VIETNAM

Country/Regional Operational Plan

(COP/ROP) 2016

Strategic Direction Summary

Version May 27, 2016

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Goal Statement

As a focus country in the initial phase of PEPFAR, the U.S. Government (USG) quickly became the largest financer of Vietnam's HIV response, with annual budgets increasing from $18M in 2004 to $98M in 2010. PEPFAR purchased a large share of HIV commodities, including antiretroviral (ARV) drugs and methadone; supported direct HIV service delivery and provided technical support in policy, planning, implementation and evaluation. This financial, programmatic, and technical support forged a bilateral partnership between the United States and Vietnam that contributed to nearly 110,000 people on anti-retroviral treatment (ART) and more than 40,000 people on methadone maintenance treatment (MMT).

However, external support delayed establishment of domestic financing and supply chain mechanisms to meet Vietnam's long-term HIV targets, elevated when Vietnam became the first country in Southeast Asia to adopt UNAIDS "Fast-Track 90-90-90" targets. To address this, and to align global budgets with global needs, the Office of the U.S. Global AIDS Coordinator (S/GAC) established a funding trajectory decreasing PEPFAR Vietnam's (VN) allocation yearly from 2011 through 2018. Similarly, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) reduced HIV grant funding and is capping ARV drug contributions at 50,000 patients through 2017. Beyond 2017, GFATM contributions to ARV drugs, methadone, prevention commodities and HIV services are contingent on GFATM's replenishment and Vietnam's eligibility for HIV grant financing.

From 2010 through 2016, PEPFAR VN will achieve ART expansion of nearly 110 percent against a funding decline of 42 percent through impactful effective systems support and efficient service delivery. COP 2016 includes intensive review of service delivery models a target-based budgeting approach. This prioritization allowed PEPFAR-supported ART expansion in five aggressive scale-up provinces – Dien Bien, Son La, Thanh Hoa, Nghe An, and Ho Chi Minh City (HCMC) - despite reduced resources. COP 2016 also marks a shift to increased domestic contributions for ARV drugs and methadone. Accelerating this shift is a COP 2016 policy priority, in particular assisting the Vietnamese government to use Social Health Insurance (SHI) to absorb significant current external donor supported HIV care and treatment costs.

PEPFAR 3.0 PIVOT: In COP 2016, the "PEPFAR 3.0" approach continues focus on sustaining epidemic control and improving efficiency through geographic and population prioritization. PEPFAR VN's goal for COP 20162016 is to demonstrate significant contributions toward "90-90-90" targets in the five aggressive scale up provinces, which contain high HIV burden, high unmet ART need, and where PEPFAR can have the greatest impact. COP 2016 strategy focuses on: (1) Enhanced case finding models and links to care for the first and second "90" in scale-up provinces; (2) Expanding viral load (VL) monitoring for the third "90"; and (3) Supporting SHI implementation, provincial financing, and procurement and supply chain reform for long-term sustainability. Programmatic focus remains on key population (KP) groups, people

who inject drugs (PWID), female sex workers (FSW) and men who have sex with men (MSM), accounting for nearly half of HIV transmission.

DEMONSTRATION OF "90-90-90": USG continues aggressive scale up in five provinces under a Ministry of Health Vietnam Administration of HIV/AIDS Control (MOH/VAAC) "90-90-90" demonstration initiative. Plan key elements include:

- The First "90" - intensifying **Outreach and Case Finding Scale-up Contribution** until at least September 30, 2017
- The Second "90" - **ART Scale-up Contribution** until at least September 30, 2017: Contributing to increased ART patient enrollment by assisting provinces to establish new outpatient clinics integrated into the general hospital system, use of commune health stations for ARV dispensing, implementing Test and Start and efficient service delivery models, including multi-month ARV pick up.
- The Third "90": **Scaling up Viral Load Testing for Routine Clinical Monitoring** with a focus on the five aggressive scale up provinces.

TRANSITION PLAN: PEPFAR continues implementing the 2010 U.S.-Vietnam Partnership Framework on HIV/AIDS which transitions USG's role to a technical assistance (TA) model. In COP 2016, S/GAC directed PEPFAR VN to complete transition from direct service delivery (DSD) support to outpatient clinics, HIV testing and counseling sites (HTC) and medication-assisted treatment clinics by the end of 2018.

In "**Sustaining / Central Support Provinces"**[1] outreach and active case finding activities concluded in January 2016; however, support continues for maintaining HTC activities at high yield PEPFAR-supported facilities. On April 1, 2016 PEPFAR VN capped ARV contributions to the national program for new patients at PEPFAR-supported facilities in 21 provinces (including HCMC); the existing PEPFAR cohort of ART patients will be maintained until these patients can be supported by domestic ARV drugs.

ADDRESSING PROGRAMMATIC GAPS: For COP 2016, PEPFAR VN will focus TA and use Mission-wide channels of health diplomacy to address the following areas in the national HIV response:

- SHI Implementation
- Coverage of People Living with HIV (PLHIV) on ART
- Coverage of VL Testing

[1] These provinces include: 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 COP 2016)*

- Test and Start
- Service Delivery Models

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

The national HIV prevalence in Vietnam is 0.26 percent with an estimated 258,586 PLHIV (Estimation and Projection Package - EPP, 2015). HIV incidence peaked in early 2000 and has declined gradually, yet the epidemic in Vietnam remains concentrated among three KPs: PWID, MSM, and FSWs. The distribution of PLHIV by KP and program coverage varies by region and province highlighting the need for a geographically tailored response.

Injection drug use is the major contributor to HIV transmission in Vietnam. There are about 3,397 new infections acquired annually among PWID and about 19.30 percent of the estimated 271,506 PWID (range: 158,000 - 385,000) are living with HIV. The 2015 HIV sentinel surveillance data indicate HIV prevalence estimates among PWID range from 19-26 percent in Thai Nguyen, Hanoi, and Quang Ninh to 2 percent in Da Nang.

However, in recent years there has been a greater recognition of the HIV epidemic among MSM in Vietnam, and several studies highlight increasing risk behaviors in this group (2013 IBBS). The overall estimated MSM population is 382,506 (range 191,000 – 573,000) with EPP estimates of a 2.49 percent national HIV prevalence and a higher prevalence estimated in Hanoi and HCMC (12 percent).

FSWs are the smallest KP group in Vietnam; there are an estimated 71,936 FSWs (range: 36,000-108,000) with national HIV prevalence estimated to be 5.4 percent in 2015. Community surveys and surveillance activities show that HIV prevalence among FSWs varies by province and is generally higher in large urban centers. The 2015 HIV sentinel surveillance noted an 18 percent HIV prevalence among FSWs in Hanoi. HIV prevalence also varies by venue; the 2013 IBBS indicated that street-based FSWs have a higher HIV burden (7.1 – 31.9 percent) compared to venue-based FSWs (2.4 - 13.9 percent).

KP size estimation is critical data for program planning, yet information is scattered and estimates vary. KP size estimates are primarily based on police reports (PWID, FSW), program mapping and size estimation activities in some provinces. These estimates vary by province, with higher concentrations of PWID in HCMC, Hanoi, Son La, the Red River Delta and the northwest regions. Most self-reported and disclosed MSM and FSWs are concentrated in large urban centers including HCMC, Hanoi, Can Tho, and Hai Phong. Recent MSM size estimates have a wide range; size estimation work in HCMC produced figures from 37,000 (personal communication, UNAIDS, 2015) to 57,000 (data triangulation for EPP 2014 input). Given these challenges, plans are in progress to conduct MSM size estimates in 13 urban centers and PWID and FSW estimates in two of the five priority provinces (Son La and HCMC) in 2016-2017.

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		All Ages*				*Source, Year*
			Female		Male		
	N	%	N	%	N	%	
Total Population	91,583,000		45,410,000		46,173,000		GSO, 2015 (Population Census 2009, estimated in next 25 years)
Prevalence (%)		0.26%		0.15%		0.36%	EPP 2015
AIDS Deaths (per year)	9,108						EPP 2015
PLHIV (2016)	260,236-		76,351		183,887		EPP 2015
Incidence Rate (Yr)							EPP 2015
New Infections (Yr)	11,562						EPP 2015
New Infections – PWID, aged 15+	3,397	29.4%					EPP 2015
New Infections – FSW, aged 15+	820	7.1%					EPP 2015
New Infections – MSM, aged 15+	859	7.4%					EPP 2015
New Infections – Male client of FSW, aged 15+	3,572	30.9%					EPP 2015
New Infections – Low Risk Female, aged 15+	1,901	16.4%					EPP 2015
New Infections – Low Risk Male, aged 15+	664	5.7%					EPP 2015
New Infections – Children 0-14	350	3.0%					EPP 2015
Annual births	1677,846						MCH/ 2015
% >= 1 ANC visit	NA						No available
Pregnant women needing ARVs	2,595						EPP 2015
Orphans (maternal, paternal, double)	NA						No available
Estimated TB cases (Yr)	180,000						WHO TB profile 2014
TB/HIV Co-infection	9,000	5%					WHO TB profile 2014
Males Circumcised	NA						N/A
Key Populations	725,948						VAAC – 2013
Total MSM*	382,506						VAAC – 2013
MSM HIV Prevalence	2.49%						EPP 2015
Total FSW	71,936						VAAC – 2013
FSW HIV Prevalence	5.40%						EPP 2015
Total PWID	271,506						VAAC – 2013
PWID HIV Prevalence	19.30%						EPP 2015

	Total		All Ages*				*Source, Year*
			Female		Male		
	N	%	N	%	N	%	
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.

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 month) *

				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	91,583,000 [1]	0.26%	260236							
Total population _ reported data			202,437[2]		106,423 [2]	85% [4]	NA	1,675,767[5]	16,826 [5]	*19,000* [6]
Population less than 15 years - estimation	21,394,000([1]	0.03%								
Population less than 15 years – reported data			NA		4,915[7]	95%[4]	NA	NA	NA	NA
Pregnant Women - estimation	1,714,622	0.23%								
Pregnant Women – reported data					NA	NA	NA	1,169,028 [5]	1.249 [5]	
MSM	**382,506**	2.46%	NA	NA	NA	NA	NA	NA	NA	NA
FSW	**71,936**	5.37%	NA	NA	NA	NA	NA	NA	NA	NA
PWID	**271,506**	20.56%	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)		EPP	NA	NA	NA	NA	NA	NA	NA	NA

*National data – calendar year2015

(1) GSO, Population Census 2009, estimated for 2015.

(2) VAAC- HIV case reporting, 2015. 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 227,154 HIV and AIDS alive by 2015, only 202,437 cases were confirmed, 24,717 cases was reported with unclear information and might be duplicated. Updating the case vital status and case verification in HIV Info will continue in 2016.

(3) VAAC – Care and Treatment department report Dec 2015,

(4) Calculated based on PEPFAR data in APR that retention at 12 months was 85% in average among adult patient and about 95% for pediatric groups.

(5) VAAC – national reporting Program (D28 and Cir 03)

(6) VAAC – Care and Treatment department report equal 16,297 for 9 months in 2015 (missing data in Jan, March and May). We estimated around 3,700 new in those missing months

(7) VAAC – M&E department report, calculated from provincial level for different project and donors (duplication removed)

1.2 Investment Profile

The HIV response in Vietnam remains heavily donor dependent, with donors (primarily PEPFAR and GFATM) contributing 77.2% of total HIV expenditures (National Health Account, preliminary results, Vietnam Ministry of Health, 2015). Overall HIV investment peaked in 2013, when multiple donors financed key components of the response. In 2013 HIV spending accounted for an estimated USD $197.7 million, approximately 1.8% of total health expenditures[i]. Per capita HIV/AIDS expenditure was $2.2 million in 2013, which was higher than in previous years. PEPFAR VN alone contributed 41% of total HIV recurrent expenditures compared to a 15% contribution from the Vietnamese government over the same period. The Vietnamese government, on the other hand, invested a majority of their state HIV funding into infrastructure development (hospitals, clinics). Since national validated expenditure figure publication typically lags two years, the PEPFAR team does not have the latest official national health and HIV expenditures data to analyze for 2014 and 2015.

However, data triangulation indicates a decline in HIV expenditures since 2013. For example, the World Bank/U.K. Department for International Development project was a major source of funding for the national HIV prevention program until the project ended in 2013. Multiple bilateral donors such as Australia, the Netherlands, Canada, and France also reduced their HIV funding. Vietnamese government support through the National Target Program (NTP) for HIV has been uncertain. There was a marked decline from $12 million in 2012 to $4 million in 2014; yet 2015 showed a slight increase to $8.6 million (this included $4 million earmarked for ARV procurement and $4.6 million reserved for HIV program activities). The dedicated NTP for HIV ended in 2015. As of 2016, HIV will be one among the seven programs under a joint National Health Priority program; it must provide annual justification for continued funding among other health priorities.

Vietnam has committed to reduce its dependence on external aid for HIV funding to less than 50 percent by 2015 and under 25 percent by 2020 (articulated in Decision 608) while ensuring financial stability for HIV/AIDS control activities for 2013-2020 (Decision 1899). Although Vietnam is far from reaching either goal, initial gains have been made to increase domestic financing. In 2015, the GVN for the first time increased its annual ARV budget to $4 million (from $0.9 million in 2014) to serve 30,000 patients for one year. In December 2015, the VAAC successfully completed the first domestic bidding for ARVs, securing a cost comparable with prices obtained by PEPFAR and GFATM. These ARVs will be distributed to treatment facilities in April 2016. This contribution has enabled Vietnam to increase its procured treatment services from 7,000 patients in 2015 to 30,000 patients in 2016, and demonstrates ownership of goals to meet the national treatment target of 150,000 patients by December 2017. Although domestic financing is progressing, PEPFAR and GFATM still finance approximately 82 percent of Vietnam's ARV consumption. Of the total $8.5 million of the state budget equivalent allocated for HIV in 2016, there is no guarantee that $4 million will be earmarked for ARVs again. With the continued and consistent message from both PEPFAR and GFATM on the transition of direct service delivery and commodity procurement in 2018, the MOH is focusing attention on finding feasible

solutions to mobilize domestic HIV resources, through central and provincial government general tax budgets, SHI contributions and patient co-pay. Domestic funding is expected to increasingly fill ARV treatment gaps; however, unless the current trajectory changes, there remains a threat to the sustainability of the HIV program beyond 2016.

Table 1.2.1 Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	59,443,283	41%	20%	15%	24%
Community-based care, treatment, and support	3,216,644	79%	21%	0%	0%
PMTCT	4,705,882	31%	22%	27%	20%
HTS	9,441,104	32%	7%	48%	13%
VMMC	0	0%	0%	0%	0%
Priority population prevention	9,458,767	49%	42%	0%	9%
Key population prevention	23,416,919	30%	22%	11%	37%
OVC	794,652	92%	8%	0%	0%
Laboratory	11,467,048	43%	57%	0%	0%
SI, Surveys and Surveillance	20,148,037	26%	31%	38%	5%
HSS	725,125	64%	36%	0%	0%
Total	**142,817,462**	**38%**	**25%**	**18%**	**19%**

Table 1.2.2 Procurement Profile for Key Commodities (2015)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs [1]	21,799,651	50.2	31.5	18.3	
Rapid test kits [2]	518,100	55,6	44.4	0	
Other drugs					
Lab reagents [4]	1,833,020	56.4	43.6	0	
Condoms [5]					
Viral Load commodities	385,665	0	100.0	0	
VMMC kits					
MAT [3]	8,208,194	32.8	48.9	18.3	
Other commodities (syringes) [6]	1,814,346	0	100.0	0	
Total	34,558,976	43.2	40.8	16.0	

(1) ARVs: Data from PEPFAR EA 2015, Global Fund ARV procurement in 2015, GVN ARV procurement in 2015

(2) RTK estimate from PEPFAR Care & Treatment TWG; 2015 Global Fund estimate provided by country team

(3) Methadone: Data from PEPFAR EA 2015; 2015 Global Fund estimate provided by country team; domestic methadone procurement by GVN (VAAC, Hanoi PAC and HCMC PAC)

(4) Lab CD4: Data from PEPFAR EA 2015, Global Fund estimate

(5) Condom: Data from Global Fund procurement in 2015, provided by country team

(6) Needle & syringe: Data from Global Fund procurement in 2015, provided by country team

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	NA	NA	NA	NA	
USAID TB	NA	NA	NA	NA	
USAID Malaria	NA	NA	NA	NA	
Family Planning	NA	NA	NA	NA	
USAID EPT	~$6,000,000	0	0	0	Prevent, Detect and Respond to Avian Influenza and other emerging pandemic disease threats.
NIH	$964,268	0	0	0	Primary objectives: enhancing the role of commune health workers in HIV & Drug Control and reducing hazardous alcohol use and viral load through an RCT in ART clinics.
CDC GHSA	~$10,000,000	0	0	0	Primary objectives: preventing/reducing likelihood of outbreaks, detecting threats early to save lives, improved multi-sectoral and international coordination and communication for rapid response
CDC NCD					
Peace Corps	0	0	0	0	
DOD Ebola	0	0	0	0	
MCC	0	0	0	0	
Total	**$612,964,268**	**0**	**0**	**0**	

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP (2015)

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT DREAMS DREAMS Innovation DREAMS Test & Start-Men VMMC Viral Load	NA	NA	NA	NA	NA	
Other Central funding mechanism Sustainable Financing Initiative	1,850,000				01	**increased domestic health financing and strategic investments through domestic resource mobilization, allocative efficiency, and technical efficiency; accountability and transparency of results and spending**
Entic Study/NTP	**298,636**		**01**		**01**	**Evaluate new TB diagnostics and diagnostic algorithms, including performance, feasibility, cost-effectiveness, incremental yield, and impact on patient outcomes; and Evaluate efficacy, feasibility, and cost-effectiveness of airborne TB infection control measures in healthcare facilities.**
SAMSHA regional activities	**0**	**0**	**0**	**0**	**0**	
Total	**2,148,636**		**01**		**01**	

1.3 National Sustainability Profile

The Sustainability Index and Dashboard (SID) results reflect progress towards improved systems components as compared with last year. Vietnam scored green in planning and coordination, and yellow in all other areas. Planning and coordination were identified as strengths under governance, leadership and accountability. Major vulnerabilities were identified based on USG discussions with the GVN and various stakeholders, and are related to health financing, procurement and supply chain, and transition to a TA model.

Increased local financing is needed for HIV epidemic control and long-term sustainability. Donors finance 73 - 77 percent of total HIV expenditures and 84 percent of medication costs. As donors' budgets decline, the Vietnamese government will have to maintain current services while expanding to reach epidemic control. To reach the goal of providing ART to 80 percent of PLHIV by 2020, an additional 95,000 people nationally need to be tested and enrolled in ART. The treatment costs alone would require an additional $22 million per year at current USG costs. The NTP for HIV ended and domestic investment through health insurance will not be fully operationalized until 2018. Reforms are ongoing, but shifts to domestic financing and changes to health policy will take time. GFATM's current HIV grant runs through 2017 and is committed to enroll an additional 3,000 patients annually in 2016 and 2017. Leveraging resources and promoting efficiency of domestic resources for HIV is a key component of PEFPAR VN's Health System Strengthening (HSS) strategy in COP16 (see Section 6.0).

An effective national HIV supply chain is an on-going challenge for sustainability of epidemic control. Despite the competitive global prices, a national procurement mechanism for HIV commodities has not yet been established. The Vietnamese government plans to establish a central procurement unit (CPU) within the MOH. In COP16, PEPFAR VN will continue to support MOH efforts by developing capacity to strengthen the supply chain system for HIV commodities, including forecasting, procurement, distribution, storage, and dispensing (see Section 6.0).

Stakeholders also highlighted the following vulnerabilities from the SID results: policies to support universal implementation of WHO Test and Start guidelines; uneven implementation of non-discrimination protection policies that limit PLHIV access to services; lack of policy for state budget allocation – particularly GVN funding for CSO activities; little understanding of the potential market for private sector engagement in HIV prevention commodities; limited responsiveness of facility and community-based services for HIV demand—i.e.: community testing, new treatment guidelines including PrEP, GVN financing for high burden areas; and HRH weak capacity in transition sites (see Section 6.0)

1.4 Alignment of PEPFAR investments geographically to disease burden

In coordinated support of the national HIV/AIDS response, the majority of PEPFAR VN FY 2015 expenditures are recurrent site-level (52 percent). Remaining expenditures include health system strengthening (26 percent), above-site program management (11 percent), site-level investments

(7 percent), and strategic information (4 percent), as seen in Figure 1. This investment trajectory aligns with the COP15 PEPFAR pivot to achieve 90-90-90 within KP groups in aggressive scale up provinces and HSS activities that support long term sustainability of the HIV/AIDS response. The largest minor cost category in FY 2015 was ARVs at 22 percent followed by personnel at 12 percent. PEPFAR VN expects these percentages to reduce over time as the Vietnamese government assumes ARV and routine operating expenditures.

Figure 1.4.1 indicates PEPFAR expenditures in 2015 per PLHIV compared to percent of PLHIV by province. The majority of expenditures are focused in locations with the highest disease burden. The aggressive scale up provinces are within the top eight provinces with highest disease burden. Provinces with low disease burden are prioritized for transferring routine operating costs (ROCs) to the MOH between 2014-2017. For example, FY 2014 and FY 2015 total expenditures per the total estimated number of PLHIV in Da Nang exceeded those of other provinces due to small disease burden. In December of 2014, all site non-commodities operating costs for Da Nang were transitioned to MOH. Additionally, in April 2016, all new ARV patients in Da Nang will be supported by MOH and methadone commodities will be provided by GFATM or MOH in COP16. In December 2015, six other low epidemiological burden provinces with higher economic capabilities transitioned their PEPFAR site routine operating expenses (ROCs) to MOH.

Figure 1.4.2 geographically maps out the total PEPFAR expenditures and PLHIV by province.

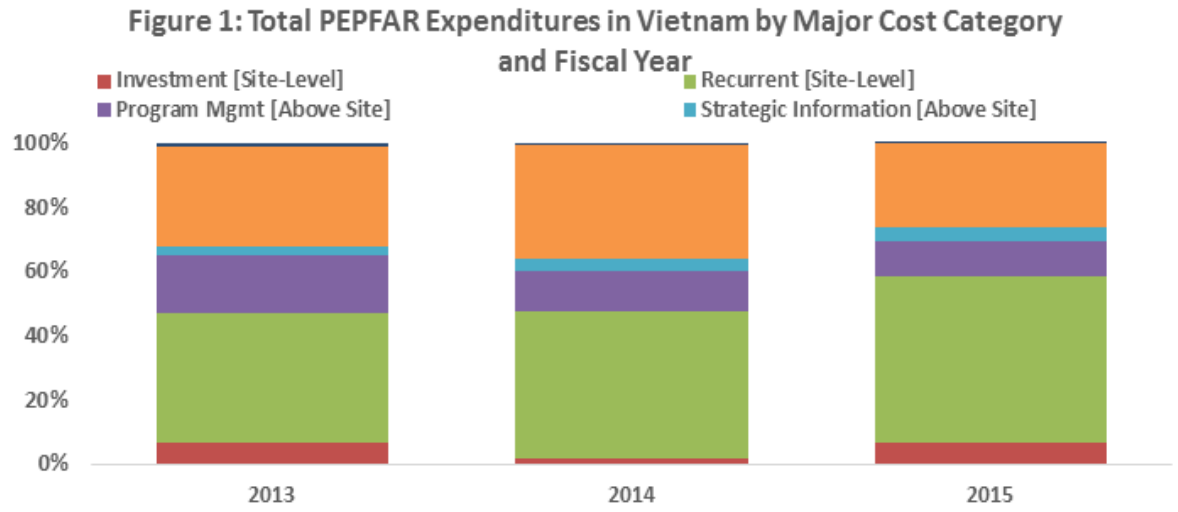


Figure 1: Total PEPFAR Expenditures in Vietnam by Major Cost Category and Fiscal Year
Investment [Site-Level]
Recurrent [Site-Level]
Program Mgmt [Above Site]
Strategic Information [Above Site]
100%
80%
60%
40%
20%
0%
2013
2014
2015

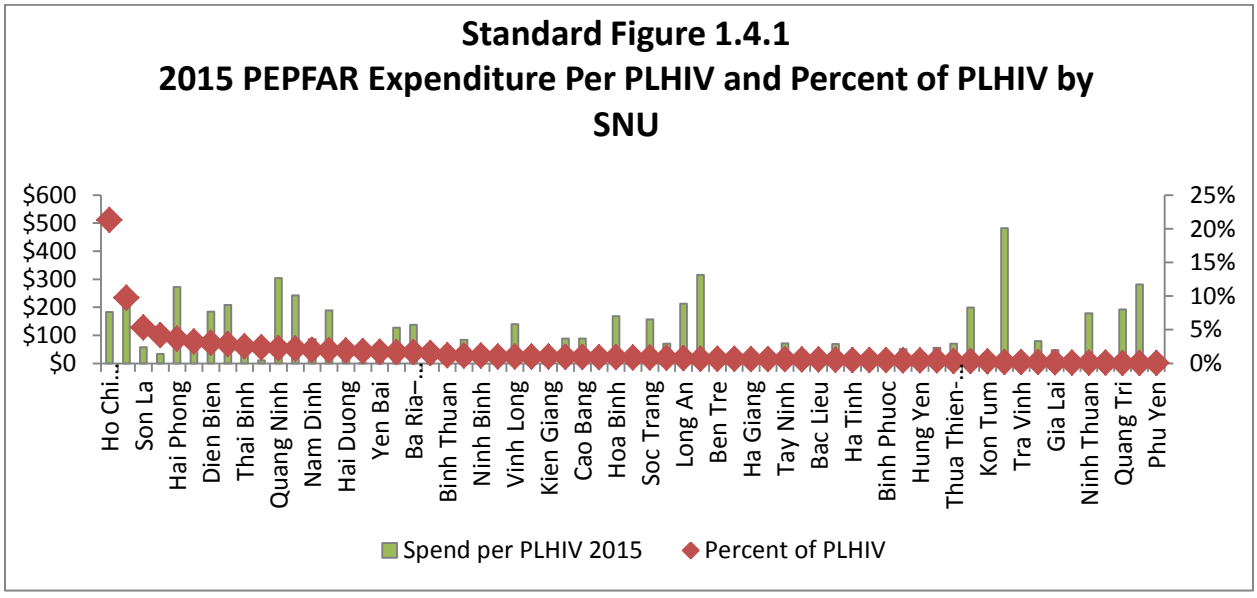
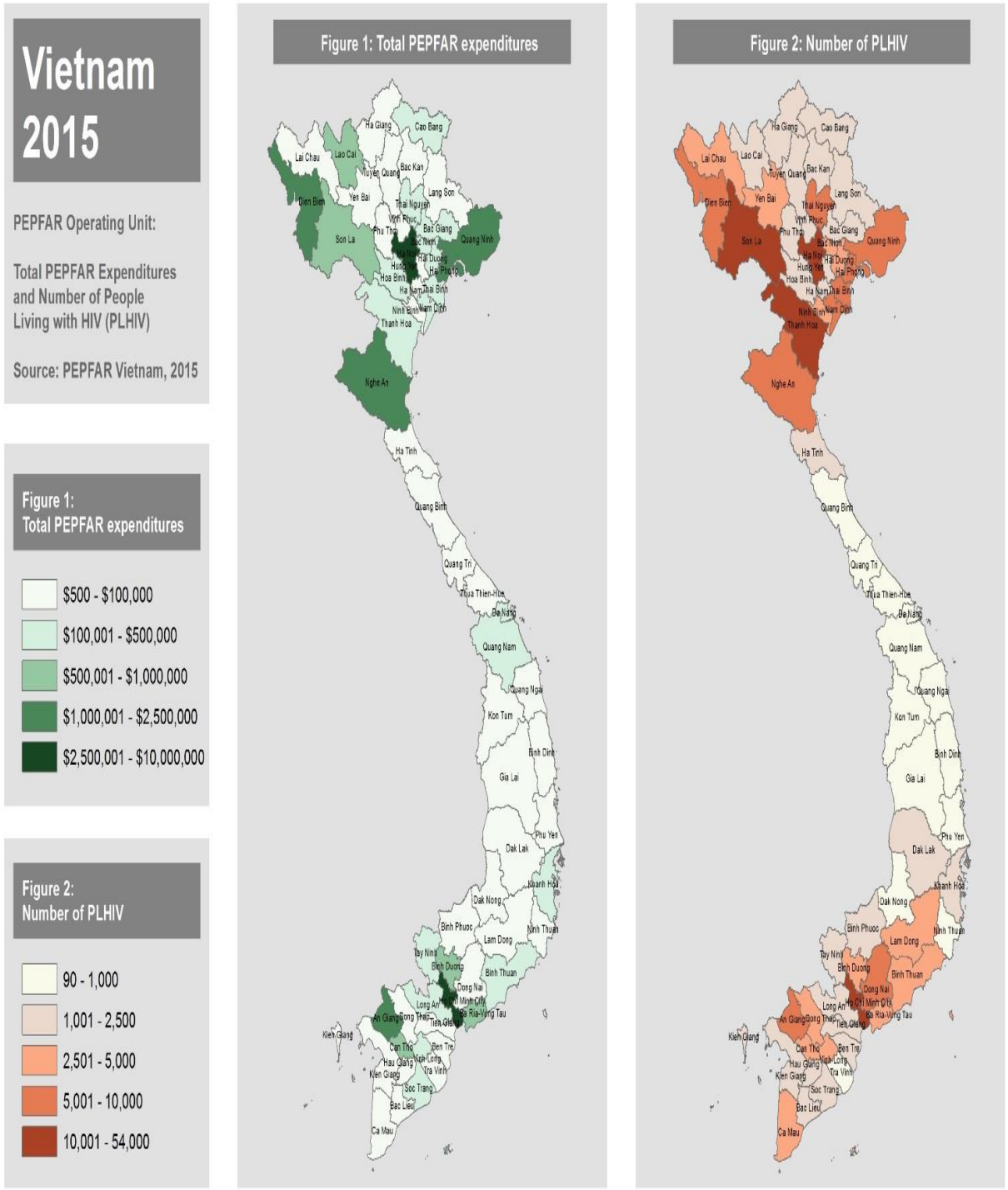

Standard Figure 1.4.1
2015 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU
$600
$500
$400
$300
$200
$100
$0
25%
20%
15%
10%
5%
0%
Ho Chi...
Son La
Hai Phong
Dien Bien
Thai Binh
Quang Ninh
Nam Dinh
Hai Duong
Yen Bai
Ba Ria-...
Binh Thuan
Ninh Binh
Vinh Long
Kien Giang
Cao Bang
Hoa Binh
Soc Trang
Long An
Ben Tre
Ha Giang
Tay Ninh
Bac Lieu
Ha Tinh
Binh Phuoc
Hung Yen
Thua Thien-...
Kon Tum
Tra Vinh
Gia Lai
Ninh Thuan
Quang Tri
Phu Yen
Spend per PLHIV 2015
Percent of PLHIV

Figure 1.4.2 Total Expenditure and PLHIV by District



1.5 Stakeholder Engagement

USG/PEPFAR regularly plays a convener role with bilateral, multilateral and CSOs in country with at least monthly meetings with stakeholders including civil society groups on PEPFAR planning and contributions to 90-90-90 goals. Stakeholder engagement activities and meetings include:

- Quarterly POART stakeholder meetings
- Annual and/or quarterly data and PEPFAR planning reviews held by the USAID SMART TA and C-Link CSO projects in Dien Bien, Nghe An and Ho Chi Minh City
- CDC regional provincial meetings with MOH and community organizations on PEPFAR implementation and planning
- SAMHSA multi-sectoral engagements on implementation of community-based substance use disorder treatment
- Country Coordinating Mechanism (CCM) committees and sub-committees, including the Executive and Oversight Committees, and the HIV and TB Sub-CCMs. USG/PEPFAR co-led the effort to expand representation on the CCM to 40% key affected population and community-based organization representatives.
- Awarding CSOs with direct and sub-awards

It is notable that the HIV response in Vietnam has given civil society members voice and access to high-level government officials in a way that is not enjoyed by many other groups working on social agenda issues in the country. However, the ability to establish wholly independent social enterprises (and benefit from tax exemptions) is a limitation. Organizations are generally organized under umbrella parastatal institutions (e.g. VUSTA) and USG is careful to focus CSO collaboration on service delivery over advocacy roles. In addition, since many KP are located outside Hanoi, the geographic spread and Vietnam's large population is a challenge for the routine engagement of civil society members.

2.0 Core, Near- Core and Non-Core Activities

PEPFAR VN continues to reduce costs by revising SD packages and decreasing or eliminating HR and commodity costs. The team has reduced the number of implementing mechanisms with the Vietnamese government, the UN system, U.S. universities, and international contractors; a total of 18 contractors ended in COP15, while 2 will end this year. By the end of 2016, PEPFAR will have transitioned 13 provinces and 40 percent of sites from DSD to TA or central support. In addition, PEPFAR VN has ceased providing certain levels of support to SOP, guideline and policy development; the remaining support will cease by the end of 2017. A proportion of training, capacity development and workforce development activities are also being phased out. Some evaluation and monitoring work is also being transitioned to the MOH and other government partners.

While there are savings from the transition of sites and the closing of projects, these cost-cutting efforts primarily allow PEPFAR remaining DSD support and TA activities to operate within a declining budget rather than reinvest extensively in new programs or sites. Appendix A lists the final decisions.

3.0 Geographic and Population Prioritization

During the May 2015 Bangkok COP15 review, PEPFAR VN established a strategy to demonstrate epidemic control (90-90-90) in five priority provinces: Dien Bien, Son La, Nghe An, Thanh Hoa and HCMC. Epidemiological data identified these provinces as locations with the greatest unmet need, large KP numbers and proven service uptake. In Dien Bien, Son La and Nghe An provinces, PEPFAR will continue aggressive case finding and enroll new HIV clients on PEPFAR-procured ARV drugs. PEPFAR will also support aggressive case finding in HCMC and Thanh Hoa; however, newly identified PLHIV will be enrolled on government or GFATM-procured ARV drugs. Based on data from the 2015 HIV sentinel surveillance data, the 2015 EPP, and the 2013 IBBS described in section 1.0, PEPFAR VN maintains its prioritization of PWID, FSW and MSM (and their sexual partners) for COP16. Population size and distribution of KPs varies between HCMC and the four northern, mountainous provinces; hence, an individualized service package has been tailored for each location.

HCMC is a large urban city in the Mekong delta, close to the Cambodian border. Its epidemic is driven by PWID, FSW, MSM and the sexual partners of each KP group. It is projected that by the end of FY 2017, 54,699 PLHIV will live in HCMC (EPP, 2015). PEPFAR VN will employ a comprehensive, innovative mix of activities to enroll 2,395 new PLHIV on treatment and increase ARV coverage (the second 90) from 53.1 percent to 57.4 percent. The various approaches include performance based incentive (PBI) case finding; new lay- and self-testing approaches that reduce reliance on stand-alone HTC; screening TB patients for HIV co-infection; and verifying lists of individuals who previously tested positive but never commenced ART. Tailored geographic and population approaches for Son La and Thanh Hoa combine the use of peer educators, PDI and PBI appropriately by population density and characteristics. In rural areas, commune health workers are maximized; in urban centers, peer education and PDI serve a more critical role. A pilot of Pre-Exposure Prophylaxis (PrEP) - specifically targeting the MSM and TG community– will also be conducted.

Nghe An, Dien Bien, Son La and Thanh Hoa are remote, mountainous provinces marked by scattered and largely ethnic minority populations, poverty, lower education levels and frequent labor migration. Drug injection is a primary driver in these provinces where a district health center may be a day's walk away and where PLHIV frequently decline treatment on the grounds they feel healthy. In these provinces, Test and Start is government implemented, and PEPFAR employs PBI and peer driven interventions (PDI). In Nghe An and Dien Bien PEPFAR will use specialized approaches to reach, test and treat KPs. Where urban enclaves exist, civil society will engage PWID networks to identify new PLHIV. In sparsely populated regions, government

hamlet health care workers are best poised to screen clients and test those at risk. Both urban and rural areas will benefit from expanded lay- and self-testing models. Per COP15 strategies, commune health stations play a greater role dispensing ARV and maintaining stable patients.

At the end of FY 2017 EPP data estimate Nghe An will be home to 7,271 PLHIV. COP16 new treatment targets (1,044) will raise the percentage of PLHIV on ART to 67.3 percent, up from the 55.5 percent planned for FY 2016. For Dien Bien, COP16 targets will increase ART coverage from 44.1 percent (planned FY 2016) to 57.2 percent (1,210 individuals) of the estimated 7,798 PLHIV. In Son La province, 1,598 individuals will initiate treatment in COP16, increasing the percentage of PLHIV identified from 29.3 percent to 39.4 percent. For Thanh Hoa, the enrollment of 1,058 new patients will improve ART coverage of an estimated 10,794 PLHIV from 33.2 percent to 41.3 percent.

PEPFAR VN lacks sufficient resources to fund national achievement of 90-90-90; however, through the COP 15 strategy PEPFAR is committed to assisting Vietnam to demonstrate that it can be achieved in the five priority provinces. With a declining budget and planned transition from DSD to TA by the end of 2018, PEPFAR will not be able to directly fund all services in these five provinces, but will rely on a systematic provision of TA. Based on the current targets for COP 16 in the five priority provinces and the current estimate of PLHIV, by end of FY 2017, there will remain a gap of 24,853 PLHIV who must initiate ARV in order to reach the goal of 80 percent PLHIV on ART. Based on the average estimated cost to place an individual on ART in priority provinces (including TB screening), this would cost an additional $3,852,215.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

All 163,318 (100 percent) individuals reached and 172,098 (83 percent) of 208,354 PEPFAR VN HTC are projected to come from the five aggressive scale-up provinces; HCMC will contribute 30 percent of outreach and 24 percent of HTC in the scale-up provinces. Case finding will target KP groups to ensure HTC and support ART initiation for new patients. COP16 targets for outreach were derived using the KP size estimation, estimated HIV prevalence from EPP, and current ART enrolment. Combined with the provincial historical data, targets for outreach at each subnational unit (SNU) were established to exceed APR15 achievements in the priority provinces. KP outreach targets will be achieved through multiple approaches incorporating incentives, peer driven outreach, internet/social networking, and contact tracing. The HTC target of 172,098 was based on the 93,706 PLHIV (EPP13) in these provinces and the COP16 7,304 new ART target. It is estimated that 90 percent of HTC positives would be linked to OPCs.

PEPFAR VN will support only 56 TA MMT sites and 4 DSD MMT sites in the 4 northern mountainous provinces; existing HCMC MMT sites have already transitioned out of PEPFAR support. MMT targets in each scale-up SNU were based on the number of provincial PWID, the existing provincial MMT uptake in FY15, and the anticipated number of supported MMT sites in COP16. Site level targets were generally set between 100-200 persons; however, 11 sites set targets that exceeded 200 persons (4 sites in Son La, 2 sites in Thanh Hoa, 4 sites in Dien Bien, and 1 site in Nghe An).

The majority, 7,304 (82 percent) of 8,856 PEPFAR VN new ART targets are projected to come from scale-up provinces; HCMC will contribute 33 percent of new ART targets. ART scale-up targets were derived using provincial ART coverage, PEPFAR site historical achievements, the anticipated number of PEPFAR supported sites in COP16, and more aggressive case finding strategies. In APR15, the three northern provinces achieved 1,737 PEPFAR VN new ART targets (PEPFAR did not support ART activities in Thanh Hoa in 2015); thus COP16 targets represent a doubling of COP14 ART achievements for these aggressive scale-up provinces (see table 4.1.1 for COP16 targets by province). As GFATM's 30 priority provinces overlap with PEPFAR's five scale-up provinces, both PEPFAR VN and GFATM will support routine VL for current ART patients in these provinces with PEPFAR funds covering VL for DSD OPCs.

Challenges in meeting targets include stigma and discrimination that increases the level of effort required for successful outreach, testing, and linkage to care and treatment. In addition, many newly identified PLHIV are reluctant to enroll in OPCs because of perceptions of good health, or fears that enrolling in SHI at the commune level will reduce privacy. Peer outreach workers and CSOs play a critical role in PEPFAR outreach programing, and have substantially contributed to case finding efforts with successful linkage to HTC and Treatment. During FY 2015, the Community HIV Links project reached 11,653 individuals in 3 priority provinces (Dien Bien, Nghe An and HCMC) of whom 5 - 7 percent were positive. The active engagement of CSOs in HIV programing has been recognized by local authorities and PEPFAR VN will work with them in COP 16 to strengthen their advocacy roles.

The COP 15 and 16 data packages triangulated the best available information to identify provinces and locales for scale-up; however, there are limitations to assessing the impact of the scale-up on KPs. HIV prevalence estimates are based on EPP input models which formulated specific numbers for highly populated SNU's, e.g., HCMC, but in the other four provinces a cluster approach was used which created less precise estimates with significant limitations. The population denominator for PWID is based on public security records that likely underestimate the number of injectors. FSW statistics are derived from the numbers of female entertainment workers, a situation likely to overestimate the number of sex workers, and exclude street-based FSW. MSM estimates are taken from Spectrum Southeast Asia modeling assessments which estimate 2 percent of adult men are MSM. In 2016, new EPP data will be available to improve estimates. In addition, PEPFAR VN will support PWID and FSW size estimations for HCMC and

PWID estimates in Son La. PEPFAR VN staff will also provide TA to UNAIDS and VAAC to conduct MSM population size estimations in thirteen cities in Vietnam, including HCMC.

Table 4.1.1 ART Targets in Scale-up Sub-National Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) TX_CURR	Newly initiated (APR FY 17) TX_NEW	ART Coverage (APR 17)
Son La	13,639	3,927	6,912	5,403	1,598	40%
Thanh Hoa	10,728	3,132	5,023	4,455	1,058	42%
HCMC*	54,363	28,856	14,634	31,417	3,600	58%
Nghe An	7,226	4,414	1,774	5,085	1,044	70%
Dien Bien	7,750	3,364	2,784	4,224	1,210	55%
Total	**93,706**	**43,693**	**31,127**	**50,584**	**8,510**	**54%**

***Data is at SNU level, contributed by all donors in the city, not necessary equal to PEPFAR target**

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-Up SNUs

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)	Identified Positive (APR FY17)	Newly initiated (APR FY 17) TX_NEW
Adults			
Clinical care patients not on ART			600**
HIV+ TB Patients not on ART			
HIV-positive Pregnant Women	*29,492*	112	197
Other priority and key populations	172,098	7,700*	6507*
Pediatrics			
Clinical care pediatrics not on ART			
HIV Exposed Infants	673	00	00
Orphans and Vulnerable Children			
Provider Initiated Testing			
Total	202,263	7,812	7,304

* Does not include cases identified and treated from non-PEPFAR-supported sites in HCMC
** Estimated number in HCMC

4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations*	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
IDUs	86,272 [(1)]	86.4%	71,946
FSW	23,474 [(1)]	31.6%	8,122
MSM	86,575 [(1)]	32.5%	30497
Other KP			45,424
Priority Population (Military)			50,000
Total			205,783

*Indicator Codes include PP_PREV and KP_PREV
[1] EPP 2013

4.2 Priority Population Prevention

All five priority provinces have established policies and implementation frameworks that enable a Test and Start approach for all HIV positive KP (the four northern provinces have Test and Start policies for all PLHIV). In COP16, PEPFAR VN will continue its targeting priority populations through active case finding in these provinces through DSD and TA. COP16 targets were based on the foundation of COP15 and an initial review of quarter one achievement. Total KP prevention targets are 155,989 individuals reached with preventive interventions. The COP 16 targets are approximately 160 percent higher than COP15 (96,384), as COP16 activities will be the most crucial to achieve the aggressive targets of up to 70% of PLHIV in the five priority provinces.

Innovative outreach approaches include PBI, leveraging KP networks through CSOs, PDI, internet social network outreach, and provision of lay and self -testing by community outreach supporters and CSOs. In addition, stakeholders recommend mobilizing Women's Unions, hamlet health workers and community leads to reach people at risk in their communities. Due to transportation challenges in remote communes, mobile testing is also needed if lay testing is not available. In border areas (Laos, China), HIV knowledge is very low and basic HIV education is needed. There are also HIV endemic sites, such as mining and forestry areas that are difficult to reach. Community leaders at these sites should be involved to support reaching KPs and provide lay testing. PEPFAR VN will continue to provide targeted TA to Provincial AIDS Centers (PACs) to effectively and efficiently implement, monitor, and evaluate and refine these approaches in the aggressive scale-up provinces.

As elevated HIV infection rates among young MSM in HCMC are of special concern, VAAC in collaboration with WHO and other potential partners, has endorsed a PrEP demonstration project among MSM and transgender (TG) in HCMC, drawing upon a Thai protocol. The manufacturer of Truvada will donate free study drugs. PEPFAR VN will pilot PrEP in HCMC for 1,000 high risk MSM and TG in COP16 to demonstrate its acceptability and feasibility in this population.

Target-based budgeting was employed for COP16. PEPFAR VN conducted a thorough review of FY15 expenditure analysis (EA) data, and found that the KP EA data ranged from $38 USD to $89 USD among different KP and implementing partners. In COP16, PEPFAR VN will standardize a KP prevention package that will result in at a unit expenditure (UE) of $26/KP prevention reached. Assumptions are that 80 percent of reached individuals will be tested, the HIV positivity should be 4 percent or more, and that 80% of those that are positive will be linked to care and treatment.

The case finding performance data reveals that as implementing partners expand HIV testing coverage, they will experience a decreasing yield. This may suggest that the HIV prevalence estimates (from EPP inputs) used to set targets may be too high, and/or that outreach and testing services are not optimized to find and diagnose new HIV-infected individuals. Innovative, low

cost strategies are needed to improve rates of case detection and linkage to treatment. In addition, there is an imperative need to institutionalize information systems solutions that eliminate risks of duplicative client registration and allow provinces to track unique clients across the cascade of clinical and community services.

As of March 2016, 26 SIMS visits have been completed at 26 prevention sites. Preliminary results indicate several issues, such as lack of beneficiary/client engagement in strategic planning, program design and M&E; lack of accounting software to check expenditures; and no systems or mechanisms for clients to report violation of stigma and discrimination policies. PEPFAR VN plans to work with partners to address these issues at either service or systemic levels.

4.2b Methadone Maintenance Treatment (MMT)

Since 2008, the Vietnam National Targeted Program (NTP) has expanded the MMT program to 241 sites in 57 provinces with over 44,000 patients. In FY 2016, PEPFAR VN supports 141 of these sites: 28 DSD MMT sites (methadone and TA only), 93 TA only sites, and 21 "neither" sites," serving 9,825, 13,010 and 6,600 patients respectively. This accounted for 29,435 (66.9 percent) of current total MMT patients.

In FY 2017, PEPFAR VN will only provide DSD and TA to MMT sites in the four northern aggressive scale-up provinces. PEPFAR VN will provide DSD support to only 4 sites, TA only support to 56 sites, and 45 sites will be supported with commodities only. Targets include 2,000 DSD patients; 9,890 TA only patients; and 12,775 patients in the "neither" sites. All the DSD and TA supported sites are in the aggressive scale-up provinces.

The MMT program has greatly contributed to HIV epidemic control. By the end of December 2015, the national program served 43,720 patients with nearly 100 percent tested for HIV; of those, 20 percent tested positive, and 80 percent of positives were placed on ART. Program monitoring did not detect a single case of HIV seroconversion while on MMT.

PEPFAR VN has successfully transitioned all MMT site operating costs by the end of 2015. These costs are covered by the Government of Vietnam and a modest contribution from patients at certain sites. PEPFAR VN is developing plans to transition medication support to provinces with low HIV burden or strong local financial resources. Findings from recent SIMS visits showed that although HTC and treatment referrals have improved significantly, risk reduction services are not provided to all patients

Table 4.2b MMT Cascade

National	271,506	63,092	80,404	43,720	36,684	8,919	20.4
Son La	19,064	7,259	6,000	1,148	4,852	251	21.9
Hanoi	30,867	6,263	8,500	3,764	4,736	1,357	36.1
Ho Chi Minh	34,323	9,984	8,000	3,473	4,527	1,402	40.4
Nghe An	9,980	3,081	3,400	806	2,594	313	38.8
Dien Bien	10,189	3,880	4,400	2,621	1,779	436	16.6
Thai Binh	7,115	816	3,000	1,643	1,357	38	2.3
Thai Nguyen	7,959	3,305	3,300	2,010	1,290	514	25.6
Hai Duong	4,851	556	1,900	837	1,063	No data	
Thanh Hoa	12,717	4,890	3,500	2,517	983	465	18.5
Lao Cai	4,677	1,159	2,431	1,555	876	155	10.0
Hai Phong	13,779	3,299	4,600	3,811	789	865	22.7
Ninh Binh	3,392	389	1,356	630	726	109	17.3
Hoa Binh	2,982	739	1,200	531	669	142	26.7
Binh Duong	5,655	1385	800	160	640	32	20.0
Ba Ria - Vung Tau	4,998	1,226	1,200	606	594	223	36.8
Can Tho	2,786	840	1,100	548	552	311	56.8
Quang Ninh	4,356	2,119	1,600	1,065	535	405	38.0
Phu Tho	5,177	1,282	1,200	673	527	157	23.3
Da Nang	2,436	238	850	343	507	22	6.4
Tuyen Quang	1,926	477	700	246	454	77	31.3
Bac Giang	3,483	669	1,213	766	447	76	9.9
Lam Dong	2,352	302	550	105	445	No data	
Binh Thuan	1,726	294	1,144	723	421	20	2.8
Dong Nai	3,639	892	1,404	996	408	202	20.3
Vinh Phuc	2,497	618	800	421	379	No data	
Dak Lak	1,984	254	400	31	369	2	6.5
Bac Can	1,934	371	800	460	340	85	18.5
An Giang	2,015	280	900	563	337	111	19.7
Ha Nam	2,103	241	700	368	332	27	7.3
Cao Bang	2,331	447	750	444	306	51	11.5
Yen Bai	5,333	1,321	1,200	913	287	96	10.5
Nam Dinh	7,127	817	1,900	1,622	278	311	19.2
Quang Tri	2,048	65	450	174	276	2	1.1
Lang Son	3,734	717	800	561	239	43	7.7
Quang Binh	1,790	57	400	193	207	1	0.5
Ninh Thuan	516	88	200	1	199	0	0.0
Tien Giang	1,726	140	350	153	197	17	11.1
Tay Ninh	2,352	577	400	240	160	31	12.9
Khanh Hoa	2,583	497	500	350	150	5	1.4
Hung Yen	2,878	330	750	620	130	80	12.9
Bac Ninh	1,799	345	500	376	124	40	10.6
Ha Tinh	1,949	62	400	289	111	31	10.7
Quang Nam	1,383	135	400	289	111	No data	
Hau Giang	677	55	100	12	88	1	8.3
Ha Giang	1,053	261	250	166	84	33	19.9
Binh Dinh	425	42	100	29	71	0	0.0
Quang Ngai	339	33	100	33	67	1	3.0
Ben Tre	637	52	300	235	65	77	32.8
Kon Tum	347	44	100	60	40	6	10.0
Dak Nong	521	67	100	64	36	0	0.0
Bac Lieu	852	69	100	81	19	21	25.9
Vinh Long	1,183	95	200	203	-3	53	26.1
Hue	682	22	200	213	-13	7	3.3
Long An	1,679	136	650	664	-14	82	12.3
Soc Trang	1,156	94	100	129	-29	41	31.8
Dong Thap	854	69	100	198	-98	No data	
Lai Chau	7,396	2,816	1,700	1,988	-288	189	9.5

4.3 Voluntary medical male circumcision (VMMC) – N/A

4.4 Preventing mother-to-child transmission (PMTCT)

In FY 2015, the VAAC issued new guidelines establishing Option B+ as a new policy; lifelong ART is now provided to all HIV-infected pregnant and breastfeeding women regardless of clinical stage, CD4 count, or pregnancy stage.

In FY 2015, PEPFAR VN supported: testing for 328,624 pregnant women, and access to ARV drugs for 1,208 HIV-infected pregnant women; nationwide implementation of Option B+; continued efforts to reduce DSD; and the integration of basic PMTCT indicators into the maternal and child health (MCH) monitoring and reporting system. One challenge for PMTCT programming is that the cost of HIV testing for pregnant women is not covered by health insurance; if is not covered by donors, pregnant women must pay the cost. FY 2015 SIMS results did not show that any clinics needed urgent remediation.

In FY 2016, PEPFAR VN provided DSD support to only 13 PMTCT sites and TA support to 12 sites, down from 113 comprehensive PMTCT sites. All non-core activities such as patient travel support; routine trainings and annual meetings; nutrition and formula support; and printing information, education, and communication materials were transitioned to the government. By the end of FY 2016, DSD support to the remaining 13 PEPFAR-funded PMTCT sites will transition to GVN, and only 5 sites will continue to receive TA in FY17.

During FY 2017, PEPFAR VN will support these 5 TA sites serving 80,000 pregnant women to develop standard operating procedures in line with MOH guidelines and harmonize with other ANC services and processes; and provide onsite TA to assure quality services continue to be provided and data collection and management are up to date. Additionally, efforts need to be made to test women earlier during pregnancy and strengthen mother-infant tracking to ensure continuum of services between facilities.
To help integrate PMTCT services into the MCH system as a routine ANC service and to support testing and referral within the MCH system, COP16 planned core and near core activities include providing TA to develop policies and clinical guidelines, revising patient clinical records, and supporting ANC rapid testing. Training on these new policies and practices will be expanded to include the private sector and to strengthen in-country TA capacity led by MCH system. PEPFAR VN will also provide onsite TA to assure quality services continue to be provided and that data collection and management are up to date.

4.5 HIV Testing & Counseling (HTC)/HIV Testing Services (HTS)

Although the PLHIV burden in the five aggressive scale-up provinces accounts for 36.5 percent of the total PLHIV burden in Vietnam, the current ART coverage in these provinces remains as low as 40.6 percent. The national KP HTS target for COP16 is 285,989 individuals, with 202,263 individuals from the five aggressive scale-up provinces. PEPFAR VN expects a positivity rate of about 3.6 percent. In comparison with APR2015 results, the COP16 HIV yield target increased by a factor of 1.4 by targeting higher HIV burden locations and intensifying active case finding strategies.

PEPFAR VN set a target to identify 7,796PLHIV in FY 2017; other donors will identify 1,971 PLHIV. The HIV positivity at PEPFAR VN supported HTS targeting KP sites in FY 2017 is estimated to be between 3.7-6.0 percent. . In FY 2017 PEPFAR VN will support 67 facility-based DSD VCT sites, 33 community-based DSD sites, 20 facility-based TA sites, and 8 community-based TA VCT sites. In addition, PEPFAR VM supports district health facility-based HTS to serve KP with comprehensive approaches that advance sustainability. PEPFAR Vietnam will also support MOH to review and inform the development of national community-based HTS guidelines for further expansion.

Community-based HTS includes mobile services deployed by district health staff to mountainous, remote, and hotspot areas; lay-testing by commune health staff; use of village health volunteers and community groups; and oral/self-testing. PEPFAR stakeholders recommend that CSOs/CBOs be trained in HIV testing at the communal level for KP groups. This strategy will reduce travel cost as only likely cases will be sent for positive confirmation. Stakeholders also suggest that the military health system be available to provide HIV testing to KP living along the border and in the mountainous provinces.

In line with the transition timeline of all PEPFAR VN DSD support by the end of 2018 and the sustainability goals agreed upon with the central and local governments, PEPFAR VN will support only 14 DSD and 10 TA facility-based HTS sites in 15 sustained provinces in FY 2017. One military site incorporates eight PEPFAR-supported TA provider-initiated HTS sites in military health care settings in Hanoi, Can Tho, Khanh Hoa, Da Nang and HCMC. PEPFAR VN will continue to provide TA support to 24 client-initiated HTS sites for KP with high HIV positivity (≥48 cases or 4.0 percent annually). PEPFAR VN support in these sustained provinces will include monitoring post-transition. These provinces will advocate for allocation of other funding sources to cover HTS costs to support activities when PEPFAR VN transitions out of DSD. PEPFAR VN will continue to provide TA to select HTS sites that have transitioned.

Several policy changes have advanced KP access to HIV testing, including:

- Government revision and approval of 16 national HIV testing algorithms for various HTS settings in July 2015

- MOH approval for the use of three HIV rapid tests for HIV positive confirmation testing in three district health facilities
- Simplification of the accreditation process and the transition of confirmatory testing approval authority to provinces in order to shorten the client waiting time to receive positive results and reduce the linkage time to care
- MOH allowed importation of quality oral HIV test kits for self-testing initiation in scale-up provinces

HTS linkages to HIV treatment services remain a priority and PEPFAR VN will assist in the improvement of a tracking system of HTS referral of all HIV positive individuals identified through facility or community based HTS services to HIV treatment sites in PEPFAR-supported provinces. PEPFAR VN will support expansion of confirmatory labs using rapid test algorithms to shorten the waiting time for positive results and HIV case referral. PEPFAR stakeholders also recommend sending suspected blood samples for confirmation through the post office system instead of in-person delivery. Benefits of early ART should be communicated through the cascade of services, from reach to test and to treatment, to encourage PLHIV early access. Advocacy for simpler treatment intake can also improve linkage from prevention to treatment.

In 2015, PEPFAR VN conducted SIMS visits at 59 HTS sites. The results from 413 (59x7) core essential elements assessed indicate that 2.9 percent (n=12) rated red (six proficiency testing, five linkages, and one HIV testing quality assurance) and that 9.4 percent (n=39) rated yellow (22 HIV testing quality assurance, eight linkages, four HIV test kit supply chain, three documentations, one proficiency testing, and one safety). PEPFAR VN's laboratory program has been working with the government to expand proficiency testing and quality assurance programs to address these issues. Efforts have been ongoing to expand standardized referral procedures and referral tracking systems between HTS, and HIV care and treatment services**.**

4.6 Facility and community-based care and support

In line with PEPFAR VN and national geographic prioritization, implementing partners provide DSD facility-based care and support and build capacity for healthcare staff at 26 newly opened OPCs in Son La, Dien Bien, Nghe An and Thanh Hoa in the first quarter of FY 2016. In FY 2017, PEPFAR VN will provide care and support services at 105 OPCs (60% in priority provinces) and TA at 32 OPCs (72% in priority provinces, including GFATM-supported OPCs). To facilitate the transition process, HIV care and treatment services should be integrated into the existing healthcare system through domestic resource mobilization and SHI to cover the costs of facility-based clinical care services (e.g. laboratory monitoring tests and opportunistic infection (OI) drugs). Following WHO guidelines and PEPFAR Technical Considerations, PEPFAR VN will streamline its support for a facility-based care and support service package at all DSD sites in FY 2017 to include only essential laboratory tests (CBC/Hemoglobin, creatinine, and CD4 at ART initiation), and ART adherence support. PEPFAR VN will transfer all laboratory monitoring tests to SHI coverage when SHI reimbursement plans are initiated or at the time of provincial transition.

In FY 2015, three new HIV community links programs (CCRD, COHED and LIFE) set up new collaboration mechanisms between CSOs and facility HIV providers. The programs support CSOs to identify PWID, FSWs, and MSM, and, link them to facility services, including HTC and OPCs. CSOs also collaborate with OPCs to provide support to PLHIV who have poor treatment adherence or are enrolled in MMT programs.

Implementing partners support training, mentoring and quality assurance to outreach workers and village/commune healthcare staff in the 5 scale-up provinces. To support the first "90" target, PEPFAR VN prevention and care and support programs reprioritized resources to support community based outreach and care and support services in scale-up provinces where decentralization of HIV care and treatment and "Test and Treat" approach was endorsed by MOH in FY 2015. The community-based service package has been streamlined and the scope of work of community-based supporters has been revised with focus on: (1) identification of KPs in the community who are newly identified as HIV positive or lost to follow up and linking them to OPCs, (2) lay HIV counseling and testing at grassroots level, and (3) ART adherence support. PEPFAR VN currently supports 125 community-based outreach, care and support service delivery points in five scale-up provinces offering HIV prevention, care and support services to KP and PLHIV. In FY 2017, PEPFAR VN will continue expand to 132 community based service delivery points (114 DSD and 18 TA points) in these provinces.

FY 2015 APR results showed that PEPFAR implementing partners provided DSD care and support services to 57,217 PLHIV, including ART and non-ART patients at 94 adult and pediatric HIV OPCs in 25 provinces and to 9,518 PLHIV in 66 community sites in 15 provinces. During FY2014 - 2015, PEPFAR VN transitioned DSD facility-based care and support delivery services to the Government of Vietnam at 4 OPCs in 2 sustained provinces (Da Nang [2 OPCs] and Binh Thuan [2 OPCs] and 8 home-based community care sites in 1 priority and 7 sustained provinces (Nghe An, Nam Dinh, Hanoi, Hoa Binh, Binh Duong, Vinh Long, An Giang, Long An). Currently, PEPFAR VN provides support for human resources and operational costs at 117 OPCs (50 percent in 5 priority provinces). By the end of FY2016, PEPFAR VN will transition DSD support at an additional OPC in Quang Nam province and shift DSD to TA support at 9 OPCs in 7 sustained provinces (Ba Ria-Vung Tau [2 OPCs], Bac Ninh [1 OPC], Binh Duong [1 OPC], Can Tho [2 OPCs], Long An [1 OPC], Quang Nam [1 OPC] and Vinh Long [1 OPC]).

In FY 2016, PEPFAR VN plans to support MOH/Vietnam Administration of Medical Services (VAMS) to assess capacity for diagnosis and treatment of patients with viral hepatitis B and C, including HIV-hepatitis co-infections in hospitals, which is expected to inform the development of a national standard operating procedures for clinical management of patients with viral hepatitis B and C, including HIV/HBV and HIV/HCV co-infected patients.

Care and support related issues identified from SIMS visits at 17 community-based sites and 34 facility-based sites in FY 2015 highlighted needs for development of SOPs for facility-community linkage and patient tracking and referral systems; implementation and documentation of positive health, dignity and prevention interventions; and nutritional assessment. To address these gaps, PEPFAR VN supports partners to implement above-site and site level activities to strengthen service linkages and assists PACs to develop and coordinate the implementation of SOPs for HTC-OPC linkage in Son La and Nghe An, and one sustained province (Nam Dinh) in FY 2015 - 2016. In FY 2017, PEPFAR VN will provide TA to PACs in additional provinces to improve SOP use for HTC-OPC linkage and intensive site TA to support the achievement of the 2nd 90 target in priority provinces.

4.7 TB/HIV

The 2015 WHO Global TB Report ranks Vietnam 14th among the 20 top high burden countries, with an estimated TB incidence (including HIV-positive patients) of 140 per 100,000. TB prevalence is 198 per 100,000; mortality (excluding HIV) is 18 per 100,000. HIV/TB incidence rate is 7.6 per 100,000, and the total TB cases reported to the National TB Program is 102,087. In 2014, 74,092 (73 percent) TB patients knew their HIV status; among them, 3,875 were HIV-positive (5 percent), and 2,827 started ART. Approximately 4,595 TB-HIV co-infections are identified annually. The 2014 national guidelines emphasize immediate ART for TB/HIV patients; however, since the national TB and HIV programs are independently managed, monitoring and evaluation of collaborative TB/HIV activities remains challenging.

In alignment with national TB and HIV strategies and WHO's recommendations, PEPFAR VN has consistently supported activities to reduce the burden of HIV among TB patients and of TB among PLHIV. In COP 2016, TB/HIV core activities at national and provincial levels are: 1) strengthened TB screening, detection and management of TB cases among PLHIV, including improved referrals and increased PLHIV access to Xpert MTB/RIF testing; 2) increased HIV testing for TB patients and fast-tracking/referral of TB/HIV co-infected patients for ART initiation; 3) improved monitoring, evaluation and reporting of collaborative TB/HIV activities, including TB/HIV integration; and 4) improved TB infection control at HIV sites. Additional areas of support include test kit supply chain management, and Strengthening Laboratory Management Toward Accreditation Program (SLMTA) training. Activities will focus on achieving 90-90-90 goals, primarily in PEPFAR priority provinces.

In 2016, the MOH set the target for HTC among TB patients at 85 percent, with 80 percent of HIV/TB co-infected patients receiving both ART and TB treatment. Site level TA support for HIV testing in TB patients is focused on TB clinics in two mountainous priority provinces and DoD supported sites.

PEPFAR VN support for TB screening, infection control, and isoniazid preventive therapy (IPT) remain a standard TA package at all PEPFAR VN OPCs. PEPFAR VN provides support for TB

diagnostic testing at all DSD supported OPCs. As DSD OPC support transitions to TA, local and GFTAM resources will be need to support TB diagnosis among PLHIV. FY 2015 APR results showed 96 percent of PLHIV at PEPFAR supported sites received TB symptom screening. In FY 2017, implementing partners will receive funding to provide TA assistance to integrate TB diagnosis and/or treatment at HIV OPCs. This will reduce burden of TB co-infection among PLHIV, facilitate patient centered approaches, and increase program efficiency.

Recent SIMS results underline the need for improvement of TB/HIV referrals, the TB diagnostic evaluation cascade, TB infection control, and the quality of data reported. In 2015, a stock-out and delayed supply of HIV rapid test kits and GeneXpert cartridges occurred when PEPFAR transitioned commodity procurement to GFATM; resolving the supply chain issues required extensive TA.

4.8 and 4.9 Adult and pediatric treatment

In 2015, the VAAC issued new National HIV/AIDS Treatment Guidelines, heralding substantial changes in ART policy. Major policy changes include:

1) The CD4 threshold for ART initiation increased from 350 to 500 cells/mm^3 and immediate ART initiation regardless of CD4 count is now recommended for multiple subgroups of patients including KP, HIV-infected people in sero-discordant partnerships, HIV/TB patients, pregnant women, and children aged <5 years;
2) A special Test and Start policy that allowed 7 remote and mountainous provinces to start ART immediately following HIV diagnosis; and
3) VL testing for routine monitoring of ART with a gradual transition out of CD4 test monitoring nationally.

As a result of these policy changes and focused case finding efforts, Vietnam significantly increased the number of HIV-infected patients on ART from 89,853 in September 2014 to 102,527 ART patients as of September 2015, a 26 percent increase in new patients. By the end of 2015, 106,400 patients, including 4,635 children aged under 15 years were receiving ART; PEPFAR support accounted for 54% of these patients (52,540 receiving direct services and 4,510 receiving TA).

Financial transitioning of OPCs from PEPFAR DSD support to the Vietnamese government began in 2014. By the end of FY2015, DSD support of 4 OPCs in 2 provinces had been transitioned to GVN financing. By the end of 2016, additional OPC sites (8 from USAID + 813 CDC + 2 DOD) will transition from DSD to TA. PEPFAR will cap ARVs for new ART patients in all provinces except in Dien Bien, Nghe An, and Son La in April 2016, but will continue to support core commodities including baseline CD4, TB ICF, and training on new national and provincial technical guidelines at DSD sites. GFATM will provide pediatric ARVs and EID supplies nationwide through 2018.

PEPFAR support for near- and non-core services including travel, nutritional support, and infant formula was discontinued in FY 2015.

ART service quality remains a high priority in COP16 regardless of site transition status. SIMS, HIVQUAL, and e-mentoring will be used for performance measurement and improvement. In two quarters of FY 2016, PEPFAR VN conducted site-level SIMS results showed that no clinics had drug stock-outs. However, some sites yielded red/yellow CEEs indicating that the documentation of successful linkages, prevention counseling, and referral feedback between facility and community was incomplete or missing; PEPFAR VNVN plans to provide site-level TA to OPC staff to strengthen referral mechanisms.

Through the technical partnership with PEPFAR VN, the government of Vietnam has established HIVQUAL as the national program for the measurement of the quality of care for PLHIV. HIVQUAL data will be used for local quality improvement activities and to monitor post-transition clinical service quality. PEPFAR continues to support MOH to integrate HIVQUAL indicators into the existing curative system's quality improvement program. PEPFAR-supported clinics benefit from additional TA through e-mentoring or on-site TA at least quarterly. E-mentoring is being incorporated into the existing health system as a sustainable model for ongoing TA. E-mentoring is being incorporated by GVN entities into the existing health system as a sustainable model for ongoing technical assistance.

Technical priorities for improved quality of care include expanding treatment coverage, earlier initiation of ART, improved referral and tracking between VCTs and OPCs, retention in care, and viral suppression. PEPFAR VN will provide TA to MOH, provincial authorities, and CSOs to assume financial, technical and programmatic support for service delivery, while ensuring the quality and sustainability of services, in the following ways:

1. **Treatment coverage and earlier initiation of ART**
    - In FY 2017, VAAC will expand treatment coverage nationally, including adhering to the new treatment guidelines and Test and Start policies for mountainous/remote provinces
    - Triple rapid test confirmatory algorithms will be rolled out to replace ELISA for confirmation in mountainous districts
    - PEPFAR VNVN will continue to pivot resources for scaling up treatment in the five provinces through aggressive case finding
2. **Retention**, with a focus on patients who demonstrate warning indications for loss to follow-up, poor adherence, or treatment failure
    - mHealth messages, telephone calls, peer support and in-person contacts will be used to improve retention in care and on treatment
    - Advocacy for the change of political environment and education to reduce stigma and discrimination

3. **VL monitoring** to achieve viral suppression
    - **Support for transition** from CD4 to VL for monitoring treatment response in FY 2017 for 42,541 patients (23%) of the national need (PEPFAR VN will eliminate support for CD4 monitoring and only support baseline CD4 testing)
    - **PEPFAR VN TA to MOH for the development of a national VL plan, which includes a joint** procurement with GFATM to reduce costs of VL tests and expand use of dried blood spots for VL testing
    - VL will be added to HIVQUAL as a national quality improvement indicator and applied to HIV clinics.

The expansion of virologic monitoring requires significant investments in planning, product selection, training of lab and HIV clinic staff, test results documentation and sharing, logistics and QA. A well-functioning network of laboratory and sample transportation and lab human resources, information systems and infrastructure are all crucial for successful virologic monitoring.

Before March 2016, government policy delegated ARV dispensing to commune levels and permitted clinic visits every six months. However, because monthly pharmacy pick-up was still required, the six month-clinic visits were not widely implemented. As a result, the policies did not reduce the routine healthcare burden to patients or the costs of care. Many barriers, including a pre-existing treatment law that requires monthly prescription, make the revision of policies and practices challenging.

PEPFAR VN is advocating for service delivery models that are more affordable and sustainable and that minimize patient burden in order to maximize patient retention and adherence. To maximize patient access to treatment, minimize patient burden, and reduce operational costs to make programs more sustainable, in FY17, PEPFAR VN will advocate with MOH to address barriers to less frequent drug dispensing and clinic visits and to develop local evidence of adherence and retention to support such policy changes; in mountainous areas where PLHIV are living far from district treatment clinics, mobile treatment services should be considered for remote communes with high number of PLHIV.

In FY17, PEPFAR VN will support MOH to revise ARV quantification and management protocol to extend supplies at sites that fit with the new pharmacy spacing. To gain efficiency and to enable SHI to cover the costs of HIV treatment, HIV services must be integrated into the routine health system; this will require provider credentialing, task shifting, patient flow, and information systems that are consistent with the routine health and health insurance system. PEPFAR VN will continue to advocate and provide TA to support the development and implementation of recommendations. Maximizing the use of the existing human resources in new service models will reduce the treatment unit expenditure per patient, lowering costs for donors and increasing

the sustainability of quality HIV care for PLHIV that is consistent with international standards and guidelines.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

PEPFAR supported sites in Vietnam have a clear timeframe in which they will either transition to central support under the MOH, or cease receiving donor support. The following definitions are based on the PEPFAR guidance and definitions outlined in COP15:

- **Sustained provinces**: provinces where PEPFAR supports facility activities, adherence and retention; site, district and national level quality monitoring.
- **Sustained sites:** consistent with current ART new patient and attrition rates; outreach will conclude, but 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.
- **Sustaining commodities:** continued national support for overarching QA/QI, and/or commodity support to sites without site level support. 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 starting April 1, 2016.
- **Central support provinces or sites:** continued national support for overarching QA/QI; site specific activities will move to direct government support of the next 6 months and will be negotiated to ensure no interruption of services.

In sustained provinces, PEPFAR outreach support concluded in January 2016, and HTC sites that did not meet the HTC-PEPFAR thresholds (defined in section 4.1) were transitioned to MOH. One-hundred and fifteen PEPFAR PMTCT and 141 MAT DSD sites were transitioned to MOH, and five high volume and high positivity PMTCT and 56 critical MMT sites are PEPFAR TA only. There will be no recurrent costs at these PMTCT, MMT, and HTC sites.

PEPFAR VN redefined its service delivery and TA packages for sustained sites and provinces this year. In COP16, 9 of 62 ART OPCs in sustained provinces will transition to TA only sites with no ROCs to PEPFAR outside of ARV drugs. At these 9 OPCs, the core package of services includes ARV procurement and assistance from MOH to collect national data on HIV/AIDS. The service package in the remaining 53 DSD ART OPCs includes ARVs, baseline CD4, annual VL or CD4 monitoring, CBC/Hb and creatinine as advised by WHO and PEPFAR, and provides limited support for OPC ROCs, personnel, in-service training, and travel. Since outreach support ended, the expected new volume of patients at the sustained sites is estimated to be reduced by 30 percent from last year, with a 4 percent attrition rate.

PEPFAR VN will continue to measure and monitor performance through the institutionalization of HIVQUAL at the national level and at all sustained PEPFAR sites, as described in Sections 4.8 and 4.9. Every six months all sites will report on their standard set of HIVQUAL data and select two quality indicators for improvement.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
HIV testing in PMTCT sites	***46,624***	**21,937**	**-53%**
HTS (only maintenance ART sites in FY 17)	***147,493***	**83,726**	**-43.2%**
Current on ART	**30,025**	**28,537**	**-5%**
OVC	***OVC_SERV***		

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

In January 2016, PEPFAR VN discontinued support for case-finding activities in non-priority areas, and ceased providing ARVs for new ART patients in 13 sustained SNUs, 2 commodity sustained SNU's, and HCMC in April 2016. In preparation for the discontinuation of DSD support in all SNUs by the end of 2018 and transition to a TA model, in COP16, 7 CDC-only supported sustained SNUs, including 7 OPCs and 7 VCT sites, will be TA-only sites with no ROC to the USG outside of HIV commodities. Other milestones in the transition include:

- All MMT sites in sustained provinces will have transitioned out of DSD to the Vietnamese government (with the exception of methadone for 7,500 clients). Only 4 PEPFAR DSD MMT sites in 2 northern scale-up provinces (Thanh Hoa and Dien Bien), and 56 TA sites in the 4 scale-up northern provinces will retain PEPFAR support
- All CDC-supported PMTCT sites will have transitioned to local government support; only 5 PMTCT sites will receive direct quarterly TA
- All HTS provided in military health facilities and 50 percent of military care and treatment sites will transition from DSD to TA by the end of 2016
- Laboratory information systems activities will be supported by Global Health Security (GHS) in the transition; support for laboratory quality management systems will be jointly supported by GHS and PEPFAR

6.0 Program Support Necessary to Achieve Sustained Epidemic Control –

PEPFAR Vietnam completed the Systems and Budget Optimization Review (SBOR) to ensure that COP16 systems investments are strategically aligned to key programmatic gaps and systems barriers in the clinical cascade and policy environment. The proposed minimum package of critical systems activities is optimally budgeted and aligned to three key programmatic gaps (Section 6.1); and two priority policy areas (Section 6.2). Other proposed systems investments in human resources for health, laboratory, strategic information, governance, and service delivery/system support are summarized in Section 6.3.

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Programmatic Gap: ART Coverage for PLHIV

PEPFAR Vietnam must address several systems barriers that currently prevent the expansion of ART coverage in order to achieve the COP16 treatment targets in the PEPFAR priority provinces. Compulsory detoxification in 06 centers hinders the ability to expand coverage. PWID avoid testing and treatment for fear of being sent to 06. Furthermore, ART can be disrupted 06 settings where HIV testing and services are limited. While the GVN perspective on civil society has shifted to allow for more growth and civil society organizations (CSOs) are emerging, CSO engagement, support, and capacity are still limited. There is a lack of formalized systems for CSO engagement in government monitoring and reporting systems, including case verification in support of the first 90. Rapid confirmatory testing is not built into ART initiation and is currently only approved in three mountainous district facilities. Limited confirmation labs and the time required for sample transportation means results are delayed and clients may be lost to follow up. There is also a lack of reliable and accurate KP size estimates, and weak linkages in the cascade between the HIV case reporting and clinical monitoring. COP16 activities will address these barriers and will be monitored by the achievement of milestones listed below towards an overall 3-year outcome of helping Vietnam to achieve the first 90.

Table 6.1.1 Key Programmatic Gap #1: ART Coverage for PLHIV						
Key Systems Barrier	**Milestones/Deliverables expected after 1 to 3 years of investment**	**Proposed COP/ROP16 Activities**	**Budget Code(s)**	**Activity Budget Amount ($)**	**Associated Implementing Mechanism ID**	**Indicator reporting frequency for POART (End Date)**
First 90 - Lay and Community Testing	• National guidelines and training manuals completed for community-based testing services	• Development and standardization of national community-based HTC training manuals/packages and tools for roll-out. • TA to Ministry of Health to develop the National Guidelines on Community-Based Testing Services, including Lay and Self-Testing	HVCT HVCT	$51,584 $69,025	9976 16803	Annual (2017) Annual (2017)
First 90 - Limited CSO Involvement	• % quarterly provincial HIV planning meetings that include CSO and KP participation • # PEPFAR-supported community-based organizations that continue HIV/AIDS activities after two years	• Identify and/or develop standard indicators, data collection forms and mechanisms for CSOs to integrate their data and information into the national M&E system for HIV/AIDS. • TA to CSOs to enhance data use at different levels, support intervention program on performance data collection and analysis to improve service quality. • Capacity strengthening for CSOs to lead & sustain CoPC intervention in Nghe An – and increase their roles in National HIV and AIDS responses. • Strengthen provincial capacity in Nghe An to deliver high quality program monitoring data of civil society contribution to case finding to ensure accountability of PEPFAR program. • Increase the role of HCMC CSOs in National HIV response, including organizational and technical capacity. • Capacity strengthening for GF/VUSTA/CSO to lead & sustain CoPC	HVSI HVSI OHSS IDUP, HVOP, HBHC HBHC, HVOP, IDUP HBHC, HVOP,	$14,307 $9,350 $185,424 $102,742 $73,400 40,313	14156 14156 17374 17374 18173 18172	Semi-Annual (after 2017) Semi-Annual (after 2017) Annual (2017) Annual (2017) Semi-Annual (after 2017) Semi-Annual (after 2017)

		intervention – and increase their roles in National HIV and AIDS responses.	IDUP, OHSS			
		• Enhanced case finding and linking KP+ to HTC/HIV care and treatment through innovative outreach approaches and CSO service delivery to ensure samples from screening sites reach HIV confirmatory labs	HVCT	40,313	18172	Semi-Annual (after 2017)
		• Based on the results of the willingness to pay and private sector service preferences survey, provide TA support to local private sector and CBO social enterprise clinics to deliver other HIV related services (eg. fee-based PREP and service delivery innovations) for KPs willing to pay in PEPFAR priority provinces.	HVOP, IDUP, HVCT, PREP	295,820	16803	Semi-Annual (after 2017)
		• In-service training TA support to C-link partners and CSOs to implement Behavior Change Communication (BCC) and demand creation activities for KPs in PEPFAR supported areas.	HVOP, IDUP, HVCT,	197,213	16803	Annual (after 2017)
		• Mentoring TA support to C-link partners and CSOs to implement Behavior Change Communication (BCC) and demand creation activities for KPs in PEPFAR supported areas.	HVOP, IDUP, HVCT,	98,607	16803	Annual (after 2017)
First 90 - Compulsory Detoxification; Few Community Treatment Options	• Increased workforce trained to address HIV and addiction to facilitate ART coverage measured by number trained and skilled gained through pre-and post-tests.	• Develop a national CME standard for health care professional working on HIV/AIDS and Addiction.	HBHC, IDUP	$6,570	1145	Bi-Annually (after 2017)
		• Develops Addiction Medicine as a sub discipline within the National Medical system to enhance the quality of care given to HIV patients.	HBHC, IDUP	$114,401	1145	Bi-Annually (after 2017)
	• GVN approach shifts dramatically to provide community treatment for more than 80% addicts	• Enhance effective use of the national Textbook for MMT.	HBHC, IDUP	$6,569	1145	Annually(after 2017)
		• Improving coordination and collaboration in capacity development in the area of MAT and Addictions.	HBHC, IDUP	$19,934	1145	Quarterly (after 2017)
	• Close or reduce number of 06 centers; limit 6% addicts in the centers	• Support the organization of national HIV/AIDS and Drug Use conference to enable policymakers, providers, patients, community social works and family	HBHC, IDUP	$6,569	1145	Annually (after 2017)
	• 80% PWID will be treated in the community					

	• 90% staff involved in drug treatment trained in best practices	member learn about the art of treatment and promote evidence based and human right based approaches.				
		• Expanding Addiction Counseling and Treatment Training Series - in selected provinces Bac Giang, Khanh Hoa, Vung Tau, and 5 prioritized provinces - System Needs Assessment, Curriculum Development with health, social and other related partners	HBHC, IDUP	$94,694	1145	Bi-annually (after 2017)
		• Workforce Development with DOLISA to deliver quality services.	HBHC, IDUP	$94,694	1145	Bi-annually (after 2017)
		• Capacity building for national training institution to enable them to provide a sustained approach to addiction and HIV services.	HBHC, IDUP	$6,569	1145	Semi-annual (after 2017)
		• Revise legal documents to guide expansion of MAT program and adapt technical guidelines for MAT implementation.	IDUP	$22,755	9976	Annual (2017)
		• Train provincial mentors and supervisors to be local trainers in CDC-supported provinces.	IDUP	$34,143	18172	Semi-Annual (after 2017)
		• Support VAAC conduct MMT ToT trainings and follow-up with trained PACs and provincial MMT mentoring network on their routine site-level mentoring and supervision (capacity building, network/organizational level)	IDUP	$50,430	18172	Semi-Annual (2017)
		• Develop the National Methadone Quality Guidance (MethQUAL) for service quality improvement. This is national TA, above site level activity.	IDUP, HVSI	$71,244	18172	Semi-Annual (after 2017)
		• Train provincial MMT staff in using Methadone Quality Data (MethQUAL) for service quality improvement.	IDUP, HVSI	$86,792	18172	Semi-Annual (after 2017)
		• Support VAAC conduct trainings and follow-up to PACs to build provincial MMT trainers (capacity building, individual level)	IDUP	$22,760	18172	Semi-Annual (after 2017)
		• TOT training of MAT patients who will support there program and assist others in their recovery using a grass roots approach	IDUP	$75,000	New	Semi-annual (after 2017)

		which is sustainable in supporting recovery. • To develop a TOT training of MAT patients that can develop a grass roots CSO that is sustainable in supporting recovery.	IDUP	$75,000	New	Semi-annual (after 2017)
First 90 - Insufficient Case Reporting Data & KP Size Estimations	• HIV Case Reporting System verified and fully reconciled with HTC and ARV managing system for improved HTC-OPC linkages • 100% provinces with updated EPP data - PLHIV and KP size estimations updated with data collection and analysis managed by Vietnamese institutions	• Guideline development and quality improvement for HIV case reporting at central level.	HVSI	$61,900	9976	Annual (after 2017)
		• Refinement and consistent use of methodology on HIV sentinel surveillance at central level.	HVSI	$92,850	9976	Annual (after 2017)
		• KP size estimation– PWID district level estimation in priority Northern provinces.	HVSI	$52,305	9977	Annual (2017)
		• Quality assurance of HSS implementation in selected high burden Northern provinces, focusing support with reduction in geo-coverage (13 provinces in COP15, 11 provinces in COP16).	HVSI	$126,997	9977	Annual (after 2017)
		• Strengthening HIV case reporting (HCRS) in high burden Northern provinces.	HVSI	$69,271	9977	Annual (after 2017)
		• HSS–Quality assurance of HSS implementation in selected high burden Southern provinces, focus support with reduction in geo-coverage (5 provinces in COP15, 2 provinces in COP16).	HVSI	$66,677	9998	Annual (after 2017)
		• Improve data quality through strengthening HIV case reporting in high burden Southern Provinces, focus support with reduction in geo-coverage (5 provinces in COP15, 2 provinces in COP16).	HVSI	$30,774	9998	Annual (after 2017)
First 90 - Insufficient Case Reporting Data & KP Size Estimations (continued)		• Support for geospatial data of provincial, district, and commune level program coverage for KP reach and access to essential services in Dien Bien and Nghe An	HVSI	$45,735	14156	Semi-Annual (after 2017)
		• Support active-case finding by strengthening National HIV case reporting (HCRS) with emphasis on data quality improvement at site levels for 2 PEPFAR 90-90-90 focus provinces (Dien Bien and Nghe An).	HVSI	$42,433	14156	Semi-Annual (after 2017)

		• Data Management system upgraded and maintained for provinces at PAC and district levels. Development and maintenance of provincial HIV/AIDS data master files to enhance data use at provincial/district/commune/site levels, with focus on 2 PEPFAR scale-up provinces: Dien Bien and Nghe An, support intervention program on performance data collection and analysis to improve service quality.	HVSI	$57,639	14156	Semi-Annual (after 2017)
		• Enhance linkages between surveillance and HIV services through case finding and sharing of case reports between clinical system and the HIV case reporting (HCRS). Time limited support to intensify case identification at community level to achieve 90/90/90 goal in selected PF focus provinces.	HVSI	$89,010	14336	Annual (2017)
		• Quality improvement of HSS survey at district and site level, time limited support to enhance data quality improvement in 3 PEPFAR focus provinces.	HVSI	$47,472	14336	Annual (after 2017)
		• Update HIV/AIDS Estimation and Projection (EPP) modeling for 2016-2020 to support national/provincial level estimates of PLHIV and KP epidemic data.	HVSI,	$60,603	18172	Semi-Annual (after 2017)
		• Development of provincial cascade information for quarterly monitoring of 90-90-90 progress and to inform programming gaps.	OHSS HVSI, HBHC, HTXS ..etc	$36,362	18172	Semi-annual (after 2017)
		• Strengthening National HIV case reporting (HCRS) with emphasis on training and technical support on implementation of circular 09 and technical support to provincial and district staff on DQA for case reporting and case verification.	HVSI	$14,307	14156	Semi-annual (after 2017)

Programmatic Gap: Routine Viral Load Coverage

Enabling universal access to viral load (VL) testing for all PLHIV receiving ART requires careful planning, with contributions from all involved stakeholders, a realistic but robust timeline, and placement strategies for introducing and disseminating the new technologies nationwide. With careful planning, reaching all PLHIV receiving ART (especially as ART delivery is decentralized to district health facilities) to have VL testing may take several years. Previously VL testing was reserved for only suspected cases of treatment failure, or about 8 percent of all ART patients. Three laboratories provide VL support, and service and sample transportation across the country can be slow and expensive. PEPFAR Vietnam will focus on increasing clinical and lab capacity to scale-up VL.

Table 6.1.2 Key Programmatic Gap #2: Routine Viral Load Coverage						
Key Systems Barrier	**Milestones/Deliverables expected after 1 to 3 years of investment**	**Proposed COP/ROP16 Activities**	**Budget Code(s)**	**Activity Budget Amount ($)**	**Associated Implementing Mechanism ID**	**Indicator reporting frequency for POART (End Date)**
Limited clinical use of routine VL	• 90% of ART patients with routine VL at 12 months • VL testing incorporated as quality measure into HIVQUAL • Documentation in medical charts of VL testing used for clinical decision making, including service delivery interventions • Expanded communication between labs and clinicians through an increase of electronic data reporting, and a measured shorter time interval between testing and clinical intervention	• Support PAC and DOH to build capacity for OPC staff on ARV clinical management, treatment adherence and patient monitoring. • TA to Strengthen capacity of OPC staff and at the national level to provide quality services through system meeting, case discussion and developing training materials and guidelines. • Strengthen VL referral network and build capacity on VL implementation and testing result interpretation. • Provide training to clinicians and lab staff for routine VL testing for patients on ART in selected provinces, including support for sample referral system and transport.	HTXS PDTX & PDCS HTXS HTXS, HBHC, HVTB	$21,024 $18,000 $103,167 $40,313	9974 10000 9976 18172	Annual (after 2017) Annual (after 2017) Semi-Annual (after 2017) Semi-Annual (after 2017)
Limited VL lab capacity	• Expansion in number of labs providing programmatic VL testing from 3 to 9 • Increased number of labs participating in VL EQA to 9 • Development of SOPs and training plan to strengthen lab capacity	• MOH-VAAC to develop a national viral load plan including negotiated price reductions for a viral load (VL) test. • Technical assistance for In-service Laboratory Safety and quality assurance to support national HIV testing programs. • Support national viral load testing network with focus on Northern provinces to assure quality of VL test results (EQA, TA and DBS validation). • Technical assistance for In-service Laboratory quality assurance to support	HLAB HLAB HLAB HLAB	$30,950 $105,061 $57,726 $47,186	9976 9977 9998 9998	Semi-Annual (2017) Semi-Annual (2017) Semi-Annual (after 2017) Semi-Annual (2017)

		national HIV testing programs. • Support national viral load testing network with focus on Southern provinces to assure quality of VL test results (EQA, TA and DBS validation).	HLAB	$20,516	9998	Semi-Annual (after 2017)
TOTAL				$443,943		

Programmatic Gap: Social Health Insurance (SHI)

PEPFAR has entered the crucial stage of transitioning out of DSD for HIV/AIDS in Vietnam. With more than 90 percent of ARV drug costs and 77 percent of the entire HIV response funded by donors, SHI is the single most important financing mechanism for the long-term sustainability of the HIV response for Vietnam. PEPFAR partners, led by the Health Finance and Governance (HFG) project, will continue to support the GVN through assistance to MOH, VAAC, and VSS to enroll PLHIV in SHI to meet the GVN's goal of 40 percentage coverage by the end of this year; integrate OPCs for eligibility of reimbursement by the HI fund; finalize and roll-out the HI BHSP for HIV services in provinces and districts; and design and pilot a financial mechanism for ARV procurement and HI reimbursement. The PEPFAR Central Initiative Sustainable Financing Initiative (SFI) (with HFG as the implementing partner) will be seen as complementary and additive to COP16 investments. SFI's objective is to deliver an AIDS-free generation built on shared financial responsibility with host country governments. In Vietnam, SFI is funding work streams that include (1) advocacy – using evidence to generate and sustain political will (i.e. through National Health Accounts) so that Vietnam will allocate more resources to health and HIV; and (2) improving the technical efficiency through supporting HI reform and options for ARV procurement that could inform the PEPFAR exit strategy on ARV financing. SFI will provide the necessary tracking of HIV domestic financing, including usage of health insurance, private expenditures, national/provincial contributions, and donor funding to systematically monitor the progress of PEPFAR's transition to domestic resource mobilization.

Table 6.1.3 Key Programmatic Gap #3: Social Health Insurance (SHI)

Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16 Activities	Budget Code(s)	Activity Budget Amount ($)	Associated Implementing Mechanism ID	Indicator reporting frequency for POART (End Date)
50% of OPCs and health centers that provide HIV services do not meet the legal requirement for contracting with the VSS HI fund to receive reimbursements	• 80% HIV PMC-based services eligible for SHI contracting and reimbursement	• Implementation of Circular 15 for Social Health Insurance for HIV/AIDS program by expansion of SHI for both providers /OPCs and users/PLHIV in 4 CDC-supported provinces. • Support MOH/VAAC and VSS and provinces in the integration of OPCs for eligibility of reimbursement by the Health Insurance fund- national level and PEPFAR supported provinces.	OHSS OHSS	$72,217 $350,000	9976 17371	Semi-Annual (after 2017) Annual (after 2017)
Current basic health services package (BHSP) does not include HTC, methadone, VL services and commodities	• New HI BHSP includes essential HIV services (VL) and draft HI preventive services includes HTC • MMT and drug addiction treatment recommended for HI revision in 2018	• SFI: Economic implication of the provision of HIV services to inform Advocacy/Policy forum for the increased of domestic financing • SFI: Strengthen VSS capacity to forecast SHI expenditures and needed revenue. • TA provided to MOH (DPF+ VAAC) for the inclusion of appropriate preventive HIV services in the BHSP paid by Health Insurance. Implementation of a pricing and payment model in place for reimbursing HIV services. • Expenditure analyses for HTC, Outreach, MMT service by site, including unit cost for single cases tested and/or referred at SMART TA-supported sites to improve efficiency.	OHSS OHSS OHSS HVCT, IDPU, HVOP, OHSS	$200,000 $500,000 $250,000 $60,604	17371 17371 17371 18172	Annual (2017) Annual (after 2017) Annual (after 2017) Semi-Annual (after 2017) Annual (after 2017)
Lack of domestic funding mechanism for pooled ARV and other HIV commodity procurement	• Increase in domestic HI funding for ART by 2018 – 33% of estimated resource for ARV covered by SHI • HI reimbursement for HIV	• Review national sustainable financing plan for HIV, and support central oversight of implementation of provincial sustainability plans, including mobilizing SHI resources. • SFI: evidence based data and strategic	OHSS OHSS	$25,792 $500,000	9976 17371	Semi-Annual (2017) Annual (After

	services functional – 55% PLHIV with SHI are reimbursed for HIV services	information (NHA HIV subaccount, resource tracking) are produced to support key advocacy objectives towards increased domestic resource mobilization for HIV in Vietnam. • SFI: Provide technical assistance for development of a financing mechanism for Social Health Insurance Reimbursement.	OHSS	$300,000	17371	2017) Annual (after 2017)
Low PLHIV enrollment in SHI (~30%)	• Monitoring mechanism in place for PLHIV HI enrolment • 60% PLHIV with HI coverage • GVN mechanism for subsidy for co-payment in place	• Domestic resource mobilization through health sector targeted program policy review and advocacy workshop for new phase of national HIV program and linking PLHIVV to SHI. • Expansion of Social Health Insurance for both providers /OPCs and users/PLHIV at the provincial level in 4 CDC-supported provinces- Hoa Binh, Thai Binh, Son La and Thanh Hoa. • Media/Advocacy campaign and promotion of achievements and review of national HIV program for increased domestic investment.	OHSS OHSS OHSS, HTXS	$36,109 $41,267 $213,683	9976 9976 18172	Semi-Annually (2017) Semi-Annually (after 2017) Semi-Annual (aft6er 2017)
TOTAL (COP16)				$1,049,672		
TOTAL (SFI)				$1,500,000		

6.2 Critical Systems Investments for Achieving Priority Policies

Priority Policy Area: Test and Start

A priority for Vietnam is to rapidly adopt the new WHO guidelines that recommend ART for all PLHIV irrespective of CD4 cell count. With its debut in 2015 in remote and mountainous provinces, Test and Start's expansion in Vietnam requires a revision of the national guidelines and the circular for multi-month ARV dispensing. The current guidelines allow for Test and Start in seven provinces and for all KP – this would need to be expanded to include all PLHIV. VAAC's primary concern is an ARV shortage,

particularly since the GVN budget in 2016 for ARVs is estimated to cover only 27,000 patients, and SHI is not anticipated to cover ARVs until 2018. While Circular 32 allows for 6-month scripting, the multi-month scripting is implemented in conjunction with monthly ARV pickup, which increases staff costs along with costs incurred by the patient for the monthly visit.

COP16 systems activities required to support Test and Start include supporting policies and guidelines to improve linkages between HTC and OPCs; strengthening systems to track and re-engage previously identified cases to HIV care and treatment services; and introducing ARV dispensing at commune health stations in mountainous districts. SHI systems activities will also support Test and Start by operationalizing the financing mechanism for ARV procurement with SHI funds.

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Milestones and custom indicators
Expand national test and start guidelines from mountainous/KP to all PLHIV	• Revised national C&T guidelines to be released by end of 2016 • Test and Start applied; all Pre-ART patients and those newly registered commence ART • Same day ART initiation policy • Increased early ART and TB treatment to HIV/TB co-infected persons (per national guidelines, based on the proportion of clients diagnosed as Stage 2 or lower) and increased update of PLHIV	• Strengthen HTC-OPC linkage across the treatment cascade and support national test and start. • Strengthen TB/HIV coordinating bodies at provincial and district levels and improve linkages and referrals between HIV and TB facilities as TB is KP for immediate test and start. • Support VAAC and NTP to scale up implementation of TB/HIV integration at district and commune levels as TB is KP for immediate test and start.	HVCT HVTB HVTB	$66,388 $72,217 $25,015	9976 9976 13234	Semi-annual (after 2017) Semi-annual (2017) Annual (2017)

Insufficient coverage and quality of HIV testing services	• Core-organizations and implementation bodies are regularly trained to use the laboratory checklist resulting in incremental and measurable quality improvements • National checklist implemented nationwide • Monitoring and evaluating of laboratory performance is strengthened at the national level resulting in an increase of labs in Vietnam achieving national/international certification and accreditation • IQC and EQA samples provided for 80 and 700 HIV labs respectively in the North • IQC and EQA samples provided for 60 and 600 HIV labs in the South	• National Laboratories Standard and Checklist for Quality management system. • Support National EQA and IQC programs for HIV serology at NIHE. • Support National EQA and IQC programs for CD4. • Support National EQA and IQC programs for HIV serology at PI HCMC.	HLAB HLAB HLAB HLAB	$15,475 $103,906 $50,264 $61,548	9976 9976 9998 9998	Annual (2017) Semi-Annually (after 2017) Semi-Annually (2017) Semi-Annually (after 2017)
TOTAL				$394,813		

Priority Policy Area: New Service Delivery Models

There are a number of barriers that must be addressed to ensure Vietnam's implementation of high-quality, cost-efficient, patient-centered HIV service delivery that optimizes the care continuum. Current approaches to care and treatment are not fully utilizing commune-level health facilities and staff, particularly in remote areas, to improve clinical management by bringing services closer to ART patients. As discussed earlier, there is a critical need to harmonize the preventative and curative branches of the Vietnamese health system, to enable HI reimbursement as well as HIV treatment reporting in the curative system. Related to domestic ARV financing, there is no central procurement unit (CPU) to manage forecasting, importation and logistics, or the procurement mechanism to apply SHI funds for pooled procurement of ARV and other HIV commodities. With the GVN's increased domestic budget for ARVs to four times that of previous years in 2015, and similar projections in 2016 and 2017, technical support for procurement and supply chain management (PSM) remains a high priority for the uninterrupted supply of HIV/AIDS commodities.

PEPFAR partners will support policy advocacy, capacity building, and TA for the GVN to undertake the centralized procurement of ARVs. The gains from improved efficiencies discussed above such as VL and multi-month ARV dispensation can be further complemented by an expanded role of commune health stations and task shifting by staff to provide routine clinical exams in the remote and mountainous priority provinces. The Global Health Supply Chain Program – Procurement and Supply Management (GHSC-PSM) will continue the work from SCMS to transition the supply chain system for PEPFAR-supported HIV commodities, with particular emphasis on working closely with the GVN to build sufficient capacity within the ARV Procurement, Supply and Coordination Taskforce (PSCT) at VAAC and CPU at MOH to manage all processes related to the procurement and management of the national PSM.

Table 6.2.2 New and efficient service delivery models

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Milestones and custom indicators
Limited patient-centered approaches to care and treatment	• National policy for ARV dispensing and patient-centered approaches adopted and implemented at commune health stations in mountainous districts in Priority Provinces • Nurses complete routine clinical exams for stable patients per national guidelines at commune health stations in mountainous districts	• Support PAC Nghe An and Dien Bien to endorse and implement ARV dispensing housed at commune health stations in mountainous districts	HTXS, HBHC, HVTB	$92,143	18172	Semi-Annual (after 2017)

No Central Procurement Unit, mechanism for HIV commodities	• Plan implemented for increased private sector role for prevention commodities • Five year, annual national PSM plans in place • CPU in MOH, with clear functions, SOPs • 100% of PEPFAR-supported ARVs transferred to GVN centralized procurement	• Monitoring and oversight of provincial sustainable financing plan and MMT user fees frameworks for CDC provinces. • Develop and implement a model for increased private sector role for prevention commodities coverage to replace free and subsidized public/donor support programs. • SFI: TA support to ensure effective and efficient domestic procurement and financing of ARV drugs and other commodities. • Advocacy for sustainable financing for MMT program. • Strengthening national capacity in HIV commodities Procurement and Supply Management (PSM).	OHSS OHSS OHSS IDUP, OHSS HTXD	$20,633 $354,984 $500,000 $22,759 $550,000	9976 16803 17371 18172 New	Semi-Annually (2017) Annual (after 2017) Annual (2017) Semi-Annual (after 2017) Semi-annual (after 2017)
Integration of Services into Hospital System	• VAAC Decision No.1240 on HIV treatment integration issued 2015; implementation ensured • 100% PEPFAR-supported HIV treatment facilities linked to HI system • OPC, PMTCT, VCT, MMT services integrated into the general health system • QI practices institutionalized - 50% of OPCs participating in HIVQUAL rounds • 80% of PEPFAR-supported OPCs have functional electronic medical record system	• Build capacity of OPC at district hospitals staff to improve quality services to HIV patients. • Deployment of HIV Care and Treatment electronic medical record software (eClinica) in 24 district OPCs in HCMC for real-time management of high quality care and treatment services provided to HIV patients and linkage to hospital eHMRs. • Increase use of monitoring data to assess the quality of MMT services and outcomes of the program at CDC-VAAC supported MMT clinics and link to preventive sector system.	HTXS HVSI IDUP	$21,024 $84,094 $51,584	9974 9974 9976	Semi-Annual (after 2017) Semi-annual (2017) Quarterly (2017)

Integration of Services into Hospital System (continued)		• Promoting effective HRH transition by policy assessment- including Decree 56 and Decree 41, and implementation in transitioning provinces and HRH assessment.	OHSS	$15,475	9976	Semi-Annual (2017)
		• TA support to scale up national HIV Care and Treatment electronic medical record software (ePMS).	HVSI	$61,900	9976	Semi-annual (2017)
		• Provide support to the MOH, DOH, and hospitals to launch legal documents, implement revised national guidelines, and integrate ANC HIV indicators within new MCH system.	MTCT	$68,090	9976	Annual (2017)
		• Support the transition of Pediatrics OPC into the curative system and strengthen linkage and tracking system for HIV-infected mothers and HIV-exposed infants.	PDTX	$61,901	9976	Semi-Annually (post 2017)
		• Post transition program monitoring in CDC transitioned provinces.	HVSI	$72,217	9976	Quarterly (after 2017)
		• Support VAAC and PACs to increase HIVQUAL coverage and build capacity for provinces to implement quality improvement.	OHSS HTXS	$123,801	9976	Semi-Annual (after 2017)
		• Support VAAC to develop national quality improvement (QI) indicators and performance assessment tools as well as standardize training curricula in quality improvement for HIV care and treatment (HIVQUAL).	OHSS HTXS	$82,534	9976	Semi-Annual (after 2017)
		• Strengthen technical capacity to establish and implement an electronic training and mentoring system within regional tertiary hospitals.	HTXS	$90,000	10000	Semi-Annually (after 2017)
		• Develop HIV quality standards and indicators which will be integrated into quality improvement programs of hospital system.	HTXS	$30,000	10118	Annually (2017)
		• Support VAMS to build capacity for provincial hospitals to implement integrated QI activities and use quality standards to evaluate their performance.	OHSS HTXS	$40,000	10118	Semi-Annual (after 2017)
		• Support VAMS to strengthen health quality system by integrating HIVQUAL in	HTXS	$40,000	10118	Semi-annual (after 2017)

Integration of Services into Hospital System (continued)		• TA support to NTP and VAAC to manage HIV rapid test kits and Xpert MTB/RIF cartridges to improve the diagnosis of TB/HIV co-infection among TB patients.	HVTB	$30,788	13234	Semi-Annual (2017)
		• TA support NTP and VAAC to increase ART and TB treatment among TB/HIV co-infection patients	HVTB	$38,484	13234	Semi-Annual (after 2017)
		• TA to improve TB intensified case finding for HIV/AIDS patients	HVTB	$29,505	13234	Semi-Annual (after 2017)
		• Capacity building for DOHs/PACs in leadership, management and supervision of provincial HIV cascade with HTC as center for case finding to meet technical program performance indicators and standard during the transition and post-transition phases.	C&T C&T	$98,635	18172	Semi-Annual (2017)
		• Prepare recommendation on planning for transition of SMART TA supported sites to GVN/PACs and to ensure the continuation and quality of critical services.	C&T	$60,604	18172	Semi-Annual (after 2017)
		• Support VAAC to build capacity of provincial levels in linking the hospital system to community-based care in high burden areas through development of SOP and TOT training, for improved retention in care.	C&T C&T	$129,401	18172	Semi-Annual (after 2017)
		• Technical monitoring training and tools (C&T, MMT, HTC, EOA) are diffused to PACs in 8 maintenance provinces and 3 priorities provinces to use and classify sites technical efficiency for transition and technical improvement plan.	C&T	$153,869	18172	Semi-Annual (after 2017)
		• TA network to support quality of case finding and care and treatment at facilities linked to HI system.	C&T	$143,974	18172	Semi-Annual (after 2017)
		• Support national HMIS program for HIV/AIDS intervention - Integrating ARV patient management and reporting into the District Hospital/Health Center Information System to enable health insurance payment as well as HIV treatment programmatic reporting in the curative system in future	C&T	$135,335	18172	Semi-Annual (after 2017)

TOTAL (COP16)		**$2,871,067**	
TOTAL (SFI)		**$500,000**	

6.3 Proposed System Investments Outside of Programmatic Gaps and Priority Policies

Table 6.3 Other Proposed Systems Investments

Activity	Results expected after 1 to 3 years of investment	Associated Implementing Mechanism ID	System Support "90"	Budget Amount	Milestones and custom indicators	Activity End Time Frame
HRH						
National capacity building for regional institutions and DOH/PACs in HTC TOT training and Revision/updating of training manuals and supervision & monitoring tools.	National capacity building for regional institutions and DOH/PACs in HTC TOT training and Revision/updating of training manuals and supervision & monitoring tools	9976	First 90	41,267	Semi-Annual	2017
Promote sustainable financing for HCWs for HIV program by tools development, implementation, and assessment at site and provincial level.	Expansion and implementation of WISN tool to estimate staffing needs and investment in Thanh Hoa, Quang Ninh and Hai Phong provinces	9976	Second 90	20,633	Semi-Annual	2017
Build capacity on program management and implementation for VNA and MMD/MOD.	Support VNA and MMD staff to attend needed training/workshops, establish and maintain the national and mil TWGs on nursing and Infection Control	12341	Second 90	32,170	Quarterly	After 2017
In-service training and CME curriculum development on HIV nursing care, HIV/TB infection control, patient safety toward task shifting for military and civilian nurses and doctors. In COP 16, the focused population for training will be the border guard medical force, in particular for 4 aggressive scale-up mountainous provinces to support 90-90-90 goal.	CME curriculum are approved to use nationwide by MOH and MOD and more than 400 health care staff were trained. In COP 16, around 60 medical staff from the border guard force at 4 aggressive scales up mountainous provinces will be trained to support 90-90-90 goal.	12341	Second 90	134,195	Quarterly	After 2017
Development of cascade information to inform programmatic gaps:- Training and technical support for CSO M&E staff on the CSO indicators and integration mechanism	Training curriculum, manual and technical coaching tools for data analysis, development of the Cascade model - M&E staff from the HIV/AIDS system and CSOs in three provinces are able to prepare and update the Cascade model,	14156	First 90	8,578	Semi-Annual	After 2017
Enhance data use at different levels, support intervention program on performance data collection and analysis to improve service quality and conduct	Training curriculum, manual and technical coaching tools for data analysis, development & maintenance of Provincial DDM master files.	14156	First 90	17,151	Semi-Annual	After 2017

trainings for district and provincial staff in selected provinces on skills and processes of data analysis and synthesis	Timely management & provision of data at provincial level to monitor and plan HIV priorities/activities in priority provinces to achieve 90 90 90 targets.					
HIV/AIDS In-service Training for Military Medical staff working at DOD Supported sites. This activity was originally approved for COP14. Given delayed grant approval from the Government, this activity has not been carried out yet. This activity will be conducted in COP16.	Ensuring optimum use and practice the best/updated international guidance in military health personnel	18149	First 90	9,450	Quarterly	2017
Support for MoD senior officers and military medical staff to participate in trainings and National workshops. This activity was originally approved for COP14. Given delayed grant approval from the Government, this activity has not been carried out yet. This activity will be conducted in COP16	Better collaboration and harmonization with national HIV program, fostering professional development of key military staff.	18149	First 90	7,965	Quarterly	2017
In-service training of trainers for the HIV/AIDS peer education program for new military recruits; trainers for the HTC program (focus to the border guard medical force)	92 trainees to become trainers on peer education of HIV/AIDS prevention for new military recruits. HTC trainers were delayed till period of EA15 so this EA14 expenditure does not capture this cost. In COP 16, the focused population for HTC training will be the border guard medical force, especially at 4 aggressive scales up mountainous provinces to support 90-90-90 goal	18149	First 90	97,200	Quarterly	After 2017
Revision and Update of peer education material	One set of main training curricula revised and approved to use at all participating military units.	18149	First 90	27,000	Quarterly	After 2017
Support hosting of peer education review exercise for MoD leadership and participating regiments.	One review workshop for commanding staff	18149	First 90	43,875	Quarterly	After 2017
Online e-learning and technical updates housed at VAAC Portal.	VAAC portal operational, with sustainability plan in place, use and uptake. All technical trainings and resources will be stored and shared online for program use. News and updates on service mapping to enable access to reliable information for KP and PLHIV will become routine practice of the VAAC website	18172	Second 90	92,143	Semi-Annual	After 2017
			HRH Subtotal	$531,627		
Activity	**Results expected after 1 to 3 years of investment**	**Associated Implementing Mechanism**	**System Support "90"**	**Budget Amount**	**Milestones and custom indicators**	**Activity End Time**

		ID				Frame
Laboratory						
Implement and support laboratory information systems (LIS) to improve HIV lab quality and surveillance data.	1. LIS introduced to 5 additional sites (primarily using local funding and resources), with a focus on priority provinces 2. LIS software updated to the latest version at all existing sites nationwide. 3. Intensive training course + mentorship provided for MOH Administration for Health IT so that they can replace 3rd party contractor for routine LIS deployment, support and maintenance 4. Software code developed and updated to make it more easily maintained and deployed by MOH IT administration	9972	Second and Third 90	55,000	Semi-Annual	2017
Implement QMS program for provincial and district level laboratories.	1.40 labs in district and provincial levels implemented and improved in QMS 2. Provincial Health Departments in 10 above provinces will be trained to monitor and support for QMS implementation in high HIV burden provinces.	9976	Second 90	103,167	Semi-Annual	After 2017
Support NIHE to validate and implement HIV drug resistance testing.	receipt of WHO accreditation for HIV-DR testing	9977	Second and Third 90	34,635	Annual	2017
Implementation of QMS training program.	1. 12 labs in HIV/AIDS and clinical system will implement QMS program and be improved based on international standards. 2. 10 in-country trainers/mentors/assessors are certified and implement QMS program. 3. 12 labs at district level in one province will implement QMS program and improved based on national standards	9998	Second 90	76,934	Semi-Annual	2017
National Laboratories Standard and Checklist for Quality management system.	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	10118	Second 90	30,000	Annual	2017
Implementation of national SLMTA program.	1. 12 labs in HIV/AIDS, 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. 15 in-country trainers/mentors/assessors are	10118	Second and Third 90	110,000	Quarterly	2017

	certified and implement SLMTA program.					
Providing Technical and Administration support for laboratories to achieve 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	10118	Third 90	105,000	Annual	2017
Support Quality Management System (QMS) Laboratory Leadership Certificate program to improve knowledge and skill for QMS implementation in HIV lab system.	1. Transition of QMS_LL packages to UMP 2. Develop in country team for lab accreditation, ISO 15189	10831	Second 90	132,415	Semi-Annual	2017
Above-site Program Management	Operational Costs	10832	Third 90	168,013	Annual	After 2017
Implementation of TB-SLMTA program for National TB Program.	1. 6 labs in TB system will implement TB SLMTA program and be improved based on international standards. 2. 5 in-country trainers/mentors/assessors are certified and implement SLMTA program.	12736	First 90	89,646	Semi-Annual	2017
TB EQA for smear microscopy, and Xpert to improve TB laboratory quality.	1. Deployment of Slide two Check software to gain efficiency of test turnaround time 2. EQA panels provided for sites using Xpert MTB/RIF for currently 39 sites, and expand to max 63 provinces) 3. EQA for fluorescent microscopy currently for 11 sites nationwide 1. Electronic TB smear microscopy EQA management system (S2C) implemented for 3 regional sites in HCMC, Da Nang and Can Tho (will expand to 49 sites nationwide in 2016) 2. EQA panels provided for sites using Xpert MTB/RIF for currently 34 sites, and expand to 38 in 2016) 3. EQA for fluorescent microscopy currently for 11 sites nationwide (expand to 16 nationwide in 2016)	10831	Second 90	166,486	Quarterly	After 2017
Support NRL for ISO 17043 accreditation and producing GeneXpert EQA panels. Support NTP to conduct LQAS for microscopic TB Labs.	1. NRL achieves ISO 17043 accreditation (requirement for an EQA provider) 2. NRL provides training on performance and safe working environment to TB lab staff 3. Domestic EQA panels for GeneXpert are produced and distributed to Xpert labs in the country	13007	Second 90	121,772	Annual	After 2017
Implement QMS program for provincial and district level laboratories.	1.10 labs in provincial level implemented and improved in QMS in Bac Ninh, Hoa Binh, Dien Bien, Cao Bang, Son La, Nghe An, Binh Duong,	14336	Second 90	237,360	Semi-Annual	2017

	Vung Tau, Vinh Long, Soc Trang, Can Tho 2. Provincial Health Departments in 10 above provinces will be trained to monitor and support for QMS implementation in high HIV burden provinces.					
Support the military medical system to build capacity of Lab quality management and blood safety.	In-service training, TA, implement SLMTA at 10 mil labs, develop military action plan on blood safety and blood bank	17369	Second and Third 90	180,421	Semi-Annual	After 2017
			Lab Subtotal	$1,610,850		
Strategic Information						
Evaluation of TDF-based ART regimens among patients co-infected with hepatitis B and C and evaluation around TB co-infections.	Complete study and inform clinical management of co-infected patients, and Annual review meeting, training workshop, TA on documentation of ICF cascades and TB diagnostic evaluation cascade, including Xpert/MTB-RIF	9974	Second 90	34,689	Semi-Annual	2017
Site supervision support to CRICS (Vietnam Cryptococcal Retention in Care Study).	Data collection follows SOP to ensure the quality of data collected	9974	Second 90	6,307	Semi-Annual	2017
Increase the use of monitoring data from VCT database, MMT database, Master patient Index and E-clinica for program evaluation and quality improvement purposes.	Use existing electronic data to assess program performance and inform design of interventions to increase service delivery coverage and quality, pre and post transition	9974	First and Second 90	52,559	Quarterly	After 2017
Strengthen national reporting system and national DQA.	1.Continue to support for D28 revised data review at central and provincial levels 2. Standardize DQA protocol process that are able to apply in province/ district and site levels	9976	First, Second, and Third 90	61,900	Semi-Annual	After 2017
PMTCT Option B+ implementation review.	1. Supervision, monitoring to improve quality of HCRS in Southern provinces, 2. Data audit regional & provincial level conducted on regular basis. 3. Regional & provincial updates of case reports produced quarterly.	9976	Second 90	61,900	Semi-Annual	After 2017
Evaluation of community and private sector linkages for enhanced KP outreach, case finding, and HIV service delivery.	Report on community-based mountainous model to achieve the 90-90-90 target with focus on cost effectiveness. Directly supports the provincial cascade on 90 90 90 by providing in-depth analysis on programmatic gaps in implementation.	14156	First 90	36,686	Semi-Annual	2017
Direct support to PAC, HTC, OPC and CBOs on collecting, managing, & reporting routine data as well as carrying out the data quality control.	Direct support to PAC, HTC, OPC and CBOs on collecting, managing, & reporting routine data as well as carrying out the data quality control	14156	First and Second 90	172,326	Semi-Annual	After 2017

Integration of Local Civil Society Organizations (CSOs) into the national HIV/AIDS M&E system - at two focus PEPFAR 90 90 90 provinces (Dien Bien & Nghe An):- Development of standard indicators, forms and mechanisms for integrating CSO data into the national information system- Training and technical support for CSO M&E staff on the CSO indicators and integration mechanism	- Filling the programmatic gaps data at provincial level – for scaling up in 90 90 90 targeted provinces as priority- Final indicators and mechanism for the integration of CSO data, including the application of UIC, Guidelines and SOP manuals- M&E staff from CSOs in two provinces are able to prepare and update the routine cascade monitoring for CSOs, and to contribute to maintaining provincial DDM master files.- Routine TA support to sites	14156	First and Second 90	31,488	Semi-Annual	After 2017
Strengthen reporting system and program review for better HIV/AIDS services at Military PEPFAR supported sites and mulitary medical system. This activity was originally approved for COP14. Given delayed grant approval from the Government, this activity has not been carried out yet. This activity will be conducted in COP16.	1. Strengthen implementation of all key program areas of the HIV/AIDS programs between MMD-DOD PEPFAR, provision of high quality services for HIV clients. 2. Essential stationaries for data management and reporting provided to DOD supported sites	18149	First and Second 90	32,400	Quarterly	2017
Conduct post transition evaluation in selected transitioned provinces.	Two years activity - to assess outcome of program performance 12 months and 24 months after transition	New	Sustained Epidemic Control	150,000	Semi-Annual	After 2017
Strengthening National HIV case reporting (HCRS) with emphasis on data quality improvement at site level.	Continue to support the vital status and ID verification after confirm positive at HTC sites where SMART TA support HTC testing services to ensure the quality data added to the HCRS database	18172	First 90	36,362	Semi-Annual	After 2017
Strengthen national capacity to deliver high quality program monitoring data and to ensure accountability of PEPFAR program.	Strengthen utilization of the national HIV database (e.g. HIV Info, Circular 03 M&E reported results at the central and provincial databases) and support the development of the provincial treatment database and monitoring.	18172	First and Second 90	106,078	Semi-Annual	After 2017
Strengthen the national capacity to deliver high quality program monitoring data and to ensure accountability of PEPFAR program.	Continue and expand the quality improvement in 3 priority 909090 provinces and other 8 maintenance provinces by supporting the robust HIV M&E system. Emphasis will be on the systematic implementation of circulars 03 and 09 and quarterly data analysis, feedback and use. This activity will ensure that instead of service delivery points report directly to PAC, the district data manager must comply with C03 requirements to collect and verify data of their own district to report to PAC. In the 909090 implementation context, this will strengthen the ownership of HIV district manager by knowing their epidemic,	18172	First and Second 90	192,449	Semi-Annual	After 2017

	knowing their response and monitoring their district program performance.					
			SI Subtotal	975,144		
Governance						
Revision and update HCMC training manuals and supervision & monitoring tools based on WHO d.	Improved quality of HIV care and treatment services in HCMC	9974	First and Second 90	10,512	Annual	2017
Support the National and military nursing and IC program to develop, finalize, submit and implement policies on nursing task shifting, military action plan on nursing development	Policies have been developed and reviewed by MoH and MoD. National implementation expected after official approval.	12341	First 90	24,817	Quarterly	After 2017
Support the National and military nursing and IC program to develop, finalize, submit and implement policies that focus on technical issues of patient safety, HIV nursing care, TB and HIV infection control.	Policies were approved by MOH and MoD to use for in-service/CME training nationwide: HIV nursing care, universal precaution. National implementation expected.	12341	First 90	83,642	Quarterly	After 2017
Revision of TB reporting indicators following WHO recommendations.	Revised TB Indicators and supports for implementation so we can measure the number of co-infected pt on ART and (work with MOH to integrate TB infection control into current infection control requirements at non-TB facilities) and SOP development or revision -- this activity helps improve the uptake of Xpert in TB diagnosis for PLHIV and tracking data to report to MER 2.0	13007	Second 90	69,004	Annual	After 2017
Above-site Program Management	Operational Costs	17375	First 90	158,678	Annual	After 2017
Enabling HIV Law to support the implementation of best international KP-focus practices and services	TA provided for review and revise the 10-year old HIV law to address new 90-90-90 targets and the necessary human and domestic financial resources to implement the new HIV/AIDS program that allow new KP-focus interventions in reach, test, treat and retain KPs for the 909090 goals	18172	First 90	287,947	Semi-Annual	2017
			Governance Subtotal	$634,600		
Service Delivery and System Support						
TA support NTP and VAAC to increase ART and TB treatment among TB/HIV co-infection patients.	Qualified supportive supervisory networks within VAAC and NTP provided technical assistance to	13234	Second 90	43,616	Annual	2017

	improve TB/HIV and MDR-TB management					
Improve linkages between HIV and TB facilities	Support Provincial TB programs to improved TB detection and treatment for HIV patients receiving HIV services in 38 SMART TA supported OPCs and GF supported TB/HIV integration clinics	13234	Second 90	48,106	Quarterly	After 2017
Support implementation of new TB diagnostic technologies under development/evaluation.	TB network has capacity to effectively implement Xpert, SL Hain test, and other new TB diagnostic technologies to diagnose TB, and MDR-TB	13234	Second 90	58,532	Semi-Annual	After 2017
Above-site Program Management	Operational Costs	10000	Second 90	66,242	Annual	After 2017
Above-site Program Management	Operational Costs	14159	First and Second 90	600,000	Annual	2017
Above-site Program Management	Operational Costs	18194	Second 90	543,400	Annual	After 2017
Above-site Program Management	Operational Costs	7345	Second 90	150,000	Annual	2017
			SD Subtotal	1,509,896		
			System Support Total	$5,262,116		

7.0Staffing Plan

Given the declining budget, PEPFAR VN continues to reduce costs while maintaining a staffing profile to deliver high-quality TA. When positions become vacant, consideration is given to both the need for the position and the alignment of duties with core activities. PEPFAR VN has replaced many direct hire or contract positions with locally-employed staff (LES) when applicable, and monitors salary savings for these vacancies. The team has also increased LES leadership in interagency and government technical working groups and in key strategic planning discussions of program activities.

This year, PEPFAR VN has further reduced its staffing with appropriate attrition and shifted some positions to GHS. The PEPFAR footprint will be reduced by a total of 3 personal service and other contractors, and 6 LES positions. Approximately 20 positions (3 DHA, 17 LE staff) are now being shared with other programs (primarily GHS), reducing the overall costs to PEPFAR. Additionally, all cost of doing business (COBD) areas were re-examined and reduced when possible; for example, to minimize travel costs, SIMS visits have been prioritized and developed in consideration with TA or DQA visits. This comprehensive analysis resulted in a 12 percent M&O reduction.

The number of existing, unfilled positions has significantly decreased, and PEPFAR currently only has 4 vacancies that are being recruited. Rehiring is justified on the basis of current or expected program priorities. Positions are also considered if they are able to meet the staffing needs of more than one PEPFAR VN agency with one hire. This results in a smaller, better-aligned staffing pattern.

Several actions are being taken to address SAMHSA's dual regional and country staffing presence in Vietnam. A decision was made to relocate the SAMHSA Regional Office and assign staff to another country in Southeast Asia. Appropriate deliberations are underway on this matter.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	See Table A.2 below		
Sub-national level			
National level			

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

Key Population Prevention	**Core Activities** • Scale-up of enhanced case finding and linking KP+ to HTS/HIV care & treatment through innovative outreach approaches, incl. engagement of CSOs in service delivery, in priority provinces • Site-level TA to improve case finding and linking KP+ to HTS/HIV care & treatment in priority provinces • Strengthening program data management system and data use for monitoring prevention program impact	**Near-core Activities** • Capacity strengthening for CSOs to lead and sustain continuum of Prevention to Care (CoPC) in priority provinces • Site-level TA to GFATM-supported CBOs to enhance case finding and linking KP+ to HTC/HIV care and treatment • TA to CSOs to implement BCC and demand creation activities for KPs to boost demand and use of HIV related goods/services • Capacity strengthening of military blood safety program and military medical system on injection safety/infection control • TA to private sector and CBO clinics to provide other HIV-related services (e.g., PREP) in priority provinces • Capacity building/TA for military HIV/AIDS peer education program	**Non-core Activities** • Pilot the OSCAR Program that was developed by SMART TA in 3 clinics • Expand the OSCAR Program into 15 Clinics • SMART TA to support the development and dissemination of the EOA guide to promote enhanced case finding and linkages to HTC and HIV care and treatment services • TA to Ministry of Health to establish and pilot the Quality Seal Program for condoms and other HIV related goods • Use market data to support MOH/VAAC to develop and implement the Total Market Approach (TMA) Action Plan for HIV related goods and services • Evaluation of community and private sector linkages for enhanced KP outreach, case finding, and HIV service delivery • Measure increased private sector supply of condom, LDSS and other related HIV goods and services • Development and standardization of linkage/referral systems focus on HTC-OPC but broadly linking across treatment cascade
Adult Care and Treatment	**Core Activities** • Support VAAC to build capacity of provincial levels in community-based care in high burden areas through SOP development and TOT training, for improved retention in care • Provincial Department of Health to improve	**Near-core Activities** • 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	**Non-core Activities** • Revise national guidelines on early ANC HIV testing for pregnant women and care and treatment services for HIV+ pregnant women in MCH system • Develop policies and mechanism to

	facility based HTC-OPC linkage • VAAC to coordinate and implement the national HIVQUAL program • 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 103 OPCs • TA to GF OPCs in 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 • PITC for TB patient in mountainous priority provinces. Support the national TB program on HIV test kits and Xpert supply chain management • Improve TB screen, IPT, TB diagnosis and treatment for PLHIV • Improve coordination and linkage between TB and HIV programs. Support the implementation of TB/HIV integration model and HIV treatment at TB clinic.	leadership and management, patient safety that focus on HIV care and support and treatment • Operationalize the VAAC portal, with online e-learning and technical updates 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 103 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 via on-line training and e-mentoring • Support TBIC management in HIV care and treatment facilities • Improve the TB and HIV paper based and electronic reporting system to enable patient monitoring across programs with improved data quality and data use. to enable patient monitoring across programs •Support MOH to modify maternal and infant patient records template to include PMTCT componenets •Update national guidelines on community based care for PLHIV •Strengthen linkages between private and public ANCs for PMTCT monitoring across programs	transition pediatrics services and TA into curative systems • Support standardization of community-based care activities for PLHIV • Technical support to NTP to implement TB prevalence survey • TA for NTP on TB diagnosis testing on sputum smear and TB culture is reduced (shifted to Xpert MTB/RIF testing)
MMT	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• Provide HIV testing among MMT patients at	• Make QA/TA visits to sites that are	• TA to Ministry of Health to revise and

	intake and repeated HIV testing for those with negative results at intake • Start or referral for ART start among MMT patients living with HIV who are not yet on ART • Support MMT patients who are on ART to improve adherence to ART • 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	being transitioned in FY 2016 to neither category to ensure that they maintain a level of quality of care • Continue advocating for sustainable financing for MMT program • Increase the use of monitoring data for evaluation and quality improvement purposes	adapt technical guidelines for MAT implementation in Vietnam
HSS	**Core Activities** •Expansion of SHI for both OPCs and PLHIV •Expansion of SHI benefit package to include cost-effective HIV services •Conduct economic and efficiency analysis to provide evidence to promoting HIV financial sustainability through increased domestic financing •TA support to ensure effective and efficient domestic procurement and financing of ARV drugs and other commodities •Strengthening national capacity in HIV commodities PSM	**Near-core Activities** •Implementation of Circular 15 & reforms to SHI •HCW reforms including generating supply and skills of HCWs, improving HCW performance, and promoting sustainable financing •Support MoD in trainings and workshops •Conduct economic and efficiency analysis •Review of national sustainable financing plan for HIV, and monitoring & oversight at provincial level •Domestic resource mobilization and increasing the role of private sector in national HIV /AIDS response •Promote HRH transition by assessing policies & implementing the transition	**Non-core Activities** •Improve HCW performance for service quality by establishing regulatory framework and piloting of CPD/CME and accreditation systems •Create adequate supply and appropriate skills mix of HCWs for HIV service delivery through reform of medical education system •Reforms to SHI to expand benefit package to include TB services •Development of the SOPs and tools for ARV, Methadone and Lab CD4 management, focusing on the reporting and quantification for requisition at facility and provincial levels
Lab Strengthening	**Core Activities** • Support National EQA and IQC programs for HIV serology and CD4, and implement QMS program •Support national viral load testing network, TB EQA, and HIV drug resistance testing •Development of national TB lab capacity network, and provide support for lab LQAs •MOH-VAAC to develop a national viral load plan	**Near-core Activities** •Implementation of TB-SLMTA and QMS training programs •Capacity building of lab quality management & blood safety •Implement and support LIS for HIV lab quality & surveillance data by introducing LIS to 5 additional sites and updating software at all existing sites •Implementation of checklist for QMS	**Non-core Activities** •Provide TA for new TB diagnostic technologies under development/evaluation •Provide nationwide TA as needed for lab(s) that participated in in Xpert MTB/RIF •Implement and monitor a standardized TB sample referral system •Implement and support LIS for HIV lab quality & surveillance data in HCMC
Strategic Information	**Core Activities** •Strengthen reporting system and program review at Military PEPFAR supported sites and	**Near-core Activities** •Conduct post transition evaluation in selected transitioned provinces to	**Non-core Activities** • Health economic evaluations to inform program planning and policy

	military medical system •Identify, advocate and policy change for prioritization of risk groups and geographic location of the HIV sentinel surveillance •Strengthen HIV case reporting in high burden provinces with a goal to improve data quality •Development of forms, indicators, and mechanisms, and providing TA for the integration of local CSOs into the national HIV/AIDS M&E system •TA to the national program for e-PMS and support scale-up, & deployment of HIV Care and Treatment electronic medical record software (eClinica) •QA of HSS implementation and QI of HSS survey •Refinement and use of HIV surveillance methodology, and enhance linkages between surveillance and HIV services •Strengthen national reporting system and DQA •Development of cascade information to inform programmatic gaps •Post transition program monitoring in CDC transitioned provinces •Geospatial data and tool to measure KP reach and access	assess outcome performance 12 and 24 months after transition •KP size estimation– identify method for national MSM estimation •KP size estimation– develop district level estimation for PWID, FSWs in HCMC •Improving functionality of HCMC eClinica patient electronic database in HCMC •Development of national Master HIV/AIDS Patient Index (MPI) system using HCMC model •Maintain and strengthen monitoring program during and after transition	development • Support performance measurement for HIVQUAL implementation in all programs accordingly to national plan • Support provincial MMT staff in data analysis and use • Evaluation of community and private sector linkages for enhanced KP outreach, case finding, and HIV service delivery
OVC	**Core Activities** **N/A**	**Near-core Activities** **N/A**	**Non-core Activities** **N/A**

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
Key Population Prevention						
• Pilot the OSCAR Program that was developed by SMART TA in 3 clinics	Transition to GVN	$US 0	$US 0		End of 2015	OSCAR Program pilot was dropped from COP 2016
• Expand the OSCAR Program into 15 Clinics	Transition to GVN	$US 0	$US 0		End of 2015	OSCAR Program expansion was dropped from COP 2016
• SMART TA to support the development and dissemination of the EOA guide to promote enhanced case finding and linkages to HTC and HIV care and		$US 0	$US 0		End of 2015	

treatment services						
• TA to Ministry of Health to establish and pilot the Quality Seal Program for condoms and other HIV related goods	Transition to GVN	$US 0	$US 0	1	End of 2015	
• Use market data to support MOH/VAAC to develop and implement the Total Market Approach (TMA) Action Plan for HIV related goods and services	Transition to GVN	$US 0	$US 0	1	End of 2015	
• Evaluation of community and private sector linkages for enhanced KP outreach, case finding, and HIV service delivery	Ending	$US 0	$US 0	1	End of 2015	
• Measure increased private sector supply of condom, LDSS and other related HIV goods and services	Ending	$US 0	$US 0	1	End of 2015	
Development and standardization of linkage/referral systems focus on HTC-OPC but broadly linking across treatment cascade	Transition to GVN	$US 0	$US 0	4	End of 2015	
Adult Care and Treatment						
• Revise national guidelines on early ANC HIV testing for pregnant women and care and treatment services for HIV+ pregnant women in MCH system	Ending	$US 0	$US 0	1	End of 2015	
• Develop policies and mechanism to transition pediatrics services and TA into curative systems		$US 0	$US 0		End of 2015	
• Support standardization of community-based care activities for PLHIV		$US 0	$US 0		End of 2015	
• Technical support to NTP to implement TB prevalence survey	Transition to other partners	$US 0	$US 0	1	End of 2015	
• TA for NTP on TB diagnosis testing on sputum smear and TB culture is reduced (shifted to Xpert MTB/RIF testing)		$US 0	$US 0		End of 2015	
MMT						

• TA to Ministry of Health to revise and adapt technical guidelines for MAT implementation in Vietnam	Transition to GVN	$US 0	$US 0	1	End of 2015	
HSS						
•Improve HCW performance for service quality by establishing regulatory framework and piloting of CPD/CME and accreditation systems	Transition to GVN	$US 0	$US 0	1	End of 2015	
•Create adequate supply and appropriate skills mix of HCWs for HIV service delivery through reform of medical education system	Transition to other partner and to GVN	$US 0	$US 0	1	End of 2015	
•Reforms to SHI to expand benefit package to include TB services	Transition to GVN or other partner	$US 0	$US 0	1	End of 2015	
•Development of the SOPs and tools for ARV, Methadone and Lab CD4 management, focusing on the reporting and quantification for requisition at facility and provincial levels	Activities ended/completed	$US 0	$US 0	1	End of 2015	
Lab Strengthening						
•Provide TA for new TB diagnostic technologies underdevelopment/evaluation	Transition to GVN	$US 0	$US 0	1	End of 2015	
Provide nationwide TA as needed for lab(s) that participated in in Xpert MTB/RIF		$US 0	$US 0		End of 2015	
•Implement and monitor a standardized TB sample referral system	Transition to GVN	$US 0	$US 0	1	End of 2015	
•Implement and support LIS for HIV lab quality & surveillance data in HCMC	Transition of routine maintenance to local level, and transition of advanced technical support and management to national level	$US 0	$US 0	1	End of 2016	
•Establish institutional home for LIS at national level	National Level	TBD	0	APHL, VAAC	Mid-year 2017	Through APHL and VAAC CoAg, the

						MOH IT Administration will be supported and mentored in order to provide ongoing technical support and program management for the National LIS Program
Strategic Information						
• Health economic evaluations to inform program planning and policy development	Ending	$US 0	$US 0		End of 2015	
• Support performance measurement for HIVQUAL implementation in all programs accordingly to national plan	Ending	$US 0	$US 0		End of 2015	
• Support provincial MMT staff in data analysis and use	Transition to GVN	$US 0	$US 0	1	End of 2015	
• Evaluation of community and private sector linkages for enhanced KP outreach, case finding, and HIV service delivery	Ending	$US 0	$US 0		End of 2015	

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$US21,316,289	**$US29,983,711**	**$US 51,300,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$231,034
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$3,528,178
IDUP	Injecting and Non-Injecting Drug Use	$4,214,863
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$2,953,830
HBHC	Adult Care and Support	$1,116,711
PDCS	Pediatric Care and Support	$59,907
HKID	Orphans and Vulnerable Children	$0
HTXS	Adult Treatment	$11,794,902
HTXD	ARV Drugs	$11,800,000
PDTX	Pediatric Treatment	$119,815
HVTB	TB/HIV Care	$666,511
HLAB	Lab	$2,674,518
HVSI	Strategic Information	$3,674,786
OHSS	Health Systems Strengthening	$3,052,093
HVMS	Management and Operations	$5,412,852
TOTAL		

B.2 Resource Projections

The PEPFAR VN team used the PEPFAR Budget Allocation Calculator (PBAC) tool to generate program area budget projections for target-based service delivery activities based on unit expenditures (UEs) developed with the PEPFAR HQ Finance and Economic Working Group (FEWG). Unit expenditures were applied at a site level to generate implementing mechanism and U.S. agency allocations for target-based budgets.

Technical assistance and systems ('above-site') investments were analyzed and rationalized through the PEPFAR Systems and Budget Optimization Review (SBOR) conducted with jointly with PEPFAR HQ in November-December, 2015. Individual activities were prioritized based on: (1) the SBOR decision algorithm; (2) ability to address needs identified in the PEPFAR Sustainability Index and Dashboard (SID); and (3) suitability within the program's budget trajectory. Further reductions to technical assistance and systems activities were made at the direction of HQ during the DC Management Meetings in early March, 2016. Decisions made in the SBOR process were used to update the core, near, non-core analysis.

Target-based and above-site allocations were merged into implementing mechanism budgets by budget code according to PBAC and SBOR allocations. In the COP 16 new funding request, U.S. agencies reduced budget code allocations for individual implementing mechanisms according to estimated applied pipeline amounts.

APPENDIX C

Systems Investments for Section 6.0

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A
Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents and supplies, travel and transport, building rental and utilities will not be included

PEPFAR VIETNAM TRANSITION STRATEGY: ADDENDUM NARRATIVE SECTION TO SDS

May 26, 2016

PEPFAR Vietnam's Transition Strategy and Vision

The PEPFAR VN strategy is to work with the Government of Vietnam (GVN), the Global Fund (GFATM), and implementing partners at the central and provincial levels to plan transition of direct service delivery costs, including health care worker (HCWs) salary support, commodities, facility, and patient-related costs, to local resources (Social Health Insurance, GVN, market forces), maintaining efficient, integrated, high quality service delivery models while providing technical expertise to government and other stakeholders in the national response.

The transition of HIV services entails collaboration with GVN, the private sector, GFATM, and civil society. Expanded application of Vietnam's Social Health Insurance (SHI) will allow successful transfer of HIV patient direct services, commodities procurement and logistics to GVN to achieve 90 90 90 goals. SHI alone will not cover all costs, especially HIV preventive services, and central and provincial governments must contribute financial support to maintain these services.

Transition out of direct service delivery support does not indicate that PEPFAR is leaving Vietnam. In fact, transition signals that the PEPFAR-GVN partnership has matured from the emergency scale-up phase to a partnership in which PEPFAR continues as a reliable technical assistance partner. PEPFAR will continue to collaborate with GVN to promote cutting-edge approaches and technology to support effective policies such as test and start to improve uptake of early ART initiation and more efficient services such as multi-month scripting to reduce costs and improve patient outcomes. PEPFAR will also build capacity for community and academic organizations and other institutions to improve the quality and coverage of HIV services.

Provincial Transition

The decision as to when to transition services, sites and provinces depends on technical, clinical, and financial readiness and political commitment to continue service delivery. The development of a provincial sustainability plan including a roadmap for supporting, recurring operating and human resource costs, commodities, quality assurance, and outlining future technical assistance needs.

The importance that PEPFAR places on responsible transition from PEPFAR support is not new. Throughout Vietnam, MMT (see SDS section 4.2b) and PITC for TB patients have transitioned. By the end of 2016 PMTCT services will transition. In January 2016 five provinces, Binh Thuan, Dak Lak, Hai Duong, Khanh Hoa, and Lang Son, with strong provincial finances and

relatively low HIV burden, completed successful transition enlisting provincial resources, GFATM, and patient co-pays. And by the end of 2016, seven additional provinces with relatively low HIV burden and high performing clinical sites, including 18 VCTs and 12 OPCs encompassing 6,096 patients, will transition. The transitioning of direct service delivery costs at these provinces and sites, excludes the cost of ARV commodities in some locations as PEPFAR ARV commodity support is transitioning separately.

For 2017 PEPFAR will seek to transition an additional eleven provinces, and in 2018, will complete the final transition of the remaining ten provinces which include the five priority provinces (HCMC, Dien Bien, Nghe An, Son La, and Thanh Hoa) and those that feature very high HIV burdens (Hanoi, Hai Phong, Quang Ninh, Lao Cai, Bac Giang). Service quality will continued to be monitored using tools developed for this purpose.

Commodities Transition

Commodities account for 26% of the COP 16 budget. PEPFAR VN believes that a responsible shift of commodity costs from donors to SHI, domestic resources, and the private sector will help achieve a more responsible partnership between PEPFAR and Vietnam. Accordingly, we collaborated with the GVN to establish a timeline for reducing and eliminating commodity support. Between COP 16 and 17 the PEPFAR commodity contribution will decrease by 40% from $12.5 million to $7.7 million. In COP 17, PEPFAR will support only ARV drug support and HIV test kits for the four northern priority provinces. By COP 18 PEPFAR will no longer invest in commodities for Vietnam.

Human Resources Transition

The PEPFAR VN strategy to transition human resources is to work with GVN and implementing partners to plan and transition HCWs costs that are currently supported by PEPFAR to GVN, while ensuring strong service delivery models remain. The team has worked with provinces and national government since 2014 to implement this transition by supporting the policy environment for improved HRH planning and increased GVN financing of HCWs (Decree 41, Decree 56). At the provincial level, PEPFAR support targets HIV outpatient clinics (OPC) and HTC staff, as well as Provincial Project Management Unit (PPMU) staff responsible for provincial coordination and administration of program services. As PEPFAR reduces service delivery support, PPMU staff in selected provinces may still receive support through COP 17 for PEPFAR-required and post-transition data collection and reporting. As program service financing is reduced, PEPFAR must monitor program performance with existing GVN routine program monitoring tools.

For seven low HIV burden provinces, all service delivery staff were transitioned to provincial funding at the end of 2015. This accounts for 320 HCWs, or 12% of PEPFAR-supported HCWs. For the remaining PEPFAR-supported HCWs, who work in provinces with extended transition timelines (2016-2018), a phased approached will be applied, with decreases in financial support

to HRH annually. However, all service delivery staff and related costs will be transitioned to the provinces in accordance with the provincial transition plan and timeline noted above. By the end of 2016, three provinces will have transitioned an additional 40% of their HR costs and six additional provinces will have transferred all HR support to GVN. By the end of 2017, eight additional provincial governments will absorb their HR costs; and finally, the remaining six provinces will be absorbed into GVNs plans by the end of 2018. In HCMC, this phased approach began with the elimination of HR costs at two large hospital- based OPC's in 2015 and will add an additional 2 hospitals (out of a total of 18 HCMC OPC's) by the end of 2016.

Social Health Insurance

In 2013 the Ministry of Health published Decision 1899, establishing a five-year strategy to ensure financing for the national HIV response. The current VAAC proposal to the Prime Minister establishes milestones for 2016-2018 including 60% of PLHIV will have health insurance and 50% of PLHIV will have their services reimbursed by SHI by 2018. Additional goals include the establishment of an SHI funding mechanism for ARV procurement in 2016. The first ARV procurement using SHI funds is anticipated to commence in 2017. Based on information from our Health Finance and Governance project, GVN and PEPFAR targets we have developed estimates of the numbers of ART patients expected to be covered by health insurance and the costs associated with the transition to SHI for each year. In 2019, when the PEPFAR direct service delivery transition is complete, we estimate that health insurance will pay $21.3 million or nearly 61% of the total USD $35 million necessary to support the expected 198,000 PLHIV on ART in Vietnam. PEPFAR VN will support this transition to SHI by continuing to provide technical assistance.

PEPFAR Site Definitions: Transitions from DSD to TA

Although, complete provincial transition will occur in accordance with the timeline above, transitioning of individual DSD clinical sites within those provinces (as demonstrated by program transitions of PITC, MMT, and PMTCT) may occur earlier. Although MER defines a DSD site and its targets as one with which PEPFAR supports quarterly technical assistance in addition to crucial commodities and services, the crucial commodities and services supported by PEPFAR-vary by site depending on the province and site. A full package of support at any DSD site can include: 1) facility costs such as staff support for contractors or overtime payments and routine operating costs (internet, electricity, water, security); 2) patient costs (examination fees, laboratory monitoring and diagnostic costs, consumables); and 3) commodities such as ARV or OI drugs. Other packages of DSD support may include only one or two of these categories if other category costs are covered by other donors or central/provincial funding sources. As sites transition some items will be eliminated or costs reduced as they are assumed by other funding sources. We anticipate as DSD MER targets decrease with site and provincial transition, TA targets will increase. Below is an illustration of what projected COP16-18 targets could be as transition continues.

Projected COP 16-18 Targets

	COP16		COP17		COP18	
	DSD	TA	DSD	TA	DSD	TA
Tx_Curr	56,614	13,721	46,657	27,810	0	50,000
KP & PP	140,989	65,000	117,230	14,000	0	124,669
VCT	148,742	38,842	127,722	47,860	0	166,803
PMTCT_STAT	0	48,929	0	0	0	
MMT	2,000	9,890	0	11,890	0	8,000

This table illustrates a projected shift in PEPFAR reported site-level targets from the Direct Service Delivery classification to the Technical Assistance classification under the PEPFAR Monitoring, Evaluation and Reporting (MER) guidance definitions. COP 2017 and COP 2018 targets are subject to annual review and approval by the U.S. Global AIDS Coordinator, as well as annual funding appropriation and approval by the U.S. Congress.

In addition, it is anticipated as transition continues PEPFAR VN's achievements will not be assessed solely by targets, and metrics and milestones will be developed to measure technical assistance performance. The table below establishes precisely how PEPFAR-VN defines DSD, regular TA, responsive TA and sustained sites through 2018. Following transition, the DSD and sustained site categories will end and only regular and responsive TA will remain.

PEPFAR Site Definitions

Program Area	DSD	Regular performance-based TA	Responsive TA	Sustained
HIV Care and Treatment	facility costs (HR + ROCs) + patient lab costs + quarterly TA*	At least quarterly regular TA*	Time-limited TA to achieve specific response/outcome*	PEPFAR procured ARV/VL only
Outreach	HR + travel costs + quarterly TA	At least quarterly regular TA	Time-limited TA to achieve specific response/outcome	
HTC	Facility costs (HR + ROCs) + HIV test kit costs + quarterly TA	At least quarterly regular TA	Time-limited TA to achieve specific response/outcome	PEPFAR procured test kits only
MAT	Quarterly TA + methadone	At least quarterly regular TA	Time-limited TA to achieve specific response/outcome	PEPFAR procured methadone only

*+/- PEPFAR-procured ARVs/VL; will end for all sites end of 2018

Global Fund Coordination

The PEPFAR VN team collaborates closely with GFATM to ensure harmonized practices and distribution of commodities. GVN manages the pooled distribution of methadone and ARV drugs procured by PEPFAR, the National Targeted Program and GFATM. Through GVN coordination, PEPFAR and GFATM are both contributing to the viral load expansion plan and pooling resources for the provision of viral load services in Vietnam. As GFATM deploys its electronic marketplace to allow countries to source health commodities at competitive prices, PEPFAR is examining opportunities to pool GVN, PEPFAR and GFATM resources through this mechanism. PEPFAR is also working to harmonize its HR support with that of GFATM which discontinued most HR support in 2015. In terms of provincial coordination, previously GFATM supported 53 provinces, but in 2014 they reduced their DSD support to only 30 "high burden" provinces and capped their ARV contributions in the non-DSD provinces. The thirty GFATM DSD provinces include the 5 PEPFAR priority provinces.

Post Transition Vision

As OPCs transition from direct service delivery, PEPFAR envisions a standard initial one-year period of quarterly technical assistance at sites to monitor performance. As sites "graduate" from routine quarterly technical assistance PEPFAR will then provide "responsive" technical

assistance to address needs at various levels that are identified by joint review with the GVN of various data sources. Following successful transition of direct service delivery support and commodities, PEPFAR envisions a relationship with Vietnam in which we continue to provide technical assistance to expand access to quality prevention and care and treatment services, promote cutting edge approaches and technology, enhance clinical care and the implementation of government guidelines across the public health sector, strengthen the capacity of CBOs, academic institutions, and institutes, address stigma and discrimination, policy advocacy, and emphasize improve data quality and use to help Vietnam achieve its 90-90-90 goals and sustained epidemic control.