



Report

7th HIV/AIDS Asia Regional Program (HAARP)

Consultation and Coordination Forum

April 14-16, 2013

Ho Chi Minh City, Vietnam

HAARP is an Australian Government, AusAID Initiative

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Executive Summary

The Seventh HAARP (HIV/AIDS Asia Regional Program) Consultation and Coordination Forum (HCCF) took place in Ho Chi Minh City, Vietnam between April 14 and 16, 2013. It was attended by over 70 representatives from partner governments, drug user (DU) networks, regional organisations, the UN, and civil society. The 5 HAARP partner countries were represented.

HAARP is Australia's response to HIV prevention among People who Inject Drugs (PWID) in the Greater Mekong Sub-Region. It is an 8 year \$47 million initiative which builds on earlier investments by the Australian Government. This 7th HCCF provided an opportunity to bring key stakeholders together to; reflect on progress to date, the challenges and achievements under the HAARP (Day 1); share information and learning from implementation in Vietnam and across the region (Day 2); and emphasise a focus on the way forward, exit strategies and monitoring and evaluation (Day 3).

This report provides an overview of all sessions and a summary of the discussions.

The 7th annual HCCF was well received by participants; participants appreciated the forum for open discussion and continued learning. There was strong appreciation for the field visits and recognition of the opportunities to share perspectives with partner governments and implementers from across the region. Participants acknowledged the importance of M&E and communicating achievements moving forward; particularly in relation to creating a legacy for the program and developing strong and effective exit strategies leading up to the end of HAARP in 2015. There was strong consensus that continued support for harm reduction programming in the region was needed beyond 2015.

Acronyms

Acronym	Definition
ANPUD	Asian Network of People who Use Drugs
APN +	Asia Pacific Network of People Living with HIV/AIDS
ART	Anti-retroviral Treatment
ARV	Anti-retroviral Drug
ATS	Amphetamine Type Stimulants
AusAID	Australian Agency for International Development
BCC	Behaviour Change Communication
CBO	Community Based Organization
DIC	Data Information Centre
DU	Drug User
FHI	Family Health International
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with HIV/AIDS
HAARP	HIV/AIDS Asia Regional Program
HBV	Hepatitis B Virus
HCCF	HAARP Consultation and Coordination Forum
HCMC	Ho Chi Minh City
M & E	Monitoring & Evaluation
MARPS	Most At Risk Populations
MIPUD	Meaningful Involvement of People who Use Drugs
MMT	Methadone Maintenance Therapy
MSM	Men who have Sex with Men
N&S	Needle & Syringe
NACD	National Authority for Combatting Drugs
NGO	Non-Governmental Organization
NSP	Needle and Syringe Program
OI	Opportunistic Infections
OST	Opioid Substitution Treatment
PCPI	Police-community Partnership initiative
PE	Peer Educator
PLHIV	People Living with HIV/AIDS
PSI	Population Services International - Vietnam
PUD	People who Use Drugs
PWID	People Who Inject Drugs
SOP	Standard Operating Procedures
TB	Tuberculosis
UIC	Unique Identifier Code
VCT	Voluntary Counselling and Testing
VNPUD	Vietnam Network of People who Use Drugs

Day 1: Welcome, Regional Updates and Country progress reports

The 7th HCCF welcome address was made by Ms Emma Tiaree, Counsellor, AusAID Mekong and Regional, Hanoi and Associate Professor Nguyen Thanh Long, Deputy Minister, Ministry of Health, Vietnam. The forum was subsequently opened by Dr. Peter Diamond, HAARP Regional Program Manager, AusAID who provided the HAARP Regional Program update.

Counsellor Tiaree's opening remarks noted the achievements of partner countries, and the increasing demands by government agencies for results. She acknowledged the innovation within the program and the process of change HAARP has undergone to ensure national programs have a legacy for harm reduction. Counsellor Tiaree emphasised the need for greater harmonisation between public security and public health agencies to address issues around access to services for people who inject drugs. Counsellor Tiaree also noted the importance of using the HCCF as a means to share success and discuss ways to overcome challenges, emphasising the real need for commitment to mainstream harm reduction in public health models. She asked participants to take the opportunity to reflect on the success of the past year and look to the future for how results can be made sustainable beyond 2015.

Deputy Health Minister Long took the opportunity to welcome all participants to Vietnam and highlight the achievements of HAARP. He acknowledged the support of the Australian government for harm reduction activities and highlights HAARP's significant contribution to the control of HIV in Vietnam. He noted the HCCF was an opportunity to: acknowledge the achievements of the program, discuss solutions to challenges and explore lessons for implementing effectively. The Deputy Minister acknowledged Vietnam's commitment to integrate HAARP activities into national systems and wished a successful discussion for the participants at this HCCF.

Following opening remarks HAARP regional program manager, **Dr Peter Diamond**, officially opened the 7th annual HCCF. He reminded participants of the major focus of the program; to strengthen harm reduction policies in partner countries, increase cross-border efforts and build a platform for sharing information, models of implementation and evidence. Dr Diamond noted the importance of accountability, effective M&E systems and communicating the success stories of HAARP. He stressed the relevance of the program based approach to ensure longevity and sustainability of harm reduction activities and pointed to the focus of HAARP on transition planning and the development of national exit strategies.

Ho Chi Minh City – Provincial AIDs Committee

The first Speaker, Dr. Tieu Thi Thu Van, Director of Standing Office, HCMC Provincial AIDS Committee, provided an overview of the host city's harm reduction activities, which have been implemented in HCMC since 1993. Key achievements highlighted include the establishment of community counselling and support centres in all 24 districts, providing a comprehensive package of services including a mobile clinic distributing condoms and N&S in hot spot areas, a critical point of contact to PWID. The methadone program, implemented in 2008 and offered free of charge to registered drug user's (DU), has six methadone administration sites established across HCMC reaching 1,300 patients. This is supported by Vietnamese Provincial AIDS Authority.

Regional Update – United Nations Office on Drugs and Crime (UNODC)

Dr Anne Bergenstrom, Regional Adviser (HIV/AIDS Prevention and Care), UNODC regional office Bangkok, presented an overview and update on HIV/AIDS prevalence, targets and coverage in the region. The presentation was framed by a discussion on the HIV/AIDS resolution adopted at the 2011 UN General Assembly where member states commit to working towards a 50 % reduction in HIV transmission among PWID by 2015. This translates to prevention of 32000 new infections among PWID in Asia. Using data from central UNODC surveillance to illustrate trends, Dr Bergenstrom noted several key points:

- A decline in HIV prevalence among PWID does not mean that harm reduction interventions are effective. (An overall decline may be due to a higher mortality rate).
- There is potential to control and reverse HIV transmission in the PWID population.
- Needle and syringe programs are most effective for preventing transmission. If country programs aim for 60% coverage they can have confidence in a lower estimate based on data patterns.
- Countries should aim to achieve 40% coverage for OST. Other countries (Australia, US) that have achieved this can report a decline in new transmission in the target population.

These statements were made in recognition that data was only as good as the information UNODC can access. If new infections are to be effectively prevented there is a need to be able to locate where new infections are occurring. Dr Bergenstrom urged participants to prioritise monitoring and collection of strong evidence.

This presentation prompted several questions from participants. Laos PDR queried why tincture of opium was not represented in UNODC data. Dr Bergenstrom indicated that methadone and buprenorphine are the only OST recommended treatment by WHO. It was noted that only two efficacy studies on tincture of opium, as an opioid substitution treatment, had been conducted underlining the need for more evidence. It was suggested that there was an opportunity in Laos PDR to support research on the safety and efficacy of this treatment.

UNAIDS Myanmar commented that the data focused on HIV risk associated with heroin as drug of choice and did not reflect the growing prevalence of other drug use, such as amphetamines. UNODC acknowledged a change in drug use trends; which suggest young people are more likely to use amphetamine type stimulants (ATS). For example PSI data for Thailand indicates that of the 1.2 million drug users, 40,000 inject drugs and of these 40,000, 70% are injecting drugs other than opiates. Dr Bergenstrom referred to UNODC Global SMART Program which produces an annual global and regional report describing patterns and trends of ATS and other drugs use.

Country Updates:

Country: Cambodia	
Speaker	Dr Chhit Sophal, Head of Centre of Mental Health and Drug Dependence (HCMHDD), Ministry of Health
Key Messages	<ul style="list-style-type: none"> • Increase in number of MMT patients • Government appeal to take action dealing with issues in the prisons
<p>Summary</p> <p>The presentation outlined the current situation of HIV and drug use in Cambodia, the working methodology of the HAARP, achievements up to 31 December 2012, identified challenges and the future direction of the program in Cambodia.</p> <p>From the IBBS 2012 preliminary findings it is estimated:</p> <ul style="list-style-type: none"> • number of PWID: 1,303 (1,086 in Phnom Penh), HIV prevalence among PWID: 24.8% • number of PWUD: 11,697 (2,034 in Phnom Penh) HIV prevalence among PWUD: 4% • 31.9% of PWID reported, sharing used needle and syringe last time they injected drugs <p>Dr Sophal noted the concern around phase out of HAARP in 2015 and a critical focus needed to be on sustainability following the close of the program.</p>	
Achievements	<p>HR service delivery (2012):</p> <ul style="list-style-type: none"> • 'KHANA' reported: 298 PWID reached • 'Friends International' reported: 240 PWID reached • 177,498 needles/syringes dispensed through the N&S program • 101,226 condoms distributed • 262 MMT patients enrolled in the program (up from 61 in 2010) <p>Ongoing activity:</p> <ul style="list-style-type: none"> • Incorporate the national HR training curriculum in police academies • Implement Police-Community Partnership Initiative (PCPI) in Phnom Penh
Challenges	<ul style="list-style-type: none"> • HR sectoral coordination mechanism is not working smoothly • Difficulty reaching PWID as they are hidden. • Accessibility to MMT still relies primarily on NGO referrals • National M&E for HR has not been established, need for unique identifier code • Limited understanding of HR concept among communities and other health service providers
Moving Forward	<ul style="list-style-type: none"> • Increase linkage to services for PUD/PWID. • Address HR service for MARPs including HR in Prison • Support HR training program through police academic schools • Support the implementation of PCPI • Support country M&E and data collection system at Drug information centre (DIC) of NACD and MoH, • Strengthen high level coordination forum at policy level – NACD • Establish service delivery coordination forum through the MoH • Build capacity of the MoH to implement HR effectively through health system • Establish PUD/PWID network

Country : Laos	
Speaker	Mr Vatthana Souvannachack, Head of Drug Demand Reduction, Laos Commission for Drug Control (LCDC).
Key Messages	<ul style="list-style-type: none"> • IEC materials have been translated into local languages • Support for peer educators is a challenge • Need continued commitment and support in remote provinces • Cross border service access is being explored
<p>Summary</p> <p>Mr Vatthana noted that prior to 2011 HIV prevalence was not recognised in Laos. According to central surveillance HIV infection among the PWID (154) is high; at 42.5%. Prevalence amongst PWID is 1.8 times higher than national rates.</p> <p>Implementation of HAARP has seen the pilot of 2 HR projects in the northern provinces. At the northern border with Vietnam the minority ethnic groups are the main beneficiary of N/S program.</p> <p>Activities over 2012 have included the development of a national HR strategy, increased focus on PWID referral system to access HIV health services at provincial level and the exploration of cross border services.</p> <p>There are continued challenges especially around low understanding and misconception of DU in Laos. Future programming will demand continued learning and close attention to trends in drug use, particularly as a shift from opium smoking to heroin injection is likely. There is a need for continued commitment and support to remote provinces.</p>	
Achievements	<p>Jan 2012 – March 2013</p> <ul style="list-style-type: none"> • PWID: 154 reached (a 300% increase from baseline of 46), 986 contacts • 31,638 clean needles disbursed over 15 months (average of 13 needles per patient, per month) • 5,247 condoms to PWID and partners (average 2 condoms per patient, per month) • 4 IEC materials: translated in to ethnic and local languages • Used syringe disposal – 2,557 (8%) returned • Gap analysis on sustaining HR interventions in Laos • All PE have received dose 1 and 2 of Hepatitis B vaccine
Challenges	<ul style="list-style-type: none"> • Variable management & community support: commitment, distance • Low technical capacity of PE and staff • Misunderstanding of harm reduction by community and partners • Poor drug dependence awareness and education at village level
Moving forward	<ul style="list-style-type: none"> • Establish stronger and more stable outreach • Introduce PE mentors for continued learning • Ensure access to VCT and ARV and case for PLHIVs • Operationalize HIV/AIDS service referral system model • Develop national HR advocacy strategy • Strategic Information (capturing, documenting and circulating information about HR and HAARP) • Linking OST to comprehensive HIV services • Country baseline on PWID and HIV (including PWID as a sentinel population) • Costed operational plan by 2015 • Seek opportunities for sustaining referral services

Country : Vietnam	
Speaker	Dr Pham Duc Manh, Project Director, HAARP Vietnam
Key Messages	<ul style="list-style-type: none"> • HR interventions, a priority for communities, are now also driven by the government • 3 services are available for drug users and affected family: voluntary counselling and testing, treatment support, regular support meetings
Summary Following the advice of authority and the MoH, HR activities are now driven by the government (Jan 2013). The data outlined below illustrates how important HR is, both to the government and to the community.	
Achievements	Government data indicates: <ul style="list-style-type: none"> • 3,214 contacts have been made: 1,463 PWID in the community, 1,519 PWID in closed setting, and 232 FSWs • 58 NSP are operational: 1,255,201 N&S disbursed • VCT: 4,200 PWID received pre-test counselling, 3,886 (92%) were tested, 3,650 returned for test result (94%), 6.1% tested HIV(+) • 1,298 received STI examination and treatment • 231 on MMT at 2 MMT sites • 4,384 referred to other health services (VCT, ART, TB, detoxification) • 177 PWID and re-integrated persons received financial support
Challenges	<ul style="list-style-type: none"> • Geographical challenges: reaching ethnic minorities and monitoring • MMT treatment adherence • Shortage of trained personnel for implementing MMT activities • NGO Coordination affects management of PEs network
Moving Forward	<ul style="list-style-type: none"> • Scaling up project activities to some districts in project provinces • Needs assessment for expansion of MMT Programme in 3 provinces. • Set up HIV transmission prevention at Lao/Vietnam border • Improve annual WP process to ensure proper project cycle • Support mechanism to strengthen NGO coordination • NSP social marketing to reduce free N&S distribution and increase sustainability for the NSP

Between the countries there were some commonly identified challenges (low levels of understanding, geographical coverage, and limited capacity) and similar priorities moving forward i.e. advocacy and capacity building and integration of services.

HAARP partner countries continue to use the HCCF as an opportunity to learn from each other and prioritise information sharing and strategic thinking across the region, particularly noting the interest in cross-border harm reduction activities and important connections with migration and trade policy.

Organisation: Yundi Harm Reduction Network, Yunnan and Guangxi Provinces, China <i>All members are from beneficiary groups (PWID, SW, PLHIV) in Yunnan and Guangxi. The mission of Yundi is to serve these vulnerable populations, recognise their rights, and help them access services.</i>	
Speaker	Dr Duo Lin
Key messages	<ul style="list-style-type: none"> • PWID death and overdose analysis report has been completed – generating evidence required to advocate for naloxone

	<ul style="list-style-type: none"> • Opportunity exists for regional and cross border collaboration • Capacity remains limited
Summary Significant progress was made in 2012, however staff capacity is low and the organisation lacks staff resources and technical support. Despite this, funding and resources have been mobilised for cross border activities. <i>Yundi</i> noted an advantage for cross-border programs as they target the populations that move within and across borders. There is no formal government led program targeting these populations; primarily it is NGOs that work on cross border activity. On the China-Myanmar border at the moment more services are provided to cross border clients (from Myanmar) rather than Chinese, however many more Chinese access methadone.	
Achievements	In 2012 Yundi: <ul style="list-style-type: none"> • Provided services for 1050 PWID (including 260 from Myanmar drug users cross border shelter and 140 for Methadone in China) • Treated 299 instances of PWID overdose with first aid • Produced 2 research reports, 2 DVDs, 8 articles • Produced the PWID death and overdose analysis report • Led advocacy activities around the release of the report
Challenges	<ul style="list-style-type: none"> • Information and financial management capacity is limited • There is a lack of timely technical support and supervision • Late budget allocation makes forward planning difficult
Moving Forward	<ul style="list-style-type: none"> • Focus on advocacy of Chinese resource and policy change for cross border Methadone and treatment. • Help Yundi's cross border service by inviting possible Myanmar or Vietnam partner's support • Develop a comprehensive service guideline and cross border model • Share lessons learnt from story or film production with regional HAARP countries and look for possible cooperation with HAARP countries

Organisation: International Drug Policy Consortium (IDPC) <i>IDPC aims to promote objective and open debate on the effectiveness, direction and content of drug policies at the national and international level, and supports evidence-based policies that are effective in reducing drug-related harm.</i>	
Speaker	Ms Gloria Lai, Senior Policy Officer
Key Messages	<ul style="list-style-type: none"> • The goal of IDPC is to encourage objective debate on drug policy • Drug control laws need to support HR activities – current laws prohibit service access for PWID who fear incarceration and discrimination • Enabling laws recognise drug use as a health issue over a criminal issue
Summary Why drug policy? <ul style="list-style-type: none"> • Laws on HIV and drug control are often separate. We need drug policy to better reiterate the connections between harm reduction and health. • Drug control laws need to support HR activities. Control laws which penalise PWID promote risky behaviour i.e. DUs are more likely to resort to more risky forms of drug use to avoid punishment and/or penalties for using. A primary example is the impact of criminalising needles. This has also made it difficult for NGOs and CSOs to deliver HR NSPs or OST. 	

- Difficulties to deliver services in closed settings are directly related to drug laws.

The 'War on Drugs' approach i.e. tough law enforcement has historically been favoured. Funding has focused on enforcement measures over HR services which portray DUs as criminals rather than patients. This had significant negative consequences for PUDs and the communities affected by drug use.

IDPC encourages debate around enabling laws that recognise drug use as a health issue over a criminal issue. This represents a shift from conventional measures of drug law success (i.e. number of arrests or number of success persecutions) towards encouraging evidence-based drug treatment services and collaboration between law enforcement and health authorities.

Civil society engagement is critical. PUDs need to be involved in formulation of policies as they are the population most affect by the implementation of these policies. Meaningful engagement of DUs will lead to better and more effective implementation of HR programs, ultimately shaping better and more supportive drug policy. Effective engagement with civil society requires investing time and energy into building relationships and trust

HAARP and IDPC will conduct a regional mapping project across 10 countries in the region (including all HAARP countries) and will map what is being done currently and where there are opportunities to provide support.

Organisation: **Asia Network of People that Use Drugs (ANPUD)**¹

ANPUD is membership network that has the MIPUD principle (Meaningful Involvement of People who Use Drugs) as their guiding philosophy.

ANPUD believes that services (prevention & treatment) for people who use drugs must be accessible, voluntary, comprehensive, evidence based and compassionate and that people who use drugs should not be criminalised.

ANPUD activities:

- *Supporting the establishment of country level PUD organisations and networks and enhancing the capacity of existing PUD organisations and networks throughout Asia.*
- *Increasing awareness of issues and experiences of people who use drugs in Asia through the development of a focused ANPUD advocacy platform.*
- *Forging partnerships and strategic alliances to achieve our goals by working with and through a variety of organisations.*
- *Increasing the technical & managerial capacity of ANPUD members and the PUD community to contribute to the development of programs designed to improve the quality of life of PUD in Asia.*

Speaker	Mr Sam Nugraha, ANPUD board member
Key Messages	<ul style="list-style-type: none"> • Needs to be a greater effort for meaningful involvement of people who use drugs in all aspects of programming • Punitive approaches are not effective

Summary

The membership network for PUD was previously an issue based membership; now it is predominately country based membership with strong networks established in India, Indonesia, and

¹ <http://www.anpud.info/ANPUD/Home.html>

Nepal. It is a network motivated by the human rights aspect.

Experience has shown attempts to involve PUD previously in HR activities has been tokenistic i.e. gave them a place at the table without making sure they understood the language. Opportunities for PUD to provide feedback on policy, program design or implementation have been limited, and often they are the forgotten members of the audience. The community needs to be informed and educated to encourage participation.

Taking a punitive approach to drug use is rarely effective. PUD are generally not harming other people, they are not criminals, they are not trafficking or dealing, rather they are consumers trying to control these habits are striving for improved quality of life.

MIPUD should involve country and organisation representatives engaging with DUs and looking for tangible positive impacts on the community.

Nothing about us, without us – HAARP Strategic Transition Advisor

The afternoon session was opened with a revision of the principles of HAARP. The concept of ‘nothing about us, without us’, which underpins all programming under HAARP, recognises the **importance of meaningful involvement of people who inject drugs** and their partners in all areas of programming: design, implementation and monitoring. Mr Narayanan emphasised the importance of the five core principles:

- *Effectiveness*: emphasising the importance of partnership and cooperation of all stakeholders – governments and communities alike.
- *Evidence to Action*: emphasising the need for good quality, evidence based approaches to scaling up of harm reduction.
- *Respect and protection*: advocating for social change, the respect for human rights (including the right to health and treatment), and protection of people who inject drugs.
- *Reducing vulnerability*: creating and enabling environments that address the criminalisation of drug use and reduces the stigma and discrimination faced by people who inject drugs.
- *Gender awareness and integration*: advocating for action and policy change that addresses the needs and role of women and men in relation to harm associated with injecting drug use.

Mr Narayanan emphasised the human and ethical imperative of involving PUDs. This introduced the second key message of the session: **the importance of consulting and engaging with drug user organisations and networks**. The functions of these organisations were to; organise community events and support organisations; produce safe injecting and HIV prevention and care materials; protect themselves and others from ill health; build coalitions and partnerships, and advocate for access to health services for other drug users and are often experts in HIV and harm reduction.

The benefits highlighted were: DUs have more ‘buy-in’ to programme, the services they design are services they, in turn, are likely to access, ensures the development of a service or programme that is realistic, useful, client-friendly, and builds a sense of self-worth and dignity of drug users who are consulted. In absolute terms of coverage **drug users reach drug users**.

This background discussion on the networks and benefits gave good foundation for continuing conversation around some of the challenges of engaging with DUs; challenges for governments – dealing with the community perception that harm reduction in some way promotes drug use, challenges for NGOs – drug use during business hours, buying drugs, performance; challenges for drug user groups – drug use in the office, selling drugs, borrowing money, sick leave, etc.

Participants were asked break into smaller country groups to continue this discussion; focusing on the challenges involving PUDs in the specific country context and what more could be done to engage the community moving forward.

1. *What are the challenges you face in involving PWUD/PWID in your programs?*
2. *What can you do to increase drug user involvement in policy dialogue, programs and M&E?*

Laos PDR – facilitated by Bijay Pandey, ANPUD Chair

The main challenges identified by Laos PDR were:

- Language barriers e.g. many ethnic minorities which are target populations have their own languages
- It is common for communities to have a low understanding regarding drug use and HR activities. More investment is needed in educating communities.
- A common misconception about the HR program e.g. the distribution of needles or syringes is promoting drug use.
- A lack of trust within the community of HR activities e.g. there was a reported misunderstanding amongst the DU that methadone is poison.

Laos PDR identified several ways to combat these challenges:

- Use peers and local community members to communicate and advocate the messages in local language.
- Build awareness of basic rights and services and capacity using various materials and methods in local language and dialect
- Misconception could be addressed by supporting self-help groups. Trust could be built through consistent awareness and advocacy activities e.g. meeting regularly in local communities

Cross border health services were raised as an issue with key questions around, how does Laos PDR facilitate these services and what could a referral system for peer educators look like? Feedback from Laos PDR suggested there was agreement on a need for self-help groups. Mr Narayanan asked if this could be future work for HAARP to support. The response was positive.

Cambodia – facilitated by Sam Nugraha, ANPUD board member

The main challenges identified by Cambodia were:

- The relation between drug laws and criminalisation. It was noted that whilst laws say options are provided to DUs this does not reflect practise.
- The discrimination towards DUs by the wider community e.g. DUs are not good role models. They are involved in criminal activity and the community will not support them.
- DUs are a marginalised group with generally low education and capacity. There is a need to invest to ensure involvement.
- DUs are a very mobile population which makes service provision difficult.
- Involvement of DUs in M&E e.g. lack of skills and capacity.
- Whilst there is a concern for priority basic needs DUs have less time for involvement.

Cambodia identified several ways forward to combat these challenges:

- Focus on raising more awareness around DUs in the community and services available.
- Provide more inputs into the program.
- Ensure that DUs are not isolated i.e. there is a recognised need to work collaboratively.

Vietnam, facilitated by Ms Pham Thi Minh, VNPUD chairperson

The main challenges identified by Vietnam were:

- stigma and discrimination e.g. DUs are people who are useless, uneducated, and engage in criminal behaviour
- DUs lack confidence to engage in processes and dialogue. Self-help groups have only been established since 2009. Now these groups are more exposed to media and community scrutiny but the capacity to defend and promote is limited.
- A lack of confidence to meet with stakeholders, particularly those in a position of authority.
- The role of DUs is not fully understood and appreciated. Self-help groups are not fully supported by local authorities and activities are limited were they could be improved.
- A limited awareness of authority on concept of HR programs. It was noted that the authority is often a barrier for implementing the MMT program effectively.
- A lack of involvement of DUs in planning, implementation and M&E of the program. More often DUs only appear in implementation after the planning process.

Vietnam identified several ways forward to combat these challenges:

- Self-help groups are looking to government for guidance. There is a need for government to help these groups manage i.e. point out achievements and limitations so capacity can be improved.
- Continuing engagement and inclusion of PUDs and ensuring authority is supportive of HR activities.
- Look for more interaction between government and implementing agencies to encourage networks to raise awareness within government.
- By strengthening capacity PUDs can be meaningfully involved in earlier planning processes and M&E. Providing opportunities to engage in these steps will be valuable. A good example is the involvement of DUs in the 06 'renovation plan' from compulsory to voluntary based drug treatment models.

Discussion

ANPUD representative, Bijay Pandey, asked how Vietnam manages coordination between 25 self-help groups. Vietnam responded by explaining there were actually 55 groups covering 21 provinces across the country; the smallest consisting of 25 members, the largest over 400. Groups exist to provide members support (e.g. social health alternative income generation amongst the DU community) and care (e.g. referral to methadone and/or ARV treatment). Of the 55 groups 15 belong to HAARP and are 4 receiving financial assistance.

Dr Premprey from Cambodia asked what has been the impact of the law (criminalisation of drugs) on the network? Ms Minh explained that since 2009 Vietnam has official practiced decriminalisation i.e. DUs are seen as patients not as criminals and are offered alternatives to arrest and incarceration; methadone, community program.

Day 2: Site Visits

The second day of the forum focused on site visits to observe HR service delivery implemented by the HCMC Provincial Aids Committee. Participants visited one of the 3 sites 1) a clinic providing combined MMT and ART services to DUs, 2) mobile services providing VCT and Primary Health Care, and 3) outreach services including NSP.

Site Visit – Group Feedback

Group 1: MMT and ART	
Summary of Services	
This clinic provides both MMT and ART services at the one location. The integration model is unique in HAARP partner countries. It is just one possible model of integration and does not reflect all clinics in HCMC. Different integration models are being used at different locations to appropriately respond to the context. Total number of patients accessing services has grown from 37 to 1800 after integration. There is approximately 30 staff to 280 patients.	
1.	<p><i>What is your overall impression of this facility?</i></p> <p>The overall impression of the facility was that its size was reasonable, sufficient and manageable for the number of patients and service delivery. The major advantage of the facility was that it integrates all treatment available, serving as a 'one stop shop' for DUs.</p>
2.	<p><i>Do you believe that this program has many advantages? What are they?</i></p> <p>The main advantages highlighted were ease of access to services, reduced waiting time, the reduced number of staff required to deliver the services and the opportunities for staff professional development. A major achievement noted was the fact that patients now did not have to go through registration. However, it was reported in discussion that police have arrested DUs whilst at meetings for methadone treatment.</p>
3.	<p><i>What are some shortcomings of this project? Or what could be improved?</i></p> <p>A shortcoming of the facility was the need for keeping dual case files for patients accessing both MMT and ART. This 'file duplication' increases the workload of staff.</p> <p><i>Dr Van clarified this point that most methadone clinics are separate so files cannot be integrated as it would restrict patients being able to receive MMT from other clinics. There have been attempts to address the issue of staff overload but there continues to be a 5 hour wait for patients; not all methadone services have ARV.</i></p> <p>It was also noted that the service package limits treatment to communicable disease only. This has serious implications for patients needing access to a wider range of services. Despite this the number of clients is increasing. Another limitation noted was the fact that target population incur costs after accessing the services if they do not have insurance.</p>
4.	<p><i>MMT and ART are provided side by side at this centre. What are the benefits?</i></p> <p>The benefits of providing MMT and ART side by side are the ease of consultation and referral. MMT staff are trained in ART and MMT staff are trained in ART. Drug interaction issues are known, discussed and referred within the same clinic. It also increases cost effectiveness and makes better use of time.</p>
5.	<p><i>What did you learn from this visit that would be relevant to your country?</i></p> <p>As a whole the group reported the value of government leadership and support for the sustainability</p>

of HR activities. The value of a 'take home' dose of treatment was noted as well as the importance of the integrated approach to service delivery.

There was discussion around the role of PE's and the value of involving PE's in service delivery. It was noted whilst under current drug law DUs may be arrested however it was noted that the presence of PE may help prevent the incidence of arrest. The involvement of PE may also encourage regular support meetings and establishment of self-help groups.

6. *What did you learn from your discussion with the PEs and patients?*

Minimal feedback related to discussion with PE. The group did not interact with patients.

There was a series of questions from participants that were noted by the facilitator and answered by Dr Van of the HCMC PAC

- Does this clinic offer all services? What is the full package of the service?

HCM city has tried to establish a health facility with ARV service included. ARV was located in preventative health centres. Now methadone can be integrated with ARV service so patients have access to both treatments at the one clinic. This clinic is closely linked to district health facility i.e. patients may enter the referral system to access a wider range of services.

It has been established as a satellite methadone service; this model is a starting point for wider integration of the services into the health system.

- What is the actual human resource capacity i.e. reduced number of staff but now over-worked?

The working hours were allocated on the basis of a staff survey. There is recognition that the flow of patients needs to be regulated; the design of the service delivery can respond to the changing needs of the patients and respond accordingly. Staff workload would be considered in these processes.

- What are the clinic's open hours?

The clinic's open hours are outside normal working hours. The aim is to make the access to services as convenient and appropriate as possible for the patients and to allow them to access the service before going to work.

- How do patients access methadone on the weekends if the clinic is closed?

The clinic makes 'take home' drugs available for all patients, even for new patients.

Group 2: Mobile services, VCT and PHC

Summary of services

VCT and PHC services are delivered out of a mobile unit (van) that aims to increase accessibility for hidden PWID who might be at risk. The mobile clinic periodically visits hot spots across the city in a number of different districts. The project initially had mobile PEs connected to the unit but now engages with the outreach team/PEs based at each site. Target groups include street based and venue based SW, PUD, MSM, female migrant workers, (Vietnamese) truck drivers. The mobile clinic offers services free of charge. Funding between 2003 and 2012 relied on international support. As of January 2013 it is a government funded project.

1. *What is your overall impression of the mobile outreach services?*

The overall impression was that the mobile clinic provided strong linkages for services; link to non-health services and social support. The outreach also created strong community links with leaders,

shop owners, managers of sex-workers and other significant stakeholders.

The group noted the value of Vietnamese government funding. As of January 2013 the service itself is managed by the government. This is particularly important in the context of the transition phase of HAARP. Government services increase the capacity at the district sites and government funding will ensure sustainability.

2. Why do you think a mobile outreach unit is important for Ho Chi Minh City? What are the advantages?

The mobile outreach unit primary importance is coverage. It serves as an entry point for health services for vulnerable groups. However referral processes and systems are weak. Government services require payment if patients do not have insurance; whilst insurance does cover some patients many, especially those from remote areas do not have insurance.

3. Do you think such a model could work in your own country or province?

Cambodia, Laos and Myanmar agreed that it could work in their countries. All suggested that the mobile unit could be effective as long as it was not implemented as a single entity but rather integrated with other health services. The recognised disadvantage was the same as a fixed service delivery unit; stigma and discrimination attached to non-discreet services.

There was debate between participants around the physicality of the mobile unit, whether the van was most practical or if other forms could encourage more use and achieve better access. For example in mountainous regions like north Vietnam and Lao, Motorbikes may be far considered more practical. The concerns were that the branding of van increases stigma and discrimination; as individuals access the services from a heavily branded unit they make themselves vulnerable to further discrimination.

Laos and Myanmar agreed that it could work in their respective countries. Myanmar suggested that different areas need to be targeted and that discrete services would be more accessible for communities. Laos was concerned with issues of sustainability; the likelihood that there would be an interruption of services if/when funding stopped. Sustainability would be easier to manage if the services had a lower profile and emphasised referral.

4. What are the most important lessons you have learnt from this visit?

Most important lesson agreed on by participants was that sustainability of the services was more likely if supported by government funding and policy. In many partner countries there is an issue of conflicting policy around drug control. Countries need evidence to advocate the need for HR activities as health service; Vietnam focused on policy advocacy at the start. Advocacy has been promoted at every level as different stakeholders contribute different resources. Critical lessons have been learnt in relation to contribution. Countries were encouraged to take lessons learnt and evidence from across the region, such as HCM, and use to advocate for change within their own government.

Laos suggested that when working with the government it may be easier to advocate for services that the whole community can access. The question was asked does this reduce stigma – if high risk populations are not targeted.

5. If you were asked to support this program how could you help to improve the services?

The group agreed that advocating for a clear work-plan that mapped linkages, influential stakeholders, and coverage would help improve the services i.e. knowing why an area is targeted, and knowing who the services will reach. It was also noted that mobile services need to remain

adaptable as the context will change. For this reason mapping needs to remain updated. Time of services also need to match the target population's needs.

Feedback discussion

In Vietnam the government has accepted that DU are a population whom need to be considered and who need specifically catered services. This is why the mobile unit has a special license to allow them to be on the road 24 hours a day. Vietnam has aimed to make many services available so that clients have choices.

Group 3: Outreach and NSP

Summary of Services

This is an NSP outreach program that focuses on providing services via PEs out in the community and clean N&S distribution. Currently 300 patients are served by PEs.

1. What is your overall impression of this service?

The overall impression reported was that this facility provided average to good care services. Outreach for PE involved a weekly group discussion and 1 to 1 contact. A mobile phone was used but PE doubted the consistency. The challenges reported by the PEs were:

- Confidentiality of patients cannot be guaranteed as there is no unique identifier code
- Greater input was required into community awareness programs. Stronger links to community needed to be established

2. How is the outreach and NSP different from what is being done in your country?

No comments were noted under question 2.

3. What are some of the advantages of the model you saw here in Ho Chi Minh City?

Cambodia noted an advantage of distributing N&S and hygiene kits from the centre.

4. What lessons are you taking home to your country from this visit?

The primary lesson learnt was the advantage of integrated activity.

5. What do you think could be improved?

The group noted that the project needed improvement. One area of improvement highlighted was communication between the supervisor's/doctors and the PEs.

There was also a contradiction with the explanation given for the 1 to 1 exchange process; the director stated they do not count the needles which would be impossible with the 1 to 1 policy. This prompted discussion on the benefits and limitations of 1 to 1 exchange. According to current world ethos needle exchange programs as considered not effective and are discouraged. Instead good practice is to give out as many needles as DUs need or ask for. Whilst the aim should be to achieve an 80% return it is not good practice to make this a rule as it may limit users seeking clean needles. An alternative option was noted: the benefits of weighing a locked box to count and monitor.

Feedback Discussion

- Does the program demonstrate gender awareness and identify cross risks between populations?

The simple answer is no. Although there are some female PE.

UNODC made a point of noting and congratulating Vietnam for its leadership on models for integration of services; 10 years ago the integrated model was just not possible in this context.

Observation/feedback

During discussion Bijay Pandey (ANPUD representative) urged participants to consider where the PUD perspective was in all of these discussions? Where was their involvement in these processes? Unless PUD are meaningfully involved in discussions, services will not be effective. The services at the moment, as this group recognised, are too professional to be drug user friendly: there is very little human emotion. He emphasised that DUs can be as professional as the people at the conference, they have the skills to document and implement. He made the point that DUs are not stats and data and their contribution should not be limited to PE.

Day 3: HAARP 2013-2015

The third day of the 7th HCCF focused on the last 2 years of HAARP and the legacy of the program beyond. Three central ideas were presented and discussed at length with the participants; monitoring and evaluation, naloxone and exit strategies.

Monitoring and Evaluation – communicating the achievements of HAARP

PSI Vietnam have been engaged by AusAID to map the gaps in monitoring and evaluation activities and systems across the program and to implement practical solutions that will allow the HAARP program to better demonstrate the positive difference it is making to the lives of people who inject drugs in Vietnam, Laos and Cambodia. This will be achieved by working in close partnerships with HAARP country program teams and AusAID regional team.

The aim of the presentation lead by Gary Mundy, (PSI), was to; review principles of good M&E systems for HIV prevention and harm reduction; review areas identified for M&E support to date; and discuss how PSI will work with country teams to strengthen M&E in their respective programs. Priorities in this process will be to:

- align with national systems i.e. clarify and/or establish how HAARP M&E sits in the national system
- establish a common framework and systems to ensure confidence in consistency of data
- provide support to develop systems that will ensure data quality and enable comparison of data over time
- explore ways to make data collection easier and reporting more streamlined

The following principles of a strong M&E systems were presented:

Relevant	The data collected and reported best represent program achievements i.e. Outcomes as well as outputs
Accurate	Measure what they intend to measure
Reliable	Measures are applied consistently
Precise	Sufficient detail
Complete	Complete data sets
Timely	Up to date, practical, and available when needed
Have integrity	Free of bias or manipulation
Confidential	Personal data not disclosed inappropriately

Key messages delivered by PSI were:

- The importance of relevance, all other principles were considered essentially redundant if the M&E system does not capture relevant information.
- If information is not available when it is needed it is not useful.
- Systems need to be in place to routinely check information, free of bias and manipulation.

The presentation closed with a 'practical next steps' for PSI Vietnam and then opened up for discussion and questions. Each country group were asked to comment on what PSI could potential help with over the next two years.

Laos PDR indicated the need to strengthen capacity of implementers to collect and report relevant data and for the HAARP program to measure whether activities were relevant, effective and efficient. Laos also raised the concern of how to capture data consistently and how to align indicators with national M&E systems. *Vietnam* emphasised the importance of alignment with existing indicators and national systems. They noted that current 'success' indicators do not reflect the actual achievements of the program. They noted that M&E is still a problem for HR in Vietnam especially around issues of quality. This was noted in the context of limited capacity at the ground level to collect and manage information and a need at the district and provincial levels to better understand and interpret the data. She also noted the complications in HAARP program level reporting when there are differences between country reporting. Limitations of the minimum data set countries are required to report against were highlighted. Countries were reminded that the minimum data set is a minimum reporting requirement and country programs are encouraged to include more information where it is relevant and informative. PSI would work with countries to refine the minimum data set.

Cambodia reiterated the value in aligning with national systems and noted their interest in developing an M&E system for HAARP that was fully integrated into the national system. Cambodia noted the importance for PSI to consider multiple stakeholders, including different donors, complex systems and existing indicators and tools. The key message was that time management is more effective when systems are integrated. Cambodia also highlighted the importance of UICs to reporting. This received support from other participants. PSI noted that whilst UICs are 'great on paper' making them work is a challenge and a package of support is needed for effective implementation. This also relies heavily on high-level leadership and support.

Naloxone

Mr Narayanan led the discussion on the importance of Naloxone— *a WHO essential drug for treating heroin overdose*

Naloxone is an antagonist drug; it specifically blocks the effects of opioids reversing an overdose. The science: *Naloxone counters respiratory depression caused by opioids. Opioids produce their effects by acting on opioid receptors in the brain and nervous system. Naloxone works by blocking*

these opioid receptors, thus stopping opioids from acting on them. This reverses the effects of the opioid².

The key message was that overdose is actually the leading cause of death amongst drug users however, despite this overdose remains a neglected area in HR in Asia. Most often overdose occurs in remote locations where the DU has little or no access to health services. Often the DU who has suffered overdose is left to their own devices as reporting the overdose or accessing health services has serious legal ramifications and leads to arrest.

Dr Duo Lin, delivered a presentation on the importance of naloxone in reversing heroin overdose and preventing fatalities. The aim of the presentation was to promote the safety and efficacy of naloxone, and discuss evidence. The comprehensive discussion highlighted important links to HR for HIV transmission. Dr Lin summarised the key points under 3 key headings; safety and efficacy; easy administration; low risk of misuse.

Safe & effective	<ul style="list-style-type: none">• Re-write this section• Without heroin in the patients system the medicine is no use. Naloxone will only work with opium overdose and therefore is very safe.• If the patient has no opium in their system there is no reaction; there is no potential for abuse as the drug on its own has little to no effect• Naloxone is very quick to take effect (1-3 minutes)• It is safe to administer repeat doses e.g. a colleague administered 54 doses of naloxone in an extreme overdose case• Naloxone has been on the WHO essential medicines list for many years and has now been made available on the China market
Easy administration	<ul style="list-style-type: none">• Multiple dosages: after the initial dose of naloxone often the effects of the overdose returns repeatedly. This is because naloxone works faster than heroin. It is expected that multiple doses are administered.• Injection is most effective way to administer. It can be intravenous or muscular injection and works equally as effectively through clothes.• Single training for administration is appropriate and allows for peer administers.
Risks of misuse low	<ul style="list-style-type: none">• Naloxone has mild side effects such as headaches, nausea, sweating. The side effects should be considered relative to the effects of the overdose.• Whilst originally there was concern peers had no medical background and were administering treatment, now the general opinion is that administering Naloxone is as safe as administering basic first aid.

PSI commented on the additional health benefits of making naloxone accessible at the community level; PSI research had indicated it increases coverage of vulnerable groups through administration by peers and decreases the rates of needle sharing among DUs³.

Several countries sought clarification on WHO recognition of naloxone. Dr Lin emphasised multiple times that naloxone is considered a basic medication by the WHO with a very low level of risk attached to the administration: the WHO recommends global access and availability. The Cambodian NGO representative acknowledged the underground use of naloxone in Cambodia since 2005. He stated the frustrations of not being able to administer in the open and absence of naloxone on the

² <http://www.netdoctor.co.uk/lung-problems/medicines/naloxone.html>

³ PSI report – statistics showing decrease needle sharing with access to naloxone

accepted drug list. Discussion explored alternative administration of Naloxone, i.e. injectable and nasal delivery. Cambodia stated its intent to consider making naloxone available.

Yundi discussed how they train peer educators to administer Naloxone. PEs have far better access to the PUD community, peers trust them, they often have many years of injecting experience themselves and are familiar with the context. PE's receive the first screening and training by formal doctors. This then qualifies them to administer Naloxone.

<i>Exit Strategies – the legacy of HAARP and ensuring sustainability</i>

The final session of the 7th HCCF: HAARP Exit Strategy focused on developing clear country program exit strategies to prepare for the end of HAARP in June 2015.

This will allow the program to exit responsibly with mitigated risk, an agreed set of activities which HAARP will work on in the remaining two years and a sustainability plan to ensure HAARP leaves a positive legacy for harm reduction for PWID in country. This will involve:

- Ensuring the essential interventions are taken on by the host government
- Ensuring an agreed set of activities prior to the end of the project
- Ensuring staff and stakeholders are aware of the exit

Identifying risks is an important part of the process. It will be essential for management to ask questions such as: what are the risks for the country, for HIV/AIDS among PWID when HAARP leaves? Will HIV prevention efforts be affected? How much? Is there a possibility of the epidemic escalating? Is there a risk for reverse in national policies related to harm reduction? It will then be important to develop mitigation strategies to manage for these risks occurring.

Participants were asked to spend time in each country group to have an initial discussion on the development of an exit strategy. Groups were asked to report back to the forum an outline of a sustainability plan, a risk matrix identifying most significant risks to the program and to highlight some achievements that are likely to become the legacy of HAARP in that country.

Feedback is summarised below. Partner countries will be expected to build on these initial ideas and develop a comprehensive exit strategy for the end of HAARP in 2015.

Cambodia: Risk Matrix		
Risk	Level of risk	Mitigation Strategy
Continued funding for MMT	M	Moving to health equity fund
Procurement of methadone	M	Methadone is included on the MoH essential drug list
MMT Referrals	H	Discuss with other NGOs and donors
NSP	H	Integration into MoH systems Global Fund will support the 2 nd half of 2015 Seek funding from other donors
EE HR curriculum	L	Integration into Police Academy Advocacy at the high level
PCPI	M	Link to existing committee at the community level Use evaluation to advocate at the high level
Coordination	L	Coordination forum to continue through government system ‘Strengthen coordination forum’ for HR service delivery
National network of PWID	H	Engage with other donors for future funding opportunities Use the government system
Legacy		
Activities:	<ul style="list-style-type: none">– Methadone Program– Harm Reduction in Health System– Needle and Syringe Program– Harm Reduction Curriculum in to Police Academy School– Police Community Partnership Initiative (PCPI)– Capacity building at Drug Information Centre (DIC)– Harm Reduction policy/ guideline/SOP– Coordination system harmonization	
Moving Forward	<ul style="list-style-type: none">– PWID network– Moving MMT to Health Equity Funds (HEF)– HR in Health System– HR curriculum in to the Police Academy School (PAS)– Strengthening the coordination Meetings of HR Program with all donor and stakeholders at high governmental level.– Policy set up SOP, Guideline before HAARP ends– Technical Assistance to the Harm Reduction– MMT at Prison– Strengthen M&E, documentation of the lessons learned	
Sustainability Checklist		
1. Continued funding for hard reduction		Yes / No
2. Ensuring that interventions are cost effective and can be taken on by government		No
3. Ensure that all programs are evidence based		Yes
4. Engagement of people who inject drugs at all levels		Not at all levels
5. Ensuring that there are policies, laws and relevant tools that support harm reductions in every country		Yes
6. Strategic partnerships are built with other donors, UN, community networks		Yes

Laos: Risk Matrix		
Risk	Level of risk	Mitigation Strategy
Discontinuation of NSP in HP and PSL	M	GoL ADB GFATM
Discontinuation of PE system	M	GoL ADB
Point of care-referral and mobile outreach	L (integrated into the health system)	GoL WHO ADB
Cross-border services	M	GoL & GoV Clinton Foundation VN ADB
Evaluate the efficacy of tincture of opium as a long term opiate substitution maintenance therapy	M	GoL UNODC
M&E Framework for HR	M	GoL UNAIDs ADB UNODC
Legacy		
Activity		Legacy
NSP Self-help groups		PEs for IDU
National HR advocacy strategy		All-level awareness (top-down)
IEC materials		All-level / community awareness
Training of core trainers		Technical skills in HR
Development SoP Pilot the model		Model point of care referral with mobile outreach
RAR IBBS		Baseline on HIV prevalence among PWID (funds for replicating HR program in other provinces)
Study on TO capsules efficacy and safety for opiate substitution maintenance therapy		Model on opiate maintenance therapy using TO capsules
Sustainability Checklist		
1. Continued funding for hard reduction		Yes
2. Ensuring that interventions are cost effective and can be taken on by government		Yes
3. Ensure that all programs are evidence based		Yes
4. Engagement of people who inject drugs at all levels		No
5. Ensuring that there are policies, laws and relevant tools that support harm reductions in every country		Yes
6. Strategic partnerships are built with other donors, UN, community networks		Yes

Vietnam: Risk Matrix		
Risk	Level of risk	Mitigation Strategy (<i>who are the partners who could sustain efforts after 2015</i>)
CHP		
Capacity building for self-help groups	M	VNPUD, INGO/PAC
Scale-up of PWUD network (to ensure legal rights and funding)	H	International Organisations
Advocacy and library of documentation (best practices)	L	CHP
Income generation of SHG	M	SHG should continue to support each other
CPMU		
Basic package: outreach, PE, VCT, NSO, CUP, STI's and MMT	L	National target program, existing health system Harmonises cost norms
Comprehensive Package	L	National target program (Gov)
Referral	L	Existing health system
Hepatitis Vaccination	H	Needs to be advocated
HR in closed setting <i>Detention centre and prison</i>		
1. IEC and BCC	L	MPS
2. Counselling (HIV, DU, Legal)	L	MPS
3. Preventative commodities (condoms/ razors)	H	Family
4. OI and STI	M	MPS (limited ability)
5. MMT	L	MPS/MPH (government priority)
06 Centre 'Renovation plan'	?	Support through international agencies, MOLISA and MoH
Social Support for PUD (micro-credit scheme)	M	Government and MOLISA
Capacity building activities	L	Government agencies: MoH, MOLISA and MPS (international agencies when required)
M&E	M	National target program by government
Vietnam: Sustainability Checklist		
1. Continued funding for hard reduction		Feasible
2. Ensuring that interventions are cost effective and taken on by government		Feasible
3. Ensure that all programs are evidence based		Feasible
4. Engagement of people who inject drugs at all levels		Feasible
5. Ensuring that there are policies, laws and relevant tools that support harm reductions in every country		Yes
6. Strategic partnerships are built with other donors, UN, community networks		Feasible

In Closing

To close the 7th annual HCCF representatives from key groups were invited to offer final remarks. Country comments are as follows:

Vietnam extended a thank-you to organisers, hosts and all participants. They noted a sense of good achievement and acknowledged the good discussion generated around challenges in each country. Vietnam noted the improvements from the previous HCCF and highlighted the value of the study visit and focus session on M&E.

Laos extended a thank-you to organisers, hosts and all participants. They noted the value of the varied meetings/presentations and the field visit. They noted the relatively new program in Laos and the difficulties of establishing government support for a young initiative; particularly when simultaneously raising institutional concern. They flagged the need for continued support from other partner countries. There was a sense of the need to implement many things activities with little time and facing the difficulty of achieving coverage. Laos noted an appreciation for the cross border work with Vietnam and ask for continued support for these activities.

Cambodia extended a thank-you to organisers, hosts and all participants. They acknowledged the value of the discussions and the study tour; in particular the final discussion around the exit strategy. Cambodia noted the sensitivities around the drug laws and the challenges they will face pushing for reform. They will consider looking to other countries to learn and will utilise the checklist to measure progress and achievement. Whilst there is understanding that HAARP will finish in 2015 Cambodia would like to see a new mechanism in its place to support HR activities.

Dr Diamond, HAARP regional program manager, officially closed the forum. He thanked participants for the open discussion and frank conversation and noted the opportunity the forum had presented for PUD involvement at a high level. The HCCF was designed to share successes and challenges experienced by all partners. In 2013 its aim over the 3 days was to allow time for directed reflection, time for observation, learning and discussion and to introduce work happening across the region (DU networks, IDPC mapping, M&E PSI). Dr Diamond summarised key discussions; including those around the importance of strengthening M&E, integrating naloxone into country programs; and re-emphasised the importance of developing exit strategies to the close of HAARP in 2015. He noted the importance of communicating the programs achievements and in the process of the exit of HAARP the need for establishing a legacy that will encourage further investment by host governments.

Appendix A: HCCF Agenda

Day 1: Tuesday 14 May Time	Agenda	Speakers
8:30 – 9:00	Registration	
9:00 - 9:15	AusAID Welcome	Emma Tiaree, Counsellor Mekong and Regional AusAID
9:15- 9:30	Vietnamese Welcome	Assoc. Prof. Nguyen Thanh Long, Deputy Minister, MoH Vietnam
9:30-9:45	Regional Update	Dr. Peter Diamond, Regional Program Manager HAARP
9:45-10:15	Harm Reduction interventions in Ho Chi Minh City	Dr. Tieu Thi Thu Van, Director of Standing Office, HCMC Provincial AIDS Committee
10.30	Tea Break	
11am	Regional HIV/AIDS Update UNODC Country Presentations <ul style="list-style-type: none"> • Cambodia • Laos • Vietnam 	Anna Bergenstrom HAARP Program Manager LCDC/CHAS HAARP Director Vietnam
12.30-1.30	LUNCH	
	<ul style="list-style-type: none"> • Yundi • IDPC • ANPUD 	Yundi Representative Gloria Lai Bijay Pandey
3pm	Tea Break	
3.30	Nothing About Us, Without Us <ul style="list-style-type: none"> • Short presentation on this key principle of HAARP • Group discussion on how we can improve the involvement of people who use drugs in all levels of programing • Feedback - plenary 	Palani Narayanan and Lissa Giurissevich
5pm	CLOSE	
7:00pm	Dinner pick up at hotel lobby	
Day 2: Wed 15 th May Time	Agenda	Speakers
8am	Briefing for Site Visit (Hotel)	Palani HCMC PAC
8.30	Leave for Site Visits <ul style="list-style-type: none"> • MMT & ART • Mobile services (VCT &PHC) • Outreach and NSP 	

12.00	LUNCH	
2pm-3pm	Group discussion from study visit	Leader of each group
3pm-5pm	Debriefing of Site Visit Question and answer	Representative from each group. Palani Narayanan and Peter Diamond HCMC PAC (Dr. Van) VAAC (Dr. Manh)

Day 3: Thurs 16th May Time	Agenda	Speakers and facilitators
9am	M&E <ul style="list-style-type: none"> What is the role of PSI/Vietnam in HAARP? This is not an evaluation of HAARP but an M&E support system for country programs and the regional office What are the steps to take in the near future and till the end of HAARP (timeline discussion) What countries can expect Q&A: What are your biggest M&E needs and requirements? 	PSI Vietnam Josselyn Neukom Garry Mundy Bui Van Truong
10.30	Tea Break	
11am	Improving the access and use of Naloxone in HAARP program	Palani Narayanan Dr. Duo Lin Yunnan Yundi
12.30	LUNCH	
1.30	Exit Strategy – Presentation & Group work	Palani Narayanan
3pm	Tea Break	
3.30pm	Exit Strategy – country presentation	Peter Diamond
5pm	Closing remarks	Peter Diamond

Appendix B: List of Participants

N o.	Name	Position	Organisation	Country
1	Gen. Phorn Boramy	Director – Law Enforcement	National Authority for Combating Drugs (NACD)	Cambodia
2	Gen. Thong Sokunthea	Director - International Cooperation Dept. (HAARP Focal Person)	National Authority for Combating Drugs (NACD)	
3	Gen. Neak Yuthea	Director - Legislation, Education and Rehabilitation Dept	National Authority for Combating Drugs (NACD)	Cambodia
4	Dr Chhit Sophal	Head – Centre Mental Health and Drug Dependence (HCMHDD)	Ministry of Health	Cambodia
5	Dr Sin Eap	NSP Program Manager	Mental Health Program	Cambodia
6	Dr Hy Someth	Chief – Aids Office	Ministry of Interior	Cambodia
7	Mr So Kimhai	Manager – Drop in centre	KHANA	Cambodia
8	Mr Man Phally	Program Coordinator	Mith Samlanh	Cambodia
9	Ms Nith Sopha	Program Manager	Family Health Int (FHI)	Cambodia
10	Ms Eng Dany	National Aids technical officer	World Health Org (WHO)	Cambodia
11	Dr Lan Van Seng	Deputy Director	NCHADS	Cambodia
12	Mr Taing Phoeuk	Executive Director	Korsang	Cambodia
13	Dr Premprey Suos	Snr Program Manager	AusAID	Cambodia
14	Mr Zhenquan Jiao	Deputy Director - Division of Aids prevention and Management	Bureau of disease prevention and control, National Health and Family Planning Commission	China
15	Ms Meng Shao	Project Officer - Division of European, American and Oceania Affairs	Department of International Cooperation, National Health and Family Planning Commission	China
16	Mr Jiangping Sun	Deputy Director	National Centre for AIDS/STD Control and Prevention	China
17	Ms Taona Kuo	A/Country Director	UNAIDS China	China
18	Ms Linna Cai	Senior Policy Officer	AusAID Beijing	China
19	Ms Kate Graham	Policy Program Manager	AusAID North Asia Bilateral Programs and Donor Partnerships Section	Canberra
20	Dr Duo Lin	Program Manager	HAARP Yunnan	China
21	Mr Zhi Luo	Manager	Yundi Harm Reduction Network	China
22	Ms Fuluan Zhang	Vice Governor	Longchuan County	China
23	Mr. Vatthana Souvannachack	Head – Drug Demand Reduction	Lao Centre Drug Control (LCDC)	Laos
24	Dr. Vannareth Thammavongsa	Head - Drug Treatment Rehabilitation Division	Ministry of Health	Laos
25	Dr. Phouthone Southalack	Deputy Director	CHAS	Laos
26	Dr. Keophouvanh Douangphachanh	Head - monitoring and Evaluation	CHAS	Laos
27	Mr. Nok Boutnouachareun	Technical staff	LCDC	Laos
28	Mr. Soulivanh Phengxay	National Programme Officer – HAARP focal	UNODC	Laos
29	Ms Irene Lorete	Technical Advisor	HAARP – AusAID	Laos
30	Ms Chiara Frattini	Program Manager	HAARP – AusAID	Laos
31	Mr. Khinnalet Bounthavy	Provincial Coordinator	UNODC	Laos
32	Mr. Chongkeu	Peer Educator	HAARP – AusAID	Laos
33	Mr. Siphaxay Saiphoungeune	Peer Educator	HAARP – AusAID	Laos
34	Mr. Chafang	Peer Educator	HAARP – AusAID	Laos
35	Ms Khanphoungeune Volat	Project Assistant	UNODC	Laos

36	Ms Amber Cernovs	First Secretary – Health	AusAID	Myanmar
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38	Mr U Kyaw Thu	Chair Person	National Drug User Network	Myanmar
39	Pol Major Nay Win	Leader	Central Committee on Drug Abuse Control (CCDAC)	Myanmar
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41	Mr Eamonn Murphy	Country Coordinator	UNAIDS	Myanmar
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48	Dr Vu Duc Long	Coordinator	Ministry of Health -HAARP	Vietnam
49	Mr Hoang Anh Tuyen	Vice Director	Ministry of Public Security of Vietnam Standing Office on Drug Control (SODC) – MPS	Vietnam
50	Mr Phan Xuan Son	Vice Director	SODC MPS	Vietnam
51	Mrs. Le Thi Ha	Vice Director	DSEP – MOLISA	Vietnam
52	Dr. Le Van Khanh	Head of 06 Policy division	DSEP - MOLISA	Vietnam
53	Dr Luc Van Truong	Vice Director	PAC Bac Kan	Vietnam
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59	Mr. Ha Thanh Giang	Self Help Group Leader	IFF	Vietnam
60	Ms Pham Thi Minh	Chairperson	Vietnam Network of People who Use Drugs (VNPUD)	Vietnam
61	Nguyen Thi Huynh	National Coordinator	HAARP Vietnam	Vietnam
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69	Mr Bijay Pandey	Chair	Asian Network of People who Use Drugs (ANPUD)	Nepal
70	Mr Sam Nugraha	Board Member	Asian Network of People who Use Drugs (ANPUD)	Indonesia