VIETNAM

Country Operational Plan

(COP/ROP) 2017

Strategic Direction Summary

April 25, 2017

Table of Contents

1.0 Goal Statement

2.0 Epidemic, Response, and Program Context
- 2.1 Summary Statistics, Disease Burden and Epidemic Profile
- 2.2 Investment Profile
- 2.3 Sustainability Profile
- 2.4 Alignment of PEPFAR Investments Geographically to Burden Of Disease
- 2.5 Stakeholder Engagement

3.0 Geographic and Population Prioritization

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations
- 4.1 Targets for Scale-Up Locations and Populations
- 4.2 Priority Population Prevention
- 4.3 Preventing Mother-To-Child Transmission (PMTCT)
- 4.4 HIV Testing Services (HTS)
- 4.5 Facility and Community-Based Care and Support
- 4.6 TB/HIV
- 4.7 Adult Treatment
- 4.8 Pediatric Treatment
- 4.9 Addressing COP 17 Technical Considerations
- 4.10 Commodities
- 4.11 Collaboration, Integration And Monitoring

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations
- 5.1 Package of Services and Expected Volume in Sustained Support Locations and Populations
- 5.2 Transition Plans for Redirecting PEPFAR Support

6.0 Program Support Necessary to Achieve Sustained Epidemic Control
- 6.1 Critical Systems Investments for Achieving Key Programmatic Gaps
- 6.2 Critical Systems Investments for Achieving Priority Policies
- 6.3 Proposed System Investments Outside of Programmatic Gaps and Priority Policies

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

Appendix A- Prioritization

Appendix B- Budget Profile and Resource Projections

Appendix C- Tables and Systems Investments for Section 6.0

Appendix D – Methamphetamine Use Among Key Populations-Implications for 90-90-90

1.0 Goal Statement

Vietnam's emergence as a lower-middle income country has led to the evolution of PEPFAR's program in Vietnam. In 2011, PEPFAR began transitioning from primarily direct-service-delivery (DSD) support to a technical assistance (TA) program that targets geographic areas and populations with the greatest need and disease burden.

HIV in Vietnam is concentrated geographically and among three key populations (KP): people who inject drugs (PWID), men who have sex with men (MSM), and female sex workers (FSW), as well as among the sex partners of these KP groups. Recent Spectrum data suggest that there are 247,357 reported HIV cases across Vietnam. Modelled estimates indicate HIV incidence peaked in early 2000 but has since declined. Nonetheless, epidemic reductions remain unstable and insufficient as the number of newly diagnosed HIV cases continues to rise in some areas, notably mountainous and remote regions. Over half (53 percent) of people living with HIV (PLHIV) are still in need of ART and of those enrolled, almost a third initiated late and with high viral loads (GFATM Concept Note, 2017).

Working across U.S. Government agencies and collaboratively with host-country government counterparts, implementing partners, civil society organizations (CSOs), and multilateral organizations, PEPFAR Vietnam supports the national HIV/AIDS response at the provincial, national, and site-levels. In COP 17 PEPFAR will provide a targeted TA package for 16 provinces, DSD support for five sustained and five aggressive scale-up provinces, and central support for two provinces to interrupt ongoing transmission through early HIV diagnosis, treatment, and viral suppression complemented by systems strengthening and strategic information. In COP 2017 PEPFAR will prioritize:

(1) Transition of the remaining PEPFAR Vietnam-supported provinces from DSD to TA by the end of CY 2018 in parallel with uptake the national Social Health Insurance (SHI) scheme.
(2) National Advocacy for increased and sustainable domestic financing, especially SHI:
    a. TA to expand application of SHI for HIV patient direct services and commodities;
    b. Legal work for SHI coverage beyond curative services (i.e. primary prevention and harm reduction);
    c. Advocacy for enrollment of PLHIV into SHI.
(3) Adoption and diffusion of current WHO ARV guidelines:
    a. National adoption of Test and Start;
    b. Routine viral load testing;
    c. Multi-month scripting (MMS);
    d. Differentiated service delivery models;
    e. Availability of PrEP for populations at substantial risk of infection.
(4) Innovative, scalable, and more effective approaches to achieve enhanced case-finding, linkage to care, retention, and viral suppression for HIV epidemic control.

(5) Strategic Information for data-driven national programs to maximize impact and sustainability.

The aforementioned TA is a comprehensive approach to achieve sustainable epidemic control in provinces with the highest HIV prevalence and ART need. The two largest cities (Hanoi and Ho Chi Minh City (HCMC)) have the largest number of HIV cases, with a high concentration of prevalent infections in PEPFAR-supported four northern mountainous provinces, i.e. Dien Bien, Son La, Nghe An, and Thanh Hoa (EPP, 2017). PEPFAR Vietnam will continue in the five aggressive scale-up provinces (noted above) in addition to proposing an intensified TA strategy for Hanoi that will support case finding, rapid treatment initiation, and SHI registration for KPs, as well as strengthened KP size estimation and HIV surveillance.

Through on-going analysis of partner performance, program expenditures, and country financial and epidemiological data, the PEPFAR team has set targets and budgeted within the funding envelope to achieve:

1. KP_PREV – mobilize efforts on case finding among KP groups for 88,736
2. HTS_TST – using multiple modalities to support 246,362 tests for KPs and high-risk partners.
3. TX_NEW – support to the Government of Vietnam to enroll 8,127 (4,269 DSD and 3,858 TA); 5,122 in the five scale-up provinces.
4. TX_CURR – support to the Government of Vietnam to enroll 77,899 new ART patients.
5. TX_RET – retain 88 percent of new patients and 95 percent of those after twelve months of ART.
6. TX_PVLS – document as virally suppressed 60,126 patients, or 77 percent of current PEPFAR patients nationally. 85 percent of PEPFAR-supported patients will have access to viral load (VL), of whom 91 percent will achieve VL suppression.
7. KP_MAT – TA-only support will be provided to 60 sites with 10,870 patients in the four aggressive scale-up provinces of Nghe An, Dien Bien, Son La, and Thanh Hoa.

The major shifts to achieve these goals include intensified TA for case finding, rapid initiation, and SHI uptake in Hanoi; continued monitoring, evaluation, and risk mitigation for transitioned provinces; introduction of HIV recency testing to identify HIV incidence hot-spots and for enhanced partner services; stronger provincial relationship building in poorly performing provinces complemented by dynamic case finding in 'untapped communities,' and ongoing robust engagement with the Government of Vietnam, donors, civil society, PLHIV, and KPs to reach 90-90-90 by 2020.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

For COP 2016, PEPFAR Vietnam used HIV estimates that were developed in 2015. Provincial stakeholders expressed their concerns that the estimates of PLHIV were higher than the actual numbers. The Vietnam Administration of AIDS Control (VAAC), in collaboration with PEPFAR Vietnam, requested UNAIDS technical support to review the existing estimates as well as to develop revised estimates at the national and provincial levels. This review and revision of the estimates involved working with various stakeholders including PEPFAR and UNAIDS. A number of workshops and meetings have since been held, and all available data were reviewed. Draft estimates of the disease burden have been revised. The information presented below is based on the newly revised draft estimates as of February 2017. Where robust data are lacking, input assumptions must be utilized to arrive at estimates. For example, there is a large gap in population size estimate data among different key populations. The review had generated a lower estimate of PLHIV at the national level as well as for some of the key PEPFAR Vietnam-supported provinces.

The national HIV prevalence in Vietnam is 0.34 percent in general population aged 15+ with an estimated 247,357 PLHIV (Draft Estimation and Projection Package-EPP, 2017). HIV incidence peaked in early 2000 and has declined gradually. The epidemic in Vietnam remains concentrated among three KPs: PWID (21.02%), MSM (2.87%), and FSWs (3.23%). 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. It is estimated that in 2016, 4,732 new infections were acquired among PWID, and about 47,683 of the estimated 226,000 PWID were living with HIV. While the national HIV prevalence among PWID is estimated at 21 percent, according to 2016 HIV sentinel surveillance findings, HIV prevalence among PWID ranged from two percent in An Giang to 24 percent in Son La.

In recent years there has been greater recognition of the HIV epidemic among MSM in Vietnam, and several studies highlighted increasing risk behaviors in this group (2013 IBBS). The overall MSM population is estimated to be 331,000. The estimated HIV prevalence among MSM is 2.87 percent. In 2016, HIV sentinel surveillance data were collected in seven provinces, and HIV prevalence among MSM ranged from one percent in An Giang and Dong Nai to 11 percent in Hanoi. FSWs are the smallest KP group with an estimated 85,000 FSWs in Vietnam. HIV prevalence among FSWs ranged from one percent in Thai Binh and An Giang to seven percent in HCMC and eleven percent in Hanoi. In the five PEPFAR aggressive scale-up provinces and Hanoi, it has been estimated that there are about 140,000 individuals who can be considered sexual partners of KPs. However, further studies need to be conducted in order to develop reliable and valid estimates of this population group.

KP size estimation data are essential 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. In Vietnam, the available KP size estimates are not uniformly robust across provinces. Given these challenges, population size estimations are planned for PWID, MSM, and FSW in a number of PEPFAR Vietnam-supported provinces, including Son La, HCMC, Hanoi, Thanh Hoa, Dien Bien, and Nghe An.

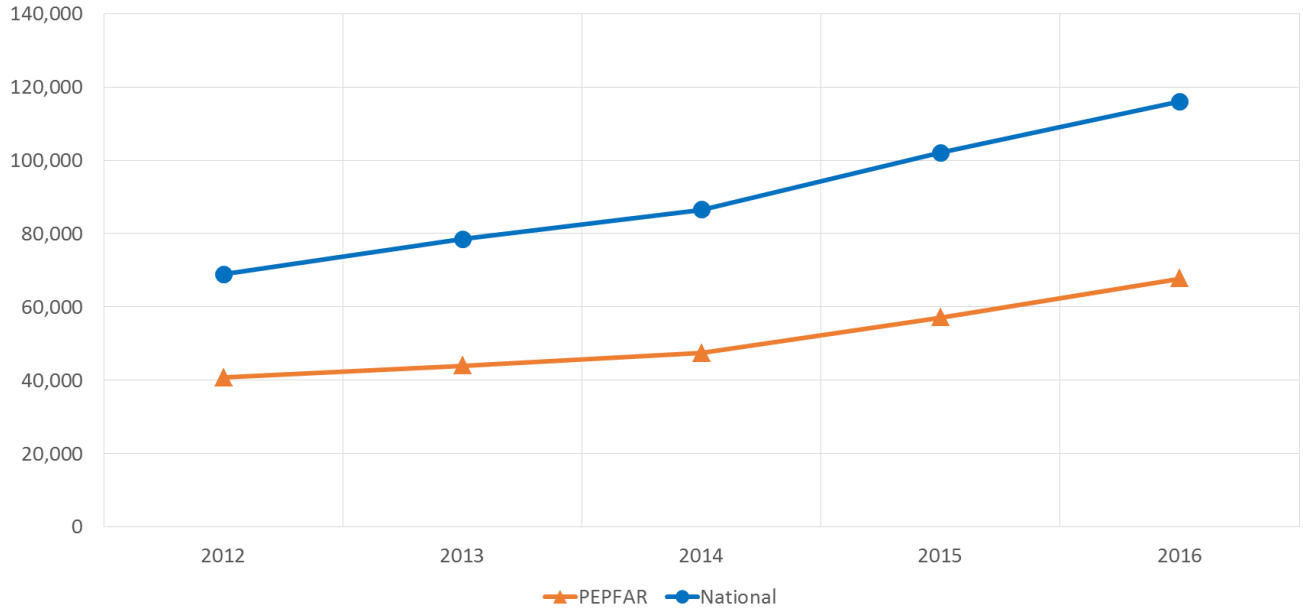
Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	92,513,000		10,476,500	11.3%	11,085,000	12.0%	7,400,000	8.0%	7,759,000	8.4%	28,750,500	31.1%	27,042,000	29.2%	GSO, 2016 (Population Census 2009, estimated in next 25 years)
HIV Prevalence (%)		0.34%						N/A		N/A		N/A		N/A	EPP 2016-2017**, 2016, adult only
AIDS Deaths (per year)	8,512		601		906		N/A		N/A		N/A		N/A		EPP 2016 (adult only) Case reporting in 2016 for children
# PLHIV	247,357 (240,815 + 6,542)		3,509		3,039										EPP 2016 (adult only) Case reporting in 2016 for children
Incidence Rate (Yr)															
New Infections (Yr)	10,719														EPP 2016 (adult only)
Annual births	1550,000														MCH/ 2016
% of Pregnant Women with at least one ANC visit	1,452,350														93.7% in MICS04, 2011
Pregnant women needing ARVs	2,595														EPP2016
Orphans (maternal, paternal, double)	N/A														
Notified TB	180.000														WHO, TB

cases (Yr)															profile 2014
% of TB cases that are HIV infected	9,000	5%													WHO, TB profile 2014
% of Males Circumcised	N/A														
Estimated Population Size of MSM*	331.515														Size estimation for EPP 2016
MSM HIV Prevalence		2.87%													EPP 2016
Estimated Population Size of FSW	85,572														Size estimation for EPP 2016
FSW HIV Prevalence		3.23%													EPP 2016
Estimated Population Size of PWID	226,860														Size estimation for EPP 2016
PWID HIV Prevalence		21.0%													EPP 2016
Estimated Size of Priority Populations (specify)															
Estimated Size of Priority Populations Prevalence (specify)															
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	92,513,000 [1]	0.27%	247,357	206,849[2]	116,027[3]	46.8%	96.8%[4]	2,305,192[5]	9,912[2]	*14,972 [6]*
Population less than 15 years	21,561,000([1]	0.03%	N/A	6542[2]	4,436 [7]	68.3%	N/A	N/A	260[2]	N/A
15-24 year olds	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25+ year olds	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MSM	331,515	2.87%	8,984	N/A	N/A	N/A	N/A	14,258[5]	1,873[5]	N/A
FSW	85,572	3.23%	3,054	N/A	N/A	N/A	N/A	25,104[5]	222[5]	N/A
PWID	226,860	21.0%	47,643	N/A	N/A	N/A	N/A	143,098[5]	5,561[5]	N/A
Priority Pop (specify)										

Figure: 2.1.3 National and PEPFAR Trend for Individuals Currently on Treatment

(Source: VAAC C&T department; PEPFAR report)



2.2 Investment Profile

The HIV response in Vietnam is shifting from a donor-dependent program to a primarily domestically funded program. Following the peak of total HIV investment in 2013, overall HIV expenditure began to steadily decline due to the culmination of the World Bank/U.K. Department for International Development Harm Reduction project at the end of 2013. Since then, bilateral donors including Australia, the Netherlands, and Canada have progressively reduced funding levels. In 2015, HIV spending was estimated at U.S. $137.5 million, approximately 1.27 percent of total health expenditures[1] in Vietnam. More than 50 percent of HIV funding is still from donor sources (primarily PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), contributing to 54.5 percent and 52.8 percent of total HIV expenditures in 2014 and 2015, respectively (National Health Account, preliminary results, Vietnam Ministry of Health, 2017). Government funding has increased both in absolute terms and in the proportion of total expenditures for HIV from U.S. $30 million and 22 percent in 2012 to U.S. $58.6 million and 43 percent in 2015. In 2015, PEPFAR Vietnam contributed to 36 percent of total HIV expenditures compared to a 14 percent contribution from GFATM over the

same period. The Government of Vietnam is taking greater responsibility in health system development, including managing human resources for health; HIV sentinel surveillance, the harm reduction program; HIV commodities (ARV, Methadone drugs), and general HIV prevention program activities. As availability of validated national health expenditure figures typically lags one to -two years, PEPFAR does not yet have access to official national health and HIV expenditures data for 2016.

In 2013, the Government of Vietnam committed to increase domestic investments in HIV, and reduce dependence on external aid for HIV funding to less than 50 percent by 2015 and less than 25 percent by 2020 while ensuring financial stability for HIV/AIDS activities for 2013-2020[2]. Vietnam is nearing its commitments with the initial gain in increasing domestic financing up to 43 percent at the end of 2015[3].

The HIV National Targeted Program (NTP), the primary domestic resource mechanism for HIV, dissolved in 2015. In 2016, HIV was bundled with seven programs under the joint National Health Priority (NHP) program. This bundling requires annual justification for continued funding among other health priorities—creating competition among all eight health activities for limited resources and thus making the sustainability of the HIV program vulnerable to setbacks.

In 2015, the Government of Vietnam for the first time increased its annual ARV budget to U.S $4 million (from U.S $0.9 million in 2014), and successfully completed its first domestic bidding for ARVs, securing drug pricing comparable to that obtained through PEPFAR and GFATM. However, in 2016, the Government of Vietnam's ARV contributions were reduced to U.S. $1.2 million due to the late approval of the new funding cycle for 2016-2020.

The tentative budget proposed by the Government of Vietnam for HIV commodities for the 2016-2020 period is approximately U.S. $4.35 million for ARVs and U.S. $29 million for Methadone. The apparent modest Government of Vietnam earmark proposed for ARVs in the National Health Priority program takes into account the substantial expected contribution from SHI from 2018 onward. SHI is projected to be the major source of funding for ARVs as PEPFAR Vietnam reduces ARV commodity support by 40 percent in COP 17, and fully transitions out of ARV commodity support at the end of 2018. SHI sources are projected to cover 85 percent of ARV needs by 2020[4], with the National Health Priorities program at central level and provincial level expected to provide ARVs for uninsured patients.

Over the past year, the Government of Vietnam stepped up planning and has focused efforts in ensuring SHI contributions to the treatment gap begin in the latter half of CY 2017. The initial estimated SHI budget proposed for Vietnam Social Security (VSS) is U.S. $1.7 million, which will provide sufficient ARVs needs for 37,000 patients toward the end of the year. A series of directives and

[2] Prime Minister Decision #1899, 2013 approving National plan on HIV Sustainable financing for 2013-2020
[3] National Health Account for 2014, 2015, preliminary results, Vietnam Ministry of Health, 2017)
[4] VAAC estimated figure- presentation in GF concept note

decisions were issued in late 2016 to mobilize and enable domestic HIV resources, through provincial government general tax budgets, SHI contributions, and relevant charities. Domestic funding is expected to increasingly fill ARV treatment gaps; however, there remains a threat to the sustainability of the HIV program beyond 2017 if the operationalization of these policies is not on track. Thus, close monitoring of policies and tracking of resources is critical moving forward.

Table 2.2.1 Investment Profile by Program Area[5]

Program Area	Total Expenditure	% PEPFAR	% GFATM	% Host Country	% Other
Clinical care, treatment and support	$47,215,621	34%	30%	36%	0%
Community-based care, treatment, and support	$266,009	100%	0%	0%	0%
PMTCT	$3,913,776	14%	5%	81%	0%
HTS	$2,865,668	78%	11%	11%	0%
VMMC	-				
Priority population prevention	$531,302	100%	0%	0%	0%
Key population prevention	$10,791,964	27%	16%	49%	7%
General Population Prevention	$5,541,969	0%	0%	100%	0%
OVC	$109,098	100%	0%	0%	0%
Medication Assisted Therapy (MAT)	$9,760,526	36%	16%	48%	0%
Laboratory	$2,856,257	100%	0%	0%	0%
SI, Surveys and Surveillance	$14,857,334	15%	9%	75%	0%
HSS	$38,767,710	47%	0%	46%	7%
Total	**$137,477,234**	**36%**	**14%**	**47%**	**3%**

Table 2.2.2 Annual Procurement Profile for Key Commodities (COP 2016)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs [(1)]	$22,950,969	45.4	44.3	5.4	4.8
Rapid test kits [(2)]	$1,503,257	17.3	81.8	0	0
Other drugs					
Lab reagents [(4)]	$516,998	0	100.0	0	0
Condoms [(5)] Viral Load commodities	$2,820,767	42.3	57.7	0	0
VMMC kits					
MAT [(3)]	$7,847,244	10.2	41.5	48.3	0
Other commodities (syringes) [(6)]	0	0	0	0	
Total	$35,639,235	35.6	47.1	14.2	3.1

(1) ARVs: Data from PEPFAR COP 16 annual procurement plan, Global Fund ARV procurement in 2017, provided by country team, Government of Vietnam ARV procurement in 2017 and Social Health Insurance ARV 2017

(2) RTK: PEPFAR budget allocation; Global Fund budget allocation, provided by country team

(3) Methadone: PEPFAR COP 16 Procurement Plan; Global Fund budget allocation, provided by country team; domestic methadone procurement by Government of Vietnam (VAAC, Hanoi PAC and HCMC PAC)

(4) Lab CD4: Global Fund budget allocation, provided by country team

[5] National Health Account for 2015, preliminary results, Vietnam Ministry of Health, March 2017

(5) Condom: GF will not procure in 2017 as the buffer stock can cover the whole year
(6) Needle & syringe: GF will not procure in 2017 as the buffer stock can cover the whole year

Table 2.2.3 Annual 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	~$2,400,000	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	**$9,364,268**	**0**	**0**	**0**	

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP (2016)						
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**
DREAMS Innovation						
VMMC – Central Funds						
LCI						
Other PEPFAR Central Initiatives Sustainable Finance Initiative (SFI)	$2,000,000	- 0	0	17371	$600,000	1. Monitor model reimbursing HIV services in SHI 2. Health Information framework that fulfills data needs of NTP 3. Enrollment of KP in SHI 4. Include preventive services SHI service package
Other Public Private Partnership						
	$298,636					

2.3 National Sustainability Profile Update

The Sustainability Index and Dashboard (SID) was completed for COP 16 and reflects progress towards improved systems components. 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 U.S. Government discussions with the Government of Vietnam and various stakeholders, and were related to health financing, procurement and supply chain, and transition to a TA model.

Leveraging resources and promoting efficiency of domestic resources for HIV is a key component of PEFPAR Vietnam's Transition Strategy. Since COP 15, PEPFAR Vietnam has implemented PEPFAR's Sustainable Financing Initiative (SFI), using evidence and harnessing health diplomacy to generate and sustain political will for Vietnam's allocation of domestic resources for HIV. With PEPFAR Vietnam's support, the Government of Vietnam's successful domestic ARV bidding mentioned above resulted in successful procurements of fixed-dose combination ARVs, enough to treat over 26,000 patients for one year, paid by the state budget. Equally important was the Prime Minister's decree enabling centralized procurement of ARVs to be paid by the SHI fund beginning in 2017, as well as a decree to provinces to allocate part of their local budgets to support SHI copayments and premiums

for PLHIV. Preliminary meetings leading up to the GFTAM funding request for 2018-2020 have included discussions of how the GFATM can support the sustainable transition of Vietnam's HIV program to SHI, such as the potential collaboration with PEPFAR to enroll PLHIV in SHI for reimbursement of ARVs. Moving forward, MOH/VAAC capacity to manage the orderly transition to SHI, particularly in the last year of PEPFAR Vietnam support for commodities, is critical to ensuring uninterrupted care and treatment.

In COP 17, PEPFAR Vietnam will continue to support the Government of Vietnam to institutionalize a functioning central procurement process for ARVs paid for by SHI. PEPFAR Vietnam will work to strengthen MOH capacity to manage the supply chain system for HIV commodities, including forecasting, procurement, distribution, storage, and dispensing in light of SHI processes and systems; and work with provinces to ensure that the transition from free-of-charge to SHI-reimbursable health services does not result in issues of access, equity, or financial protection for PLHIV (see Section 6.0).

As a result of targeted programming and advocacy towards vulnerabilities identified by stakeholders from the SID results, an improvement in sustainability is demonstrated by recent policy changes, such as support for universal implementation of WHO Test and Start guidelines, and progress toward full revision of ARV guidelines, including pilots for PrEP, MMS, and dispensing of ARVs. PEPFAR Vietnam will continue to focus on persistent vulnerabilities, such as uneven implementation of non-discrimination protection policies that limit PLHIV access to services; limited understanding of the potential market for private sector engagement in HIV prevention commodities; and weak HRH capacity in transition sites. Civil society HIV activities are currently externally funded. Given the decline in PEPFAR funding, the financing of civil society remains a key challenge to the sustainability of the national response (see Section 6.0)

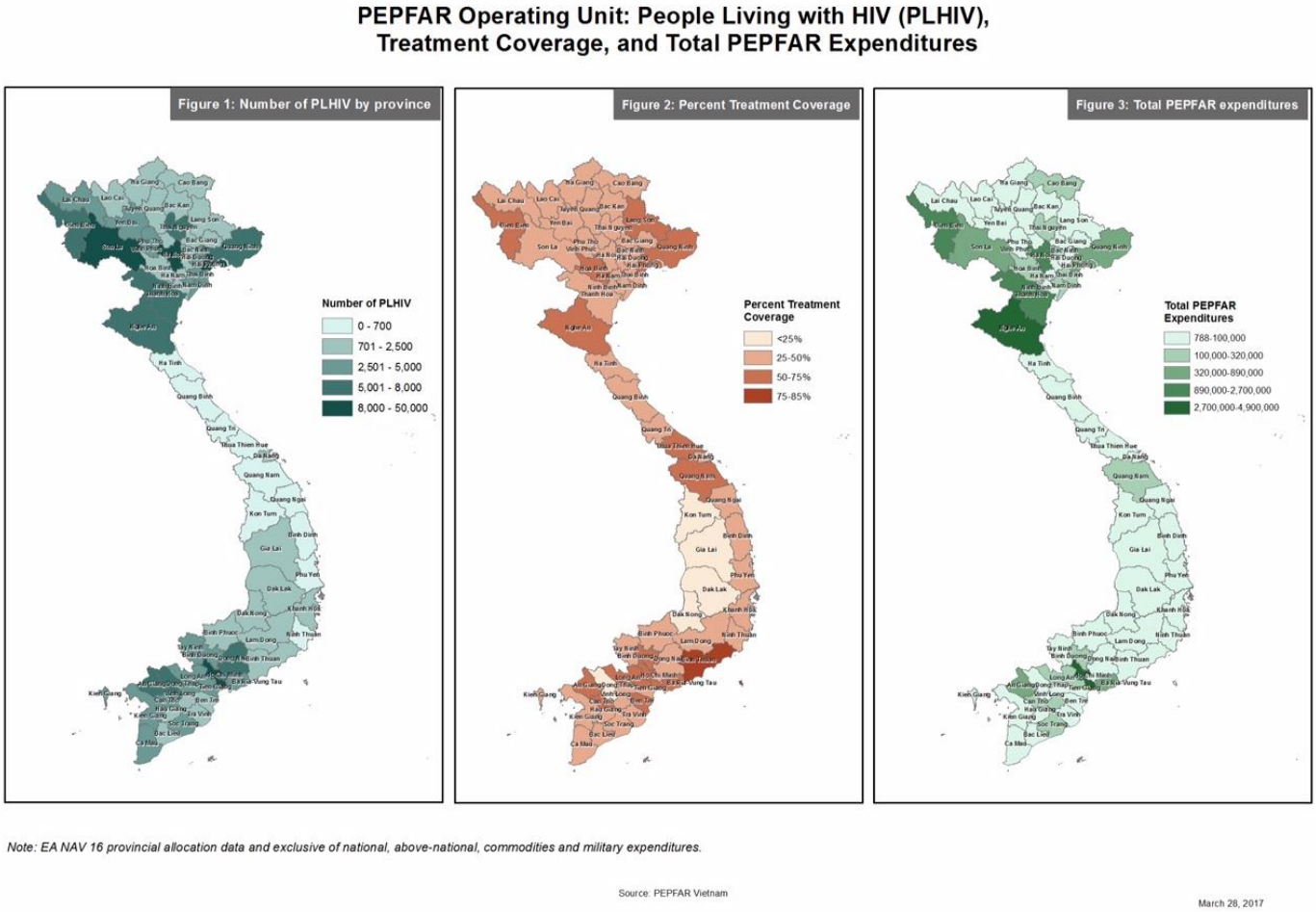
2.4 Alignment of PEPFAR investments geographically to disease burden

In the coordinated support of the national HIV/AIDS response, the majority of PEPFAR Vietnam FY 2016 expenditures are at the site-level (53 percent). Remaining expenditures include health system strengthening (26 percent), above-site program management (12 percent), site-level investments (six percent), and strategic information (two percent). This investment trajectory aligns with the COP 15 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 2016 was ARVs at 25 percent followed by personnel at 12 percent. PEPFAR Vietnam expects these percentages to reduce over time as the Vietnamese government assumes principal responsibility for ARV and routine operating expenditures.

Figure 2.4.2 indicates PEPFAR Vietnam expenditures in 2016 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 the highest disease burden. Provinces with low disease burden and higher economic capabilities have been prioritized for

transferring routine operating costs (ROCs) to MOH from 2014-2017, in line with the PEPFAR Vietnam Transition Blueprint.

Figure 2.4.2 Total Expenditure and PLHIV by Province



2.5 Stakeholder Engagement

The U.S. Government/PEPFAR regularly convenes bilaterals, multilaterals, and CSOs in country with at least monthly engagement on PEPFAR planning and contributions to 90-90-90 goals. Stakeholder engagement activities include:

- Quarterly POART stakeholder meetings
- Annual and/or quarterly data and PEPFAR planning and performance reviews held by the USAID SHIFT and C-Link CSO projects in Dien Bien, Nghe An, and HCMC

- CDC regional provincial meetings with MOH and community organizations on PEPFAR implementation and planning
- Substance Abuse and Mental Health Services Administration (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. U.S. Government/PEPFAR co-led the effort to expand representation on the CCM to ensure that 40 percent of representatives were from key affected populations and community-based organization.
- Outreach to networks of PLHIV and KP groups in informal settings.

It is notable that the HIV response in Vietnam has granted civil society members a voice and access to high-level government officials in a way that is not enjoyed by many other groups working on social issues in the country. However, the ability to establish wholly independent social enterprises (and tax exemptions benefits) is limited. Entities are generally organized under umbrella parastatal institutions (e.g. VUSTA) and the U.S. Government is careful to focus CSO collaboration on service delivery over advocacy. Moreover, 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. With nearly full staffing in the PEPFAR Coordinator's office, there has been increased outreach especially to civil society groups and KPs at the location and time best chosen by these groups.

3.0 Geographic and Population Prioritization

As part of the COP 15 pivot, PEPFAR Vietnam established a strategy to demonstrate epidemic control (90-90-90) in five aggressive scale-up provinces: Dien Bien, Son La, Nghe An, Thanh Hoa, and HCMC. Epidemiological data identified these provinces as locations with great 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 Vietnam 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 the most recent epidemiologic and programmatic data from the newly completed 2017 EPP, PEPFAR Vietnam will maintain its priority focus on PWID, FSW, and MSM—as well as the sexual partners of these KP groups. The new EPP estimates indicate that HIV burden is significantly lower and ART coverage higher in three of the four mountainous scale-up provinces (Son La, Thanh Hoa, and Dien Bien). Estimates of PLHIV in HCMC have been revised downward, but the province retains the highest disease burden, comprising 19.9 percent of all PLHIV in Vietnam. Population size and distribution of KPs vary 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. An estimated 48,104 PLHIV

live in HCMC (EPP, 2017). PEPFAR Vietnam employs a comprehensive, innovative mix of activities to enroll 1,852 new PLHIV on treatment and increase ARV coverage (the second 90) from 59 percent (FY 2016 Results) to 69 percent (COP 17 target). The various approaches include performance based incentive (PBI) case-finding; lay- and self-testing approaches, screening TB patients for HIV co-infection; and verifying lists of individuals who previously tested positive but not yet on ART. The HIV recency assay will be utilized for all newly diagnosed infections to guide partner services, and to identify population and geographic hotspots. MMS and dispensing of ARVs, planned for piloting in HCMC in FY 2017 will continue in COP 17 to inform program design and provincial and national policy

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 may decline treatment on the grounds that they feel healthy. Test and Start was implemented in these provinces ahead of national ARV guidelines revisions, and PEPFAR Vietnam employs PBI and peer-driven interventions (PDI). In Nghe An and Dien Bien, PEPFAR Vietnam will use specialized approaches to reach, test, and treat KPs. Where urban enclaves exist, CSOs will engage PWID networks to identify new PLHIV. In sparsely populated regions, government hamlet healthcare 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. For Son La and Thanh Hoa, tailored geographic and population approaches combine the use of peer educators, PDI, and PBI—shaped by population density and local characteristics—to spur case-finding and linkage. In rural areas, commune health workers are maximized; in urban centers, peer education and PDI serve a more critical role. In each of the four mountainous provinces, commune health stations play a greater role dispensing ARV and maintaining stable patients. As in HCMC, multi-month ARV scripting and dispensing will be piloted in the mountainous provinces to guide program design and inform national policy.

Although all PEPFAR Vietnam DSD support will end at the end of CY 2018, PEPFAR Vietnam COP 17 treatment targets for each of the four mountainous provinces support a trajectory of aggressive scale-up aligned with achievement of 90-90-90 goals in 2020.

Nghe An is home to 7,180 PLHIV. The COP 17 treatment new target for Nghe An of 566 will raise provincial ART coverage to 66 percent, up from current estimated coverage of 55 percent. For Dien Bien, COP 17 treatment new targets of 530 will increase ART coverage from the current level of 53 percent (APR 16) to 67 percent among the estimated 5,276 PLHIV. In Son La province, home to 8,580 PLHIV, 970 individuals will initiate treatment in COP 17, increasing ART coverage from 44 percent to 60 percent. For Thanh Hoa, the enrollment of 800 new patients on ART coverage will increase treatment coverage from 44 percent to 60 percent.

In addition to the five aggressive scale-up provinces of HCMC, Son La, Thanh Hoa, Nghe An, and Dien Bien, PEPFAR Vietnam intends to support an integrated multi-agency PEPFAR technical assistance strategy for Hanoi in collaboration with the VAAC and Hanoi Department of Health (DOH). Estimates of PLHIV in Hanoi (EPP 2017) were revised substantially upward to 29,238—second only to

HCMC and representing 12.1 percent of the entire national burden. The intensified PEPFAR Vietnam TA strategy for Hanoi will draw on the complementary strengths of U.S. Government agencies to support innovative case-finding and partner services; intensified harm-reduction efforts; rapid HIV diagnosis, linkage and treatment initiation; and strengthened epidemiologic data on key population size and risk of incident infections. The HIV recency assay will also be utilized for all newly diagnosed infections to guide partner services, and to identify population and geographic hotspots. MMS and dispensing of ARVs will be piloted in Hanoi in COP 17 to inform program design and provincial and national policy.

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP 17**	**# Current on ART (FY 16)**	**# of SNU COP 16 (FY 17)**	**# of SNU COP 17 (FY 18)**
Attained				
Scale-up Saturation				
Scale-up Aggressive	66%	42,935	48,400	51,850
Sustained	52%	47,396	50,830	54,560
Central Support				

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

4.1 Targets for scale-up locations and populations

In COP 17, PEPFAR Vietnam will mobilize efforts for case finding among KP groups (PWID, MSM/transgender (TG) and FSW). Sex partners of PLHIV and high-risk individuals will also be targeted. During COP 17, PEPFAR Vietnam will provide prevention outreach services to KP through 61 DSD sites in five scale-up provinces with 81,732 individuals reached. TA-only KP prevention outreach support will also be provided to ten sites and reach 7,681 PWID and MSM in Hanoi and HCMC. A total of 179,647 individuals will be reached with PEPFAR Vietnam support in aggressive scale-up and sustained provinces (See Table 4.1.3). PEPFAR Vietnam-supported PrEP services, initiated for the first time in FY 2017 in HCMC, will be provided to a cohort of 1,200 patients—and also expanded to Hanoi to serve an additional 500 MSM/TG clients as part of a combination prevention approach in FY 2018.

PEPFAR Vietnam targets for HIV testing services (HTS) in FY 2018 comprise a total of 249,402 tests and 8,359 newly-identified cases of HIV infection. Of these, an estimated 216,742 (86.9 percent) of tests will be among KPs and high-risk sex partners; 1,913 (0.77 percent) among TB patients; 1,127 (0.45 percent) for vulnerable children; and 29,620 (11.9 percent) at military healthcare settings. Among KP

and high-risk sex partners receiving HTS, PEPFAR Vietnam expects that 8,105 (3.7 percent) will be seropositive.

Of the 249,402 tests to be completed in FY 2018, a total of 163,216 or 65.4 percent of tests will be achieved through DSD-support in the five scale-up provinces, and 6,889 or 2.8 percent of this total number comprise TA targets in the five scale-up provinces. For the sustained provinces, FY 2018 targets for HTS coverage are 13,328 (or 5.3 percent) for DSD support, and 65,969 (or 26.5 percent) for TA-only support. These targets align with COP 17 HIV prevention and treatment needs analyses as well as Government of Vietnam-planned achievements for the 90-90-90 goals by 2020. The five scale-up provinces account for 31.6 percent (78,124/246,954) of the total number of PLHIV in Vietnam according to February 2017 MOH EPP estimates. Within these five provinces, estimated ART coverage is 56 percent. HTS targets were derived using the following inputs: the proportion of previously diagnosed PLHIV who were newly initiated on treatment; the rate of linkage of adults from HTS to ART services; the HTS positivity rate; and the current distribution of the PLHIV burden by district and province in Vietnam.

PEPFAR Vietnam-supported HIV case-finding investments will continue to target KP groups to ensure HIV testing and counseling and to support ART initiation for new patients. PEPFAR Vietnam DSD and TA support for HIV prevention services and referral linkages to other HIV services for 92,411 individuals from priority populations will include the following two subgroups: a) sexual partners of PLHIV and PWID and b) new military recruits. Identification of recent infections and contact tracing as part of partner notification and testing services will be utilized to identify and link sexual partners of PLHIV and PWID to HIV testing services and antiretroviral treatment. It is estimated that 90 percent of HTS positive cases would be linked to outpatient clinics (OPCs) as a result of HIV case finding efforts.

The majority (5,122/8,127 or 63 percent) of PEPFAR Vietnam new ART targets are projected to come from the four mountainous provinces and HCMC. A target of 3,005 (or 37 percent) new ART enrollments will come from 18 sustained provinces. ART scale-up targets were derived using provincial ART coverage, PEPFAR Vietnam site historical achievements, the anticipated number of PEPFAR Vietnam supported sites in COP 17, and aggressive case finding strategies. In FY 2018, PEPFAR Vietnam will support MOH/VAAC and Government of Vietnam Provincial AIDS Centers to diversify efficient and effective HIV treatment models, in addition to continuing the provision of cost-effective treatment through maximized capacity and efficiency of existing OPCs. A key focus in COP 17 will be PEPFAR Vietnam's continuing collaboration with MOH and provincial authorities to restore financial, technical, and programmatic support to the Government of Vietnam while ensuring service quality and sustainability pre- and post-transition. With no COP 17 funding for VL testing (as part of its planned transition trajectory), PEPFAR Vietnam is aiming to work with the Government of Vietnam, donors, suppliers, and treatment implementing partners toward the full transition of VL monitoring beginning in FY 2018, with 80-90 percent of PEPFAR-supported patients having access to VL, of which 90-93 percent will achieve VL suppression. A total of 60,126 patients (out of a total of 77,341 patients) will account for 77 percent of all existing patients who will be virally suppressed.

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. Health workers (commune and village health workers and peer outreach workers) and CSOs continue to play a critical role in PEPFAR Vietnam's outreach programing, and have substantially contributed to case finding efforts with successful linkage to HTS and treatment. During FY 2016, PEPFAR Vietnam reached 114,923 individuals in the five scale-up provinces of Dien Bien, Nghe An, HCMC, Son La, and Thanh Hoa. Additionally, 211,165 people were HIV tested and a total of 5,647 were identified as HIV positive with PEPFAR Vietnam-support in the five scale-up provinces. The contributions of the health sector and CSOs in HIV programming have been recognized by the PLHIV community and local authorities. PEPFAR Vietnam will continue to coordinate work with both in COP 17 to strengthen efforts to improve HIV case finding and linkages to treatment.

The Government of Vietnam initiated an estimation exercise to review and revise national as well as provincial estimates for PLHIV. These estimates are still being reviewed by key stakeholders including UNAIDS, PEPFAR, and the Government of Vietnam. In prior years, SPECTRUM was used to derive estimates of PLHIV. In this 2017 cycle, the Asia Epidemic Model (AEM) was used to estimate both national and provincial level estimates of PLHIV. AEM relies on available KP size estimations as well as other behavioral data among various KP groups, including high-risk men who have sex with men, PWID, and female sex workers. Many of the size estimations have limitations, but these constitute the best available data and have been vetted by both provincial and national-level key stakeholders.

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

SNU	Total PLHIV	Expected current on ART (APR FY 17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18) TX_CURR	Newly initiated (APR FY 18) TX_NEW	ART Coverage (APR 18)
Son La	8,713	4,700	2,270	5,180	971	59%
Thanh Hoa	7,481	4,000	1,985	4,456	807	60%
HCMC*	49,372	32,000	7,498	33,900	2,247**	69%
Nghe An	7,356	4,600	1,285	4,862	567	66%
Dien Bien	5,405	3,100	1,224	3,643	530	67%
Total	**78,327**	**48,400**	**14,262**	**52,041**	**5,122**	66%

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

****TX_New for HCMC represents only PEPFAR contribution**

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

KP_PREV + PP_PREV	Dien Bien	Nghe An	HCMC	Son La	Thanh Hoa	Hanoi	Total	Coverage Goal (in FY 17)	FY 18 Target
PWID	6,582	10,688	33,489	12,261	11,205	24,817	99,042	100.0%	52,231
FSW	253	1,149	17,241	577	1,898	8,794	29,912	35.1%	5,095
MSM	1,666	9,153	51,333	3,257	11,167	37,911	114,487	36.8%	29,910
PP_PREV Sex partner*	9,753	14,354	50,125	17,599	15,843	28,761	136,434	42.6%	42,411
PP_PREV Military							50,000	100.0%	50,000
Total	**18,254**	**35,344**	**152,188**	**33,694**	**40,113**	**100,283**	**429,875**		**179,647**

**PP_PREV Sex partner estimate = PWID*1.2 + Estimated remaining PLHIV not on ARV*1*

4.2 Priority Population Prevention

During FY 2017, PEPFAR Vietnam worked closely with VAAC and other stakeholders such as UNAIDS to conduct another round of EPP using the AEM. The new EPP revealed a substantially smaller number of PLHIV in the five scale-up provinces, especially in Son La, Thanh Hoa, and Dien Bien in which the estimated number of PLHIV decreased by 28 to 34 percent. The new EPP also suggested a great need for Hanoi, which ranked the second after HCMC in terms of number of PLHIV not on treatment (18,208 estimated remaining PLHIV not on ARV).

Moreover, PEPFAR Vietnam conducted a thorough review of national and provincial prevalence among KP groups by age groups using VAAC/HSS+ 2016 national case reporting system (disaggregated by age group), and the first quarter of FY 2017 of both KP outreach and HTS results. This review underscored the importance of the younger FSW, MSM, and sex partners of KP. HIV prevalence among those aged < 20 was 7.1 percent among FSW in Son La, and 13 percent among MSM in HCMC (from HSS+). Among FSW, 33 percent of total cases are aged < 20 years in both Dien Bien and Thanh Hoa (case reporting). Among sex partners of KP and PLHIV reached through outreach efforts in Dien Bien, the HIV positivity rate was 3.9 percent among those aged < 20 years and 10.2 percent among those aged 20-25 years. These data suggest the need to develop outreach models that meet the communication styles and service needs of different KP and age groups. Through COP 17, PEPFAR Vietnam will modify a communication package for a younger population of FSW, MSM, and KP in the provinces.

In COP 17, PEPFAR Vietnam will employ a comprehensive outreach strategy, targeting KP through out-reach and in-reach models. The out-reach models are designed to intensify HIV case finding; increase HTS uptake and yield through lay- and self-testing; and strengthen linkages to HIV care and

treatment services among KPs and especially males, who currently have lower treatment coverage than females (42.3 percent male vs. 49 percent female in the five scale-up provinces – EPP2017). The in-reach model refers to the broad spectrum of contact tracing, partner notification and partner HIV testing to help us reach unidentified and hidden sexual and injecting networks of PLHIV. Besides this, PEPFAR Vietnam will develop an inter-province tracking system that links client across provinces to assure treatment coverage and minimize LTFU due to migration from rural to urban areas.

During FY 2017, PEPFAR Vietnam and VAAC, in collaboration with WHO, have started a PrEP demonstration project among MSM and TG in HCMC. The project began enrolling patients in March 2017, and was able to mobilize a donation of free study drugs to the first one hundred patients. We anticipate that the pilot will demonstrate high acceptability and feasibility of PrEP among these populations, supporting incorporation of PrEP guidelines into the revised, national FY 2018 ARV guidelines.

PEPFAR Vietnam will standardize service packages to ensure 90 percent of those reached are linked to HTS, with an expected HIV positivity rate of approximately three to seven percent among those tested from KP outreach program. After more than one year implementing the COP 15 pivot in the five scale-up provinces, PEPFAR Vietnam would like to build on the successful models of community-based organization (CBO) social entrepreneurs, linking clients reached on-line to HTS services, HIV self-testing for KPs groups who are willing to pay, and partner notification and index partner HIV testing in the major HTS sites and hospitals. PEPFAR Vietnam will introduce and assess the yields of HTS in urban acute-care settings with KP-heavy catchments. PEPFAR Vietnam will continue targeted TA to Provincial AIDS Centers (PACs); DOH and CBOs to effectively implement, monitor, evaluate, and sustain effective approaches. As a result of working with partners to review quarterly program data, many low-yield, out-reach activities in the scale-up provinces are being closed during FY 2017. COP 17 is the final year for PEPFAR DSD support; therefore PEPFAR Vietnam will maximize efforts to reach and link unidentified PLHIV to treatment.

Besides the above-mentioned plan to reach sexual and injecting networks of PLHIV, in COP 17 PEPFAR Vietnam will also reach new military recruits as another important subgroup of priority populations. This effort supports Vietnam's Ministry of Defense to spread basic yet critical HIV and other STIs prevention messages to 50,000 new soldiers nation-wide. Specifically, military peer educators who are trained platoon commanders will conduct messaging sessions for 100 percent of new soldiers at participating regiments and military schools during their three months of induction immediately following enlistment. This is regarded as a top priority HIV prevention activity by Vietnam military and is categorized as a priority population activity under the COP Guidance (and Military COP 17 Guidance).

During FY 2016, SIMS visits were completed at 69 KP community sites, accounting for 76 percent of the SIMS target. Among those visits, four sites scored yellow and two sites scored red. The majority of red CEEs related to condoms and lubricants, commodities that PEPFAR no longer provides. PEPFAR Vietnam will 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 261 sites in all 63 provinces. The success of methadone assisted treatment among PWIDs is a key contributor to the overall decrease in new HIV infections. However, as of December 2016, there were 210,000 registered substance abusers, an increase of more than 10,000, when compared with 2015. Of registered drug users, 67.5 percent are in the community, including those receiving medication assisted treatment (methadone and buprenorphine); 13.5 percent are in treatment centers; and 19 percent have been sentenced to compulsory detoxification in state-run 06 detention centers (Source: Office of the Government, National Committee on AIDS, Drugs and Prostitution Prevention and Control). The MMT program has greatly contributed to HIV epidemic control. Of the approximately 51,000 patients served by the national program at the end of December 2016, nearly 100 percent of those not previously diagnosed as HIV seropositive were tested for HIV; of these, 18.2 percent tested positive, and 85 percent of positives were placed on ART. Program monitoring did not detect a single case of HIV seroconversion while on MMT.

In FY 2017, PEPFAR Vietnam continues overall technical assistance to the methadone program while providing intensive TA, per the monitoring, evaluation and reporting (MER) definition to 91 of the total sites. Of the 91 MMT sites, 31 (34 percent) sites receive methadone (commodities) only, four (four percent) receive methadone and TA, and 56 (62 percent) sites receive TA only. These 91 PEPFAR-supported sites cover 21,385 (42 percent) of the current total MMT patients nationally. PEPFAR Vietnam will continue to monitor the national MMT program to ensure the sustained quality of services and to provide responsive TA during transition and beyond.

In FY 2018, PEPFAR Vietnam will maintain above-site TA to the national MMT program while providing site-level TA to 60 methadone clinics in four scale-up provinces. PEPFAR Vietnam will no longer provide methadone to sites, but medication will be provided free of charge to patients using the local and central government allocated budgets. PEPFAR TA targets for FY 2018 in the four scale-up provinces is 10,870 patients.

Using an evidence-based best practice model, PEPFAR Vietnam continues to support achievement of the national goal of providing methadone treatment to 80,000 patients. By providing TA at site and above-site levels, PEPFAR Vietnam continues to address system barriers to sustaining epidemic control among those who use drugs.

The rapid spread of methamphetamine use, even among those in methadone treatment, is contributing to governmental entities ordering individuals into compulsory treatment centers as a response to perceived public safety and security issues. Individuals moved into compulsory establishments cannot access HIV treatment and services which erodes advances made by PEPFAR and impacts the ability to achieve zero new infections. Detention in 06 Centers prohibits access to

HIV testing, HIV treatment, and substance abuse treatment in a population that continues to drive the HIV epidemic. Moreover, the relapse rate of those detained in these facilities is high.

As PEPFAR Vietnam seeks to address the human rights challenges of those affected by HIV in Vietnam, the team acknowledges that PWID are most likely to be infected, remain untreated, infect their (primarily female) sexual partners, and experience tremendous stigma and discrimination in the community and in the healthcare system. With 38 percent of all drug users also having a criminal record, they are a most vulnerable and voiceless group. At the highest levels of the Government, it has been recognized that compulsory detention of drug users, many of whom are also mentally and physically ill, without access to HIV and substance abuse services is counterproductive. Vietnam's leaders have taken an inter-agency approach to addressing substance abuse using evidence-based approaches.

To this end, the Government of Vietnam requests the sharing of expertise to shift a punitive legal environment to one where drug users are diverted to community-based HIV and drug abuse treatment. Based on the successful engagement with the Government of Vietnam on the introduction of methadone, PEPFAR Vietnam is uniquely positioned to advocate for the needs of PWID as policy is shaped and models piloted for pre-trial substance abuse services and alternative centers to substance abuse treatment. PEPFAR Vietnam believes that the proposed efforts are in keeping with supporting the continuum of comprehensive programs for drug users, including treatment of other substance abuse disorders (methamphetamine) as outlined in the COP 17 Guidance.

Additionally, PEPFAR Vietnam will invest in Vietnam's health workforce capacity to provide needed services to those who are addicted to drugs.

PEPFAR Vietnam successfully transitioned all MMT site operating costs at the end of CY 2015, and will transition medication costs by the end of CY 2017. These costs are, or will be, covered by the Government of Vietnam with a modest contribution from patients at certain sites. Findings from recent SIMS visits showed that although HTS and treatment referrals have improved significantly, risk reduction services are not provided to all patients.

Community-based MMT Cascade by the end of December 2016

	Provincial Target	**# of Patients**	**% against target**	**# of HIV+ Patients**	**# of pts on ART**	**Current ART Gap**	**ART coverage**
National	***80,404***	***49,184***	***61.2***	***8,957***	***7,612***	***1,345***	***85.0***
Hanoi	8,500	4,510	53.1	651	556	95	85.4
Hai Phong	4,600	3,734	81.2	870	746	124	85.7
Ho Chi Minh	8,000	3,473	43.4	1430	1344	86	94.0
Thanh Hoa	3,500	2,777	79.3	402	361	41	89.8
Dien Bien	4,400	2,621	59.6	436	418	18	95.9
Thai Nguyen	3,300	2,280	69.1	607	455	152	75.0
Lai Chau	1,700	2,002	117.8	208	191	17	91.8
Nam Dinh	1,900	1,853	97.5	353	240	113	68.0

Lao Cai	2,431	1,558	64.1	180	143	37	79.4
Thai Binh	3,000	1,444	48.1	130	113	17	86.9
Son La	6,000	1,328	22.1	328	269	59	82.0
Nghe An	3,400	1269	37.3	185	175	10	94.6
Quang Ninh	1,600	1,161	72.6	445	426	19	95.7
Lang Son	800	1161	145.1	100	87	13	87.0
Dong Nai	1,404	996	70.9	202	125	77	61.9
Bac Giang	1,213	966	79.6	81	67	14	82.7
Yen Bai	1,200	945	78.8	96	79	17	82.3
Hai Duong	1,900	852	44.8	148	125	23	84.5
Binh Thuan	1,144	807	70.5	33	23	10	69.7
Ninh Binh	1,356	777	57.3	109	89	20	81.7
Cao Bang	750	662	88.3	84	69	15	82.1
Long An	650	645	99.2	55	55	0	100.0
Hoa Binh	1,200	622	51.8	107	86	21	80.4
Ba Ria - Vung Tau	1,200	612	51.0	220	188	32	85.5
Phu Tho	1,200	607	50.6	187	134	53	71.7
Hung Yen	750	604	80.5	58	49	9	84.5
Bac Kan	800	578	72.3	107	86	21	80.4
An Giang	900	564	62.7	110	90	20	81.8
Can Tho	1,100	538	48.9	155	122	33	78.7
Vinh Phuc	800	512	64.0	28	15	13	53.6
Khanh Hoa	500	500	100.0	56	53	3	94.6
Bac Ninh	500	419	83.8	55	44	11	80.0
Quang Nam	400	362	90.5	27	26	1	96.3
Binh Duong	800	356	44.5	76	39	37	51.3
Tay Ninh	400	348	87.0	52	38	14	73.1
Ha Nam	700	343	49.0	1	0	1	0.0
Da Nang	850	311	36.6	15	14	1	93.3
Dak Lak	400	297	74.3	19	17	2	89.5
Tuyen Quang	700	296	42.3	104	84	20	80.8
Ben Tre	300	292	97.3	77	67	10	87.0
Lam Dong	550	283	51.5	20	15	5	75.0
Ha Tinh	400	275	68.8	24	20	4	83.3
Hue	200	251	125.5	7	5	2	71.4
Dong Thap	100	243	243.0	20	16	4	80.0
Quang Binh	400	233	58.3	3	2	1	66.7
Ha Giang	250	232	92.8	33	29	4	87.9
Vinh Long	200	216	108.0	69	63	6	91.3
Ca Mau	350	200	57.1	24	22	2	91.7
Soc Trang	100	200	200.0	64	50	14	78.1
Tien Giang	350	198	56.6	18	11	7	61.1
Dak Nong	100	147	147.0	9	5	4	55.6
Bac Lieu	100	143	143.0	39	37	2	94.9
Quang Tri	450	126	28.0	2	2	0	100.0
Kon Tum	100	106	106.0	7	5	2	71.4
Kien Giang	150	69	46.0	10	7	3	70.0
Quang Ngai	100	58	58.0	3	3	0	100.0
Gia Lai	200	50	25.0	6	3	3	50.0
Binh Dinh	100	45	45.0	0	0	0	
Binh Phuoc	300	40	13.3	5	3	2	60.0
Hau Giang	100	29	29.0	6	6	0	100.0
Ninh Thuan	200	27	13.5	1	0	1	0.0
Tra Vinh	0	23	NA	0	0	0	
Phu Yen	0	8	NA	0	0	0	

4.3 Voluntary Medical Male Circumcision (VMMC)-N/A

4.4 Preventing Mother-to-Child Transmission (PMTCT)

Option B+ was adopted nation-wide in 2016. HIV-infected pregnant and breastfeeding women are now provided with lifelong ART regardless of clinical stage, CD4 count, or pregnancy stage.

In FY 2016, PEPFAR Vietnam supported testing for 227,229 pregnant women, access to ARV drugs for 923 HIV-infected pregnant women, and continued efforts to phase out DSD; strengthen the Maternal and Child Health (MCH) reporting system, including improving the quality of PMTCT data (indicators integrated into the MCH reporting system); and strengthen capacity of MCH to lead the program. The cost of HIV testing for pregnant women continues to be a challenge for the PMTCT program. It is not covered by SHI or national budget allocations; local Government of Vietnam funding for this service is minimal, available in only a handful of provinces, and subject to changes or elimination due to the availability of local funds. Where public and donor funding is not available, pregnant women must pay the cost. FY 2016 SIMS results did not show that any clinics needed urgent remediation.

In FY 2017, PEPFAR Vietnam will stop all DSD support and will provide only TA support to five sites, down from 12 DSD and 13 TA PMTCT sites in FY 2016. HIV testing and all non-core activities such as routine trainings and annual meetings; nutrition and formula support; and printing information, education, and communication materials were transitioned to the Government of Vietnam in 2015.

During FY 2018, PEPFAR Vietnam will stop all site-level support, and will maintain only above-site TA to the MCH program to monitor program performance, assure quality of service, develop technical guidelines (including incorporating HIV testing for pregnant women into the Antenatal Care (ANC) standard package), and seek public funding. 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 build capacity of the MCH system, efforts will be made to strengthen in-country TA capacity of the MCH system by building a core training team to train MCH health workers, and to expand training to include the private sector. PEPFAR Vietnam will also provide TA to monitor the program post-transition to assure the quality of services and of data collection and management.

4.5 HIV Testing Services (HTS)

According to the Vietnam MOH EPP (Feb 2017), there are currently 247,357 PLHIV in Vietnam, of whom 70 percent know their HIV-positive status. There are 10,700 new HIV infections each year in Vietnam. Government of Vietnam is committed to reaching the 90-90-90 goals by 2020. However, among the five aggressive scale-up provinces of Dien Bien, Son La, Thanh Hoa, Nghe An, and HCMC

(which collectively account for 31.8 percent of the total PLHIV burden in the country), only 74 percent of PLHIV know their HIV-positive status, and ART coverage remains as low as 56 percent. In alignment with community outreach and ART treatment programs, PEPFAR Vietnam sets a COP 17 target of 249,402 HIV tests with 8,359 HIV positive cases (3.4 percent), of which 86.9 percent (or 216,742 HIV tests) will be from HTS for KP. Compared with the APR 2016 results, this COP 17 HIV yield target for KP HTS is 6.8 percent higher (8,105 vs. 7,592).than the total KP HTS target, 77.6 percent (or 168,085 HIV tests with 5,794 HIV positive cases) will be offered in the above five provinces.

In FY 2018, PEPFAR Vietnam HTS will support both DSD and TA with various approaches and modalities such as client- and provider-initiated testing, facility- and community-based testing, couples testing, and index testing. PEPFAR Vietnam offers HTS services at various settings including public health, clinical, and HIV/AIDS services; prison and military healthcare in geographic locations with the highest HIV burden. HTS services target populations with high HIV prevalence such as PWID, MSM, FSWs, sex partners of PWID and PLHIV, TB patients, pregnant women, vulnerable children, and some of those who seek military healthcare services. HTS works in close partnership with community outreach programs and other outreach strategies such as PDI, PBI, online, peer educators, social media and networks to promote HTS uptake among KP and high-risk sex partners.

Community-based HTS is being expanded with PEPFAR support, including mobile-testing deployed by district health staff to mountainous, remote, and hotspot areas; lay-testing by commune/village health staff and community groups; and oral/self-testing. With PEPFAR Vietnam support, national community-based HTS guidelines and training manuals will be standardized, finalized and released by the Vietnam MOH in FY2017 for further expansion. In FY 2018, PEPFAR Vietnam will support HTS innovations such as partner notification and HIV recency testing, which will identify incident cases of HIV infection (occurring in the previous six months) to facilitate interventions to achieve greater prevention outcomes and impact. Accrediting district health facility labs to perform HIV confirmation testing is critical for reducing the turn-around time for HIV confirmatory testing and ART initiation, decreasing loss to follow up, and reducing cost. To that end, PEPFAR will work with the Vietnam MOH to increase the number of district confirmatory labs that perform the national rapid HIV testing algorithms from zero before FY 2016, to 15 by March 2017, and to 60 by the end of 2018. COP 17 PEPFAR funds will cover only 46.9 percent (85,968/183,258) of rapid HIV test kits (RTK) needs for KP HTS DSD targets. Therefore, PEPFAR Vietnam will work closely with local and central Government of Vietnam, GFATM and other donors in order to address these RTK gaps.

PEPFAR Vietnam continues to support aggressive scale-up in five provinces. In Hanoi, which has the second highest HIV/AIDS burden and unmet need in the country, PEPFAR Vietnam will significantly increase HTS targets. In line with the transition timeline of all PEPFAR Vietnam DSD support and for the goal of sustainability and quality services agreed upon with the central and local governments, PEPFAR Vietnam will continue DSD for only three productive KP HTS sites in two sustained provinces (two sites in Quang Ninh and one site in Hai Phong) and transition until Dec 2018 and transition to TA-only for the other high-yield and high volume sites in the other 14 sustained provinces. PEPFAR Vietnam support in these 14 sustained provinces will also include post-transition monitoring. These

sustained provinces will advocate for allocation of other funding sources to cover HTS costs to support activities when PEPFAR Vietnam transitions out of DSD.

Effective and early linkage of HIV-positive individuals identified from HTS program to HIV treatment services remains a high priority. PEPFAR Vietnam will continue to assist in the improvement of a standardized tracking system and support multiple localized HTS-ART linkages/referral efforts and interventions in order to ensure high successful linkage rates from both facility- and community-based services, especially in PEPFAR-supported provinces. Benefits of early ART will be continuously communicated through the cascade of services, i.e., from reach to test and to treatment, to encourage PLHIV to access treatment early.

In 2016, PEPFAR Vietnam conducted both initial and follow-up SIMS visits at 108 facility and community HTS sites. The results from 427 [(105 x 4) + (2 x 3) + (1 x 1)] core essential elements assessed indicate that 2.1 percent (n=9) rated red (six HTS referrals to HIV care and treatment, one compliance with national testing algorithm and strategy, one quality assurance of HIV testing service, and one facility level HIV proficiency testing) and that 1.6 percent (n=7) rated yellow (three HTS referrals to HIV care and treatment, two facility level HIV proficiency testing, one compliance with national testing algorithm and strategy, and one quality assurance of HIV testing service). PEPFAR Vietnam'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 Vietnam and national geographic prioritization, implementing partners provided 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 Vietnam will provide care and support services at 105 OPCs (60 percent in scale-up provinces) and TA at 32 OPCs (72 percent in scale-up provinces, including GFATM-supported OPCs). To facilitate the transition of PEPFAR support to the Government of Vietnam, 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 for COP 17, PEPFAR Vietnam 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 ART adherence support. PEPFAR Vietnam 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 HIV community programs established new collaborations between CSOs and facility HIV providers. These programs support CSOs to identify PWID, FSWs, and MSM, and, link them to facility services, including HTS and OPCs. CSOs also collaborate with OPCs to provide support to PLHIV who have poor treatment adherence or are enrolled in MMT programs.

PEPFAR Vietnam supports training, mentoring and quality assurance to outreach workers and village/commune healthcare staff in the five scale-up provinces. To support the first 90 target, PEPFAR Vietnam 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-Start was adopted 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 to 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 Vietnam currently supports 125 community-based outreach, care and support service delivery points in five aggressive scale-up provinces offering HIV prevention, care and support services to KP and PLHIV—namely: Son La, Dien Bien, Thanh Hoa, Nghe An, and HCMC. In FY 2017, PEPFAR Vietnam 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 Vietnam's Vietnam 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 FY 2014-2015, PEPFAR Vietnam transitioned DSD facility-based care and support delivery services to the Government of Vietnam at four OPCs in two sustained provinces (Da Nang [two OPCs] and Binh Thuan [two OPCs] and eight home-based community care sites in one scale-up and seven sustained provinces (Nghe An, Nam Dinh, Hanoi, Hoa Binh, Binh Duong, Vinh Long, An Giang, Long An). Currently, PEPFAR Vietnam provides support for human resources and operational costs at 117 OPCs (50 percent in five scale-up provinces). At the end of FY 2016, PEPFAR Vietnam transitioned DSD support at an additional OPC in Quang Nam province and shift DSD to TA support at nine OPCs in seven sustained provinces (Ba Ria-Vung Tau [two OPCs], Bac Ninh [one OPC], Binh Duong [one OPC], Can Tho [two OPCs], Long An [one OPC], Quang Nam [one OPC] and Vinh Long [one OPC]).

Care and support related issues identified from SIMS visits at facility sites in FY 2016 highlighted needs for development of SOPs for partner HIV testing and counseling, HIV testing of children of adult patients, STI screening and management, nutrition monitoring, systems for family planning/HIV integration, family planning/HIV integration service delivery. To address these gaps, PEPFAR Vietnam 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 HTS-OPC linkage in Son La and Nghe An, and one sustained province (Nam Dinh) in FY 2015-2016. In FY 2017, PEPFAR Vietnam will provide TA to PACs in additional provinces to improve SOP use for HTS-OPC linkage and intensive site TA to support the achievement of the 2nd 90 target in scale-up provinces.

4.7 TB/HIV

According to the 2016 World Health Organization (WHO) Global TB Report, Vietnam was ranked 14th and 11th among the 30 countries with high burden of TB and MDR-TB, respectively. The WHO estimated the incidence of TB in Vietnam in 2015 to be 137 per 100,000 population, of which PLHIV account for 5.9 per 100,000 population. In 2016, the National TB Program reported 105,839 TB cases (provisional data) resulting in TB notification rate of 111 per 100,000 population. A reported 83,467 (79 percent) TB patients knew their HIV status; among them, 2,936 were HIV-positive (3.5 percent), of whom 2,419 (82 percent) started ART.

Current national guidelines recommend immediate ART for TB/HIV patients regardless of CD4 count; TB screening; diagnostic testing for people living with HIV (PLHIV) with presumptive TB; and TB preventive therapy (TPT) for PLHIV without active TB disease. The use of the MTB/RIF assay (Xpert) has recently been scaled up nationally. However, it is not always the initial diagnostic test for PLHIV with presumptive TB as regulated by national guidelines.

Given declining external financial support and transition of DSD, the Government of Vietnam has had initial success in mobilizing domestic resources, mainly through the SHI mechanism, in order to maintain HIV care and treatment services for PLHIV. However, the consolidation of TB care and treatment services is not at the same pace as that of HIV care and treatment services. Though MOH has recently issued circulars #15 (15/2015/TT-BYT) and #04 (04/2016/TT-BYT) regulating care and treatment for HIV and TB patients through the SHI mechanism, specific standard procedures for implementation of SHI reimbursement for TB services is not yet available. The MOH has established TB/HIV coordination boards in 56 provinces. However, TB/HIV services have only been fully integrated in eight districts (either in hospital or in district health centers) of five provinces by the end of 2016 with the intent to expand the TB/HIV integration at district level among the 30 GFATM-supported provinces in 2017. Challenges to TB/HIV integration include lack of co-location of HIV and TB treatment services at the district level, limited funding for implementation, on-going supervision and coaching. The evolution of HIV and TB services has underscored the need for on-going capacity building for HIV and TB service providers on integrated clinical care, program monitoring and supervision to ensure good quality of services during and after donors' transition of DSD.

In alignment with national TB and HIV strategies and the WHO's recommendations, PEPFAR Vietnam has consistently supported activities to reduce the burden of HIV among TB patients and of TB among PLHIV. PEPFAR Vietnam's 2016 APR results showed 96 percent (14,352/15,016) of TB patients with a known HIV status (annual target: 84 percent), among them three percent (537/14352) were HIV positive, as reported by 13 TB sites (two DSD and 11 TA.N). Ninety-two percent (495/537) of TB/HIV patients received ART during TB treatment (annual target: 84 percent), as reported by twelve TB sites (two DSD and ten TA). However, TB preventive therapy (TPT) uptake among newly registered HIV patients was reported low at 65 percent (4,740/7,281) at PEPFAR Vietnam-supported ART sites. Regular reporting and recording of TPT program results from ART sites is limited. Although national guidelines specify reporting the number of newly registered ART patients that

initiate TPT, there is no current national program indicator for TPT outcomes. Furthermore, most sites, including some PEPFAR Vietnam-supported sites, do not regularly report TPT M&E indicators as recommended. At the provincial and national level, TPT indicators are rarely available and most sites report TPT HIVQual indicators only. FY 2016 PEPFAR SIMS 2.0 results identified key TB/HIV program areas for improvement: TB/HIV referrals, the TB diagnostic evaluation cascade, TB infection control, data quality, and laboratory quality management system.

In FY 2018, PEPFAR Vietnam's implementing partners will receive funds for TB/HIV core activities at national, provincial, and site levels that are in line with national and PEPFAR priorities, including: 1) routine TB screening, scaling up TPT implementation and monitoring outcomes, improved detection and management of TB and MDR-TB cases among PLHIV through increased access to Xpert MTB/RIF testing, and fast-tracking TB/HIV patients for ART initiation and TB treatment; 2) improved monitoring, evaluation, and reporting of TB/HIV collaborative activities, including sustainable TB/HIV integration; 3) improved TB infection control at HIV sites. In FY 2018, PEPFAR Vietnam will support MOH to develop standard operating procedures (SOPs) for implementation of SHI reimbursement for a TB service package for PLHIV, and, as recommended by WHO, HIV testing and counseling for TB presumptive cases. Additional areas of technical support include 1) training and coaching healthcare workers on management of TB-HIV care and treatment services in an integrated manner with the updated national HIV care and treatment guidelines; 2) ensuring availability and accessibility of INH supply to prevent TB among PLHIV; 3) on-going technical support for HIV testing and counseling for TB patients; 4) establishing in-country led Xpert MTB/RIF external quality assurance (EQA) and instrument connectivity. Activities will directly contribute to the achievement of 90-90-90 goals, primarily in PEPFAR Vietnam scale-up provinces and other provinces with a high burden of TB/HIV. Both DSD and TA activities are expected to reduce the burden of TB among PLHIV as well as the burden of HIV among TB patients, facilitate a patient-centered approach, and increase program efficiency.

In FY 2018, PEPFAR Vietnam will continue transitioning directly supported TB diagnostic services for PLHIV to a TA-only model, following the provincial transition timeline. The number of CDC partner-supported TB sites with DSD support will decrease from 18 in FY 2017 to seven in FY 2018, while USAID partners will maintain technical support at two TA sites. Depending on the provincial burden of TB/HIV, PEPFAR Vietnam's implementing partners, in collaboration and coordination with GFATM, will continue providing above-site level technical assistance to improve TB/HIV collaboration, linkage, and integration, and to ensure a high quality TB/HIV service package of TB intensive case finding and TB management; TPT for PLHIV, provider-initiated HIV testing and counseling for TB patients, and TB infection control in healthcare facilities.

4.8 Adult Treatment

In 2015, 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 serodiscordant partnerships, HIV/TB patients, pregnant women, and children aged < five years;
2) A special Test and Start policy that allowed seven 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 2016, 116,000 patients were receiving ART nationwide; PEPFAR Vietnam support accounted for 60.8 percent of these patients (55,449 receiving direct services in 115 OPCs and 15,087 receiving TA). In COP 17, PEPFAR Vietnam will support 42,589 patients in 78 DSD OPCs (including 75 adult and three pediatric OPCs) and 34,623 patients in TA sites.

Financial transitioning of OPCs from PEPFAR Vietnam DSD support to the Government of Vietnam began in 2014. By the end of FY 2015, DSD support of four OPCs in two provinces had been transitioned to Government of Vietnam financing. By the end of 2017, an additional 19 adult OPC sites will transition from DSD to TA. PEPFAR capped ARVs for new ART patients in all provinces except in the three mountainous provinces of Dien Bien, Nghe An, and Son La from April 2016, and will stop supporting core commodities (beyond ARV and test kits) in COP 17 for all PEPFAR-supported patients.

ART service quality has remained a high priority in COP 16 regardless of site transition status. In COP 17, SIMS, HIVQUAL, and e-mentoring will continue to be used for performance measurement and improvement. In two quarters of FY 2016, 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 the facility and the community was incomplete or missing; PEPFAR Vietnam plans to provide site-level TA to OPC staff to strengthen referral mechanisms.

Through its technical partnership with PEPFAR Vietnam, 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 Vietnam 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 the Government of Vietnam entities into the existing health system as a sustainable model for ongoing technical assistance.

In COP 17, technical priorities for improved quality of care include expanding treatment coverage, earlier initiation of ART, pilot MMS model, improved referral and tracking between VCTs—OPCs and among OPCs, retention in care, and viral suppression. PEPFAR Vietnam 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; 2) Retention; and 3) Viral load monitoring to achieve viral load suppression.

1. **Treatment Coverage and Earlier Initiation of ART**

In FY 2017, VAAC will expand treatment coverage nationally, including adhering to the new treatment guidelines on Test and Start and MMS policies for mountainous/remote provinces and other scale-up provinces. PEPFAR Vietnam will continue working with MOH to develop guidelines on Test and Start being applied nationwide. The approach will promote the role out of Triple rapid test confirmatory algorithms in district HIV facility in mountainous districts in replacement for confirmatory ELISA. In addition, PEPFAR Vietnam will continue to pivot resources for scaling up treatment in the five provinces through aggressive case finding

2. **Increased Patient Retention**

PEPFAR Vietnam will focus on supporting VAAC to increase patient retention. OPC staff will focus more on patients who demonstrate warning indications for loss to follow-up, poor adherence, or treatment failure. In addition, PEPFAR Vietnam continues to support increased retention for care and treatment through mHealth messages, telephone calls, peer support and in-person contacts will be used to improve retention. PLHIV networks will be encouraged to participate in tracking transferred patients who do not show up at receiving OPCs. PEPFAR Vietnam continues to advocate for changes in the political environment and education to reduce stigma and discrimination and educate hospital-based staff on HIV stigma and discrimination.

3. **VL Monitoring** to achieve viral suppression

In 2016 PEPFAR Vietnam 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. In COP 17, PEPFAR Vietnam will stop supporting VL testing for its patients and transfer responsibility to SHI. VL suppression rates will be added to HIVQUAL as a national quality improvement indicator and applied to HIV clinics.

Government policy delegates ARV dispensing to commune levels and permits 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 prescriptions, make the revision of policies and practices challenging.

PEPFAR Vietnam 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 FY 2017, PEPFAR Vietnam has advocated with MOH to address the barriers to less frequent drug dispensing and clinic visits, in addition to developing 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 also be considered for remote communes with high number of PLHIV.

In COP 17, PEPFAR Vietnam will continue supporting MOH to revise the ARV quantification and management protocol to extend supplies at sites that fit with the new pharmacy spacing requirements. 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 Vietnam will continue to advocate and provide TA to support the development and implementation of recommendations for human resources for health investments that will facilitate the uptake of new service delivery models and resulting staff roles and responsibilities. Maximizing use of 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.

4.9 Pediatric Treatment

By the end of 2016, nine of 23 pediatrics OPCs (POPCs) were transitioned from DSD to TA. Under a previous agreement with PEPFAR Vietnam, GFATM will continue to provide pediatric ARVs and early infant diagnosis (EID) supplies nationwide through 2018. PEPFAR Vietnam will also provide support for blood drawing at site-level, as well as sample transportation, patient counselling and follow up and ART services. PEPFAR Vietnam will continue to support core commodities training and onsite TA and monitoring. PEPFAR support for near- and non-core services including travel and infant formula was discontinued as of FY 2015.

For pediatric patients, the 2015 new National HIV/AIDS Treatment Guidelines indicated that:
1) All HIV positive children who are less than five years old, can immediately initiated on ART, regardless of their CD4.
2) Routine VL monitoring is also plan to take place as with adult patient.
These policy changes allow 93 percent of all pediatric patients at PEPFAR Vietnam-supported sites to be on ART.

In COP 17, SIMS and MER indicators will continue to be used for performance measurement. In FY 2016, site-level SIMS results showed that no clinics had drug stock-outs but the documentation of successful linkages and referral feedback between ANC and POPC have been identified as areas in

need of improvement. The focus of the program from 2017-onwards will be strengthened linkages. E-mentoring will continue to be used as a major method to provide TA support to site.

As the **transition** of the program cost to the government is ongoing, and in addition to the technical strategies for ART patients mentioned in adult treatment section above, pediatric assistance will focus on helping sites to consolidate, signing contracts with the SHI and helping patients to access SHI and get their healthcare costs reimbursed while remaining in care and treatment. TA will also focus on a) helping patients obtain SHI; b) supporting patients who, per SHI requirement, must transition smoothly to a new OPC while remaining on care and ART; monitoring patient transfer and tracking of retention on treatment; and c) capacity building at new OPC facilities, including SHI-mandated HIV training for healthcare staff to receive pediatric HIV patients as requirement of SHI.

At the national level, PEPFAR Vietnam will support the integration of Pediatric HIV care and treatment into the pediatric routine care and treatment system, including HIV TA. This will require the task to be officially assigned to the national and regional hospital by MOH. PEPFAR Vietnam will also support MOH to revise the ARV quantification and management protocol needed to make the transition of pediatric ARVs to the Government of Vietnam.

VL monitoring to achieve viral suppression is a new service in FY 2016. PEPFAR Vietnam will support monitoring of and TA for VL implementation at sites, identify implementation gaps and develop improvement strategies along the testing cascade. Strengthening adherence counseling to caregivers and adolescent, reinforcing age-appropriate disclosure to children to increase viral suppression among children

Adolescent health will be another area of focus in this year. After a decade of implementation of PMTCT, patients are now reaching an adolescence age at which they will need special health and psychologic care. Effort will be put in developing and implementing an adolescent healthcare package that include sexual education and psychological support; and developing procedures to help transition patient to adult OPCs

4.10 OVC-N/A

4.11 Addressing COP 17 Technical Considerations

PEPFAR Vietnam has consolidated efforts towards 90-90-90 in Vietnam by focusing on the most affected population groups and deploying the most impactful, evidence-based interventions. PEPFAR Vietnam has incorporated and applied relevant technical considerations into COP 17 strategy. These strategies and activities will further catalyze efforts to attain epidemic control in the scale-up provinces and to maintain the tremendous achievements of PEPFAR in other provinces. This document describes plans and progress to alleviate bottlenecks across the spectrum of care. This

section will briefly mention the application of the technical considerations in current COP planning (further detail is included in relevant sections of the SDS) according to the following three key areas relevant for Vietnam:

1. Implementing a strategic mix of HIV testing modalities to improve testing coverage (especially among young men and women), yield, and efficiency of HIV testing services;
2. Retaining clients on ART and care to achieve viral suppression, and;
3. Ensuring access to quality, sustainable HIV delivery systems.

Implementing a strategic mix of HIV testing modalities to improve testing coverage (especially among young men and women), yield, and efficiency of HIV testing services

In COP 17, PEFPAR Vietnam will continue efforts to improve testing coverage—especially among younger men and women. Based on the age and gender data analysis of HIV prevalence data from 2014-2016, HIV prevalence is high among young PWID (< 20 years) in Hanoi and Son La and among young MSM and FSW in five scale-up provinces and Hanoi. However, HTS program data show low uptake of HIV testing among young male and female KP (approximately six percent of total tests performed).

HIV testing demand generation activities will target KP and other priority population groups (e.g., sex partners of PWID and PLHIV, TB patients) between the ages of 20-40 through all channels (social media, interpersonal communication and mass media). PEPFAR Vietnam will tailor special messages to young KP between the ages of 15-19 years (MSM/TG, FSW, and PWID) on safe behaviors (condom use, safe injection) and use of HIV services (HIV lay-provider and self-testing, PrEP, STI) through social media, online apps (such as the Rainbow Facebook page), and MTV in addition to building capacity of CSOs in applying innovation communication technologies (to boost uptake of HIV-related services (testing, PrEP/PEP and ART).

Routine monitoring of HIV yield by geographic area and by testing modality continues to prompt decision making to continue/discontinue testing sites. PEPFAR Vietnam will discontinue active case finding in sites with low yield (< ten positive annually). For example in FY 2018/COP 17, PEPFAR Vietnam will transition out of eight DSD and TA facility-based low yield sites in Dien Bien and Nghe An, and four DSD sites in Thanh Hoa, to improve program efficiency. Moreover, PEPFAR Vietnam will interrogate testing strategies/methods calculating the cost per yield, an essential exercise to understand the cost associated with identifying a positive person as not all testing methods or technologies are sustainable or cost effective.

COP 17 will also include strategies to optimize case-finding. By deploying a more active partner services strategy in Vietnam, PEPFARs aim to conduct contact tracing and testing partners of PLHIV newly enrolled on treatment, for example, on MSM/TG and discordant couples in HCMC and Hanoi. PEPFAR Vietnam will implement partner notification and testing in all supported sites to enhance case finding. Furthermore, by use of rapid recency testing, PEPFAR Vietnam will focus on the

populations and geographical areas where new infections primarily occur to optimize available resources for case finding and halting HIV transmission. Technical assistance will be provided to MOH and provincial health departments to expand HIV testing to presumptive TB patients in high HIV/TB burden settings.

To increase access to confirmatory HIV testing and reduce the length of time from testing to receipt of confirmatory results, laboratory activities have focused on expanding access to quality HIV confirmatory testing services at the district level. In COP 16, PEPFAR provided technical assistance to 40 district HIV labs to be HIV confirmatory labs in five PEPFAR supported provinces. However many remote districts have not had confirmatory service, thus postponing treatment initiation. This year PEPFAR Vietnam will focus efforts on district-level hospital based laboratories to accelerate new HIV diagnosis, access to HIV treatment and SHI reimbursement for testing services. With the upcoming approval of Test and Start nationally, these efforts will be expanded to support provinces where data show the largest gap between the first and second 90s with TA to be coordinated among PEPFAR implementing agencies.

Retaining clients on antiretroviral treatment (ART) and care to achieve viral suppression

Initiating and retaining clients on ART and care are essential to achieving viral suppression. For COP 17, PEPFAR Vietnam has identified areas of opportunity and concern based on analysis of performance data. PEPFAR Vietnam's COP 17 strategy highlights opportunities to conduct a phased implementation of innovative strategies that are consistent with the COP 17 technical considerations and relevant to the Vietnam context.

Approaches to enroll PLHIV in care and treatment include a focus on previously diagnosed cases not on treatment. Nearly 100,000 cases are reported in the case management system nation-wide who have not yet enrolled in ART. PEPFAR Vietnam will continue to use case verification results to identify gaps and needs for linkage to ART and ART coverage and develop strategic plans for linking previously diagnosed to care and treatment. These efforts will be focused on provinces where data show the largest gap between the 1st and 2nd 90s, with TA to be coordinated among PEPFAR implementing agencies.

For FY 2016, treatment retention at twelve months after ART initiation for PEPFAR-supported patients was 88 percent overall, above 80 percent for three mountainous provinces (except for Thanh Hoa), 87-89 percent in HCMC (APR 16). VL suppression in HCMC among clients at PEPFAR-supported sites who received a VL test was above 90 percent (APR FY 2016). These data are evidence that outpatient clinics supported by PEPFAR Vietnam generally have high levels of retention for both old and new patients further supported by VL suppression greater than 90 percent of patients with VL test results. COP 17/FY 2018 differentiated care model and other service delivery interventions will include:

a) National roll out of Test and Start
b) Phased implementation of same-day ART

c) Introduction of HIV mother-infant pair management to reduce LTFU and re-engage patients LTFU in treatment
d) Innovative and effective models of integrated health services for common HIV-comorbidities, including NCD, mental health and substance abuse disorders, and the communicable diseases especially TB , including:
    1. Improved TB contact and symptom screening for PLHIV and high-risk groups including MMT patients;
    2. Implementation of new TB diagnostic technologies to improve detection of TB and MDR-TB among PLHIV; an
    3. TA to improve TB and HIV integration, referral and feedback, and utilization of existing patient management systems to increase referral and reporting; and,
e) Enhancing the access and use of VL testing.

While VL suppression rates are high among patients who received a VL test, VL testing coverage among PLHIV enrolled on treatment still has room for improvement. For all PEPFAR Vietnam-supported sites, routine VL coverage among PLHIV on ART increased from eleven percent at APR 16 to 34 percent in Q1 FY 2017. Notably in HCMC, program data showed that VL coverage increased from 32 percent at APR 16 to 60 percent in Q1 FY 2017. Universal access to viral load testing for all PLHIV receiving ART will require careful planning. To that end, PEPFAR Vietnam has worked closely with GFATM, the VAAC/MOH, and the Government of Vietnam to develop a COP 17 strategy which includes support for the on-going development of the national routine VL implementation plan laboratory component and encompasses the following key areas:

a) Policy and clinical algorithm for viral load monitoring;
b) Mapping network of viral load testing labs;
c) Quality Management Systems (QMS) for viral load testing labs;
d) The clinical interface for sharing results with clinics and use of VL test results;
e) Monitoring of VL suppression and quality improvement, including new HIVQUAL VL indicators at 172 OPCs nationwide and the development of a quality improvement plan at each OPC to increase VL coverage among ART patients and increase VL suppression overtime. (Mid-term results will be available in Jun 2017);
f) Providing TA support to OPCs to manage non-suppressed VL ART patients and provide adherence counseling to maximize VL suppression, and;
g) Focused TA to OPCs with low viral suppression (< 90 percent).

Ensuring access to quality, sustainable HIV delivery systems

SHI is critical for the sustainability of the Government of Vietnam's HIV response. PEPFAR Vietnam continues to provide TA for multiple aspects of the transitions to SHI, including supporting patients to obtain and use health insurance cards, supporting OPCs to consolidate into the treatment arm of MOH and utilize the patient management systems required for health insurance reimbursement, and

working with VSS to develop and implement packages of services for PLHIV, including those appropriate for differentiated models of care for HIV patients in different settings and circumstances.

However the transition to SHI has potential negative consequences due to: 1) the movement of stable patients out of facilities; 2) the decentralization of ART services even for stigmatized populations closer to their communities; and 3) out-of-pocket payments for services not reimbursable under SHI. As a result, PEPFAR Vietnam has proposed strategies in COP 17 to mitigate these risks and accelerate the phased implementation of differentiated models of care and other service delivery innovations in order to bolster treatment adherence and retention in care. Key COP 17 interventions will include:

a) Tracking patients transferring to other OPCs to assure patients are retained on ART (Evidence from the retrospective tracking of 840 patients transferred from one facility in HCMC in Q1 FY 2017 showed that the program was able to successfully track referral to other OPCs at 86 percent within the first three months after referral);
b) Implementation of alternative service delivery models – supported by the revised Circular 32 – to ensure effective and efficient practices are adopted including for stable patients: reduced clinical visits and multi-month ARV provision for stable clients, including among key population groups (MSM, FSW and PWID regularly enrolled in MMT);
c) Task shifting from district-level to commune dispensing level to improve client services and reduce the cost of delivery;
d) Enhancing community-based case management activities, involving PLHIV networks and commune healthcare worker to support treatment adherence;
e) Interventions to reduce stigma and discrimination among healthcare workers to encourage patients retained in care at new facilities and by new staff; and
f) Integrated site support and community liaisons into the clinics to increase community engagement and enhance these activities listed above.

As the number of people on treatment increases, data tracking will become more critical and service delivery models will need to support sustainable expansion, utilizing commune health stations staff, prioritization and task-shifting to commune level, and stable patient delivery systems.

4.12 Commodities

In line with the COP 16 approved plan, PEPFAR Vietnam will reduce its ARV contribution for COP 17 to U.S $7,554,319 based on a 40 percent reduction in overall PEPFAR commodity support in Vietnam. This translates to support for 38,065 patients based on an average of U.S $198.40 per patient-year for first and second line ARV regimens. As a result, nearly 13,000 patients supported by PEPFAR Vietnam will be transferred to the Government of Vietnam; either to be supported by the State Budget or SHI. In COP 17, PEPFAR Vietnam will support MOH/VAAC in ARV planning, procurement, and supply chain management from domestic (State Budget and SHI) and donor (PEPFAR and GFATM) resources

to ensure uninterrupted ARV treatment for all patients nationwide. COP 17 will be the final year of PEPFAR ARV commodity support to Vietnam.

Under the assumption that SHI will begin covering VL and CD4 testing in COP 16, PEPFAR Vietnam will not provide additional funds for VL and CD4 tests in COP 17. VSS and VAAC have been analyzing the cost of testing and the financial burden on patients as critical factors to accessing VL testing for insured patients. A plan will be developed for uninsured patients to continue to access CD4 and VL testing.

COP 17 PEPFAR funds ($183,200) will cover 47 percent (85,968/183,258) of rapid HIV test kits (RTKs) for the KP HTS DSD target. Ninety-seven percent (178,549/183,258) of the total RTK DSD target focuses on the five scale-up provinces and Hanoi for aggressive scale-up to meet 90-90-90 goals. PEPFAR Vietnam will work closely with GFATM and central and local government to address these RTK gaps, including advocacy for SHI coverage of tests, and mobilizing central and provincial budgets to cover RTK and testing costs. PEPFAR Vietnam will support the Government of Vietnam in developing a risk mitigation plan in the case that the Government of Vietnam and GFATM cannot meet its testing commitments to all PEPFAR Vietnam-supported provinces.

4.13 Collaboration, Integration, and Monitoring

PEPFAR Vietnam's COP 17 strategy supports the robust scale-up in DSD targets in the aggressive scale-up provinces. Just as importantly, COP 17 maintains a critical focus on assuring the successful transition of all direct-service delivery efforts to the Government of Vietnam by the end of CY 2018. COP 17 supports strategic activities at the national, provincial and site-levels to effectively transition programmatic and financial leadership to the Government of Vietnam. PEPFAR Vietnam will engage in ongoing assessment of progress in transition and perceived risks to transition and program success, and draws on existing monitoring systems and metrics to measure transition progress and effects.

As described in the Blueprint for Transition, a process of on-going risk analysis will be implemented in coordination with the Government of Vietnam, GFATM, CSOs, and other relevant stakeholders. The risk analysis will support proactive identification of challenges in and resulting from transition, in addition to informing PEPFAR Vietnam's TA efforts and priorities. Furthermore, it will support identification of exigent challenges as well as ongoing analysis of persistent systemic barriers and threats to sustainability in achieving epidemic control. The intent of establishing this risk review and mitigation process is to bring together principal stakeholders to review and identify the greatest impediments to successes, and to jointly identify proactive strategies to address them. This process is intended to guide how PEPFAR Vietnam will prioritize its responsive TA in support of the Government of Vietnam's HIV response.

Risk identification must account for both short-term and long-term risks. Ongoing risk identification through quarterly mechanism reporting, and ongoing engagement with stakeholders (i.e. the

Government of Vietnam, GFATM, PLHIV, and CSOs) will assist the team to identify and respond to short term risks. Longer term risks will be identified through strategic planning meetings, portfolio reviews, information sharing sessions, and project reporting.

The PEPFAR Vietnam M&E strategy, which includes PEPFAR MER indicators, national program indicators, and custom-made data tools and indicators, is one of the most important methods to identify, assess, respond to and control threats to sustainable epidemic control. PEPFAR Vietnam will ensure robust monitoring of key metrics of transition success and of metrics of program continuity and quality, in order to guide responsive technical assistance to minimize patient loss and ensure continued program quality. Through ongoing strategic information technical working group sessions complemented by transparent data sharing and analysis, PEPFAR Vietnam is well placed to support the Government of Vietnam to identify threats to sustainable financing, SHI, achievement of 90-90-90 targets, and program continuity and quality.

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

5.1 Package of Services and Expected Volume 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 MOH, or cease receiving donor support. The following definitions are based on the PEPFAR guidance and definitions outlined in COP 16:

- **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 has concluded, but HTS remains available through PITC models, including PMTCT and TB/HIV, or co-located voluntary counseling and testing sites if HTS volume and positivity yield remain at or above HTS-PEPFAR thresholds.
- **Sustaining commodities:** continued national support for overarching QA/QI, and/or commodity support to sites without site level support. PEPFAR Vietnam will continue to provide ARV for patients until SHI or other resources assume ARV costs. In no case will PEPFAR ARV support extend beyond 2018. The ARV maintenance (sustained) model was initiated on 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 six months and will be negotiated to ensure no interruption of services.

In sustained provinces, PEPFAR outreach support concluded in January 2016. HTS sites that did not meet the HTS-PEPFAR thresholds (defined in section 4.1) were transitioned to MOH. All DSD and TA

PMTCT sites will be transitioned through COP 17. All DSD methadone sites will be transitioned, with 60 methadone sites receiving technical assistance in COP 17.

PEPFAR Vietnam redefined its service delivery and TA packages for sustained sites and provinces through COP 16 planning. In COP 17, 18 of 43 ART OPCs in sustained provinces will transition to TA only sites with no ROCs to PEPFAR outside of ARV drugs. At these 18 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 25 DSD ART OPCs includes ARVs, 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 ten percent from last year, with a three percent attrition rate.

PEPFAR Vietnam will continue to monitor performance in sustained provinces through a variety of measures to identify and mitigate short term and long term risks to service continuity. Quarterly mechanism reporting, ongoing engagement with stakeholders (Government of Vietnam, GFATM, PLHIV, CSOs), and the use of innovations such as the individual patient tracking tool will assist the team to identify and respond to short term risks. HIVQUAL is being institutionalized 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. Longer term risks will be identified through strategic planning meetings, portfolio reviews, information sharing sessions, and project reporting.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Aggressively Scale-Up Support Districts

Sustained Support Volume by Group	**Expected result APR17**	**Expected result APR18**	**Percent increase (decrease)**
HIV testing in PMTCT sites	***33,467***	**0**	**-100%**
HTS (only maintenance ART sites in FY 17)	***166,160***	**170,105**	**2%**
Current on ART	**38,704**	**41,961**	**8%**

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group	**Expected result APR17**	**Expected result APR18**	**Percent increase (decrease)**
HIV testing in PMTCT sites	***25,320***	**0**	**-100%**
HTS (only maintenance ART sites in FY 17)	***83,192***	**79,297**	**-5%**
Current on ART	**34,303**	**35,380**	**3%**

5.2 Transition Plans for Redirecting PEPFAR Support

Central to PEPFAR Vietnam's strategy is the successful transition of all direct-service delivery programmatic and financial leadership to the Government of Vietnam by the end of CY 2018. COP 17 represents the final year of PEPFAR DSD support. Transition out of DSD support does not indicate that PEPFAR is leaving Vietnam. In fact, transition signals that the PEPFAR-Government of Vietnam partnership has matured from the emergency scale-up phase to a partnership in which PEPFAR continues as a reliable TA partner. The importance that PEPFAR places on responsible transition from PEPFAR support is not new. During CY 2016, PEPFAR Vietnam fully transitioned seven provinces from DSD support, comprising 13 OPCs, nine VCTs and 6,039 patients. An additional 11 provinces, 24 OPC sites and 23,157 patients will be transitioned by the end of CY 2017. The specific agreement on commodity support and timeline for transition is captured in the chart below:

Transition of PEPFAR Commodities Support to Domestic Financing

Commodities	#	COP 16	#	COP 17	#	COP 18
ARVs	51,000	$11,408,275	35,403	$7,554,319		$0
Methadone	7,500	$800,000		$0		$0
CD4 baseline	7,780	$0		$0		$0
Viral Load	54,285	$1,194,270		$0		$0
OI drugs		$0		$0		$0
HIV test kits	144,445	$260,000	101,766	$183,200		$0
Total		**$13,662,545**		**$7,737,519**		**$0**

Transitioning of financial and programmatic responsibility for DSD at OPC sites providing adult and pediatric treatment began in 2014; by the end of 2016, PEPFAR Vietnam will transition 21 OPC sites

from DSD to TA. As PEPFAR Vietnam reduces DSD support through the 2018 DSD to TA transition (and post transition), provincial project management unit staff, in selected provinces, may still receive support through COP 17 for PEPFAR-required post-transition data collection and reporting. PEPFAR Vietnam will support the MOH, provincial authorities, and CSOs to assume financial, technical, and programmatic ownership through expert TA/TC in the following areas:

- Treatment coverage and earlier ART initiation;
- Retention; and,
- Viral load monitoring.

GVN and PEPFAR have identified social health insurance as the mechanism for assuming treatment related costs and covering the treatment gap as PEPFAR reduces and eliminates ARV commodity support. Beginning in CY 2016, to track progress in transition to social health insurance, GVN and PEPFAR commenced monitoring OPC consolidation, SHI coverage, and HIV services reimbursement on at least a quarterly basis. Based on the collected data, implementing partners provide responsive TA to sites and provinces where delays and challenges are noted. Quarterly site visits monitor emerging issues and provide on-the-ground experiences to inform broader coordination and TA strategies.

In COP 16, PEPFAR Vietnam reduced both the number of MMT sites supported and the nature of support. Of 91 PEPFAR-supported MMT sites in COP 16, just four were DSD sites, 56 TA sites, and 31 sites provided commodities only. PEPFAR Vietnam fully transitioned all human resource and non-commodity site-operating costs in 2015; these costs are now covered by the Government of Vietnam with a modest patient co-pay at some sites. PEPFAR Vietnam has worked with MOH to advocate for increasing domestic funding for MMT commodities. By the end of CY 2016, all MMT sites in Hanoi and HCMC will use methadone procured by local government budgets. PEPFAR Vietnam will transition medication support for all provinces to local financial resources by the end of CY 2017. PEPFAR Vietnam will continue to monitor MMT programs to ensure the sustained quality of services and to provide responsive TA during transition and beyond.

PEPFAR Vietnam HTS DSD transition began in 2014 through a consensus roadmap with Government of Vietnam on an annual basis a) gradual reduction of financial support for DSD sites and b) full transition out of DSD for select sites in sustained provinces. In FY 2017, PEPFAR Vietnam continued to transition out of DSD in sustained provinces and will complete transition out of DSD at all sites in both sustained and scale-up provinces by December 2018. PEPFAR Vietnam provides TA-only from January 2019 onwards.

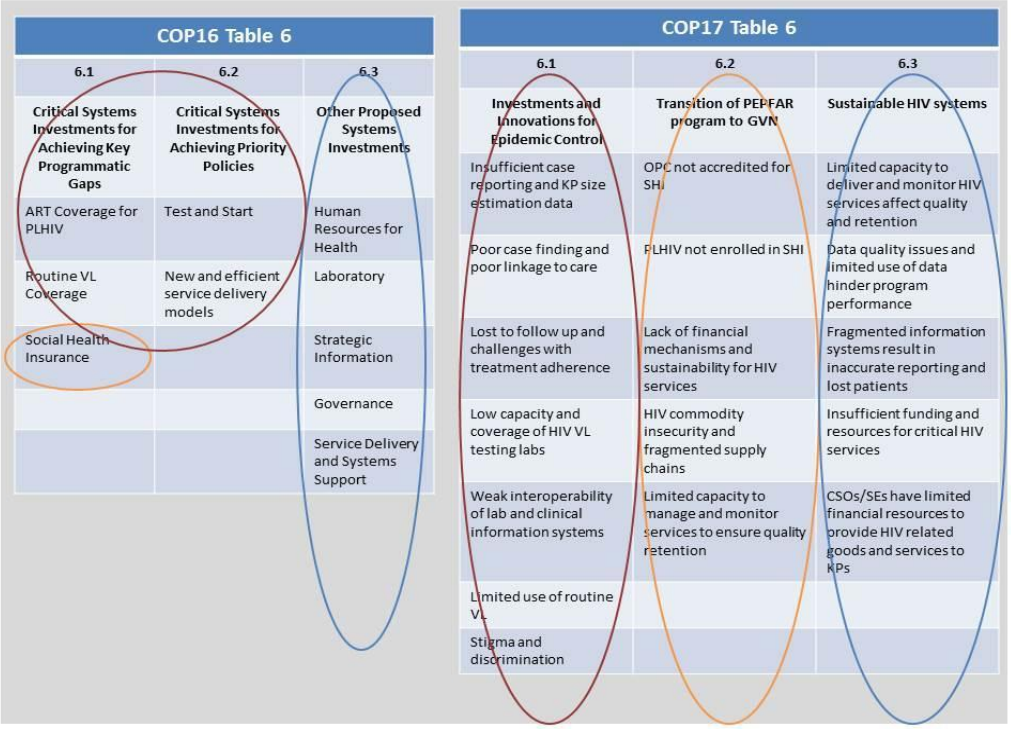
Throughout the three transition phases, PEPFAR Vietnam will engage in ongoing assessment of progress in transition and perceived risks to transition and program success. The on-going risk analysis will be implemented in coordination with the GVN, GFATM, CSOs, and other relevant stakeholders. The risk analysis will support proactive identification of challenges in and resulting from

transition, and will inform PEPFAR's TA efforts and priorities. In addition, it will support identification of exigent challenges as well as ongoing analysis of persistent systems barriers and threats to sustainability and achieving epidemic control. The intent with establishing dynamic risk matrix is to bring together the principal stakeholders with the best, varied information available to review and identify the greatest likely or potential impediments to success and to jointly identify strategies to address these proactively. The matrix should be seen as a dynamic document, always evolving with new information and challenges. The discussions arising from the matrix are intended to guide how PEPFAR prioritizes its responsive TA in support of the Vietnam national HIV response.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

In COP 16, PEPFAR Vietnam completed the Systems and Budget Optimization Review (SBOR) to ensure that systems investments are strategically aligned to key programmatic gaps and barriers in the clinical cascade and policy environment. In COP 2017, PEPFAR Vietnam further refined the investments and outcomes defined in COP 2016 in light of the PEPFAR Vietnam Transition Strategy and discussions with stakeholders. The transition strategy was developed in December 2016 to articulate a detailed blueprint for transition and it includes a timeline that delineates three phases of transition: Phase One: Intense Transition Phase (2016-2018); Phase Two: Consolidated/Post Transition Monitoring Phase (2019-2020); and Phase Three: Sustained Technical Assistance (2020+). Activities have been prioritized to address critical gaps in HIV systems and maximize the efficiency and effectiveness of the Government of Vietnam and U.S.Government responses during these phases of transition. In addition, extensive stakeholder consultations and strategic meetings during the transition strategy and COP 17 development process have informed the priorities for program support. The resulting minimum package of critical activities are optimally budgeted and aligned to the following sections:

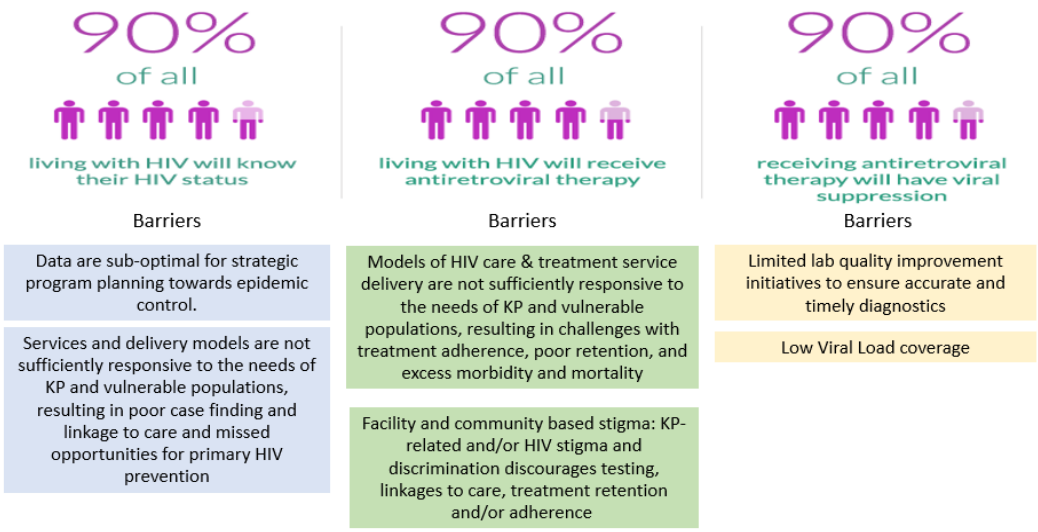
- Section 6.1: Investments and Innovations for Epidemic Control
- Section 6.2: Transition of PEPFAR Vietnam Program to Government of Vietnam
- Section 6.3: Sustainable HIV Systems



6.1 Critical System Investments and Innovations for Epidemic Control

In COP 17, Table 6.1 focuses on innovations and investments that are essential to epidemic control in provinces where PEPFAR Vietnam remains an active partner.

Table 6.1 Investment and Innovations for Epidemic Control



6.1.1: Data are sub-optimal for strategic program planning towards epidemic control: The national HIV program stills lacks reliable and accurate KP size estimates, with weak linkages in the cascade between HIV case reporting and clinical monitoring. COP 17 activities will continue to improve the quality and

rigor of surveillance data, including HSS/HSS+ and HCRS systems; and, size estimations in high burden provinces for PWID, MSM and FSW. PEPFAR Vietnam will also work to integrate CSOs into national program reporting. Additionally, PEPFAR Vietnam will introduce the use of HIV Rapid Recency test in surveillance activities to enhance understanding and response to transmission patterns.

6.1.2: Services and delivery models are not sufficiently responsive to the needs of KP and vulnerable populations, resulting in poor case finding and linkage to care, with missed opportunities for primary HIV prevention. Examples of these include compulsory detoxification of PWID in 06 detention centers hinders the ability to expand coverage since PWID avoid testing and treatment out of fear of detention. Another barrier is that, while the Government of Vietnam perspective on civil society has shifted to allow for increased CSO engagement, support, and capacity are still limited. Lastly, confirmatory testing remains centralized delaying initiation of ART.

The PEPFAR Vietnam response includes KP-friendly activities and services such as decentralizing MMT dispensing, updating MAT therapies and making PrEP/PEP available to those who are willing to pay. PEPFAR Vietnam will make partner testing services available and an active part of contact tracing in order to find and identify hard-to-reach KP groups. PEPFAR will continue to advocate for CSO engagement in government monitoring and reporting systems, including case management. We will also implement Rapid Recency testing among all new diagnoses in order to identify and target clusters of recent HIV infection for partner services and HIV testing. Promoting access to HIV testing activities includes significant increases in accredited HIV labs for decentralized confirmatory testing, updating the National HTS guidelines/HTS service package, introducing prevention provincial coaching teams to address programmatic and resource gaps not covered by SHI, such as expanding, and ensuring access to cost effective self and lay testing.

6.1.3: Models of HIV care and treatment service delivery are not sufficiently responsive to the needs of KP and vulnerable populations, resulting in challenges with treatment adherence, poor retention, and excess morbidity and mortality: A priority 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, as well as fast-track registration for the newly diagnosed, same-day ART initiation and assuring ARV supply.

COP 17 activities to support Test and Start include the development of policies and guidelines to improve linkages between HTS 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 activities support Test and Start by operationalizing the financing mechanism for ARV procurement with SHI funds.

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 SHI 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. The Government of Vietnam'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 remains a high priority for the uninterrupted supply of HIV/AIDS commodities.

Continuing on the policy gains from COP 16 PEPFAR Vietnam will implement pilots of MMS in COP 17 with an eye towards a future national roll out. PEPFAR Vietnam will continue to seek innovative models such as case management and patient tracking, to address recurring retention challenges. Finally, PEPFAR Vietnam will continue working closely with the Government of Vietnam to build sufficient capacity for ARV Procurement, and supply chain management.

6.1.4: Limited lab quality improvement initiatives to ensure accurate and timely diagnostics. Barriers to Vietnam's implementation of high-quality, cost-effective viral load testing include: the limited number of labs that can perform HIV VL testing and weak interoperability of lab and clinic information systems to ensure timely diagnosis. In COP 17, PEPFAR Vietnam will support the Government of Vietnam to expand and decentralize VL testing by scaling up hospital- and provincial-based testing and enabling SHI reimbursement. Additionally, PEPFAR Vietnam will introduce DBS samples as a way to increase efficiency and reduce costs.

6.1.5: Low Viral Load coverage: Universal access to viral load testing for all PLHIV receiving ART will require careful planning. PEPFAR Vietnam will continue to work closely with the GFATM, and the VAAC/MOH in the on-going development of the national routine VL implementation plan. COP 17 activities include: 1) policy and clinical algorithms for viral load monitoring; 2) mapping network of viral load laboratories; 3) implementing a QMS for viral load testing labs; 4) increasing demand for viral load testing among healthcare providers; 5) supporting OPCs to manage non suppressed VL ART patients; and 6) promoting advance adherence counseling to maximize VL suppression. PEPFAR Vietnam will also continue to monitor program data routinely and continue quality improvement activities, including newly added VL indicators at 172 OPCs nationwide.

6.1.6: Facility and community based stigma: HIV stigma and discrimination discourages testing, linkages to care, treatment retention and adherence among MSM, FSW, PWID and their partners COP 17 proposed activities feature the implementation of an international Stigma and Discrimination training toolkit adapted for use in the community and healthcare settings. In addition, TA will be provided to KP groups and CSOs, who have a comparative advantage in reaching hard to reach populations. These efforts will be complemented by the development of KP outreach communication

strategies to promote safe behaviors, uptake of HTS, substance abuse treatment, and HIV care and treatment at the national level.

6.2 Transition of PEPFAR Program to the Government of Vietnam

Lessons learned during COP 16 implementation have informed the refinement of Table 6.2 for COP 17, and reaffirmed the focus on the primary barriers:

6.2.1: OPCs are not accredited for HIV
6.2.2: PLHIV are not enrolled in SHI
6.2.3: Lack of financial mechanism and sustainability for HIV services
6.2.4: HIV commodities insecurity and fragmented supply chains
6.2.5: Limited capacity to manage and monitor services to ensure quality and retention

COP 17 activities to support HIV OPC accreditation will provide technical assistance to the MOH/VAAC, VSS, provinces and sites to meet treatment consolidation requirements for SHI, including advocacy with key provincial stakeholders, national policy guidance, and the reporting and tracking of consolidation milestones.

One critical benchmark for COP 17 is to ensure that 60 percent of registered HIV patients are enrolled in SHI. However, many newly identified PLHIV are reluctant to enroll because of perceptions of stigma, discrimination, privacy, and service quality. In COP 16, peer outreach workers and CSOs played a critical role for PEPFAR case-finding and contributed to the successful linking of KP to HTS and treatment. In COP 17, case finding efforts will continue. In addition, placement of social workers at sites will focus on increasing SHI enrollments and initiating ARV reimbursements. PEPFAR Vietnam TA will target SHI implementation, including policy guidance, funding mechanisms for subsidizing premiums and co-payments, tracking and reporting PLHIV coverage and movement, and improving coordination among stakeholders.

PEPFAR Vietnam will continue to monitor HIV domestic financing and progress towards country ownership of the program. For example, PEPFAR will support VSS in its ability to forecast SHI expenditures and revenues. At sub-national levels, PEPFAR Vietnam will establish support in those transition provinces with the highest number of ART patients to implement a co-payment arrangement to achieve 100% coverage and reimbursement for ART. By the end of COP 17, PEPFAR Vietnam has targeted 30 percent of PLHIV to receive ARVs procured by a centralized mechanism funded through SHI. Technical support for procurement and supply chain management remains a high priority for the uninterrupted supply of HIV/AIDS commodities. PEPFAR Vietnam partners will support policy advocacy, capacity building, and TA for the Government of Vietnam to undertake this centralized procurement. At the local level, COP 17 provides technical support to hospitals and OPCs to help them forecast ARV needs in the context of the PEPFAR commodity transition.

In addition to the technical support for SHI expansion, as the primary domestic financing source for treatment, PEPFAR will address the uncertainty of domestic resources to sustain HIV prevention services that are currently not covered by SHI, such as outreach activities implemented by CSOs. In COP17, PEPFAR Vietnam will support the Central Government agencies to develop a Prevention Benefits package (with inclusion of appropriate HIV prevention services) in the Basic Health Service Package paid by Health Insurance. In parallel, PEPFAR Vietnam will support the necessary and related advocacy and policy activities at national and provincial levels including: the inclusion of reimbursement for preventive services in the upcoming revision of the SHI law; dialogue with central and local governments to emphasize the efficiency and importance of HIV prevention outreach by CSOs; and a review of existing provincial government financial procedures and availability of funds to enable direct funding to CSOs for HIV prevention and outreach activities.

By the end of COP 17, PEPFAR Vietnam plans to achieve the following three targets to ensure service quality and treatment retention during the transition: 80 percent of onsite TA to be conducted by provincial staff, accreditation of seven HIV labs, and greater than 90 percent of HIV-tested PLHIV retained in treatment. While the timeline for these transition goals is fast approaching, the reality is that the capacity of key Vietnamese health systems to manage and monitor HIV services remains limited. In response, PEPFAR Vietnam has programmed reinforcement activities for specific health systems. To ensure quality and sufficient data for decision making, the integration of HIV data into hospital reporting systems will be prioritized. Responsive TA to strengthen the capacity of OPC staff to provide quality services will be provided through scheduled onsite case discussions, e-mentoring, and the launching of sustainable provincial care and treatment coaching teams. To address limited laboratory capacity, training and mentoring activities will be delivered onsite to permit autonomous management of the EQA and IQC aspects of HIV serology.

6.3 Sustainable HIV Systems

For PEPFAR Vietnam, sustainability of the HIV response means that Vietnam has the enabling environment, services, systems, and resources required to effectively and efficiently control the HIV and AIDS epidemic. Table 6.3 builds on the critical systems investments for epidemic control in Table 6.1 and immediate priorities for transition in Table 6.2, by further addressing the system barriers and related activities to achieve a sustainable quality HIV/AIDS program, including:

6.3.1: Limited capacity to deliver and monitor HIV services affect quality and retention
6.3.2: Data quality issues and limited use of data hinder program performance
6.3.3: Fragmented information systems result in inaccurate reporting and lost patients
6.3.4: Insufficient funding and resources for critical HIV services
6.3.5: Civil society organizations and social enterprises have limited financial resources to provide HIV-related goods and services to KPs

COP 17 activities required for a sustainable quality program addressing these barriers include: developing and implementing quality improvement programs at health facilities; integrating stigma and discrimination monitoring into provincial site-assessments; mentoring and training for provincial

coaching teams; integrating HIV information into the routine hospital health information system; ensuring community-based evidence-based treatment for substance use services meet MOH quality standards; optimizing training and data systems at military health facilities for meeting national HIV program goals and targets; advocating for an enabling environment to support fee-based HIV services for CSOs and social enterprises; and increasing domestic resource mobilization from private and public resources, including for harm reduction and prevention activities.

7.0 Staffing Plan

Given the context of a transitioning program, PEPFAR Vietnam continues to assess its staffing footprint to ensure a staffing profile covering the necessary business and programmatic functions to achieve the program's objectives. A robust technical partnership between PEPFAR and the Government of Vietnam that is advanced by the U.S. Government team is critical to the process of transition, as well as to translating promising innovations into policy and practice for accelerated impact. The PEPFAR Vietnam team continues to dedicate considerable effort to ensuring that the PEPFAR 3.0 priorities of transparency, oversight, and accountability are attained by conducting required SIMS visits, analyzing programmatic performance, and efficiencies, and engaging with external stakeholders on a regular basis. PEPFAR Vietnam has replaced many direct hire or contract positions with locally-employed staff (LES) when applicable, and monitors salary savings for these vacancies. The team continues to increase LES leadership in interagency and government technical working groups, and in key strategic planning discussions of program activities.

When positions become vacant, consideration is given to both the need for the position, and the alignment of duties with core activities. This year, PEPFAR Vietnam will continue to reduce its staffing with appropriate attrition. The PEPFAR footprint will be reduced by a total of 1.5 Direct Hire Americans (DHA) *[REDACTED]*. Approximately 20 positions (three DHA, 17 LES) continue to be 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. This year, the PEPFAR Vietnam Management and Operations (M&O) decreased by approximately three percent from COP 16 representing 24 percent of total funding.

The number of existing, unfilled positions has remained low, and PEPFAR currently only has three vacancies that are being recruited. Rehiring is justified on the basis of current or expected program priorities. Consideration is given to positions that are able to meet the staffing needs of more than one PEPFAR Vietnam agency are also considered. This results in a smaller, better-aligned staffing pattern.

APPENDIX A

SNU Prioritization

Table A.1

SNU	COP 15-16 prioritization	APR 16 Achievement	Expected Achievement by APR 17	COP 17 Prioritization	COP 17 Target (by APR 18)
Dien Bien	ScaleUp Agg	53%	57%	ScaleUp Agg	63%
Ho Chi Minh City (HCMC)	ScaleUp Agg	60%	65%	ScaleUp Agg	69%
Nghe An	ScaleUp Agg	55%	63%	ScaleUp Agg	71%
Son La	ScaleUp Agg	44%	54%	ScaleUp Agg	57%
Thanh Hoa	ScaleUp Agg	44%	53%	ScaleUp Agg	61%
Ha Noi	Sustained	39%	42%	Sustained	47%
An Giang	Sustained	59%	62%	Sustained	66%
Ba Ria-Vung Tau	Sustained	54%	54%	Sustained	63%
Bac Giang	Sustained	43%	46%	Sustained	49%
Bac Ninh	Sustained	28%	34%	Sustained	40%
Binh Duong	Sustained	60%	69%	Sustained	77%
Can Tho	Sustained	51%	58%	Sustained	61%
Cao Bang	Sustained	36%	39%	Sustained	42%
Hai Phong	Sustained	55%	55%	Sustained	56%
Hoa Binh	Sustained	68%	68%	Sustained	68%
Kien Giang	Sustained	34%	36%	Sustained	38%
Lao Cai	Sustained	37%	40%	Sustained	42%
Long An	Sustained	54%	59%	Sustained	65%
Nam Dinh	Sustained	35%	36%	Sustained	38%
Quang Nam	Sustained	51%	57%	Sustained	66%
Quang Ninh	Sustained	62%	63%	Sustained	65%
Soc Trang	Sustained	31%	31%	Sustained	36%
Tay Ninh	Sustained	46%	52%	Sustained	59%
Thai Binh	Sustained	36%	40%	Sustained	43%

Thai Nguyen	Sustained	50%	50%	Sustained	51%
Vinh Long	Sustained	43%	46%	Sustained	53%
Binh Thuan	Centrally Supported	82%	87%	Centrally Supported	94%
Da Nang	Centrally Supported	37%	44%	Centrally Supported	51%
Bac Kan	Not Supported	43%	46%	Not Supported	52%
Bac Lieu	Not Supported	47%	55%	Not Supported	59%
Ben Tre	Not Supported	52%	58%	Not Supported	63%
Binh Dinh	Not Supported	33%	35%	Not Supported	37%
Binh Phuoc	Not Supported	27%	29%	Not Supported	32%
Ca Mau	Not Supported	27%	27%	Not Supported	31%
Dak Lak	Not Supported	23%	27%	Not Supported	29%
Dak Nong	Not Supported	20%	24%	Not Supported	31%
Dong Nai	Not Supported	38%	43%	Not Supported	46%
Dong Thap	Not Supported	25%	27%	Not Supported	31%
Gia Lai	Not Supported	24%	29%	Not Supported	35%
Ha Giang	Not Supported	43%	46%	Not Supported	50%
Ha Nam	Not Supported	45%	48%	Not Supported	52%
Ha Tinh	Not Supported	40%	44%	Not Supported	52%
Hai Duong	Not Supported	47%	52%	Not Supported	58%
Hau Giang	Not Supported	39%	44%	Not Supported	57%
Hung Yen	Not Supported	38%	41%	Not Supported	46%
Khanh Hoa	Not Supported	27%	29%	Not Supported	33%
Kon Tum	Not Supported	25%	27%	Not Supported	27%
Lai Chau	Not Supported	34%	37%	Not Supported	41%
Lam Dong	Not Supported	44%	48%	Not Supported	53%
Lang Son	Not Supported	53%	63%	Not Supported	67%
Ninh Binh	Not Supported	43%	49%	Not Supported	56%

Ninh Thuan	Not Supported	50%	54%	Not Supported	57%
Phu Tho	Not Supported	42%	47%	Not Supported	54%
Phu Yen	Not Supported	39%	45%	Not Supported	52%
Quang Binh	Not Supported	43%	51%	Not Supported	58%
Quang Ngai	Not Supported	40%	46%	Not Supported	52%
Quang Tri	Not Supported	32%	36%	Not Supported	40%
Thua Thien-Hue	Not Supported	64%	70%	Not Supported	77%
Tien Giang	Not Supported	48%	54%	Not Supported	60%
Tra Vinh	Not Supported	29%	33%	Not Supported	38%
Tuyen Quang	Not Supported	41%	45%	Not Supported	48%
Vinh Phuc	Not Supported	46%	54%	Not Supported	61%
Yen Bai	Not Supported	31%	36%	Not Supported	39%
_Military Vietnam	Mil			Mil	

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 17)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY18) SNU TX_CURR**	**Newly initiated (APR FY 18) PEPFAR TX_NEW**	**ART Coverage (APR 18)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	**78,327**	**48,400**	**10,827**	**51,850**	**5,122**	**66%**
Sustained	**103,978**	**50,830**	**31,218**	**54,560**	**3,005**	**52%**
Centrally Supported	**1,901**	**1,230**	**359**	**1,350**	**0**	71%
Commodities (if not included in previous categories)						

Total	**184,206**	**100,460**	**42,404**	**107,760**	**8,127**	**58%**

* Table A2, the correct TX_CURR number is 107,760, which is an SNU-level target, not a PEPFAR target for TX_Current.

The 77,341 target is from the DataPack tab "Target Calculation", which does not include DoD's number that was hard-coded in the Tab SNU Targets for EA afterward.

APPENDIX B

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
$US21,895,495	**$US24,551,255**	**$US 46,446,750**

B.1 Resource Projections

The PEPFAR Vietnam team used the PEPFAR Budget Allocation Calculator (PBAC) tool to generate program area budget projections for IM-level target-based budgets, activity-based budget, commodities, and program management and strategic information. Based on COP 16 results and updated EPP data, interagency technical working groups (TWGs) developed the COP 17 targets by site and SNU.

Those targets were put into the data pack and assumptions and coverage rates were reviewed and verified for feasibility. The PEPFAR Vietnam team then used the data pack to transfer the IM-level targets to the IM-TBBAT tool. Within the IM-TBBAT the TWGs outlined their unit cost decisions including patient-based unit cost for DSD and site-based unit cost for TA targets. The Care and Treatment (C&T) TWG utilized mechanism-specific unit costs for All Ages ART because C&T transition timeline and technical assistance roles differ depending on the specific IM.

The Prevention TWG utilized a standard unit cost across mechanisms for HTS and outreach but differed based on method or location of testing or on key population reached. The TWGs utilized EA NAV 16 data with strategic information and program management removed as the baseline for each unit cost estimate. Slight modifications were made to account for transition and difference between urban and rural settings. Modifications are documented within the IM-TBBAT. Utilizing the IM-TBBAT, the IM-level target-based budgets were entered into the PBAC.

Above-site activities were developed during the table 6 discussions. Each activity was proposed through TWG discussions, and were prioritized, negotiated, and reviewed for potential duplication. Specific activities and mechanism totals were entered into the PBAC. Strategic information and program management IM totals were estimated by EA NAV 16 data and slight modifications were documented within the PBAC.

The PEPFAR Vietnam team utilized COP16 agreed upon transition timeline for commodities and the commodities tab of the PBAC to distribute commodities to the appropriate mechanism. The PEPFAR interagency team at the funding level and met the C&T earmark requirement. In the COP 17 new funding request, U.S. agencies either reduced budget code allocations for individual implementing mechanisms according to estimated applied pipeline amounts or increased allocations based on planned activities and pipeline amounts.

APPENDIX C

C.1 COP 17 Table 6

Table 6.2: TRANSITION OF PEPFAR PROGRAM TO GOVERNMENT OF VIETNAM

Key system barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Relevant SID Element and Score (if applicable)	COP16 table 6 crosswalk
OPCs not accredited for HIV	*100% PEPFAR supported Outpatient Clinic (OPCs) get reimbursement from SHI for HIV services *80% of HIV patients with SHI card in eligible SHI health facilities use /receive SHI reimbursement for HIV related services (including ARV) by the end of 2019 * Patient tracking system rolled out nationally and Reports generated by the SHI information system fulfil the needs of HIV monitoring system and vise versa	50% treatment facilities (70% PEPFAR funded one) signed amended SHI contract for HIV covering HIV services 40% patient with SHI are reimbursed by SHI 100% ART patients in HCMC and two additional targeted provinces provided with ITCP counseling	*60% HIV treatment facilities (90% PEPFAR funded ones) being fully integrated in health facilities and HIV services being reimbursed by SHI *60% patient with SHI and their treatment is reimbursed by SHI *Patient tracking system rolled out and demonstrated in ten targeted provinces *The SHI network's IT and Information systems is appropriately modified and aligned with the HIV monitoring requirement by Sep 2018 *Individual tracking and continuation plan (ITCP) rolled out to five additonal provinces for all SNU patients	Indicators: # facilities that have amended SHI contract for inclusion of HIV services in their reimbursement list # facilities that have SHI examination & reimbursement for HIV services # HIV patients got SHI reimbursement for HIV services Tool: VAAC quarterly Integration Progress Monitoring Tool (IPMT) * Report from VSS and national M&E system *IM Performance report	TA to CDC/PEPFAR-supported sites in 19 provinces on the development of guidance at site level regarding patient referral to SHI plans, support Media/advocacy campaign at provincial level& Mainstreaming HIV reimbursement into hospital and SHI system at provincial and site level. TA will be provided with provincial coordination with other PEPFAR implementing agencies.	HTXS	6.1 Score 0.74	Continuing (table 6.1.3 key program gap3, SHI)
					Technical assistance to MOH/VAAC and VSS and provinces in the integration of OPCs for eligibility of reimbursement by the Health Insurance fund; transition patients in selected PEPFAR provinces to the SHI system national level and selected PEPFAR supported provinces	OHSS	11.1 Score: 1.39 11.5- Score: 1.67 12.2- Score: 0.36	Table 6.1.3. SHI row 1
					Develop a guidance on SHI for site level and patient referral plan in HCMC - Media/advocacy campaign -Mainstreaming HIV	HTXS	6.1 Score 0.74	Continuing (table 6.1.3 key program gap3, SHI)

					reimbursement into hospital and SHI system			
					Technical assistance to up to 19 CDC-supported transitioned, sustained and priority provinces and sites to meet treatment consolidation requirements for SHI, including advocacy with key provincial stakeholders, policy guidance and revision, reporting and tracking consolidation milestones, and monitoring. TA will be provided with geographic coordination with other PEPFAR implementing agencies.	HTXS	11.1 Score: 1.39 11.5- Score: 1.67 12.2- Score: 0.36	Social Health Insurance, Row 1, Pg. 45
					TA for the integration of SHIFT/PEPFAR-supported clinics into multi-disease outpatient clinic services that are integrated into Vietnam's hospital system at 56 hospitals and district health centers.	OHSS	6.7. score:0.37	Table 6.2.2, page 52, row 5, 7,8
					SFI: Design and deliver a Performance-Based Financing scheme to entire PLHIV previously treated in PEPFAR facilities to use the SHI for HIV treatment, including ART (national level)	OHSS	2.2, score 0.41	Ttable 6.1.3. SHI row 1
					SFI: Support VAAC and VSS at central level to agree on a common Health Information framework that fulfills the data and report needs of the national HIV program	OHSS	15.3, score 0.89	New activity in COP17

					TA to increase treatment continuation plan (ICTP) developed in COP16 to assist different patient groups (those willing to register with SHI, those willing to pay out of pocket, and those in need of provincial GVN funding); and increase SHI usage with regular monitoring of SHI reimbursement by ART patients with SHI (provincial and site levels) at SHIFT sites and provinces.	HTXS	6.7.score:0.37	New activity in COP 17
					TA to the central GVN and up to 10 provinces , including non-PEPFAR, to develop case management strategies (sites/districts/provinces movement and referral) to ensure ART retention of existing patients during transition period from PEPFAR-funded ARVs to SHI and other domestic resources. TA will be provided in agreement with VAAC and with geographic coordination with other PEPFAR implementing agencies.	HBHC	6.7. score:0.37	New activity; Table 6.2.2, page 52, row 8, 9
PLHIV not enrolled in SHI	80% of the country's registered HIV patients are enrolled in the SHI scheme and 60% are reimbursed for SHI HIV-related services	>40% of registered HIV patients are enrolled in the SHI scheme by Sep 2017	>60% of registered HIV patients are enrolled in the SHI scheme by Sep 2018	VAAC quarterly Integration Progress Monitoring Tool (IPMT) &Ad Hoc facility exit surveys	Technical assistance to up to 19 CDC-supported transitioned, sustained and priority provinces to increase SHI enrollments and reimbursements, including policy guidance and implementation, operationalizing funding mechanisms for subsidizing premiums and co-payments, tracking and reporting PLHIV coverage, and coordination with provincial stakeholders. TA will be provided with	HTXS	11.1 Score: 1.39 11.5- Score: 1.67 12.2- Score: 0.36	Social Health Insurance, Row 4, Pg.46

					geographic coordination with other PEPFAR implementing agencies.			
					Provide TA, evidence to GVN and NA to ensure the enrollment of key populations in SHI becomes a key priority (national level)	OHSS	2.3, score 0.87	Table 6.1.3. SHI row 4
Lack of financial mechanisms & sustainability for HIV services	Financial sustainability mechanisms in place for Insurance Fund to contain the cost; fburdent free on ARV for patient and incentive for Providers taking on additional HIV patient *The Law on HI amended with inclusion of HIV preventative services in the SHI benefit package(including HTC, PreEP, MMT and drug addiction treatment) * Mechanism/legal document/guidances in place for TB/HIV related services, PMTCT, VIral Load, CD4 are being reimbursed through current SHI benefit package * PMTCT is intergrated in MCH system and being sustained 70% of PEPFAR	* Benchmark has been fulfiled:HIV treatment services included in the revised proposed BHSP packages to be reimbursed through SHI; *Comittment from GVN (Central, local ones) on GVN subsidization for SHI Preimum and Copay *Projection model for SHI fund developed *MCH capacity is strengthened in providing PMTCT *A clear roadmap of SHI reimbursement for TB services for PLHIV is developed *Costing of some innovative KP outreach models	*Policies available to ensure 100% financial burden- free on ARV drug for all patients using SHI *Projection model for SHI fund being transfered to VSS& used for policy decision *System for co-payment reimbursement for all SHI ART patients set up and functioned HIV prevention services to be costed and recomended as as one component of Prevention packages to be reimbursed through SHI *MCH system capacity provincial and district level is strengthened in providing PMTCT *50% of PEPFAR supported TB clinics in transitioned provinces start SHI reimbursement for TB related services for PLHIV * Costed of Best practice for prevention outreach is available	*GVN policy papers/draft legal framework and provincial documents *VAAC, VSS; Partner reports * % of SHI ART patients in An Giang, Can Tho, Hai Phong, Quang Ninh and Nghe An reimbursed with co-payments for ARV drugs * Percent of PEPFAR supported TB clinics in transitioned provinces start SHI reimbursement for TB related services for PLHIV # of CSO/CBOs receive any sources of finance from GVN for prevention services/acitivities	SFI: TA to VAAC, VSS for the development and implementation of financial mechanisms and strengthen capacity of VSS systems to monitor and trackdown SHI reimbursement for HIV and using financial projection model to forecast SHI expenditures and needed revenue .	OHSS	2.2, score 0.41	Table 6.1.3. SHI row 2
					Provide TA and advocacy/policy support to PEPFAR transition provinces with the highest number of ART patients to implement a SHI co-payment financing scheme to achieve 100% SHI coverage for ART patients and reimbursement for ARVs.These provinces will be selected at direction of VAAC and in coordination with PEPFAR agencies and IMs.	HTXS	2.2, score: 0.41	New activity; Table 6.2.2, page 52, row 8, 9
					Capacity building (training, supervision, coaching) to MCH system staff (central and provincial level)	MTCT	6.1 Score: 0.74	New activity in COP 17
					Develop SOPs, training materials on SHI reimbursement for TB service package for PLHIV	HVTB	6.1 score: 0.74	Social Health Insurance, Row 4, Pg.46

	supported TB clinics in transitioned provinces start SHI reimbursement for TB related services for PLHIV * Policy and financial mechanism inplace to fund/ fund raising for prevention activities conducted by CSOs		* Gap analysis on policy/mechanism for outsourcing and funding CSO is available for advocacy		(including Xpert as a diagnostic test for PLHIV with presumptive TB)- national level			
					SFI: 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; Support Ministry of Health in rolling out the Basic Health Services Package including HIV treatment at Primary Care level (Commune Health Station); Provide Evidence and Policy advice provided to Office of Government and National Assembly to socialize the concept of including non-curative services in SHI (national level)	OHSS	2.4, score 1.37	Table 6.1.3. SHI row 2
					Advocate to VAAC, VMSS to include HTC and PrEP/PEP as a treatment as prevention under SHI scheme (national level)	HVCT	12.2 score 0.36 & 12.5, score 0.86	New activity in COP 17
					Packaging best practices (incl. costing) in outreach and advocacy to GVN for prevention financing- national level	HVOP	12.5, score 0.86	New activity in COP 17
					Advocacy for mechanisms through which government funds CSO/CBO for HIV Prevention services in Nghe An, Dien Bien & Hanoi to prepare for transtion and after.	OHSS	3.4, score 0.83	New activity in COP 17
					Advocacy for a guidance/directive from GVN that allows CSO to do fund raising or provide non-profit services- national and	OHSS	3.4, score 0.83	New activity in COP 17

					provincial level to prepare for transtion and after.			
					Advocacy for mechanisms through which government funds CSO/CBO for HIV Prevention services in HCMC to prepare for transtion and after.	OHSS	3.4, score 0.83	New activity in COP 17
HIV commodities insecurity and fragmented supply chains	* 50% of ART patients in Vietnam receive ARVs procured by a centralized mechanism funded by Vietnam Social Security and GVN State Budget Allocation * Goverment contribution for HIV commodities, test kits, VL and MMT increased by 50% * Hospitals in PEPFAR supported provinces received support are fully capable to manage site-level ARV quantification for annual SHI procurment and distribution * Total market approach (TMA) is used & commercial condoms, lubricants and LDSS consistently available in all PEPFAR supported provinces (scale-up and sustained) * Self-testing OraQuick and other recency rapid tests available in Viet Nam market and accessible to KP in 5 PEPFAR provinces	* 8% of ART patients in Vietnam receive ARVs procured by State Budget +SHI Allocation by the end of 2017 *Guidelines/SOPs/tools for procurement and supply management of ARV (including Social Health Insurance ARV, State Budget ARVs and Donors-funded ARV) developed *Commercial condoms, lubricants and LDSS consistently available in 40% PEPFAR supported provinces (scale-up and sustained) * OraQuick is being considered to be registered and sold in VN market	30% of PLHIV in Vietnam receive ARVs procured by a centralized mechanism funded by Vietnam Social Security and GVN direct State Budget Allocation by 2018 *Guidelines/SOPs/tools for procurement and supply management of ARV (including Social Health Insurance ARV, State Budget ARVs and Donors-funded ARV) finalized and approved * ARV Logistics Management Information System (LMIS) is embedded into the HIS at site level * Commercial condoms, lubricants and LDSS consistently available in 70% PEPFAR supported provinces (scale-up and sustained) * Capacity in ARV procurement and supply management strengthened at all level Oral Quick and other recency rapid tests registered and sold in Viet Nam market	% domestic contribution to spending on HIV commodities in that specific year SC_STOCK Tool: *VAAC procurement reports, supply data Distribution data., Market/project reports * VAAC quarterly Integration Progress Monitoring Tool (IPMT) * Market data on # commercial condoms, lubricants, LDSS sold& # KP use; # outlet sold in PEPFAR supported provinces *# of KP use OraQuick and other recency rapid tests and # test sold in VN market	VAAC TA to MOH and 19 CDC transitioned and sustained provinces for (1) the roll-out of SHI procurement of ARVs, including policy dissemination, training and TA in ARV coordination, procurement, forecasting, quantification, and reconciliation. TA at provincial level will be provided with geographic coordination with other PEPFAR implementing agencies. (2) Consolidate procurement of viral load for national implementation.	OHSS	8.1 score: 0.42 11.1 Score: 1.39 11.5- Score: 1.67 12.2- Score: 0.36	New and Efficient Service Delivery Models, Row # 2, p. 50
					TA and capacity building to support SHIFT hospitals and district health centers to forecast all ARV needs, including SHI and other ARV sources, for central ARV procurement by the Central Procurement Unit in the context of transition.	HTXS	8. 4. Score 1.01	New activity in COP 17
					TA to GVN (VAAC/VSS) and on the finalization and training on implementation of guidelines/SOPs/tools * Guidelines/SOPs/Tool on ARV quantification from treatment facilities from all different sources for the period of three years * Guidelines/SOPs for ARV reallocation and coordination among	HTXS	8.4 Score:1.01	6.2.2 Bew& efficient service delivery models-mechanism for HIV commodities Row 1, Pg. 50

					provinces and treatment facilities * Guidelines on monitoring of SHI ARV distribution & usage * SOPs for ARV procurement, bidding and distribution TA to GVN on the ARV LMIS based on existing hospital information system, including ARV patients data and ARV stock data			
					Strengthen GVN staff capacity on ARV supply planning, quantification, bidding and procurement, distribution, recording and reporting through professional training and on-the-job training (national and provincial level)	OHSS	8.5 Score 0.42	6.2.2 Bew& efficient service delivery models-mechanism for HIV commodities Row 1, Pg. 50
					Build the national capacity of MOH-VAAC to use total market approach (TMA) to plan and budget for HIV commodities and CSOs to become sale agents of local manufactors	IDUP	8.3, score:0	6.2.2 New model and efficient service delivery model-Supply chain
					Support private sector to maintain stable supply of KP preferred and affordable condoms, lubricants and LDSS in PEPFAR provinces; Provide TA to VAAC to roll-out the TMA tool nation-wide& to PEPFAR supported provinces in use of TMA to plan and budget for HIV commodities- national level	HVOP	8.3, score:0	6.2.2 New model and efficient service delivery model-Supply chain
					TA to GVN to include OraQuick and other new recency rapid tests in the National Testing Guidelines; Conduct Oral Fluid Screening Acceptability Study; Support	HVCT	8.2, score: 0	6.2.2 New model and efficient service delivery model-

					GVN to grant licencing to those tests to make them available, accessible in the market for KPs			Supply chain
Limited capacity to manage and monitor services to ensure quality and retention	Capacity for the timely and sufficient data to maintain high quality of services in all transition provinces established and sustained (pre- and post transition evaluation)	Transition monitoring tool and protocol developed with data collection at selected sites 7+1 provinces transitioned by 2016 maintain quarter report and routine data review at provincial and site levels	7 provinces transitioned by 2016 and 11 province transitioned by 2017 maintain quarterly report and routine data review and HIV monitoring data intergrated within HIMS	_CoPC linkages - Lost to follow up information; Adhenrance - Program report (# hospitals with intergrated HIMS - HGF/VAAC quarterly Integration Progress Monitoring Tool (IPMT)	Provide TA at provincial level for Post transition program monitoring in CDC transitioned provinces	HTXS	15.5 -Score .67	COP16. Table 6: Integration of Services into Hospital System, page 51
					Integration of HIV reporting into HCMC hospital reporting systems (TA specifically with movement between OPCs and hospitals)	HTXS	15.3 - Score .89	COP16. Table 6: Integration of Services into Hospital System, page 50-51
					Integration of HIV reporting into hospital reporting systems (TA specifically with movement between OPCs and hospitals.) This activity will be implemented in a selected number of sites (ten) in selected number of CDC transitioned provinces. The number of provinces will be determined after completion of an assessment in collaboration with VAAC.	HVSI	15.3 - Score .89	COP16. Table 6: Integration of Services into Hospital System, page 50-51
					Routine data collection on retention inservice and quality of all type of services on quarterly basic (by site, by type of services, by province and geographical areas) before, during and after transition. Activities will be implemented in USAID supported provinces and sites: Dien Bien, Nghe An (scale-up) and transitioned provinces including Hai Phong, Quang Ninh, Can Tho, HCMC, An Giang. This activity will well –coordinated with CDC and other partners to avoid any overlap and duplication.	HVSI	13.9 score: 0.95	New activity in COP17

	>95% known status post referral, >95% continue receiving services % of late Treatment be reduced to below 20% and LFU rate to 3% after 3 years of Test and Start policy implementation	>80% known status post referral, 85% continue receiving services 29.1% PLHA initiated ART with CD4 <100 copied and 5% lost-follow up	>90% known status post referral, >90% continue receiving services 25% PLHA initiated ART with CD4 <100 copied and 4% lost-follow up	% of successful referral % of retention # Number of hospitals can report HIVQUAL as a component of their QI hospital Tool: QI indicator guidebook, MOH annual HIVQUAL data	At above-site level, apply HIVQUAL indicators to measure quality of services in CDC transitioned provinces at facility after transition; Build QI capacity for consolidated OPCs with new staffing and structure; 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.	HTXS	9.2 Score 1.00	Continue
					VAAC and provincial program to tailor specific strategy to prevent loss and re-engage LTFU cases in CDC-supported transitioned and priority provinces.	HTXS	6.1Score 0.74	Continue
					Apply HIVQUAL indicators at site level in 13 CDC transitioned provinces to measure quality of services at facility after transition; Build QI capacity for consolidated OPCs with new staffing and structure; 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.	HTXS	9.3 Score 0.67	Countinue
	90% of on-site TA is conducted by PCT team themselves. All HIV/AIDS service providers to be trained as MOH requirement	All HIV/AIDS service providers to be trained as MOH requirement, and 50% of on-site TA is conducted by PCT team.	80% of on-site TA is conducted by PCT team themselves. All HIV/AIDS service providers to be trained as MOH requirement	Program report on # of health staff are trained # HIV-related TA network/system developed # Number of PCT on-site TA # Number of central on-site TA # of TA visit	Training and mentoring activities to support Hanoi, Thai Binh, An Giang, Binh Duong and Son La PACs to establish and maintain sustainable provincial care and treatment coaching teams (PCT) to provide TA for their sites in provinces; E-mentoring and training for health staff & Provide	HTXS	6.1 Score: 0.74	Continuing

					training for Provincial networks of trainers (mentors, supervisors)			
					At Can Tho, Thanh Hoa, Hai Phong , Quang NInh, BRVT, Hoa Binh, Long An, Nam Dinh and Soc Trang: 1. Provide training for Provincial networks of trainers (mentors, supervisors); Support PACs to establish and maintain sustainable provincial care and treatment coaching teams (PCT) to provide TA for their sites in provinces 2. Responsitive TA to strengthen capacity of OPC staff to provide quality services through system meeting, case discussion and developing training materials and guidelines;E-menoring and training for health staff	HTXS	6.1 Score: 0.74	Continuing
	- National MTCT rate reduced to 10% (curent estimated rate is 12.5%) - 65% of provinces submited realiavble data	N/A	5 sites received responsive TA to address issues at sites 85% MCH sites incorporate PMTCT variables into program monitoring system	- # of sites receiving responsive TA - EID positivity (remain or reduce)	Provide responsive TA to HCMC sites; Strengthen data quality through training, onsite support and system enforcement	MTCT	6.1 Score: 0.74	New Activity in COP17
	* PLHIV in high HIV burden provinces have access to Xpert MTB/RIF testing in 63 provinces - an expected 2700 PLHIV will undergo Xpert testing. * 152 GeneXpert instruments using remote connectivity *100% of laboratories with GeneXpert instrument	2000 PLHIV with presumptive TB have receive an Xpert test to screen for TB. * In-country led proficiency testing pilots complete and validated by an external reference laboratory	* 2300 PLHIV with presumptive TB have receive an quality assured Xpert test to screen for TB. * 92 GeneXpert instruments using remote connectivity * 50% of laboratories with GeneXpert instrument sites participating in country-led EQA proficiency testing	Number of PLHIV who have received a quality assured Xpert MTB/RIF test for TB diagnosis (ICF) * Number of GeneXpert instruments with remote connectivity * Proportion of GeneXpert instrument sites	1. Policy and guideline revision to use Xpert for screening all PLHIV with presumptive TB. Provide TA on implementation and interpretation of national guidelines for testing PLHIV with presumptive TB with Xpert. * Establish province-specific SOPs and guidelines on referral of patients or patient samples from HIV care and treatment sites to laboratory sites with Xpert	HVTB	6.1 score: 0.74	COP16 Table 6.2.2, page 52

	participating in country-led EQA proficiency testing			participating in country-led EQA proficiency testing	testing and return results to referring OPC. 2. Xpert EQA: scale up national proficiency testing (reagents, feedback and documentation) TA for accreditation of NRL as an EQA provider. Responsive TA to sites with low/poor function (national level)			
					1. Improve results turn around time and function/M&E of GeneXpert instruments (instrument connectivity, inventory management) by establishing remote connectivity as recommended by WHO. Installing remote connection, TA for trouble shooting. Local TA providers set up for timely supports if issues identified thru the network. 2. TA for national implementation of in-country led Xpert EQA proficiency testing, TA for accreditation of NRL as an EQA provider. (national and provincial level)	HLAB	9.5. score:1.43	COP16, Table 6.3 - Proposed investment, page 56
	9 HIV testing labs meet national standard or be accredited ISO 15189, 1100 HIV testing labs participates in PT program and has satisfactory result; 95% labs has satisfactory result 100% finance support for HIV serology EQA program is by GVN 6 e- learning QMS program and an CME	5 HIV labs will be trained, mentored and completed dossiers for ISO 15189 accreditation IQC and EQA samples provided for 80 and 700 HIV labs (in the north) and 60 and 600 HIV labs (in the South) BENCHMARK ACHIEVED: 25% of HIV serology EQA and IQC program funding are from other sources	7 HIV labs (HIV confirmatory and VL labs) will be accredited ISO 15189 IQC and EQA samples provided for 80 and 600 HIV labs (in the north) and 60 and 500 HIV labs (in the South) A national guidelines on EQAs program is implemented by all national EQA providers at least one QMS and biosafety CME, and 6 e -	# HIV labs either accredited ISO 15189 or meet >85% requirements of national standard on QMS #EQA providers meet national requirements on EQA program, NIHE and PI report on # labs participated in HIV serology IQC and	Provide intensive training and mentoring for HIV testing labs (HIV confirmatory labs and HIV VL labs) to be accredited for ensuring the quality of testing (site level)	HTXS	10.3. score: 0.56	COP16, Table 6.1.2 Limited VL lab capacity row 2, page 43; and 6.2.1 row 2 on insufficient coverage and quality of testingt services, page 48
					Provide intensive and professional training courses	HLAB	9.4.score: 1.0	COP16, Table 6.3 -

	QMS, biosafety training is managed by VAMS/ HMU/ UMP/ PI		learning training course is rolled out	EQA; % labs that meet satisfactory requirement in PT program # approved QMS and biosafety training package, operated	related to ISO 15189 requirements for national technical team.			Proposed investment, page 56
					Management of EQAs and IQC HIV serology progra. Roll out of at least 6 e-learning courses for QMS and biosafety	HLAB	10. 5. score: 1.67	COP16, Table 6.2.1 , page 48, Test and start
					Transition implementation of EQA and IQC HIV serology program at national level	HLAB	10. 5. score: 1.67	COP16, Table 6.2.1 , page 47, Test and start
					Standardize and roll out national QMS and biosafety training package	HLAB	10.3. score: 0.56	COP16, Table 6.3 - Other proposed investment, page 55
	90% of community-based, evidence-based drug addiction treatment services provided with TA by PEPFAR meet MOH quality standards Local health staff can provide quality services. 100% staff are trained with EBPs to screen HIV/SUDs and refer to services	MOH quality standards for drug addiction treatment revised and instituted Providers to be trained on AST. 70% staff are trained to screen HIV/SUDs and refer to EBPs services	70% of community-based, evidence-based drug addiction treatment services provided with TA by PEPFAR meet MOH quality standards 80% of the providers to be trained on ATS. 80% staff are trained to screen HIV/SUDs and refer to EBP services	# of treatment sites implementing Methqual – approved by MOH % of treatment sites met with minimum Methqual standards % staff trained on the EBPs for ATS and WHO ASSIST tool	TA, mentoring and training for provincial DOHs in Thanh Hoa and Son La in coaching, mentoring and training capacity in prevention services; Expand prevention-focused e-mentoring activities to participating provinces; Development and application of a MethQual toolkit, anlaysis of QI results; Roll-out of a MMT MIS for QI.	IDUP	6.1 Score 0.74 6.4 Score 0.37 6.7 Score 0.37	New activity in COP 17
					Support development of ATS treatment protocol for Hanoi context/resources	OHSS	1	New Activity in COP 17
					Train clinicians and treatment providers on how to screen, diagnose, and refer to treatment for ATS abuse using ASSIST	OHSS	1	New Activity in COP 17
					Pilot test the ASSIST-linked brief intervention	IDUP	1	Continuing
Total								

Table 6.3: SUSTAINABLE HIV SYSTEM								
Key system barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Relevant SID Element and Score (if applicable)**	**COP16 table 6 crosswalk**
Limited capacity to deliver and monitor HIV services affect quality and retention	80% of facilities providing ART have HIVQUAL fully integrated into QI programs of the currative system 80% newly registered patients at HIV clinics start TPT Training material, guidelines and SOP for care, disclosure and transition of aldolescent patients are available HRH planning tools for GVN to ascertain HRH need for facility-bsaed services at the site level 100% site in minimum 3 provinces operating full ARV-HTC-HIV Info links to have data update quarterly	60% of facilities have HIVQUAL fully integrated into QI programs of the currative system	40% of facilities have HIVQUAL fully integrated into QI programs of the currative system	1. Number of hospitals have HIVQUAL integrated into currative QI program 2. Number of provinces have HIVQUAL 3. Number of HCM hospitals trained on QI	1. Expand QI integration through QI activities, SOP implementation and increasing responsibility of curative system/hospitals for their QI programs. 3. Build capacity of HCMC hospital staff on measurement of service quality, quality improvement and establish HIVQUAL at new hospital-based OPCs in HCMC	HTXS	9.2 score 2.00	Continuing (table 6.2.2 new and effficient service delivery models)
				1. Number of hospitals have HIVQUAL integrated into currative QI program 2. Number of provinces have HIVQUAL 3. Number of HCM hospitals trained on QI	At National level and in 12 provinces (including non-PEPFAR) at direction of VAAC: 1. Sustain HIV quality improvements and expand QI integration through QI activities, SOP implementation and increasing responsibility of curative system/hospitals for their QI programs. 2. Sustain QM system, develop QI handbook and build capacity for provinces to implement QI program. 3. Build capacity of hospital staff on	HTXS	9.1 Score 1.33	Yes

					measurement of service quality, quality improvement and establish HIVQUAL at new hospital-based OPCs			
		TPT monitoring tools revised and rolled out to enable program use and monitoring	* ≥70% newly registered patients at HIV clinics start TPT in PEPFAR/CDC suipported HIV sites		In HCMC: 1. Refine and implement tools to capture ICF/TPT indicators, monitor adherence and adverse events 2. TA to review program data quarterly to assess progress and inform program improvement of TPT implementation. 3. TA for linkage and referral between HIV and TB programs.	HVTB	6.1 score: 0.74	New activity in COP17
		Training material developped Diclosure and referral of aldolescen patients guidelines developped	20 Sites are trained and start implementing accordingly to guidelines	Availability of care training material and referal of adolescent guide	Training to 5 CDC-supported sites - Onsite TA/support for implementation	HTXS	6.1 Score 0.74	New activity COP17
		TPT monitoring tools revised and rolled out to enable program use and monitoring	*TPT M&E tools implemented and reported * 70% newly registered patients at HIV clinics start TPT in PEPFAR/CDC supported HIV sites	* National implementation of revised ICF/IPT M&E tools * National indicator: proportion of newly registered PLHIV starting TPT.	At CDC-supported OPCs in transitioned and priority provinces: 1. Refine and implement tools to capture ICF/TPT indicators, monitor adherence and adverse events 2. TA to review program data quarterly to assess progress and inform program improvement of TPT implementation. 3. Incorporate	HVTB	6.1 score: 0.74	COP16 Table 6.2.1, page 4

					forthcoming WHO guidance on TPT treatment options as appropriate. 4. TA for linkage and referral between HIV and TB programs. 5. TA to coordinate with TB and HIV program to ensure sustainable supply of INH (e.g. training on INH quantifiation) counseling and IEC materials for increasing patient acceptance, refresher training, TA/QA. 6. Monitor TPT implementation and patient outcomes			
		A site assessment tool for HRH needs at the facility level in the context of integration with SHI and co-location of HIV services.	Activity ends in COP 16	Results from tool implementation	HRH policy and review. Expansion and implementation of HRH planning and review tools, such as WISN, in two CDC sustained provinces.	OHSS	7.1 , score: 0.67 7.2 score: 1.00	New and Efficient Service Delivery Models, Row 3, Pg. 51 and Other systems investments, HRH, Row 2, pg. 53
		80% sites has linkages status of HIV pos into ARV tx ; cloud-based database developedin Can Tho and Dien Bien	100% sites has linkages status of HIV pos into ARV tx ; cloud-based database scaled-up in other provinces and national level	Annual report on i-cloud completion, linkage status of HTC-ARV-HIVInfo	HIV C&T database system development and scale-up: develop cloud-based database for real time HIV individual treatment extracted from VSS e-system to provide inputs for ARV central quantification and reporting purposes. Strengthen the linkage between HTC positive, ARV Tx and Case reporting to ensure the	HVSI	13.9 Score: 0.95	COP16 table 6.3 page 58 - Other Proposed Systems Investments - Strategic Information

					tracking of the 90's target from site level to provincial level.			
Limited capacity to deliver and monitor HIV services affect quality and retention	Prevention Provincial Coaching Teams (PCT) in 8 provinces provide technical mentoring and support for 80% of HIV prevention services sites Prevention Provincial Coaching Team (PCT) provides technical mentoring and support for 80% of HIV prevention services sites in HCMC Prevention Provincial Coaching Teams (PCT) in 3 provinces provide technical mentoring and support for 80% of HIV prevention services sites in their respective provinces using GVN budget	Prevention PCTs established in 8 provinces with defined Terms of Reference Training curricula developed	Satisfaction surveys to inform performance improvements of PCTs	% of HIV prevention services sites receiving at least two technical assistance visits per year by the PCT. TA visit reports. Satisfaction surveys among sites that receive TA from the PCTs MER: HTS_TEST/HTS_POS, TX_NEW, PREV_KP, MAT	Evaluation of Prevention PCT model in 9 CDC provinces (HCMC, Son La, Thanh Hoa, BRVT, BD, QN, HP, LA, ND) and advocacy for sustaining TA mechanisms with GVN budget	HVCT	6.1 Score 0.74 6.2 Score 0.19 6.7 Score 0.37	New activity in COP 17
		Prevention PCTs established in 8 provinces with defined Terms of Reference Training curricula developed	Training provided to 8 PCTs. Prevention PCT in 5 provinces provide technical mentoring and support for 40% of HIV prevention services sites in their respective provinces	% of HIV prevention services sites receiving at least two technical assistance visits per year by the PCT. TA visit reports. Satisfaction surveys among sites that receive TA from the PCTs MER: HTS_TEST/HTS_POS, TX_NEW, PREV_KP, MAT	Establishment, TA, mentoring and training for prevention-focused provincial coaching teams in 8 provinces (Son La, Thanh Hoa, BRVT, Binh Duong, Hai Phong, Quang Ninh, Long An and Nam Dinh). TA on data use to design programs, services delivery modalities, quality assurance, coaching techniques/supervision mechanisms.	HVCT	6.1 Score 0.74 6.2 Score 0.19 6.4 Score 0.37 6.7 Score 0.37	New activity in COP 17
		Prevention PCTs established inHCMC with defined Terms of Reference	Training provided to PCT Prevention PCT in HCMC provides technical mentoring and support for 40% of HIV prevention services sites in HCMC	% of HIV prevention services sites receiving at least two technical assistance visits per year by the PCT. TA visit reports. Satisfaction surveys among sites that receive TA from the PCTs MER: HTS_TEST/HTS_POS, TX_NEW, PREV_KP, MAT	Establish a Prevention PCT in HCMC. TA/mentoring for implementation of Prevention PCT activities.	HVCT	6.1 Score 0.74 6.2 Score 0.19 6.4 Score 0.37 6.7 Score 0.37	New activity in COP 17

		NA	Prevention PCTs established in 8 provinces with defined Terms of Reference Training curricula developed	% of HIV prevention services sites receiving at least two technical assistance visits per year by the PCT. TA visit reports. Satisfaction surveys among sites that receive TA from the PCTs MER: HTS_TEST/HTS_POS, TX_NEW, PREV_KP, MAT	Establishment/capacity building of a Prevention PCT in Nghe An, Dien Bien, Hanoi. TA/mentoring for implementation of Prevention PCT activities.	HVOP	6.1, score 0.74	New activity in COP 17
Limited capacity to deliver and monitor HIV services affect quality and retention	Military system capacity improved in delivering and monitoring all HIV services (direct or support) via: 1) attaining fully capable military trainers and/or coaching teams to provide mentoring and technical support to all site services including HIV prevention, HIV treatment, HIV nursing care, HIV/TB infection control, patient safety, nursing management and leadership; 2) developing critical policies/guidance in areas of HIV nursing care, infection control, nurse task-shifting... that benefit both military and civilian health systems; 3) improving	HIV Prevention: 60% facilities providing HTS attain the at-least-one-trainer target; 60% of 50 regiments & military schools rolling out military peer education program attain the at-least-three-trainer target; HIV Treatment: 75% of OPC medical staff received refreshed training on HIV/AIDS CTx; at least 90% of HIV patients at transitioned OPCs (2/4 OPCs) continue having access to quality services and retain on ART; Leadership: 60% of key military leaders and	HIV Prevention: 80% facilities providing HTS attain the at-least-one-trainer target; 80% of 50 regiments & military schools rolling out military peer education program attain the at-least-three-trainer target; HIV Treatment: 100% of military OPC staff received refreshed training on HIV/AIDS CTx; at least 90% of HIV patients at transitioned OPCs (3/4 OPCs) continue having access to quality services and retain on ART; Leadership: 80% of key military leaders and cadres involved in programs improved their planning skills and coordination with civilian services (100% after Year 3)	# of staff trained to become trainer/mentor in each technical area with verified competence; # of staff provided with refresh training on a technical area; % of key military leaders and cadres involved in programs demonstrate capabilities in planning and coordinating HIV programs;	1) Training and mentoring for military trainers/mentors on HTS, military peer education, care and treatment; 2) TA to OPCs transitioned and transitioning; 3) Ad-hoc training and/or policy capacity building workshop for military leaders and cadres particularly on linkages across program areas and with civilian system.	HVCT	7.5 In-service training, Score: 0.92	Table 6.3, HRH, Row 8+11, Pg.54
						HVOP	7.5 Score: 0.92	Table 6.3, HRH, Rows 10, 12, 13, Pg.54
						HTXS	7.5 Score: 0.92	Table 6.3 HRH, row 7&8, page 54

	laboratory quality management competence at military labs while establishing policy and technical guidance in place in military system; 4) improving planning and monitoring capacity for 100% of key cadres at central and site-leadership level in coordination with civilian services, deploying the developed trainer/mentor network and enforcing technical guidance and policies in military system;	cadres involved in programs improved their planning skills and coordination with civilian services.						
		HIV nursing care, HIV/TB infection control patient safety, nursing leadership & management: - 70% of head nurses/lead health care staff of military hospitals, military medical schools, border guard medical command of 4 scaled-up mountaineous provinces and key selected civilian hospitals received in-service training and become competent site mentor/facilitator - At least 2 policies/guidance and 3 CME curriculum in HIV nursing care and support, task-shifting, infection control and patient safety have been developed for review;	HIV nursing care, HIV/TB infection control patient safety, nursing leadership & management: - 90% of head nurses/lead health care staff of military hospitals, military medical schools, border guard medical command of 4 scaled-up mountaineous provinces and key selected civilian hospitals received in-service training and become competent site mentor/facilitator - At least 2 policies/guidance and 3 CME in HIV nursing care and support, task-shifting, infection control and patient safety have been reviewed and finalized; - Final draft of at least 2 technical modules/guidances to be integrated into pre-service training program of military medical schools reviewed and adopted by the	# of military and civilian staff received trainings on nursing management, infection control and patient safety; # of policies, guidance and CME curriculum developed; # of technical modules/guidances integrated into pre-service training program of military medical schools; National network of nursing leadership management and infection control professionals established and function;	1) Continue in-service training for military and selected civilian staff on HIV nursing care, HIV/TB infection control, patient safety, nursing leadership and management; 2) TA to develop, disseminate and integrate into pre-service training the planned number of policies, guidance, CME curriculum and technical modules; 2) Advocate for establishment of national network of professionals on nursing leadeship management and infection control (central to site levels).	HMIN	7.5 Score: 0.92	Table 6.3 HRH, row 3& 4, page 53
						HBHC	2.2 Score: 0.41	Table 6.3 - HRH, row 4, page 53 + Governance, row 2&3, page 59

			schools' academic board.					
		Lab QMS, Blood Transfusion Safety: - 75% of participating labs (12 of 16) meet at least 70% of ISO requirements (or the national equivalence) with at least 1 lab obtaining ISO accreditation; - Military guidance on blood safety and transfusion final draft ready for review;	Lab QMS, Blood Transfusion Safety: - 100% of participating labs (16 of 16) meet at least 85% of ISO requirements (or the national equivalence), with at least 3 labs obtaining ISO accreditation; - Military guidance on blood safety and transfusion approved and released; - National lab quality checklist adopted by military system.	% of ISO requirements met by participating labs through on-site assessment (based on ISO check-list); # of labs being accredited by ISO; Military blood transfution guidance in existence; National lab quality checklist in existence in the military system;	1) Continue TA and mentoring for participating labs based on ISO (or national equivalence); 2) Continue TA for military blood safety guidelines (based on national guidelines and international practices), and for strategic direction and capacity building planning for military blood program; 3) TA to integrate national lab quality checklist into military system plus advocacy for high-level leaders' commitment to program technically and financially;	HMBL	10.2 Score: 0.42	Table 6.3, Laboratory, last row Pg.57
						HLAB	10.2 Score: 0.42	Table 6.3, Laboratory, Last row , Pg.57
Limited capacity to deliver and monitor HIV services affect quality and retention	Coverage of community-based, evidence-based drug addiction treatment is increased to at least 80% of the national target Addiction Medicine is fully integrated into training agenda of all Medical Institutions in Vietnam	Coverage of community-based, evidence-based drug addiction treatment is increased to 70% of the national target Addiction Medicine is integrated into two Medical Institutions	Coverage of community-based, evidence-based drug addiction treatment is increased to 75% of the national target Addiction Medicine is integrated into two Medical Institutions	% of people received treatment at community-based, evidence-based drug addiction treatment services (MOH report) % of people received treatment at community-based, evidence-based drug addiction treatment services against provincial/ national targets (MOH report)	Introduce pre-trial drug abuse services and alternative sentencing to drug abuse treatment, including linkage to HIV testing and HIV treatment	IDUP	1	New Activity in COP 17
					3.5. Support MOH to develop CME system to provide training to site staff	IDUP	1	Continuing
					3.9. Integrate addiction treatment into SHI	OHSS	1	New Activity in COP 17
					3..8 Strengthen community-based treatment and recovery services	IDUP	1	Continuing

					3.7. Integrate HIV case finding into drug abuse treatment settings	IDUP	1	Continuing
					3.3. Build capacity in Addiction Medicine for Medical Institutions	IDUP	1	Continuing
					3.4. Develop and deliver pre-services training at Medical Institutions to support future MAT services	IDUP	1	Continuing
					3.2 Build capacity within the healthcare system to collect and use data regarding ATS use and implement evidence-based interventions.	IDUP	1	New Activity in COP 17
					3.1. Advocate for policy changes that support community-based, evidence-based drug addiction treatment	IDUP	1	Continuing
Limited capacity to deliver and monitor HIV services affect quality and retention	At least 90% of community-based, evidence-based drug addiction treatment service facilities (i.e., fully comprehensive service facility with clinical assessment, clinical follow up, treatment, and recovery) meet with MOH quality standards	At least 70% of community-based, evidence-based drug addiction treatment service facilities meet with MOH quality standards	At least 80% of community-based, evidence-based drug addiction treatment service facilities meet with MOH quality standards	# of treatment sites implementing Methqual - approved by MOH % of treatment facilities met with minimum Methqual standards	9. Provide training on data analysis from MMT database to evaluate MMT program for quality improvement	IDUP	1	Continuing
					10. Support data analysis at different levels	IDUP	1	Continuing
					4. Adapt E-mentoring system to provide mentoring across the country	IDUP	1	Continuing
					8. Provide TA for the development and finalization of MMT MIS	IDUP	9.2. score 2.0	New activity in COP 17
					3. Continue building provincial mentoring team: mentors selection, training and	IDUP	6.8. score 0.56	Table 6.1.1. Page #39

					coaching			
					2. Coach provincial trainers to train their own staff	IDUP	7.5 score 0.92	Table 6.1.1. Page #39
					4. Adapt E-mentoring system to provide mentoring across the country	IDUP	6.8. score 0.56	New activity in COP 17
					6. Support application of Methqual for quality assurance and quality improvement	IDUP	9.2. score 2.0	New activity in COP 17
					5. Support finalization and endorsement of Methqual tool-kit	IDUP	9.2. score 2.0	Table 6.1.1. Page #39
					7. Analyze Methqual results to plan for quality improvement	IDUP	9.2.score 2.0	New activity in COP 17
Limited capacity to deliver and monitor HIV services affect quality and retention	GVN-accredited facility-based stigma reduction program implemented in 6 PEPFAR provinces HIV services including HIV community testing, differentiated care, PrEP and PEP using both fee-based and	TOT training for 2 provinces in implementing the tool	TOT training for 4 additional provinces in implementing the tool	Training knowledge tests	1.1. Technical assistance in the national adaptation and provincial implementation of an international facility-based stigma monitoring and stigma reduction tool for HIV treatment sites in 3-5 CDC transitioned and sustained provinces	HTXS	2.5 Score 1.07	Revised activity for COP 16, New activity for COP 17

	non-fee based models are provided by Private clinics and KP-led CSOs under PEPFAR and GF/VUSTA support Prevention Provincial Coaching Teams (PCT) in 3 provinces provide technical mentoring and support for 80% of HIV prevention services sites in their respective provinces using GVN budget System launched; tool available to KPs in 5 provinces	1 private clinic an 1 KP-led CSO clinic offer HIV services to KP	4 private clinics and KP-led CSOs offer clinical HIV services to KP	# of private clinics providing fee-based HIV related services to KP # of KP-led CBOs providing fee-based and non-fee based HIV related services to KP # and % of clients receiving fee-based and non-fee based HIV related services	TA to GVN (MOH/VAAC) to harmonize legal frame work to ensure CSO/Social Enterprises are able to sell and offer HIV clinical services; to include roles and responsibility of CSOs and private sectors in differentiated care Evaluate and disseminate results from private sector/KP-led CSO differentiated care model Advocate for favorable environment supporting fee-based HIV related services; Provide training, mentoring and coarching to private clinics and KP-led CSOs to deliver high-quality HIV related services	OHSS	4.1, score 1.11	6.1.1 Key Program Gap #1: ART Coverage for PLHIV - First 90: Limited CSO involvement
		N/A	System developed with in-put of stakeholders from GVN, PLHIV and facilities	Results from tool implementation	Develop a web-based system to rank healthcare facilities and to provide support for KPs in choosing facilities where they would receive the best care under SHI	OHSS	2.5 Score 1.0	New Activity in COP 17
		Team of CBO/CSO master trainers established and trained	CBO/CSO master mentors team established, and capable to provide training for CBO/CSOs/ prevention program staff in selected provinces	# of trainings, mentoring and coaching sections provided by Master trainers team.	CBO/CSO Master Trainers established and trained in HCMC, Nghe An, Dien Bien and Hanoi	HVOP	6.2, score 0.19	6.1.1 ART coverage for PLHIV- limited CSO involvement
						HVOP	6.2, score 0.19	6.1.1 ART coverage for PLHIV- limited CSO

								involvemen
Data Quality Issues and limited use of data hinder program performance	Practicing of high quality data collection, reporting, analysis and use is achieved by all stakeholders (national, provincial, site staff of both civilian and military, IMs staff). Quality developed based on national and PEPFAR MER and SIMS requirements	Training curriculum, manual and technical coaching tools for data analysis available	Development, maintenance and use of Provincial DDM master files/database	• Existence of Standard Operating Procedure for development, maintenance and use of DDM Master file. • Number of provincial and district level staff trained in Provincial DDM data analysis and use	TA to enhance data use at different levels, support performance data analysis to improve service quality and conduct trainings for district and provincial staff in selected provinces on skills and processes of data analysis and synthesis. The activity will be conducted in USAID supported provinces including Dien Bien, Nghe An, Hanoi, Quang Ninh, Can Tho, Hai Phong, Thai Nguyen.	HVSI	13.9 score: 0.95	COp16 table 6.3 page 58 - Other Proposed Systems Investments - Strategic Informaiton
		Routine data collection at PEPFAR provinces and sites, including transitioning provinces	Routine data collection at PEPFAR provinces and sites, including transitioning provinces	Ensure MER indicators for PEPFAR funding sites at scaled up provinces	Capacity building at province/ district level in CDC supported provinces (Son La, Thanh Hoa, Hanoi) on data collection, processing and data use; Strengthen linkage between HIV interventions; Applying DQA to national reporting system	HVSI	15.3 - Score .89	COP16. Table 6: Strengthen national reporting system and national DQA- page 57
			HMIS integratation with SHI implementaion and program report for HIV patients at selected hospitals-	Ensure MER indicators for PEPFAR funding sites at scaled up provinces	TA to HCMC communes and DHS to implement case reporting requirements	HVSI	15.3 Score .89	COP16. Table 6: Strengthen national reporting system and national DQA- page 57

		70% of military site staff in charge of program monitoring and reporting are trained on training on data collection, reporting and analysis	90% of military site staff in charge of program monitoring and reporting are trained on training on data collection, reporting and analysis	# of military staff received training on data collection, reporting and analysis	In-service training for military staff on data collection, reporting and analysis for program planning and improvement (based on national and PEPFAR MER and SIMS requirements)	HVSI	15.3 Score: 0.89; and 15.4 Score: 1.33	Table 6.3 - Strategic Information, row 9, page 55
	Routine dashboard analysis on program performance conducted by both district and provincial specialists and managers on a quarterly basis in two priority provinces (covered by USAID)	70% of district strengthened for high quality data on quarterly basis.	100% of district strengthened for high quality data on quarterly basis.	% districts strengthened on M&E system Source: Quarterly report from partner	Strengthen the ownership of HIV district managers at USAID-supported sites to know their epidemic, know their response and actively use Circular 03 and 09 data for district and commune-level performance monitoring and program improvement. This on-going activity via SHIFT is to be continued by a local follow-on mechanism which will ensure the coordination with SHIFT on geographic and supported site to prevent overlaps and ensure the supplement each other.	HVSI	13.9 score: 0.95	COp16 table 6.3 page 58 - Other Proposed Systems Investments - Strategic Informaiton
						HVSI	13.9 score: 0.95	COp16 table 6.3 page 58 - Other Proposed Systems Investments - Strategic Informaiton
						HVSI	13.9 score: 0.95	COp16 table 6.3 page 58 - Other Proposed Systems Investments - Strategic Informaiton
	Prevention Provincial Coaching Teams (PCT) in 8 provinces provide technical mentoring and support for 80% of HIV prevention services sites in their respective provinces using GVN budget; CBO/CSOs/Prevention Outreach program staff know and use	Team of CBO/CSO master trainers established and trained; Trainings and coaching on Data Use implemented	CBO/CSOs/Prevention Outreach program staff know how to analyse and use data for planning and service quality improvement	# of CBOs/CSOs/Prevention Team use data for planning/advocacy/service quality improvement	Building capacity of data use at site level among CSO/CBO in HCMC	HVOP	6.2, score 0.19	6.1.1 ART coverage for PLHIV-limited CSO involvement
					Building capacity of data use at site level among CSO/CBO in Hanoi, Dien Bien and Nghe An provinces	HVOP	6.2, score 0.19	6.1.1 ART coverage for PLHIV-limited CSO involvement

	data for planning, advocacy and program quality improvement.							
	Data verification system and linkage betwwen community and facility services established and ultilized	Data linkage system established	PACs and CBO/CSOs/Prevention Programs in focus provinces apply data verification system	# of provinces have data verification system and linkage system from community to facility	TA to Dien Bien, Nghe An & Hanoi's DOH/PAC to enhance data linkages between health systems and CSO/CBO; between community and facility-based services	HVOP	6.2, score 0.19	6.1.1 ART coverage for PLHIV- limited CSO involvement
	High quality program monitoring data at national and provincial level (based on national and PEPFAR guidelines) is available to all stakeholders in need; quality monitoring system in place to ensure timely availability of quality data.	100% HIV data synced, linked, and clustered for use by program, intervention at both site and PAC level.	100% completion with regular update and utilization of provincial database on HIV/AIDS	% of completion for provincial HIV database	Strengthen national capacity to deliver high quality program monitoring data and to ensure accountability of PEPFAR program with focus on utilization of the national/provincial HIV database. Develop the linkages between HTC and ARV databases at district and provincial level. The activity will be closely coordinated with other IMs to supplement each other efforts.	HVSI	13.9 score: 0.95	COp16 table 6.3 page 58 - Other Proposed Systems Investments - Strategic Informaiton
					A follow-on to the on-going activity via SHIFT: Continue TA, coaching focus on utilization of the national/provincial HIV database. Develop the linkages between multiple databases at district and provincial level (C09, C03, ARV, HTC, MMT,) Activities will be implemented in USAID supported provinces and sites: Dien Bien, Nghe An (scale-up) and	HVSI	13.9 score: 0.95	COp16 table 6.3 page 58 - Other Proposed Systems Investments - Strategic Informaiton

					transitioned provinces including Hai Phong, Quang Ninh, Can Tho, An Giang. This activity will be well – coordinated with other partners to avoid any overlap and duplication.			
Fragmented information systems results in inaccurate reporting and lost patients	National standard HIV information package would enable unified SHI reimbursement, ARV drug quantification, and HIV program reporting. Standard outputs from ARC clinics/hospitals are useable for both SHI payment, ARV drug quatification and distribution, and HIV reporting requirements as VSS and VAAC regulations in 05 provinces.	Complete the SOPs for designing eHIS HIV component in 2 provinces. Developemnt of standard output requirements for ARV Tx clinics and application at 05 selected provinces	eHIS HIV component adapted and integrated in at least 5 provinces. Scale up the application of standard outputs for ARC Tx clinics by 20 provinces	Annual report on eHIS completion; Issuance of SOPs for standard outputs	eHIS: electronic hospital information system: Integration of HIV component into routine hospital HIS and compatible for SHI payment system. This activity will be implemented in USAID supported provinces (scale-up and transitioned) including Dien Bien, Nghe An, Hai Phong, Quang Ninh, Can Tho, and An Giang. Ensure integration with commodity and lab information systems for commodity forecasting/lab management at provincial and district levels. TA to VAAC/MOH to develop protocol and standard for interchangeable data exchange that support patient referral tracking and for data exchange between VSS, VAAC/PAC, and eHIS	HVSI	13.9 score: 0.95	New activity in COP17

Insufficient funding and resources for critical HIV services	Domestic resources for HIV program(private, state budget) increased, make up 70 % of total $$ for HIV program from all sources by 2020	Increase in # provinces receiving PEPFAR TA that have instituted MMT user fees framework 20% increase in $$ mobilized under Sustainable HIV financing mechanism, inlcuding for harm reduction and prevention activities 5 PEPFAR provinces subsidize SHI premium and co-payments for PLHIV	All PEPFAR provinces have approved HIV Sustainability Plan Half of PEPFAR provinces operationalize a financing mechanism for subsidizing SHI premiums and co-payments	MOH_National health account (NHA) sub analysis for HIV spending Budget allocation/execution reports from VAAC/Provinces	1.Fora for CBO engagement with HCMC provincial auhtorities to advocate for increased financing for harm reduction activities	OHSS	11.5- Score: 1.67 12.2- Score: 0.36	Social Health Insurance, Row 2, pg. 45; New and Efficient Service Delivery Models, Row 2, p. 50
					1. At national level, revision, dissemination and monitoring of SHI-related and financing policies (Circular 15, Decree 105, Dec 2188, Letter 61744, MMT user fees, Sustainable HIV financing mechanism, etc.) 2. Fora for CBO engagement with GVN at provincial level to advocate for increased financing for harm reduction activities in CDC transitioned and sustained provinces 3. Advocacy with provincial governments in CDC transitioned and sustained provinces to fund CSO/CBO prevention services	OHSS	11.1 Score: 1.39 11.5- Score: 1.67 12.2- Score: 0.36	Social Health Insurance, Row 2, pg. 45; New and Efficient Service Delivery Models, Row 2, p. 50
		Domestic resources for HIV program(private, state budget) increased, make up 50 % of total $$ for HIV program from all sources by 2017	Domestic resources for HIV program(private, state budget) increased, make up 60 % of total $$ for HIV program from all sources by 2018	MOH_National health account (NHA) sub analysis for HIV spending Budget allocation/execution reports from VAAC/Provinces	SFI: Provide TA on Financial analysis and Economic implication of the provision of HIV services to inform Advocacy/Policy forum for the increased of domestic financing	OHSS	11.5 score 1.67	Table 6.1.3 Social Health Insurance, Row 2, pg. 45; Table 6.2.2 New and Efficient Service Delivery

								Models, Row 2, p. 50)
CSOs/ SEs have limited financial resources to provide HIV related goods and services to KPs	20 CSOs/Social Enterprises financially sustain and capable to provide HIV related goods and services to KP	5 CSOs registered as social enterprises 65 CBOs became sale agents of local condom manufactures	1. 20 CSOs registered as social enteprises; 2. 20 CSOs develop and implement sustainable business plan; 3. 15 CBOs under Clink partner to be equipped to conduct demand generation activities especially on new products and services such as: lay and self-testing, PrEP/PEP, SHI 4. 25 GF/VUSTA CBOs equipped to conduct marketing and demand creation activities using ICT such as facebook, mobile apps...etc	# of CSOs registered as social enterprises (SEs) # of CSOs/SEs actively sell prevention commodities # of CSOs/SEs actively offer HIV clinical services	1. TA to CSOs to register and function as a legal social enterprises; 2. TA to CSOs/SEs to develop and implement business start/up; 3. Build capacity for CSOs in business start-up, pitching financial support from different sources (GVN, private sector, social investors)	OHSS	3.4, score 0.83	New activity in COP 17
Total								

C.2 COP 16 Table 6

Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16 Activities	Budget Code(s)	Indicator reporting frequency for POART (End Date)

	•	•		
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. • 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 intervention – and increase their roles in National HIV and AIDS responses. • 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 • 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 (e.g. fee-based PREP and service delivery innovations) for KPs willing to pay in PEPFAR priority provinces. • 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. • 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.	HVSI HVSI OHSS IDUP, HVOP, HBHC HBHC, HVOP, IDUP HBHC, HVOP, IDUP, OHSS HVCT HVOP, IDUP, HVCT, PREP HVOP, IDUP,	Semi-Annual (after 2017) Semi-Annual (after 2017) Annual (2017) Annual (2017) Semi-Annual (after 2017) Semi-Annual (after 2017) Semi-Annual (after 2017) Semi-Annual (after 2017) Annual (after 2017)

			HVCT, HVOP, IDUP, HVCT,	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. • GVN approach shifts dramatically to provide community treatment for more than 80% addicts • Close or reduce number of 06 centers; limit 6% addicts in the centers • 80% PWID will be treated in the community • 90% staff involved in drug treatment trained in best practices	• Develop a national CME standard for health care professional working on HIV/AIDS and Addiction. • Develops Addiction Medicine as a sub discipline within the National Medical system to enhance the quality of care given to HIV patients. • Enhance effective use of the national Textbook for MMT. • Improving coordination and collaboration in capacity development in the area of MAT and Addictions. • Support the organization of national HIV/AIDS and Drug Use conference to enable policymakers, providers, patients, community social works and family 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 • Workforce Development with DOLISA to deliver quality services. • Capacity building for national training institution to enable them to provide a sustained approach to addiction and HIV services. • Revise legal documents to guide expansion of MAT program and adapt technical guidelines for MAT implementation. • Train provincial mentors and supervisors to be local trainers in CDC-supported provinces. • Develop the National Methadone Quality Guidance (MethQUAL) for service quality improvement. This is national TA, above site level activity. • Train provincial MMT staff in using Methadone Quality Data (MethQUAL) for service quality improvement. • Support VAAC conduct trainings and follow-up to PACs to build provincial MMT trainers (capacity building, individual level) • TOT training of MAT patients who will support there program and assist others in their recovery using a grass roots approach 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.	HBHC, IDUP HBHC, IDUP HBHC, IDUP HBHC, IDUP HBHC, IDUP HBHC, IDUP HBHC, IDUP HBHC, IDUP IDUP IDUP IDUP	Bi-Annually (after 2017) Bi-Annually (after 2017) Annually(after 2017) Quarterly (after 2017) Annually (after 2017) Bi-annually (after 2017) Bi-annually (after 2017) Semi-annual (after 2017) Annual (2017) Semi-Annual (after 2017) Semi-Annual (2017)

			IDUP, HVSI	Semi-Annual (after 2017)
			IDUP, HVSI	Semi-Annual (after 2017)
			IDUP	Semi-Annual (after 2017)
			IDUP	Semi-annual (after 2017)
			IDUP	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. • Refinement and consistent use of methodology on HIV sentinel surveillance at central level. • 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). • 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). • 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). • 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 • 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). • 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. • Quality improvement of HSS survey at district and site level, time limited support to enhance data quality improvement in 3 PEPFAR focus	HVSI HVSI HVSI HVSI HVSI HVSI HVSI HVSI	Annual (after 2017) Annual (after 2017) Annual (2017) Annual (after 2017) Annual (after 2017) Annual (after 2017) Annual (after 2017) Semi-Annual (after 2017)
First 90 - Insufficient Case Reporting Data & KP Size Estimations				

(continued)		provinces. • Update HIV/AIDS Estimation and Projection (EPP) modeling for 2016-2020 to support national/provincial level estimates of PLHIV and KP epidemic data. • Development of provincial cascade information for quarterly monitoring of 90-90-90 progress and to inform programming gaps. • 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 HVSI HVSI HVSI HVSI, OHSS HVSI, HBHC, HTXS HVSI	Semi-Annual (after 2017) Annual (2017) Annual (after 2017) Semi-Annual (after 2017) Semi-annual (after 2017) Semi-annual (after 2017)
TOTAL				

Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16 Activities	Budget Code(s)	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	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 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 HLAB HLAB HLAB HLAB	Semi-Annual (2017) Semi-Annual (2017) Semi-Annual (after 2017) Semi-Annual (2017) Semi-Annual (after 2017)
TOTAL				

Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16 Activities	Budget Code(s)	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	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. •	OHSS OHSS OHSS HVCT, IDPU, HVOP, OHSS	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 services functional – 55% PLHIV with SHI are reimbursed for HIV services	• 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 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 OHSS OHSS	Semi-Annual (2017) Annual (After 2017) Annual (after 2017)
Low PLHIV enrollment in SHI (~30%)	• Monitoring mechanism in place for PLHIV HI enrolment • 60% PLHIV with HI coverage	• Domestic resource mobilization through health sector targeted program policy review and advocacy workshop for new phase of national HIV program and	OHSS	Semi-Annually (2017)

	• GVN mechanism for subsidy for co-payment in place	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. •	OHSS OHSS, HTXS	Semi-Annually (after 2017) Semi-Annual (aft6er 2017)
TOTAL (COP16)				
TOTAL (SFI)				

Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**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 registered at OPC	• 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	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	Annual (2017) Semi-Annually (after 2017) Semi-Annually (2017) Semi-Annually (after 2017)
TOTAL				

Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**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	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. • Strengthening national capacity in HIV commodities Procurement and Supply Management (PSM).	OHSS OHSS OHSS IDUP, OHSS HTXD	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. •	HTXS HVSI IDUP	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	Semi-Annual (2017)
		• TA support to scale up national HIV Care and Treatment electronic medical record software (ePMS).	HVSI	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	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	Semi-Annually (post 2017)
		• Post transition program monitoring in CDC transitioned provinces.	HVSI	Quarterly (after 2017)
		• Support VAAC and PACs to increase HIVQUAL coverage and build capacity for provinces to implement quality improvement.	OHSS HTXS	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	Semi-Annual (after 2017)
		• Strengthen technical capacity to establish and implement an electronic training and mentoring system within regional tertiary hospitals.	HTXS	Semi-Annually (after 2017)
		• Develop HIV quality standards and indicators which will be integrated into quality improvement programs of hospital system.	HTXS	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	Semi-Annual (after 2017)
		• Support VAMS to strengthen health quality system by integrating HIVQUAL in	HTXS	Semi-annual (after 2017)

Integration of Services into Hospital System (continued)		• TA support NTP and VAAC to increase ART and TB treatment among TB/HIV co-infection patients	HVTB	Semi-Annual (2017)
		• TA to improve TB intensified case finding for HIV/AIDS patients	HVTB	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.	HVTB C&T	Semi-Annual (after 2017) 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	
		• 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	Semi-Annual (after 2017) 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 C&T	Semi-Annual (after 2017)
		• TA network to support quality of case finding and care and treatment at facilities linked to HI system.		
		• 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 C&T	Semi-Annual (after 2017) Semi-Annual (after 2017)
		• TA to the national program for e-PMS on-going implementation and support for national scale-up.		
		• TA to national HIVQUAL program.		

TOTAL (COP16)	[redacted]
TOTAL (SFI)	

Activity	**Results expected after 1 to 3 years of investment**	**System Support "90"**	**Milestones and custom indicators**	**Activity End Time Frame**
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	First 90	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	Second 90	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	Second 90	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.	Second 90	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,	First 90	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 trainings for district and provincial staff in selected provinces on skills and processes of data analysis and synthesis	Training curriculum, manual and technical coaching tools for data analysis, development & maintenance of Provincial DDM master files. Timely management & provision of data at provincial level to monitor and plan HIV priorities/activities in priority provinces to achieve 90 90 90 targets.	First 90	Semi-Annual	After 2017
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	First 90	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	Better collaboration and harmonization with national HIV program, fostering professional development of key military staff.	First 90	Quarterly	2017

been carried out yet. This activity will be conducted in COP16				
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	First 90	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.	First 90	Quarterly	After 2017
Support hosting of peer education review exercise for MoD leadership and participating regiments.	One review workshop for commanding staff	First 90	Quarterly	After 2017
		Second 90	Semi-Annual	After 2017

HRH Subtotal	$531,627	

Activity	**Results expected after 1 to 3 years of investment**	**System Support "90"**	**Milestones and custom indicators**	**Activity End Time 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	Second and Third 90	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.	Second 90	Semi-Annual	After 2017
Support NIHE to validate and implement HIV drug resistance testing.	receipt of WHO accreditation for HIV-DR testing	Second and Third 90	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	Second 90	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	Second 90	Annual	2017
Implementation of national SLMTA program.	1. 12 labs in HIV/AIDS and clinical microbiology systems 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 certified and implement SLMTA program.	Second and Third 90	Quarterly	2017
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	Third 90	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	Second 90	Semi-Annual	2017
Above-site Program Management	Operational Costs	Third 90	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.	First 90	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)	Second 90	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	Second 90	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, Vung Tau, Vinh Long, Soc Trang, Can Tho	Second 90	Semi-Annual	2017

	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	Second and Third 90	Semi-Annual	After 2017
		Lab Subtotal		
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	Second 90	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	Second 90	Semi-Annual	2017
Increase the use of monitoring data from VCT database, MMT database, Master patient Index and E-clinical 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	First and Second 90	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	First, Second, and Third 90	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.	Second 90	Semi-Annual	After 2017
		First 90	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	First and Second 90	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	First and Second 90	Semi-Annual	After 2017
Strengthen reporting system and program review for better HIV/AIDS services at Military PEPFAR supported sites and military 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	First and Second 90	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	Sustained Epidemic Control	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	First 90	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.	First and Second 90	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 90-90-90 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 90-90-90 implementation context, this will strengthen the ownership of HIV district manager by knowing their epidemic, knowing their response and monitoring their district program performance.	First and Second 90	Semi-Annual	After 2017
		SI Subtotal		
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	First and Second 90	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.	First 90	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.	First 90	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 patients 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	Second 90	Annual	After 2017
Above-site Program Management	Operational Costs	First 90	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~~	First 90	Semi-Annual	2017

	~~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 ~90-90-90 goals~~			
		Governance Subtotal		
Service Delivery and System Support				
		Second 90	Annual	2017
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	Second 90	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	Second 90	Semi-Annual	After 2017
Above-site Program Management	Operational Costs	Second 90	Annual	After 2017
Above-site Program Management	Operational Costs	First and Second 90	Annual	2017
Above-site Program Management	Operational Costs	Second 90	Annual	After 2017
Above-site Program Management	Operational Costs	Second 90	Annual	2017
		SD Subtotal		
		System Support Total		

APPENDIX D

(COP Review Question Response)

Methamphetamine Use Among Key Populations in Vietnam—Implications for 90-90-90

Often, the earliest warning signals about new patterns or types of drug abuse are anecdotal in nature. In Vietnam, the anecdotal signals include that methadone clinics are seeing an uptick in clients currently using methamphetamine, which we know has implications for viral load suppression[i]. The Provincial AIDS Committee in Ho Chi Minh City in a meeting with the PEPFAR inter-agency team shared that methamphetamine-involved group sex activities are being reported as HIV risk behaviors. MOLISA has noted an increase in persons who have been voluntarily committed to closed rehabilitation centers due to methamphetamine-induced psychosis. MOLISA has also noted an increased number of drug users who have been arrested and remanded to 06 compulsory detoxification centers for

methamphetamine use. In the midst of all the anecdotes, media attention, and rising fear at the community level, it is reasonable to question whether there is data to support this national concern with ATS use and our proposed PEPFAR response.

Currently, Dr. Don Des Jarlais of Beth Israel Deaconess Center, New York is leading a study—DRIVE (Drug Use and Infections in Vietnam)—of injection-drug users in Hai Phong, Vietnam (Khuat, OH, Des Jarlais, et al., 2017)[ii]. Hai Phong ranks 4th nationwide for cities/provinces with highest number of PLWH and is among the highest prevalence areas for injection-drug use. Dr. Des Jarlais is one of the leading U.S-based scientists in the study of HIV in injection-drug users. The study team exclusively recruited injection drug users (N = 1385) between October 2016 and January 2017. There was a 30% HIV prevalence rate in the sample, with 70% HCV prevalence. The study subjects were mostly male (94%); average age 39 years old; 34% married; and 25% with health insurance. The subjects were mostly daily injectors (80%) with a mean 27 days of injecting out of the last 30 days. In this sample, 70% had a history of non-injecting methamphetamine use and 2% had a history of injecting methamphetamine. While only 5% indicated daily methamphetamine use, 47% indicated methamphetamine use in the last 30 days. These study subjects also mixed the use of alcohol and other drugs and 37% used methadone on the streets. More than half of the study subjects (54%) reported that they were sexually active within the last month; 70% reported unsafe sex (65% with primary partner and 5% with casual partner). In addition, 10% indicated multiple sex partners and 40% admitted unsafe sex with active methamphetamine use. There was some needle sharing (4%) with other PWIDs. This sample was mostly receiving care at an outpatient clinic (84%); 93% of those with known HIV status were adhering to ART (mean CD4 count = 467 and mean adherence score 9.27 on a scale of 1 – 10). This study is supported by the U.S. Department of Health & Human Services (HHS), National Institutes of Health, National Institute on Drug Abuse (NIH/NIDA) grant #R01DA041978 and the French Agency for Research on HIV and Hepatitis (ANRS 12363).

BRAVO (Buprenorphine to Improve HIV Care Engagement and Outcomes), an NIH/NIDA-supported study (R01DA037441) led by Dr. Todd Korthius of Oregon Health & Science University and Dr. Le Minh Giang of Hanoi Medical University, is a multi-site, randomized trial of HIV clinic-based buprenorphine/naloxone (BUP/NX) (n=225) versus referral to methadone maintenance treatment (MMT) (n=225) for treatment of opioid dependence in HIV-infected patients new to care in 6 HIV clinics in Hanoi, Thanh Hoa, and Bac Giang—epicenters of the Vietnam HIV epidemic (Korthius, T, Giang LM, 2017)[iii]. The study subjects are all over 18 years old, HIV positive, and ready for drug abuse treatment. Similar to the study in Hai Phong, this sample was mostly male (98.7%); average age 37.5 years; married (38.6%); with a mean of 30 days of injecting out of the last 30 days (100%). In this group 54.4% are on ART. There are Hep B and C and TB co-infections (17.1%; 34.0%; and 28.5% respectively). Most of the sample had a history of arrest (84.1%) and detention in an 06 Center (57.6%). Positive urine screens for methamphetamine use in this sample were 14.6%, indicating that methamphetamine use may be relatively commonplace in injection-drug users not yet in treatment.

Early studies in Vietnam by Dr. Minh Le Giang and his team also showed methamphetamine use to be prevalent among MSM, female sex workers and young PWID in urban areas[iv] [v]; most using methamphetamine infrequently (few times per month) and with their peers. A more recent survey among MSM[vi] [vii] showed 16.9% reported using in the past three months, of which more than 90% reported moderate- and high-risk use. Transgender women and male sex workers report correlations between methamphetamine use and HIV infections, raising infectious disease concerns[viii] [ix] . Most recent estimates among PWID and MMT patients showed 20% to 40% using in the past month[x] [xi].

The rapidly expanding network of MMT clinics and a parallel network of HIV outpatient clinics contributed to significant reductions in HIV prevalence among injection drug users[xii] . The system of MMT treatment, which now has about 250 clinics and more than 50,000 patients in care since 2008, is also the first structure of community-based treatment of substance use disorder in Vietnam. These early achievements, however, are threatened by a new epidemic of ATS, especially crystal methamphetamine.

---

[i] Shoptaw, S, et al, Cumulative exposure to stimulants and immune function outcomes among HIV-positive and HIV-negative men in the Multicenter AIDS Cohort Study, International Journal of STD and AIDS, 2012, Aug (23/8), p. 576-580.

[ii] Khuat OH, Des Jarlais D, DRIVE team. DRIVE (DRug use and Infections in Vietnam) Results in Hai Phong RDS One. DRIVE Scientific Advisory Board Meeting; 2017 Mar 8; Hai Phong, Vietnam.

[iii] Korthuis PT, Giang ML, and BRAVO team. Interim Analysis Report: Buprenorphine to Improve HIV Care Engagement and Outcomes (BRAVO) Randomized Trial (R01DA037441). Oregon and Hanoi: OSHU and HMU; 2017 Apr 12. 6 pages.

[iv] UNODC Vietnam Office. Amphetamine-type stimulants in Viet Nam: Review of availability, use and implications for health and security. Hanoi, Vietnam: United Nations Office on Drugs and Crime; 2012 p. 114.

[v] Ho HT, Le GM, Dinh TT. Female sex workers who use amphetamine-type stimulants (ATS) in three cities of Vietnam: Use and sexual risks related to HIV/AIDS. Glob Public Health. 2013 May 1;8(5):552–569. PMID: 23679831

[vi] Thu Vu NT, Maher L, Zablotska I. Amphetamine-type stimulants and HIV infection among men who have sex with men: implications on HIV research and prevention from a systematic review and meta-analysis. J Int AIDS Soc [Internet]. 2015 Feb 2 [cited 2016 Dec 18];18(1). Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302169/ PMCID: PMC4302169

[vii] Vu NTT, Holt M, Phan HTT, La LT, Tran GM, Doan TT, Nguyen TNN, Wit J de. The Relationship Between Methamphetamine Use, Sexual Sensation Seeking and Condomless Anal Intercourse Among Men Who Have Sex With Men in Vietnam: Results of a Community-Based, Cross-Sectional Study. AIDS Behav. 2016 Jun 28;1–12.

[viii] Colby D, Nguyen NA, Le B, Toan T, Thien DD, Huyen HT, Mai TDA, Friedman MR, Stall R. HIV and Syphilis Prevalence Among Transgender Women in Ho Chi Minh City, Vietnam. AIDS Behav. 2016 Dec 1;20(3):379–385.

[ix] Yu G, Clatts MC, Goldsamt LA, Giang LM. Substance use among male sex workers in Vietnam: Prevalence, onset, and interactions with sexual risk. Int J Drug Policy. 2015 May;26(5):516–521.

[x] Vietnam Authority of AIDS Control. Report on the Progress of HIV Prevention and Control Activities in 2016 and Plan for 2017 (Vietnamese). Hanoi: Ministry of Health; 2017 Jan.

[xi] Khuat OH, Des Jarlais D, DRIVE team. DRIVE (Drrug use and Infections in Vietnam) Results in Hai Phong RDS One. DRIVE Scientific Advisory Board Meeting; 2017 Mar 8; Hai Phong, Vietnam.

[xiixii] Des Jarlais DC, Thi Huong D, Thi Hai Oanh K, Khuê Pham M, Thi Giang H, Thi Tuyet Thanh N, Arasteh K, Feelemyer J, Hammett T, Peries M, Michel L, Vu Hai V, Roustide MJ, Moles J-P, Laureillard D, Nagot N. Prospects for ending the HIV epidemic among persons who inject drugs in Haiphong, Vietnam. Int J Drug Policy. 2016 Jun;32:50–56.