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STORY OF CHANGE: VIETNAM

# Modelling a Standard Voluntary Community-Based Drug Addiction Treatment in Vietnam

***The problem***

In Vietnam, the number of people returning to drug use after completing drug addiction therapy remains high[1]. An important factor influencing this trend is that the therapy provided in the country's drug addiction treatment facilities often fails to offer a comprehensive treatment package, one which includes medical treatment, socio-psychological therapy, and support toward social inclusion. This comprehensive approach is acknowledged in World Health Organisation and UN Office on Drugs and Crime international standards as the most effective evidence-based means of treating drug use[2].

Traditionally, healthcare centers in Vietnam only offer vaccinations, carry out prevention work and treat relatively common diseases such as Tuberculosis and Malaria. They were neither used to nor equipped to work with people who use drugs. People who use drugs were normally sent to compulsory detention centers, which are run by the Ministry of Labor, Invalids and Social Affairs, rather than the Ministry of Health. In order to be able to launch a new model of treatment and therapy for people who use drugs, the Center for Supporting Community Development Initiatives (SCDI) first had to advocate for a more progressive approach to be adopted by health care staff when treating people who use drugs. It was essential that a more progressive approach would see a reduction in cases of stigma and discrimination, with people who use drugs being seen increasingly as patients with equal rights to access the services that they need.

Vietnam's National Programme of Drug Rehabilitation Renovation Plan 2013 – 2020 introduced a model of voluntary drug addiction treatment units[3]. However, a lack of technical capacity both at the Department of Social Vices Prevention (DSVP – the national government department responsible for drug addiction rehabilitation) and among local authorities across Vietnam prevented the majority of provinces from adequately implementing the plan. Implementation was further hindered by a lack of adequate budget allocation.

In 2014, Center for Supporting Community Development Initiatives (SCDI; later PITCH partner) helped the DSVP and the Bac Giang Provincial People Committee[4] to pilot a first community-based drug

[1] For example, in Ninh Binh province [2017], 60% recurrent use soon after leaving the drug addiction treatment facilities, and 90% recurrent use one year after leaving the facilities; in Vinh Phuc province [2016], 90% of drug users returned to the drug addiction treatment facilities for another treatment

[2] The international guidelines for substance use disorder has specifically listed these interventions as being effective and evidence-based https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf

[3] http://vanban.chinhphu.vn/portal/page/portal/chinhphu/hethongvanban?class_id=2&_page=1&mode=detail&document_id=171574

[4] The executive arm of the province Bac Giang government

addiction treatment unit in the Bac Giang province. In 2015, the model was expanded to Khanh Hoa and Ba Ria Vung Tau provinces.

The treatment units are located in commune and ward[5] health centers and are managed by representatives of the Commune and Ward People's Committees (the administrative authorities at the commune and ward levels), health centers, social workers, and the police. Initially, many commune and ward health centers were reluctant to provide services to People Who Use Drugs (PWUD). Roles and responsibilities were not clearly defined and delegated, and the services were not properly integrated into the daily working schedules of health staff, who also lacked technical expertise and had not received training to provide appropriate care to PWUDs. Moreover, the treatment units were not properly supplied with the necessary medication to support people with drug addiction.

***The change process***

SCDI implemented a number of interventions between 2016–2020 to support the community-based voluntary drug addiction treatment, care, and counseling model. In the initial phase, SCDI focused on analysing drug use and addiction, drug addiction interventions, local resources, and drug addiction treatment needs in all five of the provinces involved. SCDI also organized workshops with DSVP, leaders of the Commune and Ward People's Committees, health centers, volunteers, and police officers in the local areas in order to sensitize them to science-based drug addiction treatment approaches and to start planning for the model's pilot phase. Moreover, SCDI invited international experts on harm reduction and voluntary drug addiction treatment to support the development of the model.

Between 2016 – 2020, SCDI collaborated closely with the five provincial Commune and Ward People's Committees to agree upon all necessary arrangements, such as the establishment and organization of the treatment units and the service provision procedures. Through workshops and on-the-job trainings, a lot of technical support was provided by SCDI to the Commune and Ward People's Committees to strengthen the capacity of the drug addiction treatment units and to provide basic drug addiction treatment services, including therapeutic guidelines, operational guidelines, and counseling skills. SCDI also facilitated exchange visits between units in different participating provinces to exchange knowledge and organize study tours for government bodies in other provinces, with the objective of expanding the model to these provinces. As a result, SCDI signed an MoU with the government bodies in the provinces of Lao Cai, Da Nang and Ben Tre in August 2020, to technically support the introduction of the model in the respective provinces. SCDI also conducted diverse communication to sensitize and build support for the model within communities, by using loudspeakers, television and newspapers as well as by engaging in dialogues at schools and in the community directly.

With the support of PITCH, since 2016, SCDI has been actively providing technical assistance to the government's Commune People's Committees and Ward People's Committees to establish an effective coordination and implementation mechanism for the voluntary drug addiction treatment model, while building the capacity of staff to transform their approach from control and management to addiction counselling and treatment. SCDI was the only organization who promoted the voluntarily community-based treatment model during that time. The first voluntary community-based drug addiction treatment unit was established in March 2016 in Khanh Hoa province (Phuong Son health center). Up to 2020, a total of 58 units were established in five provinces in Vietnam (Bac Giang, Khanh Hoa, Ba Ria Vung Tau, Ho Chi Minh City, Ben Tre, Da Nang, Lao Cai and Hanoi), providing care to approximately 3000 people who use drugs.

[5] Communes and wards are two types of third-level administrative subdivisions.

Once the health care staff at some of the treatment units received patients with substance use disorders, they gradually became increasingly compassionate towards the patients and their situation. Patients also felt respected and cared for in the treatment units, which was also new to them. The combination of the mutual connection between health staff and patients and the evidence-based interventions represents the key to the effectiveness of the model. As a result, health care staff have since started to advocate themselves for an expansion of the model, within their province and within other provinces. Between 2016 - 2018, the models remained stable in the provinces of Khanh Hoa, Ba Ria Vung Tau and Bac Giang. The provinces shared their success story in community-based addiction treatment in multiple forums, including an annual workshop organized by DSVP, in advocacy workshops with the National Assembly, and workshops organized by SCDI. They themselves became ambassadors of the model. With their encouragement, other provinces requested SCDI's support to implement the same in their area. One of the most significant successes is that Hanoi became one of the area to implement the model after witnessing its effectiveness in the provinces of Khanh Hoa and Ba Ria Vung Tau.

The organizational structure of the treatment units, being embedded in local health centers, is expected to contribute to the sustainability of the model. Since commune health staff are running the units, additional expenses for facilities or human resources are minimal. To further ensure their sustainability, SCDI advocated for adequate budget allocation to the treatment units from the government. This was partially successful; in 2019 the government allocated funds to cover the operational expenses of fourteen existing units and four that were newly established. In Ba Ria Vung Tau, the provincial DSVP agreed to allocate the full budget for running the treatment units and SCDI is no longer providing financial support. In addition, in the province of Khanh Hoa, the advocacy for budget allocation was initially successful and the government took over the costs. The medicine used for detoxification is in the list of controled medicine that only the addiction rehabilitation centers and psychiatrists can prescribe. According to regulations, the community treatment units are not permitted to buy these medicines. SCDI used to be able to buy the medicine with support of local DSVP and the Department of Health. However, a recent change of leadership in the Khanh Hoa provincial DSVP has

undermined the ability of the DSVP to negotiate these terms with the national level Department of Health. Staff costs, office supplies, and communication activities are still being covered from the provincial budget. In the other provinces, advocacy for budget allocation has not yet been successful.

### *Significance*

Across the 44 treatment units, comprehensive treatment could be offered to people who use drugs in five provinces. This has contributed to a measurable improvement in care for people who use drugs in those areas. According to SCDI, on average each unit provides services to about ten patients per month. The number of clients depends on the location and the experience of the unit's staff. For example, Phuong Son unit in Khanh Hoa province attracts 20- 30 clients per month, while 50km away in Cam Thuan the treatment unit only attracts as many as three clients per month. The clients come to the units voluntarily and can be anyone who is using drugs and is seeking treatment.

Unit staff and clients consider the model to be highly relevant, as it responds to the needs of people who use drugs and provides treatment that is totally voluntary and self-initiated. The accessibility of the community-based units is seen as one of their main strengths. People who use drugs can visit the units at any time without coercion, and the units give them a fair chance to rebuild their lives. The model allows for the mobilization of existing resources in the community (human resources, facilities, community solidarity) and supports the families of people who use drugs to help them rebuild their lives. The fact that the model sets out to intentionally foster linkages with the families of people who use drugs during treatment is very significant. People who seek treatment are also supported by the units in finding employment opportunities. Where possible, patients stay with their family during treatment while earning an income for themselves. This increases their resilience and reduces the risk of relapse. The continuation of support after detoxification, in particular support for social inclusion, is furthermore seen as a particular strength of the model in helping clients not to return to drug use. According to the former Head of Khanh Hoa DSVP, the rate of successful treatment in the Khanh Hoa province is at least 50% after one year.

Since the launch of these units, SCDI also observed a reduction in stigma against people who use drugs among the health staff involved, local authorities (such as the People's Committees and police), families, and communities. Likewise, there was a reduction in the self-stigma among people who use drugs. Treatment unit staff observed that after learning about the unit and the treatment, local people and family members started encouraging people who use drugs to seek treatment services. They also observed an increase in health-seeking behavior among people who use drugs; while at the beginning unit staff needed to seek clients by asking local authorities and community leaders, most of the clients now come to the unit by themselves.

> *"Nowadays, more and more staff of local authorities understand that drug addiction is a mental disease that can be cured, not a social evil that needs to be punished."* (Healthcare worker at one of the units in the Khan Hoa province)

By building the capacity of both the local governments and of health workers in the concerned provinces, SCDI has laid an important foundation for a shift from compulsory drug addiction treatment to community-based voluntary treatment in Vietnam. The successful implementation of this model has also provided important evidence to policy makers and local leaders about the feasibility, efficiency, and effectiveness of a voluntary drug addiction treatment approach. The allocation of provincial funding to the units is perceived as a sign of commitment to this model by the government.

### *Lessons learned*

PITCH partner SCDI learned that the successful implementation of this model requires effective collaboration mechanisms and support from various stakeholders (i.e. health sector, DSVP, local authorities, and police). Sensitizing all parties involved to create a common understanding of drug addiction as a mental disease that can be treated and cured has likewise been crucial to the success of the model's implementation. Based on this experience, unit staff who were consulted feel that sensitization should be a core component of any future drug prevention policies and programming. Moreover, the model requires a strong investment in capacity building to ensure that health staff are able to provide their services effectively.

Advocacy for funding from local authorities has been successful in increasing provincial budget contributions to the operation of the model. At the same time, SCDI also learned that provincial level advocacy did not lead to uniform results across provinces. Hence, future advocacy should have an increased focus on the central government level to ensure comprehensive funding for the model.

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