

MINISTRY OF HEALTH

**NATIONAL ACTION PLAN ON HARM REDUCTION
INTERVENTION IN HIV PREVENTION
IN 2007 – 2010 PERIOD**

*(Promulgated in accordance with Decision No.34 /2007/QĐ-BYT
Dated 26 September 2007 of the Health Minister)*

Ha Noi - 2007

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ACRONYMS

ADB	Asia Development Bank
CO	Community Outreach
CSWs	Commercial Sex Workers
DOH	Department of Health
DOLISA	Department of Labor, Invalids and Social Affairs
DPS	Department of Public Security
HRI	Harm reduction Intervention
IDUs	Injecting Drug Users
MOH	Ministry of Health
MOLISA	Ministry of Labor, Invalid and Social Affair
MPS	Ministry of Public Security
MOCI	Ministry of Culture and Information
MOJ	Ministry of Justice
N&Ss	Needles and Syringes
OI	Opportunistic Infection
PC	Provincial People Committee
PE	Peer Education
PLWHA	People living with HIV/AIDS
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SWs	Sex Workers
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

UNAIDS

**Joint United Nations Program on
HIV/AIDS**

PART I

RATIONALE FOR DEVELOPMENT OF ACTION PLAN

I. LEGAL BASIS FOR DEVELOPMENT OF THE ACTION PLAN

- 1. Law on HIV/AIDS prevention and control dated June 29, 2006.**
- 2. Decree No. 108/2007/NĐ-CP dated June 26, 2007 of the Government stipulating in detail implementation of some articles in the Law on HIV/AIDS prevention and control**
- 3. Decision No. 36/2004/QĐ-TTg dated March 17, 2004 of the Prime Minister on approving the National Strategy on HIV/AIDS prevention and control till 2010 with a vision to 2010.**

II. CHARACTERISTICS OF SITUATION OF HIV/AIDS, DRUG USE AND PROSTITUTION IN VIET NAM

As of December 31, 2006 the cumulative number of HIV infected cases reported from across the country was 116,565, of which 20,195 cases developing AIDS and 11,802 cases of death due to AIDS. It is estimated that by 2010, there will be 350.970 HIV infected cases, 112.227 AIDS patients and 104.701 cases of AIDS death^[1]. HIV/AIDS epidemic has spread to all provinces/cities (to be called as province afterwards), with HIV case reports received from 93% of rural and urban districts (to be called as district afterwards) and 49% of communes/wards/and townships (to be called as commune for short). The majority of HIV infected cases are found among the young age people, with the age group of between 20-39 accounting for 80.28% of the total reported HIV infected cases. HIV/AIDS epidemic is still in the concentrated phase with the HIV infected cases mainly found among the high risk groups such as the injecting drug users (IDUs), commercial sex workers (CSWs). According to data gained from reporting cases, IDU group accounts for 51.68% and CSWs 2.57% of the total HIV infected people, respectively^[1].

^[1] *Review report on 2006 HIV/AIDS prevention and control activities, 2007 work plan, Ministry of Health, 2006*

As shown by data from Ministry of Public Security, by the end of 2006 the number of managed drug users was 160.226, and the most prevalent type of drug currently used is heroin (over 80%)^[1], focusing on the groups of low education level, those who have previous criminal records, CSWs, unemployed and instable income people, or those who have regular movement of residence and work-place due to their employment features. In big cities, there have been youngsters under 20 years of age using ATS drugs and are at risk of HIV infection transmitted through unsafe sex behaviors. HIV prevalence rate among IDU group was 22.5% in 2006^[2]. Needle and syringes sharing rate is very high among IDUs (for example 37% in Ho Chi Minh City, 33% in An Giang province).

Apart from increase in drug use practice, prostitution also has its increasingly complex developments. According to data from the Ministry of Labour, Invalids and Social Affairs (MOLISA), through surveys conducted in some centers for treatment-education-social labour in some provinces, it is clear that CSWs are younger in age: mostly found in the age group of 18-35 (accounting for over 80%, and those between 18-25 years accounting for 42.4%), especially those who are under 18 years of age account for 13.4% (5-fold to compare with 2000); 20-25% of CSWs are addicted to drugs, and in some centers this group account for up to 40%. The majority of CSWs are at low education level, mainly focusing among those who are illiterate or at completion of primary or secondary levels, which account for 90%. Condom use rate with regular sex partners among CSW group, regardless being improved to some extent, remains at 12 □ 51%. Especially, it is more worrying when the irregular condom use rate among CSWs infected with HIV is very high, and according to MOLISA data, this rate is as high as 72.7%. HIV infection risk behaviours among CSW group are reflected in 3.95% of CSWs infected with HIV by 2006^[3].

^[1] *Review report on 2006 drug control activities and 2007 work plan implementation, Ministry of Public Security, 2007*

^[2] *Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam 2005-2006*

^[3] *Review report on prevention and control of HIV/AIDS, drugs, prostitution in 2006; orientation for implementation of work in 2007, MOLISA, 2007*

The above-mentioned situational characteristics show the HIV infection risk among IDUs and CSWs is very high.

III. SITUATION OF HARM REDUCTION INTERVENTION (HRI) IMPLEMENTATION IN SOME COUNTRIES WORLDWIDE AND IN VIETNAM

1. Situation of harm reduction intervention implementation in some countries in the world

The implementation of HRI varies in each country based on its HIV/AIDS situation, viewpoints and real conditions. However, HRI activities are focused on some programs: Community Outreach (CO), needle and syringe program (NSP), condom use program, substitution treatment program.

1.1. Condom use program

By the end of 2005, Thailand was estimated to have around 580,000 HIV infected cases. The main transmission route for those HIV infected cases in Thailand was through heterosexual intercourse (accounting for 80%).

Thailand has developed and boosted the 100% condom use program (CUP) in facilities associated with prostitution. In 1989, the 100% CUP was first piloted and then scaled up nationwide in 1991. As a result, the condom use rate increased rapidly: from 14% in 1989 to over 90% in 1994, and the number of sexually transmitted disease (STD) cases across the country dropped substantially from 410,406 cases in 1987 to 27,362 cases in 1994. Reduction of HIV infection rate is found in most groups such as pregnant women (from 2.35% in 1995 to 1.18% in 2003).

1.2. Needle and syringe program

According to China's report on HIV/AIDS situation in 2005 and responses, by the end of 2005, there was an estimate of 650,000 HIV infected cases and 44,3% of those cases were infected with HIV through drug injecting.

Even though the NSP has not been widely implemented across China, in Yunan and QuangXi where the pilot programs have been implemented, significant results have been recorded from NSP. In Yên Sơn, the clean N&S

use rate increase from 20% to 78%, and in Jinming □ an increase from 28% to 46%. In 2001, the N&S social marketing program was implemented in Quangdong province, and it was reported that the N&S sharing rate reduced by 50% ^[1].

1.3. Substitution treatment program

The Methadone substitution treatment programs have been implemented in many countries in the world such as Australia, the USA, the Netherlands, India, Myanmar, China, HongKong, etc. And in those countries, the Methadone programs have made substantial contributions to the reduction of crimes and HIV transmission among IDU group and from that group to the community. Specifically:

Since early 2004, China has implemented pilot Methadone programs at 8 clinics located in 5 provinces. As at the point of time of 2005, Chinese Government allowed the expansion of the program to 128 clinics in 21 provinces with the participation of 8,900 drug users.

Evaluation results show that in 8 first clinics, the proportion of drug users practicing injecting drug reduced from 69,1% to 8,8% after one year of treatment and the frequency of drug injection during the month decreased from 90 times/month to 2 times/month. The proportion of those having employment increased from 22.9% to 40.6% while crime-committed rate self-reported by the clients reduced from 20,7% down to 3.6%. Among 92 HIV negative people involved in the program and prolonged their treatment course to at least 1 year, none was infected with HIV. It is estimated that in 2007 - 2008 period, China will have about 1,500 Methadone treatment clinics serving approximately 300,000 heroin users^[2].

2. Situation of implementation of HRI in Viet Nam

^[1] *Evaluation report on situation of drug use in Asian countries in HIV/AIDS context*

^[2] *Workshop on Substitution Therapy for HIV/AIDS prevention: international conference and issues posed in Viet Nam- Party's Central Committee on Science and Education, 2005*

2.1. Implemented HRI activities in Viet Nam

In 1993, the first harm reduction intervention model was piloted in Dong Da District □ Ha Noi and District 1 □ Ho Chi Minh City with the principal activity of peer education (PE), encouragement of condom use and behavioral change communication. So far, some HRI models for high-risk behavior groups, focusing on IDUs and CSWs have been piloted in some provinces across the country and gained certain results.

According to review reports of harm reduction intervention program activities for 2000 □ 2005 period made by 42 out of 64 provinces/cities, harm reduction intervention programs or projects have been implemented in 37 provinces; harm reduction intervention activities have been conducted in 04 provinces but they ended in 2005 due to the completion of the projects; and there are 05 provinces without implementing harm reduction program. The specific results are as follows:

Among 37 provinces where harm reduction intervention activities were conducted, as many as 144 districts out of a total of 246 districts and 1,428 communes out of a total of 4,005 communes have seen the implementation of HRI activities with the involvement of 1,250 peer educators. HRI activities are executed mainly in the form of pilot projects, undertaking mainly behavioral change communication through community outreach and peer education, needles and syringes distribution and collection, condoms distribution, voluntary counseling and testing, STI consultation and treatment. Specifically:

a) The behavior change information-education-communication activities are implemented in the forms of direct communication and through the mass media, printing and distributing communication materials containing HRI program contents. Communication consent on HRI program accounted for 22 □ 43% of the communication frequency on HIV/AIDS, mainly via TV channels (43%) and local newspapers (32.4%).

b) Peer education and community outreach: This task is conducted mainly through the peer educator network with the involvement of 1,250 peer educators and as many as 202,216 persons have been contacted, including 46,691 IDUs, 44,234 CSWs and 111,291 persons from the mobile group. The

number of outreach contacts was 818,660, with 1,864,716 distributed leaflets and 552,367 distributed guiding booklets related to intervention activities.

c) Distribution of clean needles and syringes and condoms is the main intervention activity in the harm reduction program.

- Regarding the N&S distribution program: The total number of distributed N&S was 1,278,133 and 1,374,640 used N&S have been collected by peer educators (accounting for 48.5% of the total number of distributed N&S and 49.3% of the total number of used N&S collected), pharmacies (accounting for 28% of the total number of freely distributed N&S and 19.7% of the total number of used N&S collected), the network of collaborators, health care facilities and the voluntary counseling and testing (VCT) centers.

- Regarding the condom distribution program: Statistically, over the past 5 years, as many as 5,948,356 condoms have been distributed free-of-charge. Peer educators and health care facilities were the main channels distributing condom with the distributed condom quantity respectively accounting for 45.5% and 27.3% of the total number of distributed condoms. The network of counseling clinics, collaborators and pharmacies has also played certain roles in distribution and sale of condoms.

d) Drug substitution treatment program

Currently, in Viet Nam, the Methadone substitution treatment has been applied on piloting basis only at the Institute of Mental Health □ Bach Mai Hospital on a scale of a research with a small number of people involved (68 persons). The research findings have proved that the substitution treatment has significant impacts on reduction of illicit use of opioid substances as well as injecting behaviors, with the rate of 35.48% before treatment, and after 6 months of treatment, this rate was reduced by 3.22% and 0% after 9 months.

e) Some other supportive activities:

- Voluntary counseling and testing, and STI consultation and treatment have been conducted properly through some projects □ activities:

Project " HIV/AIDS prevention and care in Viet Nam □ Phase II" (Life-Gap) supported by the US Centers for Disease Control and Prevention is being implemented in 40 provinces, conducting and maintaining the operation

of 48 VCT sites. Their main activities are voluntary counseling and testing, treatment of opportunistic infections, and referral to other services.

Project "Community actions preventing AIDS" supported by the Asia Development Bank (ADB) is being implemented in 05 provinces covering such activities as STI consultation and treatment, encouragement of condom use, which has contributed to reduction of STI morbidity rate among CSW group (for example: the gonorrhoea morbidity rate among CSWs in Quang Tri province has reduced from 24.8% to 2%).

- Support for community re-integration: This activity has been conducted by a very small number of projects but it proved that a comprehensive intervention program would improve the project's effectiveness, reduce relapse rate and risk behaviors, and HIV transmission. For example, project "Peer education-based comprehensive intervention on injecting drug users in Lang Son" supported by the Ford Foundation has provided vocational training and capital/credit to 40 peer educators, organized post-detox support and rehabilitation for 100 persons, and maintained the regular group meetings. The comprehensive intervention model has contributed to reducing HIV prevalence rate among IDUs from 46% down to 32% after two years of intervention.

2.2. Difficulties

a) Attitudes and awareness

- The concept of harm reduction intervention as well as the effectiveness of harm reduction intervention program are still new to the public, thus there has not been an unification in attitudes and awareness. Stigma and discrimination towards IDUs and CSWs, PLWHA, and people who were released from Centers for Treatment - Education - Social Labor and reintegrated into the community, including peer educators implementing intervention activities in the community, have made the operational activities encountering lots of difficulties.

- While intervention activities are being implemented, collaboration among sectors, branches, organizations has not been closely linked, plus asynchronous implementation, which leads to misunderstanding on the objectives of the intervention program.

b) Regulations and policies:

- Stipulations on implementing measures on harm reduction intervention in HIV prevention: the policy framework for those activities has been promulgated but there is still a lack of guiding documents. Legal documents on drug and prostitution prevention have not included the contents of harm reduction program.

- The regimes and policies for treatment of those staff involved in AIDS prevention, direct provision of management and care to IDUs, CSWs infected with HIV in centers for treatment - education - social labor, prisons, detention centers, correctional centers, etc. are not logical in terms of the beneficiaries and the cost norms, thus attraction of working in those facilities has not been promoted.

c) Resources and funding investment

- Lack of staff working for community □ based harm reduction intervention as well as health workers working in centers of treatment - education - social labor, prisons, detention centers, correctional centers, etc.

- Funding for implementation of harm reduction activities is still limited. Currently, funding for community-based activities is mostly depended on the international support.

2.3. Constraints

a) Scope and locations for intervention are still limited and fragmented.

b) The intervention models are still at the piloting phase and not unified, which resulted in low prevention effectiveness.

c) The harm reduction intervention staff is working on a part-time basis, with insufficient knowledge and experience in implementing intervention programs due to their lack of training or inadequate training.

- Peer educators involved in the program are still practicing drug use or prostitution. There is always a high rate of drop-out among peer educators due to their health condition or returning to the centers of treatment - education - social labor.

PART II

NATIONAL ACTION PLAN ON HARM REDUCTION INTERVENTION FOR HIV PREVENTION

I. OBJECTIVES

1. General objective:

To control the HIV prevalence rate among drug injecting user group under 20% and commercial sex worker group under 3%, reduce the HIV prevalence rate among high-risk behavior groups and spread from high-risk behavior groups to the community, contribute to the successful implementation of the National Strategy on HIV/AIDS prevention and control in Viet Nam till 2010 with a vision to 2020.

2. Specific objectives

2.1. To have 100% of provinces/cities to develop the network of staff working for harm reduction intervention program.

2.2. To increase the condom use rate among the commercial sex workers to 90% and the proportion of commercial sex workers to be given sexually transmitted disease examination and treatment to 80% as in line with the regulations.

2.3. To increase the clean needle and syringe use rate among drug injecting user group to 90%, reduce the needle and syringe sharing rate among drug injecting user group to below 10% and that among HIV infected drug injecting user group at 5%, achieve the proportion of used needles and syringes to be collected at 90% of the distributed number of needles and syringes.

2.4. To implement treatment of opioid substance dependence by substitution therapy in at least 10 provinces.

II. PRINCIPLES OF PROGRAM IMPLEMENTATION

1. Organisation for implementing harm reduction intervention activities in HIV prevention should be relevant to specific situation and conditions of each ministry, sector, and locality.

2. Integration should be made between harm reduction intervention activities in HIV prevention with drug and prostitution prevention and control programs and other action plans included in the National Strategy on HIV/AIDS prevention and control in Viet Nam till 2010 with a vision to 2020.

3. Close collaboration among Ministries, sectors, branches, organisations and the People's Committees at different levels should be made in implementing harm reduction intervention program.

4. Such behaviour of taking advantages of intervention activities to create favourable conditions for drug use and prostitution should be minimised.

III. SOLUTIONS FOR IMPLEMENTATION

1. Group of social solution

1.1. Solutions on legislation and policy

Continuing the development and elaboration of legal document system related to harm reduction intervention activities in HIV prevention in order to ensure the concordance of legislation between HIV/AIDS prevention and control with drug and prostitution prevention and control, development of national guidelines on harm reduction intervention in HIV prevention.

1.2. Solutions on improving inter-sectoral collaboration and community mobilisation

a) Advocating local leaders and authorities, sector, branches, organisations, civil societies, faith-based organisations, enterprises, factories, recreational establishments, train and coach stations, hotels, rest houses, restaurants, and other service providing facilities to support and get involved in the program through conferences, thematic talks, seminars for propaganda, dissemination of education on legislation for HIV/AIDS prevention and control, holding meetings to share experience between units directly conducting harm reduction intervention measures in HIV prevention and relevant agencies, organisations and units;

b) Strengthening collaboration among staff working in the Public Security, labour-Invalids-Social Affairs and Health care staff in executing program activities;

c) Strengthening the role of the family and the residential community in propaganda, education and advocacy of safe behaviours in HIV prevention;

d) Bringing into play the proactiveness and active participation of the target population for intervention in planning and execution of the program;

d) Advocating and collaborating with governmental and non-governmental organisations, international organisations in order to mobilise the technical and financial supports in implementing intervention programs.

1.3. Solutions for enhancing information □ education □ communication and advocacy

a) Enhancing propaganda and education activities on intervention program, harm reduction intervention activities and benefits, roles of harm reduction intervention activities in order to raise the awareness of the authority personnel at different levels, staff working in the anti-social evil system of the ministries, sectors, branches, organisations with an aim to ensure the collaboration and unification in program implementation, reaching the community consensus on harm reduction intervention activities;

b) Strengthening propaganda activities for the high-risk behaviour group on HIV situation, harm reduction intervention programs and other supporting services being implemented, creating favourable conditions for improving access to intervention services as well as behaviour change and practice of safe behaviours;

c) Diversifying communication formats with a focus on direct communication.

2. Group of technical solutions

2.1. Ensuring a unified and effective implementation of the program nationwide and in line with the law provisions.

2.2. Strengthening activities conducted by outreach groups and scaling-up peer education models in HIV prevention.

2.3. Intensifying activities of N&S, condom distribution; strengthening condom social marketing to ensure the availability of N&S and condoms for an easy access.

2.4. Providing and encouraging utilization of lubricants to people involved in men having sex with men.

2.5. Gradually scaling up the treatment program for opioid substances by substitution therapy for those who are dependent on opioid substances.

2.6. Piloting the comprehensive prevention intervention in some provinces/cities and then drawing the lessons learnt and scale-up.

2.7. Integrating the harm reduction intervention program into prevention and treatment activities.

2.8. Conducting regular monitoring and supervision for quality and effectiveness assurance of the intervention program.

2.9. Conducting researches on harm reduction intervention.

3. Group of solutions for improving management capacity and strengthening resources

3.1. Elaborating the mechanism for management, execution of the program.

3.2. Capacity building for the network executing and implementing harm reduction intervention activities;

3.3. Elaborating the system of data collection, reporting and management of harm reduction intervention program;

3.4. Enhancing the supervision and monitoring of harm reduction intervention activities conducted at different levels.

3.5. Mobilizing domestic resources from programs at central and local levels, social organizations, international organizations and NGOs in order to ensure the resources for harm reduction intervention program.

IV. CONTENTS OF THE NATIONAL ACTION PLAN

1. Objective 1: To establish a network of staff, collaborators, and peer educators for implementing the harm reduction intervention program.

1.1. Setting up a pool of full-time staff (at central and provincial levels), staff responsible for harm reduction activities (at district and commune levels) within the system of HIV/AIDS prevention □ in the Health sector, the drug prevention □ in the Public Security sector, and the social evil prevention □ in the labor-Invalids-Social Affairs sector in order to implement harm reduction intervention program. A focus should be laid in developing the network at district and commune levels.

1.2. Establishing a network of collaborators from the central to local levels belonging to ministries, sectors, branches involved in harm reduction intervention program, especially the community outreach program, encouraging the participation of the social workers.

1.3. Developing a network of peer educators involved in harm reduction intervention activities:

a) Selecting and recruiting those who are voluntary and eligible to participate in harm reduction intervention activities as peer educators;

b) Compiling ground rules for peer educator's operational activities with clearly defined tasks, group working, monthly, quarterly and annual action plan and specific targets to be achieve in each activity.

1.4. Training:

a) Developing training curriculum for full-time staff, responsible staff in the area of harm reduction intervention, collaborators and peer educators. Training curriculum should be appropriate to specific characteristics of each target group;

b) Organizing training and retraining for target groups to meet their needs and the specific features of the harm reduction intervention program.

2. Objective 2: To increase the condom use rate among CSW group to 90% and increase the proportion of CSWs to be given STI examination and treatment in line with the regulation to 80%.

2.1. Conducting behavior change communication in order to improve knowledge and encourage to implement safe behaviors for HIV and STIs prevention among high-risk groups.

a) Conducting direct communication for awareness of HIV prevention, condom distribution program, encouragement of condom use, and guidance in condom use, knowledge on N&S provision program, sexually transmitted diseases (STDs), introduction of STD examination and treatment services, etc. to high-risk behavior groups so as to help them change behaviors and be aware of implementing safe behaviors:

- Holding thematic talks for CSWs, staff and receptionists working in restaurants, hotels and owners of establishments doing business in hospitality services, coach stations, ports, tourism or other cultural and social services;

- Organizing periodical group meeting among different target groups for information updates, experience sharing and access to STD examination and treatment services as well as other related services;

- Strengthening direct communication activities to high-risk behavior groups through community outreach workers.

b) Conducting communication through the mass media: providing communication equipment and facilities, arranging timeframe for TV and radio broadcasting programs to advertise the effectiveness of the intervention program, advantages of condom use in HIV prevention, propagandizing contents of the harm reduction intervention program to gain the community consensus in implementation of harm reduction intervention programs, thus reducing stigma and discrimination.

c) Compiling, printing and distributing communication materials such as pamphlets, booklets on condom program. Providing publications on marketing and encouragement of condom use.

2.2. Supplying and guiding condom use

a) Free distribution of condoms:

- **Developing a network of condom distribution through public and private health facilities, hotels, restaurants, project offices, mobile STIs service.**
- **Maintaining and developing a network of condom distribution through per educators and collaborators.**
- **Developing a new condom distribution model that will be conducted appropriately to characteristics of different target groups.**
- **Condom distribution should be conducted appropriately to characteristics of different target groups in order to ensure the availability and convenience of use.**

b) Condom social marketing:

- **Conducting marketing of and directly distributing high quality condoms to CSWs through the network of condom social marketing.**
- **Organizing propaganda, education activities for such subjects as owners of hotels, rest houses, restaurants, recreational establishments. Running training courses on the benefits of condom use in prevention of HIV and STDs, negotiation skills with clients and guidance to be given to establishment owners in order to gain their support and create availability of condoms in their establishments.**
- **Developing a network of condom supply chain such as installing condom vending machines at recreational points, train and coach stations, bus stops and other public locations.**

c) The condom subsidized sale program:

- **Developing a condom subsidized sale network through private and public pharmacies.**
- **Maintaining and developing a network of condom subsidized sale through per educators and collaborators.**
- **Developing a new condom subsidized sale model that will be conducted appropriately to characteristics of different target groups.**

d) Providing and encouraging lubricant use:

- **Developing a lubricant providing network to men having sex with men (MSM) group.**
- **Providing water-based lubricant supply simultaneously with condom supply.**

2.3. Increasing the availability of STD examination and treatment services, creating favorable conditions for CSWs to access the services (in collaboration with the National Program on STI management and treatment)

a) Establishing mobile STD examination and treatment clinic: the clinic should be located in discreet places where CSWs are numerous, with opening hours appropriate to the specific features of CSWs, creating the most favorable conditions for CSWs to get access to services.

b) Mobilizing public and private health facilities to participate in STD examination and treatment program for CSWs.

2.4. Providing training to health staff on technical issues as well as counseling and condom use.

2.5. Developing professional guidelines on implementation of harm reduction intervention measures in HIV prevention with condoms;

3. Objective 3: To increase the clean N&S use rate to 90%, reduce the N&S sharing rate among IDU group to below 10% and among HIV infected IDU group to 5%, to achieve the proportion of used N&S collected at 90% of distributed N&S.

3.1. Behavior change communication for N&S program

a) Conducting direct communication for IDU group on knowledge of prevention of HIV, clean N&S distribution program, encouragement of clean N&S use, guidance on clean N&S use, safe injecting skills through organizing talking sessions for IDUs, periodical group meetings for different groups to update information, share experience and get access to other intervention prevention services and treatment.

b) Mobilizing the community to participate in the program and support the clean N&S provision, and guidance for clean N&S use.

3.2. Provision and guidance of clean needles and syringes

a) Developing the network of clean N&S and sterile injecting equipment through pharmacies, health workers, project offices, STI mobile clinics.

b) Maintaining and developing the network of Clean N&S free distribution through peer educators and collaborators.

c) N&S subsidized sale: N&S are on subsidized sale for IDUs, CSWs practicing drug use through pharmacies, N&S vending machines and some other systems

d) N&S collection: used N&S are collected through the network of peer educators, collaborators, selected health facilities and pharmacies.

d) Distribution of sterile injecting equipments: Cotton, disinfectant gauge and distilled water are distributed simultaneously with distribution of N&S for IDUs.

e) Developing forms of N&S distribution, building different models of N&S distribution.

3.3. Developing professional guidelines on implementing harm reduction intervention measures in HIV prevention with clean needles and syringes;

4. Objective 4: Introduction of treatment of opioid substance with substitution therapy

4.1. Advocating sectors, branches, mass organizations and the public in the substitution therapy implementing sites to support and participate in the program.

a) Conducting communication on the mass media, organizing conferences, seminars, direct communications at the places where substitution therapy is being conducted on harm reduction intervention and treatment of opioid substance dependence by substitution therapy so as to gain the support from local authorities and the people, creating favorable conditions for implementation of the program.

b) Compiling, printing and distributing communication materials such as pamphlets, booklets, etc. on treatment program for opioid substance dependence by substitution therapy.

4.2. Implementation of treatment of opioid substance dependence by substitution therapy

a) For 2007-2008 period: Piloting in 02 provinces with 06 treatment sites. Substitution drugs are estimated to be given to 1,500 drug users.

b) For 2009 □ 2010 period: Based on the results to be gained from 2007 □ 2008 period, plans for scaling-up implementation of treatment for opioid substances in 08 provinces.

(A summary of action plan is available in Annex I)

PART III

PROGRAM MONITORING, SUPERVISION AND EVALUATION

(In combination with the Action Plan for HIV/AIDS Program monitoring and evaluation)

I. MONITORING AND REPORTING

1. Reporting intervention activities being implemented in accordance with the reporting regime as stipulated in the Regulation of reporting and forms for reporting HIV/AIDS prevention and control activities promulgated in attachment to Decision No. 26/2006/QĐ-BYT dated September 6, 2006 of the Health Minister.

2. Supplementing some indicators relating to harm reduction intervention activities in the forms for reporting for the purpose of monitoring and evaluation of harm reduction intervention activities □ effectiveness.

3. Developing a mechanism for information exchange in order to provide, update and exchange information on harm reduction intervention activities within the province as well as across the country.

4. Conducting training for staff who are responsible for program monitoring, supervision on utilization of indicators, data collection, synthesis and analysis.

II. ENHANCING OVERSIGHT, SUPERVISION OF OPERATIONAL ACTIVITIES IN HARM REDUCTION INTERVENTION PROGRAM.

1. Organizing meetings, periodical meetings to evaluate harm reduction intervention program effectiveness, promptly settling difficulties arising during the course of implementing program.

2. Organizing periodical and extraordinary supervisory and review visits.

2.1. Mid-term review (for 2007 □ 2008 period).

2.2. Evaluation of program activities for 2007 □ 2010 period.

3. Conducting specific and operational researches to evaluate program effectiveness as well as making necessary adjustment/revision.

3.1. Conducting studies to evaluate community outreach activities.

3.2. Conducting studies to evaluate comprehensive intervention models for high-risk groups (IDUs, CSWs, etc.), efficiency in application of treatment for opioid substances by substitution therapy.

III. EVALUATION OF PROGRAM IMPLEMENTATION

1. Purpose:

1.1. To evaluate the effectiveness of intervention program in HIV prevention in terms of the coverage, the percentage of target groups to be contacted, etc.

1.2. To evaluate the harm reduction intervention service delivery and service quality;

1.3. To evaluate the responsiveness of ministries, sectors, organizations in harm reduction intervention, and inter-sectoral collaboration;

1.4. To evaluate the responsiveness of provinces in implementing harm reduction intervention activities;

1.5. To evaluate the human resource commitment made from the central level to local level.

2. Indicators for evaluation:

2.1. Evaluation is made according to the National evaluation indicators set stipulated in Decision No. 04/2007/QĐ-BYT dated January 15, 2007 of the Health Minister on promulgation of the Indicator List for Monitoring & Evaluation of the National HIV/AIDS Prevention and Control Program.

2.2. Supplementing some indicators relating to harm reduction intervention activities which can be used for evaluating intervention program effectiveness in HIV prevention on the coverage, the percentage of target groups to be contacted, etc.

PART IV
BUDGET NEEDS

I. BASIS FOR BUDGETING

1. Human resource needs for implementation of harm reduction intervention program

2. Expenditure norms stipulated by the Government of Viet Nam and the practical application in some international cooperation projects:

2.1. The low estimate level: Based on the norms stipulated in the Inter-ministerial Circular No. 51/2002/TT-LT/BTC-BYT dated June 3, 2002 of the Ministry of Finance and the Ministry of Health guiding expenditure contents and norms for National Target Programs for prevention and control of some social diseases, dangerous epidemics and HIV/AIDS.

2.2. The high estimate level: The norms are based on the practical needs and applications in some international cooperation projects.

II. BUDGET NEEDS

1. Budget needs for 2007-2010 period

1.1. Low estimate level: 771,368 million VND

1.2. High estimate level: 1,352,286 million VND

2. Budget breakdown for activities is available in Annex 2

**BUDGET ESTIMATES FOR IMPLEMENTING PROGRAM “HARM REDUCTION INTERVENTION
PROGRAM IN HIV/AIDS PREVENTION”**

2007 □ 2010 PERIOD

Unit: million VND

No.	ACTIVITY	BUDGET ESTIMATE									
		2007		2008		2009		2010		TOTAL	
		Low level	High level	Low level	High level	Low level	High level	Low level	High level	Low level	High level
1	MANAGEMENT, DIRECTION	200	320	100	160	150	160	100	160	550	800
2	TRAINING, WORKSHOP, CONFERENCE, SEMINAR	10.062	18.240	15.400	27.400	11.000	13.600	11.000	13.600	47.462	72.840
3	INTERVENTION ACTIVITIES	91.480	159.320	91.480	159.807	198.500	303.460	198.500	303.460	579.960	926.046
4	SALARY, ALLOWANCE	5.064	21.960	5.064	21.960	12.134	47.040	12.134	47.040	34.396	138.000
5	EQUIPMENT	6.000	12.000	18.000	36.000	14.000	26.000	14.000	26.000	52.000	100.000
6	SOCIAL SUPPORT FUNDING (JOB TRAINING AND CREDIT LOAN)	3.400	6.800	3.400	6.800	3.400	6.800	3.400	6.800	13.600	27.200
7	MONITORING, SUPERVISION & EVALUATION	7.000	14.000	7.000	14.000	13.000	27.000	14.000	30.000	41.000	85.000
8	CONTINGENCIES	600	600	600	600	600	600	600	600	2.400	2.400
	TOTAL	123.806	233.240	141.044	266.727	252.784	424.660	253.734	427.660	771.368	1.352.286

Total budget for 4 years (2007-2010)

Low estimate level: **771 billion and 368 million VND**

High estimate level: **1,352 billion and 286 million VND**

Note: the Methadone substitution therapy is included for 2007 and 2008 only.

PART V

IMPLEMENTATION ROADMAP

I. FOR THE PERIOD OF 2007-2008

1. Elaborating the legal document system to form the legal basis for organization and implementation of harm reduction intervention activities.

2. Developing technical guidelines and communication materials on harm reduction intervention activities.

2.1. Developing and strengthening the contingent of full-time staff for harm reduction intervention at all levels, organizing training on harm reduction intervention.

2.2. Implementing harm reduction intervention program in 30 provinces *with the highest numbers of HIV infected people* through the following activities: communication to create an enabling environment for implementation of harm reduction intervention activities; community outreach; provision and guidance of condoms and clean N&S.

2.3. Introducing Methadone substitution therapy in 02 provinces.

2.4. Conducting specific and operational researches to form the foundation for planning of the next period: Evaluating harm reduction intervention activities in Viet Nam during 2001 □ 2006 period to be conducted in 2007, and the mid-term review (for the period of 2007-2008) to be conducted in 2009.

II. FOR THE PERIOD OF 2009-2010

1. Continuing and enhancing activities being conducted during the period of 2007-2008.

2. Implementing the harm reduction intervention program in the remaining 38 provinces.

3. Implementing Methadone substitution therapy with the expansion to 08 other provinces.

4. Evaluating the effectiveness of harm reduction intervention program during 2007-2010 periods and developing action plan for 2010-2020 periods.

PART VI
ORGANISATION OF IMPLEMENTATION

I. RESPONSIBILITIES OF THE MINISTRY OF HEALTH

1. Taking the lead in coordinating with relevant agencies and Provincial People's Committees to develop and implementing long-term and annual plans for harm reduction intervention program implementation.

2. Developing and promulgating within the given authorities or submitting to competent levels guidelines for implementation of harm reduction intervention program, with special focus on developing legal documents on coordination approaches and related regimes, policies for implementing harm reduction intervention measures in HIV prevention.

3. Collaborating with the Ministry of Justice to revise legal documents related to harm reduction intervention program in order to amend, supplement or recommend the competent authorities to amend, supplement legal documents to be appropriate to the reality.

4. Setting up the Technical Assistance Group for harm reduction intervention program consisting of experts in the field of HIV/AIDS prevention and control from such ministries, sectors, organizations as Ministry of Health, Ministry of Public Security, Ministry of Labor-Invalids-Social Affairs, Ministry of Justice, Ministry of Finance and some relevant ministries, sectors, organizations.

5. Taking the lead and collaborating with relevant agencies to conduct inspection, supervision, and summarize the progress of program implementation.

6. Conducting annual and end-of-period review and reporting to the Government and relevant agencies; evaluating the program effectiveness in 2010, which could form a basis for development of 2011-2020 period plans.

7. Allocating and mobilizing resources to achieve program objectives.

II. RESPONSIBILITIES OF THE MINISTRY OF PUBLIC SECURITY:

1. Taking the lead and collaborating with the Ministry of Health and relevant agencies in building, organizing implementation of long-term and

annual plans for harm reduction intervention program implementation within the assigned functions and tasks, and allocating appropriate resources to achieve the program objectives.

2. Giving directions to public security units at different levels to collaborate with health care units and relevant ministries, sectors, mass organizations at the same level to implement harm reduction intervention program.

3. Implementing harm reduction intervention measures in HIV prevention within the assigned functions and tasks.

III. RESPONSIBILITIES OF THE MINISTRY OF LABOR □ INVALIDS - SOCIAL AFFAIRS:

1. Taking the lead and collaborating with the Ministry of Health and relevant agencies in building, organizing implementation of long-term and annual plans for harm reduction intervention program implementation within the assigned functions and tasks, and allocating appropriate resources to achieve the program objectives.

2. Giving directions to Labor □ Invalids □ Social Affairs units at different levels to collaborate with health care units and relevant ministries, sectors, mass organizations at the same level to implement harm reduction intervention program.

3. Implementing harm reduction intervention measures in HIV prevention within the assigned functions and tasks.

IV. RESPONSIBILITIES OF OTHER MINISTRIES AND SECTORS BEING THE MEMBERS OF THE NATIONAL COMMITTEE FOR AIDS, DRUGS AND PROSTITUTION PREVENTION AND CONTROL

1. Taking the lead and collaborating with the Ministry of Health and relevant agencies in building, organizing implementation of long-term and annual plans for harm reduction intervention program implementation within the assigned functions and tasks, and allocating appropriate resources to achieve the program objectives.

2. Giving directions to units under their management to collaborate with health care units and relevant ministries, sectors, mass organizations at the same level to implement harm reduction intervention program.

V. RESPONSIBILITIES OF THE PROVINCIAL AND CENTRALLY-RUN MUNICIPAL PEOPLE'S COMMITTEES

1. Giving directions in development and organization of implementing long-term and annual plans on harm reduction intervention in their localities and allocating appropriate resources to achieve the program objectives.

2. Mobilizing all the public to support, and get involved in harm reduction intervention activities in HIV prevention.

3. Giving directions in introduction, supervision of implementation, summarizing and reporting periodically to the Ministry of Health and relevant agencies.

VI. RESPONSIBILITIES OF THE PROVINCIAL AND CENTRALLY-RUN MUNICIPAL DEPARTMENT OF HEALTH:

1. Playing the advisory role to the Provincial People's Committee in developing long-term and annual action plans on harm reduction intervention.

2. Collaborating with relevant provincial departments, sectors, and branches to guide units in implementing harm reduction intervention activities as well as supervising, monitoring and evaluation of harm reduction intervention implementation in the localities.

3. Giving directions to technical agencies under their management to implement harm reduction intervention program.

VII. RESPONSIBILITIES OF THE FOCAL POINT AGENCIES IN HIV/AIDS PREVENTION AND CONTROL IN PROVINCES AND CENTRALLY-RUN CITIES:

1. Developing long-term and short-term plans on harm reduction intervention program in the localities.

2. Being the focal point for coordinating with relevant sectors, branches, organizations within the province to direct and implementing harm reduction intervention activities in HIV prevention, including the following activities:

2.1. Implementing harm reduction intervention activities.

2.2. Organizing advocacy, conferences, workshops in order to gain the support from authorities at different levels, sectors, branches, organizations, community, individuals to get involved in harm reduction intervention activities.

2.3. Getting involved in organizing technical training courses.

3. Collaborating with relevant agencies to monitor and evaluate program implementation in the province.

THE MINISTER OF HEALTH

Nguyen Quoc Trieu

Annex 1

SUMMARY OF WORK PLAN

No.	Activity	Implementing or collaborating agency	Location/Time	
			2007 - 2008	2009 - 2010
I	<u>Objective 1:</u> To establish a network of staff, collaborators, peer educators implementing harm reduction intervention program			
1	Setting up a pool of full-time staff, staff responsible for harm reduction activities, prevention of drug offenders and prevention of social evils.	- MOH - MPS - MOLISA - Provincial PC. - DOH, DPS, DOLISA	64 provinces/cities	64 province s/cities
2	Establishing a network of collaborators from the central to local levels belonging to ministries, sectors, branches involved in harm reduction intervention program, especially the community outreach program, encouraging the participation of the social workers.	- Relevant ministres, sectors, organisations - Provincial PC	64 province s/cities	64 province s/cities
3	Developing a network of peer educators involved in harm reduction intervention activities.	- MOH - MPS - MOLISA - Provincial PC. - DOH, DPS, DOLISA	64 province s/cities	64 province s/cities
4	Training	- MOH - MPS - MOLISA - Provincial PC. - DOH, DPS, DOLISA - International organizations, NGOs	64 province s/cities	64 province s/cities

	- Developing training curriculum and contents	- MOH - MPS - MOLISA		
	- Organizing training and retraining	- MOH - MPS - MOLISA - Provincial PC. - DOH, DPS, DOLISA - International organizations, NGOs	64 province s/cities	64 province s/cities
II	<u>Objective 2:</u> To increase the condom use rate among CSW group to 90% and increase the proportion of CSWs to be given STI examination and treatment in line with the regulation to 80%.			
1	Conducting behavior change communication in order to improve knowledge and encourage to implement safe behaviors for HIV and STI prevention among high risk groups	- MOH - MPS - MOLISA - MOCCT - Provincial PC - DOH, DPS, DOLISA - International organizations, NGOs	64 province s/cities	64 province s/cities
2	Supplying and guiding condom use	- MOH - MPS - MOLISA - Provincial PC - DOH, DPS, DOLISA - International organizations, NGOs	30 province s/cities	64 province s/cities

3	Increasing the availability of STD examination and treatment services, creating favorable conditions for CSWs to access the services	<ul style="list-style-type: none"> - MOH - MPS - MOLISA - Provincial PC - DOH, DPS, DOLISA - International organizations, NGOs 	30 province s/cities	64 province s/cities
III	<u>Objective 3.</u> To increase the clean N&S use rate to 90%, reduce the N&S sharing rate among IDU group to below 10% and among HIV infected IDU group to 5%, to achieve the proportion of used N&S collected at 90% of distributed N&S			
1	Behavior change communication for N&S program	<ul style="list-style-type: none"> - MOH - MPS - MOLISA - MOCCT - Provincial PC - DOH, DPS, DOLISA - International organizations, NGOs 	64 province s/cities	64 province s/cities
2	Provision and guidance of clean needles and syringes	<ul style="list-style-type: none"> - MOH - MPS - MOLISA - Provincial PC - DOH, DPS, DOLISA - International organizations, NGOs 	30 province s/cities	64 province s/cities

IV	<u>Objective 4:</u> o introduce treatment of opioid substance with substitution therapy			
1	Advocating sectors, branches, mass organizations and the public in the substitution therapy implementing sites to support and participate in the program	<ul style="list-style-type: none"> - MOH - MPS - MOLISA - Provincial PC - Pro. Depart. Of Health - Sectors, branches, organisations 	02 province s/cities	At least 10 province s/cities
2	Implementation of treatment of opioid substance dependence by substitution therapy	<ul style="list-style-type: none"> - MOH - MPS - MOLISA - Provincial PC - Pro. Depart. Of Health - International organizations, NGOs 	02 province s/cities	At least 10 province s/cities

Annex 2

