



# Costs Associated with Implementing an Opioid Substitution Therapy Program for IDUs in Viet Nam

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# Contents

**Executive Summary .....iii**

**Abbreviations ..... v**

**Introduction..... 1**

    Viet Nam’s IDU population and HIV epidemic ..... 1

    Establishment of the methadone substitution program ..... 1

    Institutions involved in the establishment and implementation of the methadone substitution program ..... 2

    IDUs reached by the methadone substitution program..... 3

**Costs in Implementing a Methadone Substitution Program for IDUs..... 3**

    Capital/establishment costs ..... 4

    Direct costs ..... 5

    Indirect costs ..... 5

    Other transaction/hidden costs ..... 6

**Challenges in Implementing a Methadone Substitution Program ..... 6**

**Recommendations for Countries Planning a Methadone Substitution Program ..... 7**

**Appendix. Organizational Chart of the Methadone Pilot Program 2007–2008 ..... 8**

**References..... 9**

## Executive Summary

In many Asian countries, injecting drug use is the main driver of HIV epidemics. HIV prevalence rates of 20 percent to as high as 60 percent among injecting drug users (IDUs) have been recorded in many Asian countries, with the epidemic growing at an alarming high rate in Indonesia and Viet Nam (UNAIDS and WHO, 2007). Even in countries where the overall prevalence rate has been lowered, the rate among IDUs continues to rise. For example, in Thailand, despite an overall decline in new HIV cases, prevalence among IDUs has remained high over the last 15 years, ranging from 30–50 percent. In Indonesia and Viet Nam, the majority of new HIV cases are estimated to occur as a result of contaminated injection equipment and sexual transmission among most-at-risk populations. In 2005, more than 40 percent of IDUs in Jakarta tested HIV positive (UNAIDS and WHO, 2007). One effective intervention to reduce high-risk behavior among IDUs, such as sharing contaminated needles, is to reduce their drug dependency by providing opioid substitution therapy (OST).

Clinical studies have consistently shown that OST—for example, as part of methadone maintenance treatment programs—can reduce opioid and other illicit drug use, risk of HIV and Hepatitis C (HVC) exposure, risk of overdose, and criminal activity; and also lead to improved physical and psychological health and social functioning. Although the problem of HIV transmission among IDUs is well documented, access to OST for HIV-positive IDUs is limited in Asia. The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) recognizes the importance of targeted interventions to achieve significant reductions in HIV incidence and HIV infection risk among both most-at-risk populations and the general population. Comprehensive palliative care—encompassing care provided from the time HIV is diagnosed and through the continuum of HIV infection—is essential to the health and well-being of people living with HIV and is an integral part of PEPFAR.

In many Southeast Asian countries, the establishment of OST is still in its nascent stage. To inform countries that are planning to introduce substitution therapy, Task Order 1 of the USAID | Health Policy Initiative supported ASEAN in conducting an analysis to estimate the costs of establishing and implementing an OST program. While the analysis summarized in this paper focuses on Viet Nam, the process and information can be applied by other countries to estimate the costs within their own countries.

In 2006, Viet Nam’s National Assembly approved the Law on HIV/AIDS Prevention Control, which endorsed harm-reduction activities for the prevention of HIV transmission, including the treatment of drug addiction by using opioid substitutes. A methadone pilot program was then initiated, and the Ministry of Health (MOH) assigned the Viet Nam Administration for AIDS Control to manage and implement the program.

To analyze the costs of implementing the pilot program in Viet Nam, information and data were collected from November 2007–January 2008. The costs of each program component were estimated for five of the six methadone sites<sup>1</sup> in two cities, Hai Phong and Ho Chi Minh City. Direct and indirect costs were estimated; and based on the estimated number of patients that could be reached by the program in the five sites (1,250 total), the estimated cost per patient/day was calculated. Potential transaction costs were also identified; though, they were not quantified due to time limitations in conducting the analysis. The total estimated cost for the two-year methadone pilot program for the five sites is US\$580,704; and the estimated unit cost per patient/day of treatment is a little more than US\$1.00, with some variation due to different labor costs in the site locations. Direct costs account for 57 percent of the total program costs, with labor constituting 66 percent of this category. Drug costs account for 13 percent of the total unit cost

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<sup>1</sup> Costs were estimated for the five sites funded by the U.S. government (USG). The sixth site is funded by the World Bank.

per patient/day of treatment. According to medical regulations, the methadone daily dose for an average Vietnamese patient is 40mg for 4ml of methadone syrup. The methadone cost for treatment per patient/year is US\$48.18. According to MOH regulations, the required tests for methadone treatment include the CBC, AST/ALT, HBsAg, HCV, HIV, and urine tests. It is estimated that, on average, it would cost US\$22.20 per year to cover the necessary tests and consumables required for one patient. Note that transaction costs have already been incurred, as the program has been hiring staff and procuring space. However, program implementation has not started because of caution surrounding the perceived security risk that methadone patients would pose. The security measures required by law add implementation costs to the overall program. Furthermore, bureaucracy in obtaining approval to import the drugs can add delays of weeks and could cause stockouts.

The methadone pilot program has a duration of only two years; the MOH acknowledged the necessity to sustain the methadone program for a longer term—at least for the patients in most need. This study gives an initial cost estimate of the program, so additional data should be collected as the program continues to capture any further or unexpected costs.

## Abbreviations

AIDS	acquired immune deficiency syndrome
ASEAN	Association of Southeast Asian Nations
AST/ALT	aspartate aminotransferase test/alanine aminotransferase
AWP II	ASEAN Work Programme on HIV/AIDS II
AWP III	ASEAN Work Programme on HIV and AIDS III
CBC	complete blood count
CDC	Centers for Disease Control
DFID	Department for International Development (United Kingdom)
DOH	Department of Health (provincial level)
DOLISA	Department of Labour, Invalids, and Social Affairs (provincial level)
DPS	Department of Public Security (provincial level)
FHI	Family Health International
GDSEP	General Department of Social Evils Prevention
HCMC	Ho Chi Minh City
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IBBS	Integrated Biological and Behavioral Surveillance
IDU	injecting drug user
MOH	Ministry of Health
MOLISA	Ministry of Labor, Invalids, and Social Affairs
MMT	methadone maintenance treatment
MPS	Ministry of Public Security
MSH	Management Sciences for Health
OST	opioid substitution therapy
PAC	Provincial AIDS Committee
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
USAID	United States Agency for International Development
USG	United States Government
VAAC	Viet Nam Administration for AIDS Control
WB	World Bank
WHO	World Health Organization

## **Introduction**

Through the ASEAN-USAID collaboration under the ASEAN Work Program for HIV/AIDS II (AWP II), the association took several steps to address the need for prevention, treatment, and care services for injecting drug users (IDUs). An advanced training curriculum on HIV prevention, treatment, and care for IDUs was developed—the first in Asia covering treatment and care for HIV-positive IDUs—and a pilot training workshop was held in August 2006. Also through the collaboration, ASEAN took key steps toward joint negotiations and the bulk purchasing of antiretroviral and opportunistic infection drugs, as well as HIV diagnostic reagents.

Subsequently, through the ASEAN-USAID collaboration under the ASEAN Work Programme for HIV and AIDS III (AWP III), Task Order 1 of the USAID | Health Policy Initiative supported ASEAN in conducting an analysis to estimate the costs of establishing and implementing an opioid substitution therapy (OST) program. The analysis, presented in this paper, focused on the experience of Viet Nam and estimated the costs of each component of the country's methadone pilot program in two sites, Hai Phong and Ho Chi Minh City (HCMC). Information and data were collected from November 2007–January 2008 by interviewing the key people involved in the Pilot of Methadone Use for Treatment of Opiate Addiction program, which the Ministry of Health (MOH) approved in December 2007 (see the Appendix for the pilot program organizational chart).

The framework and methodology used in the analysis identified the detailed costs and steps required to establish and implement an OST program. The methodology incorporated an “ingredients approach,” whereby all the program components are listed and their contribution to the overall total cost is then quantified. The ingredients approach allows one to assess whether the costs can be generalized. With this information, other ASEAN Member States can better estimate the costs of providing an OST program within their own countries.

### **Viet Nam's IDU population and HIV epidemic**

The number of IDUs is growing rapidly in Viet Nam. According to the General Department of Social Evils Prevention (GDSEP) under the Ministry of Labor, Invalids, and Social Affairs (MOLISA), as of the end of 2007, the authorities have files on 170,000 drug use recidivists—an increase of 6 percent from 2006 and 1.8 times the number in 2000 (GDSEP, 2008). The total number of drug users in the country is much higher than the official record of recidivists. The cities and provinces with the largest IDU populations are HCMC, Hanoi, Hai Phong, Thai Nguyen, Son La, and Dien Bien (GDSEP, 2006).

Injecting drug use remains the major mode of HIV transmission in Viet Nam. The Integrated Biological and Behavioral Surveillance (IBBS) for 2005–2006 found that HIV prevalence was very high among IDUs in Hai Phong (65.8%) and Quang Ninh (58.7%) and high—from 24 to 36.6 percent—in other major urban provinces, such as Hanoi and Can Tho (MOH, 2006). In HCMC, where the majority of IDUs were in rehabilitation (06) centers for years, the sentinel surveillance in these centers found that HIV prevalence was as high as 60 percent, compared with a rate of 34 percent the IBBS found among the IDU population in the community (MOH, 2006). The national HIV prevalence rate among IDUs was estimated at about 34 percent in 2006 (United Nations/Viet Nam, 2006). The IBBS results also showed that HIV was quickly spreading among young and new IDUs.

### **Establishment of the methadone substitution program**

The MOH supports methadone as a drug substitute, as an intervention for HIV prevention—albeit with a highly cautious attitude. Given that Vietnamese laws view both the sale and consumption of addictive substances as offenses and subject to punishment (unless accompanied with a specific medical permit from

the relevant authority), this attitude is understandable. From 1997–2002, the National Mental Health Institute was permitted to carry out a small methadone pilot activity for the treatment of opiate addiction, with the funding from the National Program for Fighting and Prevention of Drug Injection (Program 06). Although the pilot only treated 68 patients, in 2005, an inter-ministerial specialist council, in reviewing the pilot results, recognized the positive impact of methadone use in reducing drug injecting behavior.

In 2006, the National Assembly approved the Law on HIV/AIDS Prevention and Control, which endorsed harm-reduction activities for the prevention of HIV transmission, including the treatment of drug addiction by using methadone as a drug substitute. The law, however, did not specify the terms and conditions for organizations and individuals to use drug substitutes. One year later, in June 2007, Decree of the Government No.108 promulgated the necessary terms and conditions, specifying which health facilities are allowed to implement methadone substitution treatment methods and the procedures for monitoring and managing the use of drug substitutes.

With the initiative and support from the donor community [e.g., the World Health Organization, USAID, the World Bank (WB), and the United Kingdom Department for International Development (DFID)], preparation for a larger methadone pilot program began in 2006. A technical group was formed to assist the MOH with drafting regulations on methadone use and producing the methadone program document. A series of workshops, training courses, and discussions were conducted among the Vietnamese and international specialists and MOH staff in charge. USAID assisted the Viet Nam Administration for AIDS Control (VAAC) with preparing the methadone program document, which was approved by the Vice-Minister of Health in December 2007 after several months of consideration. The Pilot of Methadone Use for Treatment of Opiate Addiction is currently a two-year program, effective 2007–2008, and is the only existing substitution treatment option available to use methadone-assisted substitution therapy for IDUs in Vietnam wishing to stop their drug use.

### **Institutions involved in the establishment and implementation of the methadone substitution program**

The organization of the methadone pilot program is complicated, with four levels of government administration involved: central, provincial, district, and rural commune/urban ward (see the Appendix for the pilot program organizational chart). The MOH assigned the VAAC to manage and implement the program. At the central level, the VAAC coordinates with other MOH departments—including the Department of Therapy, the Department of Pharmaceutical Management, and the Health Inspectorate—and also the Mental Health Institute of Bach Mai Hospital and donors to ensure the disbursement of funds, the import and delivery of drugs, and the proper operation of methadone sites. The VAAC receives support from the relevant departments of MOLISA and the Ministry of Public Security (MPS). To ensure coordination with the other line ministries and the international donor community, a technical assistance group was formed, including representatives of all major stakeholder groups.

At the provincial level, the Provincial AIDS Committee (PAC) is responsible for monitoring and supervising the overall operation of the methadone sites in the province and reports to the VAAC. The committee is chaired by the Vice-Chairman of the City People's Committee and includes representatives of the provincial-level Department of Health (DOH); provincial-level Department of Labor, Invalids and Social Affairs (DOLISA); provincial-level Department of Public Security (DPS), and other relevant organizations.

A Selection Commission, chaired by the manager of the methadone clinic, reviews and selects patient candidates. Other members of the committee include, the treatment medical doctor, a representative from the public security sector, a medical doctor, a representative from DOLISA, a representative from the PPSC, and counselors. The methadone site reports to the provincial HIV/AIDS center and to ensure proper

operation, it works closely with the local authorities (district and ward people’s committees), the police, the local 05/06 centers, and other health facilities and relevant organizations involved in preventing injecting drug use (such as mass organizations and community groups).

Four donors provide funds to the methadone pilot program. USAID—with US\$455,437 from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR)—is the main donor, supporting the operation of five out of the six methadone sites. The U.S. Centers for Disease Control (CDC) is responsible for program implementation in two sites in HCMC, and FHI is responsible for two sites in Hai Phong and one in HCMC. In addition, Management Sciences for Health (MSH) is assisting with the importation of methadone through the project Supply Chain Management System.<sup>2</sup>

The WB has committed US\$65,267 to cover operations of one methadone site in Hai Phong. DFID and the Norway Embassy, through the Project Prevention of HIV/AIDS Transmission in Viet Nam, have committed US\$60,000 together to support management and monitoring activities at the central level.

### **IDUs reached by the methadone substitution program**

It is expected that the pilot program will reach 1,500 IDUs in two cities, Hai Phong and HCMC. Each methadone site will have capacity to provide a full service package to 250 IDUs.

## **Costs to Implement a Methadone Substitution Program for IDUs**

Table 1 summarizes the estimated total and unit costs of the two-year methadone pilot program for five of the six sites. Data were collected from all the USG program implementers, as preparation for the pilot has already commenced. The total estimated cost for the two-year methadone program for the five sites is US\$580,704, and the estimated unit cost for treatment per patient/day is a little more than US\$1.00. In the most expensive city, HCMC, the unit cost of treatment per patient/day is slightly higher at US\$1.07. Note that the estimates do not account for additional transaction costs and program delays that could increase the recurrent costs.

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<sup>2</sup> MSH is expected to cooperate with the Vietnamese Central Pharmaceutical Company No. 1 to import methadone for the program. However, for an unknown management reason, the MOH has not yet approved the company selection.

**Table I. Estimated Cost of the Methadone Pilot 2007–2008**

	Total Program Estimates for 5 Sites in HCMC and Hai Phong		CDC Estimates for 2 Sites in HCMC	
	Total Cost (US\$)	Unit Cost, Per Patient/Day (US\$)	Total Cost (US\$)	Unit Cost, Per Patient/Day (US\$)
<b>Capital/establishment costs</b>	<b>181,300</b>	<b>0.32</b>	<b>71,491</b>	<b>0.37</b>
House renovation	30,000	0.05	27,957	0.14
Equipment	79,000	0.14	20,534	0.11
Training	69,000	0.12	23,000	0.12
Other establishment items	3,300	0.01	-	-
<b>Recurrent costs</b>	<b>399,404</b>	<b>0.69</b>	<b>136,146</b>	<b>0.70</b>
<b><i>Direct</i></b>	<b><i>330,054</i></b>	<b><i>0.57</i></b>	<b><i>112,930</i></b>	<b><i>0.58</i></b>
Personnel	218,400	0.38	70,560	0.36
Drugs and consumables	111,654	0.19	42,370	0.22
<i>of which methadone daily dose</i>		<i>0.13</i>		<i>0.13</i>
<b><i>Indirect</i></b>	<b><i>69,350</i></b>	<b><i>0.12</i></b>	<b><i>23,216</i></b>	<b><i>0.12</i></b>
Central and provincial management	50,000	0.09	8,296	0.04
Site operation and maintenance	11,700	0.02	14,920	0.08
Drug import and distribution	7,650	0.01	-	-
<b>Total costs</b>	<b>580,704</b>	<b>1.01</b>	<b>207,637</b>	<b>1.07</b>

Sources: USAID and CDC (implementers of the program in five sites).

### **Capital/establishment costs**

The estimated capital costs for establishing the methadone sites include house renovations; equipment purchases; and other one-time only costs, such as introductory training for staff at all levels on methadone use and management and a field trip to survey and select the sites for setting up the methadone provision site. According to policy, buildings and equipment must be depreciated over a conventionally fixed period or until they are no longer usable. In this case, however, rough financial estimates are used, and it is unknown whether the program period will be extended (from the two years). Therefore, the capital expenditures are considered one-time establishment costs, which are then allocated to each patient-day to get the establishment cost per patient-day. Capital or establishment costs constitute 31 percent of the total program costs (and 34% based on CDC's estimates for two sites in HCMC).

Due to the limited time and scope for the data collection, some establishment costs were omitted—related to the one-year preparation process for making the program possible and the land and house needed for the sites. The costs include the salaries of the technical experts and staff (e.g., of USAID, WHO, DFID, WB, FHI, CDC, MSH, VAAC, and MOH) working on the methadone program; training and workshop expenses; office supplies; and travel expenses. With all the methadone sites situated at the city's center, the costs of

the land and house might be significant. Note that according to MOH regulations, the area of a methadone site must be at a minimum 100 square meters.

## Direct costs

Table 2 summarizes the direct costs estimated for a patient-day and a patient-year.

**Table 2. Program’s Estimates of Direct Costs**

<b>Items</b>	<b>Total Cost, Per Patient/Day (US\$)</b>	<b>Unit Cost, Per Patient/Year (US\$)</b>
Personnel	0.38	137.66
Methadone	0.13	48.18
Tests and other consumables	0.06	22.20
<b>Total direct costs</b>	<b>0.57</b>	<b>208.03</b>

The estimated direct costs—including for personnel and drugs, tests, and consumables—account for 57 percent of the total program costs. According to MOH regulations, each methadone site must have at least 11–13 staff, including two doctors, two or three nurses or consultants, two pharmacists, two administrators, and three or four guards (who provide services for 24 hours per day). This personnel requirement results in significant labor costs, constituting 66 percent of the total direct costs. The labor costs for one year of service per patient are US\$137.66.

The methadone program covers all costs for drugs, tests, and other consumables required for the treatment. According to medical regulations, the methadone daily dose for an average Vietnamese patient is 40mg or 4 ml of methadone syrup. This daily dose costs US\$0.13 or 13 percent of the total program cost per patient/day. The methadone costs for one year of treatment per patient is US\$48.18.

According to MOH regulations, the required tests for methadone treatment include the CBC, AST/ALT, HBsAg, HCV, HIV, and urine tests. In addition, patients with TB might need mantoux (IDR), a chest X-ray, and other tests. It is estimated that, on average, it would cost US\$22.20 per year to cover the necessary tests and consumables required for one patient.

## Indirect costs

The estimated indirect costs include central and provincial management costs, site operation and maintenance costs, and drug import and distribution costs. The central and provincial management costs cover operation of the central and provincial steering committees (mainly conferences and meetings) and monitoring and evaluation expenses. The central and provincial management costs constitute 8.6 percent of the total program costs.

The site operation and maintenance costs cover accounting, electricity and water, telephone and internet, travel expenses of the site staff, office supplies, patient files and records, photocopying, and miscellaneous items. Site operation and maintenance costs account for only 2 percent of the total program costs; however, the CDC’s estimate shows that these costs could be higher at up to 7 percent of the total program costs.

The drug import and distribution costs, at only 1 percent of the total program costs, are minor expenses compared with other cost items.

## **Other transaction/hidden costs**

Anecdotal reports reveal hidden transaction costs, resulting from delays in procurement, quotas on the importation of methadone, and other factors that might not be quantifiable but prohibit effective implementation of the program.

## **Challenges in Implementing a Methadone Substitution Program**

In Viet Nam, methadone has a limited scope of use. Decree No.108 only allows the use of methadone as a drug substitute in health facilities (under MOH management) and prohibits its use in drug rehabilitation centers (under MOLISA management). As the majority of drug use recidivists in most need of methadone treatment are in 06 centers, the number of IDUs who could most benefit from the methadone program is reduced.

A lot of reluctance and doubt about OST remains among the decisionmakers and program implementers. Some consider methadone use as “replacing one addictive substance with another addictive substance.” Others are concerned about security because methadone sites are perceived as centers for IDUs—many of whom have previous convictions or police records. Sixty percent of filed IDUs have previous convictions or offenses (MOLISA, 2007). The reluctance of decisionmakers was the main factor in the delay of the program’s approval from approximately October to mid-December 2007, and it continues to hinder program implementation. The delays, in turn, have raised the costs for all the stakeholders involved. While waiting for the approval, stakeholders—such as USAID, FHI, and CDC—continued paying salaries for their full-time staff in charge of the program. Houses reserved for the methadone sites were left unused.

Bureaucracy also hinders program implementation and raises costs. According to the MSH representative, for each importation of methadone, a lengthy series of steps must be repeated and permits must be signed. For example, each time the VAAC writes a drug importation request, other departments of the MOH must review it—the Department of Pharmaceutical Management approves the quota for the drug and suitability of the distributor; the Department of Therapy ensures that the drugs conform with treatment regulations; and the Department of Planning and Finance confirms that the overall donation fits within the agreed quota and budgets and also validates the quantities against the supplier’s invoice. The lack of coordination among the various MOH departments can result in long delays.

The planned treatment date for the program was delayed from January 2008 to April 2008 because the methadone would not arrive in time. One reason is that the MOH had not appointed a domestic pharmaceutical company to be the importer of the program. In November 2007, the Vietnamese Central Pharmaceutical Company No.1 was identified; however, the MOH has yet to give its approval. Given that it takes 12.5 weeks for the methadone to go through the importation process and arrive at the site warehouse, the drug is unlikely to be available even by April 2008. The delay from January to April is already costing at least three months of house rent, depreciation of the equipment purchased, salaries of the recruited staff, and other overheads. Moreover, the patients are not receiving treatment.

The trend toward moving methadone sites into separate facilities might also raise costs (this is part of the overall trend to “verticalize” HIV/AIDS-related services and move them to a separate HIV/AIDS center). The costs could include establishment costs (for new land and housing, furniture, and equipment) and salary costs for additional medical staff and guards. Separation of the methadone sites might also increase stigma toward the patients.

Finally, some methadone experts (e.g., Dr. Tuan from the Mental Health Institute and Dr. Jacka from WHO) view the type of methadone facility established by Viet Nam as too labor intensive and expensive—for example, viewing the 11–13 full-time staff for one methadone site as superfluous. In addition, they believe that having two part-time doctors instead of one full-time doctor would create greater flexibility. With fast-growing labor costs in Viet Nam, it is likely that the labor unit cost of methadone treatment will increase, threatening the program’s sustainability. Also, note that there is some debate about salary norms. USAID’s policy is to set equal salaries for its program staff across the sites. However, in HCMC, the cost of living is much higher; and therefore, requests are being made for higher salaries than those paid in Hai Phong. The dispute could reduce staff motivation in either city and, in turn, reduce labor productivity.

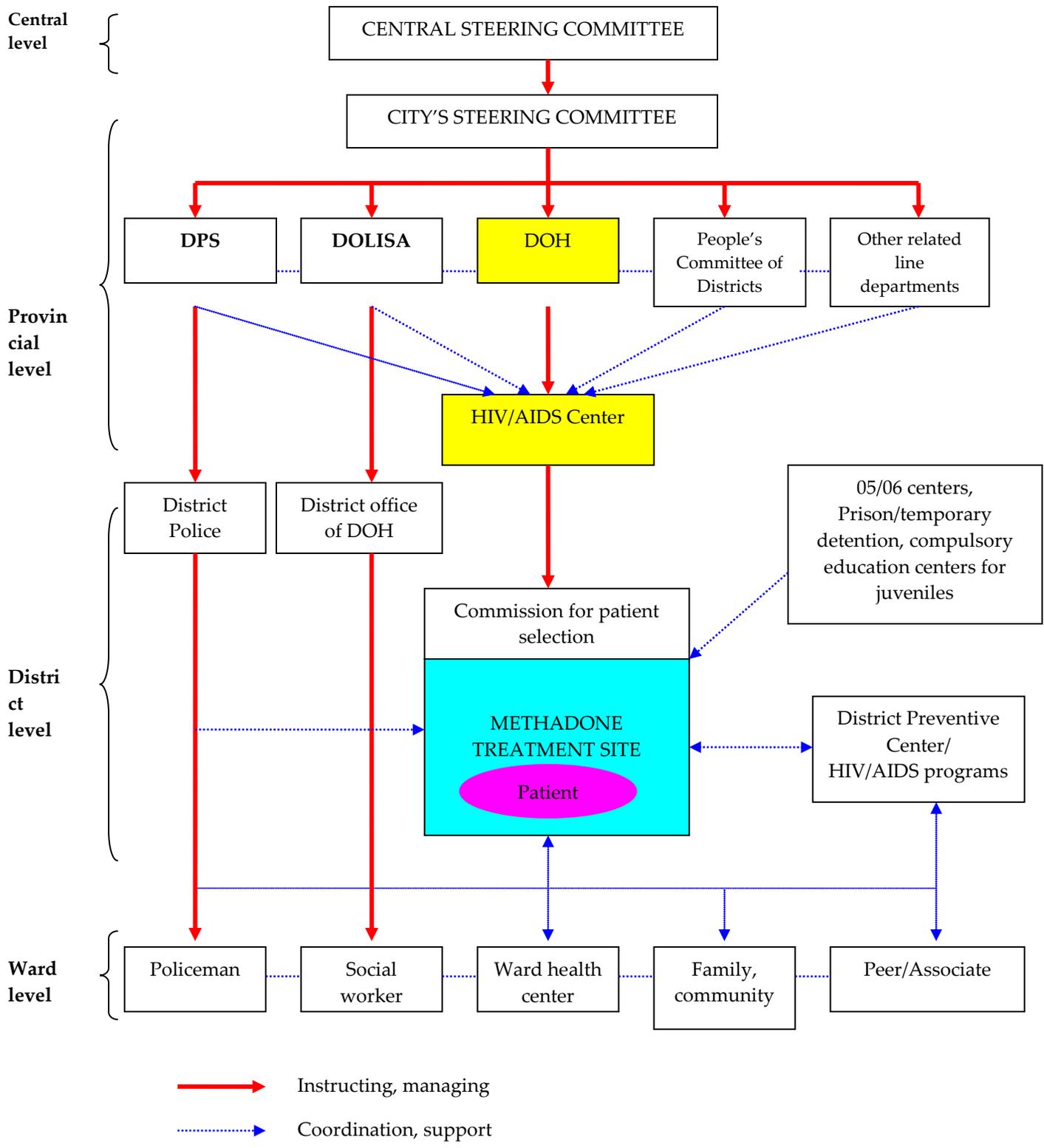
The methadone pilot program has a short duration of only two years; the MOH acknowledged the necessity to sustain the methadone program for a longer term—at least for the patients in most need (MOH, 2007). The call for the additional resources has been made, and several donors have reportedly expressed their support; however, additional donor support is only a short-term solution.

## **Recommendations for Countries Planning a Methadone Substitution Program**

Implementation of the Vietnamese methadone pilot program is just beginning. Therefore, the analysis conducted did not account for costs that might be incurred at a later stage in the program—such as hidden transaction and unexpected costs and potential scale-up costs. Political will might be the most important internal factor influencing the variation in program costs. Thus, continued financial tracking linked to program outcomes is recommended to determine the actual total cost of implementation.

This paper does not address financing and sustainability. In a country like Viet Nam, advocacy and legal changes and funding needs will continue long after a methadone substitution program is formally established. Moreover, programs will not provide sustainable results without a long-term approach to drug substitution and treatment for patients. For known medical reasons, some patients may have to use methadone for the rest of their lives; therefore, it is important that the methadone program be sustainable. Delays in treatment could bring more harm than benefit to some of the beneficiaries. Note that for sustainability to be achieved, it must be considered during the planning stage of the program.

# Appendix. Organizational Chart of the Methadone Pilot Program 2007–2008



Source: MOH, 2007.

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