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The relationship between health policy and public health interventions: a case study of the DRIVE project to “end” the HIV epidemic among people who inject drugs in Haiphong, Vietnam

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Abstract

We present a case study of the effects of health policies on the implementation and potential outcomes of a public health intervention, using the DRIVE project, that aims to ‘end’ the HIV epidemic among people who inject drugs in Haiphong, Vietnam. DRIVE’s success depends on two policy transitions: (1) integration of donor-funded HIV outpatient clinics into public health clinics and expansion of social health insurance; (2) implementation of a “Renovation Plan” for substance use treatment. Interviews and focus group discussions with key informants and review of policy documents and clinic data reveal that both policy transitions are underway but face challenges. DRIVE promises to show how evolving policy affects health interventions and how advocacy based on project data can improve policy. Broad lessons include the importance of clear and consistent policies, vigorous enforcement, and adequate funding of promulgated policies.

Keywords

HIV treatment; Vietnam; People who inject drugs; Substance use treatment

Background

Public health interventions are not implemented in vacuums. Policy frameworks fundamentally influence the operation and outcomes of interventions. We offer a case study of the influences of policies on the implementation and possible outcomes of the DRIVE project that aims to ‘end’ the HIV epidemic among people who inject drugs in Haiphong,

Vietnam. In this case, the policy environment for funding and delivery of HIV and substance use treatment services is complex, dynamic, and in some respects inconsistent, posing challenges to the implementation of the DRIVE interventions.

The literature on the effects of policy on HIV interventions and related health behaviors is sparse [1]. Laws and policies may exert chilling, facilitating, or conflicting influences. Criminalization of HIV transmission, sex work, drug injection, and homosexual behavior has been shown to impede access to or discourage individuals from attending HIV prevention or treatment services [2]. In a review by Gruskin [3], 78 governments and 108 civil society organizations reported laws and policies considered obstacles to HIV services. Beletsky and Heimer detailed the damage done to needle/syringe and other harm reduction programs for people who inject drugs by drug paraphernalia laws and other provisions of the “war on drugs” in the US [4].

Laws and policies can also promote healthy behaviors and reduce HIV prevalence and incidence. Gruskin [3] found examples of positive influences and emphasized the need for policy environments that enable effective delivery and utilization of HIV services. In Uganda, a policy change from voluntary to routine HIV testing in antenatal clinics resulted in sustained increases in testing among pregnant women and their partners [5]. In the Dominican Republic [6] and Mexico [7], policy initiatives such as a 100% condom use program or legal registration of sex workers who agree to regular HIV and sexually transmitted infection testing were associated with more consistent condom use, rejection of client requests for unsafe sex, and reduced rates of sexually transmitted infections. Revision or reinterpretation of drug paraphernalia laws and enactment of laws permitting over-the-counter syringe sales have been linked to reduced sharing of injection equipment in the US [4]. Worldwide, multi-city ecological studies [8, 9] reveal a consistent and statistically significant relationship between the existence of needle/syringe programs and lower HIV prevalence among people who inject drugs. Many needle/syringe programs in the US have been established without a formal legal basis [10], but this can be a perilous approach offering no protection against changing political or ideological winds.

Conflicting or inconsistent policies pose more complex challenges for interventions and may undermine their effectiveness. In Malaysia, it is illegal to possess needles and syringes outside health facilities but the government supports harm reduction programs that include needle/syringe provisions for people who inject drugs [3].

The HIV epidemic and response in Vietnam

Vietnam has experienced a classic concentrated HIV epidemic among key populations, particularly people who inject drugs, sex workers, men who have sex with men, and sexual partners of these key population members. The country has made substantial progress in its HIV response [11] and antiretroviral treatment currently covers approximately 60% of people living with HIV.

Vietnam faces challenges for sustaining its HIV response. Policies regarding HIV and substance use treatment that will surely affect the DRIVE project have been contentious and

slow to progress [12, 13]. Donors fund approximately 70% of HIV services; the centerpiece is a system of free outpatient clinics. Since Vietnam achieved middle-income status, the growth of its epidemic slowed and donors are reducing their support. The US President's Emergency Plan for AIDS Relief (PEPFAR), in particular, is planning to withdraw completely within the next 5 years and is shifting from support of direct services to technical assistance only. Responsibility for funding the HIV response is shifting to Vietnam's government.

Because the Asia-Pacific region has in general relied on donors who are reducing their support, host governments are left to fill daunting funding gaps [14]. The Lao People's Democratic Republic has no national health insurance and people living with HIV there face catastrophic out-of-pocket costs [15].

Vietnam and several other countries in the region are also transitioning from reliance on compulsory detention of injection drug users, which is ineffective and involves serious human rights violations [16] to voluntary, community-based treatment. In Malaysia, people completing voluntary in-patient treatment were far less likely to relapse to drug use than those released from compulsory centers. [17] A qualitative study suggested that patients in voluntary centers were better able to adhere to treatment regimens and had access to a greater range of programs and stronger social support than was provided in compulsory centers [18].

The DRIVE project

The DRIVE project began in October, 2016 in Haiphong, the fourth largest city of Vietnam with an estimated 6000 people who inject drugs [19] using multiple capture/recapture studies to estimate the population size of persons who inject drugs (PWID) in Hai Phong, Viet Nam. Draft manuscript]. Haiphong experienced a serious HIV epidemic among people who inject drugs, with a prevalence of 60% in 2006 [20] but down to 25% in 2015, largely the result of deaths and expansion of methadone maintenance treatment, needle/syringe programs, and antiretroviral treatment.

DRIVE combines mass HIV screening, using repeated respondent-driven sampling surveys to identify the remaining HIV-positive people who inject drugs and those in need of methadone treatment, along with peer support for access to antiretroviral and methadone treatment. The objective is to 'end' the HIV epidemic among people who inject drugs by halving the HIV population viral load from 15 to 7% prevalence of viremia and reducing HIV incidence from ~ 2 to 0.5/100 person-years at risk [21].

The success of DRIVE relies on two key policy transitions in Vietnam's response to HIV and substance use: (1) integration of donor-funded outpatient clinics into public health clinics and related expansion of social health insurance coverage and (2) implementation of the government's Renovation Plan for substance use treatment that calls for a transition from compulsory drug detention to voluntary, community-based treatment.

We show how a complex, evolving, and, in some aspects, unclear, internally inconsistent, and unevenly enforced policy framework on HIV and substance use treatment is affecting

and will continue to influence the implementation and outcomes of DRIVE. More broadly, this study provides the opportunity for a natural experiment to assess both the effects of policy on a public health intervention and the use of project data to advocate for improved policies and programs going forward.

Methods

We base this paper on 15 semi-structured interviews and three focus group discussions (20 total participants) with key informants and stakeholders in Hanoi and Haiphong between late August and late September, 2016. We selected informants based on their knowledge of, responsibility for, or experience with the two key policy transitions relevant to DRIVE. We identified policy respondents at both central level and provincial levels. Central-level interviewees in Hanoi included officials of the Ministry of Health, Vietnam Administration on HIV Prevention and Control, the Ministry of Labor, Invalids, and Social Affairs (in charge of substance use treatment), the National Assembly Social Affairs Committee, a leading Vietnamese nongovernmental organization active in the relevant policy arenas (Supporting Community Development Initiatives), and the Abt Associates/Health Finance and Governance Project, funded by the US Agency for International Development.

In Haiphong, interviewees included staff of the Department of Health, Provincial HIV/AIDS Center, Department of Labor, Invalids and Social Affairs, People's Committee, People's Council, and researchers at Haiphong Medical University involved in the DRIVE project.

Individual interviews were based on semi-structured questions focusing on the two key policy transitions most relevant to DRIVE. Interviewers asked respondents to assess progress, barriers, and facilitators of these transitions and to comment on the quality and effectiveness of the evolving systems for HIV and substance use treatment, including accessibility, documentation required, and retention in care. We also conducted focus group discussions with health care providers (leaders of clinics providing HIV treatment and methadone programs) and local community-based organizations. Discussion guides for the focus groups explored the same questions as the individual interview guides.

We conducted interviews and focus group discussions in Vietnamese but did not transcribe or analyze them using qualitative research software. Rather, co-author Nguyen Thu Trang took detailed notes during the interviews and focus group discussions on the key policy and operational issues affecting the two transitions. Ms. Trang then provided English-language summaries of key points and themes. Thus, this research is not based on systematic analysis of qualitative data but rather on an effort to understand the progress, barriers, and facilitators of the two policy transitions.

We also reviewed key legal and policy documents and data on outpatient clinics and public health clinics providing antiretroviral treatment in Haiphong. Haiphong Medical University and the Health Finance and Governance project provided the clinic data.

The institutional review boards of Haiphong Medical University and Icahn School of Medicine at Mount Sinai, New York approved the DRIVE project protocol, including the policy and qualitative research components.

Results

Our interviews, focus group discussions, and secondary data on HIV clinics and methadone programs enabled us to assess progress in the two transitions as well as barriers and facilitators that affect the evolving policy landscape and, in turn, the operation and outcomes of the DRIVE interventions.

Outpatient clinic integration and social health insurance expansion

As in other low- and middle-income countries in Southeast Asia and elsewhere, reduction of donor support for HIV services in Vietnam necessitates a radical reorganization of the delivery of those services. Governments are replacing provision of free antiretroviral treatment in outpatient clinics supported largely by international donors with care in public health clinics and commune health stations. This transition is directly affecting how newly diagnosed people living with HIV, including those identified by DRIVE, and continuing patients access care and are able to adhere to their regimens.

Key issues in this policy transition include the following:

The timing of the transition from donor-funded outpatient clinics to public health clinics—In Haiphong, as of July, 2017 donor-funded outpatient clinics served 52% of HIV patients and public health clinics served 48%. This dual system will continue until the donor-funded outpatient clinics close, probably by 2019. Patients receiving care in public health clinics must either have health insurance or pay for services out of pocket.

Inducing patients to move to public health clinics—Many patients and community-based organizations perceived HIV care in public health clinics to be inferior to that in donor-funded outpatient clinics with less personal attention, fewer supportive services (such as adherence counseling), and more stigma and discrimination. Patients may be limited to which public health clinics they can attend, based on geography and clinic capacity [Khuat Thi Hai Oanh, Director, Supporting Community Development Initiatives. Interview, Hanoi, 9 September 2016]. Staff turnover, lack of trained and experienced personnel, and loss of confidentiality were also considered challenges in public health clinics [Hospital-based outpatient clinics. Focus Group Discussion, Haiphong, 1 September 2016; Pham Thi Hue, Head of communications, Center for Community Health Care and HIV/AIDS Prevention (Haiphong NGO). Interview, Haiphong, 27 September 2016]. Some Haiphong community-based organization members predicted that the transition from donor-funded outpatient clinics to public health clinics would be a “real mess” that would cause many patients to be lost to treatment [Haiphong community-based organization members, Cao Thi Kim Giang and Ha Quang Hiep (Friendship Arms), Nguyen Hoang Long and Truong Thi Cuc (Lighthouse), and Le Thi Loan (Virgin Flower). Interview, Haiphong, 28 September 2016].

Possible reasons for patients to move to public health clinics include greater convenience, especially in remote areas, and the opportunity to obtain all of their primary health care, including HIV treatment, in one place [Naz Todini, Chief of Party, Abt Associates Health Finance and Governance Project. Interview, Hanoi, 26 August 2016]. Decentralizing some basic HIV care, including medication resupply and treatment adherence monitoring to

commune level, may also increase accessibility and convenience of services [Bui Duc Duong, Vice Director for Care and Treatment, Vietnam Administration for HIV/AIDS Control. Interview, Hanoi, 5 September 2016].

Increasing social health insurance coverage—As of July 2017, only 30% of people living with HIV in Vietnam had social health insurance but the government aims to reach 100% coverage by 2020. Law requires people to enroll in health insurance in their home provinces but differences exist across and within provinces in the requirements for enrollment [Bui Duc Duong, Vice Director for Care and Treatment, Vietnam Administration for HIV/AIDS Control. Interview, Hanoi, 5 September 2016]. Pursuant to a Decision of the Prime Minister [Decision No 2188/Q -TTg, 15 November 2016. Regulating the payment mechanism for centralized procurement of ARV drugs using Health Insurance Fund and the support for ARV users], Haiphong committed to providing free social health insurance cards to all people living with HIV, regardless of socioeconomic status [Haiphong People's Committee, Decision No. 102/QD-VBNR, February, 2017] but funding for this initiative has not been confirmed. At least some people living with HIV, especially those in key populations such as people who use drugs, may not take advantage of this offer because obtaining free health insurance cards would mean disclosing their HIV status [Haiphong community-based organization members, Cao Thi Kim Giang and Ha Quang Hiep (Friendship Arms), Nguyen Hoang Long and Truong Thi Cuc (Lighthouse), and Le Thi Loan (Virgin Flower). Interview, Haiphong, 28 September 2016]. DRIVE is also providing free health insurance cards to individuals in the project's HIV-positive cohort.

Qualifying for free or subsidized social health insurance as poor or near poor does not require disclosing HIV status but respondents pointed to difficulties obtaining and maintaining certification. For example, a family certified as poor was disqualified when a relative gave the family a television set [Pham Thi Hue, Head of communications, Center for Community Health Care and HIV/AIDS Prevention (Haiphong NGO). Interview, Haiphong, 27 September 2016].

Obtaining social health insurance coverage is the first step. Some respondents also mentioned disadvantages of receiving care under it, such as required copayments, burdensome bureaucratic procedures, and longer waiting times for services [Haiphong community-based organization members, Cao Thi Kim Giang and Ha Quang Hiep (Friendship Arms), Nguyen Hoang Long and Truong Thi Cuc (Lighthouse), and Le Thi Loan (Virgin Flower). Interview, Haiphong, 28 September 2016].

Requirements for identification papers—Individuals must present identification to obtain health insurance cards. Once a patient has an insurance card with photograph, he/she has no need to present an additional form of identification to receive services. However, currently most social health insurance cards do not include a photograph and holders of such cards must present identification to enroll in services. The requirements for identification present problems for many patients. People purchasing social health insurance cards as a household must produce a “residence book” listing all family members, while those enrolling individually must present a national identification card [Khuat Thi Hai Oanh, Director, Supporting Community Development Initiatives. Interview, Hanoi, 9 September 2016].

2016]. Some respondents erroneously said that an identification paper is not required to obtain the card while others said that it was. One said that a 3-year stay is required to establish legal residence and obtain identification papers [Dang Thuan Phong, Vice Chair, Social Affairs Committee, National Assembly. Interview, Hanoi, 16 September 2016]; another said people could get their cards based on 6 months' temporary residence [Nguyen Minh Trung, Department of Health Insurance, MOH. Interview, Hanoi, 29 September 2016]. At this writing, identification requirements appear to be under review and possible revision.

Contracts with Vietnam Social Security—Public health clinics providing HIV services must have contracts with Vietnam Social Security to receive reimbursement through social health insurance [Khuat Thi Hai Oanh, Director, Supporting Community Development Initiatives. Interview, Hanoi, 9 September 2016]. As of September, 2016, 56% of HIV treatment facilities in Haiphong had contracts but only 40% of patients were receiving care in facilities with contracts [Vietnam Administration for HIV/AIDS Control. VAAC Deployment of Prime Minister's Decision #2188/QD-TTg on Health Insurance for HIV/AIDS Treatment, VAAC PowerPoint, Danang, 27 November 2016; HFG Project, unpublished data, 2016].

Under current law, social health insurance reimbursement is only available for curative services; coverage of preventive services is prohibited. Although they provide treatment services, most of the donor-funded outpatient clinics are part of the preventive medicine system and do not qualify for health insurance contracts unless they can convert to being “dual-function”—preventive and curative—facilities.

Obtaining a contract is only the first challenge. According to clinic staff, to obtain social insurance reimbursement, providers' invoices must be letter perfect, and other onerous bureaucratic requirements make the system difficult to navigate [Hospital-based outpatient clinics. Focus Group Discussion, Haiphong, 1 September 2016]. Because antiretroviral drugs, the largest cost element in HIV care, are still provided free of charge in all facilities and will be until 2019, facilities and patients have limited incentives to use social health insurance for the other HIV services currently covered. Thus, some facilities have not moved to delivery of and reimbursement for insurance-covered services even after they had signed contracts and some patients with social health insurance cards have been reluctant to use them.

Services covered by Social Health Insurance—Several government documents purportedly specify HIV services and medications covered by social health insurance. These documents include Circulars 15 (2015) and 40 (2014) and the Basic Health Care Service Package for Medical Examination and Treatment Services for HIV Patients Paid by Health Insurance Fund [Vietnam Ministry of Health/VAAC, Draft Basic Health Services Package: February, 2016]. However, questions persist about what medications and services will continue to be free once the integration of outpatient clinics is complete, and what services will be covered under social health insurance. (As noted, antiretroviral drugs fully funded by donors and Vietnam's National Target Program for HIV will not come under health insurance coverage until 2019.) Several respondents asserted that CD4 and viral load tests will continue to be free but others said that the new system might reduce free laboratory tests

because of withdrawal of donor funding [Standalone outpatient clinics. Focus group discussion, Haiphong, 1 September 2016]. Under current plans, third-line regimens are not covered by social health insurance and this may be a serious problem because rates of drug resistance are on the rise in Vietnam [Didier Laureillard. Remarks at VAAC/Global Fund meeting, Hanoi, 6 March 2017]. Prevention and treatment of opportunistic infections are covered by social health insurance [Le Thi Thu Huong, Director, Treatment Department, Haiphong PAC. Interview, Haiphong, 26 September 2016] but the extent of this coverage remains unclear.

Renovation Plan for substance use treatment

The evolving legal and policy environment on substance use treatment will influence whether the approximately 800 potential new methadone patients identified by DRIVE in Haiphong and others in need of new and continuing substance use treatment will receive the services they need. In 2013, the Prime Minister approved a Renovation Plan for substance use treatment, the objective of which is to reduce dramatically Vietnam's reliance on compulsory drug detention centers ("06 centers") and establish instead a system of voluntary, community- and evidence-based treatment [Prime Minister of Vietnam, Decision No. 2596/QĐ-TTg. Approval for Drug Rehabilitation Renovation Plan 2013–2020. Hanoi, 27 December 27; Prime Minister of Vietnam. Decision No. 2187/QĐ-TTg. Approval of Implementation Plan of the Drug Treatment Renovation Plan in Vietnam until 2020. Hanoi, 5 December 2014].

The government is committed to full implementation of the Renovation Plan [Nguyen Duc Phan, Director, Department of Social Evils Prevention, Haiphong Department of Labor, Invalids and Social Affairs. Interview, Haiphong, 26 September 2016; Le Van Khanh, Deputy Director, Department of Social Evils Prevention, Ministry of Labor, Invalids and Social Affairs. Interview, Hanoi, 5 September 2016] but, notably, it is "just a plan without force of law" [Khuat Thi Hai Oanh, Director, Supporting Community Development Initiatives. Interview, Hanoi, 9 September 2016]. The Renovation Plan aims to reduce to 6% by 2020 the proportion of all recipients of substance use treatment who are in 06 centers. In Haiphong, the number of compulsory residents dropped from 7300 in 2013 to 200 in June, 2016 [Nguyen Dinh Thuan, Vice Head, Department of Health and Education, Haiphong People's Committee. Interview, Haiphong, September 27, 2016]. With support of government and donors, methadone treatment has been sharply expanded and has been beneficial for many patients. Haiphong has approximately 4000 methadone clients [Nguyen Duc Phan, Director, Department of Social Evils Prevention, Haiphong Department of Labor, Invalids and Social Affairs. Interview, Haiphong, 26 September 2016].

At the same time, some powerful officials and interests oppose the Renovation Plan and its shift from treating drug addiction as a "social evil" and moral failure deserving punishment to a chronic, relapsing disease calling for intensive but voluntary treatment [Khuat Thi Hai Oanh, Director, Supporting Community Development Initiatives. Interview, Hanoi, 9 September 2016]. A major challenge in closing the 06 centers is the fate of their staffs who may be particularly strong in opposing closure [Nguyen Duc Phan, Director, Department of

Social Evils Prevention, Haiphong Department of Labor, Invalids and Social Affairs. Interview, Haiphong, 26 September 2016].

Key issues in this policy transition include the following:

Inconsistent legal framework—The Law on Handling Administrative Violations (2012) that requires a court decision for commitment to a 06 Center and other bureaucratic requirements (per Decision 221) renders such commitments more difficult [Le Van Khanh, Deputy Director, Department of Social Evils Prevention, Ministry of Labor, Invalids and Social Affairs. Interview, Hanoi, 5 September 2016; Pham Thi Huyen, Vice Head, Social Affairs Department, Haiphong People’s Council. Interview, Haiphong, 28 September 2016]. The difficulty of committing people to 06 centers may encourage enrollment in voluntary treatment as patients become less afraid of being arrested by police observing treatment facilities.

Recent decrees may reverse some of the progress, however. Decree 90 [Government of Vietnam. Decree No 90/2016/ND-CP. Regulation on replacement therapy/methadone maintenance therapy for opioid dependence. 1 Hanoi, July 2016] provides that anyone on methadone treatment with two positive urine tests for heroin or one positive test for another illicitly used drug be dropped from the program and subject to commitment to a 06 center. It remains unclear how strictly these provisions will be enforced in Haiphong [Haiphong community-based organization members, Cao Thi Kim Giang and Ha Quang Hiep (Friendship Arms), Nguyen Hoang Long and Truong Thi Cuc (Lighthouse), and Le Thi Loan (Virgin Flower). Interview, Haiphong, 28 September 2016] but a police crackdown on drug users began in November 2016, which caused drug “hotspots” to disappear and depressed enrollment in DRIVE’s first survey.

Two decrees issued in 2016 [Government of Vietnam, Decree No. 56/2016/ND-CP. Amending a number of articles of the Government’s Decree No. 111/2013/ND-CP, 30 September 2013, on the application of the administrative handling measure of commune-, ward-, or township-based education; Government of Vietnam. Decree 136/2016/N -CP on amending a number of articles of the Government’s Decree No. 221/2013/ND-CP dated 30 December 2013, prescribing the application of the administrative handling measure of consignment of drug addicts to compulsory detoxification establishments] weaken the criteria for commitment to 06 centers in terms of relapse while on “commune-based education” and with regard to the categories of staff empowered to render the necessary diagnoses of addiction.

Requirements for methadone maintenance treatment enrollment—Police certification of a prospective client as a registered drug user is no longer needed for methadone enrollment but requirements for identification may differ across clinics. Some clients may enroll with merely a “letter of motivation” or a letter from a personal sponsor. A national identification card or residence book is not generally required for enrollment, but clients in some sites must produce at least a driver’s license [Tran Thi Bich Thuy, Vice director, Haiphong Department of Health. Interview, Haiphong, 26 September 2016]. Methadone treatment copayments are 12,000 VND (about \$0.52) per day and in some

clinics an unofficial payment and/or an initial payment to support maintenance or renovation of the clinic may be required. Requirements for documents and additional payments depend on personal relationships and caseloads in relation to government targets for methadone patients.

Attrition rates from methadone maintenance treatment—Attrition from methadone treatment is substantial—400–500 per year in Haiphong or approximately 10% of the patient population. Some drop out because they cannot make the required copayments or qualify for a waiver [methadone treatment providers. Focus Group Discussion, Haiphong, 31 August 2016]. Other reported reasons included insufficient doses, relapse to heroin use, difficulty appearing for daily dosing (especially for employed clients), unwelcoming or unavailable staff, and treatment fatigue [Nguyen Thi Nga, Monitoring and Evaluation and Methadone Treatment Department, Haiphong PAC. Interview, Haiphong, 26 September 2016]. A recent study by Khue and colleagues of methadone treatment drop-out rates in Haiphong found many of the same reasons as mentioned by our respondents. In particular, one-third of drop-outs in the Khue study were receiving less than the minimum daily dose of 60 mg recommended by the US National Institutes of Health [22].

Lack of voluntary treatment options—The most serious challenge to implementation of the Renovation Plan is that voluntary treatment services—a range of outpatient counseling and in-patient treatment in addition to methadone—needed for the transition do not yet exist [Dang Thuan Phong, Vice Chair, Social Affairs Committee, National Assembly. Interview, Hanoi, 6 September 2016]. The government continues to fund 06 centers and has not yet diverted funds saved through reduction of these centers to support voluntary treatment programs [Nguyen Dinh Thuan, Vice Head, Department of Health and Education, Haiphong People's Committee. Interview, Haiphong, 27 September 2016].

Amphetamine-type stimulant use, which may be associated with elevated HIV sexual risk behaviors, is surging in Vietnam. Reportedly, 20% of methadone patients in Haiphong are also using amphetamine-type stimulants [Methadone treatment providers. Focus Group Discussion, Haiphong, 31 August 2016]. No treatment for amphetamine use is available, except referral to psychiatric hospitals. Social workers and community-based organizations can provide support but few of them have the required training and experience [Dang Thuan Phong, Vice Chair, Social Affairs Committee, National Assembly. Interview, Hanoi, 6 September 2016].

Haiphong has a 3-year plan for instituting community-based voluntary treatment but implementation is challenging. Voluntary treatment facilities are unpopular with the public because of the resulting congregation of drug users [Pham Thi Huyen, Vice Head, Social Affairs Department, Haiphong People's Council. Interview, Haiphong, 28 September 2016].

Conclusion

This case study of the influence of policy on a public health intervention yields lessons specific to DRIVE and broader conclusions and recommendations for the field of policy analysis in health. With regard to the two key policy transitions:

1. Transition of antiretroviral treatment patients from donor-funded outpatient clinics to public health clinics is underway, but whether and how continuing policy challenges are met will surely affect the success of DRIVE in achieving its goals for antiretroviral treatment initiation, retention of new and existing patients, and reduced HIV incidence and community viral load.
2. Significant progress has also been made in the transition from compulsory detention of people who inject drugs to a system of voluntary, community-based substance use treatment. Key national and provincial leaders have committed to implementation of the Renovation Plan calling for this transition. However, serious challenges still face DRIVE participants' ability to obtain and stay in treatment and reduce their risks for acquiring and transmitting HIV.

Broader lessons also arise from the experience of DRIVE that may be relevant to other low- and middle-income countries implementing public health interventions in the face of reductions in donor funding and/or changes to substance use treatment or other health programs. These lessons include the importance of comprehensive, clear, and coherent policies and vigorous enforcement of those policies once adopted. In Vietnam, policies are currently inconsistent, unclear, or entirely lacking in too many areas relevant to HIV treatment, prevention, and care, substance use treatment, and therefore to the DRIVE project. These include the precise timing of outpatient clinic integration, requirements for enrolling in social health insurance and obtaining antiretroviral treatment, services to be covered by social health insurance, criteria for commitment to O6 centers, and provision of voluntary substance use treatment, including treatment for use of amphetamine-type stimulants. Moreover, the policy landscape is littered with 'unfunded mandates,' that is, plans or directives with no resources allocated for their achievement. The lack of voluntary substance use treatment options and lack of confirmed funding for the provision of free social health insurance to all people living with HIV are examples. These insufficiencies in formal policy and funding can adversely affect interventions and programs dependent upon them.

Respondents offered recommendations to address the identified policy weaknesses. Recommendations regarding outpatient clinic integration and insurance expansion included providing universal free HIV care in public health clinics and waiving all requirements for identification papers for social health insurance enrollment. Recommendations for substance use treatment included issuing a new decree requiring a system of voluntary treatment, eliminating inconsistencies in the policy framework on drug use, allowing social health insurance coverage of addiction treatment (currently prohibited under the Law on Health Insurance), providing free substance use treatment for those without social health insurance or socioeconomic certification, making methadone treatment more client-friendly, and providing more and better treatment for amphetamine use.

Having clear and consistent policies is the first step. Once promulgated, they must be consistently enforced. The DRIVE policy assessment revealed many instances (e.g., requirements for identification papers and residence documentation) where erroneous interpretation and uneven enforcement of policy are rife. Respondents differed not only on what the official policies say (or will say once finalized) but also on how these policies are

implemented across clinics and providers. These apparent discrepancies probably make for confusion and uncertainty among patients. The disagreements among respondents and inconsistencies in implementation reflect the fact that the legal and policy environment in which DRIVE is being implemented is a constantly ‘moving target’ that will continue to change as the project proceeds.

DRIVE will continuously monitor the evolving policy environment, assess the effects of specific policies on project implementation and outcomes, and advocate for improvements in policies and programs based on project data. To support these efforts, questions about the effects of policy will be included in the follow-up quantitative surveys and qualitative interviews with participants, providers, and other stakeholders. Designers and implementers of other public health interventions in similarly evolving or uncertain policy environments should incorporate policy monitoring and policy advocacy in their projects.

DRIVE has the opportunity to add to this evidence by demonstrating that a combination of policy change and scaling-up public health prevention and treatment interventions can help to ‘end’ an HIV epidemic among people who inject drugs in a lower middle-income country setting. More broadly, the project promises to provide lessons on how policy affects public health interventions and, conversely, how data generated by intervention projects can be used to improve policy.

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