United States Department of State

Washington, D.C. 20520

FY 2015 Vietnam Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Vietnam.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

VIETNAM

Country Operational Plan 2015

Strategic Direction Summary

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Goal Statement

As a focus country in the initial emergency phase of PEPFAR, the U.S. Government (USG) quickly became the largest financer of Vietnam's HIV response, with annual budget allocations increasing from $18M in 2004 to $98M in 2010. Historically, PEPFAR has purchased the majority of HIV commodities, including anti-retroviral (ARV) drugs and methadone; scaled up facility-based care and support, including human resource investments; provided technical support in policy, planning, implementation and evaluation; and built the capacity of civil society organizations (CSOs) and the private sector to provide HIV services and commodities outside of state institutions. In so doing, PEPFAR helped forge a bilateral partnership between the United States and Vietnam that has contributed to nearly 100,000 people on anti-retroviral treatment (ART) and more than 30,000 people on methadone maintenance treatment (MMT).

However, rapid scale up of external support may have deterred establishment of domestic financing and supply chain mechanisms to meet Vietnam's ambitious long-term HIV targets, which were recently elevated when Vietnam became the first country in Southeast Asia to adopt the "90-90-90" targets. To address this, and to better align global budgets with global needs, the Office of the U.S. Global AIDS Coordinator has set a funding trajectory that will continue to decrease PEPFAR Vietnam's (VN) spending allocation yearly from 2011 through 2018. Over the past 5 years, PEPFAR VN has expanded ART programs by 60 percent against a funding decline of 42 percent by refining support and focusing on key core activities. However, this combination of HIV/AIDS program expansion and reduced spending cannot continue unencumbered without threatening support to patients, core activities, or both. Global Fund has reduced HIV grant funding and is capping ARV drug contributions at 50,000 patients until mid-2017 and will transfer its methadone contribution to the government at the end of 2016. With these reductions, domestic resources are not yet able to guarantee that newly diagnosed clients will able to easily access HIV treatment in every province.

PEPFAR 3.0 PIVOT: Against this background, the "PEPFAR 3.0" approach has renewed focus on sustained epidemic control and improving efficiency through geographic and population prioritization. Adhering to S/GAC's funding trajectory for Vietnam, PEPFAR VN's goal for COP 15 is to demonstrate significant progress toward epidemic control and "90-90-90" targets in 5 "aggressive scale up" provinces – Dien Bien, Son La, Thanh Hoa, Nghe An, and Ho Chi Minh City - which contain high HIV burden and high unmet ART need and where PEPFAR can have the greatest impact, while continuing a transition plan for facilities and activities that are able to be taken over by domestic institutions. Through use of S/GAC-developed analytical innovations and consultations with headquarters, the program is prioritizing case-finding to contribute towards provincial ART targets at 70 of 130 outpatient clinics and ARV dispensing sites, and 65 of 131 HIV testing and counseling (HTC) sites in the 5 aggressive scale up provinces. PEPFAR VN's programmatic focus will remain on key population groups of people who inject drugs (PWID), female sex workers (FSW) and men who have sex with men (MSM) which account for nearly half

of HIV transmission. In addition, the COP 15 strategy plays an expanded role in achieving "90-90-90" goals by: (1) Introducing and institutionalizing enhanced case finding models for the first "90" in the scale-up provinces; supporting (2) Health financing, procurement and supply chain reform; and (3) Expanding viral load monitoring for the third "90".

DETAILED "90-90-90" APPROACH AND TRANSITION PLAN: PEPFAR continues implementation of the 2010 U.S.-Vietnam Partnership Framework on HIV/AIDS under which the U.S. Government's (USG) fundamental role is transitioning to a technical assistance model. It is expected that PEPFAR will phase out direct service delivery (DSD) support to most outpatient clinics, HIV testing and counseling sites and medication-assisted treatment clinics by 2018, including human resource and commodity support. The transition of DSD support is being balanced with targeted USG contributions to aggressive scale up in five select provinces with high unmet need under a MOH/VAAC "90-90-90" demonstration initiative. Key elements of this plan include:

- The First "90": **Outreach and Case Finding Scale-up Contribution**: Dien Bien, Son La, Thanh Hoa, Nghe An, and Ho Chi Minh City Provinces
  - Intensifying outreach and HIV testing toward "90-90-90" targets in the 5 aggressive scale up provinces until at least September 30, 2017;
  - Concluding outreach in 27 sustaining and central support provinces as of January 1, 2016;

- The Second "90": **ART Scale-up Contribution**: Dien Bien, Son La, Thanh Hoa, Nghe An, and Ho Chi Minh City Provinces
  - Contributing to increased ART patient enrollment toward "90-90-90" targets in the five aggressive scale up provinces of Dien Bien, Son La, Nghe An, Thanh Hoa, and Ho Chi Minh City until at least September 30, 2017;
  - Targeting, budgeting and procuring increasing amounts of ARVs for new patients in only the 3 provinces of Dien Bien, Son La and Nghe An until at least September 30, 2017;
  - Capping and maintaining ARV contributions for the existing cohort of patients in Ho Chi Minh City enrolled in PEPFAR-supported facilities from April 1, 2016, until these patients can be supported by domestic ARV drugs (PEPFAR has not previously supported ARV drugs for Thanh Hoa);
  - Coordinating with the national program and Global Fund to cover ARV procurement for all new patients in Thanh Hoa and Ho Chi Minh City provinces from April 1, 2016;

- The Third "90": **Scaling up Viral Load Testing for Routine Clinical Monitoring** with a focus on the five aggressive scale up provinces of Dien Bien, Son La, Nghe An, Thanh Hoa, and Ho Chi Minh City;

- **Sustaining / Central Support Provinces**: An Giang, Bac Giang, Bac Ninh, Ba Ria – Vung Tau, Binh Duong, Binh Thuan*, Can Tho, Cao Bang, Dak Lak, Da Nang*, Hai Duong, Hanoi, Hai Phong, Hoa Binh, Khanh Hoa*, Kien Giang, Lang Son*, Lao Cai, Long An, Nam Dinh, Soc Trang, Thai Binh, Thai Nguyen, Quang Nam*, Quanh Ninh, Tay Ninh, Vinh Long; *(*denotes provinces transitioning before or during COP 15)*
  - Concluding outreach and active case finding but supporting HIV testing and counseling on a "passive" or walk-in basis to PEPFAR-supported facilities;

- Maintaining DSD and technical assistance investments necessary to safeguard and monitor the quality of care at PEPFAR-supported facilities until they can be fully transitioned to domestic institutions;
- Capping and maintaining ARV contributions to the national program for the existing cohort of patients (including Ho Chi Minh City) enrolled in PEPFAR-supported facilities from April 1, 2016, until these patients can be supported by domestic ARV drugs;
- Coordinating with the national program and Global Fund to cover ARV procurement for new patients in the 27 provinces listed above from April 1, 2016;

- Systems Support
  - Supporting health financing and other systems needed to accelerate the financial support transition;
  - Providing technical assistance for systems critical to sustaining the quality of the national HIV program;
  - Strengthening the role of civil society organizations and the private sector to support services and commodities; and
  - Using Mission-wide channels of health diplomacy to advocate domestic resource mobilization.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country profile

There were an estimated 256,818 people living with HIV (PLHIV) in Vietnam as of 2014, with 139,911 cumulative AIDS-related deaths reported (Estimation and Projection Package (EPP), 2013); MOH case reporting from July 2015 estimates 226,964 PLHIV. In recent years, new cases of HIV have declined from a reported 16,000 per year in 2010 to 11,825 in 2014. The epidemic in Vietnam is comprised of many sub-epidemics and remains concentrated among three populations defined by high levels of HIV-transmission risk behaviors: PWID, MSM, and FSWs. The distribution of cases by key population (KP) and ARV coverage rate also varies significantly by region, province, and within provinces, highlighting the need for a geographically tailored response.

Injecting drug use is the primary contributor of HIV transmission in Vietnam. While the national HIV prevalence rate is 0.26 percent for ages 15-49 years, the 2013 estimation and projection based on data from three rounds of the HIV/STI Integrated Behavioral and Biological Survey (IBBS) and national sentinel HIV surveillance shows that up to 21 percent of the estimated 271,506 PWID (range: 158,000-385,000) are living with HIV.

In recent years there has been greater recognition of the HIV epidemic among MSM in Vietnam and numerous studies have highlighted increasing risk behaviors in the MSM community. The estimated MSM population is 382,506 (range 191,000 – 573,000) with EPP estimates of HIV prevalence up to 12 percent in Hanoi and Ho Chi Minh City (HCMC).

There are an estimated 72,000 FSWs (range: 36,000-108,000) in Vietnam. Data from three rounds of IBBS show that HIV prevalence among FSWs varies largely by province and exceeds 10 percent in Hanoi, Hai Phong, Can Tho, and HCMC in 2013. IBBS also indicates that street-based FSWs have a relatively higher HIV burden (7.1 – 31.9 percent) compared to venue-based FSWs (2.4-13.9 percent).

Overlapping risk behaviors amplify HIV transmission risks for FSWs and MSM who also inject drugs, as 2013 IBBS data indicate that the odds of an FSW or MSM infected with HIV are significantly higher who also report injecting drug use behavior. An estimated six to 24 percent of venue-based FSWs also inject drugs. Among FSW who inject drugs, the HIV prevalence is 26-50 percent. According to 2014 HSS data, 30-40 percent of MSM in five southern provinces reported previous or current sex work and 12-17 percent reported injecting drugs.

The sizes and distribution of KPs vary. PWID are concentrated in HCMC, Hanoi, Son La, the Red River Delta and the northwest region; FSWs are highest in big cities including HCMC, Hanoi, Can Tho, Hai Phong, the Mekong Delta and southwestern Vietnam; and self-reported, disclosed MSM are clustered in major cities. The size estimations of PWID and FSWs are based on government reports, program mapping, case reports, population census estimates, and reports on arrests and entertainment venue work. MSM population size in HCMC and Hanoi are two percent of the adult male population, based on the UNAIDs recommendation that MSM account for one to three percent of the adult male population.

Sexual partners of these KPs are an additional at-risk population that requires targeted interventions. Fifty-four percent of HIV-positive women reported that their only HIV risk behavior was sex with a long-term partner with high-risk behavior.

Standard Table 1.1.1

	Total		All Ages*				*Source, Year*
			Female		Male		
	N	%	N	%	N	%	
Total Population	90,654,368		45,715,257		44,939,111		GSO
Prevalence (%)		0.26%		0.19%		0.47%	EPP 2014
AIDS Deaths (per year)	9,309						EPP 2014
PLHIV	256,818		72,254		177,345		EPP 2014
Incidence Rate (Yr)							EPP
New Infections (Yr)	11,825						EPP 2014
New Infections – PWID, aged 15+	3,696	31.26%					EPP 2014
New Infections – FSW, aged 15+	813	6.88%					EPP 2014
New Infections – MSM, aged 15+	856	7.24%					EPP 2014
New Infections – Male client of FSW, aged 15+	3,509	29.67%					EPP 2014
New Infections – Low Risk Female, aged 15+	1,936	16.37%					EPP 2014
New Infections – Low Risk Male, aged 15+	562	4.75%					EPP 2014
New Infections – Children 0-14	455	3.85%					EPP 2014
Annual births	**1,714,622**						MCH/ 2013
% >= 1 ANC visit	NA						No available
Pregnant women needing ARVs	2,759						EPP 2014
Orphans (maternal, paternal, double)	NA						No available
TB cases (Yr)	**105,524**						National TB plan estimation 2014
TB/HIV Co-infection	**11,248**						National TB plan estimation 2014
Males Circumcised	NA						N/A
Key Populations	**725,948**						VAAC - 2013
Total MSM*	**382,506**						VAAC – 2013
MSM HIV Prevalence	2.46%						EPP 2014
Total FSW	**71,936**						VAAC – 2013
FSW HIV Prevalence	5.37%						EPP 2014
Total PWID	**271,506**						VAAC –

	Total		All Ages*				*Source, Year*
			Female		Male		
	N	%	N	%	N	%	
							2013
PWID HIV Prevalence	20.56%						EPP 2014
Priority Populations (specify)							N/A
Priority Populations Prevalence (specify)							N/A

*To be consistent with the data package/epi summary sheet, these populations contain all ages.

Standard Table 1.1.2a

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population _ estimation	90,654,368	0.26%	256,818							
Total population _ reported data			171,000[1]	97,211[2]	93,298[3]	79,303[4]	NA	1,755,251[5]	17,233[5]	NA[6]
Population less than 15 years - estimation	23,264,382	0.03%	7,219							
Population less than 15 years – reported data			4,830[1]	4,788[2]	4,558[3]	4,330[7]	NA	NA	NA	380
Pregnant Women - estimation	1,714,622	0.23%[8]	3,944[9]							
Pregnant Women – reported data				NA	NA	NA	NA	1,126,458[10]	1,498[10]	1,733[11]
MSM	**382,506**	2.46%	9,410	NA	NA	NA	NA	NA	NA	NA
FSW	**71,936**	5.37%	3,863	NA	NA	NA	NA	NA	NA	NA
PWID	**271,506**	20.56%	55,822	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)		EPP	EPP	NA	NA	NA	NA	NA	NA	NA

1.(1): HIV case reporting, 2014. There has been a process of verifying vital status of cases in the National case reporting system and data is being updated in the HIV Info reporting program. While counting in the HIV Info indicates 206,314 HIV and AIDS alive by 2014, rapid reports from 63 provinces shows that number of alive PLHIV reported is around 171,000 cases. Updating the case vital status in HIV Info will continue in 2015.
2.(2): National Reporting Program (D28), 2014. Figure obtained from D28 online report is adjusted to include number of patient on care at national level OPCs.
3.(3): National Reporting Program (D28), 2014. Figure obtained from D28 online report is adjusted to include number of patient on ART at national level OPCs.
4.(4): Calculated based on HIVQual data in 2014 that retention at 12 months is 85%
5.(5): National Reporting Program (D28), 2014. Figures include testing from VCT and PMTCT.
6.(6): In an assessment of HTC-OPC linkage conducted in 5 provinces in Viet Nam under the VAAC-USCDC project, about 50% of HTC positive clients were referred and registered in care within 18 months after HIV testing. Proportion of those who initiated ART within 12 months post HIV testing is but anticipated to be lower than 50%.
7.(7): Calculated based on data of the VAAC-USCDC project which contributes to the major number of pediatric patients in Viet Nam. From 2012-2014, on average, the 12 month retention rate of pediatric patients under this project is 95%.

Standard Table 1.1.2b – MMT Cascade

Vietnam	Est. PWID - EPP 2013	Est. PWID PLHIV - EPP 2014 projections	Provincial MMT Target	MMT Patients Jan 2015	MMT Gap Jan 2015	Est. MMT Patients HIV+[1]	HIV prevalence among MMT Patients
National	**271,506**	**63,092**	**80,404**	**26,663**	**53,741**	**6,879**	**25.8**
Hanoi	30,867	6,263	8,500	2,123	6,377	453	21.3
Ho Chi Minh	34,323	9,984	8,000	2,048	5,952	868	42.4
Son La	19,064	7,259	6,000	411	5,589	N/A	
Hai Phong	13,779	3,299	4,600	3,407	1,193	850	24.9
Dien Bien	10,189	3,880	4,400	1,457	2,943	N/A	
Thanh Hoa	12,717	4,890	3,500	1,531	1,969	401	26.2
Nghe An	9,980	3,081	3,400	502	2,898	139	27.7
Thai Nguyen	7,959	3,305	3,300	1,668	1,632	310	18.6
Thai Binh	7,115	816	3,000	1,285	1,715	53	4.1
Lao Cai	4,677	1,159	2,431	556	1,875	59	10.6
Hai Duong	4,851	556	1,900	840	1,060	N/A	
Nam Dinh	7,127	817	1,900	1,348	552	204	15.1
Lai Chau	7,396	2,816	1,700	1,182	518	68	5.8
Quang Ninh	4,356	2,119	1,600	887	713	358	40.4
Dong Nai	3,639	892	1,404	241	1,163	93	38.6
Ninh Binh	3,392	389	1,356	354	1,002	N/A	
Bac Giang	3,483	669	1,213	428	785	73	17.1
Hoa Binh	2,982	739	1,200	416	784	53	12.7
Ba Ria - Vung Tau	4,998	1,226	1,200	456	744	75	16.4
Yen Bai	5,333	1,321	1,200	468	732	108	23.1
Phu Tho	5,177	1,282	1,200	549	651	130	23.7
Can Tho	2,786	840	1,100	556	544	175	31.5
An Giang	2,015	280	900	468	432	93	19.9
Da Nang	2,436	238	850	353	497	17	4.8
Vinh Phuc	2,497	618	800	39	761	N/A	
Lang Son	3,734	717	800	132	668	38	28.8
Bac Can	1,934	371	800	365	435	75	20.5
Cao Bang	2,331	447	750	214	536	26	12.1
Hung Yen	2,878	330	750	494	256	48	9.7
Tuyen Quang	1,926	477	700	179	521	47	26.3
Ha Nam	2,103	241	700	262	438	27	10.3
Long An	1,679	136	650	375	275	82	21.9
Khanh Hoa	2,583	497	500	36	464	5	13.9
Bac Ninh	1,799	345	500	37	463	N/A	
Binh Thuan	1,726	294	500	409	91	10	2.4
Quang Tri	2,048	65	450	101	349	2	2.0
Quang Binh	1,790	57	400	89	311	0	0.0
Ha Tinh	1,949	62	400	225	175	31	13.8
Ben Tre	637	52	300	132	168	45	34.1
Ha Giang	1,053	261	250	40	210	7	17.5

[1] Data not available for all Son La, Dien Bien, Hai Duong, Ninh Binh, Vinh Phuc, and Bac Ninh; total PLHIV MMT patients based on national MMT prevalence rate

1.2 Investment Profile

The HIV response in Vietnam is heavily donor dependent, contributing 78 percent of total HIV expenditures (Vietnam Country Progress report to UNAIDS, 2014). For ARV drugs, PEPFAR VN and Global Fund currently finance approximately 95 percent of Vietnam's consumption. In 2012, the total HIV expenditure (not including out of pocket) in Vietnam was estimated at USD 136,000,000[i]. PEPFAR VN alone represented 51 percent of total HIV expenditures compared to 22 percent from the Vietnamese government over the same period. National AIDS Spending Assessment (NASA)-based analysis from 2014 calculated a drop in overall per capita HIV funding. PEFPAR-supported National Health Accounts (NHA) data will be available in late 2015 to build on the NASA data set, triangulating a clearer picture of resources available and funding gaps. Overall HIV investment peaked in 2012 when other donors were still financing key components of the response. For example, the World Bank/U.K. Department for International Development project was a major source of funding for the prevention program until the project ended in 2013. Vietnamese government support through the National Target Program (NTP) for HIV has shown a marked decline from $12m in 2012 to $4m in 2014. This is in contrast to the ministerial decisions that agreed to reduce dependency on external aid to below 50 percent by 2015 and below 25 percent by 2020 (Decision 608) while ensuring financial stability for HIV/AIDS control activities for 2013-2020 (Decision 1899). In 2015, the Vietnamese Government allocated an additional $3 million in central funding for HIV/AIDS but would only increase the government's contribution by ten percent and government funds earmarked for HIV beyond 2015 are uncertain. At present, the majority of centralized Millennium Development Goal (MDG)-related NTPs, including HIV, may end by 2016. With PEPFAR VN and Global Fund signaling a continued reduction of direct service delivery and commodity support over the next 3 years, the Vietnam Ministry of Health (MOH) is trying to mobilize domestic HIV resources, through central and provincial government general tax budgets, social health insurance (SHI) contributions and patient co-pay. However, unless the current trajectory changes, the financing situation presents a major threat to the sustainability of the HIV program and may lead to a gap in ARV treatment availability in late 2016.

Table 1.2.1 Investment Profile by Program Area[2]

Program Area*	Total Expenditure	% PEPFAR**	% GF	% GRP	% Other
Prevention	$31,858,692	36%	20%	24%	20%
Care and treatment	$26,844,025	67%	16%	13%	4%
Orphans and Vulnerable Children	$950,785	86%	0%	1%	14%
Program Management and Administration Strengthening	$59,177,889	47%	9%	31%	12%
Human Resources	$6,713,648	47%	23%	11%	19%
Social Protection and Social Services excluding OVC	$445,594	59%	15%	3%	23%
Enabling Environment	$8,912,726	79%	8%	0%	12%
Research	$1,147,096	57%	1%	2%	41%
Total	$136,050,455	51%	13%	22%	14%

* NASA Figure for 2012, unpublished report in 2014/UNAIDS
**PEPFAR figure extracted from EA provided data for NASA team

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GVN	% HAARP
ARVs	$20,627,895	53%	41%	5%	0%
Rapid test kits	$1,017,000	35%	65%	0%	0%
Other drugs (Methadone)	$3,085,731	39%	49%	7%	5%
Lab reagents	$1,148,066	67%	33%	0%	0%
Condoms	$1,500,000$	0%	100%	0%	0%
Needle & Syringe	0$	0%	0%	0%	0%
Total	$25,056,988	49%	46%	5%	1%

*ARVs estimates from PEPFAR EA 2014, Global Fund approved budgets for ARV procurement in 2014, National Plan on Coordination of ARV Supply Chain for 2014

**RTK estimate from PEPFAR Care & Treatment TWG; 2014 Global Fund estimate from country team
***Methadone estimates from PEPFAR EA 2014; 2014 Global Fund estimate provided by country team; domestic methadone procurement mechanism to begin implementation in 2015
****Estimated by Care & Treatment TWG based on 2013 actuals
******Needle & syringe commodities were consuming stock from World Bank project, GF project will begin procuring in 2015

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	N/A	N/A	N/A	N/A	N/A
USAID TB	N/A	N/A	N/A	N/A	N/A
USAID Malaria	N/A	N/A	N/A	N/A	N/A
Family Planning	N/A	N/A	N/A	N/A	N/A
NIH	N/A	N/A	N/A	N/A	N/A
CDC NCD	N/A	N/A	N/A	N/A	N/A
Peace Corps	N/A	N/A	N/A	N/A	N/A
DOD Ebola	N/A	N/A	N/A	N/A	N/A
MCC	N/A	N/A	N/A	N/A	N/A
Private Sector	N/A	N/A	N/A	N/A	N/A
PEPFAR Central Initiatives	Pending - Global Health Security Agenda, Sustainable HIV Financing Project, SAMHSA regional activities				
Total					

[2] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

1.3 National Sustainability Profile

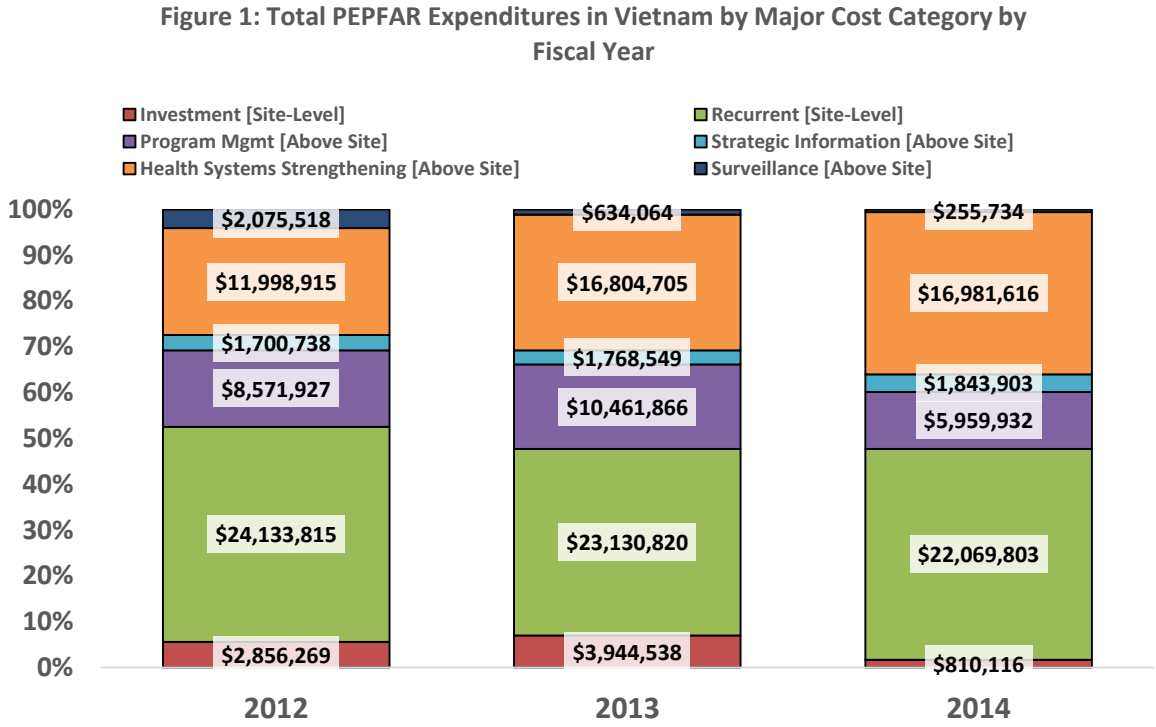
The Sustainability Index and Dashboard identified two broad areas as unsustainable for the National HIV response: 1) commodity security and supply chain and 2) DRM: resource generation. Based on discussions with the Government of Vietnam and various stakeholders, the primary barrier to HIV epidemic control and long-term sustainability in Vietnam is domestic financing for HIV/AIDS services. As external donors' budgets continue to decrease, the Vietnamese government will have to increasingly absorb existing HIV/AIDS services into the public health system while expanding patient access to ARVs to reach its national goal of "90-90-90" epidemic control by 2030. To reach the goal of providing ART to 80 percent of all PLHIV, an additional 95,000 people need to be tested and enrolled in ART. The ARV costs alone would require an additional $22 million per year at current U.S. government costs. To date, the Vietnamese government has financed only 5 percent, or $1 million, of its ARVs. Further, the SHI scheme currently only covers 30 percent of PLHIV and only limited services are covered. Currently, SHI does not cover the majority of HIV services and it is not expected to be fully implemented until at least 2018. Global Fund's current HIV grant runs through 2017 and is committed to enroll up to 50,000 patients, which is approximately 5,000 net new ARV patients from July 2015. Deputy Prime Minister Vu Duc Dam recently made a provision for an additional $3 million for ARVs in 2015/2016, a positive step that stakeholders hope signals expanded commitments from the central government in the future. Leveraging new resources and promoting efficiency in the use of domestic resources for HIV is a key component of PEFPAR VN's Health System Strengthening (HSS) strategy in COP 15 (see section 6.3).

An effective national HIV supply chain is also needed to sustain achievements made towards achieving epidemic control. As the sustainability index highlighted, a national procurement mechanism for HIV commodities has not yet been established in Vietnam. However, the Vietnamese government is interested in the international procurement of ARVs and establishing a central procurement unit (CPU) within MOH. In COP 15, PEPFAR VN proposes to support MOH efforts by strengthening the supply chain system for HIV commodities including forecasting and procurement, distribution, and storage and dispensing (see section 6.3).

1.4 Alignment of PEPFAR investments geographically to disease burden

This section provides a further analysis of PEPFAR VN expenditures in relation to the Government of Vietnam and other donor-related expenditures in support of the national HIV/AIDS response in Vietnam. In line with COP 14, the majority (93 percent) of fiscal year (FY) 2014 expenditures are recurrent site-level, program management above-site, and HSS. Above-site expenditures comprised 52 percent of the total FY 2014 expenditures, with the remaining 48 percent focused on site-level recurrent or investment expenditures. FY 2014 HSS-related above-site expenditures increased 12 percent over FY 2012 and FY 2013 expenditures. The largest proportional change in reported by expenditures was a decrease of program management expenditures by 42 percent from 2013 to 2014.

Table 1.4.1: Total PEPFAR Expenditures in Vietnam by Major Cost Category by Fiscal Year



A further analysis of HSS above-site expenditures found that the majority were within personnel (31 percent) or program management (25 percent) for facility-based care and treatment, strategic information, laboratory, HTC, methadone assisted therapy, community-based treatment support services, and KP outreach, which all align with PEPFAR VN's current program areas.

Table 1.4.2: Total PEPFAR Above-Site Level HSS Expenditures in Vietnam by Cost Category in Fiscal Year 2014

The majority of total PEPFAR expenditures by program area in FY 2014 were attributed to facility-based care and treatment services (46 percent), HIV counseling and testing (17 percent), laboratory services (11 percent), and methadone assisted therapy (8 percent), with a 12 percent increase in expenditures for HTC from FY 2013.

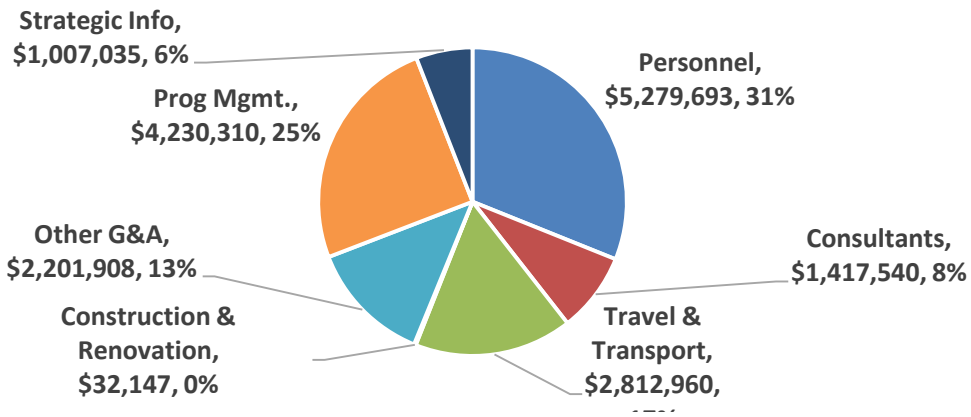


Table 1.4.3: Total PEPFAR Expenditures in Vietnam by Program Area in Fiscal Year 2014

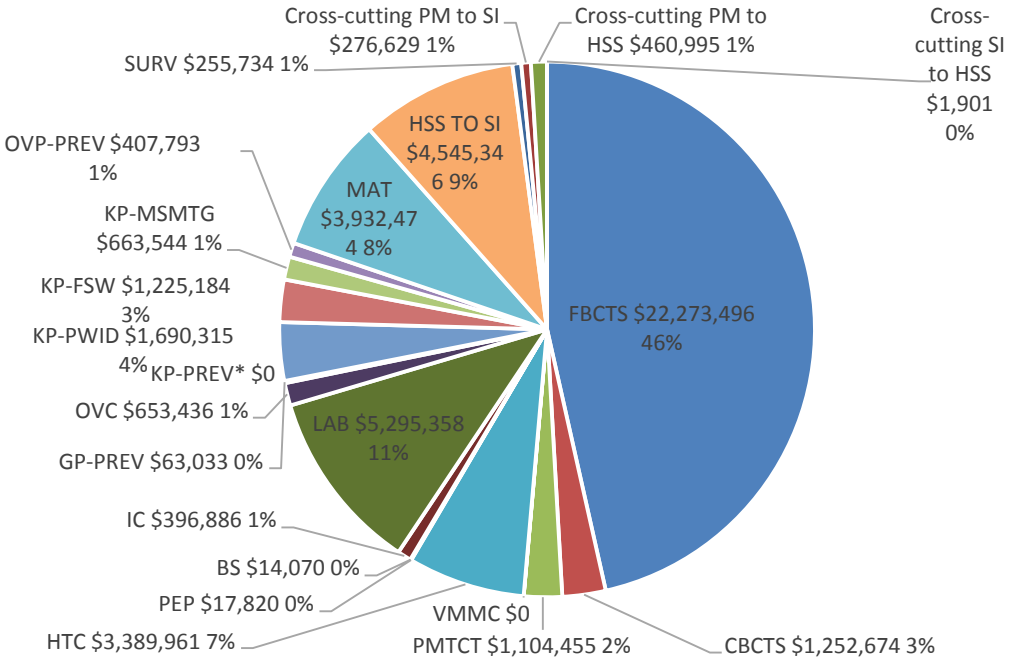


Table 1.4.4: FY 2014 PEPFAR Expenditures per PLHIV and Percent of PLHIV by SNU

Table 1.4.4 provides an analysis of PEPFAR expenditures in 2014 in relation to the burden of disease by province. Overall, expenditures show a correlation between PEPFAR spending and disease burden by province. FY 2014 total expenditures per the total estimated number of PLHIV in Da Nang exceeded those of other subnational units (SNUs) due to low volume and low yield sites; therefore, all site-support for Da Nang was transitioned to Ministry of Health central support in 2014.

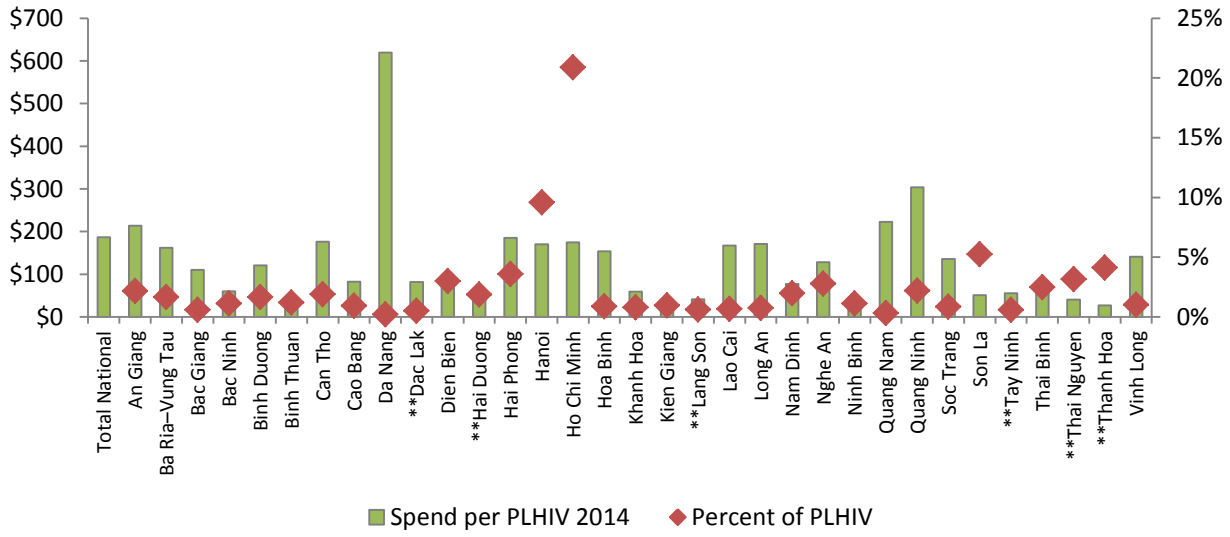


Table 1.4.5: 2014 PEPFAR Care and Treatment Expenditure, Total PLHIV, and Number on ART by SNU

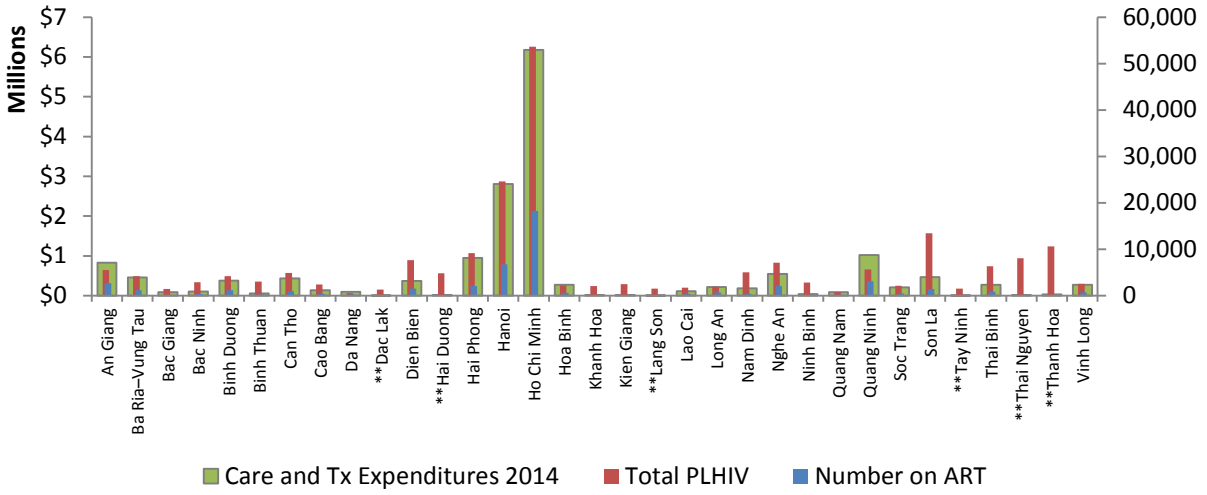


Table 1.4.5 shows PEPFAR VN 2014 expenditures compared to total PLHIV and total people on ART by province. While the graph showcases overall strong alignment of funding, some provinces seem to have higher HIV/AIDS burden, low ART coverage and insufficient PEPFAR care and treatment resources being mobilized. In some of these provinces, many services for PLHIV are provided by Global Fund without PEPFAR VN support. The chart below filters out non-presence provinces in which expenditures totaled $3,000 or less in 2014.

1.5 Stakeholder Engagement

The PEPFAR VN team worked directly with MOH, Ministry of Defense (MOD), the Global Fund's Country Coordinating Mechanism, UNAIDS, and CSOs to: 1) conduct the required data analysis for resource allocation for COP 15 and reporting requirements; and 2) finalize COP 15 proposed activities. Embassy leadership, agency leads, and staff have all been actively involved in the COP 15 development process.

PEPFAR VN's civil society engagement strategy follows the four step process outlined in the COP 15 guidance. On March 11, 2015, the PEPFAR VN team held a consultation meeting with CSOs in Dien Bien Province. Participants included community service providers from six project districts in Dien Bien province; community-based organizations (CBOs) from PEPFAR VN focus provinces; and representatives from the Vietnam PLHIV network. The engagement meeting was jointly hosted by the Dien Bien Provincial Department of Health (DOH), MOH, and the Center for Community Health Research and Development. Outcomes from this consultation meeting were incorporated into COP 15 planning and utilized to complete the required Sustainability Index and Dashboard tool.

Since the regional COP review in Bangkok in May 2015, the PEPFAR VN team had consultations with the National Assembly, Ministry of Health, multilateral and bilateral partners, and held an open stakeholders meeting. PEPFAR VN is in discussions with UNAIDS to find innovative ways to continue engaging civil society, including co-sponsoring quarterly civil society stakeholder meetings.

2.0 Core, Near-Core and Non-Core Activities

The "core, near-core, non-core" prioritization exercise has been underway for several COP cycles in order to maintain support for KP prevention services and patients on ARV and methadone treatment, while preserving priority health systems activities.

PEPFAR VN has taken a thorough approach to reducing costs including cutting the overall prevention program in half since 2010, concluding all general population prevention and orphans and vulnerable children activities. At a partner level, the team has cancelled or is closing out 18 cooperative agreements with the Government of Vietnam, the UN system, U.S. universities and international contractors in recent COP cycles. At a provincial level, CDC, which had been working in 28 provinces, will conclude direct service delivery (DSD) support in 16 provinces by the end of 2016. Likewise, USAID is working to transition activities and sites from its service delivery partner to central support by 40 percent over the same period. Additionally, at a site level:

1. Seventy of 115 prevention of mother-to-child transmission (PMTCT) sites will be fully centrally supported by the Government of Vietnam by the end of 2015 with an estimated cost savings of $39,000 according to the PEPFAR Site Expenditure Analysis tool;
2. Similarly, 42 of 108 HTC sites will be fully centrally supported by the end of 2015 with an estimated savings of approximately $640,000 using Expenditure Analysis data; and
3. Twenty-four of 113 ART outpatient clinics (OPCs) will be centrally supported or will be sustained as a TA model with no routine operating costs to the U.S. government outside of HIV commodities, with an estimated cost savings of $642,000.

While there are savings from the transition of sites and the closing of projects, these cost-cutting efforts primarily permit PEPFAR to stay within a declining budget rather than reinvest extensively in new programs or sites.

In the COP15 processes, the PEPFAR VN went through numerous versions and discussions with SGAC about core, near-core and non-core decisions. The final decision is located in Appendix A.

3.0 Geographic and Population Prioritization

PEPFAR VN has undergone geographic prioritization since October 2013, when CDC and the MOH completed a financial and epidemiologic analysis to determine a timeline for transition of PEPFAR DSD support in 28 provinces. Provinces with more resources and/or lower HIV burden will be transitioned to central support earlier than provinces with lower resources and higher burden. In consultation with S/GAC, it is planned that all PEPFAR VN supported provinces will be on a trajectory to transition DSD support by 2018. For CDC, this includes one province centrally supported in 2014, seven in 2015, eight in 2016, seven in 2017, and five in 2018. The USAID SMART TA program also features transition trajectory based on epidemiology, performance, and financial readiness. In 2015 the number of SMART TA DSD sites will drop from 107 to 70; the following year, only 39 DSD sites will remain.

Initial provincial-level analysis identified large urban centers (HCMC and Hanoi) and a northwest mountainous province (Son La) with the greatest unmet need for ART. However, further analysis identified that the majority of high yield sites (HTC, PMTCT, and OPC) were not limited to these three provinces. HTC sites in 16 provinces account for 80 percent of all PEPFAR newly diagnosed PLHIV. Similarly, 15 sites identified 80 percent of HIV positive pregnant women in just 10 provinces.

However, for COP 15, PEPFAR VN is focused on HIV testing, treatment, and retention of key populations in 5 aggressive scale-up provinces where epidemiological data identify greatest unmet need, large KP numbers and proven service uptake. Prevention activities focusing on KP in these 5 scale-up provinces will include MSM, FSW and/or PWID KP outreach and MMT. COP 15 will continue to sustain support for high yield sites in high burden provinces while steadily cutting DSD costs.

PEPFAR VN has also conducted site-level analyses in different program areas. PMTCT site level data conclude that, of 112 PEPFAR PMTCT sites operating in April 2014, only 15 DSD sites will be continued through COP15. Sites that identified no HIV infected pregnant women will be transitioned to central support by March 2015; sites that identified fewer than five women in 2015 will be transitioned to central support by December 31, 2015. All remaining sites will be transitioned to central support by December 31, 2016. Additional PMTCT support will occur above-site, including integration of PMTCT into routine maternal and child health (MCH) services, advocating routine antenatal care (ANC) HIV testing as part of SHI, and PMTCT program monitoring to help MOH assess outcomes.

HTC analysis concluded 16 HTC DSD sites failed to detect a minimum 48 HIV positive cases in a year and at least four percent HIV positive yield, and will be transitioned to central support in 2015. These sites are in addition to overall transition of seven provinces. Support will continue for 100 DSD HTC sites in 24 provinces: 65 sites in 5 aggressive scale-up provinces will be prioritized for scale-up of HTC and 35 sites will transition to a passive enrollment model. KP outreach will focus on the most effective and sustainable performance based models to reach PWID, FSWs, and MSM in only the 5 aggressive scale-up provinces. MMT is currently supported in 42 provinces and 50 DSD sites. In FY 2016 the number of DSD methadone sites will be reduced to 27 as the Vietnamese government assumes recurrent costs at more existing MMT sites. Any new MMT sites in Vietnam will be supported with PEPFAR TA only.

In COP 15, low volume PEPFAR-supported HIV OPCs will be collapsed into nearby OPC sites or integrated into routine district health services. In COP 15, 12 OPCs will centrally support to "neither" sites, where PEPFAR will stop supporting all operational costs except ARVs and need-based TA.

HIV/TB services are prioritized in the same high burden aggressive scale-up provinces as HIV treatment. PEPFAR DSD supports intensified case finding (ICF) among PLHIV, including smear, chest x-ray, and culture and GeneXpert testing. Site-level analysis of DSD TB clinics identified seven clinics that can be centrally supported in 2015, with sustained PEPFAR DSD support for 48 sites in COP 15.

Provinces by PEPFAR classification are listed below:

Aggressive Scale-up Provinces with Expanded ARV Support	**Aggressive Scale-up Provinces without Expanded ARV Support**	**Sustained Support Provinces**	**Central Support Provinces**
Dien Bien	Ho Chi Minh City	An Giang	Binh Thuan
Nghe An	Thanh Hoa	Bac Giang	Danang
Son La		Bac Ninh	Khanh Hoa
		Ba Ria – Vung Tau	Lang Son
		Binh Duong	Quang Nam
		Can Tho	
		Cao Bang	
		Dak Lak	
		Hai Duong	
		Hanoi	
		Hai Phong	
		Hoa Binh	
		Kien Giang	
		Lao Cai	
		Long An	
		Nam Dinh	
		Soc Trang	
		Quan Ninh	
		Tay Ninh	
		Thai Binh	
		Thay Nguyen	
		Vinh Long	

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

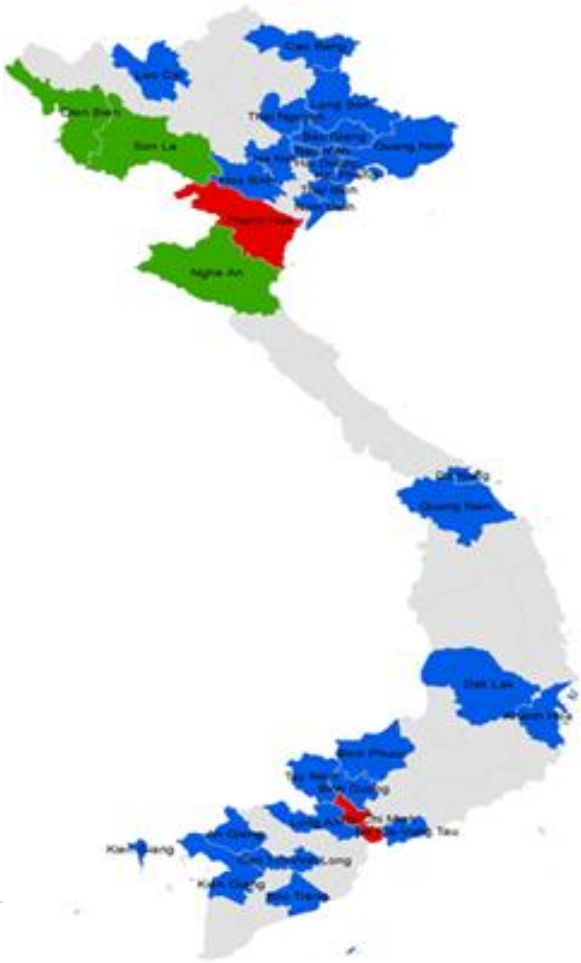
PEPFAR VN targeting rests on three key assumptions. First, our interagency team cannot deliver nationwide epidemic control based on 80 percent ARV coverage. PEPFAR VN inputs currently support treatment for approximately 50,000 individuals while 80 percent ARV coverage would require an additional $22 million annually in ARV costs alone. Second, DSD transition will build on efforts to date which have halved prevention investments, reduced PMTCT sites, and integrated low efficiency sites. Third, TA will enable transition from a donor-funded HIV response to one planned, managed, and funded through local actors and by the Government of Vietnam.

The program will make an immense geographic pivot to maximize impact of declining DSD investments, identifying the most effective case finding methods in 5 aggressive scale-up provinces with the greatest need and where sites are best positioned to aggressively reach and test individuals in key population groups and enroll them on ARVs.
The basics of this approach are represented in the map below at right:

1. Continued funding of ARV treatment expansion and intensified case finding in 3 high HIV burden, high unmet need priority provinces (provinces highlighted in green)

2. Intensified case finding in 2 high HIV burden, high unmet need priority provinces; ARV treatment maintenance for current patients (provinces highlighted in red)

3. Transition service delivery to a sustainable, country-owned HIV response by end of 2018; sustained ARV treatment for current patients (provinces highlighted in blue)



Initiating PLHIV on ART relies on aggressive targeted outreach and HTC in 5 high yield aggressive scale-up provinces. Sixty-four percent of HTC targets and 66 percent of new ARV targets are projected to come from these provinces. Case finding will target over 81,000 individuals in key population groups in aggressive scale-up provinces to ensure HTC for PWID, FSW and MSM and supporting ARV initiation for approximately 5,999 new patients. This strategy requires tradeoffs. The contracted number of aggressive scale-up provinces and DSD sites mean many provinces

with significant KPs will not benefit from PEPFAR's aggressive scale-up services.

Diminishing DSD investments highlight the importance of PEPFAR TA to the national HIV response. Strong local quality improvement systems ensure that quality is self-sustaining in the national system. Investments in the private sector will shift prevention work from free risk-reduction commodities for key populations, to utilizing rational market. Civil society and enhanced outreach will focus case finding on empowering networks of friends and communities to bring hard to reach community members into services. Health financing collaborations will advocate for domestic financing for HIV/AIDS, define mechanisms for ARV procurement and reimbursement to PLHIV under the SHI scheme, while enabling the Vietnamese government to make informed HIV funding decisions.

The COP 15 data package triangulated the best available information to identify: provinces and locales with the highest unmet need; high capacity ARV sites; and the most productive case finding methods. Nonetheless, there are limitations to assessing key population impact. While HIV prevalence estimates are based on EPP models, KP size estimates may be less precise. The population denominator for PWID is based on arrest information that likely underestimates the number of injectors. FSW statistics are derived from the numbers of women entertainment workers, a situation likely to overestimate the number of sex workers.

Table 4.1.1 ART Targets in Priority Sub-national Units for Epidemic Control

SNU	Total PLHIV *(EPP)*	***Expected current on ART (2015) (National number target estimate)***	**Additional patients required for 80% ART coverage** (80% EPP-FY15 target estimate)	**Target current on ART (in FY16) *TX_CURR*** *(PEPFAR target)*	**Newly initiated in FY16 *TX_NEW*** *(PEPFAR target)*
Dien Bien	7,648	2437	**3,681**	**3,364**	**1,013**
Ho Chi Minh	53,649	27836	**15,083**	**21,558**	**1,600**
Nghe An	7,131	3036	**2,669**	**4,414**	**1,406**
Son La	13,460	2887	**7,881**	**3,927**	**1,056**
Thanh Hoa	10,587	2892	**5,578**	**3132**	**924**
Total	**92,475**	**39,088**	**34,892**	**36,395**	**5,999**

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 16) – PEPFAR sites

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART by the end of FY2015 = **2724**			
Clinical care patients not on ART – new enroll on care			**5999**
TB-HIV Patients not on ART			
HIV-positive Pregnant Women		**289**	
Other priority and key populations	**113,934**	**7025**	
Total			

Note:
-PEPFAR HTCs and OPCs serve in different locations. New clients for Care and Treatment sites might come from different HTC and already identified before.
- PMTCT program funded in PEPFAR in HCMC onl, in other provinces, PMTCT funded by GF or NTP.

Table 4.1.3 –VMMC (Not Applicable)

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

PEPFAR sites

Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY16)	FY16 Target
All Key Population Prevention - PWID, MSM, FSW			
Dien Bien	12,180	**N/A**	**11438**
Ho Chi Minh	111,969	**N/A**	**28,035**
Nghe An	21,760	**N/A**	**14246**
Son La	23,622	**N/A**	**13,951**
Thanh Hoa	26,790	**N/A**	**13,460**
Total	**196,321**		**81130**

Notes:
- *Size estimates include PWID (37%), FSW (10%) and MSM (53%).*
- *Program interventions target mainly IDU and FSW in most provinces while targeting MSM in only few provinces (Ho Chi Minh, Hanoi, Hai Phong)*

Table 4.1.5 – Targets for OVC and Pediatric HIV Testing, Care and Treatment (Not applicable)

4.2a Priority Population Prevention

PEPFAR VN outreach programs address gaps in KP needs across the HIV cascade. Priorities include: enhanced community outreach models that most effectively link KP to HTC and HIV care and treatment; program monitoring to improve impact; availability of prevention commodities through private sector engagement; and increasing the role of CSOs in the National HIV response.

With COP 14 funds, PEPFAR VN supported outreach in 29 provinces. Based on a systematic review of epidemiology, KP risk, gaps and site-level performance, 5 provinces with highest burden, unmet need for KP HIV testing and greatest ART gaps were identified. COP 15 funds will support outreach services in these 5 aggressive scale-up provinces and will transition DSD support for outreach activities in other 24 provinces by the end of December 2015. The total KP prevention target for COP 15 is 91,180 individuals reached with preventive interventions. This represents an increase of 13 percent compared to APR2014 achievement (80,681). Innovative outreach approaches including performance-based incentives (which increases testing from 38 percent to 85 percent of those reached), peer driven interventions, and internet outreach for MSM will boost case finding. PEPFAR VN will continue TA to MOH and Provincial DOHs and Provincial AIDS Centers (PACs) and establish provincial TA networks to implement, monitor, and evaluate and refine these approaches in the 5 aggressive scale-up provinces. PEPFAR VN has supported MOH to develop a behavior change communication (BCC) strategy to boost KP demand for HIV prevention goods and services. COP 15 TA will assist DOHs/PACs to operationalize the BCC strategy and tools.

Civil society engagement in planning, implementation, monitoring, and accountability remains a vital element of the PEPFAR VN program. In COP 15, PEPFAR VN will continue strengthening the role of CBOs by enlisting experienced Vietnamese non-government organizations (NGOs) to identify and improve the capacity of CBOs working with key populations.

KP prevention requires commodities. Vietnam historically relied on donor-funded condoms, but this approach is inefficient and unsustainable. Since FY2014 PEPFAR has supported HIV-commodity and service security through the Healthy Market Project that encourages private sector engagement to grow a viable commercial market for goods and services that meet KP needs. In COP 14, PEPFAR VN supported MOH development of the national Total Market Approach for commodities based on market and consumer surveys. In COP 15, we will provide TA to roll-out the strategy through public-private partnership models for private sector engagement in HIV-related goods and services and implement condom quality control measures and anti-counterfeit measures for the free market. In COP 15, PEPFAR VN will provide TA to local manufacturers to produce and distribute low dead space syringes for PWID.

As of February 2015, SIMS visits have been completed at 35 prevention sites. Preliminary results indicate unique identification code in referral to HTC and care and treatment is not standardized, making it difficult for outreach workers to track clients through the cascade. Availability of condoms and other commodities since the end of PEPFAR social marketing in 2013 is a concern. Lack of involvement of KP in program planning was highlighted. Enhanced outreach, utilizing innovative approaches noted above, is anticipated to address many challenges identified during

SIMS visits, while Healthy Markets private sector work will increase access to condoms and other commodities.

4.2b MMT (Medication – Assisted Treatment in the form of methadone)

The National Targeted Program adopted methadone maintenance treatment (MMT) in 2008. Currently, 145 MMT clinics in 42 provinces serve 32,081 patients (or 40% of the national target). PEPFAR VN program supports the national program with methadone procurement and TA. In FY2015, PEPFAR VN contributed to 98 sites: 50 DSD MMT sites, 47 TA only sites and one "neither" site," serving 14,560, 7,385, and 300 patients respectively (MER definition). This accounted for 22,245 (81.8 percent) of the current total of MMT patients. In FY2016 PEPFAR VN will continue the transition from DSD, and reduce its TA presence. In 2016, PEPFAR VN will support 27 DSD (from 50), 23 TA sites (from current 47) and 26 sites will be commodities only. Targets include 8,340 patients in DSD sites; 8,200 patients in TA sites; and 6,880 patients in the "neither" sites. Direct service funding for "neither" sites will come from the provincial government with patients paying a modest amount for the service.

In the last year, MMT has seen a proliferation of policies that directly affect service development and delivery. For further information on these policies please see Appendix C.

MMT contributes to epidemic control. The national program serves 27,180 patients with 90 percent tested for HIV, and of those 27 percent tested positive and 70 percent of positives were placed on ARV treatment. An evaluation of methadone program participants didn't find a single case of sero-conversion while on treatment.

PEPFAR invests in methadone in provinces with the highest number of PWID and HIV prevalence including the 5 aggressive scale-up provinces - Dien Bien, Son La, Nghe An, Thanh Hoa and Ho chi Minh City (HCMC). To initiate HIV services within the MMT program, all patients are screened for HIV and those with positive results are referred to an OPC for CD4 testing and ART. Those with negative results are encouraged to repeat HIV testing every 6 months. MMT, HTC and ART are being integrated so that individuals can receive all at one location.

Though PEPFAR VN is transitioning out of service delivery costs for MMT, TA will continue for quality assurance. Findings from recent SIMS visits showed that current MMT services lacking interventions for patients who are poly drug users and risk reduction services are not provided to all patients.

4.3 VMMC – NA

4.4 Preventing mother-to-child transmission (PMTCT)

The PEPFAR VN PMTCT program has reduced DSD and is supporting Option B+ services implementation in accordance with new WHO guidelines. In 2014, PEPFAR VN has worked to support integration of PMTCT into the national MCH system by integrating basic PMTCT indicators into MCH monitoring and evaluation system. Fifty sites with zero or low prevalence centrally supported operational costs and management to local government. Seventeen PEPFAR

VN-supported sites in HCMC have begun Option B+ services and staff at 92 of 115 PEPFAR supported sites received Option B+ training. One key challenge in Vietnam is that most pregnant women seek ANC services from private clinics; therefore, testing, referral, and early treatment at private clinics require additional attention.

The PEPFAR VN PMTCT COP 15 strategy will continue; 1) transition of DSD support to TA and 2) expand Option B+ services to sustain PMTCT through integration into the MCH system and increase HIV testing and treatment through expanded Option B+.

To reduce DSD support, PEPFAR VN will provide TA to integrate PMTCT into the MCH system as a routine ANC service and supports testing and referral in the MCH system. Core and near core activities provide TA to develop policies and training to include the private sector, support ANC rapid testing, and strengthen in-country TA capacity.

In FY 2016, PEPFAR VN will test 168,000 pregnant women and initiate ART for 500 HIV-infected women through TA-support of expanded Option B+. Core activities include: 1) Option B+ training for the remaining 12 DSD and 2 TA sites; 2) develop standard operating procedures for Option B+ referral; and 3) onsite quality assurance TA for 41 PMTCT sites. PEPFAR VN will transition operational management and costs, including HIV test kits, to the local government for 101 of the 113 PMTCT DSD sites. These sites will receive regular TA for one year to monitor and maintain service quality. PEPFAR VN will also provide TA to four PMTCT sites where SIMS visits identified missing or incomplete documentation of HIV testing in early pregnancy.

PEPFAR VN will discontinue non-core activities such as patient travel support, some training, nutrition and formula support, information, education, communication material printing, and annual meeting support. PEPFAR VN will continue commodity-only support for ARVs for Option B+ at 49 ANC sites until April 2016.

4.5 HIV Testing and counseling (HTC)

HIV testing coverage has increased over the past years but remains consistently low among KPs and their sexual partners. The 2014 HIV Sentinel Surveillance Plus in 40 provinces reported that 28 percent of PWID, 39 percent of MSM, and 38 percent of FSWs were tested for HIV over the past 12 months, with variance between provinces. Preliminary results from the 2013 IBBS (in nine provinces of high HIV burden and prevalence of KPs) indicated that 50 percent of PWID, 32 percent of MSM, 60 percent of street-based sex workers, and 58 percent of venue-based sex workers had ever been tested for HIV.

The Government of Vietnam approved the national HIV rapid testing algorithms in April 2014 as a result of many years of advocacy efforts and TA from PEPFAR VN and other donor programs. Although three HIV rapid tests (in serial testing) can be used for the confirmation of HIV infection, confirmatory testing must be performed at HIV confirmation labs certified by MOH. PEPFAR VN will provide support for HIV confirmatory testing using rapid testing algorithms at district health facilities in 13 select districts starting in FY 2015. Furthermore, the MOH also issued guidance in 2013 that allows rapid HIV testing using finger-prick as an alternative to venipuncture. These policy changes have had a positive impact on HTC accessibility among KPs.

PEPFAR and HTC implementing partners have reviewed site-level data and reached consensus on thresholds for DSD support: annual minimum numbers for five key indicators for each PEPFAR VN-supported HTC site include a) number of clients served (≥1,200); b) proportion of KPs and high risk sex partners (≥50 percent); c) number of HIV-positive cases identified (≥48 cases or 4.0 percent); d) return rate among HIV-positive clients (≥85 percent); and e) proportion of identified HIV positive clients referred successfully to HIV/AIDS care and treatment sites within three months upon diagnosis (≥70 percent).

By the end of FY 2014, PEPFAR VN had transitioned 21 DSD HTC sites to the Vietnamese government. During COP 15 development, PEPFAR VN reviewed the APR2014 results from 94 DSD HTC sites and identified that 42 sites (45 percent) were below the established threshold of 48 HIV-positive cases identified per year. Of these 42 sites, 20 sites will be fully transitioned to the Government of Vietnam by the end of FY 2015; 10 sites will continue to receive PEPFAR VN support in FY 2016. Taking into account the unmet need for KPs testing and ART where these sites are located – these sites will also receive intensive TA to improve HIV yield and linkage to care and treatment services supported by PEPFAR and other donors programs. An additional 12 sites supported through the U.S. Department of Defense (DOD) will be maintained as passive HTC sites at minimum cost since PEPFAR VN continues ART in DOD sites. Of the 52 sites above the established threshold, PEPFAR VN will include full transition of one site to the Government of Vietnam (which is located in a low burden province), sustain DSD support for 49 sites, and transition the rest to TA-only or commodity-only sites. In FY 2016, PEPFAR VN will also continue to support three DSD HTC sites newly opened in early FY 2015 to scale up services for KPs in high burden provinces.

In partnership with targeted community outreach programs, PEPFAR VN will intensify HTC efforts to increase HIV identification in 5 aggressive scale-up provinces with high HIV burden and unmet need for HIV testing of KP and ART. HTC services will be sustained without targeted active case finding strategies (35 sites) in locations where ART gap is narrowing. The total KP HTC target for COP 15 is 190,320 tests with expected 9,200 HIV newly identified infections (~5.0%). In comparison with APR2014 results, the testing target is almost the same but the HIV yield target increases by ~29% (7,151 vs. 9,200), showcasing that efficiency will have to increase by targeting resources to higher HIV burden locations, transitioning low yield sites to central support, and intensifying active case finding strategies.

In COP 15, PEPFAR VN will invest our HTC TA efforts in two key priority areas: 1) development and evaluation of innovative HTC models that help increase HTC uptake among KP in 5 aggressive scale-up provinces; and 2) development and standardization of linkages/referral systems between HTC and HIV care and treatment.

As of Feb 2015, PEPFAR VN conducted SIMS for 26 HTC sites. The preliminary results show that the most common issues across partners are: 1) Site level QA for HIV rapid testing are not performed due to lack of internal quality control (IQC); 2) Some sites have not participated in the external quality assurance (EQA) program for HIV proficiency testing; and 3) A successful referral tracking system is not in place. PEPFAR VN's laboratory program has been working with the government to expand both IQC and EQA programs to address the HIV rapid testing quality assurance. Efforts have also been made to develop and standardize referral procedures, including the referral tracking systems, between HTC and HIV care and treatment services.

4.6 Facility and community-based care and support

In Vietnam, approximately 20 percent of PLHIV do not know their HIV status and a similar proportion of those diagnosed with HIV are not linked to care. The two primary goals of PEPFAR VN's care and support programs in COP 15 are: 1) to improve access to HIV testing for KPs and timely linkage to and retention in HIV care; 2) to enhance access to diagnosis of and treatment for co-infections in PLHIV. PEPFAR VN has transitioned out non-core services such as nutrition support, mental health, end-of-life care and symptom management since COP 13.

To improve access to testing, linkage, and retention in FY 2016, PEPFAR VN will continue to support the development and implementation of national standard operating procedures (SOPs) on referrals to strengthen linkages from HIV testing and counseling sites to HIV care and treatment OPCs. Since 2013, PEPFAR VN has reduced its direct support to government of Vietnam care and support sites and is phasing out/transitioning these sites to local financing and implementation while concurrently increasing the number of DSD community-based care sites provided by CSOs within the Community Link Initiative. PEPFAR VN currently provides support for human resources and operational costs to 178 care and support sites (13 Government of Vietnam community home-based care (HBC) sites, 83 OPCs, and 82 community-outreach sites that offer HIV prevention and care services). In 2015, PEPFAR VN will phase-out 6 community HBC sites and transition 6 community HBC and 22 community-outreach sites while increasing the number of CSO DSD community-based care sites performing case management by 24.

In FY 2014, PEPFAR VN provided direct support, including opportunistic infection (OI) drug support, to almost 60,000 PLHIV including ART and non-ART patients at both facility and community levels; nearly 60 percent of all national care and support achievements. Since 2014, PEPFAR VN supports only 10 essential OI medications, compared to 22 in 2012. PEPFAR VN will collaborate with the Government of Vietnam and other stakeholders to facilitate transition of OI medication to local resources and health insurance.

In addition, PEPFAR VN also provides above site level support for hepatitis B (HBV) and C (HCV) co-infections. HBV and HCV co-infection rates are high among PLHIV (about 30 percent PLHIV co-infected with HCV and 12-15 percent with HBV), and PEPFAR VN has been working with the Government of Vietnam to review the impact of screening, including the use of the rapid strip assay for HBV and HCV screening, and to develop guidelines for screening and clinical management of viral hepatitis co-infection with HIV.

In 2014, SIMS was conducted at 4 community-based sites and 21 facility-based sites and identified critical issues and gaps in SOPs for facility-community linkage, implementation and documentation of positive health, dignity and prevention interventions as routine care, documentation of nutritional assessment results, patient tracking and referral systems.

4.7 TB/HIV

Vietnam is a high TB, MDR TB, and HIV burden country (WHO TB report 2014). The annual reported number of TB cases is about 100,000 (2012: 103,906; 2013: 100,721; 2014: 102,070). The burden of TB is highest in the southern provinces and the red river delta region. HIV and TB are managed in two parallel systems. Provider-initiated testing and counselling (PITC) services are offered at TB clinics for TB patients. When a TB patient is identified as HIV positive, they are

referred to HIV clinics for HIV care and treatment services such as ART. Registered HIV/AIDS clinic patients, if positive after TB screening, are referred to TB clinics for further TB work up and treatment. Therefore, the linkage between the two systems is important.

National targets set by the MOH aim to have 90 percent of TB patients tested for HIV and 90 percent of HIV-infected TB patients receiving treatment for both diseases by the end of 2015. The country revised national guidelines and placed more emphasis on offering immediate ART for HIV-positive patients with TB disease.

National reports show that 70 percent of reported TB cases receive PITC and with a 6 percent HIV positivity rate, each year about 4,000 HIV cases are identified among TB patients. If the national PITC targets increase to 90 percent, the number of HIV-infected TB cases would increase to 5,200 annually. HIV testing is available in all TB sites at different levels and TB treatment is provided free of charge to TB patients In FY2015, all HIV test kits for TB patients will be transitioned from PEPFAR funding to TB programming with Global Fund resources.

As reported, 68 percent (2936 out of 4301 HIV-infected TB patients) have been provided with ART during TB treatment in 2013. Given the national target of 90 percent of TB cases tested for HIV and 90 percent of HIV-infected TB patients treated with ART, the estimated number that needs to be put on ART is 4,680 in 2016. Efforts needed to treat this additional 22 percent (equal to 1744 HIV-infected TB patients) are substantial.

PEPFAR VN will focus efforts at the national level and in 5 PEPFAR aggressive scale-up provinces and other provinces with high burden of TB and HIV (provinces with >2000 HIV cases and >1,000 TB cases). In COP 15, our core activities are 1) increasing case finding for both TB and HIV (PITC, ICF) 2) increasing the number of HIV-infected TB patients on TB treatment and ART 3) supporting the development and implementation of national guidelines, and SOPs for both the "3 Is" and linkage between programs; and 4) improving monitoring and evaluation systems to reflect routine program data, focusing on referral, tracking, and reporting of TB and HIV diagnostics. PEPFAR VN continues to reduce DSD, while focusing efforts on TA. In FY 2015, only the ICF component is sustained as DSD in 55 sites and the central support of 85 sites.

Reports from SIMS visits in Q4 FY2014 to Q2 FY 2015 at HIV and TB sites highlight the need for improvement of the TB diagnostic evaluation cascade and TB infection control. Four of 15 sites were scored as red due to unavailability of a SOP and a lack of documentation of both TB test results and referrals of HIV-positive patients with suspected TB symptoms to TB clinics for TB evaluation. Six of 13 sites were scored as yellow for these core essential elements (CEEs). In addition, there have been interruptions of HIV test kits for PITC and Xpert MTB/RIF cartridge supply after transition, and difficulties in isoniazid supply for isoniazid prevention therapy in the country.

4.8 Adult Treatment

In Vietnam, there are an estimated 256,817 PLHIV and 89,853 people who received ART as of September 2014. This is a 28-fold increase since 2005. A little over half of those were supported directly by PEPFAR VN. The government of Vietnam has a target of 105,000 patients on ART by 2015 and has placed 94,000 people on life-saving ART thus far.

PEPFAR VN HIV treatment goals are to support HIV treatment for epidemic control, while also transitioning PEPFAR DSD support to domestic financing. Epidemic control will be addressed by 1) increasing access and treatment coverage for eligible PLHIV in PEPFAR-supported provinces through case-finding and ART among high-risk populations and 2) patient monitoring for treatment failure, including use of viral load, and management of adherence and retention**.** Transition of DSD support and sustainability of core services will be addressed through 3) enhanced ART service quality; and 4) sustainability and efficiency of services.

Core activities to support these goals are TA to: 1) improve linkages and case management from diagnosis to early ART initiation and retention in care, 2) improve HIV quality improvement systems, and 3) enhance sustainability and efficiency of HIV treatment services. Activities identified as near-core but important in the short-term until COP 17, include 1) support to establish local TA networks from national to provincial levels, thereby shifting direct TA from U.S. government and international partners to local institutions; and 2) support to update guidelines of in-service training for site and above-site level staff.

Increasing Access and Treatment Coverage for all Eligible PLHIV
In July 2015, MOH issued updated national guidelines on ART following the WHO consolidated guidelines in 2013. The new guidelines include increasing CD4 eligibility for ART from 350 to 500 regardless of WHO clinical stage, and immediate treatment for HIV-infected people including key populations, sero-discordant partnerships, HIV-infected TB patients, children less than five years of age, all HIV-positive pregnant and breastfeeding women (Option B+).

In COP 15, PEPFAR VN will continue to focus on the high burden geographic areas and key populations with the largest treatment gaps. To achieve the second "90" goal, PEPFAR will prioritize and scale up ART in three high burden provinces (Dien Bien, Nghe An and Son La) and provide robust technical assistance to GFATM and GVN sites in Thanh Hoa and Ho Chi Minh city, where PEPFAR VN can make the most significant contributions to the national HIV response. PEPFAR estimates a total of 7,038 new patients on ART in COP 15, including 6,575 identified at HTC and the rest referred from MMT and TB/HIV sites. The PEPFAR VN current ART target for COP 15 is 58,000, which in combination with the Global Fund target by end of December 2016 of 43,095 that contribute to a total of 133,518 nationally by December 2016. Strategies include the strengthening of cascade from outreach to KP and PLHIV through diversifying outreach activities, rolling out mobile HTC model, training for HTC and OPCs staff on early treatment, referrals and improvement of service quality.

Monitoring Patient for Treatment Failure and Management of Adherence and Retention
To support the government of Vietnam in achieving viral suppression in 90 percent of patients, PEPFAR will provide TA to MOH to develop a national viral load plan including negotiated price reductions for a viral load (VL) test and expanded use of dried blood spot for VL testing. A transition from CD4 towards routine VL monitoring should be considered as a part of a long-term plan to maximize the success of PEPFAR-supported ART programs. In COP 15, PEPFAR will coordinate with Global Fund and NTP to initiate routine VL test for patients on ART in selected provinces.

Enhanced ART Service Quality:
PEPFAR VN has also partnered with Government of Vietnam, Vietnamese partners, and other international stakeholders to develop the national quality improvement program to improve the

quality of care for PLHIV. The initiative, known as HIVQUAL, establishes a performance data system to measure the quality of care and to use the data for local quality improvement activities, thereby increasing early access to treatment and reducing AIDS-related deaths. The Quality Improvement (QI) program is aligned with the 2015 PEPFAR Quality Strategy. Supporting MOH's efforts to bring QI and quality management (QM) programs to all HIV facilities is a PEPFAR VN priority.

In two quarters of FY 2014, PEPFAR VN conducted site-level SIMS data in 18 DSD clinics. The results showed zero clinics needed urgent remediation and none had drug stock-outs. However, tracking patients, especially with pre-ART groups in 3 OPCs, and expansion of QM/QI to all HIV clinics need to be improved. In COP 15, PEPFAR VN will conduct SIMS in all clinics, starting with high burden sites in PEPFAR-supported provinces**.**

Sustainability and Efficiency
In COP 15, PEPFAR will continue to transition from a DSD model, largely funded by outside donors, to an expanded focus on TA. By FY 2016, PEPFAR VN will transition 12 DSD treatment sites to TA and another 3 sites to commodity only.

PEPFAR VN will work with MOH and provincial authorities to restore financial, technical and programmatic support for DSD to the Government of Vietnam and CSOs, while ensuring the quality and sustainability of services. Recognizing that services need to be affordable for the host government, PEPFAR VN will continue to provide TA to improve service affordability, support service integration (e.g. 3 in 1 sites), and decentralization. By maximizing the use of the existing human resources, the workload will be shared to a wider workforce without additional cost to the Vietnamese government, reducing the treatment unit expenditure per patient.

At low volume DSD sites, PEPFAR VN is working with the Vietnamese government to identify the most sustainable option for each site: consolidate into the existing primary health care system; integrate into another project-based OPC if available; or transition to TA-only. If integration is not possible and the Government of Vietnam is not ready to take over after negotiations, PEPFAR VN will set a reasonable and fixed timeline to inform the local government on when and how PEPFAR VN will be reducing DSD support to low volume clinics. In addition, in COP 15, PEPFAR VN will continue applying e-mentoring TA to build capacity for provincial healthcare workers (HCWs) as a cost-saving model.

4.9 Pediatric Care and Treatment

There are approximately 5,000 HIV-positive children in Vietnam (2 percent of PLHIV), with 3,990 (80 percent) children receiving ART in 59 of 63 provinces. Vietnam's concentrated HIV/AIDS epidemic poses challenges to pediatric geographic coverage and makes it difficult to develop expertise and infrastructure. A handful of sites in urban areas provide care to large numbers of HIV-exposed and infected children, but facilities in the rest of the country are not prepared to meet minors' needs. For APR2014, PEPFAR VN provided ART direct support for 3,351 children (84 percent of all national pediatric ART patients) at 44 HIV clinics (17 are pediatric only). PEPFAR VN also provided care services to 1,300 HIV-exposed infants referred by PMTCT, accounting for 73 percent of HIV-exposed infants born in Vietnam during reporting period. The new 2015 national guidelines changed ART eligibility to include all PLHIV with CD4 less than 500 and all children

less than 5 years. It is anticipated these changes will increase the pediatric ART coverage to 90 percent.

For COP 15, PEPFAR VN prioritized two areas for TA: 1) strengthening of a local TA system and 2) pediatric ART service quality, focusing on HIV disclosure to adolescent patients and patient assessment and management for ART failure. Site-level operational and clinical pediatric TA has already been transitioned from an international NGO, the Partnership for Health Advancement in Vietnam (HAIVN), to two Vietnamese pediatric hospitals; HAIVN will continue to provide TA to strengthen their mentoring and coaching skills.

SIMS visits to pediatric sites yielded red/yellow CEEs indicating that the documentation of referral feedback between facility and community was often incomplete or missing and insufficient documentation of TB screening and adolescent support services. Sites with red/yellow CEEs will be prioritized for TA. PEPFAR plans to provide site level TA to site staff to strengthen referral mechanisms, TB screening, practice and mastery of disclosure, and support for patient clinical and ART management using clinical and virologic criteria.

In 2014, the human resource and operational costs for one HIV OPC were transitioned to the Government of Vietnam, and in 2015 these costs at two OPCs in low prevalence/burden geographic areas will be transitioned. In 2016, 16 OPCs in medium prevalence/burden geographic areas will be transitioned; only 25 sites will receive PEPFAR DSD support by the end of 2016. With low volume DSD sites (<5 pediatric ART patients), PEPFAR VN will advocate for early transition. PEPFAR VN will continue supporting core commodities (CD_4, VL) while Global Fund provides pediatric ARVs and EID supplies through 2018. Near- and non-core activities and services including travel, nutrition, infant formula, and trainings support have been substantially reduced or discontinued. PEPFAR VN will continue to support core activities including essential OI drugs, support for TB ICF, and training on the new ART guidelines while working with facilities and the MOH/provincial DOH to expand pediatric patient health insurance coverage.

4.10 OVC – NA

5.0 Program Activities to Sustain Support for Other Locations

5.1 Sustained package of services in other locations–

Following PEPFAR Guidance, the VN program describes sustained provinces, sustained sites, sustaining commodities, and centrally supported provinces and sites as defined below. All sites have a clear timeframe to transition to central support by the MOH or ending financial support completely. Below are the definitions that were used:

- Sustained Provinces: Facility activities, adherence and retention; site, district and national level quality monitoring
- Sustained sites: consistent with current ART expansion rates. Thus sites in which outreach will conclude, but in which HTC may remain available through PITC models, including PMTCT and TB/HIV, or co-located voluntary counseling and testing sites if HTC volume

and positivity yield remains at or above HTC-PEPFAR thresholds. The Case Finding model will be implemented from January 1, 2016.

- Sustaining commodities: include continued National Support for overarching QA/QI etc, and/or commodity support to sites without site level support. Thus sites in which PEPFAR VN will continue to provide ARV for patients until sites are fully transitioned to domestic resources. The ARV Maintenance (sustained) model will be implemented from April 1, 2016
- Central Support provinces or sites: include continued National Support for overarching QA/QI etc., site specific activities move to direct government support over the next 6 months but must be negotiated with the government to ensure no interruption of services, and/or site level support would end by Sept 2015-March 2016.

For example, 70 of 115 PMTCT sites and 39 of 108 HTC sites will be fully transitioned to the host country government by the end of 2015. At these PMTCT and HTC sites there will be no recurrent costs. In addition, 24 of 113 ART OPCs will be transitioned or will be maintained as a TA sites with no routine operating costs to PEPFAR outside of ARV drugs. At these 24 OPCs, the core package of services includes ARV procurement and assistance from the MOH to collect required national data on HIV/AIDS.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts

Maintenance Volume by Group	Expected result APR 14*	Expected result APR 16	Percent increase (decrease)
Sustained / Central Support Provinces			
HTC Total**	91014	41052	-55%
HTC positives	3417	2240	-34%
Care Current	28740	29797	4%
ART Current	23329	28209	21%

Notes:

- * **Achievement APR2014**
- ** **VCT budget code numbers only**

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

PEPFAR VN targets conclusion of DSD support in 2018, therefore any cost savings from ARV and case-finding sustained and central support sites will only be used to add minimal DSD cost new sites, such as commune-level ARV dispensing sites or TA-based ARV and HTC models in aggressive scale-up provinces. Additionally, in COP 13-15 planning cycles, the team has cancelled or is closing out 18 separate contracts and cooperative agreements with the Government of Vietnam, the UN system, U.S. Universities and international contractors. While there are savings

from the transition of sites and the closing of projects, these cost cutting efforts permit the team to stay within a declining budget rather than reinvest heavily in new programs or sites.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

The PEPFAR VN Laboratory Program works with local and international partners to expand access to quality laboratory testing services, which are critical for diagnosis, care and treatment of PLHIV. To meet these goals, the lab program has focused efforts in testing services, quality management systems, TB, and laboratory information systems (LIS), with a goal of enhanced domestic programs and service delivery (SID domain 2). To ensure a sustainable transition, the lab program supports activities through numerous governmental partner agencies, with international partners providing TA when required. The impact of PEPFAR VN lab strengthening activities on laboratory quality has been broad. As programs like the Global Health Security Agenda (GHSA) begin investing in health systems, the achievements of PEPFAR VN are a foundation to further strengthen health and surveillance systems. PEFPAR VN support for some activities is expected to diminish as GHSA funding becomes available.

Access to quality testing services
PEPFAR VN support has strengthened HIV diagnostic, CD4, viral load (VL), and drug resistance testing, in laboratories and at the point of care, through mentorship, quality assurance programs, procurement of instruments, creation of sample referral networks, and training. Through PEPFAR support, CD4 testing sites in PEPFAR VN provinces receive commodity support for laboratory reagents, ensuring access to care (SID Element 3). The limited domestic financing available for these reagents remains a significant threat to program sustainability (SID element 6).

To ensure the quality of testing, PEPFAR VN has supported national programs for implementing Internal Quality Control (IQC) and External Quality Assessment (EQA). The National Hospital for Tropical Diseases (NHTD) currently coordinates CD4 EQA using Health Canada's QASI program. To ensure long-term sustainability of this program, PEPFAR VN will support the Pasteur Institute in Ho Chi Minh City (PI) to produce CD4 IQC and EQA panels domestically. To ensure that care reaches targeted populations, the lab program will provide TA to implement a CD4 referral system and ensure that instruments, including point of care platforms, are optimally deployed in priority provinces. PI and National Institute of Hygiene and Epidemiology (NIHE) will provide EQA and IQC for HIV serology.

The lab program has supported the development of early infant diagnosis (EID) guidelines, supported validation and training for dried blood spot (DBS) collection and molecular lab

techniques, and launched EID testing services at NIHE and PI. PEPFAR VN laboratory and treatment programs have worked with the government to develop national guidelines for viral load testing and support viral load testing for suspected virologic treatment failure in 20 provinces. These policies have created an enabling environment and have encouraged leadership to implement national testing programs in a sustainable way (SID element 14 and 15). Routine testing for monitoring ART adherence has not begun, as MOH has been reluctant to apply it with limited resources. PEPFAR VN will provide TA to MOH as they assess feasibility, choose platforms and specimens types, and develop procurement, implementation and scale-up plans. NIHE will provide training for DBS collection and testing techniques, and a system for quality assessment.

Finally, the lab program has supported PI with equipment and training to achieve HIV drug resistance (HIVDR) WHO accreditation. PEPFAR VN will provide mentoring for the HIV reference lab at NIHE to reach HIVDR WHO accreditation as well, using low cost HIV-1 drug resistance genotyping kits. VL and HIVDR testing provide critical epidemiologic data to the national program and are a strong metric of the success and sustainability of the response. Access to high-quality national-level data will promote sustainability of the national response (SID Element 1, 10 and 11).

Strengthening the Quality Management System (QMS)

Strengthening Laboratory Management Toward Accreditation (SLMTA) is an innovative, scalable and practical approach to improve lab quality. Labs receive training and TA, conduct improvement projects and are evaluated in a stepwise process using a standard stepwise laboratory improvement process towards accreditation (SLIPTA) checklist. After a successful first cohort, the program is being expanded by PI, NTP, U.S. DoD and FIND to reach more laboratories. There are currently three master trainers in Vietnam who are able to conduct training of the trainer (ToT) workshops. Following expansion and ToT in COP 15, a larger cohort of trainers will be available to scale up the program using local resources. This activity address key sustainability elements in the SID, including HRH sufficiency and transition, institutionalization of in-service training, and implementation of national policies for lab quality, staff competency and training (SID Element 5, 7 and 14).

The lab program also provides direct support to key laboratories seeking ISO-15189 accreditation to increase the reliability of testing results and reinforce other laboratory strengthening initiatives. Accreditation status is also important because inter-laboratory recognition of results remains a challenge. Out of 35 laboratories accredited under ISO-15189 in Vietnam, PEPFAR VN supported 11 (31 percent) to achieve accreditation through FHI360 and Vietnam Administration for Medical Services (VAMS). In COP 15, this activity will be supported entirely by the local partner, VAMS, and the FHI360 lab contract will be discontinued, thus improving the efficiency of the program and supporting a sustainable transition. This need was highlighted by SID elements 7 and 11.

PEPFAR VN also supports basic training programs on the laboratory quality management system (QMS) based on the WHO training package. To ensure easier access and reduced costs, PEPFAR VN is working with American Society for Clinical Pathology, VAMS, PI and NIHE to develop a web-based training program for delivery in COP 15. Through the Clinical Laboratory Standards Institute, PEPFAR VN has also worked with MOH to create a QMS certificate program for laboratory leadership. Graduates now serve as instructors, reducing the cost of international TA, and the curriculum will be integrated into undergraduate and graduate programs at medical universities next year. Through this approach, HRH sufficiency and transition have been strengthened, as well as the quality management system in individual sites (SID element 5, 7 and 14)

Many patients, including HIV patients, come directly to national/provincial level hospitals for diagnosis and treatment due to concerns about the quality of district-level hospitals, which has led to overcrowding. Addressing reliability of district-level lab testing can help address the health access and efficiency issues that are crucial to program sustainability (SID Element 4 and 11). PEPFAR has implemented a training and TA program in district level laboratories. A pilot conducted in Nam Dinh province showed significant improvement in laboratory capacity and test result reliability. To COP 18, PEPFAR will provide intensive TA to HIV/AIDS priority provinces to increase access to quality care and treatment services.

Laboratory Information Systems (LIS):
Through PEPFAR support, an open-source LIS has been implemented in 32 health facilities in Vietnam. LIS has been shown to reduce errors and improve quality and throughput, and it has become a vital tool as laboratories pursue national and international accreditation. To streamline management and reduce costs, these programs will be transferred to the national program over the next two years. The Association of Public Health Laboratories' scope of work will shift to TA, technological development, and coordination with the global OpenELIS community.

Recently, support cost per LIS site has decreased significantly. While this trend is promising, financial planning and programmatic investment is required to ensure a sustainable transition. This year, Ministry of Health issued a decision to co-fund a LIS technical support team. PEPFAR VN funding to implement LIS at new and existing sites (including hardware, software, IT support, consumables, and HR support) will end by 2018. By requiring shared investment from revenue-generating facilities (like hospitals), resources over the next three years can be focused on under-served facilities, particularly provincial facilities. Data exchange between LIS and key health IT systems, including Hospital Information Systems, eClinica, and other national surveillance systems, is a continuing priority as it will support improved management and use of epidemiologic data (SID Element 1 and 7).

TB/HIV
TB remains the most common infectious cause of death among PLHIV. Thus TB screening, appropriate diagnostic evaluation among PLHIV with presumptive TB and treatment for TB are

important throughout the continuum of care. PEPFAR has supported MOH efforts to through three main partners, National TB Program (NTP), FIND, and WHO.

The TB Lab national strategic plan has been approved and implemented. National and regional reference laboratories are being supported to pursue ISO 15189 accreditation so that they can provide support for QMS implementation at lower level labs. National Tuberculosis Program (NTP) and FIND are supporting laboratories with the SLMTA curriculum. This strategic approach to QMS and HRH strengthening has increased the sustainability of the national response. (SID element 7, 14 and 15)

NTP has successfully implemented EQA for direct smear in regional and provincial TB labs. FIND provides Xpert MTB/RIF and LED EQA panels. Through CDC-WHO CoAg, two TB reference labs National Reference Laboratory (NRL) and Pham Ngoc Thach laboratory participated in Drug Sensibility Test EQA program provided by the supranational TB lab. PEPFAR also supports an electronic EQA management database (S2C: slide to check) to support the slide re-checking program. The application helps labs carry out in-depth analysis of their results and allows faster reporting of quality health data (SID element 7). PEPFAR will extend S2C for all 59 provincial supervisory sites through FIND (SID element 7 and 11).

PEPFAR will also support roll-out of Xpert® MTB/RIF to improve identification of TB and multi-drug resistant (MDR) TB disease, including near-point-of-care placement where appropriate and integration of Xpert® MTB/RIF into existing reporting systems and algorithms. Recent EU approval of Xpert HIV 1 Viral testing creates the opportunity to co-locate HIV VL and TB testing services at the point of care, leading to better care and decreasing loss to follow up (SID element 4 and 6).

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6 IM ID	7 SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Support national viral load testing network to assure quality of VL test results (EQA, TA and DBS validation)	1. 5 labs received EQA-VL panels. 2. Validation of DBS for VL testing is conducted	1. 10 labs receive EQA-VL panels. 2. 20 provinces received trainings on DBS collection and 15 labs received technical transition	HLAB $80000	HLAB $165000	99979998			X	X		X
Support National EQA and IQC programs for HIV serology at NIHE	1. IQC and EQA samples provided for 80 and 1,000 HIV labs respectively 2.EQA programs for Microbiology, will be provided 10	1. IQC and EQA samples provided for 140 and 1,200 HIV labs respectively 2.EQA programs for Microbiology will be provided 30 3. Pre-service curriculum for QA/QC updated and CME training package for QA/QC launched	HLAB $146000	HLAB 191000	9977 9998 14336		X	x	x		
Support National EQA and IQC programs for CD4	1. CD4-EQA QASI program coordinated and managed for 55 CD4 labs 2. National CD4 EQA program introduced nationwide for 22 CD4 labs 3. National CD4 IQC samples provided for 22 labs in the South	1. CD4-EQA QASI program coordinated and managed for 55 CD4 labs 2. National CD4 EQA program implemented nationwide for all CD4 labs 3. National CD4 IQC samples provided for all CD4 labs	HLAB $49000	HLAB 69000	9998 9976			x	x		
Support NIHE to validate and implement HIV drug resistance testing	1. Assay validated with technical assistance from CDC-Atlanta	1. With technical assistance from CDC-Atlanta, NIHE received WHO accreditation for HIV-DR testing	HLAB $35000	HLAB $35000	9977		X	x	x		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6 IM ID	7 SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Support Quality Management System (QMS) Laboratory Leadership Certificate program to improve knowledge and skill for QMS implementation in HIV lab system	1. MOU established with University of Medicine and Pharmacy (UMP) in Ho Chi Minh city for continuation transition of QMS_LL certificate program 2. 52 participants trained in May/June 2015, Aug/Sep 2015 1, and Dec 2015/Jan 2016	1. 26 participants graduate from program in May 2016 2. UMP's lecturers deliver the contents of the QMS_LL packages	HLAB $240000	HLAB $220616	10831		X	X			
Implementation of SLMTA program	1. 46 Labs in HIV/AIDS, TB and clinical microbiology system will implement SLMTA program and be improved based on international standards. 2. 20 in-country trainers/mentors/assessors are certified and implement SLMTA program.	1. 42 labs in HIV/AIDS, TB and clinical microbiology system will implement SLMTA program and be improved based on international standards. 2. SLMTA curriculum will be imbedded into medical universities under CME programs. 3. 30 in-country trainers/mentors/assessors are certified and implement SLMTA program.	HLAB/ HVTB $274000	HLAB / HVTB $285000	17370 10832 9998 10118 10001 12736		X	X			
Providing Technical and Administration support for laboratories to achieve ISO 15189 accreditation	1. Bureau of Quality Management/VAMS staff are trained to support laboratory on ISO 15189 standards 2. 5 sites will be trained, mentored and completed dossiers for ISO 15189 accreditation	1. 5 sites will be trained, mentored and completed dossiers for ISO 15189 accreditation 2. VAMS's staff are capable to provide training and mentorship for selected sites	HLAB $130000	HLAB $170000	10118 10832 10001		X	x			
Implement and support laboratory information systems (LIS) to improve HIV lab quality and surveillance data	1. Software developed to improve reliability, functionality, and ease of maintenance 2. LIS introduced to 14 additional sites (PMC, PAC, TB and regional institutes), improving their informatics capacity/quality 3. National LIS Technical Workgroup is convened and supports sustainable transition and reduces need for contracted IT support services	1. LIS introduced to 8 additional sites (primarily using local funding and resources) 2. LIS software updated to the latest version at all sites.	HLAB $260000	HLAB $279685	9972 9974 9976			X			

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6 IM ID	7 SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
	4. LIS policy and plan is developed										
Implement QMS program for provincial and district level laboratories	1.96 labs in district and provincial levers implemented and improved in QMS 2. Provincial Medical Departments will be able to monitor and support for QMS implementation in high HIV burden provinces.	1.61 labs in district and provincial levers implemented and improved in QMS 2. Provincial Medical Departments will be able to monitor and support for QMS implementation in high HIV burden provinces.	HLAB $498000	HLAB $272000	9974 10118 9998 14336 10001		X	x			
National Laboratories Standard and Checklist for Quality management system	1. National committee establishes the national standard checklist for laboratory quality management system. 2. Checklist is distributed, and assessors are trained	1. Core-organizations and implementation bodies are trained to use the checklist 2. National checklist implemented nationwide 3. Monitoring and evaluating of laboratory performance is strengthened at the national level	HLAB $15000	HLAB $30000	10118		X	x			
Technical assistance for In-service Laboratory Safety and quality assurance to support national HIV testing programs	1. 25 staff in 10 high-burden target provinces becomes certified trainers for QC and method validation packages 2. DST EQA panels provided to 2 reference labs, performance assessed 3. 10 provinces gain skills to safely collect specimens 4. Intensive TA provided to microbiology section of laboratory in two hospitals 5. e-learning sytem established at PI training Center	1. Trainer from TOT will provide training for 15 provinces with minimum support 2. 25 provinces launch CME training on safe specimen collection 2. 10 labs can perform good quality of Viral Load testing 3. Rapid testing algorithm validation exercise conducted 4. Development of biosafety training course for eLearning platform begins	HLAB $338000	HLAB $248039	10832 9972 13779		X	x			
Support for new TB diagnostic technologies under development/evaluation		1. Provide technical support for TB diagnosis, TB DST for 8 regional and national reference labs 2. Develop TB lab certification programme 3. Implementing integrate solutions to link TB and HIV diagnosis			12736			X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6 IM ID	7 SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
TB EQA for smear microscopy, and Xpert to improve TB laboratory quality		1. Electronic TB smear microscopy EQA management system (S2C) implemented for 3 regional sites 2. EQA panels provided for sites using Xpert MTB/RIF for 22 sites 3. EQA for fluorescent microscopy offered for 30 sites		HVTB $260,000	12736			X			
Development of national TB Lab capacity and service networks	1. EQA program provided for direct smear testing in TB labs at national, regional and provincial level 2. Capacity and quality of TB culture laboratories monitored using newly developed electronic checklist 3. Lab staff from national, regional and provincial labs gain skills to conduct TB Lab Assessments	1. EQA program provided for direct smear testing in TB labs at national, regional and provincial level (66 labs) 2. Provide TA for lower level: technical trainings, mentoring, assessment	HVTB $140000	HVTB $140000	13007			x			

6.2 Strategic information (SI)

1. Context for PEPFAR Vietnam SI Response

PEPFAR VN investments for COP 15 are focused on transitioning and supporting the Government of Vietnam to solidify core functions for surveillance, program monitoring, and health management information systems (HMIS).

a. Correlation of PEPFAR Strategic Information Investments with Priorities

PEPFAR VN strategic information activities proposed for COP 15 are directly aligned with 90-90-90 targets for PEPFAR VN, as well as selected domains and priorities for epidemiological and performance data systems strengthening as identified through the PEPFAR VN Sustainability Analysis for Epidemic Control. The PEPFAR VN COP 15 response will work to address continued gains and value added in strengthening the Government of Vietnam's national and provincial capacity to generate and utilize high quality data for epidemic monitoring and control among key populations (KP) – particularly PWID, MSM, and Female Sex Workers, and other emerging risk groups.

PEPFAR VN COP 15 SI investments will focus on remaining gaps in data collection, data quality assurance, analysis, and use of epidemiological and performance data at national, provincial, district, and commune levels. Additionally, COP 15 will support the wider engagement of civil society organizations and the private sector in the national monitoring and reporting system. Planned operational research under COP 15 will also help expand the availability of data to monitor technical and allocative efficiencies with PEPFAR support – including assessments of program coverage, cost effectiveness, and access to priority services among KP.

Geographic focus of SI Investments

PEPFAR VN strategic information activities will be aligned with the new geographic prioritization of activities in COP 15. Surveillance, Program Monitoring, and HMIS activities will be implemented to strengthen the collection of data for the monitoring of epidemic control and program impact. USG contributions by HHS/CDC, USAID and DoD will focus on the generation of high quality data to support case finding, enrollment, and retention in prioritized geographic locations.

2. Explanation of Core, Near-core, and Non-core Activities by Program Area to Support the SI Programmatic Response in COP 15

a. Surveillance: PEPFAR VN will work closely with in-country surveillance institutions to improve quality of the national surveillance systems including the HIV sentinel surveillance and the HIV case reporting. This is to ensure surveys and surveillance activities funded by PEPFAR are embedded in the national surveillance system led and financed by Government of Vietnam (SID #1). PEPFAR VN will also collaborate with local NGOs that have networks with PLHIV to enhance coverage and quality of HIV case reporting at the community level. PEPFAR VN will also develop methods and support implementation of KP size estimation including PWID, FSWs, and MSM to improve understanding of program coverage.

Key COP 15 surveillance deliverables include robust sampling and data collection of HIV sentinel surveillance, improved quality of sentinel surveillance surveys in high burden provinces, and higher quality HIV case reporting data. Additional activities include an in-depth analysis of HIV prevalence, trends and risk behaviors in high burden provinces and districts. A number of KP size estimation activities have been conducted in prior years and these activities have produced varying results. Available size estimation data will be triangulated with

other surveillance and program data to arrive at more accurate estimates among different sub groups and at district, provincial and national levels. Higher quality data on HIV sero-prevalence, reported PLHIV numbers and key population size estimates will contribute to a more accurate HIV epidemic estimation and projection. This informs our understanding of coverage and gaps in HIV testing and ART uptake and evaluation of epidemic control through the overall national response.

b. Program Monitoring: Program monitoring deliverables include strengthening capacity to collect, analyze, and disseminate data to measure the reach, coverage, access, and retention of key populations in priority HIV services. PEPFAR VN strategic investments will be made through USAID and CDC-MOH partners.

A key near-core program monitoring priority initiated in COP 14 but continuing in COP 15 will be the provision of site-level transition monitoring support and capacity building through service delivery partners to facilitate the ongoing assessment of site-level readiness for transition and post transition monitoring. This support has been classified as near core given the significance of supporting site-level transition as an outcome of PEPFAR DSD and TA-SDI support.

c. HMIS: PEPAFR HMIS investments for COP 15 are to be accomplished through joint collaboration and focused technical assistance support through service delivery partners and will facilitate patient tracking across the CoPC. Additional support will be provided through the prevention IDUP budget code to further deployment and staff training in the use of the GVN MMT MIS system.

d. Program Evaluation: PEPFAR VN investments in operations research and program evaluation are core due to their significance in providing an additional layer of analysis on the reach, effectiveness, and cost efficiency of approaches for accelerating cascade performance (such as the Test and Treat Model for Mountainous and Remote areas), or expanding the role of CSOs and the private sector in case finding and provision of essential HIV services to KPs. Additional TA and university partners will assist with the completion of high impact evaluations and operations research to inform ongoing programmatic implementation and as well as the extent to which cost effectiveness, increased program coverage, and allocative efficiencies are being achieved with PEPFAR support.

Near-Core Considerations:

Additional research and public health capacity building activities have been identified as near core or non-core activities, but they have not been included in this logframe due to COP 15 funding limitations. These include stand-alone epidemiology and biology courses for general public health individuals, short courses on epidemiology and biostatistics for Fogarty fellows. While these investments are important for building a cadre of public health professionals in Vietnam, the impact to HIV/AIDS epidemic control is not immediate.

Table 6.2: Strategic Information

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Surveillance											
1. Strengthen National HIV sentinel surveillance system particularly on refinement and consistent use of methodology, data quality improvement at central, regional provincial and sub-provincial level	1-Strengthen national coordination on surveillance; 2-Improve quality of HSS/HSS+ implementation in 11 high burden provinces; 3- capacity building, monitoring and coaching to provinces & districts; 4-Enhance data management analysis and routine epidemiologic update.	Continue and expand the quality improvement in 20 provinces.	HVSI $350,000	HVSI $536,854	9976, 9977, 9998, 14336	1. Epi and Health Data, Q3; Score: 2.5	x	x	x	x	
2. Strengthening National HIV case reporting (HCRS) with emphasis on data quality improvement at all level	1-HCRS assessment; 2- SOP development; 3- Vital status verification of reported cases; 4-Supervision, monitoring and coaching at provincial and district level to improve data quality in 11 high burden provinces	1-Continue data quality improvement; 2-Data audits of the HCRS at national, regional and provincial level; 3-Updated database and reports routinely available; 4-Enhance programmatic and data linkages between HCRS and VCT, OPC services and CoPC	HVSI $365,000	HVSI $390,000	9976, 9977, 9998, 14336, 14156	1. Epi and Health Data; Q5; Score: 1.6	x	x	x	x	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
		linkages at community level.									
3. Method identification and implementation of size estimation of Key Populations	1-Develop district level estimates of IDUs based on method identified earlier; 2-Data triangulation to estimate KP size in 9 high burden provinces	1-Develop district level estimates of FSWs based on method identified earlier; 2-identify method for MSM size estimation; 3-Data triangulation to estimate KP size in 9 high burden provinces	HVSI $80,000	HVSI $150,000	9977, 9998, 14159	1. Epi and Health Data; Q5; Score: 1.6	x	x	x	x	
4. HIV/AIDS modeling-– Continued national/provincial level estimates	1- Technical assistance to National level AEM & EPP updates (EPP 2015); 2-Resource Need Modeling (GOALS) for PACs on Provincial Annual Planning	1- Technical assistance to AEM & EPP at national and provincial level; 2- TA to PACs on using modeling for planning	HVSI $20,000	HVSI $40,000	14159	1. Epi and Health Data; Q5; Score: 1.6	x	x	x	x	x
Program Monitoring											
1. Strengthen national capacity to deliver high quality program	- Improved data quality through routine quality review of National program	- Improved data quality through routine quality review of National program	HVSI $927,410	HVSI $630,000	9976 9974	3. Performance Data; Q1,	x	x	x	x	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
monitoring data and to ensure accountability of PEPFAR program	data - Support for Routine Program Monitoring and Quality Improvement Implementation - PEPFAR supported sites including MoD and Civil Society engagement.	data - Support for Routine Program Monitoring and Quality Improvement Implementation in PEPFAR supported sites/ provinces including MoD and Civil Society engagement.			14159 17370	Score: 7					
2. Development of cascade information to inform programmatic gaps		- Provincial cascade model would be developed to inform programmatic gaps and future planning – aggressive scale up provinces as priority	HVSI $80,000	HVSI $140,000	9998 9977 14156 14159	3. Performance Data, Q2; Score: 5; Q3; Score3	x	x	x	x	x
3. Enhance data use at different levels, support intervention program on performance data collection and analysis to improve service quality;	- Provincial HIV/AIDS Master File in PEPFAR-supported provinces - Support performance measurement for HIVQUAL implementation in Care and Treatment	- Provincial HIV/AIDS Master File development institutionalized and Advocacy for HIV/AIDS responses at provincial level. - Support performance measurement for HIVQUAL	HVSI $270,000	HVSI $260,000	14156 9976 14159	3. Performance Data; Q2; Score: 5	x	x	x	x	x

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
	program - Support Prevention pilots on KP intervention	implementation in all programs accordingly to national plan - Support pilots interventions									
4. Maintain and Strengthen monitoring program during and after transition	- SMART monitoring and Assessment of site Transition Readiness Post transition program monitoring	- SMART monitoring and Assessment of site Transition Readiness Post transition program monitoring in transition out provinces	HVSI $80,000	HVSI $110,000	14159 9976	2. Financial /Expenditure Data; Q1; Score: 0 3. Performance Data, Q3; Score:3	x	x	x	x	
HMIS											

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
1. . Support national HMIS program for HIV/AIDS interventions	1. Support to develop and deploy electronic patient monitoring system nationally and across PEPFAR partners to improve TB-OPC, HTC-OPC, and MMT-OPC linkages. 2. Assess MMT program using patient monitoring and program data 3.Train provincial MMT staff in using patient monitoring and program data for quality improvement and advocacy purposes"	1. Support to improve the implementation and data use using electronic patient monitoring system nationally and across PEPFAR partners 2. Support provincial MMT staff in data analysis and use	HVSI $324,575 IDUP $50,000	HVSI $350,106 IDUP $40,000	9976 9976 14159 13773	Performance Data, Q3; Score: 3	x	x	x	x	x
Program Evaluation and Operations Research											
1. Program evaluation for Test and Treat (TaT) model in Vietnam mountainous provinces		. Program evaluation conducted in close collaboration with PEPFAR program TWGs, VAAC and Global Fund program TWG		HVSI $50,000	14159	11. Technical Efficiency; Q2; Score: 2	x	x	x	x	x

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
		2. Recommendation disseminated to the VAAC/MOH to inform national guidelines for HIV/AIDS epidemic monitoring and control in mountainous areas.									
2. Evaluation of community and private sector linkages for enhanced KP outreach, case finding, and HIV service delivery.	1. Develop protocol for evaluation of CSO program coverage, service delivery unit costs and quality of KP outreach and referral activities. 2. Complete evaluation field work in selected PEPFAR provinces to assess program coverage and KP access to essential services	1. Conduct CSO performance evaluation and dissemination of results 2. Complete second round consumer and market share surveys to assess KP reach/access to commercial market for HIV services (condoms, LDSS)	HVSI 175,000	HVSI $365,000	14156 14086 16803	11. Technical Efficiency; Q2; Score: 2	x	x	x	x	
3. Evaluation of provincial, district, and commune level program coverage for KP reach and access to essential services	1. Completion of evaluation field work in selected PEPFAR provinces to assess program coverage and KP access to essential services	1. Preparation of results and recommendations for planning (with PACs) and program prioritization at district/commune	HVSI $75,000	HVSI $25,000	14156	3. Performance Data; Q3 11. Technical	x	x	x	x	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
		level.				Efficiency, Q2: Score 2					
4. MSM cohort to monitor HIV incidence, evaluate outreach strategies and assess HIV risk factors, behaviors and health seeking practices among MSMs	1 Finalize protocol for IRB clearance and start the baseline data collection to evaluate outreach strategies and HIV risk factors, behaviors and health seeking practices among MSM.	1. Complete baseline data collection and continue follow-up data collection to measure HIV incidence among MSM.	HVSI $380,000	HVSI $85,000	14336	1. Epi and Health Data, Q5; Score: 5	x	x		x	
5. Expenditure and Cost effectiveness analyses of HTC-OPC linkages and TB HIV linkages for KP reach, test, and treat approaches	1. Conduct Expenditure analyses for HTC, Outreach, MMT service by sites, including unit cost for single cases tested and/or referred. 2. Conduct cost-effectiveness analysis of HTC-OPC linkage to provide evidence to VAAC on scaling up this currently piloted model.	1. Conduct Expenditure analyses for HTC, Outreach, MMT service by site, including unit cost for single cases tested and/or referred. 2. Prepare recommendation on planning for transition of SMART TA supported sites to GVN/PACs and quality 3. Conduct cost-effectiveness analysis	HVSI $135,000	HVSI $135,000	14159 14336	10. Allocative Efficiency; Q1; Score: 2.75 11. Technical Efficiency; Q2: Score 2	x	x	x	x	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
		of TB-HIV linkage to provide evidence to VAAC on expansion of this service model to other provinces.									

6.3 Health System Strengthening (HSS)

Sustainability and transition planning are core objectives of the PEPFAR HSS work in Vietnam. This includes efforts to promote domestic resource mobilization and long term financing for HIV as well as financial protection for PLHIV; to integrate HIV procurement and supply chain functions within the government system; to harness key contributions from private sector and civil society (including PLHIV and key populations); and to transition PEPFAR-funded health worker incentives, capacity-building efforts and other HRH systems support to the GVN and local institutions.

Health Financing

The National HIV program faces critical resource gaps as the major international donors (USG/PEPFAR and the Global Fund) have signaled their intent to cap and/or reduce funding over the next few years, with significantly greater levels of domestic financing expected from Vietnam in order to justify further donor investment.

The GVN's approach to sustainably finance the HIV response is contained in Prime Minister Decision 1899 (1899/QD-TTg of 16/10/2013), which references a plan for "Financial stability for HIV/AIDS control activities for 2013-2020". This emphasizes resource mobilization from diversified funding sources and improved efficiency in their use and management, with Social Health Insurance (SHI) as a key financing mechanism. Legislation and policies guiding the effective implementation of SHI include the Law on HIV Prevention and Control (2006) which mandates treatment for PLHIV to be covered by health insurance, and the recent MoH Circular 15 (Circular 15/2013/TT-BYT dated 24/5/2013) which provides guidance on medical examination and treatment covered by health insurance for HIV patients and people who use medical services related to HIV/AIDS.

However, to ensure that PLHIV and key populations utilize SHI benefits for HIV services requires:

- Definition and financing of the HIV/AIDS interventions to be included in the SHI benefit package, and the mechanism that would enable the SHI fund to pay for ARV drug costs.
- Higher rates of health insurance coverage (currently at ~35%) in order to provide financial protection to PLHIV and reduce out-of-pocket expenses;
- Strategies to operationalize the inclusion of HIV service delivery in the SHI scheme, especially given that OPCs and health centers categorized as "prevention" facilities do not meet the legal requirements for contracting with the insurance fund to receive reimbursements.

Under COP15, PEPFAR-funded health financing work will include targeted actions to inform, facilitate and/or quantify the transition from donor to domestic financing of the HIV response, and in addition helping to ensure that the costs of HIV services are not transferred to PLHIV in the form of high out of pocket payments. Addressing the above challenges for improving SHI is at the core of this work, being led by the Health Financing and Governance (HFG) project. In COP

15, HFG will generate needed data on the cost effectiveness and financial liability of including HIV/AIDS prevention, care and treatment services in the benefit package covered by SHI, allowing these services to be eventually funded by insurance and thus transitioning responsibility for HIV to domestic funding sources. HFG and CDC-CoAg support for advocacy and policy will encourage greater enrollment of key populations in SHI and promote use of SHI reimbursement mechanisms for HIV-related services particularly in high burden sites.

HFG will further support the MoH to review the experience and the challenges of implementing new policies/guidance on HIV and health insurance. Results are expected to inform the integration of HIV services into the health insurance scheme particularly at the grass roots level of the health system (Commune Health Stations).

The USAID/Washington Sustainable Financing Initiative activities (with HFG as the implementing partner) will be seen as complementary and additive to COP 15 investments. The Initiative is funding work streams that include 1) support to the GVN to improve efficiency of resource allocation and financing from domestic resources, including work with the MoH and the Vietnam Social Security (VSS) fund to ensure inclusion of HIV services in the reformed SHI scheme; 2) analytics such as National Health Accounts/HIV sub-accounts and other cost analyses that will build the evidence base for domestic resource mobilization and strengthen advocacy for improved public spending on HIV; and 3) work with key MoH departments to develop the necessary institutional and financing arrangements for centralized procurement of ARVs.

Procurement and Supply Chain Management (PSM)

An effective national HIV supply chain is needed to sustain previous PEPFAR gains made towards achieving epidemic control and to guarantee an uninterrupted supply of HIV commodities in response to new 90-90-90 treatment targets. To date, PEPFAR VN has played a critical role in preventing stock-outs and expiry of key USG-funded HIV commodities (ARVs, methadone, lab reagents), and has begun shifting ownership and responsibility for key supply chain functions to government institutions. Yet, much remains to be done to realize effective integration and transition from PEPFAR-supported work to GVN-led financially sustainable procurement and supply chain systems. At present, the key issues effecting this transition include:

- Gaps in national level capacity i.e. for central quantification, forecasting & supply planning; procurement, contracting & product management; logistics, warehousing & distribution;
- Lack of a centralized mechanism within the MoH to conduct national level quantification and forecasting and through which domestic resources for HIV procurements could be channeled;
- Inadequate domestic financing to offset PEPFAR's current share of ARV treatment costs, complicated by the GVN's preference for locally procured ARVs (at prices two to six times higher than that paid by donors, and with not all ARVs needed for the HIV program available on the domestic market), as well as limitations on the use of domestic budget for international procurement; and
- The need for better inclusion of the private sector to ensure sustainability of the HIV response, including improved access of key populations to HIV prevention commodities.

In response to these needs in COP 15, SCMS will continue to engage in routine supply planning with VAAC, PACs and key stakeholders. This will include developing national supply plans for 2016 – 2017 - for ARVs initially and then methadone and lab reagents - that will coordinate the resources of the main HIV commodities programs: PEPFAR, the Global Fund and the National Target Program, to cover patient needs for the country. SCMS procurement planning will remain responsive to any future shifts in the PEPFAR program that are intended to rationalize resources (i.e. capping ARV and methadone procurement) while maximizing epidemic control.

PEPFAR VN in previous years has, through SCMS, worked to ensure proper pharmaceutical management at facilities, enabling adequate inventory management for an efficient stock control as well as requisition and supply planning for reliable quantification and forecasting of demand. This work will be fully transitioned at provincial level to all PACs (ARVs, lab reagents) and the Departments of Health (methadone) in 2015. To monitor this transition, SCMS under COP 15 will continue to review provincial consumption data as well as new patient enrollment that will feed into quarterly national level quantification, forecasting and procurement of the different PEPFAR-financed commodities.

SCMS support will also help to actualize a Central Procurement Unit (CPU) within the MoH as per government Decree 63/2014, providing technical support to strengthen the capacity of the Unit to manage all processes related to the GVN's preferred procurement mechanism (direct, national, international competitive bidding etc.) and related financing arrangements (see also **Health Financing**). SCMS, in its final year of implementation under COP15, will transition activities to a new mechanism to ensure continuity in supporting the procurement and supply chain system, including for central forecasting and procurement, distribution, storage and dispensing, and supervision and monitoring, that will respond to the needs of different segments of the HIV program (including potential shifts in procurement and supply chain activities with the addition of viral load testing).

Begun in COP 14, PEPFAR support has been helping to grow a viable commercial market for HIV-related goods and services, including condoms, lubricant, low dead space syringes (LDSS), and HIV testing and counseling (HTC) capable of meeting the needs of key populations. The Healthy Markets program in COP15 will continue working with the GVN to develop and implement Public-Private Partnership (PPP) models that will serve to increase demand for private sector HIV-related goods and services that reflect the needs and preferences of the populations most at-risk, and for the longer term, will increase the market share of private sector condoms.

Civil Society Engagement for HSS

Engaging with and building capacity for Civil Society Organizations (CSOs) remains a high priority for the PEPFAR program in Vietnam. As part of the HSS approach, COP15 will include capacity-building activities across the three local non-government organizations comprising the USAID Community HIV Link program: COHED – northern coast, CCRD – northern mountains,

and LIFE Center - southern. In addition to strengthened support to delivery of community-based HIV prevention and care services in geographic areas with an elevated burden of HIV infection (see also 4.6.Facility and community-based care and support), the Community Link partners will work to build capacity of KP networks and emerging community-based organizations to meet the legal requirements to operate. To ensure sustainability for the CSOs beyond PEPFAR's investment, the Partner Capacity Development (PCD) mechanism will provide targeted assistance to the Community Link partners in the areas of organizational leadership, financial management and resource mobilization, and human resource management.

Health systems development for enhanced service delivery for HIV Program
The PEPFAR VN strategy on reaching key populations and PLHIV at high-burden/high-volume sites and provinces requires robust national and provincial systems to improve healthcare worker and site level performance through quality improvement and technical assistance mechanisms that can address bottlenecks and weaknesses in performance through regular, routine technical support and monitoring. Although the SID scores are high in this area, institutionalization of these programs is a priority in COP 15 in order to meet epidemic control goals.

As referenced in the Care and Treatment program area logframe, HIVQUAL is the national quality improvement program being coordinated by VAAC and led by VAMS. At the national and above site level, PEPFAR will support the revision of National QI indicators for OPCs, as well as protocol and indicator development for other HIV programs- MMT, HTC and PMTCT. HAIVN and a follow-on IP for HEALTHQUAL NY will provide technical assistance in the development of the protocol and guidelines, as well as to VAAC and VAMS standardization of a national QI training program for new provinces and sites. An overarching goal of this activity is for regular QI data collection, use, and analysis to inform national program performance and to address weaknesses in the service delivery system, and to prepare for the post-transition period.

A well-functioning, cost efficient, and sustainable TA system for clinical mentoring, QI, monitoring site performance and enhanced linkages between central and provincial levels, as well as across facilities will be expanded in COP 15. As indicated in the Care and Treatment logframe, HAIVN and FHI 360 will support VAAC in standardizing protocols and new modes of TA delivery through an e-mentoring system and other web-based initiatives. This e-mentoring will also strengthen the capacity and sustainability of coaching for QI of HIV services. In addition to the hospital system providing support to care and treatment sites, the TA system will be expanded to include the MMT and HIV/TB programs within the National TA system, thus establishing a comprehensive HIV program TA approach. FHI 360 will also partner with VAAC to establish SOPs, TA protocols, and other related guidance for care and treatment sites to operate in primary healthcare settings, which is a significant step towards integration of HIV services within the primary healthcare system.

Human Resources for Health (HRH)

The vertical nature of the HIV system acutely affects the ability of PEPFAR to address larger HRH issues facing the country, despite their impact on the sustainability and service quality of the HIV program. HIV-specific issues include:

- At the policy level, VAAC has little influence in the development of larger HRH policies; there is weak engagement of other MOH HRH-related entities in HIV HRH workforce development and sustainability; and provincial level variation in interpretation, application and funding of relevant HR policies hampers standardized approaches to addressing HCW recruitment, retention, and deployment at site level;
- No HRIS for the health sector as a whole to track HCWs and their training needs;
- Uneven distribution of HCWs and over-reliance on curative/treatment doctors and the provincial hospital system;
- A majority of training and capacity building for HCWs are project-focused with no formalized national or systematic CME/CPD frameworks for ensuring skills update; and
- Credentialing for key staff who have been involved in outreach and prevention activities for years needs to be addressed at the central level—these HCWs do not have the credentials or educational requirements to be transitioned into government service. This requires policy and guidance at the central level through a focal entity that has the mandate to make such decisions and enact them, of which the focal entity has not been identified.

COP 15 HRH approaches will address components of all 5 objectives of the OGAC HRH strategy, with emphasis on capacity development of local institutions to produce and retain adequately trained HCWs for the HIV program, especially at high burden/high volume sites. Given the country context, this will require PEPFAR to address as best possible larger systems issues, such as pre-service training reform and CME/CPD regulatory framework development, in order to ensure that training needs will be met both at present and in the near-future as the program transitions out of service delivery.

Specific interventions for HRH at site level, particularly for high-yield, high-burden and in priority provinces, are addressed at the service delivery level under care and treatment and prevention logframes. These include addressing stigma and discrimination in service delivery, QA/QI for effective site monitoring and technical assistance, and training related to enhanced service delivery to meet 90-90-90 goals.

Small-scale, discrete efforts to assess HRH capacity through training needs assessments, site level observations, SIMS, and HIVQUAL data show that sustainability of training systems is necessary to maintain PEPFAR's significant investments in the health workforce and to intensify case findings and increased enrollment in care. Therefore, one component of PEPFAR VN activities will focus on creating an adequate supply and appropriate skills mix of HCWs for HIV service delivery by the establishment and strengthening of pre-service HIV training systems and institutions, and other accreditation systems. PEPFAR, through HAIVN, is leveraging the MOH-World Bank medical education reform project by partnering with medical universities to link the HIV system to these efforts by supporting rotations of medical students at OPCs and revision of

HIV content of these courses with the expectation that these activities will be absorbed by local institutions by end of COP 15. Addiction Treatment including MMT is relatively a new field in Vietnam and through collaborations between SAMHSA Co-Ag with HMU, UMP, UCLA, Hennepine Center, an institutional home for addictions science and treatment will ensure local capacity for training of this cadre.

Improving health worker performance for service quality will focus on supporting the regulatory framework for CPD/CME at the national level to accredit HIV related training, and strengthening training and accreditation systems for HIV service delivery at the national level. HMU will develop nationally accredited CME HIV modules towards the legal mandate HCW training for at least 24/hours a year. In this way, all HCWs in the HIV system will be able to access CME/CPD through a nationally accredited system rather than via project-based activities. FHI 360 will work with VAAC to develop a national training package for HIV care in closed settings, ensuring that this population will receive HIV care in a routine and systematic way. Other activities include development of an accreditation system for private HTC providers, online ART certification as an example of multiple efforts of cost-effective training modalities, MMT in-service accreditation and training system development, and enhancing military healthcare worker capacity in HIV service delivery.

The GVN and PEPFAR have significant concerns about retaining and incentivizing HIV HCWs as program support declines and the impact on service quality. Therefore, establishing sustainable financing for HCWs in the HIV program by policy review, implementation and monitoring will be a priority of the VAAC in COP 15. Building on HRH policy assessments and reviews conducted in 2014, VAAC will take steps to guide PACs into tapping into hardship payments/allowances (by disease and geographic location) policies for GVN HCWs to offset declining overtime payments made by PEPFAR, as well as other mechanisms to mobilize domestic resources to finance the training and retention of HCWs in high-burden sites. Implementing partners will also assess outcomes of MMT-OPC-HTC service integration on HCWs and HRH structures, the competencies needed, and tasks shifted to determine the optimum HR structure needed to scale up this model. Monitoring of all HCWs at transitioning sites will be conducted to assess program quality and document post-transition challenges. Discussions and activities to find institutional homes for community-based HCWs (peer and outreach programs) will continue as VAAC engages more intensively into HRH financing and planning in COP 15 and beyond to prepare for full HCW and program transition in 2018.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Procurement and Supply Chain Management (PSM) Systems											

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Strengthening national capacity in HIV commodities Procurement & Supply Management (PSM)	1. GVN assumes management of PSM activities and of 13 PEPFAR lab sites 2. TA to establish centralized planning and procurement 3. Support development of commercial supply systems to ensure availability of and KP access to condoms and other HIV goods and services 4. Increase access to low dead space syringes among PWID through local and international suppliers	1. Capacity-building, TA and monitoring of GVN capacity to undertake PSM and contracting/ procurement actions, including for centralized procurement of ARVs 2. Support VAAC and PHD/PAC to develop and implement public-private partnership (PPP) models for engagement of the private sector in HIV commodities and services 3. Continue strengthening commercial supply systems to expand availability of and KP access to condoms and other HIV goods and services 4. Implement condom quality control measures and anti-counterfeit initiatives in the free market	OHSS $0	OHSS $548,996 HVOP $200,000	SCMS 7345 CDC-CoAg-9976 HM 16803	6Q1=0 6Q4=0 6Q3=0 11Q4=0	x		x	x	x

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Health Financing											
Conduct of economic and efficiency analysis to provide evidence for promoting HIV financial sustainability through increased domestic financing	1. Cost analyses and studies done to identify feasible financing options and inform national HIV funding decisions 2. Financial contributions from MMT user fees and other domestic resources for HIV tracked 3. Reviews of provider payment mechanisms done to expand fiscal space for financing HIV 4. HIV service models reviewed for integration with primary healthcare system 5 Advocacy to promote increased domestic investment	1. VAAC financial tracking tool developed to routinely monitor flow of HIV resources 2. Increased domestic financing through provincial HIV sustainable financing plans approved and monitored 3. Feasibility assessments of user fee implementation undertaken with GVN 4. Expenditure analyses for HTC, Outreach, MMT service by site, including unit cost for single cases tested and/or referred 5. cost-effectiveness analysis of TB-HIV linkage to provide evidence to VAAC on expansion of this service model to other provinces 6. Recommendation prepared on planning for transition of SMART TA supported sites to GVN/PACs and quality 7. Consolidated HIV service delivery system is accessible	OHSS $1,000,000	OHSS $1000,000	HFG-17371 CDC-CoAg 9976	9Q2=2 11Q2=2	x	x	x	x	x

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
		to HI for PLHIV 8. Advocacy and promotion of achievements and review of national HIV program for increased domestic investment									
Reforms to Social Health Insurance to expand benefit package to include cost-effective HIV services and	1. GVN roadmap developed for Basic Health Service/Health Insurance packages 2. Actuarial and other analyses done to inform resource allocation and health insurance liability	1. Comprehensive Benefit Package drafted that includes HIV prevention, care and treatment services to be financed by SHI 2. Cost analysis of HIV/AIDS services done to inform SHI Benefit	OHSS $1,500,000	OHSS $900,000	HFG 17371 CDC-CoAg 9976	8Q1=3 11Q2=2	x	x	x	x	x

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
promote efficiency/cost control in delivery of the package	for treatment of PLHIV 3. Policy forums undertaken on integration of HIV in the Benefit Package for health insurance	Package 3. Mechanisms defined for SHI procurement of ARVs and reimbursement to PLHIV 4. Advocacy/policy forums undertaken for endorsement of SHI package inclusive of HIV									
Civil Society Engagement											
Capacity strengthening for CSO to lead & sustain CoPC intervention – and increase their roles in National HIV and AIDS responses - overlap with PTWG	1. TA provided to National, provinces, districts and CBOs to transition key HIV program components 2. HRH transition negotiated in DSD districts and provinces 3. TA provided to strengthen data collection/data management system 1. CSOs institutional capacity assessments completed 4. Advocacy forums undertaken to strengthen CSO role in the HIV response 5. Strengthen	1. Project continues to demonstrate effective transition of key components of HIV program to National, provincial, and district GVN and/or CBOs 2.Updated CSO organizational strategies (incl. HR development and succession plan) 3. Finalized OD plans include establishment of Board of Governance, Board of Advisors; M&E system; capacity-building in fund raising, financial and HR management 4. Advocacy forums undertaken to strengthen CSO and KPs voice in	OHSS $780,075	OHSS $50,000 HTXS $150,000 HVOP $80,000	PCD-17373 COHED-17374 CCRD-17375 LIFE-173766	13Q3=3.5 13Q4=0	x	x	x	x	x

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
	organizational capacity of 3 Community Link Partners (COHED, CCRD & LIFE) to enable them to be independent and direct US-grant receivers: a. Upgrade quality of training delivery to improve transfer of skills to CBOs b. Strengthen communication skills 6. Build organizational and financial capacity for local CSOs in 9 high burden provinces (Hai Phong, Quang Ninh & Nghe An, Can tho, An Giang, HCMC, Dien Bien, Lao Cai Hanoi) to enable them to deliver HIV & AIDS services effectively and sustainably 7. Build technical capacity for local CSOs to enable them to meet the International best practices on HIV and AIDS services	prevention and treatment 7. TA continued: a. assist CCRD to improve the quality and effectiveness of beneficiary services b. assist LIFE Center to improve the sustainability, quality and effectiveness of its client services c. assist COHED to detail and support capacity building action plan 8. organizational and financial capacity of local CSOs increased in 9 high burden provinces to enable them to deliver HIV & AIDS services effectively and sustainably 9. Continue to build technical capacity of local CSOs to enable them to meet the International best practices on HIV and AIDS services									
Private Sector Engagement											

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Increase the roles of private sector in the National HIV and AIDS responses	1. Market Growth Advisory Board formed 2. Policies and regulations reviewed to identify barriers for private sector engagement 3. Market analyses and supplier mapping done to identify opportunities for private sector engagement 4. MOCST supported to implement and enforce the Condom Circular	1. Private sector contributions to HIV response assessed; recommendations inform new National Action Plan 2. Advocacy continued for private sector engagement and investment in HIV/AIDS thru Market Growth Advisory Board	OHSS $150,000	OHSS $0 Plus other budget codes	HMA-16803		x	x		x	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Human Resources for Health											
Create adequate supply and appropriate skills mix of HCWs for HIV service delivery via establishment and strengthening of pre-service HIV training systems and institutions, and accreditation systems	1. 25 Bachelors in public health informatics graduated 2. Medical students complete first year in an integrated learning curriculum 3. 3rd year medical students complete rotations at OPCs in multiple provinces 4. HIV content, including MMT, in HMU and UMP pre-service curricula are updated 5. Addiction treatment unit within HMU established 6. Support to processes for obtaining MOET's approval for a training code on addiction medicine/MAT and sustainable financing for training provision 7. 3-year strategic plan for the VHATTC with linkages, partnerships, and collaborative relationships with agencies and organizations engaged in related system development activities 8. Plan of activities and materials to disseminate evidence-based and innovative practices to strengthen the MMT and addictions workforce.	1. Increase in number of OPCs participating in rotations for 3rd year medical students and updated HIV curricula content 2. Continued support to processes for obtaining MOET's approval for a training code on addiction medicine/MAT and sustainable financing for training provision, including development of training curricula, training workforce, and training plans (e.g., in-service, pre-service) 3. A 1-year plan for the VHATTC based on training needs for addictions workforce at pre and in-service level 4. Continued integration of appropriate contents on MMT and addiction medicine, PMTCT, pediatric HIV care, and other HIV topics, in the medical training curriculum.		IDUP $240,000 OHSS $105,000	HAIVN-1000, HMU-14336, UCLA/VHATTC 13942, Hennepin County Medical Center 14048, USAID-Program for Appropriate Technology in Health-Healthy Markets 16803	Element 5. HRH, Q.4 Score: 1.8	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Establish sustainable financing for HCWs in HIV program and sustainable workforce for HIV by policy review, implementation and monitoring	1. Recommendations from review of HRH policies (Decree 41, Decree 56) to inform HRH policy needs at national level 2. Strengthened capacity at national, sub-national and site level in tools and methodologies for HRH planning and assessment 3. Recommendations on how HIV program HR policies are aligned with national policy	1. Increased GVN financing for HCWs through policy adoption. 2. HCW quality and quantity monitored in transitioning and maintenance sites		OHSS $173,275	VAAC-9976	Element 5, Q.1 Score: 3, Q. 2 Score: 2, Q3 score: 0, Q7 score: 0					
Improve health worker performance for service quality by establishment of regulatory framework for CPD/CME and strengthening training and accreditation systems for HIV service delivery	1. CME standards and body to inform MOH CME regulatory policy development 2. HIV training institution alignment to National policies piloted 3. Provision of clinical training for new and existing methadone clinics to assess treatment guideline adherence and to provide direct medical mentorship to clinicians and staff 4. Development of advanced curriculum based on surveyed needs of physicians currently providing MMT 5. Inputs given to GVN and relevant ministries on drug treatment policies 6. Plan of VHATTC activities and materials for dissemination of evidence-based and innovative practices to strengthen the workforce. 7. Institutionalized MMT training curricula and trainers to train physicians, pharmacists	1. CME unit operationalized at HMU and # of HIV courses and modules submitted for CME approval at HMU 2. Delivery of HIV CME/CPD courses under regulatory system with 2 partner institutions receiving TA 3.Development of specific training materials and institutionalization of MMT in-service training, 4. Inputs given to the government of Vietnam and relevant ministries on drug treatment policies 5. Web and online courses and materials developed for MMT/Addictions, ART, care and treatment updates and SOPs etc. 6. Certification for online ART training course established and issuing certification 7. MOD military health system, including nurses', capacity in QI, management and leadership, and cross linkages enhanced 8. Development and implementation of accreditation system for private sector HTC		IDUP $200,000 OHSS $161,000 HTXS, $535,000 HVCT $20,000	VAAC 9976, HAIVN 1000, FHI 360 SMART TA 14159, USAID-Program for Appropriate Technology in Health-Healthy Markets 16803, HHS/SAMHSA-Hennepin Faculty Associates Addiction Medicine Program Methadone Clinical	Element 5: Q.5 score: 2	X	X	X	X	X

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
	and counselors 8. Online ART certification course developed	services 9. Nationalized technical package of HIV care in closed settings/prisons			Support 14048, UCLA/VHATTC, HMU 13942, MOD						

7.0 Staffing Plan

Given the declining budget, PEPFAR VN's goal has been to reduce costs while maintaining a staffing profile to deliver high-quality TA. When positions become vacant, careful consideration is given to both the need for the position and the alignment of duties with core activities. PEPFAR VN has reduced the number of direct hire or contract positions and replaced them with locally-employed staff (LES) and by monitoring and anticipating salary savings when positions are temporarily vacant. Efforts have also been made to encourage increasing LES leadership in technical working groups and in key strategic planning discussion of program activities.

PEPFAR VN will continue to seek opportunities to streamline staff costs as vacancies arise but anticipate challenges that will limit the ability to reduce costs. An increase in capital security cost sharing costs of nearly 80 percent will come into effect in FY 2016 and will have a significant impact. After a four year freeze on LES salaries, significant salary increases are expected in late FY 2015 and further increases can be expected in FY 2016. Both of these increases will offset other savings and may increase management and staffing costs overall.

To maximize travel costs, SIMS visits have also been prioritized and developed in consideration with TA visits. As the number of SIMS visits expands quarterly through FY 2015, a third party contractor will also help reduce travel costs.

The number of existing, unfilled positions has decreased significantly as the PEPFAR VN team has begun transitioning costs and responsibilities during the past years; that number is now very limited. Refilling of positions is justified on the basis of current or expected program priorities. If it is possible to meet the staffing needs of more than one PEPFAR VN agency with one hire, this is considered as well. Overall, this is leading to a smaller, better-aligned staffing pattern.

PEPFAR VN has also been able to reduce costs by shifting technical support through external partners. For example, the complexity and specialized nature of commodity forecasting, procurement and logistics requires a dedicated partner. Health financing is a similarly complex aspect of the portfolio for which PEPFAR VN supports the Vietnamese government through an international partner. In reverse, PEPFAR VN has reduced costs by using U.S. government staff provides direct TA to build Vietnamese government capacity instead of relying on external partners, as in support for strategic information and laboratory systems. As a result, the amount of external TA is being reduced over time.

Appendix A Program Core, Near-Core, and Non-core Activities for COP15

Updated for July 8, 2015 version of Core, Near-core, Non-core Activities submitted to S/GAC

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15[ii]

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities[iii]
Site level	See Table A.2 by Program Area		
Sub-national level			
National level			

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Key Population Prevention	Core Activities	Near-core Activities	Non-core Activities
	• • Enhanced case finding and linking KP+ to HTC/HIV care & treatment through innovative outreach approaches, incl. engagement of CSOs in service delivery • Enhanced case finding and linkage to HTC and HIV care and treatment services • Improve data use for monitoring prevention program impact • Increase the role of CSOs in National HIV response, including organizational and technical capacity • Ensure and sustain the availability/accessibility of prevention commodities through engaging private sector	• • Strengthen capacity of military blood safety program and military medical system on injection safety/infection control • Increased delivery of PHDP messages in OPC settings	• Outreach in low yield sites and low burden provinces • Advocate for CSOs voice Ministry of Culture, Sport and Tourism (MOCST) on Condom Circular enforcement
Adult Care and Treatment	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• Support VAAC to build capacity of provincial levels in community-based care in high burden areas through development of SOP and TOT training, for improved retention in care • Provincial Department of Health to improve facility based HTC-OPC linkage • VAAC to coordinate and implement the national HIVQUAL program	• Update national technical guidelines on community-based care for PLHIV • Build capacity on C&T site operation at primary health care settings • Support the national and military health system to build capacity for nurses and health care staff on nursing leadership and management, patient safety that focus on	•

	• MOH to develop a national viral load plan including negotiated price reductions for a viral load (VL) test and expanded use of dried blood spot for VL testing • VAAC to provide quality HIV care and treatment services in prisons • Maintain ART to HIV patients at 83 OPCs • TA to GF OPCs at priority provinces to increase uptake of new patients on ART and improve the quality of services • Pre-treatment DR (PDR) or Acquired DR (ADR) surveillance • Initiate routine VL test for patients on ART in selected provinces. •	HIV care and support and treatment • Online e-learning and technical updates online housed at VAAC website • Develop and implement national training package for viral hepatitis B and C co-infection with HIV • HIV care and support, including OI drugs, to HIV patients in care at 83 OPCs • HIV care and support services at community-outreach sites, and 24 CSO-led community case management sites • Integrate HIV-related QI into general QI program at hospital system • VAAC and PACs to establish a sustainable national clinical HIV TA system and to develop provincial coaching for quality improvement • Improve capacity of national hospitals to support national HIV TA system through clinical TA and CME to HIV care sites through on-line training and e-mentoring •	
HTC	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• Transition effective KP HTC services including RTRR TA on HTC models for KPs in closed setting • Mobile HTC model for KP, including rapid tests with rapid results • Development and standardization of linkage/referral systems focus on HTC-OPC but broadly linking across treatment cascade • Exploration of piloting oral/HIV self-testing •	• Increase the role of private sector in delivery of HTC services • National capacity building for regional institutions and DOH/PACs in HTC TOT training and Revision/updating of training manuals and supervision & monitoring tools • Capacity building for DOHs/PACs in leadership, management, and supervision of provincial HIV cascade with HTC as center for case finding • TA for innovative HTC demand generation to increase HTC among KPs based on behavior surveys • HTC model for KP in closed setting •	• HTC services in 42 sites in low burden provinces/low yield sites
MMT	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• Promote HIV testing uptake among MMT patients and their partners, incl. services integration and improved linkage to HTC services • Promote ART uptake among MMT patients living with HIV, incl. services integration and improved linkage to HIV care and treatment services	• TA to Sites in the neither category to ensure that they maintain a level of quality of care (2016 • Advocacy for sustainable financing for MMT program • Increase the use of monitoring data for evaluation and quality improvement purposes	

	• Provide TA to MMT sites to ensure quality of services • Build capacity on MMT training, mentoring and supervision for leading Medical Institutions and Provincial Department of Health • •	• Provide TA to sites in provinces with relatively lower burdens of drug use and HIV • TA to Ministry of Health to revise and adapt technical guidelines for MAT implementation in Vietnam •	
TB/HIV	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• TA to national TB Control Program (NTP) on PITC for TB patients to achieve national target of 85% TB cases get PITC by end of 2015 and 90% by end of 2016 • TA support NTP and VAAC to increase ART and TB treatment among TB/HIV co-infection patients (the national number in 2013 was 61%). Target is supporting NTP and VAAC to increase this to 80% by the end of 2015 and 85% by the end of 2016. • TA and DSD to improve TB intensified case finding for HIV/AIDS patients. Different partners work at different level of the system. • Improve linkages between HIV and TB facilities •	• EnTIC study (Evaluation of an Enhanced TB Infection Control Intervention in Healthcare Facilities in Vietnam and Thailand) • Strengthening reporting and recording system: update NTP indicators and support NTP to implement the NTP updated reporting and recording system •	• Advocacy to improve local commitment and investment for TB program. • HIV test kits for TB sites
Pediatric Treatment	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• Provide care and TX services (except Ped ARV and EID covered by GF) to ped patients •	• Strengthen capacity of OPC staff to provide quality services thru system meeting, case discussion and training •	• Formula support to infants born to HIV infected mothers • TA to VAAC and PACs on adolescent HIV care and treatment • TA for OPC to increase patient uptake on ART • Build clinical, mentoring, monitoring capacity, and health care workforce in pre-service training • TA for VAAC, PACs and Pediatric OPCs to implement HIVQUAL in PEPFAR-supported sites
PMTCT	**Core Activities**	**Near-core Activities**	**Non-core Activities**

	• HIV testing for pregnant women at 13 sites to enroll the positives into care and treatment • PMTCT B(+): Improve ARV uptake for pregnant women • private clinics to increase the participation of private ANCs in PMTCT •	• integrate PMTCT indicators with MCH ones • Support the military health system to build capacity for health care staff on PMTCT, including: adaptation of the related national policies, guidelines; provision of technical assistance and training at leadership and site levels • Work with VAAC and MCH to develop long term strategy for PMTCT intervention and integrate PMTCT into the MCH system by seeking official mandate of PMTCT to be a routine service within MCH •	• Nutrition and infant formula • IEC activities
HSS	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• Strengthening national capacity in HIV commodities Procurement & Supply Management (PSM) • National and provincial-level health accounts collection and analysis to coordinate and increase resource mobilization, efficiency and impact of host country funding for HIV programs. • Expand Social Health Insurance benefit package to include cost-effective HIV services and promote efficiency/cost control in delivery of the package •	• Capacity strengthening for CSOs to lead & sustain CoPC interventions and increase their roles in the National HIV/AIDS response • Human resources/capacity strengthening in pre-service education, including medical education reform, MMT/Addictions Capacity Building, etc. • Establish sustainable financing for HCWs in HIV program and sustainable workforce for HIV by policy review, implementation and monitoring • HRH- Development of policy for in-service training systems for CPD/CME • HRH in-service training and training system development for epi control, including formalizing e-mentoring model, online ARV certification, HTC credentialing, etc •	• To increase the supply of quality assured medicines (locally produced/procured Methadone and ARVs) • Strengthening provincial capacity in HIV commodities supply management • Strengthening Management and Leadership Capacity for the HIV System • Leadership, Capacity building and strengthening TA networks among health care providers in HCMC
Lab Strengthening	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• Support National EQA and IQC programs for HIV serology • Support National EQA and IQC programs for CD4 • Support national viral load testing network to	• Develop Specimen Collection standard training package and initial training implementation • Develop an e-learning platform for QMS and Biosafety training	• In-service QMS training • Pre-Service training curriculum • TA from WHO to support TB Dx and DST testing quality

	assure quality of VL test results (EQA, TA and DBS validation) • Implementation of QMS Program for provincial and district lab level and provide technical support for this program •	• Implement and support laboratory information systems (LIS) to improve HIV lab quality and surveillance data • Implementation of Strengthen Lab Management Toward Accreditation (SLMTA) program • to VAMS to establish a system of monitoring National Laboratories Standards for QMS • Support Quality Management System (QMS) Laboratory Leadership Certificate program to improve knowledge and skills for QMS implementation in HIV lab system • Validate and implement HIV drug resistance testing to regional institutes for WHO accreditation for HIV DR monitoring • For HIV clinical laboratories to achieve ISO 15189 accreditation • Provide microbiology TA to hospitals to increase laboratory identification of OI's • Development of national TB Lab capacity and service at 6 regional laboratories •	• Support pursue ISO 17043 accreditation for proficiency testing scheme providers • Develop national QA/QC standard training package and initial training implementation • Technical assistance to National Institute of Hygiene and Epidemiology to support HIV test kit validation
Strategic Information	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• Program monitoring post transition • HIV Sentinel Surveillance among KP • National HIV Case Reporting • Size estimation for key populations • Program M&E • Cascade information • Program evaluation of test and treat • Evaluation of provincial, district, and commune level program coverage for KP reach and access to essential services • Enhance data use at different levels, support intervention program on performance data collection and analysis	• MSM cohort to monitor HIV incidence, evaluate outreach strategies and assess HIV risk factors, behaviors and health seeking practices among MSMs •	• IBBS-behavioral surveillance • Epi/biostatistic courses

to improve service quality; HIV/AIDS modeling--Continued national/provincial level estimates

- Patient tracking systems for TB-OPC, HTC-OPC and MMT-OPC linkages
-

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
See Table A.2 by Program Area						
Totals						

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

	Applied Pipeline	New Funding	Total Spend
		$33,462,106	$57,000,000
PEPFAR Budget Code			
MTCT	$292,312	$651,283	$943,595
HVAB			
HVOP	$1,588,979	$965,182	$2,554,161
IDUP	$1,188,154	$3,267,568	$4,455,722
HMBL			
HMIN			
CIRC			
HVCT	$1,461,893	$1,591,963	$3,053,856
HBHC	$1,180,534	$3,312,374	$4,492,908
PDCS	$45,380	$150,000	$195,380
HKID			
HTXS	$2,783,804	$8,136,659	$10,920,463
HTXD	$6,986,044	$4,443,925	$11,429,969
PDTX	$282,858	$299,418	$582,276
HVTB	$693,266	$1,425,700	$2,118,966
HLAB	$1,112,564	$1,795,968	$2,908,532
HVSI	$1,630,709	$2,141,645	$3,772,354
OHSS	$832,628	$2,525,165	$3,357,793
HVMS	$3,458,769	$2,755,256	$6,214,025
TOTAL	**$23,537,894**	**$33,462,106**	**57,000,000**

B2. Resource Projection

The PEPFAR VN team used the PEPFAR Budget Allocation Calculator (PBAC) tool to generate program area budget projections for service delivery activities based on unit expenditures (UEs) developed with the PEPFAR HQ Finance and Economic Working Group (FEWG). PBAC calculations were cross-walked to implementing mechanism budgets on a proportional basis. The Vietnam Technical Working Groups then conducted a core, near, non-core exercise for above site technical assistance using an adapted activities log frame similar to what it required for HSS, lab and SI. The PEPFAR VN Management Team reviewed the log frames and made adjustments of final budgets and core and near core decisions based on overall priorities and funding availability, and HQ review. Finally, pipeline analysis was used to offset implementing mechanism budgets to maintain projected pipelines within a projection of approximately 6 months of funding at the end of FY 2016.

[ii] To reduce redundancy, all activities are listed by program area but also include level of implementation.
[iii] Non-core activities listed are discontinued and not funded in COP 15.

Vietnam COP15 Targets by Province: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
_Military Vietnam	18,200	131	766	111	729
An Giang	10,308	282	3,272	274	3,177
Ba Ria-Vung Tau	3,591	152	1,682	147	1,404
Bac Giang	-	49	397	48	385
Bac Kan	-	-	-	-	-
Bac Lieu	-	-	-	-	-
Bac Ninh	1,242	41	440	40	427
Ben Tre	-	-	-	-	-
Binh Dinh	-	-	-	-	-
Binh Duong	17,226	192	1,683	186	1,530
Binh Phuoc	-	-	-	-	-
Binh Thuan	-	-	-	-	-
Ca Mau	-	-	-	-	-
Can Tho	887	130	1,219	125	1,183
Cao Bang	1,035	30	509	29	454
Da Nang	-	-	-	-	-
Dak Lak	-	-	-	-	-
Dak Nong	-	-	-	-	-
Dien Bien	17,318	1,042	3,466	1,013	3,364
Dong Nai	-	-	-	-	-
Dong Thap	-	-	-	-	-
Gia Lai	-	-	-	-	-
Ha Giang	-	-	-	-	-
Ha Nam	-	-	-	-	-
Ha Noi	39,921	837	8,955	814	8,442
Ha Tinh	-	-	-	-	-
Hai Duong	-	-	-	-	-
Hai Phong	22,316	171	2,411	165	2,320
Hau Giang	-	-	-	-	-
Ho Chi Minh City	120,856	1,724	22,206	1,600	21,558
Hoa Binh	1,853	129	877	122	844
Hung Yen	-	-	-	-	-
Khanh Hoa	-	-	-	-	-
Kien Giang	840	-	-	-	-
Kon Tum	-	-	-	-	-
Lai Chau	-	-	-	-	-
Lam Dong	-	-	-	-	-
Lang Son	-	-	-	-	-
Lao Cai	2,394	113	662	104	642
Long An	1,384	87	850	84	756
Nam Dinh	856	68	555	66	539
Nghe An	19,205	1,461	4,546	1,406	4,414
Ninh Binh	120	-	-	-	-
Ninh Thuan	-	-	-	-	-
Phu Tho	-	-	-	-	-
Phu Yen	-	-	-	-	-
Quang Binh	-	-	-	-	-
Quang Nam	18	34	288	33	279
Quang Ngai	-	-	-	-	-
Quang Ninh	11,079	237	3,447	230	3,345
Quang Tri	-	-	-	-	-
Soc Trang	10,382	107	743	104	721
Son La	32,655	1,090	4,043	1,056	3,927
Tay Ninh	1,134	-	-	-	-
Thai Binh	1,017	75	857	73	831
Thai Nguyen	840	-	-	-	-
Thanh Hoa	23,120	953	3,227	924	3,132
Thua Thien-Hue	-	-	-	-	-
Tien Giang	-	-	-	-	-
Tra Vinh	-	-	-	-	-
Tuyen Quang	-	-	-	-	-
Vinh Long	850	130	950	110	930
Vinh Phuc	-	-	-	-	-
Yen Bai	-	-	-	-	-
Total	**360,647**	**9,265**	**68,051**	**8,864**	**65,333**

Vietnam COP15 Targets by Province: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
_Military Vietnam	50,000	-	-
An Giang	-	324	-
Ba Ria-Vung Tau	-	505	-
Bac Giang	-	-	-
Bac Kan	-	-	-
Bac Lieu	-	-	-
Bac Ninh	-	319	-
Ben Tre	-	-	-
Binh Dinh	-	-	-
Binh Duong	-	189	-
Binh Phuoc	-	-	-
Binh Thuan	-	-	-
Ca Mau	-	-	-
Can Tho	-	-	-
Cao Bang	-	400	-
Da Nang	-	-	-
Dak Lak	-	100	-
Dak Nong	-	-	-
Dien Bien	-	11,438	-
Dong Nai	-	-	-
Dong Thap	-	-	-
Gia Lai	-	-	-
Ha Giang	-	-	-
Ha Nam	-	-	-
Ha Noi	-	3,528	-
Ha Tinh	-	-	-
Hai Duong	-	120	-
Hai Phong	-	2,200	-
Hau Giang	-	-	-
Ho Chi Minh City	-	43,289	-
Hoa Binh	-	235	-
Hung Yen	-	-	-
Khanh Hoa	-	240	-
Kien Giang	-	245	-
Kon Tum	-	-	-
Lai Chau	-	-	-
Lam Dong	-	-	-
Lang Son	-	-	-
Lao Cai	-	750	-
Long An	-	131	-
Nam Dinh	-	203	-
Nghe An	-	14,246	-
Ninh Binh	-	-	-
Ninh Thuan	-	-	-
Phu Tho	-	-	-
Phu Yen	-	-	-
Quang Binh	-	-	-
Quang Nam	-	113	-
Quang Ngai	-	-	-
Quang Ninh	-	493	-
Quang Tri	-	-	-
Soc Trang	-	250	-
Son La	-	13,951	-
Tay Ninh	-	300	-
Thai Binh	-	425	-
Thai Nguyen	-	346	-
Thanh Hoa	-	13,460	-
Thua Thien-Hue	-	-	-
Tien Giang	-	-	-
Tra Vinh	-	-	-
Tuyen Quang	-	-	-
Vinh Long	-	150	-
Vinh Phuc	-	-	-
Yen Bai	-	-	-
Total	**50,000**	**107,950**	**-**

Vietnam COP15 Targets by Province: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
_Military Vietnam	-	-
An Giang	-	-
Ba Ria-Vung Tau	-	-
Bac Giang	-	-
Bac Kan	-	-
Bac Lieu	-	-
Bac Ninh	-	-
Ben Tre	-	-
Binh Dinh	-	-
Binh Duong	14,266	46
Binh Phuoc	-	-
Binh Thuan	-	-
Ca Mau	-	-
Can Tho	-	-
Cao Bang	-	-
Da Nang	-	-
Dak Lak	-	-
Dak Nong	-	-
Dien Bien	-	-
Dong Nai	-	-
Dong Thap	-	-
Gia Lai	-	-
Ha Giang	-	-
Ha Nam	-	-
Ha Noi	21,810	106
Ha Tinh	-	-
Hai Duong	-	-
Hai Phong	17,238	57
Hau Giang	-	-
Ho Chi Minh City	131,800	584
Hoa Binh	-	-
Hung Yen	-	-
Khanh Hoa	-	-
Kien Giang	-	-
Kon Tum	-	-
Lai Chau	-	-
Lam Dong	-	-
Lang Son	-	-
Lao Cai	-	-
Long An	-	-
Nam Dinh	-	-
Nghe An	-	-
Ninh Binh	-	-
Ninh Thuan	-	-
Phu Tho	-	-
Phu Yen	-	-
Quang Binh	-	-
Quang Nam	-	-
Quang Ngai	-	-
Quang Ninh	11,526	54
Quang Tri	-	-
Soc Trang	8,000	16
Son La	-	-
Tay Ninh	-	-
Thai Binh	-	-
Thai Nguyen	-	-
Thanh Hoa	-	-
Thua Thien-Hue	-	-
Tien Giang	-	-
Tra Vinh	-	-
Tuyen Quang	-	-
Vinh Long	-	-
Vinh Phuc	-	-
Yen Bai	-	-
Total	**204,640**	**863**

Vietnam COP15 Targets by Province: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
_Military Vietnam	700	-
An Giang	-	-
Ba Ria-Vung Tau	-	-
Bac Giang	-	-
Bac Kan	-	-
Bac Lieu	-	-
Bac Ninh	-	-
Ben Tre	-	-
Binh Dinh	-	-
Binh Duong	-	-
Binh Phuoc	-	-
Binh Thuan	-	-
Ca Mau	-	-
Can Tho	-	-
Cao Bang	-	-
Da Nang	-	-
Dak Lak	-	-
Dak Nong	-	-
Dien Bien	-	-
Dong Nai	-	-
Dong Thap	-	-
Gia Lai	-	-
Ha Giang	-	-
Ha Nam	-	-
Ha Noi	-	-
Ha Tinh	-	-
Hai Duong	-	-
Hai Phong	-	-
Hau Giang	-	-
Ho Chi Minh City	6,390	451
Hoa Binh	-	-
Hung Yen	-	-
Khanh Hoa	-	-
Kien Giang	-	-
Kon Tum	-	-
Lai Chau	-	-
Lam Dong	-	-
Lang Son	-	-
Lao Cai	-	-
Long An	-	-
Nam Dinh	-	-
Nghe An	-	-
Ninh Binh	120	5
Ninh Thuan	-	-
Phu Tho	-	-
Phu Yen	-	-
Quang Binh	-	-
Quang Nam	-	-
Quang Ngai	-	-
Quang Ninh	-	-
Quang Tri	-	-
Soc Trang	-	-
Son La	-	-
Tay Ninh	-	-
Thai Binh	160	6
Thai Nguyen	-	-
Thanh Hoa	-	-
Thua Thien-Hue	-	-
Tien Giang	-	-
Tra Vinh	-	-
Tuyen Quang	-	-
Vinh Long	-	-
Vinh Phuc	-	-
Yen Bai	-	-
Total	**7,370**	**462**