Leads

| | |
|---|---|
| 2004–2008 | Dr. Karl White (Oct.–Sept.) |
| 2008–2015 | Dr. Kevin Mulvey (Aug.–Sept.) |
| 2015–2016 | Mr. Kenneth Robertson (Sept.–Nov.) |
| 2016–2017 | Mr. Humberto Carvalho (Nov.–Jan.) |
| 2017–2019 | Dr. Nadine Rogers (Jan.–Jan.) |
| 2019–present | Dr. Hoang Vu (Jan.–present) |

SAMHSA personnel who served in Vietnam were supported by the following Washington, DC–based SAMHSA officials from 2005 to 2015, including:

Westley Clark, MD, PhD, Director of CSAT
Kim Johnson, PhD, Director of CSAT
Robert Lubran, MPA, Director, Division of Pharmacologic Therapies
Thomas Kresina, PhD, Division of Pharmacologic Therapies
Anne Herron, MS, Director, Intergovernmental and External Affairs

## **Appendix E:** Occupancy of Compulsory Rehabilitation Centers Established by Resolution 06/CP (1993), 2012–2020*

| Year | Occupancy |
|---|---|
| 2012 | 35,436 |
| 2013 | 35,953 |
| 2014 | 24,088 |
| 2015 | 17,361 |
| 2016 | 28,427 |
| 2017 | 32,610 |
| 2018 | 36,368 |
| 2019 | 38,244 |
| 2020 | 34,982 |

## **Appendix F:** International Partners and Funders, 2005–2020†

The Atlantic Philanthropies

Bloomberg Philanthropies

Catholic Relief Services

Elton John AIDS Foundation

Ford Foundation

Gilead Sciences

The Global Fund

Government of Australia

Government of France

Government of Ireland

Government of the Netherlands

Government of the United Kingdom

Open Society Foundations

UNAIDS

United Nations Office on Drugs and Crime

United States
- National Institutes of Health (NIH) – National Institute on Drug Abuse (NIDA)
- The United States President's Emergency Plan for AIDS Relief: United States Agency for International Development, Centers for Disease Control and Prevention, US Department of Defense

World Health Organization

* Source: GVN/MOLISA/DSVP via SAMHSA/PEPFAR

† International partners and funders listed were those referenced in interviews and may not include all participants and funders involved from 2005 through 2020.

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