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MAIN*line*

HARM REDUCTION FOR KEY POPULATIONS WHO USE METHAMPHETAMINE IN VIETNAM

An acceptability and feasibility
evaluation report

By the centre for training and research on substance
abuse and HIV, Hanoi medical University.



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ABBREVIATION

ATS	Amphetamine-type stimulants
CBO	Community-based organization
IEC	Information, Education, Communication
HCMC	Ho Chi Minh City
HRI	Harm reduction intervention
KP	Key population(s)
LGBT	Lesbian, Gay, Bisexual, Transgender
MA	Methamphetamine
MSM	Men who have sex with men
ORW	Outreach worker(s)
PWUD	People who use drugs
SCDI	Support Centre for the Development Initiatives
SW	Sex worker(s)
TG	Transgender people

EXECUTIVE SUMMARY

In 2018, a project “Developing community capacity to deliver harm reduction services to people who use meth in Vietnam” was developed by the Centre for Supporting Community Development Initiatives (SCDI) in Vietnam with technical assistance from Mainline, the Netherlands. The project responded to the rise of crystal methamphetamine use in Vietnam and the social and health concerns it caused. The goal of this project – executed between September 2018 and October 2020 – was to strengthen the capacity of outreach workers of community-based organisations (CBOs) in Hanoi and Ho Chi Minh City (HCMC) in 1) harm reduction to people who use meth and 2) community-based mental health screening and referral to treatment. This evaluation examines the acceptability and feasibility of the project.

This evaluation – supported by Mainline and Aidsfonds, the Netherlands – provides relevant evidence to strengthen current harm reduction training and intervention programs and can be used to advocate for scale-up in Vietnam and the Asian region. The evaluation has four specific objectives: 1) To review the existing literature on effective ATS interventions among key populations including necessary skills and knowledge; 2) To describe the actual implementation of harm reduction intervention for key populations who use methamphetamine ; 3) To investigate the acceptability and feasibility of the implementation, factors of success and potential challenges for scaling up the implementation; 4) To examine the impact of the training program in enhancing the capacity and confidence of ORW delivering harm reduction intervention. To achieve the objectives above, a desk review of outreach journals and monthly reports of CBOs, 19 in-depth interviews and 3 focus group discussions with a total of 36 key informants, and a literature review was conducted.

The literature review showed that psychosocial interventions and harm reduction remained the key strategies to reduce the harms related to meth use, given pharmacotherapy was unavailable yet for meth abuse. Among psychosocial interventions, the effectiveness of motivational interviewing, contingency management, and cognitive-behavioural therapies has been solidly documented. The review also showed a paucity of research on ATS interventions in low-and-middle-income countries (LMIC), especially on ATS harm reduction. The review indicates that the interventions (motivational interviewing, outreach and peer-based interventions, mental health screening, brief interventions, and referral to treatment) delivered in

this project are evidence-based and important to fill in the gap of community-based interventions, especially harm reduction for people who use meth in LMIC.

The findings of this evaluation showed that community-based interventions for people who use meth are acceptable and feasible. Despite the impact of the COVID-19 outbreak in Vietnam from the beginning of 2020, the project established a network of 41 outreach workers and reached out to 300 clients in Hanoi and HCMC between February and September 2020. While the recruitment was low in the first eight months (21 new clients/month), it rocketed to 134 new clients in September when the COVID-19 epidemic in Vietnam was under control. The results showed reductions in the prevalence of current use of most substances and the frequency of meth use. Specifically, the percentage of clients who reported heavy use (several times a week) decreased at the 2nd visit. Regarding services, all clients received harm reduction services and half of them received mental health support. People in need also received shelter and food support – the leveraged resources from SCDI’s other projects. Clients unanimously expressed great appreciation for such care and support from outreach workers and the project. The capacity-building component of the project resulted in better skills and greater confidence of the outreach workers in working with clients.

The challenges facing the project included the expected turnover of outreach workers and the difficulties reaching out and providing mental health by the outreach workers. The turnover of outreach workers was compensated with booster training courses to ensure the continuity of the intervention. Outreach workers reported that as people who use meth were often active at night-time, arranging visits with them was harder than with people who use heroin. How to start discussing the taboo topic of mental health issues was another challenge. Long-term capacity-building activities are needed to enhance the capacity of ORWs on mental health and offering low-threshold mental health interventions. Moreover, while the suboptimal rate of follow-up visits (43%) might result from the COVID-related social distancing and lockdown measures, strategies to improve this rate should be considered.

Based on the literature review and assessment of the project outcomes, we propose the following recommendations to improve the impact of community-based interventions for people who use meth:

For interventions:

- To improve client's retention in the project and their reduction of meth use: contingency management should be added as a component of the intervention package.
- To facilitate mental health treatment: having a network of addiction psychiatrists who are willing and available to work with people who use meth would be critical for successful referrals to treatment services.
- To enhance the impact of harm reduction: adding safer smoking kits to the service package would be helpful. What to add depends on a greater understanding of current meth use practices.

For outreach management:

- The project should revise frequency and existing outreach strategies to address the identified challenges in working with people who use meth.
- Given that working with people who use meth might require other strategies and resources than working with other key populations, the project should cover these additional requirements for outreach workers.

For capacity building:

- Further coaching and training should pay greater attention to how to deliver mental health support in the field and to enhance motivational interviewing skills.
- The training-of-trainer program is critical to build local capacity to provide more intense and consistent support for outreach workers.

For building an enabling environment:

- This project should be part of the work at different levels (policy, clinical treatment, research, community support...) to maximize and sustain its impact. Especially in mental health, it is imperative to collaborate with and sensitive service providers.
- Policy advocacy should be continued to ensure the same vision of key stakeholders and donors regarding interventions for people who use meth.

Future projects:

- Since the project interventions delivered by outreach workers are shown to be acceptable and feasible, funding is needed for future projects to scale up these interventions and assess their impact at a greater scope. The project training program should be expanded to serve these interventions.

I. OVERVIEW OF THE EVALUATION

1 Rationale of the project

The use of stimulant drugs, especially methamphetamine (hereafter: meth), has become a major concern across the world. In Vietnam, meth has gradually replaced heroin to be the first drug of choice with 60.7% of people who use drugs (UNODC, 2020). Meth use is threatening the achievements of Vietnam HIV programs as it is associated with higher risk of HIV infection due to sexual risk behaviour, faster progression to HIV, higher viral load, development of ART resistance and lower enrolment in methadone maintenance treatment (Feelemyer et al., 2018, 2020; Michel et al., 2017; Vu et al., 2017).

In 2018, a situational assessment from Aidsfonds, Mainline & SCDI showed a rise of crystal meth use among high risk key-populations, i.e. sex workers (SW), LGBT communities and people who use drugs (PWUD) (Doan et al., 2020). This assessment explored the bio-behaviour of people who use meth. The assessment showed that about 40% of clients used meth for a period of 1 and 4 years and more than 30% used meth between 5 and 10 years. Two thirds of the sample used meth twice or thrice a week. The data from the baseline assessment of another project with youth who use drugs of SCDI (Saving the Future) and programmatic data showed that there was a huge need for harm reduction and treatment of health problems associated with smoking stimulants, including HIV, STIs and mental health disorders. An additional situational assessment was held by Mainline to understand current knowledge, skills and interventions provided by CBOs in this area. The assessment included focus-group discussions and in-depth interviews with several stakeholders and observations in the field. The situational assessment concluded that there was a need for knowledge and skills for community-based service providers on the substance, outreach strategies and development of a harm reduction (and mental health) intervention package. Based on the outcomes of the assessment, Mainline and SCDI developed a project to build the capacity of community-based organizations in providing quality harm reduction services for people who use meth in Vietnam. This was the first project targeting people who use meth who are not in treatment. The combined expertise from Mainline (on harm reduction among vulnerable populations who use stimulants) and SCDI (on community-based work with key populations in Vietnam) was expected to strengthen the capacity of outreach workers of CBOs in Hanoi and HCMC in serving people who use meth. This project also pilots

community-based mental health interventions including mental health screening, first-aid support and access to mental health treatment.

The results of this pilot – initiated by cross-key population collaboration between Aidsfonds, Mainline and SCDI - sparked the interest of national and international organisations. The harm reduction programme is planned to be scaled-up nationally by the Global Fund and internationally through other international donors. In order to further scale up this programme to other regions in Asia, it is important to ensure that effectiveness and feasibility of these interventions and trainings are ensured.

2 Objectives of the evaluation

This evaluation aims to assess the acceptability and feasibility of the pilot intervention, with a goal to provide necessary evidence to strengthen harm reduction programme for people who use meth. Specifically, this evaluation would help to identify the ways in which the capacity strengthening topics strengthen sustainable service delivery and how the capacity strengthening trajectory could be integrated in HIV programming.

The evaluation has the following specific objectives:

- Objective 1: To review the existing literature on effective meth interventions among key populations including necessary skills and knowledge.
- Objective 2: To describe the actual implementation of harm reduction intervention (HRI) for key population (KP) who use meth.
- Objective 3: To investigate the acceptability and feasibility of the implementation, factors of success and potential challenges for scaling up the implementation.
- Objective 4: To examine the impact of the coaching program in enhancing the capacity and confidence of ORW delivering harm reduction intervention.

II. METHODOLOGY

1 Literature review

We conducted a search for peer-reviewed and grey literature on meth interventions with a focus on key populations.

- Populations: people who use drugs, sex workers, men who have sex with men

- Types of intervention: meth intervention, ATS interventions, harm reduction intervention and its synonyms such as strategy, campaign, etc.
- Context: worldwide

Search methods

- Study designs included: cross-sectional study, case-control study, cohort study, crossover study, randomized control trial (RCT), qualitative study designs.
 - + Excluded: case series, case report
- Timeframe: 10 recent years for observational research, 5 recent years for experimental and quasi-experimental research (e.g., RCT, crossover study)
- Context: we first narrowed the literature into low- and middle-income countries. However, given there was only one article met the criteria, we decided to remove this context criteria.
- Although our literature review focused on meth use, we kept the term ‘ATS’ for not missing relevant articles that reported on meth as an amphetamine-type stimulant.

Database

- + Online database (Pubmed, Cochrane library): using keywords (Tables 1 & 2)
- + Cross-references: based on the final list of references resulted from Online databases

Table 1: Syntax to identify scientific articles of interest.

IN PUBMED	Keywords
Settings	
Types of Intervention	
(1) Methamphetamine/ATS	(methamphetamin*[Title/Abstract]) OR (amphetamine-type stimulant [Title/Abstract])
(2) Intervention	(intervention [Title/Abstract]) OR (harm reduction[Title/Abstract])
<i>A = (1) AND (2)</i>	
Key populations	
(3) PUD	(((((people who use drugs [Title/Abstract]) OR (pud[Title/Abstract])) OR (pwid[Title/Abstract])) OR

	(pwud[Title/Abstract])) OR (inject* drug user*[Title/Abstract])) OR (idu[Title/Abstract])
(4) MSM	((men who have sex with men [Title/Abstract]) OR (men who have sex with men[Title/Abstract])) OR (msm[Title/Abstract])) OR (gay men[Title/Abstract])
(5) SW	((sex work*[Title/Abstract]) OR (people who sell sex [Title/Abstract])) OR (fsw[Title/Abstract])
(6) TG and others	(transgender [Title/Abstract]) OR (lgbt*[Title/Abstract])
<i>B = (3) OR (4) OR (5) OR (6)</i>	

IN COCHRANE	Keywords
Types of Intervention	
(1) Methamphetamine/ATS	methamphetamin* OR amphetamine-type stimulant
(2) Intervention	intervention OR harm reduction
<i>A = (1) AND (2)</i>	
Key populations	
<i>B.</i>	(people who use drug*) OR (pud) OR (pwid) OR (pwud) OR (inject* drug user*) OR (idu) OR (men who have sex with men) OR (men who have sex with men) OR (msm) OR (gay men) OR (sex work*) OR (people who sell sex) OR (fsw) OR (transgender) OR (lgbt*)
<i>Search syntax: (A) AND (B)</i>	

The search in PubMed yielded 190 articles, in Cochrane library 100 articles. After excluding duplications, we included 258 articles for title and abstract screening. Ultimately, 31 relevant articles were identified for full-text review. We also added additional peer-review articles and grey literature as recommended by Mainline as an expert in the field.

2 Study design

We conducted a desk review of existing documents and collected primary data from in-depth interviews and focus group discussions with key informants in Hanoi and HCMC. The documents for desk review included monthly reports of CBOs, outreach journals of ORWs,

technical support reports of SCDI and of Mainline staff from the beginning of the implementation.

In-depth interviews (IDI) and focus group discussions (FGD) were conducted with clients, ORW, SCDI staffs and a Mainline trainer to elicit feedback from key stakeholders on the advantages and challenges of the intervention and its implementation.

The changes in the capacity of ORWs were assessed based on the observation/coaching tools that trainers used in coaching. We also asked CBOs how they perceived their capacity improve throughout the intervention in FGD.

Table 2: evaluation outcomes, key indicators and data sources

Outcome	Key indicators	Existing data	Additional data collection		
Implementation description	Quality of services. Activity assessment	M&E capacity assessment. Outreach data regarding activities by month	FGD with ORW	IDI with SCDI staff	IDI with clients (with different number of visits)
Feasibility	Intervention cascade; characteristics of clients and ORW; dropout rates	Outreach data	FGD with ORW	IDI with SCDI staff	IDI with clients (with different number of visits)
Acceptability	Satisfaction of clients and ORWs		FGD with ORWs		IDI with clients (with different number of visits)
Advantages and challenges of the intervention and its implementation	Perceived advantaged and challenges		FGD with ORWs	IDI with SCDI staff	IDI with clients (with different number of visits)

Impact of the coaching program	Confidence of ORWs; changes in the intervention notes of ORWs	Observation/coaching tools by trainers; intervention notes of ORWs	FGDs with ORWs	IDI with Mainline trainer and SCDI staff	
Review of effective ATS interventions and recommendation for training			Literature review		

2.1. Quantitative component

Clients who participated in the intervention came from 4 CBOs in Hanoi and 5 CBOs in HCMC. 4 of them served MSM-TG, 3 served people who use drugs (PWUD), 1 served sex workers (SW) and 1 served both PWUD and SW. For the sake of confidentiality, we assigned them pseudonyms such as HN-MSM/TG 1 or 2, HCM-SW 1 or 2 or HN-PWUD/FSW. These pseudonyms revealed their target populations as CBOs reported but did not necessarily mean their clients only belonged to these populations.

We collected two types of data, as follows:

- Population-level data using for the description of the implementation.
- Individual-level data for evaluating the feasibility of the HRI.

Description of the available data for desk review

1) Data sources

Although the project started its training activities since September 2018 and its intervention in 2019, there was no systematically collected data in this period to make a valid analysis. For the sake of analysis, we decided to focus on the data collected from February to September 2020.

Below is our description of the data sources.

- SCDI consolidation data file (with inputs from CBOs' monthly reports) with the following information:
 - o Number of clients, Number of visits
 - o Educational/communication group sessions: visits, clients

- Harm reduction and mental health screening individual sessions: visits, clients
 - Referrals to health services: HIV testing, PEP, PrEP, ART, psychiatric treatment
 - Receiving HR materials: condom, lubricant, lip balm, communication materials; number of clients received
 - Training sessions attended by CBO, number of clients recruited, etc.
 - ORWs' information such as training sessions attended, number of clients recruited.
- Outreach journals at a semi-open format:
- + Closed-ended questions:
 - Clients ID
 - Year of birth
 - Visit dates.
 - Types of drugs currently used.
 - Frequency of meth use

Note: The timeframe of the questions related to drug use was unspecified. Thus, we assumed all information regarding 'current drug use' pointed to the time of the visit.

- + Open-ended questions:
 - Living conditions and lifestyles
 - General physical health
 - Risk behaviours (e.g., sexual behaviours and/or drug use behaviours)
 - Frequency of meth use
 - Meth use characteristics (e.g., administration routes, people to use meth with, doses...)
 - Services offered to clients at the visit: harm reduction counselling, mental health screening and counselling, provision of HR materials, referrals to other services (follow-up information about referrals was not recorded)
- Coaching reports of SCDI staffs about the knowledge and skills of ORW at selected sessions with clients.

There are 2 monitoring tools to assess the knowledge and skills of ORWs were developed by SCDI with inputs from Mainline trainers. The skill assessment tool included two components of basic skills (29 items) and optional skills (10 items). ORWs were expected to use basic skills consistently. The optional skills could be used when appropriate.

For both basic and optional skills, each item was scored from 1 to 5 points (from very weak to excellent performance). The total scores of the basic skill assessment ranged from 29 to 145 and of the optional skill assessment from 10 to 50. These total scores covered 5 categories:

- 0-50%: Never Meets Standards/Unacceptable Performance
- 50-75%: Meets Standards Sometimes,
- 75-100%: Meets Standards Mostly/Acceptable Performance,
- 100%: Always Meets Standards,
- 150%+: Significantly exceeds Standards.

The knowledge assessment tool had 7 items. Each item was scored from 1 to 5 points (equivalent to “little or non-knowledge” to “mastering knowledge”). The total score ranged from 7 to 35 and covered 5 categories:

- 0-25%: Little or non-knowledge,
- 25-50%: Some knowledge
- 50-75%: Moderate knowledge
- 100%: A lot of knowledge
- 150%+: Mastering knowledge

Since these tools have not been validated for both their contents and scoring and the overall score (>100%) seems illogical. In order to better interpret scores, we classified scores into 4 categories as follows. It should be noted that this categorisation is arbitrary too.

Skill assessment:

- Weak (0-50%): Never Meets Standards/Unacceptable Performance
- Moderate (More than 50%-75%): Meets Standards Sometimes,
- Fair (More than 75%-90%): Meets Standards Mostly/Acceptable Performance,
- Good (More than 90% -100%): Always Meets Standards

Knowledge assessment:

- Weak (0-25%): Little or non-knowledge,
- Moderate (More than 25% - 50%): Some knowledge
- Fair (More than 50% - 75%): Moderate knowledge

Good (More than 75% to 100%): A lot of knowledge or Mastering knowledge

- A list of training sessions from September 2018 to September 2020 that contained the names of CBO, ORWs, dates and training topics.

2) Data quality

- Inconsistent data between different sources

The SCDI consolidation data file and ORWs' outreach journals provided the same information about numbers of clients, visit dates, numbers of services delivered, and numbers of referrals.

However, some data in these two datasets were inconsistent. For example, as of September 2020, 303 clients were showed in the monthly reports of CBO and SCDI consolidation data file; but the outreach journals recorded the information of only 301 clients. The 3rd visits of 12 clients were recorded in the outreach journals but the monthly reports of CBOs showed 20 clients. We opted to keep the greater value and assumed that the data difference was missing value.

- Missing value:

The monthly reports of CBO and SCDI consolidation data file showed raw data with little missing information.

However, information related to the open-ended questions in the outreach journals was not recorded consistently. This information was considered as missing at random (MAR).

In details:

- Sociodemographic characteristics:
 - o Sex at birth: 9 missing values,
 - o Year of birth: 1 missing value
 - o Dates of visits: 3 missing values
- Relationship with people that clients lived with 110 missing values.
- Types of drugs: 1 missing value
- Frequency of meth use
 - o 1st visit: 3 missing values
 - o 2nd visit: 14 missing values
- Information of people that clients used methamphetamine with 61 missing values.

Coaching reports by SCDI staffs had been done for 6 out of 9 CBOs. Among the three CBOs that had not been observed, two groups (HN-PWUD and HN-MSM/TG 2) withdrew from the project

during March and April 2020 and another had only one client. Among the 6 CBOs assessed, 16 ORWs were observed. Of them, 16 were observed on basic skills, 14 on basic knowledge, 7 on optional skills.

The list of training sessions showed 6 training sessions for ORW from 2018 to now with no missing information.

Table 3 presents the key indicators at individual level classified by sources.

Table 3: Indicators of interest and methods of data collection

Dimension	Variables/Indicators	Sources
<i>Existing data (outreach data)</i>		
ORW data	# ORW by CBO	Monthly report of CBO and SCDI consolidation data file
	# training times	List of training sessions
	% by training content/session	List of training sessions
	# total number of clients they outreached to and worked with	Monthly report of CBO and SCDI data consolidation file
	# basic skills and knowledge of ORW by observation	Observation/coaching reports by SCDI
Client data	% by CBO	Outreach journals
	#year of birth	Outreach journals
	# sex at birth	SCDI data consolidation file
	# visits/meetings with ORWs	Outreach journals
	% by services being referred to	Monthly report of CBO and SCDI consolidation data file
	% by services delivered (HR counselling, HR material provision...)	Monthly report of CBO and SCDI consolidation data file
	% by drug types	Outreach journals
	% by frequency of meth use	Outreach journals

2.2. Qualitative component

We conducted 03 FGD with ORWs (01 in Hanoi, 02 in HCMC) following the distribution of ORW groups in the two cities. We also conducted 15 in-depth interviews with clients who stayed in the intervention and those who dropped out in Hanoi and HCMC. Clients were selected from the program database to cover a range of characteristics including sex, age, family situation and living arrangements.

Examples of questions inquiring clients' feedback about the intervention included: *What do you like about joining group sessions? What do you find difficult about it? What do you think of each of the following aspects of group session: locations? Time? Contents? Other clients? How helpful were the individual meetings with ORW to you? For what reasons did you decide to keep coming to the group (or stop joining the group)?*

Examples of questions we asked ORWs in FGD about their feedback on the project interventions included: *Generally, how would you rate the methamphetamine harm reduction strategies of this project? Compared to other methods you know? (In terms of efficiency, complexity, and human resource requirements?) What is the most difficult part of the job? Give specific examples? What do you do in those situations?*

We conducted in-depth interviews with 4 SCDI key staffs including 01 vice-director, 01 program manager and 02 program officers who had been involved in the program and 01 international trainer from Mainline. In total, 19 interviews were completed. We came back to the SCDI staff to get their approval of the findings and to get more information for what was missed from the first interviews.

Examples of questions for SCDI staffs regarding the project management and sustainability: *There is less groups currently working in the project than at the beginning. In your opinion, what is the main reason why some groups do not continue in the project? How do groups that stay differ from the groups that have dropped out? How did they overcome these difficulties? How do you see the sustainability of the program? What are the advantages? What is the biggest difficulty? After the CD36 project ends, how do you plan to continue this intervention? Using which resources? What actions has the SCDI taken to help make the intervention sustainable?*

Examples of questions for the Mainline trainer regarding the proposed interventions included: *How was the intervention package developed? What interventions were proposed?*

What is the background of the proposed interventions? How were the training and coaching activities conceived? By whom? What was the rationale for these activities? What were the expectations of the training? Of the coaching?

(See Appendix 2 for the guidelines of FGD and in-depth interviews)

Participants provided verbal consent before the interviews/FGDs began. All interviews and FGDs were audio-recorded and transcribed verbatim. All personally identifiable information was removed before coding.

Data management and analysis

The first step of data analysis strategies was to derive all sorts of data including quantitative (outreach data) and qualitative data (IDI & FGD).

In terms of quantitative data, we used STATA to clean and arrange data. Proportions and median (interquartile)/mean were used to describe the qualitative and quantitative variables, respectively. We then used Chi-square and Mann-Whitney tests to summarize the difference between two proportions and two medians. We compared sub-groups of clients by CBO, by number of visits attended and by other characteristics using individual-level data.

The quantitative data was derived from two sources: monthly report of CBO and outreach notes of ORW. We access the information of CBO report through the data consolidation of SCDI. Information of outreach note was at a semi-open format, part of information was structural questions and others were handwritten. We first collected all outreach data via Kobo Toolbox, then coding handwritten information into categories in Excel; ultimately we imported and analysed data in Stata 14.0. As of September 2020, 303 clients were showed in the consolidation of monthly CBO report; outreach notes were available among 301 clients. We presented results of data analysis as much as possible from two sources of data and would notice in each table/figure.

For qualitative data: the interviewers summarized key points of each interview/FGD at the end of the session. These findings were summarized by themes of interest for the preliminary finding report. The verbatim transcriptions of these interviews/FGD were analysed in details using Atlas.ti 8. We conducted a thematic analytical approach to data (Braun & Clarke, 2006).

2.3. Limitation of the evaluation

Since we used a retrospective design to review the data related to the implementation process, some information in outreach journals and CBO monthly were missed (e.g. information about the key populations that clients belonged to) and inconsistent. The lack of details in outreach journals on behaviour changes assessed might undermine the evidence of the program's effectiveness. The monitoring tools to assess ORW's skills and knowledge have not been validated yet. Moreover, we were not able to interview ORWs who left the program about the reasons of their discontinuation. These ORWs might face greater challenges in providing the intervention than the ORWs who stayed. The fact that the evaluation ended its quantitative data collection at the end of September 2020 did not do justice to the project, given the substantial increase in the number of clients recruited in September and the COVID-related lockdown and social distancing in the earlier months.

III. KEY FINDINGS

1 Effective meth interventions among key populations

1.1. Types of interventions

In general, the effective interventions to reduce stimulant use and its harms are the same among different key populations. What is particular and innovative is how these interventions are implemented in contexts/ settings most suitable to a particular population.

Among 31 articles identified from PubMed and Cochrane, 24 reported on interventions targeting MSM, 2 on SW and 5 on other people using meth. All articles reported on meth use outcomes. 9/31 articles also reported intervention outcomes related to the use of other stimulants including amphetamines and cocaine (Bakker & Knoops, 2018; Carrico et al., 2014; Landovitz et al., 2012; Page et al., 2019; Parsons & Golub, 2014; Platteau et al., 2020; Reback et al., 2010; Siefried et al., 2020; Tucker & Pedersen, 2017). Only two articles mentioned the particular crystal form of meth (Bakker & Knoops, 2018; Mimiaga et al., 2012). Administration routes are not specified in the literature. The articles reported on three types of interventions including pharmacotherapy, psychosocial interventions and harm reduction.

Pharmacotherapy

With the expectation to identify an effective medication to reduce meth use like methadone to opioids, pharmacological studies have been conducted over the last two decades, still yield unconvincing results (Knight et al., 2019; Radfar & Rawson, 2014). Medications have been used to remediate meth-induced symptoms (Radfar & Rawson, 2014). For example, antidepressants and anxiolytics have been showed to have limited effectiveness in treating meth withdrawal; neuroleptics might treat meth-induced psychotic symptoms. However, no evidence to date has been established for the pharmacology of meth dependence. Different medications have been in trial, targeting different brain mechanisms like the agonist mechanism or depression mechanism. Recent studies on stimulant agonist treatment, naltrexone, topiramate yield promising results (Siefried et al., 2020). Other medications targeting the serotonin uptake are being studied.

Nonpharmacological / Psychosocial interventions

In contrast to pharmacotherapy, nonpharmacological interventions have been shown to be moderately effective (AshaRani et al., 2020). These interventions include broadly three types of strategies, namely motivational interviewing, contingency management and cognitive behavioural therapy (AshaRani et al., 2020; Knight et al., 2019). These interventions are implemented under different models and in different contexts. Recent pilot studies examined the effectiveness of different combinations of evidence-based interventions (including motivational interviewing, contingency management, cognitive behavioural therapy and SMS messaging to deliver elements of the above mentioned techniques) over 8, 12 or 16 weeks on meth use and HIV outcomes among methadone patients using meth in Vietnam (Giang et al., 2020; Hoe et al., 2020). All combinations resulted in significant reductions in not only meth but also in concurrent opioid use among methadone patients. The high retention rate (>80%) suggested these models of interventions were acceptable and feasible in this context (Giang et al., 2020; Hoe et al., 2020). Other nonpharmacological therapies including physical exercise, Repetitive Transcranial Magnetic Stimulations (rTMS), case management and technology-based interventions and residential rehabilitation programs also showed significant reduction in meth craving and relapse at post-discharge but these therapies need to be studied more widely (AshaRani et al., 2020).

Motivational interviewing

Motivational interviewing is a counselling style, theorised by William R. Miller and Stephen Rollnick, and characterized by the theory of change and patient-centred counselling style (Miller & Rollnick, 2002). Motivational interviewing helps individuals to identify their motivation to change and move them up their stages of changes. Motivational interviewing can be used in a single session or in multiple sessions (Knight et al., 2019). Different studies examined how to integrate motivational interviewing to reduce substance use and HIV risk behaviours in contexts of medical or social interactions. Motivational interviewing can be used by professionals or peer outreach workers with various audience (Miller & Rollnick, 2002). Consistent use of motivational interviewing can result in significant behavioural changes (Miller & Rollnick, 2002). Two studies examined whether the intensity of motivational interviewing (duration, number of sessions) was positively associated with reduction in meth use. Polcin et al. (2014) compared two motivational interviewing conditions (9 sessions vs. 1 session) and found that both groups showed significant reductions in meth use. However, there were no differences between the two groups. A greater reduction in psychiatric symptoms including anxiety and depression was found among those receiving more motivational interviewing sessions (AshaRani et al., 2020; Galloway et al., 2007; Polcin et al., 2014).

Contingency management

Contingency management has showed the strongest evidence in treating meth use disorders (AshaRani et al., 2020; Brown & DeFulio, 2020). It has also been known to be effective in reducing other drug use including alcohol, cannabis, nicotine and opioids (Lussier et al., 2006). Contingency management is based on the theory of conditioning whereas incentives are used to strengthen the target behaviour such as abstinence, reduction of sexual risk behaviours or other health-promoting behaviours like retention or adherence to treatment (Brown & DeFulio, 2020). While this strategy is most effective for behavioural changes, current findings suggest using it as a standalone intervention might be counterproductive. Contingency management would work best in combination with other psychosocial interventions or education (Knight et al., 2019). Incentives for the achievement of target behaviours are also positively viewed by most participants (Brown & DeFulio, 2020). The longer duration of contingency management was more effective for maintaining meth abstinence (Roll et al., 2013). Still, the efficacy of contingency management might be reduced by greater problem severity and complex combinations of medical, social and psychological challenges (Brown & DeFulio, 2020). The

major concerns about contingency management are about its sustained effect when the incentives end and the adoption of the technique by treatment providers (AshaRani et al., 2020; Brown & DeFulio, 2020).

Scholars have also studied the best schedules to deliver contingency management to achieve to the greatest outcomes (Brown & DeFulio, 2020). Roll & Shoptaw (2006) in Brown & DeFulio, (2020)'s review found that participants in the escalating-and-reset schedule (participants receive increasing rewards for consecutive abstinences but if the streak of negative drug tests is broken, their rewards would come back to the starting level) submitted more negative drug urine samples than participants in the escalating-without-reset condition.

Cognitive behavioural therapy

There are various forms of cognitive behavioural therapy including the Matrix model, brief intervention, cognitive training, cognitive counselling or behavioural activation intervention (AshaRani et al., 2020; Knight et al., 2019). Cognitive behavioural therapy aims at changing unhelpful cognitive distortions and behaviours (e.g. meth use and risk behaviours). Among them, the most popular intervention is the Matrix model (AshaRani et al., 2020; Radfar & Rawson, 2014). This 16-week intervention combines different elements of effective approaches including cognitive and behavioural treatment using accurate information on the effects of stimulants, relapse prevention skill training, 12-step program participation and family education (Rawson et al., 2004). Its manualised treatment protocol also ensures fidelity when the model is implemented in different settings. Psychosocial interventions yield consistent effectiveness in reducing risky sexual behaviours and methamphetamine use across studies (AshaRani et al., 2020). While contingency management outperforms standalone psychosocial interventions, the combination of these two approaches results in higher retention rate and longer meth abstinence at 1-year post-treatment (Shoptaw et al., 2005).

Harm reduction

Harm reduction for people who use meth is important but often understudied. Harms of meth use include direct (e.g. cardiovascular disease, pulmonary disease...) and indirect medical harms (e.g. blood-borne diseases due to unsafe injection practices) and indirect social harms (e.g. increase in crimes and violence) (Radfar & Rawson, 2014). Harm reduction for meth use not only targets the drug use behaviour, but also cares about the comprehensive needs of individuals

such as nutritional and physiological needs or meth-induced mental disorders management (Carrico et al., 2014; Pinkham & Stone, 2016). The harm reduction approach acknowledges that people might not be willing and able to change their risk-taking behaviours; thus, it is important to engage them in the process of change. Among the 31 studies included in this review, we only found one report on the effectiveness (Carrico et al., 2014) and another one on the feasibility and acceptability of a harm reduction program (Rose et al., 2006). The studies reported by Carrico et al (2014) (the Stonewall Project) assessed the Matrix model for meth-using MSM from a harm reduction perspective. The intervention outcomes were reductions in sexual risk behaviours and risky injection practices. Treatment focused on strategies to manage substance use instead of abstinence. These strategies included transitioning to less potent modes of meth administration, self-care strategies while doing meth and safer injection practices. Clients were not asked to provide urine samples. The study findings showed reductions in days of stimulant (including meth) use and sexual risk behaviours. Other psychosocial interventions, although not focusing on harm reduction, might also result in less risk behaviours (i.e. unprotected sexual intercourse)(Knight et al., 2019; Zule et al., 2012). The addition of contingency management to different harm reduction (i.e. Post-Exposure Prophylaxis use) or drug treatment strategies can boost the effectiveness of these interventions (Brown & DeFulio, 2020; Landovitz et al., 2012).

Interventions should be adapted to the norms and context of the target populations

Evidence shows that interventions that are culturally adapted to the target populations yield more positive results (AshaRani et al., 2020; Knight et al., 2019). Three out of five studies comparing gay-specific CBT with contingency management or standard CBT plus contingency management reviewed by AshaRani et al., (2020) found greater performance of the gay-specific CBT in reduction of risky sexual behaviours, meth use and other outcomes (Jaffe & Rotheram-Fuller, 2007; Reback & Shoptaw, 2014; Shoptaw et al., 2005). For this reason, a common practice of intervention studies is to conduct a formative examination to understand the cultural norms of the target populations and adjust the interventions accordingly. Bakker et al. (Bakker & Knoop, 2018) reported Mainline foundation has adjusted their discussion to alternative risk reduction strategies as Dutch MSM refused to use condom and might get irritated at a consistent focus on condom use. Carrico et al., (2016) also learned about the economic reasons behind meth use among Cambodian female entertainment and sex workers and adjusted the conditional cash transfer based on this knowledge. The literature review by Mainline in 2018 suggested that

female-specific interventions (e.g. sexual and reproductive health services, nutritional support for pregnant women who use meth) that took into account the different needs of women who use meth had better results than gender-neutral interventions (Rigoni et al., 2018).

1.2. Examples of meth interventions among key populations

As meth use is the major driver of high-risk sexual behaviours among MSM, this population has been most widely studied. Innovative approaches to deliver interventions to out-of-treatment MSM have been reported. A project implementing contingency management for homeless, out-of-treatment MSM in a community HIV prevention setting showed reduction in substance use and increase in health-promoting behaviours during the 24-week intervention period and sustained reduction in substance use at 9- and 12-month follow-up (Reback et al., 2010). In this study, participants earned points as they achieved various health-promoting behaviours including drug/alcohol abstinence, scheduling an appointment with a health or social worker, enrolling in a vocational training program or getting a job. The number of points was proportional to the impact of the behaviours. Participants provided 48.5% of all scheduled urine samples during the intervention. The authors suggested that contingency management was feasible and especially potent for individuals at disadvantaged conditions (Reback et al., 2010).

The results of a pilot study among meth-using MSM who were not in treatment suggested a single motivational interviewing session (55 minutes at the beginning) was effective in reducing meth use and sexual risk behaviours at follow-up (self-reported data) (Zule et al., 2012). Another study among homeless young adults using four group-based sessions using motivational interviewing style also reported positive changes in alcohol use, motivation to change drug use and condom use self-efficacy, although no significant treatment effect was found for average frequency of meth use in the past three months (Tucker & Pedersen, 2017). The attrition rates in these two studies are about 80% (Tucker & Pedersen, 2017; Zule et al., 2012). These findings, together with the reports of Polcin et al., (2014), suggest a single-session or group-based motivational interviewing intervention may be useful to reduce meth use in settings where more intensive interventions are not feasible.

Safer smoking kits has been listed among twelve harm reduction practices identified in the literature review by Mainline (Rigoni et al., 2018). This practice has been found to significantly decrease injection practices and prevent injuries to the mouth and lungs (Malchy et al., 2011).

Obtaining safer smoking equipment from a health service point also might also foster a trustful relationship between people who use meth with healthcare workers.

Chemsex interventions

Chemsex or sex under the influence of psychoactive drugs, is popular among MSM and transgender people (Edmundson et al., 2018). It has become a public concern for facilitating the infection of HIV and sexually transmitted diseases and for decreasing PrEP, PEP and ARV treatment adherence (Edmundson et al., 2018). A recent survey with 296 male participants who reported doing chemsex in the last three months in Vietnam showed that crystal methamphetamine was the most popular sexualised substance with 62% of users, followed by ecstasy (37%), amphetamine (20%) and other substances (8%) (Lighthouse, 2020). Our search for chemsex interventions resulted mostly in harm reduction reports including direct services like one-on-one counselling, provision of harm reduction materials, PrEP or indirect services like mobile applications, SMS or web-based interventions (Ma & Perera, 2016; Platteau et al., 2020; Reback et al., 2019; Stardust et al., 2018). The theory-based text-messaging interventions developed by Reback et al., (2019) resulted in significant reductions in meth use, sex on meth and condomless anal intercourse with casual male partners. At the time of this report, this intervention is currently tested among transgender people in HCMC, and methadone patients using meth in Hanoi. Lighthouse, a Vietnamese social enterprise, will also provide chemsex online and on-site harm reduction services in the coming time (Lighthouse, 2020).

Interventions for sex workers and female-focused interventions

Two articles of one intervention study assessed the performance of a contingency management program among Cambodian female entertainment sex workers who used ATS (Carrico et al., 2016; Page et al., 2019). The intervention was developed based on the awareness of the economic reasons behind these women's drug use. The intervention included 12 weeks of conditional cash transfer plus 4 sessions of the Matrix model. The study was able to recruit 84% of eligible participants and retained 93% of participants through 18 months of follow-up. At follow-up assessment, participants reported fewer sexual partners with 50% decrease at 12-months. They had 60% lower odds of being positive with ATS at 6-month and non-significant reductions at 12- and 18-months. Economic well-being indicators also improved at 12- and 18-month follow-up.

Outreach and peer-based interventions

Outreach work is sometimes carried out by multi-professional teams in mobile unit. An initiative of providing van-based harm reduction services for late night population of MSM in San Francisco, U.S. has showed to be feasible in reaching a large number of meth-using MSM (Rose et al., 2006). In this study, a van was parked in a neighbourhood notable for drug use and gay population between 1 and 5am. A ‘buffet’ of services (needle exchange, harm reduction information, oral HIV testing, and urine based sexually transmitted infection testing accompanied by counselling and consent procedures) was offered. The project reached more than 600 individuals over 4 months.

Limitation of the existing literature

Most of the existing studies were done in high-income settings like Europe, Australia and the United States. Evidence on the effectiveness of interventions in low- and middle-income countries remains scarce. Most of the reviewed studies examined clinical samples. Only the few studies on harm reduction services recruited community, out-of-treatment participants. Moreover, these articles did not assess the effectiveness of harm reduction strategies. This limits the generalisability of the findings and a straightforward application of the interventions onto people who use meth and who are not in treatment like the target population of this project. Additionally, the long-term effects of the studied interventions were often not sufficiently assessed due to the common “loss to follow up” in addiction research. This paucity of literature requires further studies to establish the evidence of treatment and harm reduction strategies for meth use.

2 Description of the project implementation

The project started in 2018 with the initial assessment with CBOs and clients who use drugs and capacity building activities for CBOs on harm reduction and outreach strategies in HCMC. In 2019, SCDI and Mainline allocated funds for harm reduction intervention in HCM, and at the same time, started training for CBO in Hanoi. In 2020, following the training framework developed by Mainline, both CBOs in Hanoi and HCM implemented the intervention in a similar approach and procedure. Together with these activities, SCDI, with technical inputs from Mainline and insights from CBOs, has developed an outreach strategy for CBOs to systematically provide services to their target clients. Other information-education-

communication (IEC) materials on harm reduction for people who use meth were also developed.

Between February and October 2020, SCDI and its partners - CBOs for these key populations started providing harm reduction services for people who use meth. Booster training was provided to the outreach workers (ORW) from these CBOs in Hanoi and Ho Chi Minh City (HCMC) throughout 2019 and 2020. Training topics consisted of outreach strategies to clients who use meth, meth use behaviour change strategies, motivational interviewing, harm reduction and health promotion service provision, mental health screening and interventions & building a referral system to health service providers. After the training, ORW received on-the-job coaching and refresher trainings. They also regularly monitored their own progress using a self-evaluation tool. The information from coaching helped to identify rooms to be strengthened in the next training courses. Two project officers of SCDI completed a 2-year training program to be certified international trainers on harm reduction for people who use meth by Mainline. With this expertise, SCDI has provided training on meth-related harm reduction, behaviour changes and outreach skills for CBOs, health and social work professionals and police officers in seven provinces in Vietnam (Hanoi, HCMC, Hai Phong, Ninh Binh, Thai Binh, Quang Ninh, Nghe An). This expansion covers 19 CBOs and 70 new outreach workers and other professionals to work with people who use meth. The participants of these training are expected to deliver harm reduction services in the Saving the future project and in the Global Fund project (at a lower level), and continue to receive monitoring and on the job coaching from SCDI's technical officers. SCDI also serves as a technical hub to transfer skills and materials to provinces and organisations in need.

2.1. Organisations involved in the project

a. Collaboration between SCDI, Mainline and Aidsfonds

Starting from 2018, SCDI has collaborated with Mainline, through the Bridging the Gaps 2 programme to develop community capacity in harm reduction for people who use meth. In 2018, after initial assessment with CBOs and people who use meth in HCMC, Mainline and SCDI conducted training for outreach workers on harm reduction and outreach strategies. Based on the discussion in 2018, they developed together a workplan for intervention in 2019 in HCMC, and later on, a plan for a technical hub in Hanoi. In 2019, through the OSF project, SCDI and

Mainline started training the trainers for this technical hub, which was expected to be one of the regional model and learning hub for meth interventions.

b. Collaboration between SCDI and community-based organisations

SCDI is one of the three sub-recipients of Global Fund programme, responsible for implementation in 5 provinces in Vietnam. Vietnam Union of Sciences and Technology Associations (VUSTA) – the Principal Recipient of the Global Fund (GF) programme - leads a civil society consortium that establishes a community system in 15 province with the highest HIV burden and implement HIV prevention, case finding and treatment support on key populations (KPs). Prevention activities of the GF focus on KPs, including people who inject drugs (PWID), SW, men who have sex with men (MSM) and transgender people. Services include distribution of condoms and lubricants, needle and syringes, HIV screening, testing and information on HIV prevention.

Since 2016, with support from the 5% Initiative, SCDI implemented Saving the Future - a 3 years project, which ended in 2019. The project focuses on innovative strategies to prevent HIV transmission among young people who use drugs. This project, which targeted youth between 16-24 years old using mostly methamphetamine, complemented and filled in the gaps of the Global Fund project. It was the very first project that focused on harm reduction interventions for non-injecting people who use drugs. Through this project, SCDI has also built capacity for CBOs of PWUD, MSM, TG people and SW to reach and delivery services to young people who use drugs. SCDI staff has also gained a lot of experience and knowledge in harm reduction and intervention for non-injecting users. During the project, 20 trainings have been organized on various topics: working with adolescents, basic knowledge about drugs and harm reduction, safe sex and STI prevention, motivational interview, communication skills and mental health. 58 CBOs members have been trained. The knowledge and lessons from the Saving the Future has been carried out by SCDI staff and CBOs into other projects that works with key populations and shared with the Vietnam network of PWUD and other partners through training and policy advocacy. This created a pool of capable ORWs who were willing to work in this current harm reduction project for people who use meth. The CBOs working in this project assigned their team members to provide direct services to clients who use meth. SCDI served as the capacity building resource for training and technical assistance.

c. Characteristics of Vietnamese CBOs

Civil society organisations (including CBOs) have grown rapidly in number and capacity with the HIV/AIDS prevention activities since the early 2000s in Vietnam (Khuat, 2007). These CBOs work with key populations of people who inject drugs, female sex workers and men who have sex with men. They receive funding from non-governmental (like SCDI, VUSTA) or governmental organizations (like Provincial HIV/AIDS Prevention Centers) to carry out activities. These activities focus on harm reduction including provision of harm reduction materials (e.g. condoms, syringes and needles...), informational and social support through group sessions and referral to HIV-related and methadone treatment (Khuat, 2007). One CBO is often consisted of a leader and several key members. CBOs have on average 14 staffs (The Asia Foundation, 2012). Most of the members work part-time for their CBOs. Their effort might depend on the number of projects their CBOs are involved in at the time. How CBO members get paid depends on the arrangement between them and their CBOs and on the requirements of the projects. It can be a monthly wage or per-case payment. Most of Vietnamese CBO struggle with high staff turnover due to unstable funding and better benefits offered by other organisations (The Asia Foundation, 2012).

2.2. Other activities to produce an enabling environment

This intervention project is embedded within SCDI's comprehensive approach to drug and HIV issues including policy advocacy, health system strengthening and capacity building for civil society organisations. With funding from various sources, SCDI has conducted different policy advocacy activities such as workshops to revise HIV and drug policies, technical assistance for ministerial institutions in the development of drug and HIV intervention guidelines, including the Decision #786/QD-BYT on Amphetamine-Type Stimulant intervention guidelines released in March 2019.

Since 2016, SCDI has conducted a capacity building project on addiction medicine for medical universities in general and for psychiatrists in particular in Hanoi and HCMC. Recently, two training courses were provided for physicians in different provinces. This helps to build a national network of mental health services for PWUD.

In the third quarter of 2020, SCDI have worked with the Vietnam – Addiction Technology Transfer Centre (V-HATTC) in HCMC to conduct a mapping of mental health services in the city. The research team interviewed and conducted a thorough analysis of the existing system for

mental health service provision in HCMC, access to services and shortfalls. Four important recommendations are suggested: 1) Improve the capacity and service quality of existing mental health facility, 2) Provide capacity building and training on substance abuse and related mental health issues for doctors and health workers in existing services, 3) Promote the participation of health facilities in service provision 4) Increase the participation of CBO network in supporting access to service.

In Quarter 4 of 2020, SCDI collaborated with both V-HATTCs in HCMC and in Hanoi to organize 2 trainings for psychiatrists on mental health diagnosis and treatment for drug users. 44 psychiatrists in the South and 39 psychiatrists in Northern provinces have received updated knowledge about Psychoactive drugs, addiction, meth-induced mental health disorders, screening tools, etc. from national and international expert in psychiatry. After the trainings, SCDI has built a network of psychiatrists who can provide services to people who use drugs in Ha Noi, HCMC, Hai Phong and some other provinces. Follow-up activities will also be discussed in 2021 to maintain the network and help improve the psychiatrists experience and expertise. A training course will be organized in 2021 for methadone physicians too.

The capacity building activities for CBOs on various aspects that have been included in previous projects (see Section 2.1.b. Collaboration between SCDI and CBO) are critical to gradually enhance the capacity of these civil society organisations. An essential part of the capacity building package is organisational management skills to help CBOs to sustain their structure and to cope with unstable funding resources.

3 Acceptability and feasibility of the interventions

3.1. Implementation progress and recruitment

The review of outreach journals and monthly reports of CBOs showed that 303 clients had been enrolled in the program. Although client retention rate was not an indicator of the program, ORWs were encouraged to keep track of their clients over time. At the time of this evaluation, 130 clients (43%) had a 2nd visit with ORWs, 20 clients (6.6%) had a 3rd visit¹ and 2 clients (1%) had a 4th visit. The time gap from the 1st and the 2nd visits ranged from 1 to 114 days, median of 16 days, IQR 11 – 30. Among 164 participants who were enrolled in the intervention before September 1st, 74 people (45%) had a 2nd visit, 10 people (6.1%) had a 3rd visit. Having said that,

¹ 8/20 outreach journals were missing.

the retention rates of two periods (before September and within September) was similar. In univariable logistic regression to identify the factors associated with having a 2nd visit, we found that clients older than 40 were 5.6 times more likely to have a 2nd visit than clients younger than 20; other age groups did not show significant difference. PWUD and SW (as a group) were 1.8 times more likely (95% CI: 1.1 – 3.0) to have a 2nd visit than MSM/TG.

Figure 1 presents the number of clients recruited by month from January to September 2020. While the number of clients remained low (varying between 12 and 31 clients) from January to August, it rocketed to 134 clients in September. This effect might be in line with the COVID-19 related social distancing in the first three quarter and the success in controlling the epidemic of Vietnam in September.

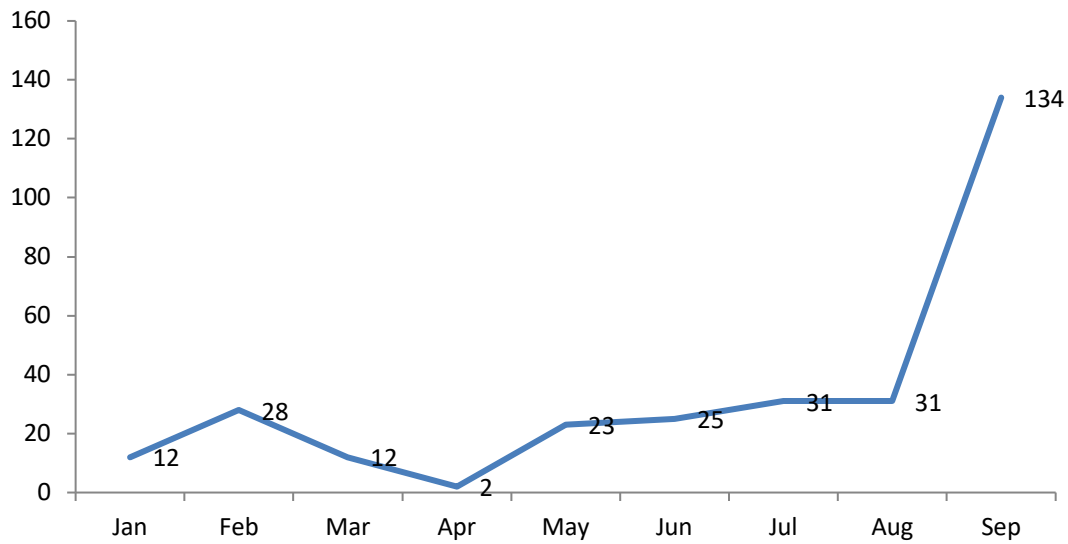


Figure 1. Number of clients by month

In total, Hanoi CBOs recruited 187 clients; and the ones in HCMC recruited 116 clients. The HN-MSM/TG 1 recruited nearly half of all clients.

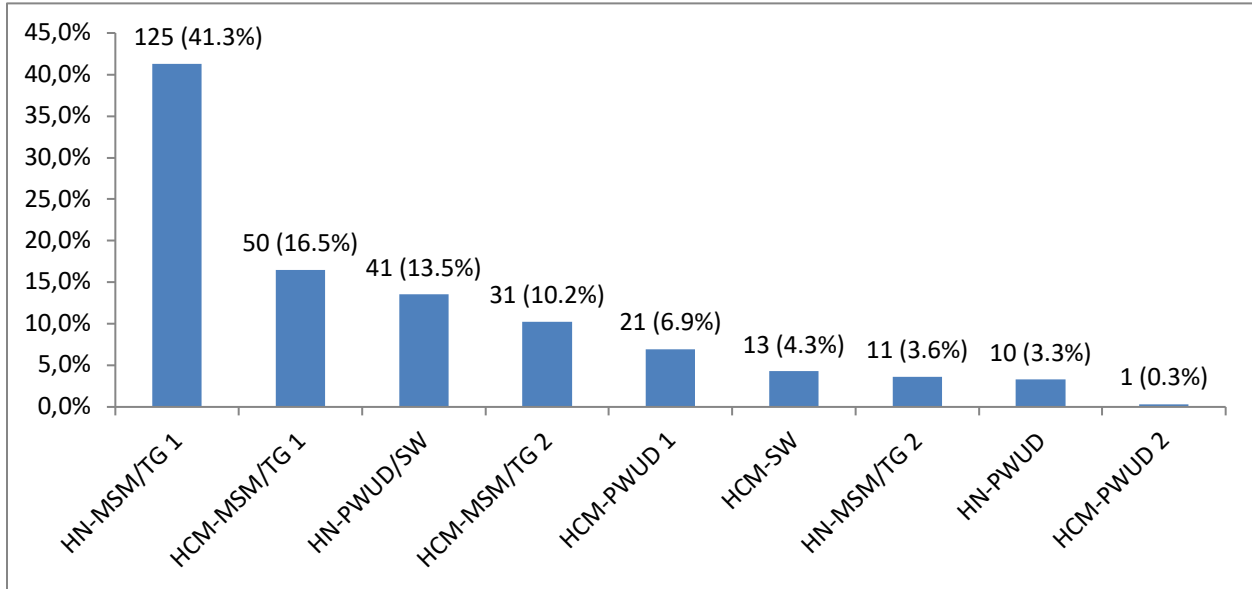
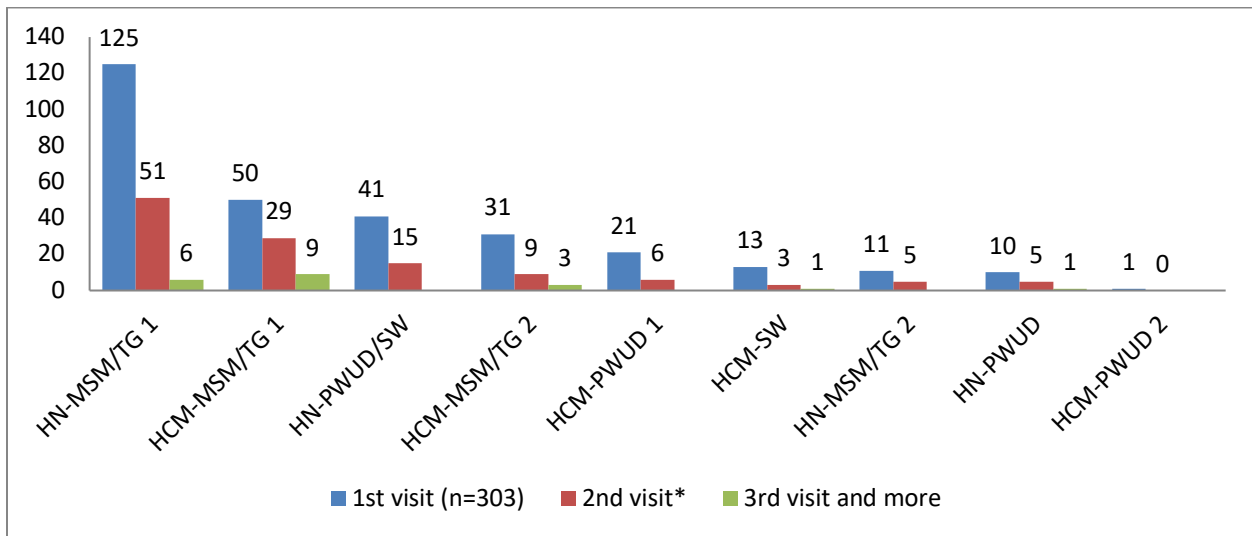


Figure 2. Number of clients by CBO

Figure 3 describes the number of clients by visit and by CBO. Although the HN-MSM/TG 1 had most clients at 2nd visit (n=51), HCM-MSM/TG 1 had a greater number of clients at 3rd visit (n=9). Given the retention rates was the same in September and before September, HCM-MSM/TG 1 had also the highest percentage of second follow up with 29/50 (58.0%), HN-MSM/TG, HN-PWUD/SW and HCM-MSM/TG 2 were at 40.8%, 36.6%, 29.0%, respectively.



*missing 7 values

Figure 3. Number of clients by CBO and by visit

General characteristics of participants: ORW and clients

Twenty-nine ORW participated in the project, ranging from 1 to 8 ORW per CBO. The red line shows the caseload of each CBO. HN-PWUD/SW had the largest caseload as there was only one ORW for 41 clients. Other CBOs with large caseload included HN-MSM/TG 1, HCM-MSM/TG 2 and HCM-MSM/TG 1 with 15.6, 15.5 and 10 clients per ORW, respectively.

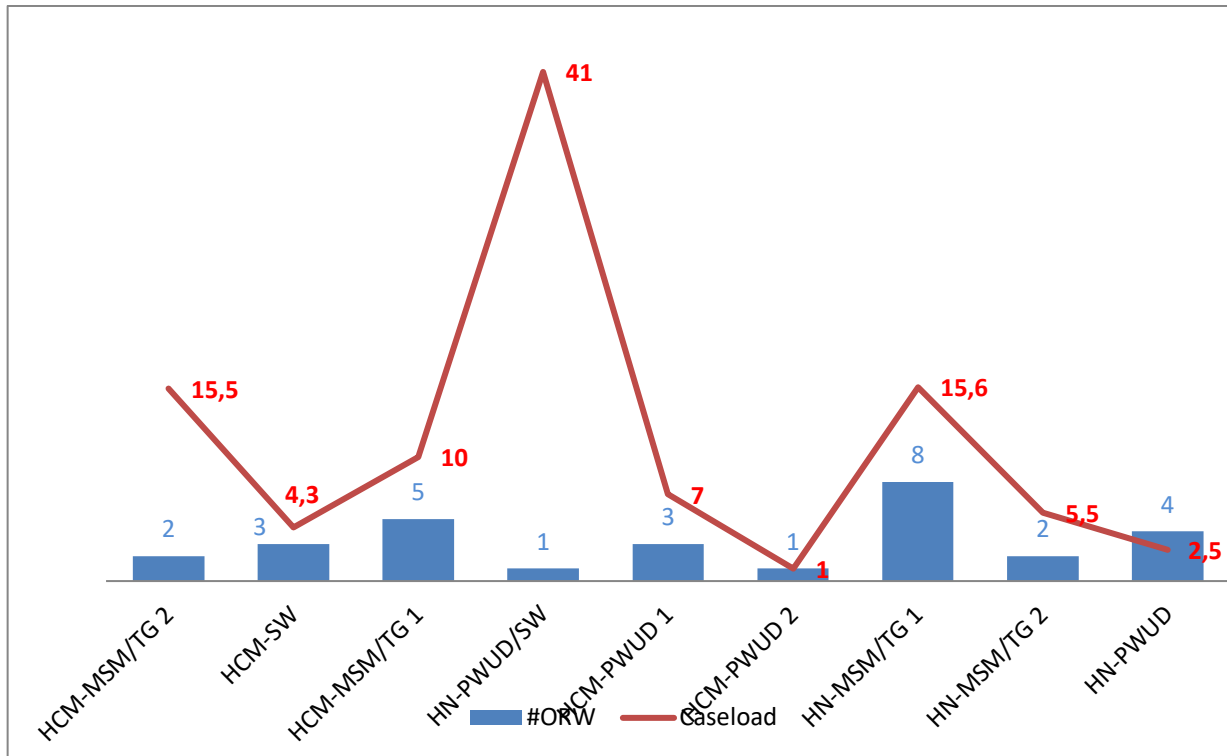


Figure 4. Number of ORW by CBO and their caseload

Table 4 summaries clients' characteristics reported in the outreach journals. The median of age was 25 with the interquartile from 22 to 30. The majority was from 20 to 29 years old. Approximately 12.9% was older than 40. Most clients were of male sex at birth (86.5%). Information about people to live with was available for 191 clients. Of these 191 clients, 27.3% were living alone and 22.5% with their friends. 6.0% of all clients left their house and were homeless due to conflict or being neglected by their family.

Table 4. Characteristics of clients enrolled in the intervention

	Total (n=303) n (%)
Age (n=302), Median (IQR)	25 (22 – 30)
<20	19 (6.3)
20-29	198 (65.6)
30-39	46 (15.2)
≥40	39 (12.9)
Sex at birth (n=303)	
Male	262 (86.5)
Female	32 (10.5)
Lack of information*	9 (3.0)
Living with (n=191)	
Parents	48 (25.1)
Partner/spouse	37 (19.4)
Alone	52 (27.3)
Friend(s)	43 (22.5)
Others (siblings, relatives, etc.)	11 (5.7)
Housing status (n=301)	
Homeless	18 (6.0)
Rented house	26 (8.6)
No information	257 (85.4)

*9 clients were noted as transgender, with no information of sex at birth

At the 1st visit, all clients (n=300) reported currently using meth. Popper/inhalants and cannabis were also common with 28.0% (n=84) and 25.0% (n=75) of clients, respectively. Only 4.0% participants reported currently using heroin.

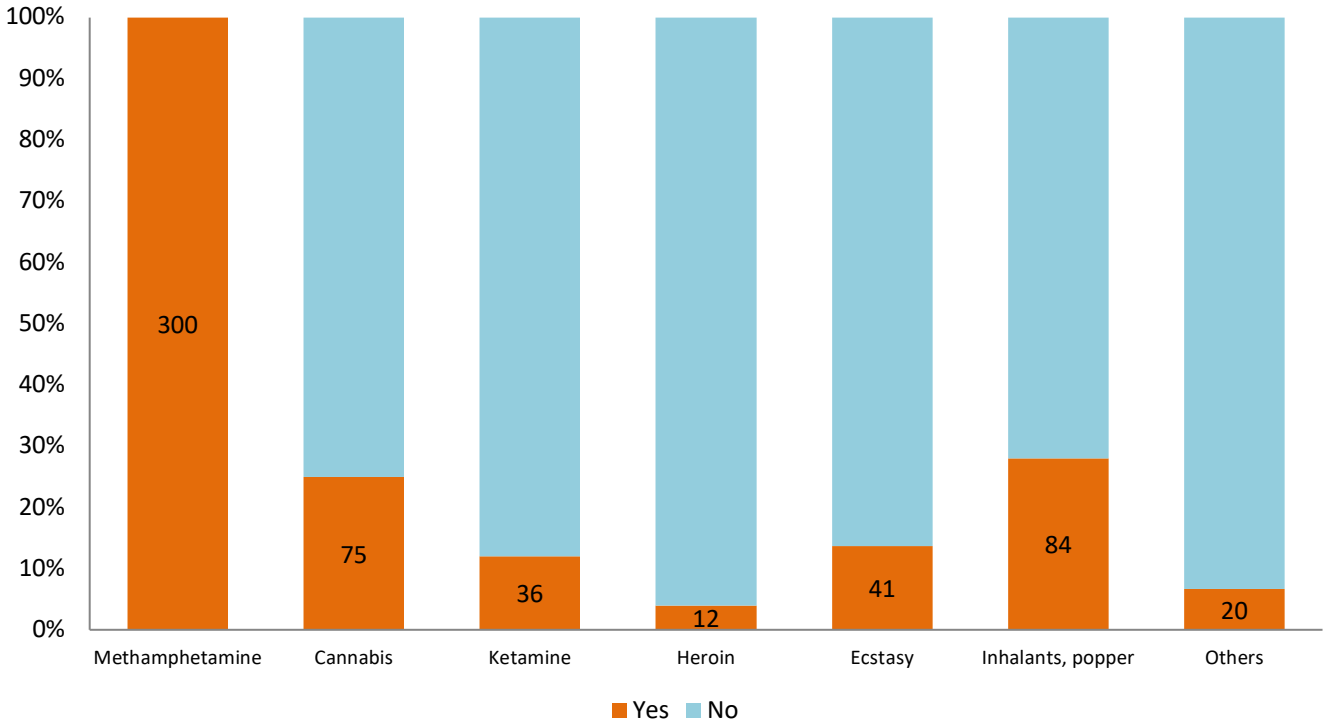


Figure 5. Characteristics of drug use at the 1st visit (n=300)

Information about people that clients used meth with was available in the records of 240/303 clients. The majority of clients used meth with their close friends or within a group of friends (57.1%). 30.8% used meth with their sex partner(s). 7.5% used meth with their sex clients.

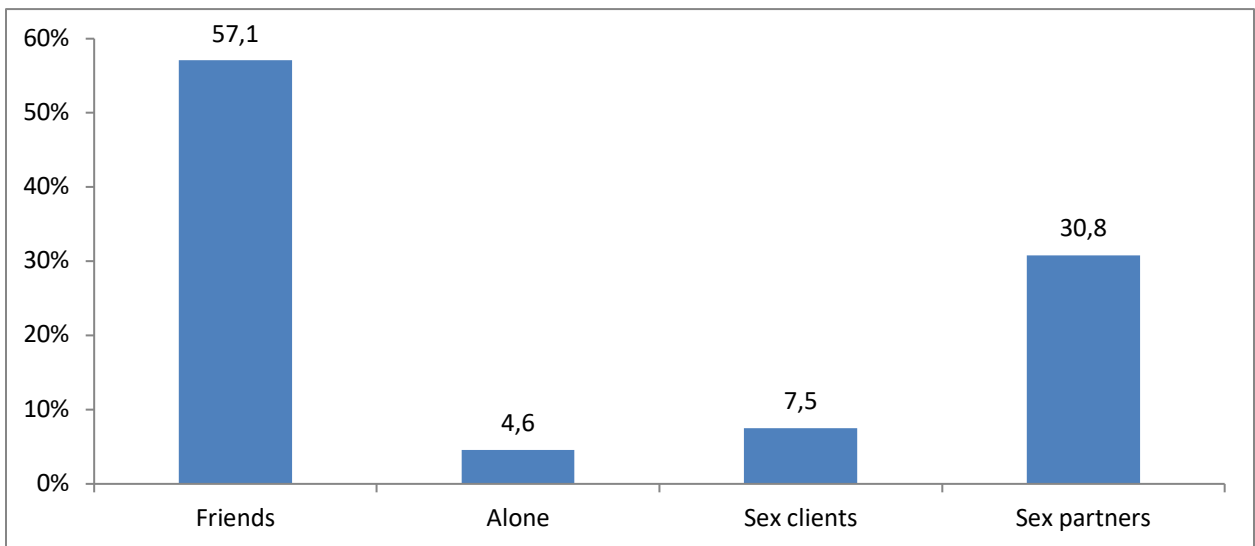


Figure 6. People to use methamphetamine with (n=240)

Figure 7 shows the number of clients by the type of services they received throughout the intervention. Almost all clients received some kind of harm reduction services (advices regarding HIV and meth-related harm reduction strategies, provision of condoms, lubricants, lip balm and IEC materials). 131 out of 303 clients had participated in educational group sessions facilitated by CBO key members. 166 clients had been screened for mental health issues and provided with counselling to change negative thoughts. 42 clients had been referred to HIV testing, ARV, PrEP, PEP and mental health services. However, follow-up data on referrals was not recorded.

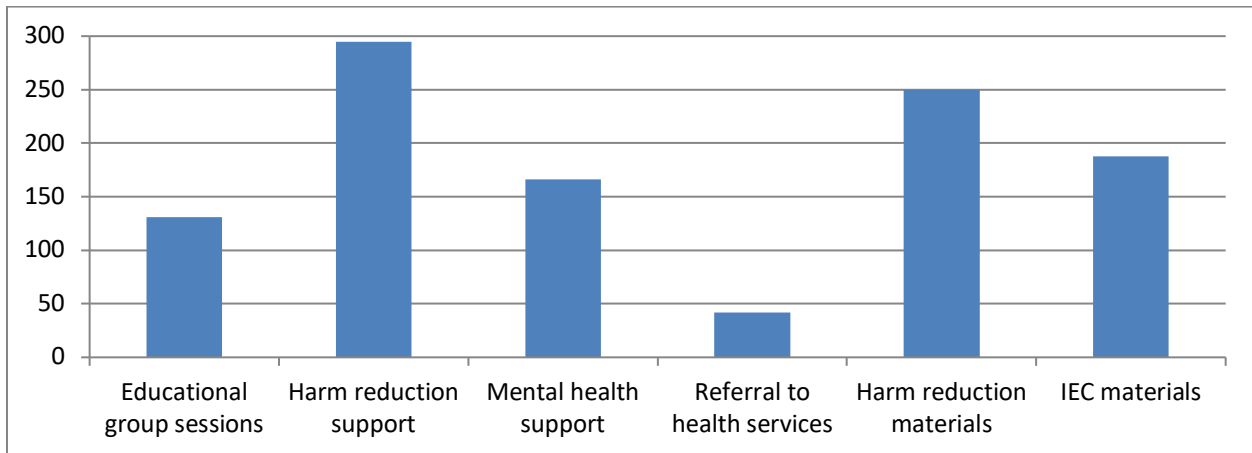


Figure 7. Number of clients by type of services

3.2. Preliminary changes in behaviours

Drug use behaviours

Figure 8 shows comparisons of drug use at the 1st and 2nd visits. The percentage of self-reported current use had declined for most substances (except heroin). The percentage of meth and cannabis use decreased slightly while there were substantial decreases in the use of ketamine (12.0% to 1.5%), ecstasy (13.7% to 6.9%) and popper (28.0% to 17.7%). Given the small number of clients reported using drug in the 2nd visit (Figure 8), we chose popper use as an outcome for further analysis to identify factors associated with changes.

In a univariable logistic regression, age, sex at birth and city, mental health support and materials received were considered covariates to popper use in the second visit. As results, clients in HCMC were 13 times (95% CI: 4.3 – 44.5) more likely to use popper than those in Hanoi (compared to 1.3 times of the first visit, 95% CI: 0.8-2.2). Clients who received harm reduction /ICE materials in the 1st visit were 1.52 times less likely to use popper in the 2nd visit

than those who did not receive such materials but it was not statistically significant. MSM/TG were 3.6 times (CI 95%: 1.3-10.1) more likely to reported using popper at the 2nd visit than PUD/SW.

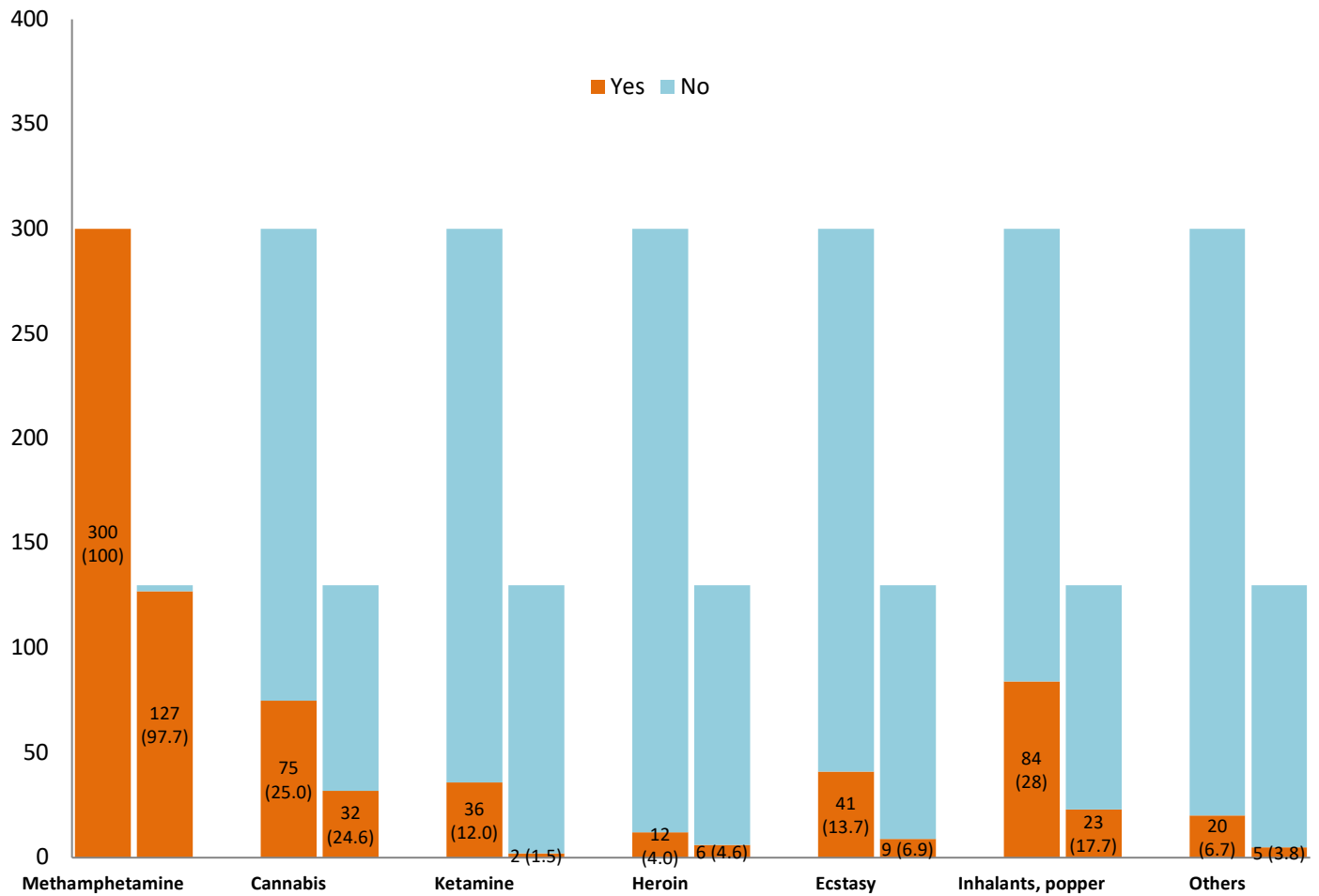


Figure 8. Characteristics of drug use at the 1st and 2nd visits

Frequency of methamphetamine use

Figure 9 shows the frequency of meth use between the 1st and 2nd visits. Clients who reported using meth every day or several times per day at the 1st visit did not show significant changes at the 2nd visit. The percentage of clients who used meth less than once a month increased at the 2nd visit (15.5% vs. 1.0% at 1st visit). At the 2nd visit, the percentage of clients reported using meth several times per week reduced from 40.3% to 31.9%. We categorised the

frequency of meth use into two groups: regular use (several times/day, daily, several times/week) and irregular use (using few consecutive days then pausing, several times/month, only weekend, less than once/month). In a logistic regression, HCMC clients had lower odds of using meth regularly than Hanoi clients (OR=0.38, 95% CI: 0.17, 0.82); clients who received HR materials/IEC materials and mental health support in the 1st visit had lower odds of regular meth use (in the 2nd visit) than those who did not but the associations were not statistically significant.

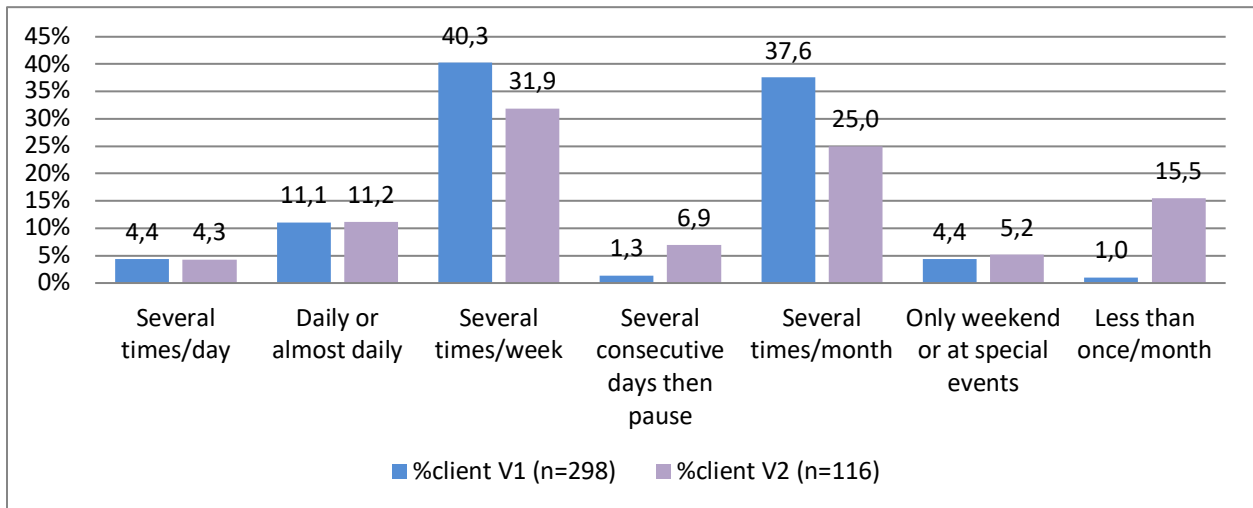
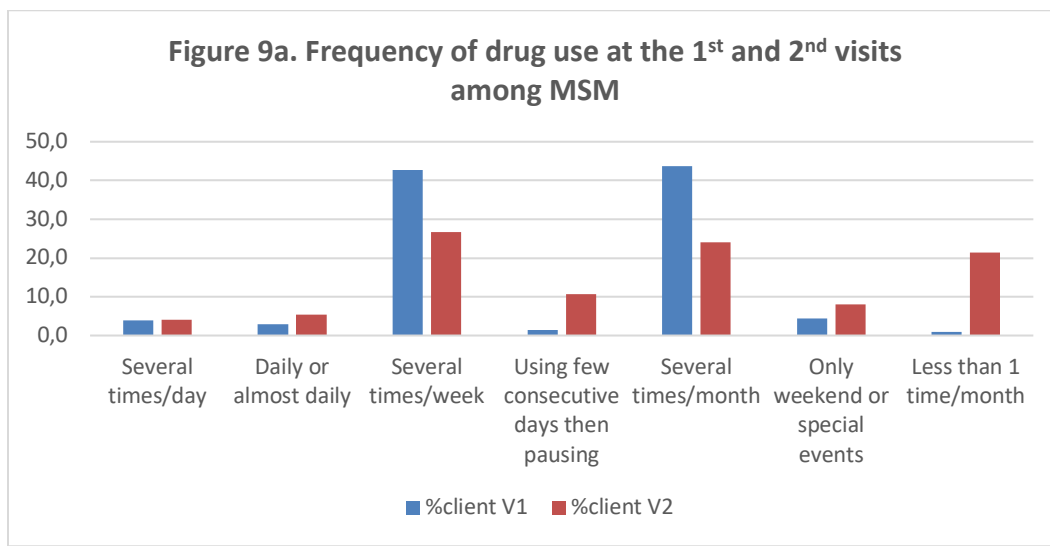
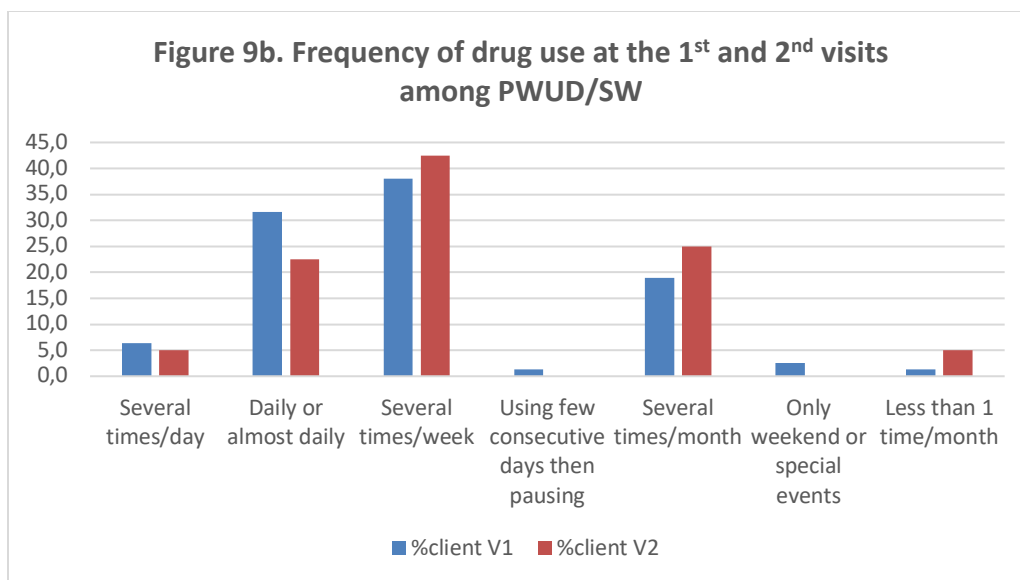


Figure 9. Frequency of drug use at the 1st and 2nd visits





3.3. Client satisfaction

When being asked about what they thought about intervention activities that they were involved in, many respondents expressed their satisfaction with the organization of these activities. Most respondents agreed that comfortable time and location was the first thing they noticed about the intervention. A MSM client in HCMC shared that:

“Time and place for meetings are quite convenient so I could join the group meetings.” [MSM, client, HCMC]

One important thing that attracted clients to participate in the intervention activities is useful information about related behaviours and diseases, provided through ORW visits and IEC materials in group meetings.

When attending activities, I received a lot of useful information regarding ATS use, how to reduce harms, how to safely use methamphetamine. [Male, client, HCMC]

Besides, individual intervention sessions also brought benefits to clients. Clients appreciated the way ORWs motivated them to change their thinking and behaviours, as said by a male client in Hanoi:

“H (the ORW) helps me to realize that I need to move on. I have to stop [drug use] for my children. When thinking about my kids, I no longer want to use heroine, and now I also reduce my meth dose. My reduction in use is not

because of the harm from meth as I did not experience any, but it's all because of my kids". [Male, client, Hanoi]

Many clients stated that intervention activities provided them emotional support. Joining intervention activities, they had the space to share their experience and their feelings.

"I found it's really useful to join these activities as it helps to cheer me up. There I had someone to talk to. And when I need support, I could call her (the outreach worker)". [Female, client, HCMC]

The last but extremely important thing made them satisfy with the intervention activities is many other support provisions. A client in HCM shared that he had received food and nutritious products from the outreach worker of the program. Additionally, instead of money, the program supported clients by providing other essential services, such as healthcare services, health insurance or foods.

"She (the outreach worker) went with me to the hospital for health check-up. I took blood test and HPV test, then the physician told me to hospitalize. I did not have money so she helped me out. She also helped me to get health insurance" [Female, client, HCMC].

3.4. What needs to be addressed for a better implementation

The pilot identified several challenges to the implementation of the intervention from the viewpoints of SCDI program staffs and outreach workers. The challenges were at program-, intervention- and client-level.

The challenges at the program level included the recruitment of qualified and committed outreach workers. Since CBOs often run various projects at the same time, sometimes they would move their ORWs to other projects, forcing this program to recruit new ones. The fact that many ORWs only worked part-time for the project and had other priorities resulted in limited commitment to the intervention activities. Discussing this issue, a male program officer in HCMC said:

They are busy with many different works so it was hard for them to arrange time for these activities. [Male, program officer, HCMC]

The challenges at the intervention level included the difficulty level of the skills required to provide outreach and work with people who use meth. Since these skills were totally new to ORWs, it was challenging to develop these skills within the short time of the pilot. At the beginning of the intervention, even after ORWs had attended training courses, it was challenging to recruit ORWs with enough skills and capacity.

Outreach workers here are well-equipped with HIV-related intervention skills but not with ATS-related intervention skills because the latter skills are more complicated. It's not just the provision of testing or treatment services, the intervention requires much more. [Female, program officer, Ha No].

Among the intervention package, mental health support seemed to be most challenging for ORWs to deliver. Although this service was a focus of the intervention, there were a lack of recognition of mental health issues and some reluctance to discuss these. A program officer in Hanoi explained this challenge as below:

"This is the first intervention which addresses mental health issues using community-based approach so people don't have much knowledge and experiences. They seem to hesitate discussing this issue. [Female, program officer, Ha Noi]

The difficulties in working with people who use meth relied in the particular characteristics of this population. The first challenge was how to reach out them since people who use meth formed small and hidden groups. The behaviour-altering effects of meth also made users' behaviours less predictable. Thus, it was hard for ORWs to arrange visits with clients who use meth:

Heroin users do heroin at specific times during the day. Meth users are totally different. If they have money, they'll use [meth] days after days. It's hard to know when they are sober enough to talk to them. Moreover, when they're high, some people don't want to get into contact with anyone while others only want to hang out with their friends. (FGD with ORWs in Hanoi)

Additionally, in order to protect themselves, ORWs often saw their clients in tea or coffee shops instead of doing home visits. This incurred drink and food expenses for clients. While these

expenses were deemed necessary to establish good relationships with clients, they did not get reimbursed. This made ORWs feel uncomfortable when doing their work.

In addition to the general satisfaction toward the intervention, there were also client-level factors affecting the acceptability of clients to the intervention activities, the effectiveness of the visits and the feeling of connection to the intervention. For several clients, long distance from their home to the intervention place is one of their challenges to participate in the services. A female client, whose house is more than 20 km away from the centre business district of HCMC said:

It is too far from my home so I quit. It has been 3 months. It's because the incentive is not enough for my travel expense. [Female, client, HCMC].

The locations of some group meetings in public spaces (like coffee and tea shops) might be a barrier to attend for clients who worried about their privacy.

Busy schedule is another challenge for clients to participate in intervention activities. Clients usually had jobs which make it hard for them to arrange appropriate time for regular participation, particularly in daytime as a client said:

I'm quite busy so I could just attend some sessions in the evening or at weekend.
[MSM, client, HCM]

Another client who reported using meth daily, although showed his appreciation towards the advices of ORWs regarding healthy lifestyle on meth, suggested the frequency of visit (once a month for him) might not be sufficient for meaningful changes since “*people would forget what was said the last time if it takes too long to meet the ORW again*”.

4 Capacity building program for ORW

4.1. Description of the capacity building program

As one ORW said, the whole capacity building program provided in this project was like a ladder. At the first rung, ORW received training by Mainline and its national trainers from SCDI on topics relevant to harm reduction and mental health interventions for people who use methamphetamine. At the second rung, ORW would go out into the community including hotspots to outreach potential clients and recruit them into the program. At the third rung, Mainline or SCDI trainers would go with ORW during the first meetings with clients. When ORW were more confident and skilful, they would work with clients without supervision. At the last rung, experienced ORW would provide this on-the-job coaching to novice ones.

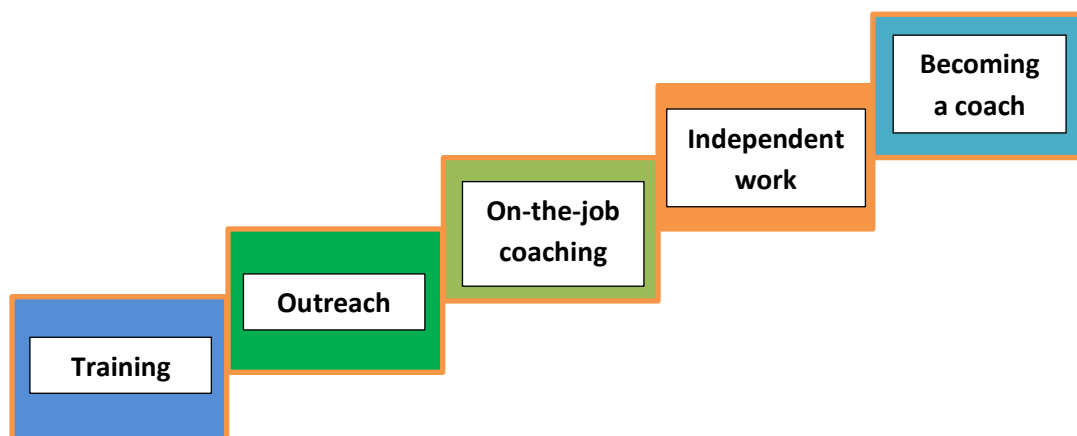


Figure 10. Capacity building strategy for sustaining the capacity of CBOs

The capacity building component was considered a key element contributing to successes of the project implementation. In 2018, Mainline conducted a capacity assessment to understand the rooms to improve, then to identify the scope and extent of the capacity building program.

The capacity building activities of the project began in September 2018 within the cooperation between SCDI and Mainline. 47 ORWs from 11 CBOs in both Hanoi and HCMC had been trained in 6 courses by certified trainers from Mainline and SCDI. Among the ORWs who took part in the project since the beginning, 12 left before this evaluation for a number of reasons including time conflicts with other works. The training covered outreach skills, harm reduction, communication skills, and mental health interventions. Two SCDI trainers attended a 2-year training program delivered by Mainline to become certified national trainers.

Table 5 – Recapitulation of training courses

Date	Training topics	Participants
Training for ORW		
Sep 2018	Outreach + Harm reduction	16 ORWs from 6 CBOs
Nov 2018	Communication skills	5 ORWs from 5 CBOs
Apr 2019	Mental health	15 ORWs from 6 CBOs

Oct 2019	Full curriculum	11 ORWs from 3 CBOs
Jun 2020	Harm reduction, outreach, communication skills	14 ORWs from 5 CBOs
Aug 2020	Harm reduction, outreach, communication skills	5 ORW from 2 CBOs
Feb-Sep 2020	On-the-job coaching	16 ORW
Feb-Sep 2020	Monthly meetings between Mainline and SCDI trainers to monitor performance of ORWs	Mainline and SCDI trainers

Observations from coaching provided insights to trainers to develop refresher training for ORWs. The assessment was based on 1) manners of ORW towards clients (personal characteristics), 2) communication skills, 3) preparation and provision of harm reduction materials and IEC, 4) specific advice/counselling on harm reduction appropriate to the health behaviours of clients, 5) skills in maintaining conversation with clients; 6) motivational interviewing skills and 7) mental health intervention (including screening and explanation of the importance of mental health).

In this project, coaching on the job was provided to 16 ORWs from 6 CBOs. The number of coaching sessions to ORWs ranged from 1 to 23, 10.8 sessions on average. 13/16 ORWs had at least two observation/coaching sessions on basic skills, 12 ORWs had at least two observation/coaching sessions on basic knowledge. The intervals between coaching sessions were inconsistent.

The average score in the basic skill assessment of ORW was 102.3/145 (70.6%, read Moderate: meet standard sometimes). The average score in the optional skill assessment was 3.48/5 (69.6%, read Moderate: meet standards sometimes). The average score in the basic knowledge assessment was 3.56/5 (71.2%, read Moderate knowledge). As the data in basic skill assessments was most completed, we were able to identify two basic skills that scored the lowest (2-3/5). These skills were 1) *Allow client time to talk without interruption – Use the 10 second rule* and 2) *ORW explain for client: what is mental health and debunking mental health stigma and myths* (e.g.: Mental Health is as important as Physical Health).

We compared the average scores of ORWs’ basic skills and knowledge of the first and the most recent coaching sessions. The time gap between these two sessions was 2.8 months on average, ranging from 0.7 to 9 months. The average score in the most recent session was 0.7 point higher than the score in the first session (equivalent to 14% increase). The basic knowledge score was 0.37 point higher in the most recent session compared to the first session (7.3% increase). The optional skills were assessed for 7 ORWs but we found no changes between the first and last sessions (average score: 4/5).

Topic	Criteria	10.07.20	10.07.20	13.7.20	28.7.20
A: BASIC SKILLS THAT OWs NEED TO IMPLEMENT (REQUIRED)					
Personal characteristics	OWs are open minded, approachable and non-judgmental	5	5	5	5
	OWs be confident with words and demeanor	4	5	4	5
Communication skills	OWs show good listening skills i.e.. Let clients talk more, eye contact, leaning forward, summarizing	4	5	5	5
	When engaging with beneficiaries OWs ask open ended questions	4	5	4	4
	OWs do NOT force their opinions or views on beneficiaries	5	5	4	4
	Allow client time to talk without interruption – Use the 10 second rule	4	4	4	4
	ORW minimises use of their phone while in conversation with client	5	5	5	5
	ORW always has prior agreement of the client before inviting other people into the conversation	5	5	5	5
	OW is confident, assured and sensitive when talking about sensitive topics with clients’	4	5	4	5
	Before taking notes, OW should have the client permission	5	5	5	5
Prepare and providing commodities and IEC	OW always bring harm reduction materials and commodities such as tests, condoms, lubs when doing outreach.	5	5	5	5
	When distributing commodities and IEC materials for clients, Ows always explain why clients should use/read them; show them how to use commodities or guide clients to use IEC materials	4	5	5	5
Harm reduction offers	OWs ask clients more information about their lifestyle, their health, their risk	4	4	5	5
	OWs offer a specific harm reduction intervention appropriate to the lifestyle, health, frequency of usage and risk behaviour of the client’	4	5	5	5

Example of an observation sheet of ORW’ skills by coaches

Coaching or **on-the-job training** is a new approach, by which trainers accompany outreach workers throughout the implementation process. The coaching component was designed to strengthen the capacity of outreach workers to implement harm reduction services among target populations. The trainer from Mainline who also served as the technical assistance provider for this project, emphasized coaching as the key component of the capacity strengthening project for CBOs. SCDI officers also explained how they saw the role of coaching in their long-term plan:

“The ultimate goal of coaching is to develop a hub of experts from communities in the future. These people will be pioneers to providing ATS-related interventions, not only in Vietnam but also in the region. [Female, program officer, Ha Noi]”

One of the typical characteristics of the coaching program is that the trainers were always going together with trainees. At the beginning of the program, experts from Mainline provided trainings for both trainers from SCDI and outreach workers, then SCDI trainers took over the responsibility. They went to the individual meeting sessions with outreach workers from the beginning of the program.

“At the beginning, we (program officers) went to all the individual meeting sessions with outreach workers to support them during the sessions or made suggestions to better the service after the sessions. I think we did it in the first one or two months of the implementation. After a while when they had enough skills and experiences, we let them work on their own, but we keep monitoring them in different ways such as case reviews and random observation. [Male, program officer, HCMC]”

After that, SCDI staffs had provided **recurrent technical support and assessment** throughout the progress of ORWs’ outreach and harm reduction service delivery. In addition to direct observation in intervention sessions, other coaching activities such as monthly meeting or regular case discussion have been conducted:

“Since last June [after the COVID lockdown], ORW have been more active in providing services. We just conducted monitoring in rotation. Additionally, we organized monthly meeting for reports and case discussion. [Male, program officer, HCMC]”

Not only trainers support trainees, this program also developed the **peer support model** in which ORWs with more skills and experiences would support others. A program officer in HCMC talked about the model:

As we don’t have enough resources to follow all intervention sessions and we want to gradually empower ORWs to conduct interventions so we let those who have more skills and experiences help those with less. One more thing is that sometimes, the presence of program officers in intervention sessions makes clients hesitate to share. I think that would be better to have another peer help them.” [Male, program officer, HCMC]

Perceived challenges by ORW

Our focus group discussions with CBOs and its ORW found a number of challenges in providing and maintaining the intervention. The first challenge was the lack of experiences in

working with people who use methamphetamine. Clients often missed visits with ORWs or came late to these visits, making it challenging for ORW to schedule their outreach sessions. Since ORWs were paid by visits with clients, missed visits resulted in a loss of income for them. The amount of incentives was insufficient since ORWs often had to pay for clients' drinks when they met in coffee shops. Second, ORWs in this project had no working cards that they could show to the police when they did their work in hotspots. Some ORWs voiced out their fear of being arrested without being able to prove their position. Third, ORWs found mental health screening and intervention skills challenging. Moreover, the shortage of available mental health services in the two cities made it difficult to refer clients to appropriate services.

4.2. Impact of the capacity building program

Coaching component significantly contributed to the success of the program. ORWs who participated in focus discussion groups gave positive feedbacks on the coaching component in strengthening their capacity and confidence in implementing harm reduction interventions. A female outreach worker in HCM highly valued this approach, she said:

I found it really useful. There are some cases I could not handle, then the program officer supported. They showed me how to do, or reminded me when I forgot things. [Female, outreach worker, HCMC]

Agreed with that statement on the effectiveness of coaching component, another male outreach worker in HCMC said:

I think I'm not ready to do it on my own so I need support from the program officer. When they are there, I will learn from them. For example, when the client said that they would quit using, I did not know that I should recommend them to gradually reduce their use. If the officer was there, he would instruct me how to give an appropriate advice. [Male, outreach worker, HCMC]

Additionally, ORWs also appreciated the training contents and format:

The training courses lasted about 2 months. It covered many knowledge and skills, such as how to eat, rest, sleep or practice meditation... I often find training tiresome since we just sit and speak. But in this course, we feel very relaxed.

. [Male, outreach worker, HCMC]

IV. DISCUSSION

This evaluation assessed the feasibility and acceptability of the “Developing community capacity in delivering harm reduction services for people who use meth”, factors of success and challenges to scaling up the intervention. To our knowledge, the assessed project is the first attempt to provide interventions for people who use meth in Vietnam. It started in September 2018 and has been scaled up to seven provinces in 2020. The evaluation included a literature review of effective interventions towards people who use meth, a description of the actual implementation of the project, and an examination of the impact of the project’s capacity building trajectory.

Evidence-based interventions

Our literature review shows that psychosocial interventions and harm reduction remain the key strategies to reduce the harms related to meth use, given pharmacotherapy is unavailable yet for meth abuse. Among psychosocial interventions, the effectiveness of motivational interviewing, contingency management and cognitive-behavioural therapies has been solidly documented. Contingency management yields the most promising positive outcomes in the reductions of meth use and risk behaviours. This strategy can be used on its own or in combination with other interventions to produce a greater impact. Among these psychosocial interventions, we found only one study that assessed the effectiveness of contingency management in out-of-treatment samples (Reback et al., 2010). However, since single session of motivational interviewing is effective in reducing meth use and thus, it is suitable to do this with harder-to-reach populations who are not in frequent contact with health and social services. Moreover, the use of incentives to reinforce desirable behaviours works best with more disadvantaged populations like homeless people. Harm reduction services are understudied but its effectiveness has been evidenced in the few studies dedicated to this intervention (Carrico et al., 2014; Rose et al., 2006). The clear gap of studies on harm reduction effectiveness and in non-clinical samples emphasises the importance of the assessed project.

The literature review, thus, indicates that the interventions delivered in this project are evidence-based. The intervention package includes most identified effective interventions like motivational interviewing, outreach and peer-based interventions and some forms of contingency management (travel allowance for participants to attend group sessions). It also includes mental health screening and referral to treatment. Although we did not include this intervention into the

scope of our literature review, mental health interventions are of great importance, given the great mental health needs of key populations (Buckingham et al., 2013; Stahlman et al., 2015).

Acceptability

The evaluation showed that clients highly appreciated the intervention for the benefits they received including useful information and advice about health promoting behaviours and diseases, emotional support and other necessity support for food, shelter and healthcare. The emphasis of homeless participants on these necessity supports showed that clients' basic needs should be ensured first since meth use might be a solution for clients to cope with their difficult life situations. This echoes what were observed in the study with Cambodian female entertainment and sex workers who used meth (Carrico et al., 2016; Page et al., 2019). Moreover, since many clients, especially clients of MSM/TG groups, also joined other activities organised by CBOs, incorporating meth use interventions into existing projects might be beneficial and cost-effective.

While the 43% percentage of clients having a 2nd visit with ORWs in this project seems lower than the retention rate in another study with homeless, out-of-treatment MSM who use meth in the U.S. (about 60% at 9-month follow-up) (Reback et al., 2010), these two projects are not really comparable due to geographical and population differences. The fact that clients older than 40 and PWUD/SW were more likely to have a 2nd visit with ORWs than clients younger than 20 and MSM/TG suggests that younger and MSM/TG clients might be harder to track since they are more mobile (UNAIDS & Vietnam Administration of AIDS Control, 2019).

Feasibility

Despite the global COVID outbreak, over 9 months, the intervention provided services to 300 clients who used meth. While the recruitment remained low (about 21 new clients/ month) in the first eight months of the project, possibly due to the COVID-19 lockdown and social distancing, it went up to 134 clients in September and 286 new clients in October and November (updated statistics from SCDI) when the COVID epidemic in Vietnam has been under control. Although the common challenge of recruiting out-of-treatment people who use drugs into intervention could have played a role in the low recruitment in the first eight months, this number is promising and the trend in client recruitment should be observed in the coming months.

The data from outreach journals showed reductions in current use of most substances (except heroin), especially ketamine, ecstasy and popper between the 1st and 2nd visits. For meth use, the percentage of clients reported using meth several times per week also significantly decreased at the 2nd visit (from 40.3% to 31.9%) and the percentage of those who reported using meth less than once a month increased (15.5% vs. 1% at the 1st visit). Still, it should be noted that the percentage of people with daily meth use did not change at the 2nd visit. This suggests those with daily meth use may benefit from more contacts and more interventions. The findings on changes in drug use behaviours are promising, although the self-reported nature of the measured outcomes and the lack of specific timeframe for “current drug use” require careful interpretation.

Among all the interventions provided in this project, harm reduction services (advice and IEC materials) were delivered to all clients. This is understandable as ORWs and CBOs are more familiar with this kind of services in previous HIV prevention programs in Vietnam. Mental health interventions, due to its difficulty level, have not been delivered to as many clients as planned. This finding is comparable to what has been found in Jakarta, Indonesia where clients often associated mental health with insanity and thus, refused to acknowledge their mental issues and to receive mental health interventions (Rigoni et al., 2019). However, more than 50% of clients had been screened for mental health issues and received some kind of support for these problems. This number is encouraging and suggests this service is doable.

The number of referrals to health services in general (42/300) was low, given that HIV-negative participants should take quarterly HIV tests due to their increased sexual risks while doing meth. This specifies a room for improvement in the coming time.

The lack of follow-up information on service referrals prevents us to assess the success rate of this activity. The low coverage of mental health services in Vietnam somehow explained the challenges reported by ORWs and SCDI program officers in referring clients to these services. This challenge is familiar to other studies even in countries with better developed service network (Brooner et al., 2013; King et al., 2014). A study with methadone patients in the U.S. shows that participants who were referred to psychiatric services outside of their usual care settings were less likely to initiate psychiatric treatment (Brooner et al., 2013). Suboptimal retention in psychiatric care might be another issue (King et al., 2014).

The turnover of ORWs is noted but not unexpected. This is the rationale for building a technical hub at SCDI. Due to the nature of unstable funding, high turnover rate of ORWs is common in other HIV programs (The Asia Foundation, 2012). The difficulty of mental health interventions and outreach work with people who use meth possibly discouraged some ORWs. The timely refresher training provided for newly joined ORWs ensured the continuity of the intervention. Still, this infers that capacity building on harm reduction, including mental health interventions for people who use meth requires more efforts and longer time. SCDI and its CBO partners would benefit from further training on outreach management and more specifically human resource management.

While ORWs in this harm reduction program worried about being arrested by the police when they recruited or visited their clients in hotspots, we did not note any actual intervention of the police in the field. This is different from what was reported in the harm reduction program for people who use meth in Jakarta, Indonesia that witnessed interventions of the police in the middle of the outreach activities (AIDS Research Center & Atma Jaya Catholic University, 2020; Rigoni et al., 2019). In Vietnam, although there is no systematic data on the number of people who use meth being arrested, the rise of meth and new psychoactive drug use is causing many policy makers to consider fostering compulsory drug rehabilitation. In late 2020, the National Assembly is considering to pass a revised Law on Drug that puts more emphasis on expanding compulsory closed-setting rehabilitation as the solution for the emerging drugs. If the new version of the Law is passed (as widely considered a real possibility in 2021), it is expected that the number of people being sent to centre-based drug rehabilitation would increase in the coming time.

Capacity building

The project completed all the five steps in the capacity building process. While the training, outreach, coaching and independent work have been completed with ORWs, the two certified national trainers at SCDI serve as the mentors for new ORWs, given the particular governance model and collaboration in Vietnam. This also helps to sustain local capacity. Coaching was provided for 16/35 ORWs who stayed in the program and was complimented with other forms of technical assistance including regular case-based discussions and meetings to discuss technical issues. Despite the difficulties in outreach and mental health interventions with people who use meth, we found that the capacity of ORWs improved overtime between the first

and most recent sessions of coaching. ORWs also reported that coaching made them feel more confident in working with clients. This finding suggests that more experiences and consistent technical assistance would make outreach work and intervention easier.

The evaluation also suggests rooms to improve the project's capacity building program. The first point is the long interval between coaching sessions (2.8 month on average). Moreover, the number of coaching sessions varied greatly (between 1 and 23) for different ORWs. The extended interval between sessions might result from the rate of 2 coaches for 16 ORWs and the low recruitment during the COVID-19 months. A greater and more balanced frequency of coaching for ORWs might yield better improvements and accelerate the process of ORWs to work independently and become a coach. The assessment of scores also suggests that the training programs should pay more attention to the two skills of allowing clients to talk without interruption and of explaining to clients what mental health is. As single motivational interviewing session could be effective in reducing meth use, mastering motivational interviewing skills is of great importance in working with hard-to-reach clients.

V. RECOMMENDATIONS

For interventions

Contingency management might be an added component to improve attendance rate and client outcomes. Contingency management is effective on its own but would work well in combination with existing interventions. Reback et al. (2010) also found that even with homeless, out-of-treatment participants, contingency management boosted the study completion rate. Although the project currently provided clients with some travel allowances for attending visits and educational group sessions, it might consider other forms of incentives to reward clients who showed up to these events and/or who showed reductions in meth use.

The program would be more effective if a network of available medical and social services for key populations in the community is established and known. To facilitate mental health treatment, having a network of addiction doctors who are willing and available to work with people who use meth would be critical for successful referrals to treatment services. The projects of SCDI to map mental health services in HCMC and to build addiction medicine with medical universities in Vietnam promises to address this gap.

Regarding harm reduction services, adding safer smoking kits provision into the package might be helpful in both reducing meth-related harms and fostering a trustful relationship between clients and ORWs. What the project can provide would depend on the funding and greater understanding of current meth use practices.

For outreach management

The difficulties in outreaching people who use meth as reported by ORWs should be taken into consideration. Given that people who use meth are often active at night time and that ORWs often feel insecure in outreaching clients who use meth, this pilot provides insights to revise the existing outreach strategies (e.g. how to outreach clients at night time? Where to meet with clients if they could have psychotic symptoms?). Visits should be of greater frequency to be more effective since long intervals between visits might make harm reduction messages less retained, as some participants suggested.

Regarding the expenses incurred during outreach work, ORWs suggested they should be covered by the project. Moreover, given the difficulties in arranging a visit with clients who use meth, ORWs proposed both types of payment: some monthly wage plus per-case payment. Receiving monthly wages would make them feel more committed to the project. Competitive salary could be a plus to minimize staff turnover.

For capacity building

The project's capacity building program received positive feedback of ORWs. Based on their suggestions and the observations of coaches, further coaching and training on mental health support are needed. Specifically, ORWs should be coached more on how to start discussing mental health issues, especially when clients were not sober enough, in public locations or with a group of clients. Motivational interviewing skills should be enhanced to take the most advantage out of visits with clients. In order to see a greater improvement in the skills and knowledge of ORWs, more time and efforts should be dedicated to build ORWs' capacity. To do so, the training of trainer program is critical to build local capacity to provide more intense and consistent support for ORWs. When coaching could be restrained by the availability of SCDI technical providers, regular case discussion, online clinical supervision and peer support would help ORWs in their job.

For building an enabling environment

The project should be part of the work at different levels (policy, clinical treatment, research, community support...) to maximize and sustain its impact. Specifically, an advisory board for the harm reduction program for people who use meth could be established to define the long-term objectives of the intervention and coordinate different activities to serve the sustainability of the program. This advisory board should be composed of policy makers, chiefs of key non-governmental and institutional agencies. With this expertise, the advisory board could guide policy advocacy work to ensure the same vision of key stakeholders and donors regarding interventions for people who use meth. **Further studies are needed**

The literature review of effective ATS interventions among key populations suggests that community-based intervention projects are much needed to shed light on how interventions with established effectiveness in clinical samples could be applied onto a different population of people who are not in drug treatment. Studies based on this pilot program should be developed to generate evidence regarding this important work.

VI. CONCLUSION

This evaluation examined the acceptability and feasibility of the “Developing community capacity to deliver harm reduction services to people who use meth in Vietnam” project. We found that the evidence coming from this project is important to fill in the gap of community-based interventions, especially harm reduction with out-of-treatment people who use meth. Our findings show that the project interventions were acceptable and feasible despite the impact of the COVID-19 outbreak in Vietnam from the beginning of 2020. Clients provided positive feedback about the project support package. Reductions in meth use among clients were also reported. The evaluation identified several challenges facing the project including the expected turnover of outreach workers and the difficulties in outreaching and providing mental health services to people who use meth. We conclude that this intervention package can and should be expanded in larger scale in Vietnam and in other regions. The evaluation proposed recommendations for future interventions, outreach management and capacity building for ORWs for effective implementation of the intervention.

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APPENDIX 1 – QUANTITATIVE DATA COLLECTION FORM

1. Profile:

Client's ID:	Age:
Time to start tracking:	
Classification:	
Lifestyle:	
Health:	
Risk behaviour:	

2. Outreach strategy and support:

- a. Time, location and how to reach client:

- b. Harm reduction interventions and materials for client:

3. Topics of group education sessions:

Time	Topics	Remarks

4. Outreach journal:

Time: Location:	Name/ID of client: Classification (MSM, PUD, SW, TG):
<p>1. Drug use:</p> <p>Classification of drugs:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Cannabis (popper) <input type="checkbox"/> Others: _____ </div> <div style="width: 30%;"> <input type="checkbox"/> Ketamin (ke) <input type="checkbox"/> Heroine </div> <div style="width: 30%;"> <input type="checkbox"/> Ecstasy <input type="checkbox"/> Inhalants, glue </div> </div> <p>Frequency:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Several times a day <input type="checkbox"/> Continous days then take a break <input type="checkbox"/> Only at weekend or on special occations month </div> <div style="width: 30%;"> <input type="checkbox"/> Everyday <input type="checkbox"/> Several times a week <input type="checkbox"/> Several times a month <input type="checkbox"/> Less than once a month </div> </div> <p><i>(routes of administration, habits of use, frequencies, use with whom, any changes since last time?)</i></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	
<p>2. Risk behaviour: <i>(please specify)</i></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Inject <input type="checkbox"/> Drink alcohol & use drugs </div> <div style="width: 30%;"> <input type="checkbox"/> Unsafe sex <input type="checkbox"/> Have sex & use drugs </div> </div> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	
<p>3. Physical health: <i>(please specify)</i></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Lose weight <input type="checkbox"/> Insomnia </div> <div style="width: 30%;"> <input type="checkbox"/> HIV infection <input type="checkbox"/> STIs </div> <div style="width: 30%;"> <input type="checkbox"/> HCV <input type="checkbox"/> HBV <input type="checkbox"/> TB <input type="checkbox"/> Reproductive health <input type="checkbox"/> Others </div> </div> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	
<p>4. Mental health: <i>(please specify)</i></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Hallucination <input type="checkbox"/> Anxiety </div> <div style="width: 30%;"> <input type="checkbox"/> Delusion <input type="checkbox"/> Thought disorder </div> <div style="width: 30%;"> <input type="checkbox"/> Depression </div> </div>	

	<input type="checkbox"/> suicidal thought <input type="checkbox"/> Panic attack <input type="checkbox"/> Self-harm <input type="checkbox"/> Withdrawal symptoms
5. Client's issues: (please specify)	<input type="checkbox"/> Health <input type="checkbox"/> Relationship <input type="checkbox"/> Legistration <input type="checkbox"/> Finance/job <input type="checkbox"/> Other (specify)

6. Harm reduction interventions offered to client this time:	
6.1. Harm reduction interventions (please specify)	
6.2. Support about mental health (please specify)	<input type="checkbox"/> Mindfulness <input type="checkbox"/> Self soothing <input type="checkbox"/> Gratitude exercises <input type="checkbox"/> Self-help group <input type="checkbox"/> Cognitive reframing <input type="checkbox"/> Scaling – the crapometer
6.3. Materials (please specific)	
6.4. Commodities	

<i>(specify name and quantity)</i>	
6.5. Referral	Referral service: Address:
6.6. Other support <i>(please specify)</i>
7. Next plan to support Time: Location: Plan:	

APPENDIX 2 – FGD & IDI GUIDELINES

1. Focus group discussions with CBOs
2. In-depth interviews with clients
3. In-depth interviews with SCDI staff
4. In-depth interview with Mainline trainer

1 Guidelines for focus group discussions with CBO

Number of FGD: 1 in HN, 2 in HCMC

Participants: CBO group members

Topic:

- Describe the implementation process
- Feasibility of the intervention: assessment of the intervention; advantages and disadvantages to implement intervention
- Acceptable level of intervention
- Effectiveness and impact of training and support for out-reach workers

Introduction:

Hi guys. Thank you for joining today's group discussion. You are invited to participate because you are outreach workers of the CD36 project (the project name given by SCDI). The purpose of today's discussion consists of three topics: 1) the implementation process from the first stage; 2) Your thoughts on the advantages and disadvantages of the intervention and 3) Your comments on the project training program. We are at Hanoi Medical University, invited by SCDI to get your comments in order to support the project. We want to hear from everyone. There is no right or wrong answer. All the information you share today will only serve to improve the quality of intervention. The discussion takes about 60 minutes. At the end, you will receive 200,000 VND each for the time you spend in the discussion. We would also like to get your permission to record the discussion for not missing the information you provided, do you agree?

General Introduction:

Let's start by introducing ourselves, including: name (for easy communication during conversation, pseudonyms can be used), age (for proper manner of addressing others), which group you belong to, when did you join the group, what is your role in the group?

Describe the implementation process:

- How did you first hear about the CD36 project? (Who introduced you to? What did you hear about it? What did you think about the project at the time? (potential difficulties and advantages?) Why did you agree to participate in the project?)
- What are the CD36 project's similarities and differences compared to the previous projects your group has implemented?
- How long have you been working with SCDI? What projects did you involve in? What about Mainline? Are there other organisations involved in the project?
- Please describe the timeline from learning about the project to the beginning of the intervention (learning about project - signing contracts - selecting members - training (on the job coaching) - recruiting and intervening clients). Till now, what stage is the project at?
- Description of the intervention process after the training:
 - o What is the mission of out-reach workers?
 - o How many case is each person in charge of?
 - o How do you recruit clients? (How do you know if they have used ATS (ice)? Where to go for recruitment? How to contact them?)

Advantages and disadvantages of intervention and implementation

- Out-reach workers' feedback:
 - o Generally, how would you rate the methamphetamine harm reduction strategies of this project? Compared to other methods you know? (In terms of efficiency, complexity, and human resource requirements?)
 - o What is the most difficult part of the job? Give specific examples? What do you do in those situations?
 - o Currently in Hanoi, only your group is still active in the project. What do you think is the main reason why other groups do not continue to be involved in this project? What makes your group able to participate in the project up to now?
 - *If the participant has not mentioned it, ask how much out-reach workers in the project are paid? How suitable is this payment? If it needs to increase, then how much?*

- About clients' feedback:
 - What is the client's attitude towards the out-reach workers and intervention?
 - What are they most interested in and uninterested in?
 - On average, for each client, how many times have you met since the beginning of the intervention? If the number is low, why?
 - What is the percentage of dropped-out clients? What is the main reason? Are there any differences between on-going group and dropped-out group?
- Sustainability of intervention:
 - How do you feel about maintaining the current program for your group? What is the biggest difficulty?
 - After the CD36 project ends, how do you think this kind of intervention can be continued? Using what kind of resources?

Out-reach workers' training:

We would like to ask you more specifically about your feedback on the training and job coaching for outreach-workers, as well as the extent of SCDI's support during the intervention.

- Before implementation, you already participated in a training course. Please tell us: what have you been trained in CD36? Give some examples.
- Who are the instructors of this course? How would you rate the expertise and experience of the teachers? About training methods?
- How do you assess the content of the training course? What content do you use the most at work? What content is the least? Which skill do you find most difficult to use?
- How was the job coaching for out-reach workers? Who supported? Frequency? What was the feedback mechanism between the learner and the supporter? When you responded, how did the support group respond? How effective?
- After the job coaching, how did you receive support at work? Who supported? Frequency? What was the feedback mechanism between the learner and the supporter? When you responded, how did the support group respond? How effective?

- In general, how do you rate the training and professional support in this project? On a scale of 0 to 10? What needs to be done to make this support get a higher score, to help you more?

End of discussion.

2 Guidelines for in-depth interviews with clients

Number of participants: 8 in HN, 7 in HCMC

Participants: Clients who use meth

Topic:

- Describe the implementation process
- Feasibility of the intervention: assessment of the intervention; advantages and disadvantages to implement intervention
- Acceptable level of intervention

Introduction:

Hello, thank you for coming to this interview. My name is (*interviewer's name*) at Hanoi Medical University. I am working for the CD36 project that you participated in. You are invited to this interview because you are a client of (*CBO's name*) working in this project. This interview aims to get your feedback and advices for the project activities. Everything you tell us today will only serve to improve the quality of the intervention and stay in the evaluation team. Information will be reported as from a group. We do not collect personally identifiable information like names or addresses. You can use pseudonyms if you want. Our interview lasts between 45 and 60 minutes. As we finish, you will receive 200 000 dongs for your time. During our conversation, if there is any question you don't feel comfortable to answer, please let us know. We would like to get your permission to record our interview. After transcribing the recording, we will discard it. Do you agree?

General Introduction:

- Please start by introducing yourself: How old are you? Who are you living with? What do you do? What is your specialty? How long have you been in Hanoi / HCMC?
- How did you know the [CBO's name] group? When?

About joining the project:

- What do you know about the project that you are participating in with the ____ group? Where did you find that information? When did you begin to participate in this program (if clients can distinguish between different programs of the group)? What was your main reason for being in this program with the ____ group? What do you expect when you decide to join the program? Do you worry about participating in this program?
- Please describe the activities you did when you joined the group program _____. How many times did you go to the group activities? Frequency? What do you like when you come to the group? What do you not like about or find it difficult in attending group discussions? What happens when you work privately with outreach workers?
- What do you think about each of following:
 - o About the place?
 - o About the time?
 - o About the content?
 - o About other clients?
- How many times have you met your out-reach workers since the beginning of the program? Please describe a meeting. (Discussion content: What did you say? What did the out-reach workers say? What did you get after each meeting?) Are these meetings helpful for you? If so, in what aspect? If not, why not?
- What is the reason you continue to participate or not participate in the program?
- Would you recommend anyone to join this program? How do you introduce? Why these people and not others? Of those referred, how many declined? What is the reason for refusal?
- How many people do you know use methamphetamine but have not received any intervention?
- If you were invited to participate in the next programs, would you be willing to? Why?

Describe the process of drug use

- Money spent.
 - What kind of substances have you used so far (drugs: heroin, methamphetamine, marijuana, ecstasy, ketamine, funkyball ...; legal substances: alcohol, tobacco, popper, over-the-counter medicines...)? What are the main types of drugs you are using now?
 - Have you ever tried to reduce or stop using that drug? Why? If so, what did you do at that stage? How effective? How did you feel during that period of trying to stop using it? If you ever stopped using it, what did you do to keep it going? What is the main reason you use it again?
- Current usage:
 - What do you like about using (*main type of drug: methamphetamine? ____*) nowadays? (not only the feeling when using the substance but also its impact on other aspects of your life: activities, relationships, finances ...)
 - On the contrary, is there anything you don't like about using the substance? Likewise, it's not just the feeling of use, but the impact of use on other aspects of life: activities, relationships, finance ...
 - How do you use (*main type of drug: meth? ____*)? Administration routes? Frequency? Use in what circumstances? With whom?
 - How do you think about your current use (*main type of drug: meth? ____*)? Do you think you have been dependent on (*main type of drug: meth? ____*)? What would this situation look like in the next few years?

Mental health

- What are your worries now in your daily life? (Eg. family relations, finance, problems with the police, law ...) Why?
- Do you often feel sad, worried or stressed? When did you feel that way?
- What do you do to feel more comfortable in that state? (eg. doing something you enjoy, talking to someone? Drinking alcohol, smoking, using drugs?) How effective are these ways?

- When you have problems in your life, can anyone help you? Individuals? Groups? (family, friends, colleague, medical staff ...?)
- How do you imagine your future in the next few years?

3 Guidelines for in-depth interviews with SCDI staff

Participants: 4 (01 Vice director, 01 program manager, 02 program officers in Hanoi and HCMC)

Subjects:

- Description of the intervention implementation process
- Feasibility of the intervention: assessment of the intervention; advantages and disadvantages to implement interventions
- Acceptable level of intervention

Introduction

Hello. Thank you for coming to today's interview. I am (*name of interviewer*) at Hanoi Medical University, invited by SCDI to assist in assessing the feasibility and acceptability of the CD36 project. The interview has three main purposes: 1) To understand the implementation of the intervention; 2) Find out about the feasibility of the intervention, including the advantages and disadvantages to implement the program and 3) Acceptability of the intervention. The information you shared will be reported in the form of collective feedback. The session lasts about 45 - 60 minutes. At the end, you will receive 200,000 VND for the time you spend on the interview. During the discussion, if you have any questions you are not comfortable answering, please let us know. We would also like permission to record the discussion so as not to miss the information you provided. Do you agree?

General introduction

- Let us start by introducing ourselves, including: name, age, since when have you been with SCDI? What position? What are your specific duties?
- Please tell us about your work experience:
 - In what fields are you trained?
 - What is your experience working in the addiction field and with drug users?

What makes you continue to work in this field?

Describe the intervention implementation process

- Please describe the CD36 project development process.

- How do ideas start? Who came up with the idea? What were you in charge of at the time? How do you receive that idea (imagine advantages and disadvantages)? Process from idea to outline and implementation?
- How is the project implemented? With which partners? Why choose those units / groups / individuals?
- At what stage is the project up to now?

- What is the CD36 project similar to and different from the projects you have implemented in the past?

Advantages and disadvantages of intervention and implementation of intervention

- In general, how do you evaluate the harm reduction intervention with ice users of this project? Compared to other measures you know? (About efficiency, complexity, and human resource requirements?)

- Please comment on the advantages and disadvantages of this project. Give specific examples? What do you do to handle those situations?

- The number of groups currently in the project is lower than the original number of groups. In your opinion, what is the main reason why some groups do not continue in the project? How do groups that stay differ from the groups that have dropped out? How did they overcome these difficulties?

- If not mentioned by the participant, what is the budget for the outreach workers of the project? How suitable is this budget given their tasks? How is this budget compared to this payment in other projects? Is money the reason some groups stopped participating in the project? Do you need to increase funding? If yes, then how much?

- On average, how many times have the outreach workers met each client since the beginning of the intervention?

- From your perspectives, how did customers receive the project's intervention?

- What are they most interested in? Not interested in?
- What is the percentage of clients that do not continue to maintain the intervention? What is the main reason?
- Are you satisfied with the results of the project? Why? What aspects of the project do you think can be improved to get better results?

Sustainability of intervention

- How do you see the sustainability of the program? What are the advantages? What is the biggest difficulty?
- After the CD36 project ends, how do you plan to continue this intervention? Using which resources?
- What actions has the SCDI taken to help make the intervention sustainable?

4 Guidelines for in-depth interview with Mainline trainer

Topics:

- Background and evidence of the intervention
- Description of the training and coaching activities
- Perceived effects of training and coaching

Introduction

Thank you for joining me in this interview. As you might know, we at Hanoi Medical University are conducting an assessment of the ATS harm reduction project by SCDI and Mainline. Since you have been involved with the project as a trainer, your insights are valuable to our understanding of the project. The interview will last between 45 to 60 minutes. Please let me know if there is any question that is hard to understand. I would like to record our exchanges in order to faithfully capture what you say. If you agree, should we start?

General information

- To begin, could you please introduce yourself? (name, work position, where you are living, educational background)
 - o How long have you worked for/with Mainline? In which position?
- What are your experiences in working with people who use drugs? (what types of work? For how long?)
- What do you think of working with this population? What do you like / dislike about this?
- Please describe Mainline and its fields of expertise. What are Mainline's experiences with harm reduction with people who use drugs in general, methamphetamine in specific?

Description of the training and coaching activities

- What/Who introduced you to this project? How was the project described to you?
- How was the intervention package developed? What interventions were proposed?
 - o What is the background of the proposed interventions?

- How were the training and coaching activities conceived? By whom? What was the rationale for these activities? What were the expectations of the training? Of the coaching?
- Who delivered the training activities? What was the training format?
- Who did the coaching with the trainees? Under what format? For how long?

Perceived effects of training and coaching

- How effective do you think was the training? The coaching? How well did these activities meet the initial expectations?
- What was the feedback of the trainees (CBOs) for the training course? For the coaching activities?
- What would you change in the training and coaching activities for them to better prepare the trainees for their work?

Perceived challenges of the intervention

- From your perspectives of a trainer, what challenges do you think the outreach workers groups are facing to deliver this intervention, given only one group in Hanoi and 4 groups in HCMC stay in the project so far?
- What should be done to remediate these challenges?

Sustainability of the intervention

- From your experiences, how sustainable is this kind of intervention? What factors would be key to sustain it? What are the challenges?
- What does Mainline want to go from this project? What are your other projects in Vietnam and in the region?

APPENDIX 3 – COACHING TOOLS

Instruction on how to use the evaluation form for OWs

This evaluation form is designed to help SCDI's officers to monitor and evaluate the skills and knowledge of OWs through their performances in each outreach session. This form also shows which skills / knowledge an OW has done well; what needs improving and where OWs have already managed to make improvements.

Ows will be evaluated based on the following parts:

A: BASIC SKILLS THAT OWs NEED TO IMPLEMENT (REQUIRED SKILLS): These are the basic skills and OWs are required to always implementing when doing outreach

B: BASIC KNOWLEDGE OWs NEED TO ACQUIRED: These are topics of knowledge that OWs need to be master when doing outreach with clients

C: OTHER SKILLS THAT OWs CAN USE WHEN NEEDS (OPTIONAL SKILLS): These are some skills that OWs can use when appropriate (in the case the client needs)

Assessment scales

Scale 1 - Using for part A, C (Skills parts)		Scale 2 - Using for part B (Knowledge part)	
1 - Very weak	Never Meets Standards/Unacceptable Performance (0-50%)	1	Little or non-knowledge (0-25%)
2- Weak	Meets Standards Sometimes (50-75%)	2	Some knowledge (25-50%)
3- Fair	Meets Standards Mostly/Acceptable Performance (75-100%)	3	Moderate knowledge (50-75%)
4- Good	Always Meets Standards (100%)	4	A lot of knowledge (100%)
5- Excellent	Significantly exceeds Standards (+150%)	5	Mastering knowledge (+150%)
	Did not discussed in the outreach session		Did not discussed in the outreach session
	Clients mentioned about a problem but Ows did not solve		Clients mentioned about a problem but Ows did not solve

How to rate:

SCDI's officers using two assessment scales for evaluating skills and knowledge of each OWs, in which:

+ Scale 1: Using for part A and C

+ Scale 2: Using for part B.

This is an online form. **When joining outreach with OWs, you can use the offline version to evaluate skills and knowledge of OW. After the outreach session, SCDI's officers can fill the data in this form from the offline version.**

If you would like to add an explanation for the reason of a particular score, you can do this by just adding a comment to the cell.

Scale 1 - Using for part A, C (Skills parts)		Scale 2 - Using for part B (Knowledge part)							
1 - Very weak	Never Meets Standards/Unacceptable Performance (0-50%)	1	Little or non-knowledge (0-25%)						
2- Weak	Meets Standards Sometimes (50-75%)	2	Some knowledge (25-50%)						
3- Fair	Meets Standards Mostly/Acceptable Performance (75-100%)	3	Moderate knowledge (50-75%)						
4- Good	Always Meets Standards (100%)	4	A lot of knowledge (100%)						
5- Excellent	Significantly exceeds Standards (+150%)	5	Mastering knowledge (+150%)						
	Did not discussed in the outreach session		Did not discussed in the outreach session						
	Clients mentioned about a problem but Ows did not solve		Clients mentioned about a problem but Ows did not solve						
Topic	Criteria	DD	DD	DD	DD	DD	DD	DD	DD
A: BASIC SKILLS THAT OWs NEED TO IMPLEMENT (REQUIRED)									
Personal characteristics	OWs are open minded, approachable and non-judgmental								
	OWs be confident with words and demeanor								
Communication skills	OWs shOWs good listening skills i.e.. Let clients talk more, eye contact, leaning forward, summarizing								
	When engaging with beneficiaries OWs ask open ended questions								
	OWs do NOT force their opinions or views on beneficiaries								
	Allow client time to talk without interruption – Use the 10 second rule								
	ORW minimises use of their phone while in conversation with client								
Prepare and providing commodities and IEC	ORW always has prior agreement of the client before inviting other people into the conversation								
	OW is confident, assured and sensitive when talking about sensitive topics with clients'								
	Before taking notes, OW should have the client permission								
Harm reduction offers	OW always bring harm reduction materials and commodities such as tests, condoms, lubs when doing outreach.								
	When distributing commodities and IEC materials for clients, Ows always explain why clients should use/read them; show them how to use commodities or guide clients to use IEC materials								
Harm reduction offers	OWs ask clients more information about their lifestyle, their health, their risk behavior								
	OWs offer a specific harm reduction intervention appropriate to the lifestyle, health, frequency of usage and risk behaviour of the client'								
	OWs offer EAT, DRINK, SLEEP and REPEAT for clients and explain why they are important								

STEP UP PROJECT
Site Self Evaluation

Mental Health and Community based interventions	OW offer Mindfulness (often used for people who has depression, anxiety, stress symptoms) when appropriate OW offer Cognitive Reframing (often used for people who has negative self-talk) when appropriate OW offer Gratitude Exercises (often used for people who has a decrease in self-esteem, anxiety) when appropriate OW offer Self - soothing (often used for people who is dealing with psychosis, depression, anxiety or self-cut) when appropriate OW offer Scaling (often used for people who self-harm or is dealing with anxiety, depression, withdrawal as well) when appropriate OW offer Self-help groups when appropriate OW refer the clients who have MH issues to see doctors/clinics, etc.										
	MI	Ows help to build a plan for behavior change with client by: + Asking client whether they ready to make change or not + Show them Pros and Cons of Change and Pros and Cons of Keeping Things the Same + Make a small steps/plan to begin with new behaviours									
		(If not the first meeting) Always refer back to previous topics visited and previous conversations. Ask them how they are doing with previous issues									

APPENDIX 4 – IEC MATERIALS OF THE PROJECT



Tài liệu này được xây dựng bởi Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng (SCDI). Tài liệu được xuất bản và lưu hành trong khuôn khổ 2 dự án:

||| Bảo vệ tương lai: Dự án nhằm củng cố chất lượng can thiệp HIV trong nhóm thanh niên từ 16 đến 24 tuổi có sử dụng ma túy thông qua các chiến lược mới.

||| Đẩy mạnh các chương trình điều trị nghiện tự nguyện dựa vào cộng đồng do Mạng lưới Người sử dụng Ma túy tại Việt Nam (VNPUD) và các nhóm thành viên tự lực của người sử dụng ma túy triển khai tại Việt Nam.

Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng (SCDI)
Tài liệu lưu hành nội bộ
Xuất bản tháng 11 năm 2016



[What are the effects of ice on your body?]



Mục lục

1. Ma túy đá ảnh hưởng đến hoạt động của não bộ như thế nào?.....3
2. Trầm cảm là gì?.....8
3. Loạn thần là gì?.....13
4. Rối loạn lo âu là gì?.....20
5. Tôi có thể làm gì để hạn chế những rối loạn tâm thần khi sử dụng ma túy đá?....26
6. Làm thế nào để giao tiếp và giúp đỡ một người đang trải qua rối loạn tâm thần do sử dụng ma túy đá?.....29

[Mental health: Questions – Answers]

TÀI LIỆU NÀY KHÔNG KHUYẾN KHÍCH SỬ DỤNG MA TÚY



GIẢM HẠI KHI SỬ DỤNG MA TÚY TỔNG HỢP
(Tài liệu lưu hành nội bộ)

Chịu trách nhiệm xuất bản: KHUẤT THỊ HẢI OANH
Biên tập: Trần Thương - Nguyễn Linh - Hằng Lại
Trình bày: Đặng Thư - Vân Anh
Vẽ bìa: Đặng Thư
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[Safe use of ice]



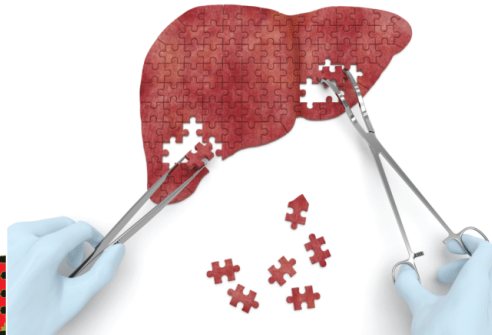
Để được **MIỄN PHÍ** tư vấn và xét nghiệm Viêm gan C, xin vui lòng liên hệ:

* Mạng lưới Người sử dụng Ma túy tại Việt Nam

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[Hepatitis C and liver care]