Vietnam

Country Operational Plan

COP 2022

Strategic Direction Summary

2 May 2022

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Contents

1.0 Vision and Goal Statement

The PEPFAR Vietnam Country Operational Plan (COP) 2022 will focus work to achieve three primary objectives:

1) **Achieving epidemic control (95-95-95)** by continuing a full package of services in high burden provinces, providing focused technical assistance (TA) that supports local ownership of quality HIV services, delivering strategic continuous quality improvement (CQI) across the HIV cascade, working to strengthen the key population (KP) community and their service delivery activities, and expanding recency and case surveillance;

2) **Transitioning to local ownership of HIV services** by continuing to build the local capacity of antiretroviral treatment (ART) supply management, supporting increased government financing of social contracting and pre-exposure prophylaxis (PrEP), developing provincial financial sustainability plans and increased provincial financing of HIV, and increasing private sector resources and engagement in HIV;

3) **Responding to emerging HIV hotspots across the country** through a public health cluster response (PHCR) by supporting national protocols using recency signals as alerts, capacitating provincial technical teams (PTTs) and community partners, and responding in real time to stop clusters of active transmission.

PEPFAR Vietnam's COP22 goals seek to advance the three above stated objectives in 11 PEPFAR priority provinces of the Northern Economic Zone (NEZ) and Ho Chi Minh City (HCMC) Metro regions. NEZ and HCMC Metro together account for over half of the HIV burden in Vietnam, and there is clear evidence of high HIV incidence, prevalence, and undiagnosed infections among urban men who have sex with men (MSM). Through PEPFAR support, the two regions drive innovation and spur national adoption of best practices.

Progress on the ambitious 95-95-95 goals in the PEPFAR priority provinces of NEZ and HCMC Metro regions has been notable despite ongoing challenges of the COVID-19 pandemic, and PEPFAR will continue to provide tailored support at the provincial level to meet targets. Performance on the third 95 across Vietnam has been exceptional and is in the top tier globally. Nationally, the third 95 target has been over-achieved, with 98% of those on ART having viral load test results at <200 copies/ml, or undetectable. Vietnam is on track to achieve the second 95 in PEPFAR-supported provinces through effective linkage interventions and treatment continuity using evidence-based, person-centered approaches for vulnerable populations, like younger MSM, transgender women, and sex workers. Continued advocacy for same-day ART, as well as for PrEP, will be crucial in COP22 to empower clients with choices. PEPFAR remains committed to differentiated models to support ART and PrEP initiation, continuity, and return to treatment such as multi-month dispensing (MMD) and tele- and mobile-medicine.

The first 95, case-finding, remains challenging in a concentrated epidemic where HIV and key population-associated stigma creates barriers to HIV testing Using epidemiologic and other data, PEPFAR will identify hard to reach networks of persons at risk for HIV to target them for testing. The COP22 plan further optimizes case-finding by expanding the HIV self-test (HIVST) market; integrating syphilis testing with HIV testing and PrEP referral; and blending social network strategies with safe and ethical index partner testing. In COP22, community engagement and monitoring will continue to be central to assuring that PEPFAR delivers high-quality, stigma-free services across the cascade; builds the capacity for increased HIV service delivery by the community; and provides a platform for community participation in the national public health cluster response.

PEPFAR Vietnam will continue supporting the Government of Vietnam (GVN) to establish a nimble, locally owned, sustainable public health cluster response. PHCR will contribute to epidemic control goals through monitoring and rapidly responding to alerts from recent infections as case surveillance is expanded and optimized, resulting in efficient targeting of resources and interruption of active transmission. The PHCR approach is an indigenously driven system, led by the GVN, in collaboration with civil society, academic, and community-based organizations (CBOs), leveraging and capacitating systems and long-term assets supported by PEPFAR in a coordinated response. Outside of PEPFAR priority provinces, PHCR technical assistance will be implemented with government-to-government support through PTTs and engagement of CBOs, relying on the Global Fund and domestic resources (including Social Health Insurance—SHI) to finance service delivery.

To complement the public health cluster response, COP22 will support rationalization and streamlining of digital health investments to ensure ongoing availability of timely, high-quality data and interoperable data systems. PEPFAR will also continue investments to strengthen case surveillance and other critical health information systems at the national, provincial, and community levels, as well as provincial CQI and Program Quality Monitoring (PQM).

In COP22, PEPFAR will continue its objective of transitioning components of the HIV response to the GVN. The GVN has already taken over the financing and administration of HIV treatment and procurement of antiretroviral medicines (ARVs) through SHI. By the end of 2020, GVN had procured almost 70% of all needed ARVs through SHI.

COP22 will increase efforts to mainstream a robust and sustainable Social Contracting framework that leverages and solidifies the important role of CBOs within the national HIV response strategy. These efforts will create a clear path for direct community service delivery that is funded and supported by the GVN.

The COP22 strategy—jointly planned with the Vietnam Administration for HIV/AIDS Control (VAAC), the Global Fund, the Joint United Nations Program on HIV/AIDS (UNAIDS), and community stakeholders—ensures a coordinated, person-centered HIV response with broad political and community buy-in and engagement.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

The national HIV prevalence in Vietnam is 0.24 percent of the general population of approximately 98 million, with an estimated 242,000 people living with HIV (PLHIV) by the end of 2021. The epidemic remains concentrated among three KP groups: MSM at 13.4 percent prevalence in 2020; people who inject drugs (PWID) at 12.7 percent prevalence in 2019; and female sex workers (FSW) at 3.1 percent prevalence in 2020 according to the latest round of HIV sentinel surveillance. The distribution of PLHIV by KP group and degree of program coverage varies by region and province, highlighting the need for a tailored response.

PEPFAR is currently supporting efforts to obtain MSM population size estimates (PSEs) in 6 provinces (results expected in September 2022) and an additional 4-5 are planned for COP22. These PSEs will be used as denominators for calculating program coverage and to extrapolate national size estimates and projections of the HIV epidemic. In 2019, with support from PEPFAR, PSE activities among FSW and PWID were conducted in two PEPFAR NEZ provinces (Hai Phong and Thai Nguyen) using globally recognized standards (multiple capture-recapture sources). The results of PSE activities from the empirical data showed differences when compared to less robust provincial program estimates or public security reports, which has prompted PEPFAR to support this work at the national level. Provincial size estimates vary

greatly based on standardization methods, which may have led to overestimations in the north while underestimating population sizes in the southern provinces.

PEPFAR Vietnam will continue to focus on two regions, NEZ and HCMC Metro, to reach 95-95-95 and epidemic control. HCMC Metro includes seven provinces and 34% percent of the national HIV burden. As the economic hub of the South, HIV transmission in this region is driven predominantly by sexual behaviors. HIV transmission clusters span multiple provinces, especially in districts near the HCMC provincial borders. NEZ includes four provinces and about 16.4 percent of the national HIV burden. The epidemic in this region is driven by both injecting and sexual behaviors. In the NEZ, a large proportion of undiagnosed infections may not be among KPs and may represent older infections from former KPs or partners of KPs in the past. Recency data in FY19, FY20 suggest that there is an ongoing epidemic in the South, with some provinces (HCMC, Long An, Dong Nai, Can Tho) reporting over 25% of newly identified PLHIV as confirmed as recent infections, indicating that they had been infected within the past year. Recency results in the North seem to suggest a smaller group of new transmissions, with recency proportions less than 10% among all newly diagnosed PLHIV

The national HIV sentinel surveillance system among PWID and FSW in 20 provinces and MSM in 12 provinces show opposing epidemic trends in Vietnam. While HIV prevalence and estimated incidence rates among PWID and FSW decrease over time, we observe increases in HIV prevalence and estimated incidence among MSM from 2012-2020. These data once again confirm that a strategy focused on MSM is key to epidemic control in Vietnam.

Partners of PLHIV and those identified as “other” require more attention. UNAIDS has projected that women in Vietnam will have higher transmission rates in the coming years and there is a need to better understand subpopulations that do not identify as KP during this last mile of HIV epidemic control. In COP22, the revised Circular 09 supporting risk classifications in case surveillance and the proposed KP study will shed light on other high-risk groups and help understand health-seeking behaviors. For 'other' subpopulations, the disaggregation identifies the following groups with higher risk of transmission: heterosexual males and females, patients with TB, pregnant women, and prisoners. There is little information about size estimates, HIV prevalence and risk of transgender people in Vietnam. PEPFAR will provide technical support to GVN to do transgender size estimates and a pilot of HIV surveillance among the population.

Standard Table 2.1.1

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	98,183,219		11,383,810	11.6 %	12,459,240	12.6 %	6548836	6.7 %	6,931,002	*7.1%*	31,305,747	31.9 %	29,554,584	30.1 %	GSO, Population Census 2019, estimated for 2021.
HIV Prevalence (%)		0.24													VAAC estimation for 2021
AIDS Deaths (per year)	3,800														UNAIDS Estimated for 2020
# PLHIV	242,000														VAAC estimated for 2021
Incidence Rate (Yr)															N/A
New Infections (Yr)	6,100														UNAIDS estimated for 2019
Annual births	1,588,404														MOH, Mother and Child Health Department 2019
% of Pregnant Women with at least one ANC visit		97%													97% in SDGCW Vietnam, 2020-2021
Pregnant women needing ARVs	2,200														UNAIDS estimated for 2020

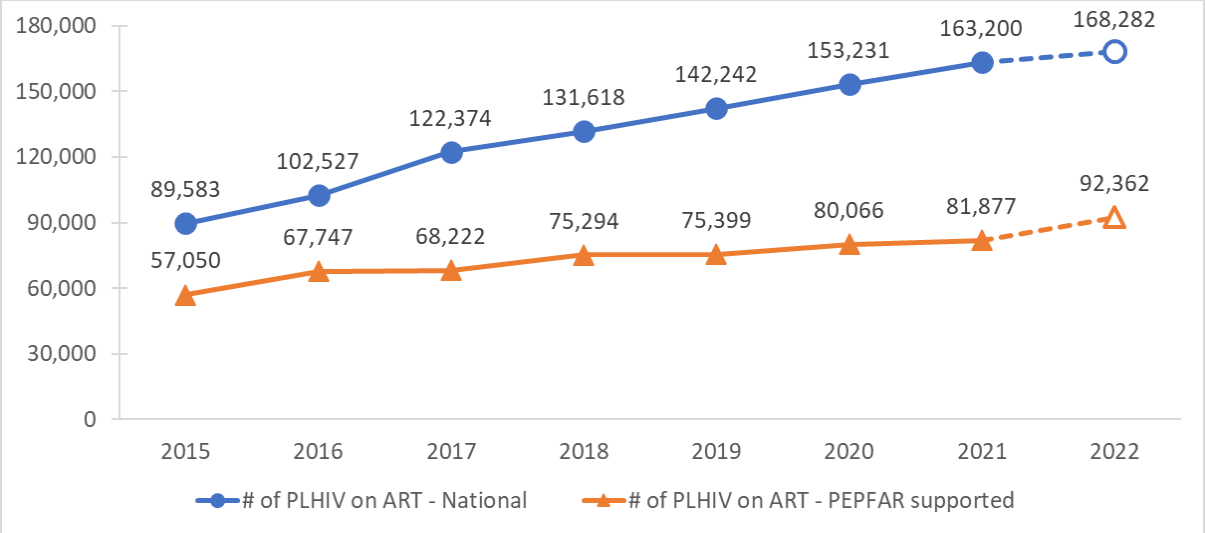
Orphans (maternal, paternal, double)															N/A
Notified TB cases (Yr)	101,749	98	752	0.74	925	0.91	3712	3.65	5476	5.38	24269	23.85	66615	65.47	NTP case report, 2019
% of TB cases that are HIV infected	2.841	2.81 %	23 (0.8%)				248 (8.7%)				2570(90.5%)				NTP- case reporting 2020
% of Males Circumcised															N/A
Estimated Population Size of MSM	256,883														MSM estimation workshop estimated for 2020
MSM HIV Prevalence		13.4													HSS+ 2020
Estimated Population Size of FSW	85,459														AEM 2018 Estimated for 2020
FSW HIV Prevalence		3.1													HSS+ 2020
Estimated Population Size of PWID	189,581														AEM 2018 Estimated for 2020
PWID HIV Prevalence		12.7													HSS+ 2019

Standard Table 2.1.2

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression[2]										
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	98,183,219 [7]	0.24	242,100 [8]	207,252,[3]	172.500 [4]	71.3	96[5]	2,898,661[6]	26,366[6]	*16,306*[6]
Population <15 years	23,843,050[7]	0.03	4,300[8]	4,000	3,910[4]	91	93[5]	NA	NA	*110*[5]
Population 15+ years	74,340,169[7]	0.27	237,800 [8]	203,242 [3]	168,590 [4]	71	96[5]	NA	NA	*16,196* [6]
MSM	256,883 [10]	11.4[9]	N/A	NA	NA	NA	NA	163,236 [6]	14,056[6]	NA
FSW	85,459[8]	3.6[9]	N/A	NA	NA	NA	NA	27,043[6]	135[6]	NA
PWID	189,581 [8]	12.7[9]	N/A	NA	NA	NA	NA	137,868 [6]	1,766[6]	NA

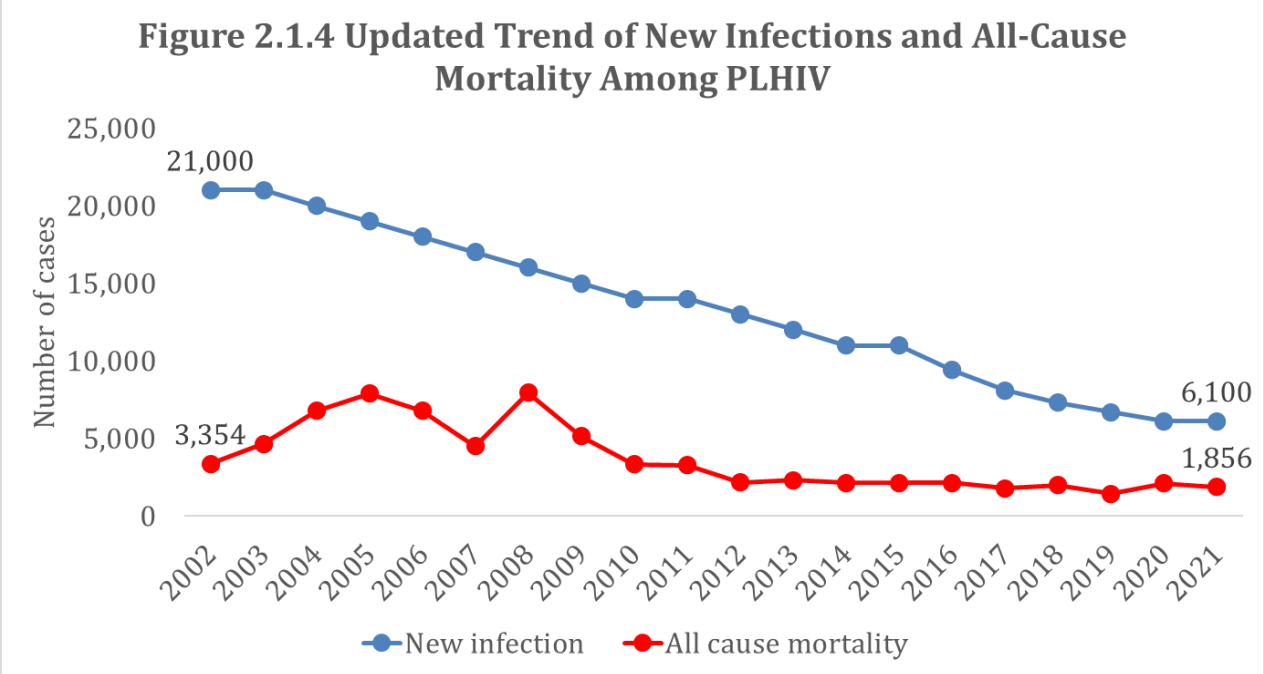
[2] National data- GSO– Calendar Year 2021
[3] VAAC - Source: VAAC case reporting system (Cir. 09) - Data has been reported cumulatively from provincial level and some de-duplication was estimated
[4] VAAC – Dec 2021, the number included estimation of self ART – was not reported to national reporting system.
[5] Est. from C03, PEPFAR reported age band in 11 surge provinces as 88.
[6] VAAC – National reporting Program (Cir 03) – Data from October 2020 to September 2021; some duplication may exist, no UIC available for HTS_TST and HTS_TST_POS. For TX_NEW it is known that national institutes did not report to C03 so we need to add their number in.
[7] GSO, Population Census 2019, estimated for 2022.
[8] AEM model, VAAC M&E department 2021
[9] HSS+ 2018 and HSS+ 2019
[10] MSM estimation workshop in 2020

Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment



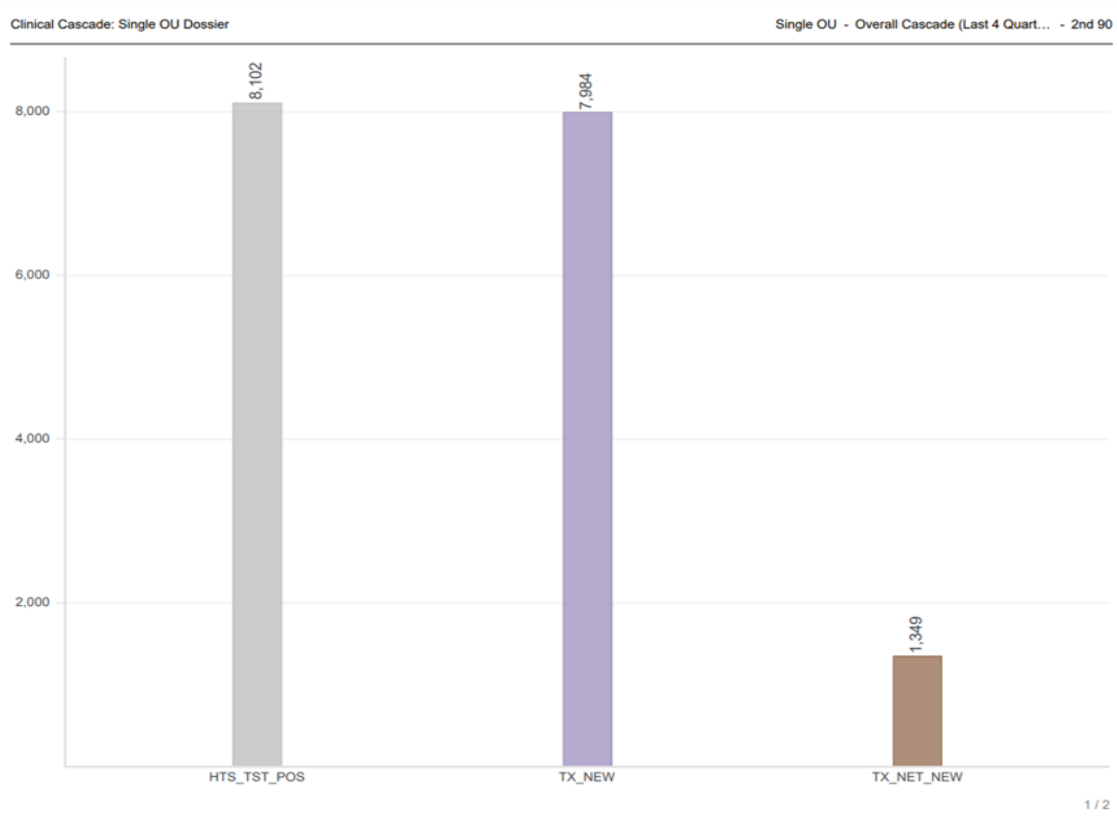
Sources: VAAC- Presentation of VAAC at COP stakeholder meeting, Mar 12, 2022. PEPFAR report, Quarter 1, FY 2022.

Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV



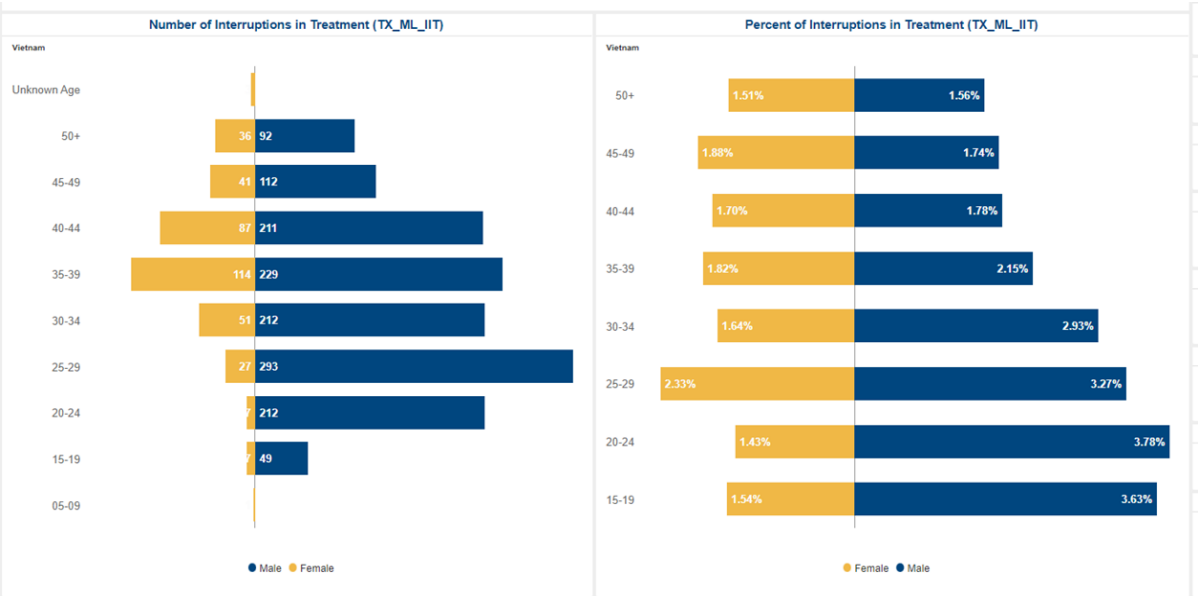
Source: All-cause mortality, VAAC- Presentation of VAAC at COP stakeholder meeting, Mar 12, 2022. New infection, Epi Data - UNAIDS Spectrum HIV Estimates, 2021

Figure 2.1.5 Assessment of ART program growth in FY21



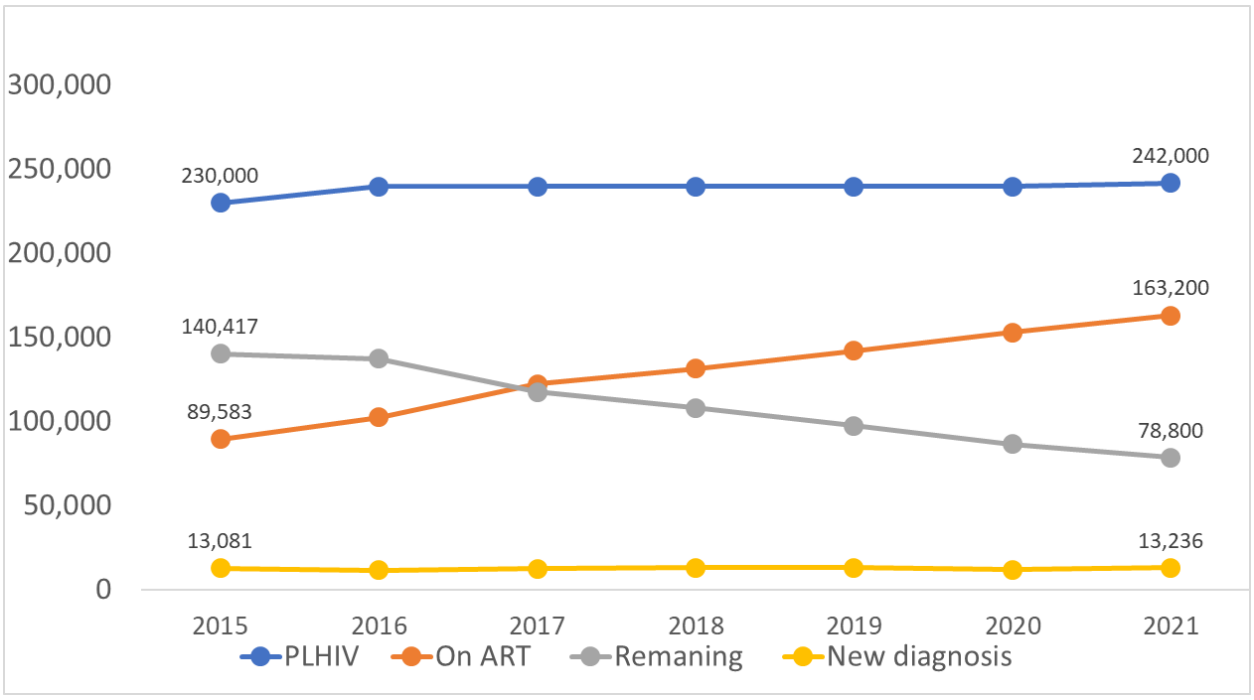
Source: PEPFAR panorama clinical cascade: Single OU Dossier – last 4 quarter- download on April 04, 2022

Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4



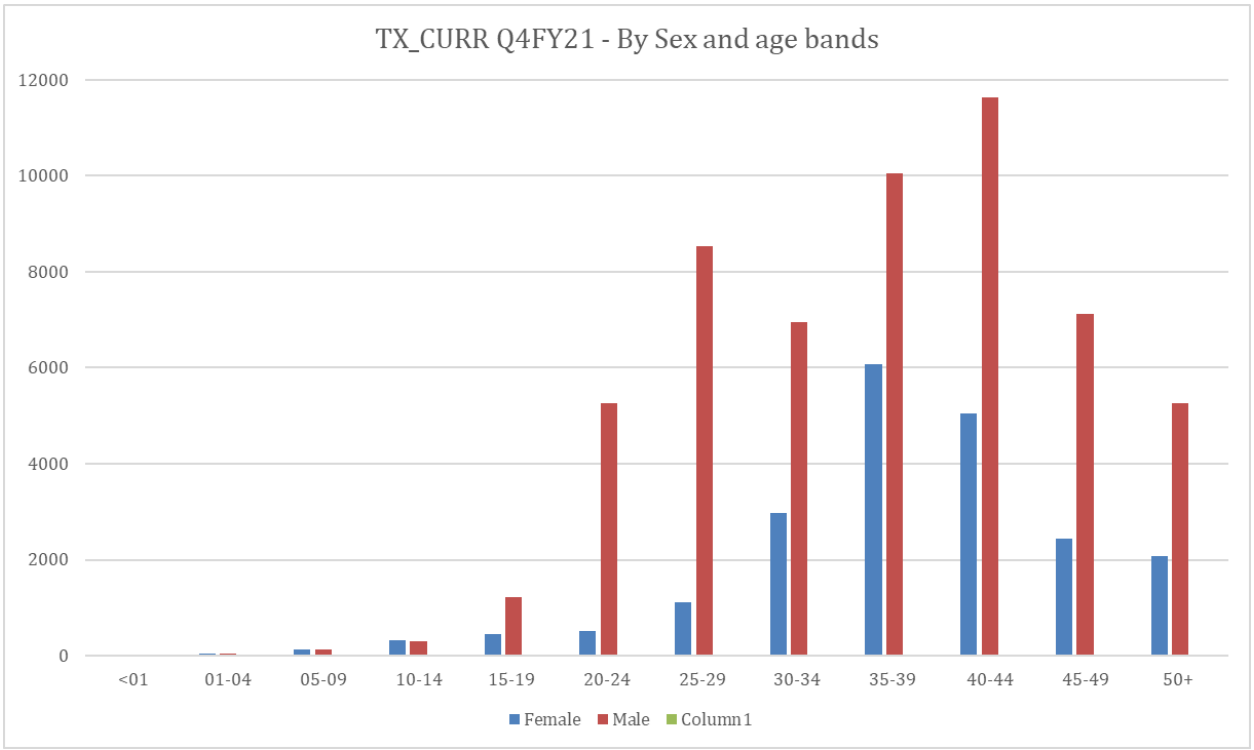
Source: Q4FY21 PEPFAR panorama clinical cascade: Treatment Single OU Dossier –- download on April 04 2022

Figure 2.1.7 Epidemiologic Trends and Program Response for Vietnam (Figure 2.1.1.3 in COP22 Guidance)



Source: VAAC - Presentation of VAAC at COP stakeholder meeting, Mar 12, 2022. Epi and Treatment Data - UNAIDS Spectrum HIV Estimates, 2021

Figure 2.1.8 PEPFAR Supported HIV treatment by sex and age bands 2021 Q4



NOTE: *The PEPFAR Vietnam program has reported data by fine-age and sex bands since Q1FY21. Data from before Q1FY21 is not available for comparison. Moreover, there is still about 15% of TX_CURR that could not be broken down to fine-age and sex bands at Q1FY22. PEPFAR Vietnam is working with partners to ensure that detailed data will be reported as soon as possible.*

2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

Maintaining treatment continuity and quality will continue to be a priority in COP22. During the COP virtual planning meeting (VPM) the team conducted an analysis of trends by region for clients not returning to treatment. This analysis highlighted key areas specifically in the South around treatment interruptions. Major contributors to program loss were transferred-out (49%) and interruption in treatment (TX_ITT 35%). Based on sub-group analysis, targeted interventions will focus on health facilities and clients with high frequency of treatment interruption and transfers out. In COP22, client and site-level TA including CQI activities to track treatment continuity and follow up will be done to ensure clients are successfully retained in care at either current or referred facilities. For example, PEPFAR will use SMS appointment reminders and track missed visits in real-time, ensuring these clients are contacted right away and navigated to care using a “welcome back” approach. PEPFAR will also ensure wrap-around services – now including cervical cancer/HPV screening – will be available to ensure a one-stop shop, whole-of-person approach to care for new and returning ART clients. PEPFAR will also scale-up return of VL results via SMS to support VL literacy, patient empowerment, and ART continuation. Provincial technical teams will be re-invigorated in COP22 to maintain quality of the treatment cohort both inside and outside the PEPFAR priority provinces, ensuring that PLHIV across the country have access to PEPFAR best practices.

COVID-19 mitigation plans and supply chain security will continue to be closely monitored to minimize treatment interruptions, with a regular monthly meeting with PEPFAR, drug supply partners, VAAC and others to be initiated prior to the beginning of COP22. The program will continue to engage with community partners, the private sector and public facilities to put clients at the center of care using community models such as community advisory boards (CABs), with new research documenting outcomes to support the mainstreaming of these approaches. Community will also play an increasingly important role in the PHCR in COP22. In COP22, new inputs around specific high-risk groups will be studied to gain a better understanding around care-seeking behaviors. A KP study will be done in COP22 to understand these trends across various groups including serodiscordant KP couples. PLHIV estimations will be conducted with the VAAC to further strengthen understanding of the trends around transmission, in particular key KP groups, and support VAAC on strategic approaches for targeted case finding and PrEP approaches. Specific service delivery activities which will be new in COP22 include expansion of PrEP service delivery sites in both public and private sector as well as implementation of tele-PrEP pilot for PrEP initiation. Furthermore, CAB LA – once approved by WHO and available in-country – will require support to VAAC for national guideline changes and an implementation pilot to understand acceptability and feasibility.

2.3 Investment Profile

In 2020, domestic funding started to surpass the external funding to HIV programs both in terms of absolute dollar amount and proportion of the total expenditure in Vietnam. This milestone has been achieved thanks to the successful transition of the HIV treatment program that was once donor-dependent to the one that is increasingly financed through Vietnam Social Health Insurance (SHI) An updated evaluation of national HIV expenditure for 2021 shows that the

overall proportion of domestic resources, including both public- and private-sector spending, has increased from 35% in 2015 to approximately 53 percent in 2021.

In 2021, the Government of Vietnam budget (including central and local government budgets) covered approximately 23 percent of total HIV expenditures. Contributions from SHI have been gradually increasing and represented 14% of the total HIV expenditure in 2021. Central government funding still covers a small portion of ARV drugs (around 5% of total ARV need) for some target groups that are not eligible for SHI and methadone for harm reduction programs. Very modest funding was for regular monitoring, oversight and technical support activities at the central level; development of new policies and revision and adaptation of new guidelines; and HIV sentinel surveillance.

In addition to Social Health Insurance, considered a major source of funding for ARV treatment services from 2019 onward, provincial government funding has been considered to cover the HIV response, especially for HIV prevention services in the years to come. The Prime Minister's decision approving the National Strategy to End AIDS in 2030, has paved the way for the development and endorsement of the Provincial Sustainable HIV Plan for the next 10 years that requires all 63 provincial authorities to commit sufficient funds for their local HIV responses. Up to now, 44 out of 63 provinces nationwide have issued such a plan with funding commitment to their provincial HIV prevention and control and allocation of funding for 2021. However, resource gaps still remain high in those with approved financing plans, at 17% of total resource needs. There is a budget line that allows provincial funding to cover the subsidy of ART for those who transfer to SHI and a budget line that supports community-based prevention services. However, the unclear guidance or conflicting interpretation of existing policies on the use of provincial funding for such purpose still requires further refinement and consistent guidance from the central level. To ensure equity and a smooth transition to SHI, provinces will continue to use the Global Fund resources to cover SHI premiums and copayment costs for clients when domestic resources are insufficient or when there are unclear guidelines for those who receive drugs from SHI through price negotiation methods.

SHI contributions have increased significantly from 2020 due to the gradually increased numbers of patients transferred to SHI and receiving examination and treatment services from this scheme. In 2021, SHI reimbursements for HIV services and ARVs almost doubled those in 2019, estimated at $16.2 million, including provision of ARVs to 112,000 PLHIV. It is expected that the GVN will cover ARVs for around 80 percent of all PLHIV through SHI in Vietnam by 2023. It is to be noted that as it is a curative scheme, SHI does not cover HIV prevention services. Therefore, domestic financing for HIV prevention activities, especially targeting KPs, is limited. Public expenditure for essential activities for KP prevention programs, such as case-finding, testing, and PrEP, only accounts for 20% of total public expenditure, and services are still primarily financed by donors.

Standard Table 2.3.1

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Care and Treatment	$52,409,693	76%	14%	10%	0%	
HIV Care and Clinical Services	$10,578,947	0%	52%	48%	0%	
Laboratory Services incl. Treatment Monitoring	$1,925,062	0%	89%	11%	0%	
Care and Treatment (Not Disaggregated)	$39,905,684	99%	0%	0%	0%	
HIV Testing Services	$5,777,909	0%	31%	69%	0%	
Facility-Based Testing	$2,036,046	0%	45%	55%	0%	
Community-Based Testing	$1,886,293	0%	32%	68%	0%	
HIV Testing Services (Not Disaggregated)	$1,855,570	0%	15%	85%	0%	
Prevention	$17,112,405	20%	48%	32%	0%	
Community mobilization, behavior and norms change	$2,882,537	0%	32%	68%	0%	
Voluntary Medical Male Circumcision	$0					
Pre-Exposure Prophylaxis	$4,827,590	0%	34%	66%	0%	
Condom and Lubricant Programming	$2,226,887	0%	100%	0%	0%	
Opioid Substitution Therapy	$1,673,528	0%	91%	9%	0%	
Primary Prevention of HIV & Sexual Violence	$136,650	0%	100%	0%	0%	
Prevention (Not Disaggregated)	$5,365,213	65%	32%	3%	0%	
Socio-economic (incl. OVC)	$70,235	0%	100%	0%	0%	
Case Management	$0					
Economic Strengthening	$0					
Education Assistance	$0					
Psychosocial Support	$0					
Legal, Human Rights, and Protection	$70,235	0%	100%	0%	0%	
Socio-economic (Not Disaggregated)	$0					
Above Site Programs	$14,898,403	11%	11%	78%	0%	
HRH Systems	$980,937	0%	11%	89%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$450,000	0%	0%	100%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$5,814,038	14%	16%	70%	0%	
Laboratory Systems Strengthening	$805,247	0%	0%	100%	0%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$5,892,757	0%	11%	89%	0%	
Laws, Regulations and Policy Environment	$160,000	0%	0%	100%	0%	
Above Site Programs (Not Disaggregated)	$795,424	100%	0%	0%	0%	
Program Management	$26,240,477	71%	6%	23%	0%	
Implementation Level	$26,240,477	71%	6%	23%	0%	
Total (incl. Commodities)	**$116,509,123**	**54%**	**18%**	**28%**	**0%**	
Commodities Only	$33,056,321	59%	33%	8%	0%	
% of Total Budget	*28%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table S3. Investment Profile (Expenditures) for HIV Programs, 2020						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2020
Care and Treatment	$56,465,598	51%	29%	10%	10%	
HIV Care and Clinical Services	$18,179,154	0%	72%	28%	0%	
Laboratory Services incl. Treatment Monitoring	$1,810,191	0%	99%	1%	0%	
Care and Treatment (Not Disaggregated)	$36,476,253	78%	5%	1%	15%	
HIV Testing Services	$5,765,307	6%	45%	42%	7%	
Facility-Based Testing	$577,724	0%	0%	100%	0%	
Community-Based Testing	$1,257,178	0%	0%	100%	0%	
HIV Testing Services (Not Disaggregated)	$3,930,405	8%	66%	16%	10%	
Prevention	$21,434,019	39%	25%	21%	16%	
Community mobilization, behavior and norms change	$4,567,769	0%	40%	60%	0%	
Voluntary Medical Male Circumcision	$0					
Pre-Exposure Prophylaxis	$2,611,456	0%	51%	49%	0%	
Condom and Lubricant Programming	$329,366	0%	100%	0%	0%	
Opioid Substitution Therapy	$2,912,578	35%	25%	0%	41%	
Primary Prevention of HIV & Sexual Violence	$5,693	0%	100%	0%	0%	
Prevention (Not Disaggregated)	$11,007,157	66%	10%	3%	21%	
Socio-economic (incl. OVC)	$0					
Case Management	$0					
Economic Strengthening	$0					
Education Assistance	$0					
Psychosocial Support	$0					
Legal, Human Rights, and Protection	$0					
Socio-economic (Not Disaggregated)	$0					
Above Site Programs	$12,356,018	45%	11%	44%	0%	
HRH Systems	$448,610	0%	0%	100%	0%	
Institutional Prevention	$40,630	0%	0%	100%	0%	
Procurement and Supply Chain Management	$932,670	0%	17%	83%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$2,408,045	0%	27%	73%	0%	
Laboratory Systems Strengthening	$245,840	0%	0%	100%	0%	
Public Financial Management Strengthening	$220,933	0%	0%	100%	0%	
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$4,287,099	63%	6%	31%	0%	
Laws, Regulations and Policy Environment	$670,120	0%	43%	57%	0%	
Above Site Programs (Not Disaggregated)	$3,102,071	94%	0%	6%	0%	
Program Management	$10,871,747	46%	13%	40%	0%	
Implementation Level	$10,871,747	46%	13%	40%	0%	
Total (incl. Commodities)	$106,892,689	45%	26%	21%	9%	
Commodities Only	$37,376,405	42%	56%	2%	0%	
% of Total Budget	*35%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Standard Table 2.3.2

Table 2.3.2 Investment Profile (FY2022 Funding Landscape) for HIV Commodities						
	Total	Domestic Government	Global Fund	PEPFAR	Other Funders	Trend
	Current year	%	%	%	%	2018-2021
Antiretroviral Drugs	17,000,000	2.9	17.6	6.5	72.9	
Condoms and Lubricants						
Female condoms						
Male condoms	500,000		100.0			
Other condoms and lubricants						
Rapid Test Kits	1,256,402	0.6	20.0	74.6	4.8	
Laboratory Supplies & Reagent						
CD4	296,000		100.0			
Viral Load	1,390,000		100.0			
Other Laboratory supplies						
Medicines						
Essential Medicines						
Tubeculosis Medicines	14,042,810	9.2	26.0	0.8	64.0	
Other Medicines						
Consumables						
VMMC Kits and Supplies						
Other Consumables						
Health Equipments						
Health Equipments						
Service and Maintainance						
PSM Cost	1,450,000		95.0	5.0		
Total Commodities Only	**34,485,212**					
Source: VSS data, VAAC data, GF data, PEPFAR data						

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Antiretroviral Drugs	$24,581,384	79%	16%	4%	0%	
Laboratory Supplies and Reagents	$2,704,362	0%	99%	1%	0%	
CD4	$0					
Viral Load	$0					
Other Laboratory Supplies and Reagents	$2,704,362	0%	99%	1%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$684,160	0%	87%	13%	0%	
Essential Medicines	$594,160	0%	100%	0%	0%	
Tuberculosis Medicines	$90,000	0%	0%	100%	0%	
Other Medicines	$0					
Consumables	$3,731,821	0%	72%	28%	0%	
Condoms and Lubricants	$1,935,833	0%	100%	0%	0%	
Rapid Test Kits	$1,477,986	0%	29%	71%	0%	
VMMC Kits and Supplies	$0					
Other Consumables	$318,002	0%	100%	0%	0%	
Health Equipment	$20,889	0%	100%	0%	0%	
Health Equipment	$20,889	0%	100%	0%	0%	
Service and Maintenance	$0					
PSM Costs	$1,333,704	0%	79%	21%	0%	
Total Commodities Only	$33,056,321	59%	33%	8%	0%	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table S4. Investment Profile (Expenditures) for HIV Commodities, 2020						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2020
Antiretroviral Drugs	$22,224,562	45%	54%	1%	0%	
Laboratory Supplies and Reagents	$2,430,200	0%	100%	0%	0%	
CD4	$0					
Viral Load	$3,038	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$2,427,162	0%	100%	0%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$7,203,673	70%	28%	2%	0%	
Essential Medicines	$537,747	0%	100%	0%	0%	
Tuberculosis Medicines	$175,422	0%	0%	100%	0%	
Other Medicines	$6,490,504	77%	23%	0%	0%	
Consumables	$3,585,053	20%	74%	6%	0%	
Condoms and Lubricants	$1,147,238	0%	100%	0%	0%	
Rapid Test Kits	$1,733,794	19%	69%	12%	0%	
VMMC Kits and Supplies	$0					
Other Consumables	$704,021	55%	45%	0%	0%	
Health Equipment	$810,295	0%	100%	0%	0%	
Health Equipment	$810,295	0%	100%	0%	0%	
Service and Maintenance	$0					
PSM Costs	$1,122,621	0%	98%	2%	0%	
Total Commodities Only	**$37,376,405**	**42%**	**56%**	**2%**	**0%**	

Source: HIV Resource Alignment; Note: Domestic Gov't and Other Funders data included where available. Aggregated Domestic Gov't data has been included where disaggregation is not available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Standard Table 2.3.3

Table 2.3.3 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 Global Health Security	$6,000,000	0	0	0	N/A
USAID TB	$7,000,000	$600,000	1	0	Advocacy for inclusion of essential TB drugs in SHI
CDC (Global Health Security)	$5,700,000	$1,900,000	4	0	To help improve Vietnam's ability to prevent, detect and respond to infectious disease outbreaks.
NIH	$1,600,000	0	0	0	The NIH established collaborative HIV/AIDS Clinical Trials Networks (HPTN) to advance the science of HIV prevention and treatment and to contribute to the

					end of the HIV epidemic. Funds noted reflect FY22 grants only.
Total	**$20,300,000**	**$2,500,000**	**5**	**0**	

2.4 National Sustainability Profile Update

The HIV response in Vietnam has become a more domestically funded program since 2020. Bilateral donor funding has declined since 2013. According to available information at the end of 2021, government/public spending on HIV has reached 41% of total expenditure. The overall proportion of domestic resources (including both government/public and private sources) has increased from 35% in 2015 to an estimated 53% in 2021. Since 2016, the Vietnamese government has sought ways to mobilize domestic HIV resources through provincial government budgets, SHI contributions, and user fees. From 2019 onward, Vietnam is significantly increasing contributions from the national Social Health Insurance to fund HIV/AIDS treatment costs and aims to reach 80% from SHI contribution for ART services by 2023.

Local civil society in Vietnam has been an active partner in the HIV/AIDS response through service delivery, advocacy efforts, and as a key stakeholder to inform the national HIV/AIDS response. However, domestic funding remains limited for civil society. Social contracting for KP-led organizations is being piloted in several provinces with PEPFAR and UNAIDS support, and the VAAC has established a timeline for national use of social contracting for HIV programming by 2025.

The sustainability of the Vietnam HIV response and the health and well-being of PLHIV and key populations is at a critical inflection point. From April 2021 until now, a devastating 4th wave of COVID saw Vietnam have periods of the highest rate of COVID infection globally, with periods of strict lockdown and other highly restrictive social and physical distancing measures. The burden on the health system has negatively impacted financial, technical and human aspects of the health system. It will doubtless have an impact on the HIV program in the short-term and medium term.

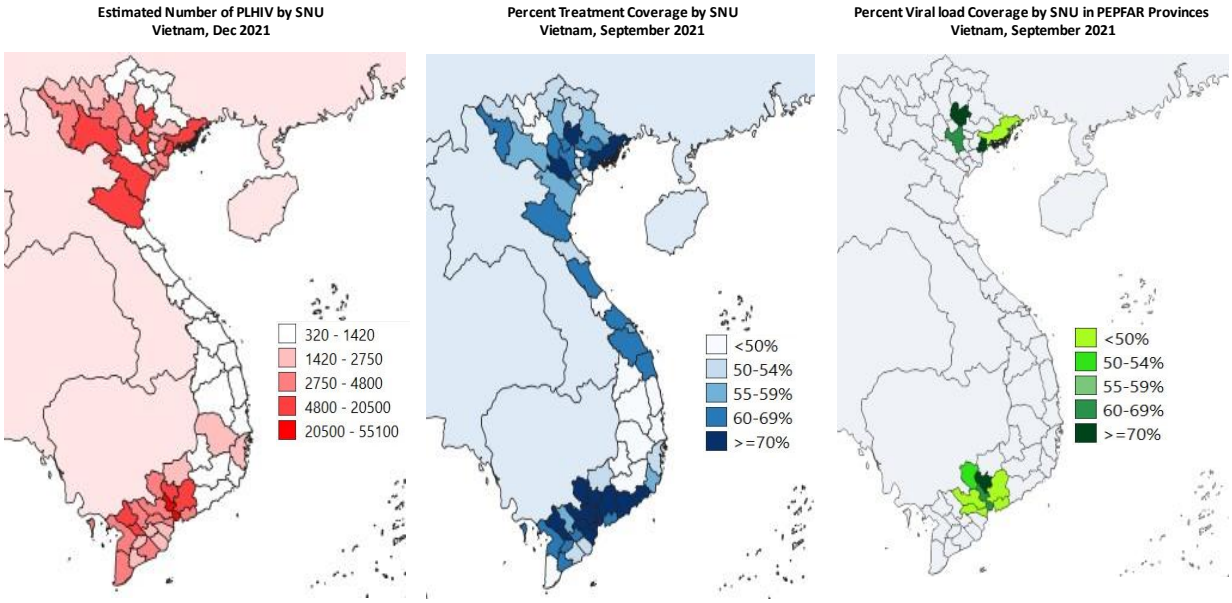
The Government of Vietnam and partners such as PEPFAR, the Global Fund and UNAIDS are committed to supporting a robust sustainability plan that ensures a strong HIV program for years to come.

2.5 Alignment of PEPFAR investments geographically to disease burden

The PEPFAR COP22 budget outlined in the Funding Allocation to Strategy Tool (FAST) adheres to the program and geographic focus of PEPFAR to achieve sustainable epidemic control in NEZ, HCMC Metro, and potential newly identified hotspots of disease transmission outside of the current 11 PEPFAR supported provinces. COP22 focuses on expanding the case surveillance system, implementing a public health cluster response approach, and achieving our direct service delivery targets. The program will support non-service delivery programming in direct support of the 95-95-95 targets and ensure a sustainable transition of the HIV response to the GVN. All commodities included within the FAST except recency testing will be used in NEZ and HCMC Metro.

Figure 2.5.1

Figure 2.5.1 People living with HIV, Treatment coverage and VL coverage in Vietnam



Data Source: Vietnam Administration for HIV/AIDS Control (VAAC), PEPFAR Vietnam

2.6 Stakeholder Engagement

In preparation for COP22, the PEPFAR team hosted a virtual national stakeholder conference on February 17, 2022, to gather input and feedback on how to prioritize resources in support of the national HIV response. The meeting was an opportunity to introduce the PEPFAR COP22 strategic direction to all the stakeholders, update on the national and provincial epidemic context, review program results and progress to date, identify prioritized technical areas and activities, and collect inputs for provincial joint plans. The team actively worked with GVN, development partners, IMs and civil society to identify and finalize the COP contents.

2.6.1 Host Country Government

Throughout the year, PEPFAR will continue to share updated implementation results with all stakeholders through quarterly POART slides. At the national level, the team will maintain regular meetings with the VAAC leadership and technical leads. At subnational levels, there are frequent meetings and visits by the management team, the agencies, technical teams, and IMs, with/to the provinces in NEZ and HCMC Metro Region. This level of engagement ensures the PEPFAR strategy and results are updated to all partners and local governments, challenges are identified and addressed, and new models that work are promoted.

2.6.2 The Global Fund and other External Donors

The management team members join the quarterly health partners meetings hosted by the MOH, gathering all development partners working in health in the country (including WHO, UNAIDS, PEPFAR, and the Global Fund, etc.) The team often meets with UNAIDS to discuss coordination with GVN and among development partners.

The PEPFAR Vietnam team and Global Fund (Geneva) maintain close contact via email and phone calls to ensure coordination and collaboration. At the country level, the PEPFAR Country Coordinator is a member of the Global Fund Country Coordinating Mechanism (CCM), and serves on both the CCM Executive Committee and the CCM Oversight Committee. PEPFAR

continually provides support in capacity building for CCM CBO/KP members, particularly in the oversight function.

2.6.3 Civil Society/Community

The team ensures people in the community are informed and heard. As part of the COP planning, PEPFAR ensures that key community representatives from all the provinces in NEZ and the HCMC Metro Region, both those receiving PEPFAR and/or Global Fund funding are well informed and offered opportunities to provide inputs to the strategic direction and work plans. In the COP22 process, 6 KP/CBO/PLHIV representatives were selected to attend the virtual COP Review meetings, and before that they had reached out to their networks and constituencies to gather community's input, comments, concerns, and suggestions to PEPFAR. The community representative presentation on the first day of the COP review meetings was very much appreciated and highly valued by PEPFAR and all the stakeholders.

2.6.4. Private Sector

As willingness to pay for health-related goods and services increases with Vietnam's economic growth, leveraging the private sector will be crucial for a sustainable HIV response in Vietnam. Engaging with the private sector was stated very clearly in the updated 2020 HIV law[1] and the new National Strategy for ending AIDS by 2030. With PEPFAR Vietnam's support, the first ever Private Sector Engagement (PSE) plan has been developed and approved by the MOH in 2021, market-based thinking and human-centered design has enabled more than 40 organizations to offer new HIV commodity and services alternatives to those affected by HIV in ways that promote choice, self-reliance, and innovation. Partnerships and significant investment from multinational and local companies have also improved health outcomes for people most at risk of HIV and had a positive impact on the companies' bottom line.

In COP22, the team will continue to strengthen its collaboration with community representatives, CBOs and KP-led social enterprises and businesses in efforts to improve access to HIV prevention (including testing and PrEP) and treatment among KPs and generate sustainable services in the long run. The capacity of the networks of people living with HIV (VNP+), people who use drugs (VNPUD), MSM, and TG people in the 11 surge provinces will be enhanced to deliver comprehensive HIV-related activities, including: outreach, lay, and self-testing; social network testing; index partner testing; PrEP/nPEP; linkages to treatment services and public health cluster response.

In addition, PEPFAR Vietnam will continue to work with private health providers to expand access to HIV testing, especially self-testing, PrEP/nPEP, and other HIV services. For example, PrEP services will be scaled through high quality one-stop-shops for MSM and transgender women in all 11 surge provinces. PEPFAR Vietnam continues to foster market entry for new HIV self-testing products and PrEP drugs (e.g CAB-LA) and continues to increase MOH capacity as an HIV commodity market manager through total market approach (TMA). PEPFAR Vietnam will support the first National Market Assessment on demand and supply of HIV-related services provided by the private sectors as the baseline to support rolling out the National PSE Plan. CBO and KP-led social enterprise and private clinic business capacity will be strengthened, and key private sector investors (such as pharmaceutical, diagnostics and medical supply companies) will continue to be engaged in developing the sustainable local market for HIV-related goods and services in Vietnam.

[1] https://thuvienphapluat.vn/van-ban/The-thao-Y-te/Luat-71-2020-QH14-Phong-chong-nhiem-vi-rut-hoi-chung-suy-giam-mien-dich-o-nguoi-HIV-AIDS-sua-doi-366792.aspx

2.7 Stigma and Discrimination (S&D)

PEPFAR Vietnam implements a robust S&D portfolio to address key populations-related internal, anticipated, perceived, and experienced HIV stigma in health and community settings. Since 2019, Vietnam joined the Southeast Asia Regional S&D Quality Improvement Collaborative, which tracks 8 common S&D indicators throughout the region with the goal of scaling up facility-based best practices to eliminate HIV-related stigma through quality improvement interventions with documented effectiveness. In sites that participate in this program, we document reduction of stigma across all the 8 indicators.

The initiative continues in COP22 with additional indicators to track PrEP-related stigma, expanded sites, and focus on incorporating person-centered perspectives in all site-level activities to eliminate stigma. In 2021, the Vietnam Network of People Living with HIV completed the 3rd round of the Stigma Index (final report to be released). It showed that 88% of PLHIV reported self-stigma, and TGW and FSW experienced higher levels of stigma in healthcare settings (over 20%) and avoided healthcare at the same rates. There were 43% of those surveyed who reported mental health issues such as anxiety and/or depression. The data is being used, along with the facility S&D data, community-led monitoring (CLM) findings and other client satisfaction data, to design mental health interventions and to scale up community-facility linkage models such as the Community Advisory Boards and C2P to engage in stigma-free program design with complementary community initiatives. COP22 investments will support GVN to expand these effective interventions and on-going measurement to document progress towards stigma elimination.

3.0 Geographic and Population Prioritization

Since COP18, the PEPFAR priority regions are defined as NEZ: Hanoi, Hai Phong, Quang Ninh, and Thai Nguyen provinces; and HCMC Metro: HCMC, Ba Ria-Vung Tau, Binh Duong, Dong Nai, Long An, Tay Ninh, and Tien Giang provinces. Within each region, there is a dynamic process of internal migration for economic opportunity and movement across provincial borders to access HIV services, including ART. Within NEZ and HCMC Metro, district-level prioritization has further focused PEPFAR resources and partner efforts into those areas with the highest HIV disease burden, highest rates of new case identification, and highest clinic patient loads.

Taken together, NEZ and HCMC Metro comprise more than 50 percent of the HIV disease burden in Vietnam. Within these zones, prevalent HIV infections are concentrated among MSM and TG persons, PWID, commercial sex workers (CSWs), and their sexual partners. Recency data in four case surveillance provinces suggests a higher percentage of recent HIV infections among HIV positive MSM aged 15-29 years at 12%. These data suggest that MSM have emerged as key contributors to the ongoing epidemic in Vietnam. Data from studies of urban MSM and recency surveillance confirm a larger and growing HIV risk among MSM, and especially among young MSM.

COP22 retains PEPFAR Vietnam's commitment to achieve 95-95-95 in the priority provinces, with focus on improving case-finding and linkage efforts. Strategic community-based testing, enhanced index testing, and contact tracing approaches will be applied for case finding within demographic and geographic hotspots identified through recency. As case surveillance continues to be implemented, insights from newly diagnosed cases will provide novel strategic information to design additional case-finding approaches, if needed. Using case surveillance for this purpose may allow for better characterization of non-KP networks to address any current testing gaps. Increased PrEP access and marketing will also serve as an entry point for HIV testing and to facilitate same-day access to PrEP for those at substantial risk for infection and same-day treatment for those who are diagnosed with HIV. This strategy reflects PEPFAR

Vietnam's commitment to focusing resources and efforts to achieve maximal impact and the goal of sustainable epidemic control.

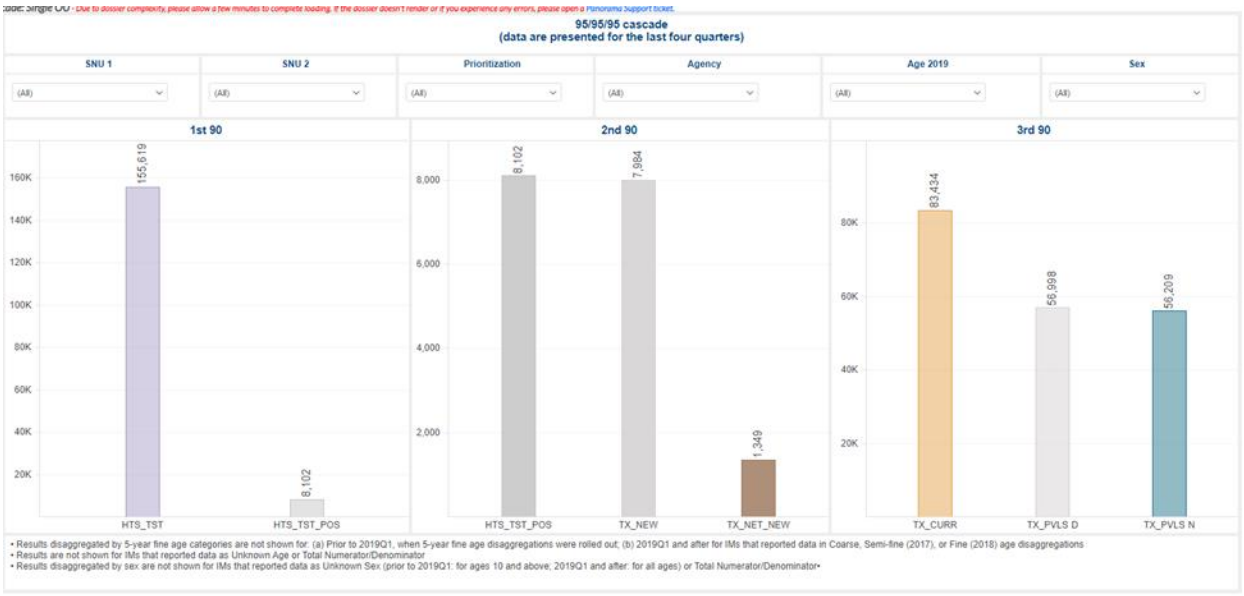
In addition, PHCR provides a real-time framework to shift and pivot resources in response to emerging hotspots and allows PEPFAR to effectively move and establish support where it is most needed. In COP22, PEPFAR will continue supporting VAAC to monitor for future outbreaks nationwide, and the interagency PHCR team will ensure dissemination of best practices and TA support through the VAAC and provincial CDCs to ensure capacity building for sustainable HIV epidemic control for both the region and nationally.

Table 3.1

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP22**	**# Current on ART (FY21)**	**# of SNU COP21 (FY22)**	**# of SNU COP22 (FY23)**
Attained	NA	NA	NA	NA
Scale-up Saturation	82,100/33.9%	65,625	7	7
Scale-up Aggressive	39,600/16.4%	30,585	4	4
Sustained	NA	NA	*NA*	NA
Central Support	NA	NA	NA	NA

4.0 Client-Centered Program Activities for Epidemic Control

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



Source: PEPFAR MER data only

4.1 Finding people with undiagnosed HIV and getting them started on treatment

Achieving epidemic control requires a sustained decrease in incident HIV infections. Achieving and maintaining this decrease is most effectively accomplished through a comprehensive package of interventions: 1) assuring that PLHIV are identified, linked to treatment, and supported to maintain fully suppressed viral loads; and 2) PrEP for persons at substantial risk for HIV. Both full viral suppression among PLHIV and PrEP for those at substantial risk of infection begins with entry into HIV testing.

Nationally, an estimated 242,000 persons are living with HIV in Vietnam and the first 95 - case-finding – remains challenging with only 84% of PLHIV aware of their HIV status. And among the people who recorded knowing their HIV status, about 5% of them have incorrect and incomplete identification information which could be duplicated and would need further verification. Therefore, the actual proportion of people who know their HIV status is likely lower than 84%.

National data from case reporting systems, HHS+ and recency testing show trends in declining HIV incidence among PWID, but increasing incidence among MSM, mostly young MSM. In addition, sexual partners of PLHIV are contributing about 25% of newly identified HIV cases. National data also show the increase in the proportion of estimated and reported HIV cases in the South. Therefore, PEPFAR Vietnam is increasing focus to Ho Chi Minh City metro and supporting public health cluster responses outside of PEPFAR DSD provinces, including in the Mekong Delta. PEPFAR Vietnam also has developed a comprehensive approach to reach, test and link MSM, especially young MSM, and sexual partners of PLHIV to ART or PrEP. In the meantime, we maintain coverage of services among other KPs.

In response to this public health need, in COP22, PEPFAR Vietnam will tailor case-finding and service delivery activities to KPs, focusing on MSM and sexual partners of PLHIV, through a multi-pronged approach. PEPFAR Vietnam will continue diversifying testing strategies to meet the unique needs of MSM, PLHIV contacts and other KPs. To reach adolescent and young MSM, in addition to a comprehensive package of services, PEPFAR Vietnam will work with the Government of Vietnam on guidance for sex-positive HIV prevention and stigma reduction geared to youth in high schools, universities and workplaces and launch evidence-based interventions in high burden provinces.

In COP22, self-testing will be further expanded and emphasized as a key strategy to overcome stigma and discrimination that may be barriers to facility testing for KPs. Clients opting for self-testing will have the option of blood-based or oral HIV self-tests to increase choice. Social network strategies and lay- and self-testing will be integrated into index case testing to expand opportunities to test sexual and injecting partners and quickly link them to ART or PrEP, a strategy which will be deployed in a PCHR effort. In addition, PEPFAR Vietnam will scale up the Duo HIV/Syphilis test for MSM/TGW to promote HIV testing.

PEPFAR will prioritize differentiated services based on client choice to improve access to and uptake of services. Recognizing the lack of KP-friendly sites with integrated HIV services, PEPFAR Vietnam will scale up one-stop shops in PEPFAR provinces to provide integrated sexual health services for KPs especially MSM and transgender women. At all sites, clients will receive no-cost walk-in packages of HIV/sexually transmitted infection (STI) testing and sexual health examinations. Adopting an innovative “status neutral” approach, those testing negative for HIV with risk factors will receive same-day PrEP, while those testing positive for HIV will receive same-day ART. On-site wrap-around services—like index case testing (ICT), mental health support, and harm reduction services for ATS (amphetamine-type stimulants) – will be provided at the visit whenever possible; for highly specialized services—such as dermatology and venereology services for specific STIs—the clients will be referred within network, with the assurance that any in-network site will be KP-friendly and capacitated to provide holistic sexual health care.

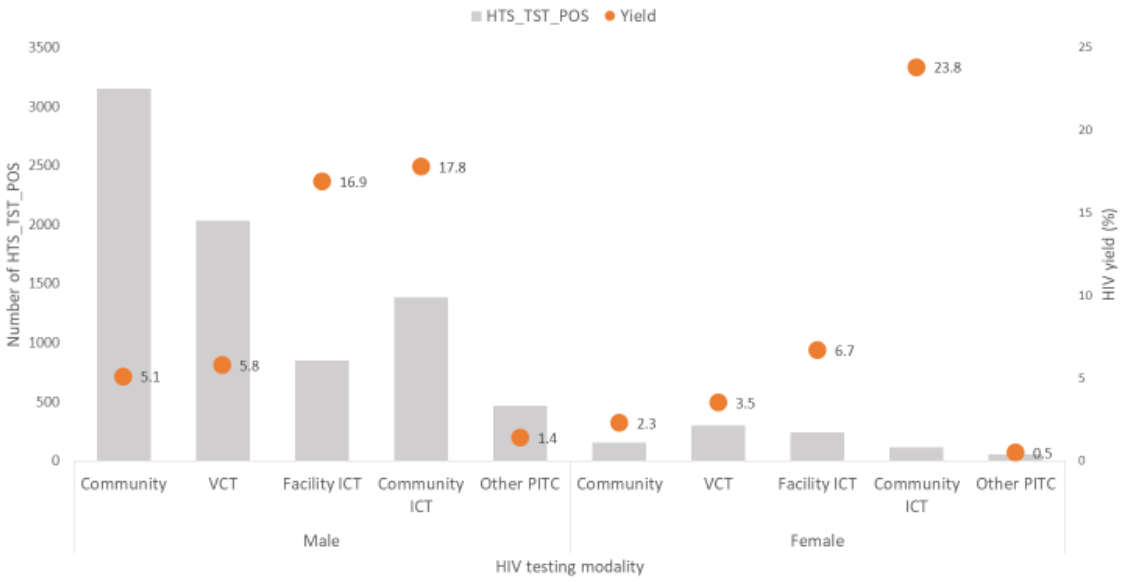
PEPFAR Vietnam will use social media and internet-based approaches to encourage KPs to get tested, in care, and retained on ART or PrEP. The one-stop shop network will create demand for services through popular social networking websites and dating apps that MSM frequent. Once clients start receiving ART care or PrEP services, counselors at the sites will leverage information community technology and social media to proactively check in with clients on their health status, adherence, etc. Secure internet-based platforms will also be used for online-to-offline service delivery (e.g., teleconsults), appointment booking, anonymous partner notification, and other social network strategies. Social media can be rapidly leveraged during a public health cluster response to raise KP community awareness and promote engagement, ensuring the client experience informs and strengthens the quality of HIV service delivery locally.

PEPFAR Vietnam will regularly engage the KP community at all levels of service delivery by: 1) holding community consultations on topics of interest to KPs, ensuring current programming meets their needs; 2) creating mechanisms for community feedback at the site level, such as with community scorecards; and 3) scaling up community advisory boards and case management. The community will be an integral part of all phases of the PHCR by providing inputs, supporting the response, and participating in ongoing monitoring with an aim to enhance the quality of HIV service delivery.

Among all PLHIV, PEPFAR Vietnam is committed to advancing work on differentiated service delivery to remove barriers to accessing and continuing on ART. In COP22, PEPFAR Vietnam will fully institutionalize same-day ART by continuing to decentralize HIV confirmatory labs,

which in turn will decrease turnaround time to making a positive diagnosis. PEPFAR Vietnam will normalize 3-month MMD, including through SHI, and will advocate for 6-month MMD in select patients.

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21



This visual comes from: testing single OU dossier; testing and yield: modalities by age/sex/modality page, all 4 quarters, coarse age bands.

4.2 Ensuring viral suppression and ART continuity

Key populations, specifically young MSM and PWID aged 55+ years are at highest risk for loss to follow-up (LTFU) in PEPFAR Vietnam provinces. While Vietnam has among the highest global VL suppression rates, it is important to maintain high retention through multiple approaches, including reducing stigma; increasing understanding of the negative consequences of stopping ART; and providing adherence support through health providers and the community. PEPFAR Vietnam will encourage strong coordination between health facility providers and community-based supporters to ensure follow-up of clients who have dropped out of care. This will include prompt follow-up of those clients who have missed an appointment and referrals to KP-friendly services driven by patient choice. Individualized Treatment Continuation plans have been developed in PEPFAR sites to ensure clear messaging and follow-up between providers and clients. For young people, evidence-based approaches - e.g., using technology and leveraging peer support - will be employed.

Continuing Tailored Approaches in COP 22 to Improve Outcomes in Youth Including Young KP

- N=4,199 children and youth on ART
- 70% aged ≥10
- 45% lost one parent
- 30% aged >10 undisclosed HIV status
- **11% unsuppressed VL**
- 50% above 16 linked to adult TX sites
- High rotation among HCW at Ped clinics, new staff need to be trained on youth friendly services

Work with **community** & understand needs
- An **online survey** conducted by VAAC to identify the gaps/needs in COP 21

Diversify health education channels
- **Ongoing cross-provincial forums** for HCWs and youth to share experiences on youth-friendly care

MMD-3 and **optimize regimens** with DTG 10 mg
- Revised **national guidelines** with preferred DTG regimen in COP 21; continued implementation/CQI in COP 22

Use **peers** for health promotion & service delivery
- Ongoing engagement of **peer educators** for health education and psychosocial/ART adherence support

Apply **technology** to support the cascade
- Implement **telehealth platforms** in COP 22

Data sources: VAAC 2021

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Advancing Person-Centered Program Services to Maintain TX Continuity in COP22

Person-centered services
- Institutionalize whole-of-person care, including advanced disease package and comorbidity screening/referral to care
- Expand holistic services by collaboration with co-located GYN for cervical cancer/HPV screening
- Standardize welcome back to care model
- Advocate for novel ARVs and utilize when available

Stable SHI services
- Address the gaps to assure no interruption of services in transition to SHI

Data-driven for program improvement
- CQI and promotion of friendly services

Apply technology in providing services
- Telehealth platforms

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Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex – PEPFAR MER indicators in 11 supported provinces, Q1FY22. Data has been updated using detail partners report

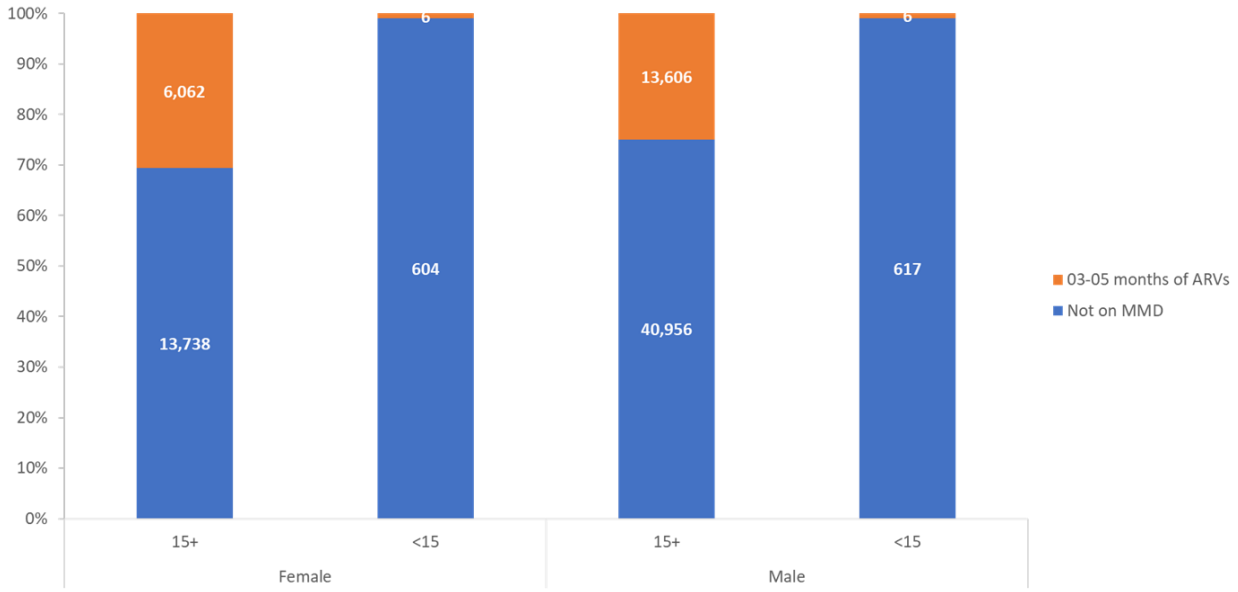
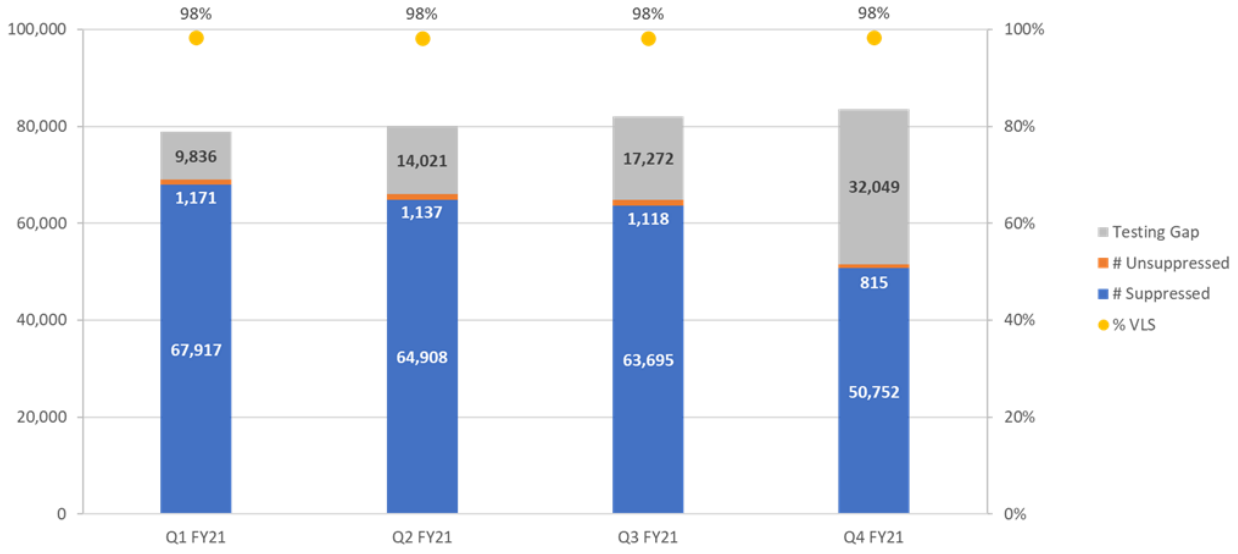


Figure 4.2.2 Viral Load Outcomes, FY21. PEPFAR MER indicators in 11 supported provinces



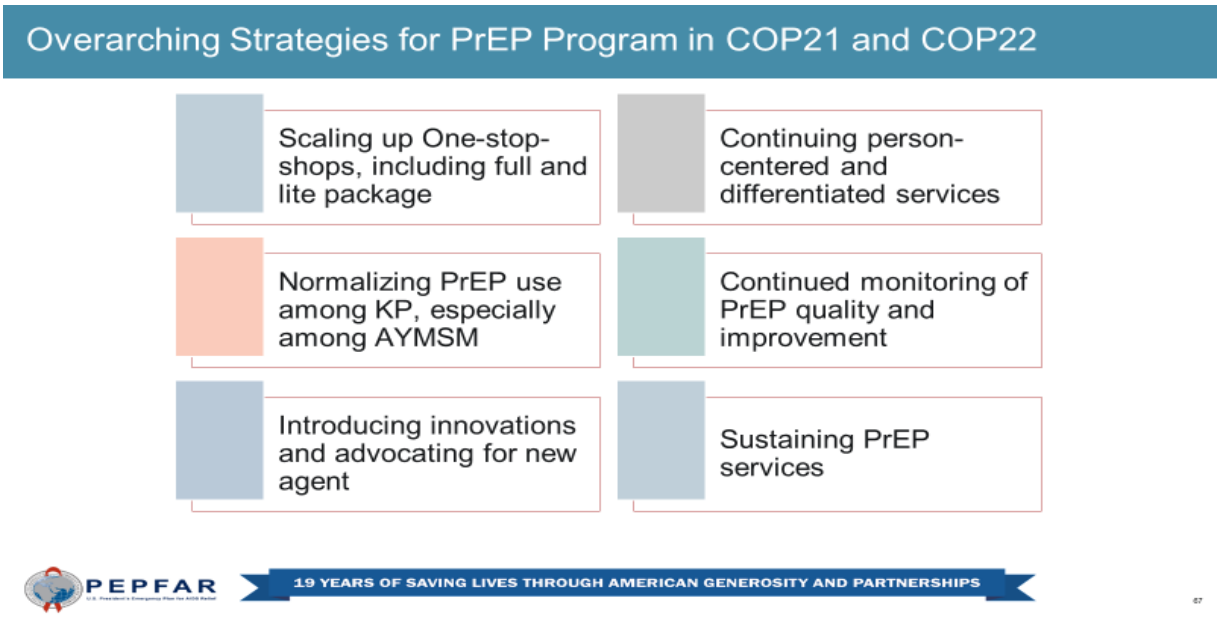
4.3 Prevention, specifically detailing programs for priority programming:

In COP22, PEPFAR Vietnam prevention activities will continue to focus on achieving the first 95 targets in the two priority regions, NEZ and HCMC Metro. PEPFAR Vietnam will boost HIV prevention and case-finding packages through targeted, confidential, and person-centered approaches that focus on enabling a strong PrEP program through cross-cutting interventions

by the public, private and community. Testing remains the entry point for PrEP and supporting prevention awareness among HIV negative clients.

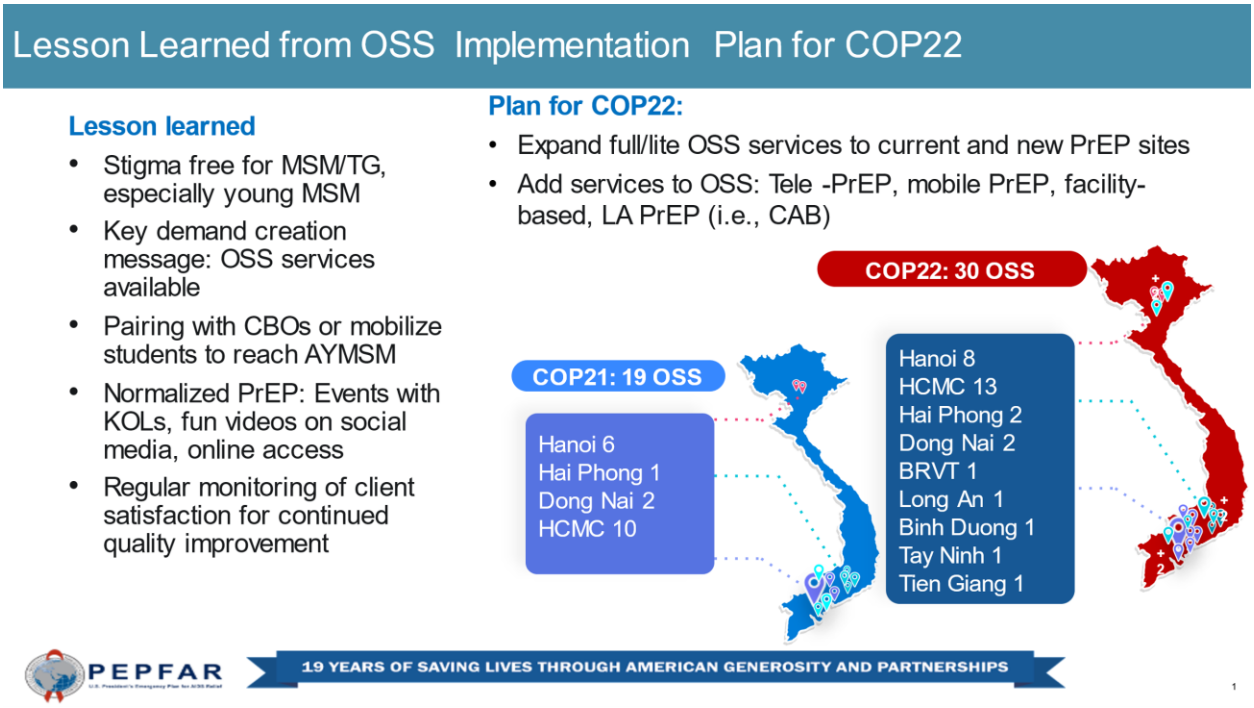
In COP22, PEPFAR Vietnam will provide PrEP services for 18,000 new clients and maintain PrEP service for 15,972 clients in the 11 surge provinces. To meet these targets, services will be scaled to more than 100 sites including public, academic, and private sites, which will be strategically located in high-burden zones and capacitated to be community-oriented, person-centered, and KP-friendly. Further, PEPFAR Vietnam will scale differentiated and innovative models of PrEP service delivery through one-stop shops for MSM and TGW, community health stations, pharmacies, mobile and tele-modalities. In addition, PEPFAR Vietnam will work with the GVN to demonstrate community-based PrEP drug distribution and long-acting injectable PrEP (CAB-LA). These evidence-based innovations are vital to reaching the large population who could benefit from PrEP while also reducing the burden on existing facilities.

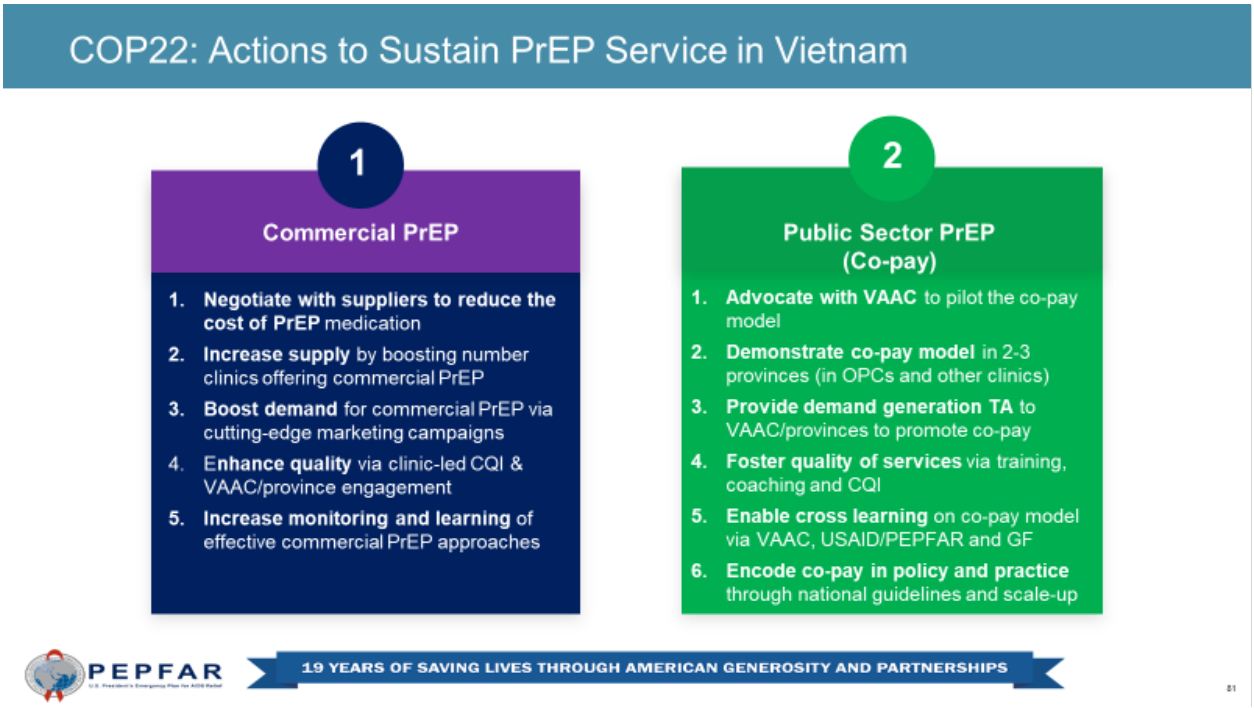
To optimize resources, PEPFAR Vietnam continues to leverage existing prevention programming to support PrEP, with recruitment and linkage of high-risk negative persons from testing access points, including both facilities and community-based, to PrEP sites. Also, PEPFAR Vietnam will continue to diversify its recruitment methods by implementing social network strategy (SNS) and enhanced peer outreach approach and in fact both CDC and USAID are using novel SNS approaches like EPOA and have shown some promising results. Other SNS approaches include, using multiple social media channels, targeted PrEP campaigns at national and provincial levels to normalize PrEP use and reach hidden KPs, especially, adolescent and young MSM/TG in schools, universities and industrial zones. With VAAC, PEPFAR will continue to support ED-PrEP for MSM, finalizing the health information system (HIS) for better management of PrEP clients and services and continue to create an enabling environment for implementation of long-acting injectable PrEP. Using navigators and other person-centered strategies, PEPFAR Vietnam will also provide adherence and continuation support tailored to address needs of diverse PrEP users. There will be continued efforts to enhance mechanisms of community monitoring and client feedback and to use program data to improve the quality of services and address barriers to PrEP access, including stigma by institutionalizing this continued quality improvement work in the PrEPQual as part of the National PrEP HIS. Finally, PEPFAR Vietnam will continue to explore multiple financing options to sustain PrEP through SHI, provincial budgets through co-pay model, and the private sector.



One-Stop Shops

PEPFAR Vietnam recognizes that HIV prevention programs must be responsive to client needs and risk profiles. With PEPFAR support, the GVN issued the national guidelines on implementation of HIV interventions for MSM in FY2019, which clearly defines a core package of services to curb the HIV epidemic among MSM. To operationalize this, PEPFAR Vietnam team will continue to support 19 MSM-friendly “one-stop shops” in Hanoi and HCMC and open 11 new ones in other surge provinces, aiming to improve access to and uptake of tailored behavior change communications, sexual health care, HIV/STI testing and treatment, PrEP/nPEP, ART, and other important services such as mental health and substance use.





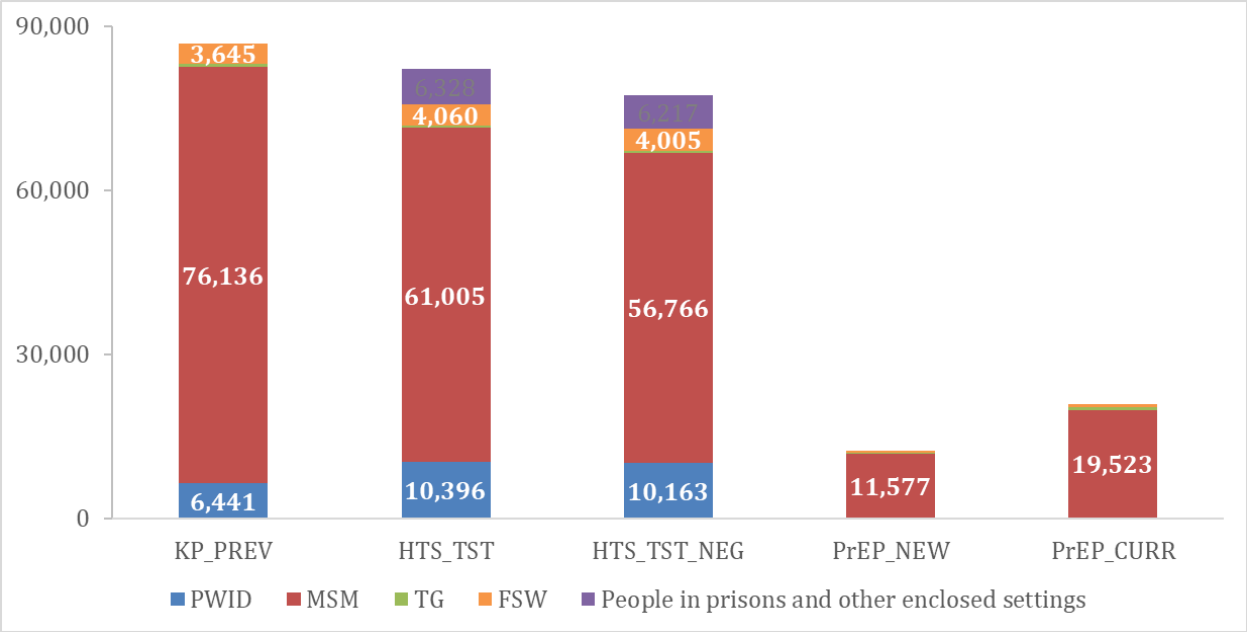
Military HIV Prevention Programs

PEPFAR Vietnam will continue to provide TA for the two military HIV prevention programs as prioritized by the military government: 1) HTS in military health care facilities in the surge regions, and 2) HIV/AIDS awareness and prevention for military active-duty personnel, particularly newly recruited soldiers. These supports are included: strengthening capacity for military health care staff; consolidating essential HIV prevention and case finding messages and practices in the military settings with special attention to PrEP, index testing, recency (either through offering the service or linking clients to civilian and community service offerors); promoting integration/adaptation of innovative case finding and prevention models and approaches that best fit into the military setting. At the national level, this TA will assist the military medical system to enhance its contribution to the overall national HIV prevention and control goals, since from 80 to 90 percent of clients/patients of military health care facilities are civilians, and HIV prevention messaging for military personnel, particularly newly recruited soldiers, remains a critical component of the national HIV/AIDS strategy and action plan.

Coordination with the Global Fund and other Programs

In COP22, PEPFAR Vietnam will continue to work closely with Global Fund-supported activities to leverage existing resources for achieving the 95-95-95 targets of the two priority regions. PEPFAR Vietnam will coordinate with the Global Fund at all levels of the cascade to ensure combined efforts, and consistency in technical approaches and certain managerial issues such as cost norms. Examples of this coordination include the national campaign to promote PrEP services, PEPFAR's virtual technical assistance to Global Fund-supported PrEP sites on demand generation activities, Global Fund-supported CBOs contributing to case-finding and linkage to PEPFAR-supported PrEP and ART services, and PEPFAR-supported prevention programs having access to preventive commodities (condoms, lubricants, and self-test kits) funded by the Global Fund.

Figure 4.3.1 Prevention Continuum by Key Population Group -. PEPFAR MER indicators in 11 supported provinces



4.4 Additional country-specific priorities listed in the planning level letter

Vietnam's COP22 Planning Level Letter specifically identified the following priorities, which are covered in other sections of this SDS. Additional technical directives detailed in the Planning Level Letter and descriptions of how the COP22 will address them are found in Appendix E.

1. **Investing in a sustainable Public Health Cluster Response, based on interoperable health systems focused on case surveillance and person-centered approaches across Vietnam.** PEPFAR Vietnam will continue to support the Government of Vietnam's resilient and capacitated country public health system, including MoH and indigenous community organizations, to effectively respond in geographic areas – both inside and outside the 11 PEPFAR provinces – where case surveillance observes active HIV transmission, e.g., through signals such as time-space clusters of recent and acute cases. Recognizing the critical role of community in the PHCR, in COP22 PEPFAR prioritizes local community partners in PHCR at all levels – district, provincial and national – for a person-centered response. Diverse data streams will be linked, building sustainable, interoperable systems: a) for real time data triangulation to support a robust CS system capable of providing PHCR alerts; b) to reduce monitoring burden and ensure all clients are receiving quality services that reduce treatment interruptions and build towards epidemic control.
2. **Truly reaching the 95-95-95 goals across Vietnam by continuing to evolve case-finding strategies to reach and treat all PLHIV as part of a sustainable Public Health Cluster Response.** Case-finding strategies will be efficient and sustainable, yet free of stigma and discrimination in COP22. Examples include blending social network strategy with index case testing and scaling use of HIV self-test kits (STK,) including for PrEP monitoring. PEPFAR continues its commitment to KP-friendly care in COP22 by institutionalizing training and other interventions in facility and community healthcare settings. PEPFAR will work with GVN to assess which prevention and testing strategies the GVN can take on.

3. **Continuing to balance the competing priorities of responding to the HIV and COVID-19 epidemics.** PEPFAR remains committed to ensuring gains made in the HIV response are not lost as the country adapts to a new normal during the COVID-19 pandemic. PEPFAR will use CQI methods to identify persons who miss appointments, triggering rapid responses to bring clients back to care with a "welcome back" rather than a punitive approach. PEPFAR will continue to advocate for institutionalization of tele- and mobile-medicine approaches along with decentralized drug distribution to maintain ART/PrEP continuity during pandemic disruptions. Finally, PEPFAR will work to maintain viral load coverage in the setting of increased demand for COVID-19 testing in the laboratory system.
4. **Increasing the role of local organizations in the HIV response, including those directly funded by PEPFAR.** In COP22, PEPFAR reaffirms commitment to a locally-owned HIV response including PHCR as described above. In addition to ongoing support to local public institutions (e.g., national laboratories, academic institutions), COP22 will see enhanced support for developing community-based organizations into social enterprises and expansion of the social contracting roadmap, as well as private sector engagement.

4.5 Additional Program Priorities

Policy priorities for PEPFAR Vietnam during COP22 include:

- Updating Circular 4210 for inclusion of VL results in data exchange between MOH and VSS
- Evidence to tele-medicine policy pathway after pilot for using tele-PrEP for first visit/initiation
- Social contracting evidence to policy pathway for institutionalization of Social contracting of HIV services to CBOs using GVN funding

1. *What are the plans to ensure scale up of index testing in alignment with the PEPFAR Guidance on Implementing Safe and Ethical Index Testing? What are the plans for ongoing monitoring, action and accountability to ensure compliance with the above guidance?*

   Scale up of index testing with inclusion of safe and ethical testing practices will continue to be a priority for PEPFAR Vietnam in COP22. Standard operational procedures are already in place and on-going monitoring will be supported through bi-annual reviews.

2. *What decisions were made on the program direction in COP22 based on the assessment of program performance reflected in COP20 Q1-Q4 POART findings and discussions and COP21 performance to date?*

   Based upon performance to date, key decisions for COP22 include further expansion of case finding best practices inclusive of expanding self-testing, social network testing, and enhanced peer outreach approaches, as well as strengthening community and health facility linkages to promote reach, test, counsel, and link. Successful PrEP models including one-stop shops will continue to be expanded in COP22 both through the private and public sectors and these modalities will include a prioritization of demand generation as core to reach more clients at risk for HIV transmission. Furthermore, academic partnerships will be strengthened to promote reaching high-risk groups including young men and TGW.

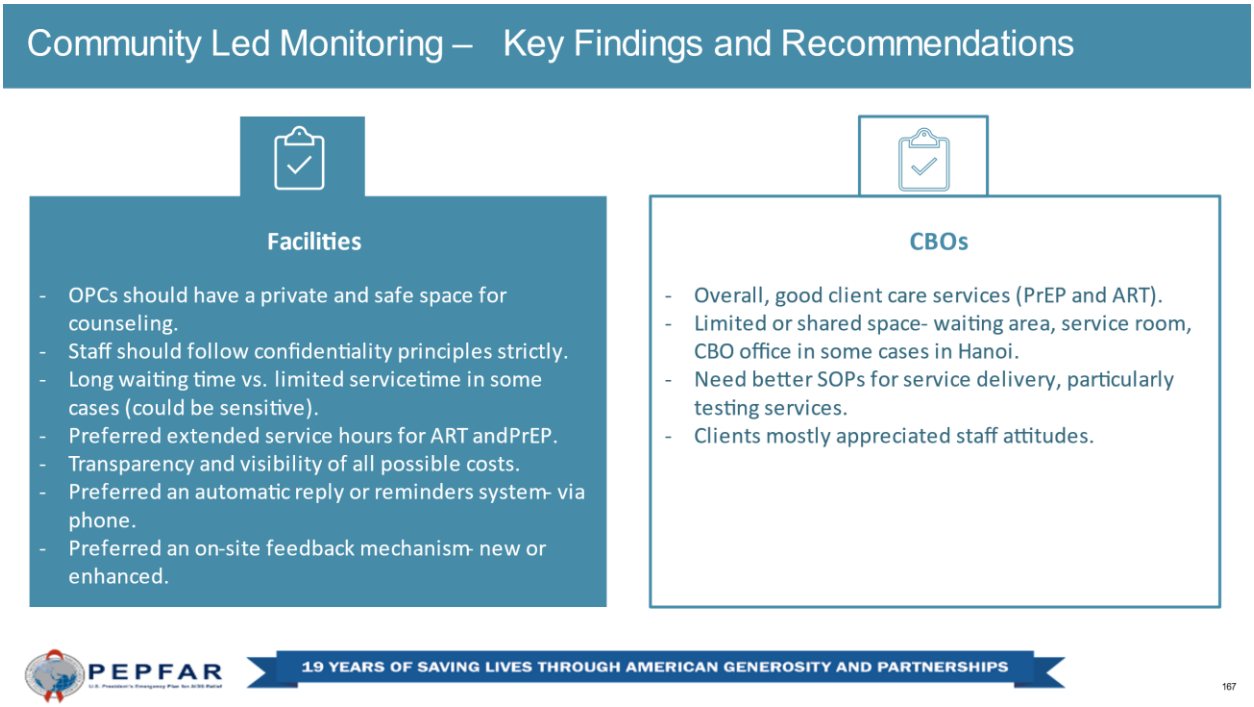
3. *How are Implementing Partners managed to ensure alignment with PEPFAR program strategy and to improve partner performance in an ongoing and timely manner?*

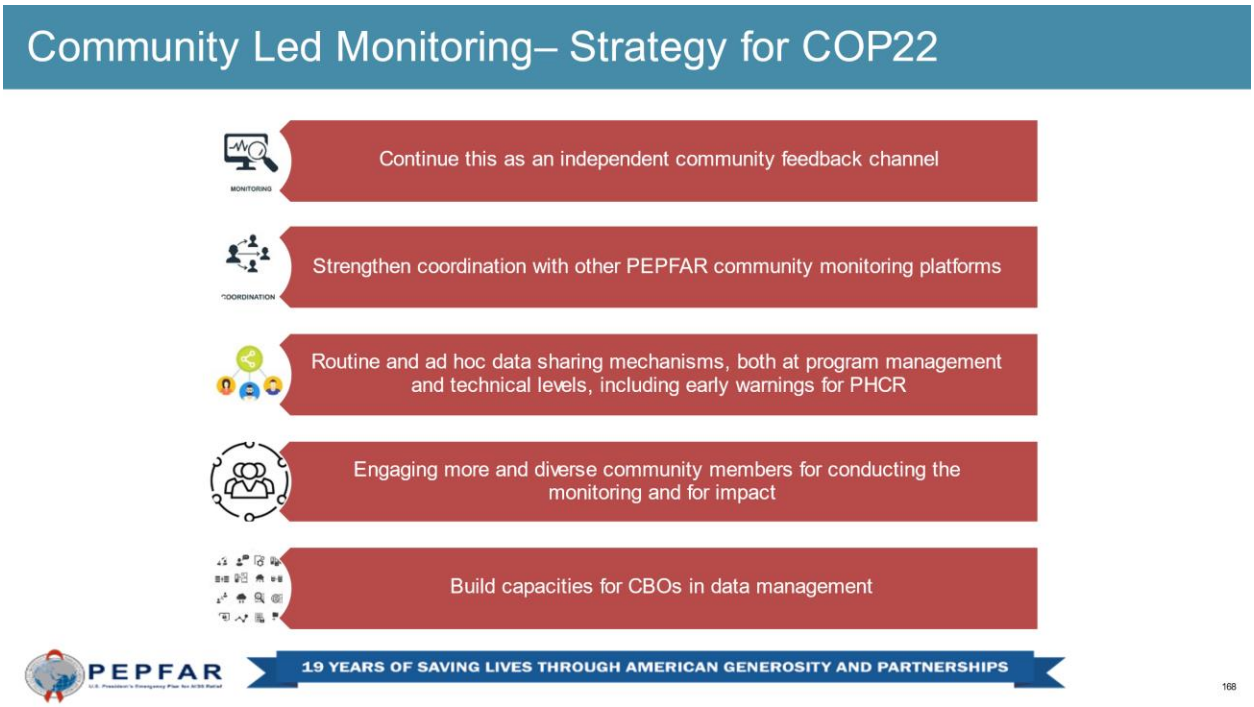
Implementing partner management will continue to be a priority during COP22 including data reviews both with partners and GVN stakeholders to ensure transparency and joint planning for poor performance. Routine meetings and data reviews will continue to use digital platforms to access real-time data and promote data use for decision-making discussions with GVN stakeholders.

4. *Describe the community-led monitoring plans and program, including focus on key populations, and how teams will ensure findings are utilized to drive program improvement.*

   Community-led monitoring surveys clients at PEPFAR supported sites, both public facilities and KP-led CBO sites, on a random convenience sampling basis. Thirty to 50 clients at each site are interviewed (for sites with less than or more than 1,000 clients, respectively) using semi-structured questionnaires (12 monitoring criteria for facilities and 8 for CBO sites) to evaluate feedback on testing, PrEP, ART, and overall care service quality. Survey plans were made in collaboration with the respective IMs and provincial CDCs.

   In the first year, quarterly reports were shared through USG agencies to IMs and sites. From the second year, site feedback will be shared in real-time at the technical level from the CLM team directly to IMs and sites, and provincial CDCs if needed, for prompt remediation if needed. Consolidated reports for HCMC Metro and NEZ are still prepared and shared routinely for overview, trending and comparison purposes. The CLM team also re-visits low-scoring sites after 6 months to measure improvement and make sure CLM findings were reviewed and solutions identified and implemented.





4.6 Commodities

PEPFAR purchased ARVs for Vietnam from 2005 until 2018 when SHI began procuring ARVs. Under VAAC's 2021-2025 ARV supply plan, SHI is the major source of funding for ARVs in Vietnam, increasing its contribution from 50% in 2020 to 94% in 2025. MoH has successfully conducted the price negotiation for the most common ARVs (TLD and TLE400) for the period March 2022 – March 2024. There have been policy/political and technical/programmatic issues with SHI ARV procurement over the last two years. The policy/political issues include reforms to current policies to simplify or improve the system. Examples of areas for improvement include multiple competing circulars that control ARV procurements; out of date revisions of relevant circulars/guidelines; and poor coordination among the many MOH stakeholders. The technical issues consist of: short-term timing of framework agreements (6-9 months in 2021); risk of procurement failure due to limited number of marketing authorizations; lack of interest from vendors; stock outs that stem from the lack of reconciled supply data with associated alerts; and the need for sufficient buffer stock and a plan that ensures goods can be delivered to the site(s) on short notice. PEPFAR technical assistance plays a critical role in supporting the coordination and advocacy for procurement between the various stakeholders at the MOH and VSS. In COP22, PEPFAR will continue to provide technical assistance to the GVN to expand SHI coverage to achieve these targets and support sustainable and functional systems for effective commodities security.

One of the most important activities happening in COP21 and that will continue in COP22 for planning future procurements is the development and operationalization of the Drug Security Plan. This plan will be an overarching planning document that looks at all sources of ARV drugs and plans procurements for the next 5 years. It will lay out the various options for procurement and the actions that need to be taken by the MOH. This includes the timelines for successful and timely procurement actions. This plan will also clearly outline roles and responsibilities of the various MOH stakeholders in the procurement process (VAAC, DAV, NDCPC, DPF, and VSS). In order to provide the stock status at all levels as well as to alert the insecurity supply of ARV drugs, PEPFAR will regularly monitor supply data and share information on a monthly basis with VAAC, PEPFAR and other stakeholders. In addition, the MOH needs to come up with

viable options for procurement for the pediatric, second-line and third-line ARVs that are very small quantities and most likely will never have marketing authorizations which cannot be transitioned to SHI. Options for procurement include considering international pooled procurement mechanisms.

PEPFAR continues to coordinate with VAAC and the Global Fund for continued acceleration of SHI routine viral load testing throughout the country. PEPFAR continues to monitor VL testing access and SHI coverage; increase provider and patient demand through viral load literacy and K=K messaging; support viral load testing decentralization; and provide technical assistance to VAAC to identify and expand potential viral load SHI copayment financing mechanisms at the provincial level. In addition, in COP22 PEPFAR will focus on the “last mile” of achieving universal viral load suppression and coverage by: reducing turnaround time for test results and providing them to clients; focus on prisoners, pediatrics and PWID who are shown to be at risk of high viral loads; and monitoring viral load testing gaps/pauses (due to COVID-19, cessation of donor-funded VL co-payments, other disruptions) for recovery support.

In COP22, PEPFAR Vietnam will procure 182,730 rapid fourth-generation HIV test kits, of which 143,964 will be for HIV testing services to identify 8,553 HIV positive cases; 38,766 will be for PrEP initiation/continuation. The fourth-generation HIV test kits and recency test kits can detect acute and recent infections, respectively, which will enable PEPFAR Vietnam to triage resources for the HIV response effectively. PEPFAR Vietnam also will procure 96,352 blood-based self-test kits, of which 57,585 HIVST will be used for case finding and 38,766 HIVST kits will be used for PrEP monitoring. There is currently enough stock of the oral self-test kits for COP22.

With support from PEPFAR, recency surveillance has been integrated in national guidance for epidemic control and PHCR since June 2021. In COP22, PEPFAR Vietnam continues to procure 20,000 Asante tests to scale up recency surveillance in Vietnam, through UCSF mechanism. PEPFAR Vietnam commits to provide technical assistance to GVN to expand the coverage of recency surveillance and to use recency data for PHCR and reaching epidemic control.

During FY19-21, PEPFAR implementing partners made progress in improving TPT uptake; however, TPT completion rates remained below the program target of 90%. By the end of Q1FY22, 96% of active ART patients at PEPFAR supported clinics had ever been on TPT, of whom 83% completed the regimen. Over the past years, PEPFAR has financially and technically supported the government of Vietnam (GVN) to fill TPT commodity gap and to demonstrate WHO’s recommended short-course TPT regimen (3HP) in 11 PEPFAR provinces, including the provision of technical assistance for national guidelines development. From May to December 2021, 30 PEPFAR-supported HIV clinics provided 3HP to 1,830 PLHIV, of whom 60% completed the course to date; only 0.8% reported having adverse events. PEPFAR has also supported Vietnam in the adoption of WHO recommendations on C-reactive protein (CRP) tests and urine LF-LAM as a point-of-care triage test.

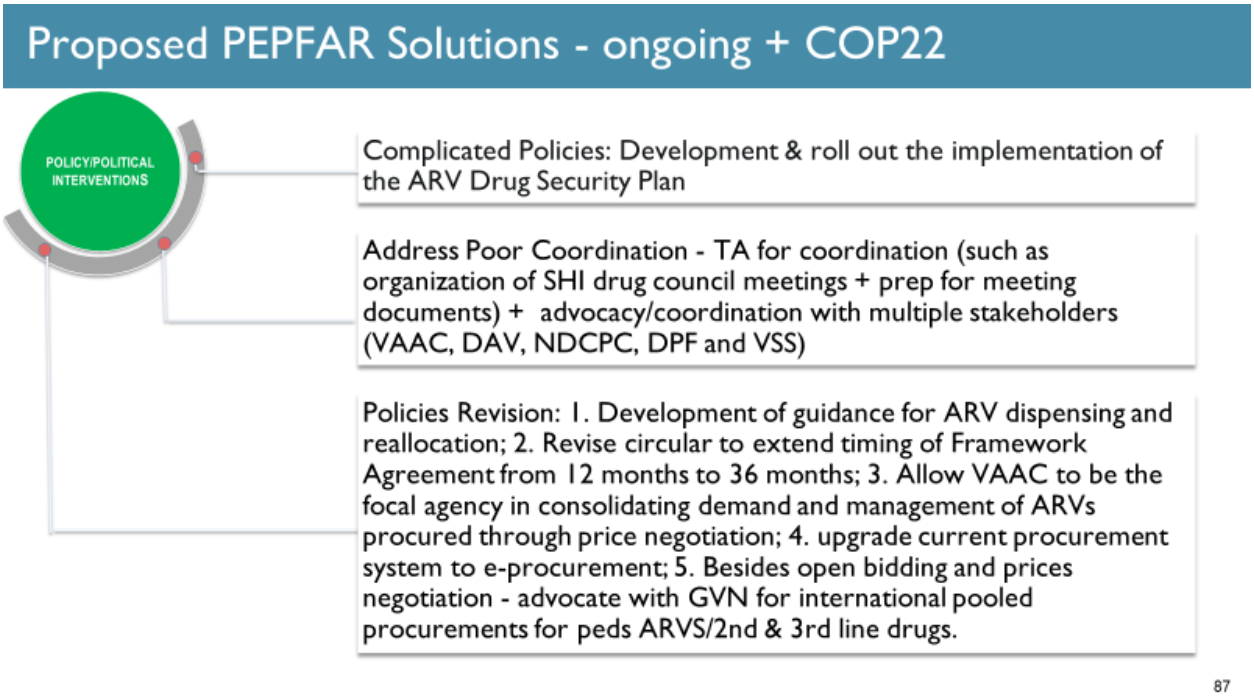
Currently, COP19-funded rifapentine (single-dose tablets) is available at site level. COP20-funded rifapentine (single-dose tablets) and COP21-funded 3HP (fixed-dose combination tablets) are expected to arrive in the country in mid-2022. In COP22, PEPFAR will not allocate funds for TB/HIV commodities. Current stock of PEPFAR-funded TB/HIV commodities is likely sufficient through mid-FY24. To avoid treatment interruption, Global Fund plans to support commodities to cover the gap until the social health insurance reimbursement mechanism is in place (anticipated by the end of 2026).

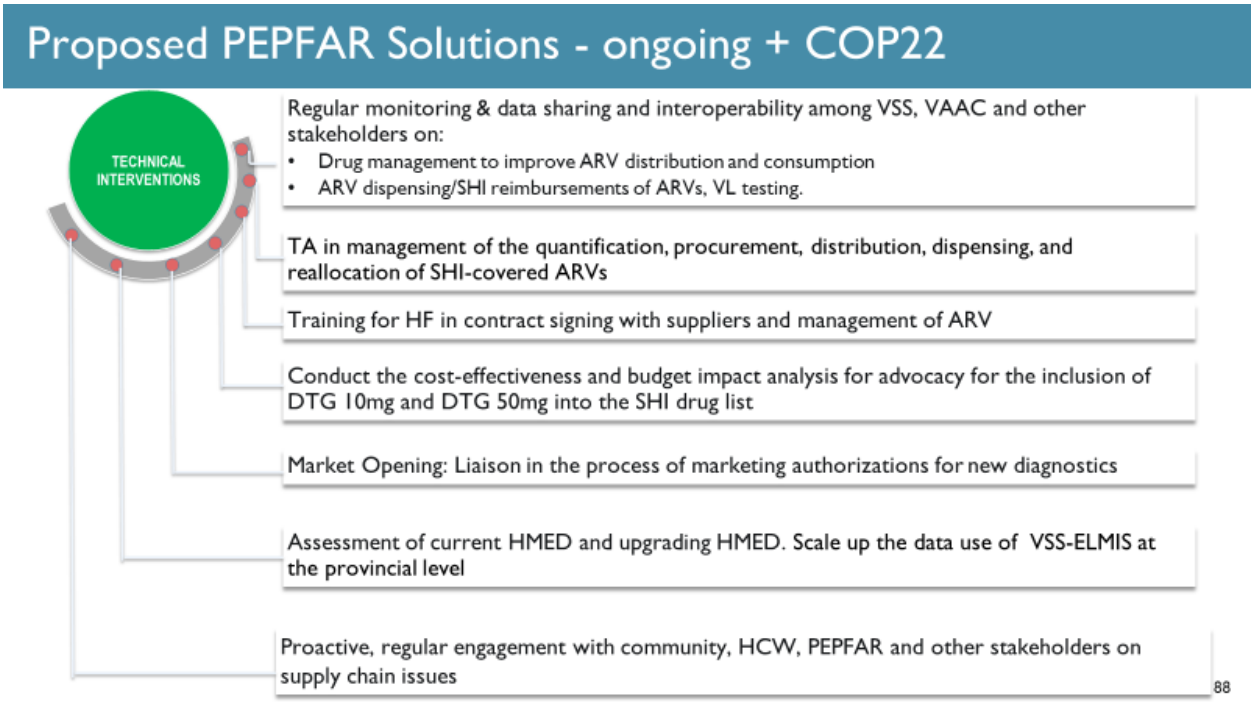
To support SHI coverage, PEPFAR will use 3HP implementation data from the demonstration, including uptake, completion, and pharmacovigilance. Advocacy will also include client and healthcare workers’ inputs and feedback to ensure scale-up of 3HP and other TB/HIV

innovations is sustainable and person-centered. In COP22 PEPFAR will work closely with healthcare workers and community partners to support literacy for and address barriers to using TPT/3HP to further improve uptake and completion rates.

Table 4.6.1 Summary of PEPFAR-supported commodities

Item	Comments	List Price Reference (US$)	Commodity Quantity (a)
PrEP Drug		3.95	229,452
Alere HIV-1/2 Ag/Ab Combo		2.20	182,730
Atomo Mylan Self Test		3.50	96,352
Asante HIV Rapid Recency Assay, Bulk Format, 100 Tests/Kit		725	200





4.7 Collaboration, Integration and Monitoring

PEPFAR Vietnam's COP22 strategy focuses on attaining 95-95-95 goals in NEZ and HCMC Metro regions. Concurrently, PEPFAR Vietnam will ensure continued sustainable transition of primary financial, administrative, and technical responsibility of HIV care and treatment services to the GVN, while supporting a GVN-led public health cluster response to dynamic epidemic needs. The targets to achieve 95-95-95 in the two regions will be supported by tailored packages of technical assistance and direct service delivery (DSD) to enhance case-finding, treatment linkage and continuity, and PrEP uptake.

Programmatically, there has been close interagency discussion as well as coordination with other stakeholders, like civil society, GF and GVN, around priority activities in COP22. These include: integrating SNS and index partner testing; increasing self-testing including for PrEP monitoring; supporting universal recency coverage and case surveillance to identify time-space clusters in the PHCR approach; continuing commitment to person-centered care with differentiated models (e.g., MMD and tele- and mobile-medicine), biomedical innovation, and integrated primary care services for PLHIV; further decentralizing HIV confirmatory testing to support same-day ART across sites; coordinating SHI and donor resources to assure universal routine viral load testing; and maintaining aggressive targets for PrEP services for key populations.

Across the cascade, PEPFAR Vietnam is committed to robust site-level monitoring and partner management using a CQI approach, to ensure consistent high-level performance and provide tailored resolution of site-level implementation challenges as they are identified. Above-site activities are monitored regularly against benchmarks, with close collaboration of partners. Community engagement and monitoring continues to be a critical strategy to ensure all PEPFAR programs are person-centered, stigma-free and implemented with an equity lens in COP22.

In parallel, case surveillance, enabling HIV sentinel events to be monitored at the individual level from diagnosis to death and underpinning the public health cluster response, builds on the planning, standards-setting, and provincial-level implementation in COP20 and COP21. COP22

will expand the national structure of a comprehensive HIV case surveillance system, including a system for assigning unique identifiers, and operationalize case surveillance in the 11 PEPFAR priority provinces and an additional four non-PEPFAR provinces on the path to full-scale national implementation.

4.8 Targets by population

Standard Table 4.8.1

Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY22)	Additional patients required for 90% ART coverage	*Target current on ART (APR FY23) TX_CURR*	*Newly initiated (APR FY23) TX_NEW*	ART Coverage (APR 23)
Attained	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Scale-Up Saturation	**82,100**	**69,224** **65,615**	**73,890**	**74,046** **70,192**	**6,011**	**90%**
Scale-Up Aggressive	**39,600**	**32,016** **26,383**	**35,640**	**33,821** **27,940**	**2,127**	**85%**
Sustained	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Central Support	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Commodities (if not included in previous categories)	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Mil				**338**	**56**	
Total	**242,100**					

***PEPFAR VN will not cover 100% in those SNUs; therefore, we provide estimation of whole SNU expected # and then PEPFAR targets in our supported sites**

**** Vietnam program proposes to reach 959595 mean 90% ART coverage in HCMC Metro and reach 81% ART coverage in NEZ in 20**

Standard Table 4.8.2 (VMMC) - not applicable to Vietnam

Standard Table 4.8.3

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control in PEPFAR supported SNUs			
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY23 Target**
MSM	**167,587**	**20,809**	**29,866**
TG	**11,747**	**1,201**	**5,531**
PWID	**65,050**	**9,596**	**10,944**
FSW	**38,797**	**1,758**	**9,978**
Total KP_PREV	**283,181**	**33,364**	**56,319**
Military recruitments			**50,000**
Others -PP_PREV			**77,442**
TOTAL			**183,761**

Those data were estimated for PEPFAR supported 11 SNUs. Data came from national/ provincial size estimation activities, then adjusted using program data.

Standard Table 4.8.4 (OVC) - Not applicable to Vietnam

4.9 Cervical Cancer Program Plans - Not applicable to Vietnam

4.10 Viral Load and Early Infant Diagnosis Optimization - Not applicable to Vietnam

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

PEPFAR Vietnam's commitment to achieving sustainable epidemic control incorporating a public health cluster response is reflected in above-site investments for COP22. PEPFAR Vietnam's above-site investments also reflect the program's continued commitment to the GVN and country stakeholders to responsibly transition the program, translate successful innovations and best practices for broader scale-up in the rest of the country, and ensure the quality and sustainability of the national HIV program.

As Vietnam approaches epidemic control, there is a need for a robust public health cluster response that can rapidly detect and address new infections while maintaining program quality. This robust response requires five key elements:

1) Data systems – including case surveillance, data collection, quality assurance – and data use.
2) Human resources for health (HRH) capacity for technical and timely public health cluster response.
3) Service delivery systems for recency testing, HIV prevention, treatment, and laboratory by the public sector, civil society (including CBOs) and the private sector through Social Contracting.
4) Sustainable domestic financing, including for prevention services and PrEP, and supply chain systems.
5) Increasing Local Partner capacity and KP-led community engagement.

Data systems, including case surveillance, data collection, quality assurance, and use for a robust HIV public health cluster response.

An efficient and responsive HIV program requires a case surveillance system, a culture of routine data analysis and use, and the ability to use the information for real-time response. Building on the pilot implementation of HIV case surveillance, and to expand the monitoring and reporting systems to support the public health cluster response, PEPFAR Vietnam will ensure the implementation of the CS in all 11 PEPFAR epidemic control provinces, and an additional four high-burden provinces, as well as finalize the architecture and minimum requirements of the national database in COP22. Recency testing will be scaled and included in routine monitoring and reporting platforms. Issues around interoperability of multiple program data streams will be resolved. Updated size estimations for key populations will also provide accurate data on HIV burden and need. Expected outcomes from these activities include: HIV case surveillance system components are linked and operational; HIV/AIDS data interoperability platform is established; and surveillance data are used routinely to measure and monitor performance and inform the HIV public health cluster response.

To address limited capacity for provincial and national-level authorities to access, aggregate, and interpret data for an evidence-based HIV program quality monitoring for sustained epidemic control, in COP22 PEPFAR Vietnam will support the development and scale-up of an easy-to-use, comprehensive provincial program monitoring dashboard that will include key program and systems indicators from national reporting streams and linked to CS data where relevant. Provincial technical teams and the national program will use both the CS and the Program Quality Monitoring dashboard to monitor and analyze input routinely, with the overall expected outcome that national and provincial HIV managers and experts can collect, analyze and interpret data to provide appropriate public health cluster responses.

Human resources for health capacity for technical and timely public health cluster response

2019-2022 was a particularly vulnerable period as the few remaining provincial AIDS centers were absorbed into provincial CDC structures in which HIV is mandated under a broader public health entity. There are also central level changes to the HIV program administrative structure during this period. To mitigate the potential for health system restructuring to compromise the delivery of HIV program technical assistance and provincial governance capacity for the PHCR, activities will focus on sustaining HIV expertise and deploying specific TA where needed. This includes scaling up and capacitating provincial HIV expert teams from different sectors and disciplines to address gaps in the HIV cascade, with provision of responsive technical assistance to address program gaps. Expected outcomes include: provincial program and HIV data are regularly collected and analyzed to track the program quality; and provincial technical capacity is standardized and mandated to implement a robust provincial public health cluster response.

Service delivery system including for HIV prevention, treatment, and laboratory by the public sector, civil society, including community-based organizations, and the private sector.

HIV service delivery systems lack innovative and person-centered models for an effective public health cluster response and for sustaining epidemic control achievements that facilitate reaching, testing, and retaining KPs and PLHIV across the HIV cascade. PEPFAR Vietnam works closely with the GVN and other stakeholders to promote the rapid adoption of innovative approaches, especially around reaching, finding, and testing KP. In COP22, PEPFAR Vietnam will build upon status-neutral messaging through institutionalizing the “ARVs for Prevention” framework with community-led design of status neutral health services in public and private sector (One-Stop Shops). PEPFAR Vietnam will continue working with private health providers to expand access to HIV testing, including self-testing, PrEP/nPEP, and other HIV services. Service delivery innovations focus on gaps in the clinical cascade while maintaining impressive adherence and viral suppression through differentiated care, despite COVID setbacks. Expected outcomes include: innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health cluster response; all PLHIV access person-centered differentiated care for viral suppression; and sustainable viral load coverage through SHI for ART clients in the two PEPFAR supported regions.

PEPFAR Vietnam can claim multiple successes in achieving extraordinary viral suppression rates, among the highest in PEPFAR, rapid scale-up of same-day ART, (SDA) and the expansion of recency surveillance, with recency data informing programmatic and public health cluster response. However, as PEPFAR phased out of direct commodity support, access to HIV confirmatory testing, recency testing, and VL testing remains a challenge resulting in limited use of routine VL and for recency testing for the public health cluster response. For viral load, the Vietnam program will focus on increasing the number and quality of labs that can process SHI reimbursements for improved coverage and access. HIV confirmatory labs will also be supported to increase in both number and quality to address challenges for SDA scale-up. PEPFAR Vietnam will support the GVN to institutionalize recency testing for improved surveillance and programming with expansion of recency testing. Expected outcomes include: increased capacity of HIV confirmatory labs in NEZ and HCMC Metro to increase case finding and access to early ART initiation; recency surveillance data used for coordination of public health cluster response at provincial and national levels; and increased access to viral load testing to maintain the third 95 and decrease forward transmission.

Sustainable epidemic control including domestic financing and supply chain

To maintain epidemic control and pivot to a robust public health cluster response, vulnerable domestic financing will be addressed through promoting and ensuring successful SHI transition of PEPFAR patients and services and scaling up diverse domestic financing streams, including

from national and provincial financial mechanisms, and through the scale up of private sector investments. While PEPFAR will continue to advocate for inclusion of HIV prevention services under SHI, priorities also include pursuing other innovative HIV prevention financing options to mobilize additional domestic resources. Additionally, PEPFAR will continue to engage with the private sector in providing HIV services and mobilize their investment in HIV prevention services and commodities. Expected outcomes include: all insured PEPFAR patients receive HIV treatment services reimbursed through SHI; GVN ensures no financial barriers for PLHIV to accessing treatment under SHI; and key HIV prevention interventions, such as PrEP and HIV testing, included under the SHI law.

PEPFAR support was significant to ensure that SHI can reimburse for HIV services and ultimately procure ARVs for PLHIV. In addition, the availability of initial TLD procurement also relied heavily on PEPFAR technical assistance and advocacy. To maintain progress in ensuring essential HIV commodities are available and accessible for all KP and PLHIV, PEPFAR will continue to resolve nascent domestic capacity in rapid expansion of procurement and supply management, and coordination for the HIV public health cluster response. This includes on-going support to standardize supply chain systems for ARVs especially for SHI, and to monitor potential quantification and stock-out issues. Expected outcomes include: increased GVN capacity to manage and coordinate HIV commodities procurement and supply chain from multiple sources; increased access to TLD through SHI; and increased access to essential HIV prevention commodities through diversified markets.

Increasing local partner capacity and KP-led community engagement

Flourishing community engagement with the public sector and KP-led services are crucial to providing person-centered options for KP and PLHIV to access HIV services. The lack of capacity and legal status of community organizations, including the private sector, to engage in the public health cluster response, provide community monitoring, and deliver innovative HIV services impacts case finding and prevention achievements. PEPFAR will continue to strengthen its collaboration with CSOs/CBOs and KP-led social enterprises and businesses in efforts to improve access to HIV prevention and treatment among KPs, generating sustainable services in the long run. PEPFAR Vietnam will support the scale-up of independent community monitoring on critical aspects of the HIV program. PEPFAR will also continue to support and scale social contracting for CBOs, as well as on-going capacity building for KP and CBOs to support the HIV program. Expected outcomes include: KP-led CBOs/private clinics and CSOs are legally included in the health workforce for HIV service delivery; increase in quality and quantity of diverse groups, including KP-led CBOs and civil society and social workers; and civil society, particularly community-based organizations actively monitor the HIV program for a true public health cluster response.

In addition to the above-site investments highlighted above, the PEPFAR Vietnam program will support the following:

1. Scaling up national and provincial case surveillance system
2. Update KP and PLHIV size estimations
3. Deploy surveillance technical assistance to high-burden provinces under the PHCR.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR Vietnam continues to assess its staffing footprint to ensure a staffing profile aligned to funding levels, programmatic goals, and performance. Staff time and focus continue to be in NEZ and HCMC Metro. The team continues to increase LES leadership within agencies, in the interagency and government technical working groups, and in key strategic planning discussions of program activities. No new positions are requested in COP22.

All cost of doing business (CODB) areas are re-examined and reduced when possible. There are no notable changes to CODB from COP21 to COP22. The PEPFAR Vietnam Management and Operations (M&O) COP22 budget represents 26 percent of total funding. The team constantly adjusts for slight changes in the International Cooperative Administrative Support Services (ICASS) and Capital Security Cost Sharing (CSCS) budgets, and within their travel allocations, maximizing savings and reducing costs when feasible.

Program and partner monitoring is an essential component of our staff's responsibilities. PEPFAR Vietnam has assigned provincial POCs for all 11 provinces in the NEZ and HCMC Metro, tasked with ensuring data monitoring, partner performance review on a monthly and quarterly basis. SIMS work has also been built into the annual work plan of all PEPFAR Vietnam staff to implement and enhance real time monitoring and technical assistance for sites and implementing partners. In COP22, PCO will continue to implement community-led monitoring through the small grants mechanism, which will be monitored and managed by the Coordinator's team.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	COP18 Prioritization	Overall TX Coverage (by APR 19)	COP19 Prioritization	Overall TX Coverage (by APR 20)	Cop20 Prioritization	Overall TX Coverage (by APR 21)	Cop21 Prioritization	Overall TX Coverage (by APR 22)	Cop22 Prioritization	Overall TX Coverage (by APR 23)
Ba Ria-Vung Tau[2]	ScaleUp Agg	71%	ScaleUp Agg	67.20 %	Saturated	72.6%	Saturated	77.5%	Saturated	85.51 %
Binh Duong	ScaleUp Agg	73%	ScaleUp Agg	77.20 %	Saturated	80.7%	Saturated	84.8%	Saturated	90.25 %
Dong Nai	ScaleUp Agg	63%	ScaleUp Agg	73.70 %	Saturated	80.8%	Saturated	84.9%	Saturated	90.26 %
Ha Noi	ScaleUp Agg	63%	ScaleUp Agg	58.30 %	ScaleUp Agg	75.1%	ScaleUp Agg	79.5%	ScaleUp Agg	85.50 %
Hai Phong	ScaleUp Agg	69%	ScaleUp Agg	72.90 %	ScaleUp Agg	76.9%	ScaleUp Agg	80.8%	ScaleUp Agg	85.51 %
Ho Chi Minh City	ScaleUp Agg	74%	ScaleUp Agg	79.70 %	Saturated	80.7%	Saturated	84.7%	Saturated	90.25 %
Long An	ScaleUp Agg	69%	ScaleUp Agg	72.40 %	Saturated	77.0%	Saturated	83.1%	Saturated	90.24 %
Quang Ninh	ScaleUp Agg	72%	ScaleUp Agg	80.90 %	ScaleUp Agg	83.8%	ScaleUp Agg	84.5%	ScaleUp Agg	85.51 %
Tay Ninh	ScaleUp Agg	70%	ScaleUp Agg	72.00 %	Saturated	77.0%	Saturated	83.2%	Saturated	90.25 %
Thai Nguyen	ScaleUp Agg	67%	ScaleUp Agg	72.90 %	ScaleUp Agg	77.6%	ScaleUp Agg	81.5%	ScaleUp Agg	85.51 %
Tien Giang	ScaleUp Agg	71%	ScaleUp Agg	74.40 %	Saturated	79.0%	Saturated	85.8%	Saturated	90.25 %
An Giang	Ctrl Supported	67%	Not Supported	72.70 %	Not Supported		Not Supported			
Bac Giang	NOT DEFINED	50%	Not Supported	58.90 %	Not Supported		Not Supported			

[2]COP20 surge provinces are highlighted in blue

Bac Kan	Not Supported	53%	Not Supported	50.80 %	Not Supported		Not Supported			
Bac Lieu	Not Supported	60%	Not Supported	66.70 %	Not Supported		Not Supported			
Bac Ninh	NOT DEFINED	41%	Not Supported	49.90 %	Not Supported		Not Supported			
Ben Tre	Not Supported	64%	Not Supported	65.80 %	Not Supported		Not Supported			
Binh Dinh	Not Supported	38%	Not Supported	49.80 %	Not Supported		Not Supported			
Binh Phuoc	Not Supported	33%	Not Supported	45.80 %	Not Supported		Not Supported			
Binh Thuan	Not Supported	96%	Not Supported	81.20 %	Not Supported		Not Supported			
Ca Mau	Not Supported	32%	Not Supported	44.60 %	Not Supported		Not Supported			
Can Tho	Ctrl Supported	62%	Not Supported	79.70 %	Not Supported		Not Supported			
Cao Bang	NOT DEFINED	43%	Not Supported	51.30 %	Not Supported		Not Supported			
Da Nang	Not Supported	52%	Not Supported	56.60 %	Not Supported		Not Supported			
Dak Lak	Not Supported	30%	Not Supported	46.20 %	Not Supported		Not Supported			
Dak Nong	Not Supported	31%	Not Supported	42.80 %	Not Supported		Not Supported			
Dien Bien	Ctrl Supported	65%	Not Supported	65.30 %	Not Supported		Not Supported			
Dong Thap	Ctrl Supported	32%	Not Supported	55.10 %	Not Supported		Not Supported			
Gia Lai	Not Supported	36%	Not Supported	44.90 %	Not Supported		Not Supported			
Ha Giang	Not Supported	51%	Not Supported	55.10 %	Not Supported		Not Supported			
Ha Nam	Not Supported	53%	Not Supported	56.00 %	Not Supported		Not Supported			
Ha Tinh	Not Supported	53%	Not Supported	62.60 %	Not Supported		Not Supported			
Hai Duong	Not Supported	60%	Not Supported	60.60 %	Not Supported		Not Supported			
Hau Giang	Not Supported	59%	Not Supported	63.70 %	Not Supported		Not Supported			
Hoa Binh	NOT DEFINED	70%	Not Supported	69.40 %	Not Supported		Not Supported			
Hung Yen	Not Supported	47%	Not Supported	58.30 %	Not Supported		Not Supported			

Khanh Hoa	Not Supported	33%	Not Supported	49.70 %	Not Supported		Not Supported			
Kien Giang	Ctrl Supported	39%	Not Supported	58.90 %	Not Supported		Not Supported			
Kon Tum	Not Supported	28%	Not Supported	34.60 %	Not Supported		Not Supported			
Lai Chau	Not Supported	42%	Not Supported	54.10 %	Not Supported		Not Supported			
Lam Dong	Not Supported	55%	Not Supported	64.20 %	Not Supported		Not Supported			
Lang Son	Not Supported	69%	Not Supported	71.40 %	Not Supported		Not Supported			
Lao Cai	NOT DEFINED	43%	Not Supported	51.30 %	Not Supported		Not Supported			
Nam Dinh	NOT DEFINED	39%	Not Supported	46.20 %	Not Supported		Not Supported			
Nghe An	Ctrl Supported	72%	Not Supported	66.80 %	Not Supported		Not Supported			
Ninh Binh	NOT DEFINED	57%	Not Supported	68.30 %	Not Supported		Not Supported			
Ninh Thuan	Not Supported	59%	Not Supported	56.00 %	Not Supported		Not Supported			
Phu Tho	Not Supported	55%	Not Supported	64.70 %	Not Supported		Not Supported			
Phu Yen	Not Supported	54%	Not Supported	38.00 %	Not Supported		Not Supported			
Quang Binh	Not Supported	59%	Not Supported	60.80 %	Not Supported		Not Supported			
Quang Nam	NOT DEFINED	67%	Not Supported	63.70 %	Not Supported		Not Supported			
Quang Ngai	Not Supported	53%	Not Supported	67.70 %	Not Supported		Not Supported			
Quang Tri	Not Supported	41%	Not Supported	45.70 %	Not Supported		Not Supported			
Soc Trang	Ctrl Supported	37%	Not Supported	50.90 %	Not Supported		Not Supported			
Son La	Ctrl Supported	58%	Not Supported	63.10 %	Not Supported		Not Supported			
Thai Binh	NOT DEFINED	44%	Not Supported	44.70 %	Not Supported		Not Supported			
Thanh Hoa	Ctrl Supported	62%	Not Supported	57.60 %	Not Supported		Not Supported			
Thua Thien-Hue	Not Supported	79%	Not Supported	78.20 %	Not Supported		Not Supported			
Tra Vinh	Not Supported	39%	Not Supported	59.80 %	Not Supported		Not Supported			

Tuyen Quang	Not Supported	49%	Not Supported	56.80 %	Not Supported		Not Supported			
Vinh Long	NOT DEFINED	54%	Not Supported	61.40 %	Not Supported		Not Supported			
Vinh Phuc	Not Supported	62%	Not Supported	62.70 %	Not Supported		Not Supported			
Yen Bai	Not Supported	44%	Not Supported	40.90 %	Not Supported		Not Supported			
_Military Vietnam	Mil									

APPENDIX B – Budget Profile and Resource Projections

B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

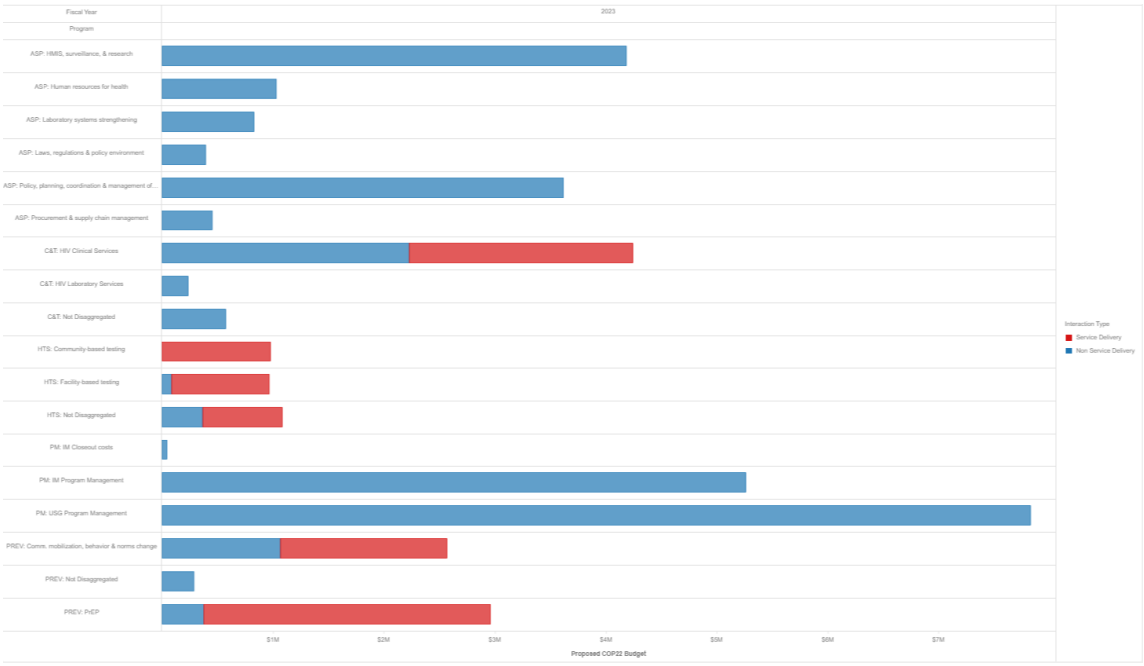


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$28,828,242**	**$8,671,758**	**$37,500,000**	**77%**	**23%**	**100%**
C&T	**Total**	**$3,032,830**	**$2,015,406**	**$5,048,236**	**60%**	**40%**	**100%**
	HIV Clinical Services	$2,228,459	$2,015,406	$4,243,865	53%	47%	100%
	HIV Laboratory Services	$231,440		$231,440	100%		100%
	Not Disaggregated	$572,931		$572,931	100%		100%
HTS	**Total**	**$450,379**	**$2,571,696**	**$3,022,075**	**15%**	**85%**	**100%**
	Community-based testing		$973,138	$973,138		100%	100%
	Facility-based testing	$85,000	$881,594	$966,594	9%	91%	100%
	Not Disaggregated	$365,379	$716,964	$1,082,343	34%	66%	100%
PREV	**Total**	**$1,727,570**	**$4,084,656**	**$5,812,226**	**30%**	**70%**	**100%**
	Comm. mobilization, behavior & norms change	$1,063,265	$1,504,872	$2,568,137	41%	59%	100%
	Not Disaggregated	$287,500		$287,500	100%		100%
	PrEP	$376,805	$2,579,784	$2,956,589	13%	87%	100%
ASP	**Total**	**$10,491,406**		**$10,491,406**	**100%**		**100%**
	HMIS, surveillance, & research	$4,180,735		$4,180,735	100%		100%
	Human resources for health	$1,026,775		$1,026,775	100%		100%
	Laboratory systems strengthening	$826,705		$826,705	100%		100%
	Laws, regulations & policy environment	$393,500		$393,500	100%		100%
	Policy, planning, coordination & management of disease control programs	$3,613,691		$3,613,691	100%		100%
	Procurement & supply chain management	$450,000		$450,000	100%		100%
PM	**Total**	**$13,126,057**		**$13,126,057**	**100%**		**100%**
	IM Closeout costs	$40,000		$40,000	100%		100%
	IM Program Management	$5,261,729		$5,261,729	100%		100%
	USG Program Management	$7,824,328		$7,824,328	100%		100%

Table B.1.3 COP22 Total Planning Level

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget	
Operating Unit	Applied Pipeline	New
Total	$5,067,687	$32,432,313
Vietnam	$5,067,687	$32,432,313

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget						Percent to Total					
	Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Vietnam	Total	$5,048,236	$3,022,075	$5,812,226	$10,491,406	$13,126,057	$37,500,000	100%	100%	100%	100%	100%	100%
	Key Pops	$3,990,143	$2,671,582	$5,624,505	$4,856,015	$472,944	$17,615,189	79%	88%	97%	46%	4%	47%
	Non-Targeted Pop	$1,036,543	$265,493	$30,951	$5,116,236	$12,515,113	$18,964,336	21%	9%	1%	49%	95%	51%
	Priority Pops	$21,550	$85,000	$156,770	$519,155	$138,000	$920,475	0%	3%	3%	5%	1%	2%

B.2 Resource Projections

PEPFAR Vietnam used the FAST to generate IM-level strategic interventions, initiatives, and budgets using the incremental budgeting approach. Based on previous years' results, the latest EPP data, and the strategic focus of epidemic control in the two urban regions, the technical working groups (TWGs) developed the COP22 targets by site and sub-national unit (SNU). Those targets were put into the DataPack and assumptions and coverage rates were reviewed and verified for feasibility. The interagency PEPFAR Vietnam team reviewed and updated standard service delivery packages established in COP19 for each essential HIV service; reviewed prior years' spending patterns across partners for key service components; reviewed and updated existing common cost norms for packages, with adjustments for facility size and rural/urban locations; and continued a common budgeting structure used across interagency implementing partners.

PEPFAR Vietnam used the commodities tab of the FAST to distribute commodities to the appropriate mechanism, taking into account the PEPFAR and Global Fund collaboration on commodity provision. PEPFAR Vietnam is at the funding level and met the C&T earmark requirement.

APPENDIX C – Tables and Systems Investments for Section 6.0

For easier readability, refer to the accompanying pdf or excel file

1 Key Systems Barriers-E

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)						Vietnam
Step 1: Select SID element	SID score (autopopulated)	Step 2 - What is the outcome expected from investing in this element? (may duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed	Comments
4. Private Sector Engagement	8	KP-led CBOs/private clinics and civil society organizations are legally included in the health workforce for HIV service delivery	Legal, policy or regulatory constraint	Lack of capacity and legal status among local organizations, including the private sector, to engage in the public health response, community monitoring and deliver innovative HIV service.	4-5 years	
3. Civil Society Engagement	5.1	Increase in quality and quantity of diverse groups, including KP-led CBOs and civil society, social workers, and law enforcement, providing HIV and drug treatment services.	Lack of technical capacity	Lack of capacity and legal status among local organizations, including the private sector, to engage in the public health response, community monitoring and deliver innovative HIV service.	6-9 years	
3. Civil Society Engagement	5.1	Civil society, particularly community-based organizations actively monitor the HIV program for a true public health response.	Lack of managerial capacity	Lack of capacity and legal status among local organizations, including the private sector, to engage in the public health response, community monitoring and deliver innovative HIV service.	6-9 years	
6. Service Delivery	6.9	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health response.	Lack of technical capacity	HIV service delivery systems lack innovative and client-centered models for an effective public health response to reach, test, and retain KPs and PLHIV across the HIV cascade.	4-5 years	
6. Service Delivery	6.9	All PLHIV access client-centered differentiated care for viral suppression.	Lack of sufficient HRH	HIV service delivery systems lack innovative and client-centered models for an effective public health response to reach, test, and retain KPs and PLHIV across the HIV cascade.	4-5 years	

6. Service Delivery	6.9	Sustainable viral load coverage through SHI for ART clients in two regions.	Legal, policy or regulatory constraint	HIV service delivery systems lack innovative and client-centered models for an effective public health response to reach, test, and retain KPs and PLHIV across the HIV cascade.	2-3 years	
10. Laboratory	7.6	Increase capacity of HIV confirmatory labs in NEZ and HCMC/Metro to increase case finding and access to early ART initiation.	Lack of technical capacity	Access to HIV testing (including recency testing and VL) remains a challenge, resulting in limited use of routine VL and recency testing as an essential part of the public health response.	2-3 years	
10. Laboratory	7.6	Recency data used for better management and coordination of public health response at provincial and national levels.	Lack of technical capacity	Access to HIV testing (including recency testing and VL) remains a challenge, resulting in limited use of routine VL and recency testing as an essential part of the public health response.	4-5 years	
10. Laboratory	7.6	Increase access to viral load testing to maintain the third 95 and decreasing forward transmission.	Legal, policy or regulatory constraint	Access to HIV testing (including recency testing and VL) remains a challenge, resulting in limited use of routine VL and recency testing as an essential part of the public health response.	4-5 years	
14. Epidemiological and Health Da	5.7	HIV case-based surveillance system components are linked and operational	Lack of technical capacity	Limited HIV case-based surveillance, monitoring, and reporting systems to support the public health response.	4-5 years	
14. Epidemiological and Health Data	5.7	HIV/AIDS data interoperability platform is established	Legal, policy or regulatory constraint	Limited HIV case-based surveillance, monitoring, and reporting systems to support the public health response.	4-5 years	
16. Performance Data	8.7	Surveillance and program data are used routinely to measure and monitor performance and inform the HIV public health response.	Lack of sufficient HRH	Limited HIV case-based surveillance, monitoring, and reporting systems to support the public health response.	4-5 years	

16. Performance Data	8.7	Provincial program and HIV data are regularly collected and analyzed to track the public health response.	Lack of technical capacity	Health system restructuring compromises both the delivery of HIV program technical assistance and the provincial governance capacity for the public health response.	4-5 years	
7. Human Resources for Health	7.8	Provincial technical capacity is standardized and mandated to implement a robust provincial public health response.	Lack of technical capacity	Health system restructuring compromises both the delivery of HIV program technical assistance and the provincial governance capacity for the public health response.	4-5 years	
11. Domestic Resource Mobilization	7.7	All insured PEPFAR patients receive HIV treatment services reimbursed through SHI.	Lack of Financial Resources	Domestic financing remains vulnerable, especially for the HIV public health response.	4-5 years	
2. Policies and Governance	6.3	GVN ensures no financial barriers for PLHIV to accessing treatment under SHI.	Legal, policy or regulatory constraint	Domestic financing remains vulnerable, especially for the HIV public health response.	4-5 years	
11. Domestic Resource Mobilization	7.7	Key HIV prevention interventions, i.e. PrEP and HIV testing, included under SHI law.	Legal, policy or regulatory constraint	Domestic financing remains vulnerable, especially for the HIV public health response.	4-5 years	
8. Commodity Security and Supply Chain	7.5	Increased GVN capacity to manage and coordinate HIV commodities procurement and supply chain from multiple sources.	Lack of technical capacity	Nascent domestic capacity to rapidly expand commodity procurement and manage the supply chain, including coordination efforts for the HIV public health response.	4-5 years	

8. Commodity Security and Supply Chain	7.5	Increased access to TLD through SHI.	Lack of technical capacity	Nascent domestic capacity to rapidly expand commodity procurement and manage the supply chain, including coordination efforts for the HIV public health response.	4-5 years	
13. Market Openness	9.4	Ensure access to essential HIV prevention commodities through diversified markets.	Underdeveloped private market	Nascent domestic capacity to rapidly expand commodity procurement and manage the supply chain, including coordination efforts for the HIV public health response.	4-5 years	
9. Quality Management	7.8	National Provincial HIV managers in charge of HIV prevention, treatment and systems in can collect, analyze and interpret data to provide appropriate public health responses	Lack of technical capacity	Limited capacity for provincial and national-level authorities to access, aggregate and interpret data for an evidence-based HIV public health response.	4-5 years	

2 Table 6-E

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued once all benchmarks have been achieved?	Notes
$ 330,000	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	8.73	N/A	Civil society, particularly community-based organizations actively monitor the HIV program for a true public health response.	Lack of managerial capacity	Lack of Financial Resources		CSO Engagement Fora; Public and media engagement programs; Public programs addressing stigma and discrimination; Community-led monitoring	COP20	Post COP25	OGAC requirement	Community-led monitoring started in COP20 and implemented over 1,000 clients from 30 sites in the 11 PEPFAR provinces. The plan for COP21 is to survey 1,500 clients from 40 sites. COP22 targets are built on this progress and also the strategy to build data collection, analysis and presentation skills for community leaders and CBOs. In recent years, 5-6 small grants were provided annually to local CBOs in the HIV public diplomacy program. These grants served to fund CSO engagement fora, public and media engagement programs, and public programs addressing stigma and discrimination. Products varied from TV and media shows, public events gathering hundreds to thousands of participants, to online communication campaigns with high views and interactions. The grants also	Yes	Building on CLM results in COP20 and COP21. Building on and continuing to build public diplomacy capacities for local CSOs through the HIV Public Diplomacy small grants. Building on existing relations with media outlets and through them reaching out to the general public.	At least 1,500 PLHIV and KP individuals interviewed for community led monitoring At least 6 CSOs granted directly and many more (CBOs and stakeholders) engaged in small grants activities; At least 20 media outlets briefed and trained on HIV/AIDS services, and through them tens of thousand individuals in the general public are reached via traditional and social media; At least 40 sites monitored by community	Quarterly report	Yes	Community-led monitoring
$ 310,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	3. Civil Society Engagement	4.25	5.08	3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	Increase in quality and quantity of diverse groups, including KP-led CBOs and civil society, social workers, and law enforcement, providing HIV and drug treatment services.	Legal, policy or regulatory constraint	Lack of managerial capacity	Lack of information on costs and program requirements	National/Provincial: National: Partner with USAID IPs and national social contracting partners (US CDC, UNAIDS, GF) to strengthen government and community capacity to plan, finance, implement, monitor, and effectively use data as part of a phased transition plan. Provincial: Efforts will focus on provincial leadership while collaborating with partners working on community strengthening efforts and national advocacy. Sustain efforts for social contracting in Tay Ninh, Dong Nai, and Tien Giang; expand to two additional provinces selected in consultation with the TWG; transition out of PEPFAR support for social contracting in Nghe An, documenting lessons learned around provincial level GVN budgetary commitments and performance monitoring.	COP21	Post COP25	Activity requires multiple years to reach the goal	Yes	SC pilot preparation started in Tay Ninh, Dong Nai and Tien Giang	1.Dong Nai province commits at least 25% financial contribution in FY23 and has a financial mechanism in place to mobilize local funding for social contracting efforts in future years. 2.Tay Ninh agrees to contribute at least 25% of the costs of social contracting agreements by end FY23. •Nghe An mobilizes a 50% contribution for social contracting by end FY23. 3.A sustainable financing plan is approved by the Provincial People's Council of Tien Giang by end FY23 to enable the provincial CDC to access local funding for social contracting. 4.Each of the provincial CDCs from Tay Ninh, Tien Giang, Dong Nai and Nghe An maintain at least one full-time staff member dedicated to social contracting work in FY23.	Annual report and financial data captures from provinces IP progress report Provincial approved document	Yes	
$ 120,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	8.73	16.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	Provincial program and HIV data are regularly collected and analyzed to track the public health response.	Legal, policy or regulatory constraint	Lack of managerial capacity		Continuous quality improvement: Establish effective procedures for collecting and responding to community and facility CQI data (PEPFAR, Circular 03, PQM, and community feedback) & PQM dashboard. Work with public sector facilities, community members, and private facilities where needed to address 1) Treatment interruption constituting significantly to attrition above the monthly threshold; 2) Deaths contributing significantly to attrition above threshold; 3) PrEP seroconversion and retention; and 4) Index testing, HTC/PrEP uptake and treatment initiation.	COP20	COP24	TA requires multiple years	Yes	TA provided to HCMC, Dong Nai, Tay Ninh, Tien Giang and Quang Ninh	Community and facility CQI data model focused on the use of CQI together for overall program quality review and CQI actions.	Expansion of provincial CQI data to national in partnership with VAAC; continued support for CQI and PHCR in all provinces with USAID DSD support.	100% CBOs and facilities supported in USAID EpiC provinces and sites use CQI data to improve service quality.	Yes	
$ 80,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	8.73	16.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Provincial program and HIV data are regularly collected and analyzed to track the public health response.	Lack of technical capacity			PLHIV estimation & CS: Provide technical assistance to the national CS TWG to support Case Surveillance and support CS implementation in Tay Ninh, Tien Giang, Dong Nai and Quang Ninh- based upon National CS guidelines with National CS TWG support. Collaborate with other stakeholders to provide technical assistance to the GVN to carry out the next round of HIV size estimation and projections in HCMC and other provinces as determined by the VAAC.	COP20	COP23	TA requires multiple years	Yes	EpiC LOE to the national TWG, the new estimation for selected PEPFAR provinces completed	CS data pulled as national TWG requested. National HIS CS tool to be rolled out and incorporated.	Updated reports for provinces prioritized by the VAAC for estimation in FY23.	Quality CS data incorporated into the national CS system.	No	
$ 300,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Civil society engagement	3. Civil Society Engagement	4.25	5.08	3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	Increase in quality and quantity of diverse groups, including KP-led CBOs and civil society, social workers, and law enforcement, providing HIV and drug treatment services.	Legal, policy or regulatory constraint	Lack of information on costs and program requirements	Lack of managerial capacity	National: Social contracting advocacy and central policy development • Facilitate dialogues, consultations, and learning events to support the development of a policy framework enabling social contracting for HIV services in Vietnam • Support MOH in the development and advocacy plan for the endorsement of HIV as a public service under the revised Prime Minister Decision using generated evidence on social contracting implementation, results from the SC pilot for the two-year pilot and international best practices and standardization of SC GVN cost norms • Support national oversight trip during the pilot implementation and cross exchange/learning during COP 22 for key GVN stakeholders (including GF) to travel to provinces to see how social contracting models are working Organize cross exchange/learning events for key GVN stakeholders and provinces to share experience on the implementation of SC (Eg. Provide direct guidance (supervision/TA trips) or TA or guidance on costing for HIV service packages to pilot provinces if required) • Work with other IPs to support VAAC to monitor the implementation and gather lessons during the social contracting pilot for HIV service provision at the national level. Contribute to the pilot evaluation/design and preparation of policy brief promoting SC	COP21	COP25	TA requires multiple years	Partial	1> HIV preventive services to be included in adhoc PM Decision as Public services 2> Provincial sustainable plans in targeted provinces include funding commitment for CSO led services 3> Evidence on SHI and public funding eligibility for HIV prevention services	Pilot implementation plan in place	1.SC pilot monitoring tool and biannual reports for national pilot is available Exchanged events (each per quarter) are organized to allow provinces learning and sharing experience in social contracting implementation. MOH Decision on HIV SC to be public health services 2 .Advocacy workshops and 4 working group to promote SC 3.HIV services in the MOH proposal to PM on public service for health 4.oversight/monitoring trips are organized	M/VAAC SC progress update report Monitoring tool for SC MOH policy document Meeting minutes for event	Yes	
$ 350,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Program and data quality management	16. Performance Data	8.73	8.73	16.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	Provincial program and HIV data are regularly collected and analyzed to track the public health response.	Legal, policy or regulatory constraint	Lack of managerial capacity		Support coordination and data sharing and interoperability between VSS and VAAC on (1) ELMIS/HMED and (2) VSS Eclaim and HIV info 1. Support regular monitoring and data sharing and interoperability between VSS/ELMIS and VAAC/HMED on drug management to improve ARV distribution and consumption 2. Support regular monitoring of ARV dispensing/SHI reimbursements of ARVs, VL testing and 5 copays through ELMIS at the national level to support the continuity and quality of HIV treatment service. 3. Support VSS and MOH to scale up the data use of VSS-ELMIS at provincial level through on the job training to Provincial CDCs and HF staff to understand drug usage levels and inform provincial stock forecasting and decision making 4. Support VAAC to update standard variables for core indicators for HIV program management and support data sharing mechanism for HIV indicators between VSS and VAAC/MOH	COP20	COP24	TA requires multiple year and data exchange and triangulation between two systems is not functioned as yet	HMED/eLMIS upgraded versions to meet the management requirements	Yes	HMED and EIMS are ready to use	Regular (monthly alert) to VAAC and PEPFAR team on the ARV drug consumption Quarterly Analysis on SHI reimbursement of ARV, VL testing and copays amount provided to VAAC, PEPFAR team 63 provinces have eLMIS accounts to extract SHI data and can use the data for improved drug management Official GVN decision for data sharing between VSS and VAAC for HIV program management	Regular report	Yes	

$ 250,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.20	6.85	6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	Increased GVN capacity to manage and coordinate HIV commodities procurement and supply chain from multiple sources.	Lack of technical capacity	Lack of managerial capacity		Strengthening the Government led procurement system for ARV: 1) Policies Revisions: Technical advice and support to the revision process of * Policy to enable the appropriate procurement options for ARV (Revision of Circular 15/2019 on procurement of drugs in public health facilities, including pooled procurements, domestic or international procurement, including the procurement of special drugs categories (pediatric ARVs, 2nd line/3rd line drugs). * Policy related to drug bidding and procurement regulations/policy to enable particular ARV that was excluded in the price negotiation list. 2) Procurement & Supply * Provide support on coordination, advocacy and ad-hoc TA among VAAC, NDCPC, VSS during the procurement processes as needed * Support the MOH in the development of the Recommended National Procurement Options by expanding to the international pooled procurement rather than opening bidding and price negotiation and to upgrade the existing system to the e-procurement (similar to GF/WAMBO for example) as needed * Conduct the cost-effectiveness and budget impact analysis and work with MOH on the preparation of dossier and advocacy for the inclusion of DTG 50mg and DTG 10mg	COP20	COP24	There are still ongoing issues with the SHI ARV Procurement and Supply Management that require technical support/assistance from PEPFAR	1) DTG10mg registered in VN. Additional non-Mylan TLD and TLD cartonless registered in Vietnam 2) National PrEP sustainability plan in place	Partial	1 non-Mylan TLD and TLD cartonless registered in Vietnam 2) National PrEP sustainability plan in place	Circular 15/2019 – Drugs Bidding in public health facilities/Finalization in COP22 Circular 15/2020 – List of medicines procured in public health facilities/Finalization in COP22 Circular 22/2020 – Procurement and Supply of ARV Drugs/Finalization in COP22 Recommended National Procurement Options are developed Cost-effectiveness analysis (CEA) and budget impact analysis (BIA) are available MA Dossiers for the long acting injectable ARV and PrEP and other ARVs (TLD, DTG10/50) submitted successfully to DAV	4 new Policies issues Report on national procurement option # of evidences/study prepared for MA dossier and progress report	Yes	
$ 200,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	8. Commodity Security and Supply Chain	6.86	7.49	8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all sectors? Select only ONE answer.	Increased GVN capacity to manage and coordinate HIV commodities procurement and supply chain based on data from multiple sources.	Lack of technical capacity	Lack of managerial capacity	Legal, policy or regulatory constraint	In COP22, the project will provide technical assistance to: 1) Support regular monitoring, data sharing, effective use and interoperability between VSS/ELMIS and VAAC/HMED on drug management to improve ARV distribution and consumption and quantification. Its benchmark is Regular (monthly alert) to VAAC and PEPFAR team on the ARV drug consumption and the early warning on the stock status and MMD implementation;; 2) Provide technical assistance at the national level to related entities (VAAC, DAV, DPF and VSS) to roll out the implementation of the ARV Drug Security Plan (including all events/incidents in ARV drug supply and all scenarios in ARV supply to secure/manage the continuum of HIV treatment) (this plan being developed with LHSS in COP21)	COP20	COP24	GVN just started their SHI management of ART so requires some more years to be functional	SOPs/Guidelines on SHI ARVs Management SOPs for GVN Price Negotiation/Open Bidding ARV drugs security plan for 2022-2026	Yes	SHI procurement for 2021 2022 are finalized Stock status at facilities are available at national level for analysis and reviewed	GVN fulfilled the SHI procurement and supply for FY2023 Monitored and alerted stock status of ARV drugs to VAAC and PEPFAR which affects to the MMD implementation GVN implemented the ARV Drug Security Plan to ensure no treatment interruption	% drugs supplied according to the framework agreement No stock-out %patients on MMD	Yes	
$ 280,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.38	6.33	2.4 User Fees for Other Health Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any non-HIV services in the public sector, such as MCH/SRH, TB, outpatient registration, hospitalizations, and others?	GVN ensures no financial barriers for PLHIV to accessing treatment under SHI.	Legal, policy or regulatory constraint	Lack of managerial capacity		National & provincial adhoc TA on SHI ARV Copayment subsidies 1. Monitor the annual budget allocation and quarterly expenditure to SHI ARV copayment by funding source (Local budget, donor, others) and procurement method 2. Provide technical assistance to MOH in the revision of related policies on ARV copayment subsidies (Circular 22, Decision 2188..) or development of financial guidance on the implementation to ensure the equality in financial protection for HIV patients regardless of ARV procurement methods (public bidding or price negotiation). 3. Technical support to VAAC/MOH and PEPFAR supported provinces to advocate for local budget increases for planning and allocation to provide subsidies for premium and ARV copay. 4. Conduct follow-up ART patient exit assessments to review out-of-pocket payments and impact on MMD and catastrophic health expenditures among antiretroviral therapy (ART) patients in Vietnam when the primary financing of ART changed to social health insurance since March 2019.	COP19	COP24	GVN just started their SHI management of ART so requires some more years to be functional	Policies changed and modified to accommodate new requirement for SHI Regular update on SHI reimbursement for HIV services	Partial	44/63 provinces has financial commitment through approved provincial sustainable financing plan for 2022-2030	63 provinces have Sustainable Financial Plans for HIV approved and Local budgets are annually allocated and tracked to HIV program at the provincial level Increased number of provinces committed and allocated funding, esp. local budget to subsidize PLHIV for SHI ARV copayment Assessment of OOP for PLHIV accessing SHI ART and VL services and evidence on impact of copay to PLHIV is available	Approved provincial plans Evidence on 5 committed through provincial budget annually OOP Asaessment data and report	Yes	
$ 200,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Market openness	13. Market Openness	9.33	9.41	13.2 Requiring license or authorization: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies establish a license, permit or authorization process as a requirement of operation?	Ensure access to essential HIV prevention commodities through diversified markets.	Underdeveloped private market	Lack of technical capacity	Lack of managerial capacity	National Level: Continue to support market expansion and entry for new HIV products including but not limited to: 1. Self-test kits (HIV, HCV, Syphilis) 2. New ARV and PrEP drugs (eg CAB-LA) 3. Other point of care platforms and test kits (HBV, HBC, duo HIV & syphilis, GN/CT) 4. Expand distribution platforms in USAID supported provinces for key products through pharmacies, e-commerce, tele-health, KP CBOs/SE, clinics 5. Pilot and expand bundled Self Test/self-care packages tailored to different populations 6. TA to VAAC to lead Self-testing Innovation Community of Practice and other innovations CoP such as CAB-LA.	COP20	COP25	HIVST kit market is still limited and need to provide TA to the PS to register in Vietnam. Long-acting cabotegravir (CAB LA) is still on discussion and need to explore the potential for local registration of International Partnership.	Yes	1. TA to Abbott and OS on product registration; both Abbott and OS have submitted dossiers to MOH for product review and approval 2. Ongoing discussions with ViiV on LA-CAB registration 3. Draft TelePrEP protocol under final approval review 4. Regular National Forums on demand gen and DSD 5. Agreement on inclusion of telehealth in the draft Law of Medical Examination and Treatment	1. One new HIVST product registered and available in VN market with a market entry strategy in place (pricing, distribution and marketing/demand generation) 2. CAB-LA registered in the local market with a TMA strategy in place (access and commercial pricing, distribution, marketing/demand gen, post-market surveillance); preliminary market exploration of MOH/KP demand for long-acting PrEP products in the pipeline like Lenacapavir, Islatravir and delivery methods (eg micro-array patch) completed 3. Integrated POC platform pilots for COVID19, HBV, HBC, duo HIV & syphilis, GN/CT underway; market entry plan for HCV ST in place; rapid COVID-19 self-test product analysis conducted (approvals, performance, price, supply chain) use cases defined	Routine M&E tools CQI Quarterly progress report	Yes	
$ 250,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Private sector engagement	4. Private Sector Engagement	6.99	7.99	4.5 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?	KP-led CBOs/private clinics and civil society organizations are legally included in the health workforce for HIV service delivery	Legal, policy or regulatory constraint	Lack of information on costs and program requirements	Lack of technical capacity	National & Provincial Levels: Continue to build capacity for Social Enterprises (SEs) & KP-Led Private Clinics Growth and Expansion: 1. Development of TA Package on Organizational & Business Development for SEs & KP-Led Private Clinics tailored to their development stage 2. Provide tailored TA to new and current social enterprises and KP-Led private clinics based development stage and needs and gaps identified 3. Grow a network of business mentors, investors, partners to support SEs & KP-Led Private Clinics at different stages of development 4. Develop community KP-SE Community Best Practice Forum for sharing experiences and best practices in start-up and running business 5. Nurture a leading SE/KP-Led Clinics (eg. Glink) to become an incubator for young SEs and clinics 6. Expand tailored KP-clinic models (clinic-based, OSS, mobile, tele-health) and offerings tailored to needs of segments of TG, MSM (younger, older), PWID, FSW, PLHIV and sero-discordant couples 7. Package KP-Led clinic SOPs, CQI, client engagement and feedback tools, demand gen for TA/learning among KP-organizations 8. Provide direct TA to SEs and KP-Led Clinics in USAID supported provinces and provide TA to GFTAM.	COP19	COP25	In COP21, SE provided TA and coaching on business development plan. In COP22, STEPS continue to review current business status and provide TA package to SE/KP-led business to support their business growled and expanded to delivery HIV services.	1. Build capacity for 5 Social Enterprises on Business Development Plan; application of qualified HIV service delivery models and continued quality improvement (CQI) 2. Provide TA to 10 KP-led and private clinics on accreditation, adoption of high quality & innovative different HIV service delivery models and application of new tools/technologies and continued quality improvement (CQI)	Yes	1. TA and intensive coaching on business development provided to SEs and KP-led clinics. 2. Regular CQI TA	1. TA Package on Organizational & Business Development for SEs & KP-Led Private Clinics developed 2. At least 13 SEs/KP-Led clinics will be provided with direct TA 3. A network of business mentors, investors, partners increased from 15 to 25 to support SEs & KP-Led Private Clinics at different stages of development 4. At least 3 KP-SE Community Best Practice Forum meetings held 5. At least one leading SE/KP-Led Clinics (eg. Glink) with measurable progress in capacity to become an incubator for young SEs and clinics 6. At least two new clinics established & supported to offer comprehensive services targeting TG and young MSM 7. At least four private/KP clinics supported to strengthen their	TA package Routine M&E tool CQI Progress project report	Yes	
$ 80,000	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Private sector engagement	4. Private Sector Engagement	6.99	7.99	4.6 Private Sector Engagement Governance: Is there a national policy, plan, strategy or framework in place for the use of private sector engagement* that is utilized for the HIV/AIDS response? *Private sector engagement is a strategic approach to planning and programming where country governments consult, strategize, align, collaborate, and implement with the private sector for greater scale, sustainability, and effectiveness to achieve epidemic control.	Diversify sustainable domestic financing for HIV through private sector engagement	Legal, policy or regulatory constraint	Lack of information on costs and program requirements	Lack of technical capacity	National and Provincial Levels: Provide TA to VAAC and GFATM provinces to roll-out National PSE Plan and Increase Private Sector Contributions in HIV related goods and services: National: 1. National Private Sector Market Assessment (both for demand and supply) to produce national/provincial estimate/baseline benchmarks for PSE Plan 2. TA to MOH to develop an HIV/healthcare/public-private partnership (PPP) circular that allows for more innovative HIV service and strategic purchasing PPP models Provincial (within PEPFAR provinces and responsive TA outside the 11) 3. Develop national/provincial TA package on how to engage with private sector including: training on TMA, segmenting the market by using/updating the TMA calculator tool; support provinces to integrate PSE in provincial HIV workplans, and develop a digital tracking system for PSE contributions in HIV related goods and services 4. TA to VACC and provinces to adapt and apply CQI to private sector HIV testing, prevention and treatment services 5. Support the implementation of the PSE Plan in 2-3 provinces (HCMC, Dong Nai and potentially one other province TBD)	COP20	COP25	PSE plan approved, but there is no systematic management mechanism and coordination of PS engagement and contribution. Therefore STEPS continue to provide TA at national and provincial level for rolling out the PSE plan.	1. Support VAAC to develop the Private Sector Engagement (PSE) Action Plan under new HIV Law and National Strategy 2. Support VAAC to capture 5 amount invested by PS in HIV & AIDS responses as part of the domestic financing resources for AIDS. 3. Advocate inclusion of PSE in the Provincial Sustainable Financing Plan for HIV & AIDS	Yes	1. PSE plan approved 2. Partial PS investment tracked annually	1. National PSE task force established 2. National Private Sector Market Assessment conducted and used to shape activities 3 - 6 3. TA package developed (for national and provincial levels) on how to engage with private sector including training on TMA 4. Digital PSE investment tracking tool as part of HMED developed; VAAC tracks PSE/investment annually 5. VAAC and provinces applies endorsed/adapted CQI to private sector HIV services 6. PSE plans developed & implemented in 2-3 provinces	Progress project report M&E tool Investment tracking tool	Yes	

$ 50,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.20	6.86	6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health response.	Physical Infrastructure not complete/further investment needed by donors	Lack of technical capacity	Lack of managerial capacity	Provincial Level: in USAID provinces provide TA and implementation tools to public sector partners/providers in PrEP innovative models (e.g Tele-PrEP, PHC/CHS PrEP, Mobile PrEP, OSS), integrated-person centered PHC/OSS and other innovative models and approaches, adapted to the resources/structures of public sector	COP20	COP25	There are some new models needed to provide TA to PrEP sites	1. Provide training to all public PrEP sites in all USAID supported provinces on demand generation 2. Provide TA to all public OSS by pairing them with KP-led OSS	Yes	1. Innovative HIV self-test and PrEP campaigns implemented and reinforced (online, QR code, livestream, tiktok...) 2. Online trainings to PrEP sites on demand generation conducted 3. Monthly Online Forum on Digital Marketing with participants from social enterprises and clinics conducted. 4. Piloted and implemented PHC/CHS and mobile PrEP	1. TA package developed in how to design and implement Innovative PrEP Models (e.g Tele-PrEP, PHC/CHS PrEP, Mobile PrEP, OSS) will be developed and PrEP innovations will be adopted by 100% of sites 2. Provides direct support to at least five public sector partners/sites in PrEP models (eg Tele-PrEP, PHC/CHS PrEP, mobile PrEP), OSS and other innovative models and approaches, adapted to the resources/structures of public sector	Progress report Routine M&E tools CQI/satisfaction survey	Yes	
$ 57,500	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Civil society engagement	3. Civil Society Engagement	4.25	5.08	3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	Increase in quality and quantity of diverse groups, including KP-led CBOs and civil society, social workers, and law enforcement, providing HIV and drug treatment services.	It is not included in local HIV response plans	Legal, policy or regulatory constraint	Lack of Financial Resources	Provincial and national: Within USAID Provinces: Provide capacity building and technical assistance to eligible and capable Civil Society Organizations (community-based organizations) and social enterprises to apply for and successfully implement social contracts with high quality services based upon national social contracting guidelines; National: Document, share and promote good practices and lessons learned on social contracting implementation with VAAC, MOH, MOP and other partners to advocate for incorporating social contracting into procurement policies of GVN agencies.	COP21	COP25	TA requires multiple year	- 10 CBOs and other KP groups received capacity building on social contracting related procedures - At least 02 (among 12) CBOs contracted under social contracts with GVN/provincial agencies in the project sites - Tool to monitor and evaluate CBOs' performance of social contracts developed and used	Yes	- 10 CBOs and other KP groups received capacity building on social contracting related procedures - At least 02 (among 12) CBOs contracted under social contracts with GVN/provincial agencies in the project sites - Tool to monitor and evaluate CBOs' performance of social contracts developed and used	CBO being awarded subcontract with GVN oversight and funding provided for agreed services rendered - 15 CBOs and other KP groups received capacity building on social contracting related procedures - At least 05 CBOs contracted under social contracts with GVN/provincial agencies - Good practices and lessons learned on providing technical assistance to CBOs for their implementation of social contracts shared with VAAC and other development agencies working on social contracting.	1. Number of CBOs receiving funding support through social contracts 2. Number of CBOs supported following the SCANA baseline assessment	Yes	
$ 253,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Civil society engagement	3. Civil Society Engagement	4.25	5.08	3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	Civil society, particularly community-based organizations actively monitor the HIV program for a true public health response.	Lack of technical capacity	Legal, policy or regulatory constraint	Lack of Financial Resources	National, Provincial, Community: 1. Support development of national Public Health Cluster Response (PHCR) framework/algorithm in coordination with national PHCR TWG + provincial GVN, and define SOP for national community response teams; 2. Provide direct technical assistance from the KP clients/community perspectives for PHCR, based upon needs aligned by VAAC; 3. Conduct situational assessment of community needs and co-develop action plans on PHCR response with primary focus to close clusters and provide roadmap of community needs, inclusive of quality service delivery, including counselling, PNS, linkage to ART, PrEP, C2P implementation and other support services under national guidelines and PEPFAR program priorities;	COP21	COP25	TA requires multiple year	National PHCR framework, algorithm and SOPs are developed to include community and civil organization engagement.	Yes	National PHCR framework, algorithm and SOPs are developed to include community and civil organization engagement.	National PHCR framework, algorithm and SOPs are developed; and community-based PHCR is effectively implemented to control HIV cluster infections. CBOs in up to 4 provinces (PEPFAR supported and non-PEPFAR supported) being utilized for supporting PHCR as a time-bound and prompt community level response.	- National algorithm and SOPs include a section on "Community Engagement" formalizing the participation and role of community partners in supporting a public health cluster response; - CBOs in agreement with Provincial CDC to participate in PHCR; - Basic workshop to orient CBOs and CDC Province on process flow for activating community partners in PHCR; - CBOs demonstrate contribution to case identification and prevention efforts in the community given early warning response;	Yes	
$ 149,500	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Civil society engagement	3. Civil Society Engagement	4.25	5.08	3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	Increase in quality and quantity of diverse groups, including KP-led CBOs and civil society, social workers, and law enforcement, providing HIV and drug treatment services.	Lack of technical capacity	Legal, policy or regulatory constraint	Lack of Financial Resources	National & Community: Increase operational and financial sustainability of community-based organizations by supporting interested KP groups to develop business planning efforts and support graduated CBOs with registration as a legal entity and other supportive services to promote CBO graduation pathway to social enterprises in collaboration with STEPS and other partners.	COP21	COP25	TA requires multiple year	- Increasing number of CBOs have legal status. - 05 CBOs supported to have legal status	Yes	Increasing number of CBOs have legal status. - Increase number of CBOs who achieve legal status by an additional 5 nationally. [For "operational sustainability" this will require a combined assessment of two domains 'governance, administration and operations' and 'financial management and sustainability', for both we expect that year to date monitoring will show growth in these areas to reach at least a '3'-'4' on the SCANA tool – this will be done in tandem with STEPS/INVEST as appropriate. - 05 CBOs supported to have legal status	Based on baseline assessment, additional or increased number of CBOs having legal status and achieve legal status by an additional 5 nationally. [For "operational sustainability" this will require a combined assessment of two domains 'governance, administration and operations' and 'financial management and sustainability', for both we expect that year to date monitoring will show growth in these areas to reach at least a '3'-'4' on the SCANA tool – this will be done in tandem with STEPS/INVEST as appropriate. - CBO scored of '5' on item 3.1.1 of the SCANA tool. With regards to operational and financial sustainability, organizations scoring a '3' on average using SCANA tool for the "financial management and sustainability" domain.	There will a standard SCANA tool to assess CBO capacity for different dimension for every 06 months, including operational and financial status. The respective SCANA items for two domains 'governance, administration and operations' and 'financial management and sustainability'.	Yes	
$ 172,500	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	8.08	5.74	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	HIV/AIDS data interoperability platform is established	Physical Infrastructure not complete/further investment needed by donors	Legal, policy or regulatory constraint	Lack of Financial Resources	Continue to support Ho Chi Minh City CDC to operate and launch CHIS model that has been built in COP21 (supported by Dog). This will include 1) Providing technical assistance to HCDC to review all the legal documents regarding HIV confidentiality and data sharing. 2) Supporting HCDC to develop all required consent form to support launching the system. 3) Supporting HCDC to maintain CHIS server and Piloting CHIS model. 4) Facilitating CHIS data use activities to support community-led monitoring and PHCR in Ho Chi Minh City. Expand CHIS model to Dong Nai province, this will include: 1) Promoting DHealth app as a provincial community app for whole all Dong Nai and Pooling data from other community apps to D-Health to create provincial community data for Dong Nai. 2) Develop data exchange from community and facility in Dong Nai 3) Facilitating CHIS data use to support community-led monitoring and PHCR in Dong Nai	COP21	COP25	TA requires multiple year	Community digital tools developed and updated, standard community data shared with provincial CDC data hubs - The project supported app (D.Health) has been upgraded to regularly collect clients' profile and behavioral data and feedback that inform early warning and response/ public health cluster response, tailored service provision and continuous quality improvement - Process underway for sharing D.Health data to CHIS of Ho Chi Minh City	Not applicable	Community digital tools developed and updated, standard community data shared with provincial CDC data hubs The project supported app (D.Health) has been upgraded to regularly collect clients' profile and behavioral data and feedback that inform early warning and response/public health cluster response, tailored service provision and continuous quality improvement Process underway for sharing D.Health data to CHIS of Ho Chi Minh City	CHIS model launched and operated in Ho Chi Minh City. CHIS data used to monitor community program and PHCR in Ho Chi Minh City. CHIS model expanded in Dong Nai by promoting D.Health app to be a provincial community app and pooling data from other community apps to create a provincial community data hub for all Dong Nai province, processing data exchange between community and facility in Dong Nai. CHIS data used to monitor community program and PHCR in Dong Nai D.Health will be publicly launched so will be available nationally, however, its full function of setting appointments for referrals will be focused on current project supported provinces where C2P is established (Dong Nai, HCMC, Hanoi).	Ad-hoc reporting (qualitative and quantitative). - Number of users using D.health - Number of clients registered	Yes	
$ 268,585	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	7.20	6.86	6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	All PLHIV access client-centered differentiated care for viral suppression.	Lack of technical capacity	Lack of sufficient HRH		1) TA and support to national learning network for KP-competent care to promote equitable access and uptake of HIV services. Develop and revise KP-competent care tools, job aids, guidelines focused on equity, accessibility and differentiated and diversified care models for wide-scale adoption in CDC-supported sites & provinces, PTTs and other clinical support/TA provision entities 2) Engage KP and community in provision of person-centered, KP competent care with foundational bio-medical innovation approach through collaborating with VNP+ on regular HIV Science sessions and scale up of a treatment literacy network 3) Advocate and provide evidence-base for HIV biomedical innovation with VAAC and other critical decision-makers at policy and technical levels; proactive engagement and leadership in the development of HIV clinical technical guidelines and their implementation; support for the coordination and implementation of national HIV clinical science meetings 4) On-going responsive TA to for HIV treatment quality at national, provincial and site levels	COP20	COP23	Need for continued work in ensuring KP-focused and competent care in the public sector	At least 12 PTTs in PEPFAR and high-needs provinces are providing TA and support to program quality and PHR responses	Partial	1.ART optimization and MMD recovery after resolution of ARV supply issues 2.Resolve program issues and gaps with CQI approach 3.Track continuity of treatment for reduced interruptions in treatment 4. Promote health equity through strengthening service quality and friendliness for all systems including public, private, KP-led clinics 5. Implementing viral load literacy for patients through scale-up of providing VL results via SMS	KP competent standards established. KP-competent standards disseminated to all CDC-supported sites for all HIV health providers and through KP learning network Improved treatment, viral load and broader HIV health literacy among clients at PEPFAR-supported sites GVN endorses treatment optimization through biomedical innovation (such as CAB-LA, etc.) Normalize and institutionalize diversified person-centered models of care: telehealth, decentralized drug distribution model (DDD) such as via community members, mailing/ shipping, home-delivery beyond COVID outbreak	# PTTs/Sites that have received technical assistance # Provincial health experts that provide technical assistance to sites # TA events # providers that have participated in public health response planning and/or implementation HIV program cascade data	Yes	

$ 170,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	8.73	16.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	Surveillance and program data are used routinely to measure and monitor performance and inform the HIV public health response.	Lack of technical capacity			Assure high-quality data collection system for program monitoring at all levels of the epidemic monitoring including site, province and national. 1. Collect program monitoring data at all levels to meet PEPFAR MER requirements 2. Conduct data abstraction and reporting for monitoring service quality and retention 4. Conduct data review by site and SNU for program planning and intervention/remediation activities. 5. Support and ensure program data quality nationally through updating national DQA guideline, training of trainers and providing TA for DQA in selected high HIV burden provinces to meet requirement of data utilization for epidemic monitoring under National Responsive TA framework 6. Monitor, strengthen and ensure program quality through CQI	COP18	Post COP25	Program monitoring provide data to evaluate program quality and identify program gaps	High quality data are collected and accessible in 90% of priority provinces	Yes	Program Monitoring Data (MER) is collected regularly (quarterly) through multiple platforms and accessible in CDC direct supported provinces. Data now is collected and prepare for data use in 127 sites (HTS, TX and PrEP) in 6 CDC supported provinces	Program Monitoring Data (MER) is collected regularly (monthly and quarterly) through multiple platforms and accessible in CDC direct supported and other prioritized for PHCR provinces. Those MER data will be collected monthly and quarterly in 150 sites in 3 DSD and 3 TA provinces. Program data in at least 3 PHCR provinces will be collected and prepared for data use at both site and provincial level	1. Number of sites submitted program data on time 2. Number of sites/ SNUs review data monthly and develop CQI plan 3. Number of DQA visits from VAAC to provinces	Yes	
$ 180,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	11. Domestic Resource Mobilization	8.21	7.70	N/A	GVN ensures no financial barriers for PLHIV to accessing treatment under SHI.	Lack of Financial Resources	Legal, policy or regulatory constraint		TA to 7 CDC-supported provinces for provincial sustainability plans, treatment continuity, and civil society engagement in delivery of person-centered services: 1) On-going support to social contracting in 2-3 CDC/PEPFAR provinces 2) Provincial sustainability planning support- for financing pathways to cover/address gaps for social contracting, VL and ARV co-payments, and other financing needs 3) Align KP-competent HCW accreditation for compensation policies for provision of HIV-related services	COP19	COP25	Provincial financial sustainability plans do not currently fill in gaps in SHI co-payments and coverage. Social contracting is still under pilot phase.	% uptake of VL testing through SHI Identified mechanisms/pathways for social contracting in CDC provinces	Partial	1. Support VAAC and CDC supported provinces to strengthen the private-public collaboration, promoting quality of HIV services and national reporting in the private sector 2. Promote the use of HIV self-test among key populations, especially those who never tested for HIV. 3. Marketing for self-test through multiple channels including but not limited to websites, dating apps, Fanpages and other social media 4. Expand partnership with pharmaceutical system to distribute self-test along with linkage to other services 5. Maintain person-centered PrEP services to promote PrEP initiation and continuation, with focus on young MSM/TG in high burden CDC provinces. a. Develop PrEP sites to become DSS	All CDC-supported provinces submit provincial HIV sustainable plans, with plans to cover SHI ARV co-payment gaps Social contracting pilot completed in two provinces	% of PLHIV on ART are covered by SHI and being reimbursed for services % domestic contribution to spending on HIV program and commodities % and amount of $$ invested in social contracting	Yes	
$ 220,400	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.20	6.86	6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Provincial technical capacity is standardized and mandated to implement a robust provincial public health response.	Lack of technical capacity	Lack of sufficient HRH		1) On-going national oversight, coordination, tracking, and TA to high-needs PTTs to ensure HIV program quality and robust implementation of KP-competent innovations, models and services. 2) Responsive TA through Provincial Technical Teams (PTTs); strengthening and deployment with focus on high-burden provinces to ensure HIV program services meet GVN quality and technical standards. 3) Focused technical assistance to maintain treatment quality in high-need provinces, utilizing existing systems-CS, PTTs- and promoting data alignment (e.g. Can Tho, Kien Giang and Soc Trang, CDC/PEPFAR provinces)	COP19	COP24	Expansion of PTT technical capacity and institutional oversight into new high-needs provinces to support broader National Program and sustainable epidemic control is needed.	At least 12 PTTs in PEPFAR and high-needs provinces are providing TA and support to program quality responses	Partial	1. Multiple high-needs provinces still in COVID and ARV supply recovery' leading to gaps in HIV program treatment and negative impact on VN treatment cohort 2. VAAC developed an algorithm using key program data to identify sites and provinces with needs and/or gaps 3. TA events are documented and monitored for on-going follow-up	All clinics (in high-needs provinces and non-PEPFAR supported sites) provide quality of services and follow national guidelines including SDA, MMD, retention, and VLS 80% new patients start SDA 85% patients retained on treatment 80% patients get a VL test and 95% of them having VL suppression Patient level data system set up for patient monitoring and reporting	% of Provincial TA teams that are conducting TA to sites for program quality and/or PHCR % of PTT members who are capacitated to deliver TA for PHCR # of clinics receiving support # and % increase in clients who access DDM, SDA, tx continuity	Yes	
$ 130,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	8.06	5.74	14.3 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (	Expected outcome: Strengthen the technical capacity for local staff to improve the quality of national surveillance system to inform program planning and monitor epidemic	Lack of sufficient HRH	Lack of Financial Resources	Lack of technical capacity	1. In the Northern region, provide technical assistance for the implementation of an advanced case reporting system for surveillance activities to monitor the epidemic. 2. Provide on-going technical assistance to Northern provincial CS scale-up 3. Implement a size estimation exercise among MSM and other KP populations in other Northern high priority provinces to inform provincial estimation and program planning. 4. Provide on-going technical assistance of HSS+ (routine and new method including web-based survey and mail testing) in Northern provinces 5. Ongoing support & strengthening of monitoring and surveillance systems (benchmarks, key indicators, SOPs and alert system) to quickly identify public health issues for response 6. Provide training on outbreak investigations for HIV systems to provincial and district staff	COP18	Post COP25	Case surveillance will be maintained in previous provinces and scale up in other prioritized provinces. Size estimation exercises will be expanded to other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach hidden KP.	1. Technical assistance provided to implement new HSS+ sampling methodologies to measure disease burden and risk behaviors in northern HSS+ provinces (Ha Noi, Hai Phong). 2. High-quality KP size estimates in two provinces 3. Key indicators for epidemic monitoring identified 4. CBS scale-up in NE2 PEPFAR provinces and surge northern provinces (part of Ha Noi, Hai Phong, Thai Nguyen)	Partial	1. CS is primally established in Hai Phong, Thai Nguyen and part of Hanoi 2. Size estimation of MSM population available in Hanoi, Thai Nguyen and Hai Phong	1. Advanced case reporting is established in northern provinces. 2. CS is well function in NE2 PEPFAR provinces and surge northern provinces (Hanoi, Hai Phong, Thai Nguyen) 3. High-quality KP size estimates are completed in another selected northern province 4. New HSS+ sampling methodologies is implemented in selected provinces 5. Key indicators for epidemic monitoring are visualized and used in northern provinces	1. Number of provinces are able to submit data to case reporting system 2. Number of TA visits to CS provinces 3. Number of provinces completed KP PSE 4. Number of provinces completed HSS+. 5. Number of provinces with CS implemented are able to monitor sentinel events to track PLHIV from diagnose to death. 6. Number of staff trained in HIV outbreak investigation	Yes	
$ 195,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	8.06	5.74	14.3 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	Expected outcome: Strengthen the technical capacity for local staff to improve the quality of national surveillance system to inform program planning and monitor epidemic	Lack of Financial Resources	Lack of technical capacity	Lack of sufficient HRH	1. In the Southern region, provide technical assistance for the implementation of an advanced case reporting system for surveillance activities to monitor the epidemic. 2. Provide on-going technical assistance to Southern provincial CS scale-up 3. Implement a size estimation exercise among MSM population in other southern high prioritized provinces to inform the provincial estimation and program planning. 4. Provide on-going technical assistance of HSS+ (routine and new method including web-based survey and mail testing) in Southern provinces 5. Ongoing support & strengthening of monitoring and surveillance systems (benchmarks, key indicators, SOPs and alert system) to quickly identify public health issues for response 6. Provide training on outbreak investigations for HIV systems to provincial and district staff	COP18	Post COP25	Case surveillance will be maintained in previous provinces and scale up in other prioritized provinces. Size estimation exercises will be expanded to other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach hidden KP.	1. Technical assistance provided to implement new HSS+ sampling methodologies to measure disease burden and risk behaviors including collection of recency, VL in southern province (Can Tho). 2. High-quality KP size estimates in two provinces 3. Key indicators for epidemic monitoring identified 4. CBS scale-up in HCMC Metro PEPFAR provinces and surge southern provinces (HCMc, Long An, Ba Ria - Vung Tau, Binh Duong, Can Tho, Soc Trang)	Partial	1. Implement new HSS+ sampling methodologies in selected southern province. 2. Size estimation of MSM population available in HCM, Can Tho and Binh Duong 3. CS is established in HCM, Long An, BRVT, Binh Duong, Can Tho, and Soc Trang.	1. Advanced case reporting is established in southern provinces. 2. CS is established and well functioning in HCMC Metro PEPFAR provinces and surge southern provinces (HCMc, Long An, Ba Ria - Vung Tau, Binh Duong, Can Tho, Soc Trang and two selected province) 3. High-quality KP size estimates are completed in other three selected southern provinces 4. HSS+ i is implemented in selected provinces 5. Key indicators for epidemic monitoring are visualized and used in northern provinces 6. Provinces are able to conduct HIV outbreak investigation	1. Number of provinces are able to submit data to case reporting system 2. Number of TA visits to CS provinces 3. Number of provinces completed KP PSE 4. Number of provinces completed HSS+. 5. Number of provinces with CS implemented are able to monitor sentinel events to track PLHIV from diagnose to death. 6. Number of staff trained in HIV outbreak investigation	Yes	
$ 120,000	ASP: Laboratory systems strengthening-NSD	Key Pops: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	7.79	7.68	10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? Select only ONE answer.	Recency data used for better management and coordination of public health response at provincial and national levels.	Lack of managerial capacity	Lack of technical capacity		1. Provide responsive TA for provinces in doing recency testing for public health cluster response for CDC supported provinces and assigned southern provinces 2. Introduce phylogenetic analysis to support PHCR monitoring and implementation, at national and provincial levels and in coordination with VAAC and PHCR task force. Active identification of HIV transmission clusters for PHCR through molecular data analysis 3. Enhance the quality of HIV testing services (incld. HIV serology, HIV VL, CD4 and recency testing and community testing)	COP20	COP25	By end of COP21, recency surveillance covers at least 32 highest HIV burden provinces therefore, it is very important to ensure the quality of HIV recency testing by responsive TA from national institutes. In addition, HIV testing (VL, CD4, HIV serology) was fully transferred to GVN, National Institutes play a crucial role to ensure the quality and continuity of those tests.	1. High-quality lab system (including HIV testing, CD4, HIV VL) for public health response is maintained 2. Molecular clusters are identified and follow-up actions taken for HIV public health response 3. TAT for CDC-supported sites reduced to 72 hours	Yes	- 20/22 southern provinces with recency implementation, all provinces in initial phase of using recency data for PHCR - EQA panel is distributed to all HIV serology, CD4 labs in southern provinces	- All southern provinces implement and use recency surveillance for PHCR - All HIV testing labs in southern provinces maintain atleast level 3 of LQMS following MOH's requirements	1. # of provinces implement HIV recency testing for recent HIV infection response 2. % of labs participate and pass 2 rounds EQA for HIV serology and recency testing 3. # of molecular cluster identified and responded to 4. # of transmission clusters are identified and responded to	Yes	
$ 130,000	ASP: Laboratory systems strengthening-NSD	Key Pops: Not disaggregated	Surveillance	14. Epidemiological and Health Data	8.06	5.74	N/A	Recency data is routinely monitored for PHCR A HIV DR lab network is set up for ongoing HIV DR surveillance	Legal, policy or regulatory constraint	Lack of managerial capacity	Lack of technical capacity	1. Develop policy and guidance to set up an HIV drug resistance laboratory network and technical assistance to systematically collect existing available HIV drug resistance data 2. Routine analysis and monitoring of HIV recency data at national level for public health cluster response and advocacy 3. TA for provinces in implementing/conducting data analysis for PHCR	COP18	COP25	HIV testing (VL, CD4, HIV serology) was fully transferred to GVN, National Institutes play a crucial roles to ensure the quality and continuity of those testing	1. HIV transmission clusters are identified and responded timely manner 2. An HIV recent infection framework and guidance is endorsed and applied nationwide	Yes	-All HIV testing labs meet minimum requirements on LQMS following MOH guidance - Legal framework is available for recency implementation nationwide - No network of HIV DR labs or technical working group is available	"- A system and technical working group of HIV Drug Resistance labs is set up and functioned - A national platform for recency data analysis is routinely monitored to inform policy makers and other stakeholders - At least 50% of provinces implemented recency testing will be provided onsite/ virtually TA for quality improvement	1.# of provinces issue and implement a SOP of site -level response for recent infection cases 2. Development of SOP and Job aids 3. A network of HIV DR labs is set up and routinely shares lesson learned	Yes	

$ 215,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	8.06	5.74	14.8 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.) Please note most recent survey dates in comments section.	HIV case- surveillance system components are linked and operational	Lack of Financial Resources	Lack of technical capacity	Lack of sufficient HRH	1. Lead expansion of the national case surveillance system by coordinating with all partners on development of the CS framework, e.g. standardizing minimum requirement, endorsing adapted SOPs, etc. Complete all policy requirements to prepare for national roll-out. 2. Lead the expansion of sustainable HIV epidemic monitoring 3. Institutionalize monitoring and surveillance systems (benchmarks, key indicators, SOPs and alert system) to quickly identify public health issues for response 3. Update national KP size estimations utilizing internationally-endorsed methodologies in conjunction with global subject matter experts 4. Lead in design and development of a robust national HIV health information system to support epidemic monitoring and program management and improvement. 5. Lead the implementation of advanced case reporting system nationally to support case verification process and epidemic monitoring.	COP18	Post COP25	Case surveillance will be maintained in previous provinces and scaled up in other prioritized provinces. Size estimation exercises will be expanded to other burden provinces and national size estimation will be extra populated. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach hidden KP.	Partial	1. CS expanded to 11 PEPFAR and 4+ surge provinces (Can Tho, Soc Trang, An Giang, Kien Giang). 2. National CBS platform developed with minimum standards in place. 3. Complete SOP/policy for epidemic monitoring. 4. Update provincial KP size estimates	1. CS expanded to 6 CDC/PEPFAR provinces and 2+ surge provinces (Soc Trang and Can Tho). 2. National CBS platform developed with minimum standards in place. 3. Complete SOP/policy for epidemic monitoring. 4. Update KP size estimates in number of selected provinces is used for PLHIV estimation and projection.	1. CS maintain in 6 CDC/PEPFAR and expand 4+ surge provinces (Soc Trang, Can Tho and other two selected provinces). 2. National CS platform developed and preliminarily established. 3. Use SOP/policy for epidemic monitoring. 4. Update KP size estimates at national level 5. National advanced case reporting system is established and well function.	Case report system data analysed and used for development of the case-based surveillance system. Existing data platforms reviewed. Case surveillance system components established. KP sizes are estimated. Advanced case reporting system is established nationally.	Yes	
$ 187,200	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	7.20	6.86	6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health response.	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH	On-going G-to-G recency-driven public health cluster response coordination at national level, including implementation, monitoring and documentation in PEPFAR and other high-need provinces under the direction of the VAAC/National HIV program: 1) Ensure provincial capacity to monitor and implement PHCR through training, guidance, and other technical assistance by national level 2) Coordination of national TWG to review alerts for potential investigations and response; promote data use and linkage across multiple platforms 3) Implementation of time-bound provincial/local responses based on an established core package and leveraging PITs, rapid response teams, community experts and other provincial stakeholders and experts. Direct close coordination with community response implementation partners at national, provincial and site levels. 4) M&E, monitoring and documentation of the PHCR during implementation and after close-out of the time-bound response 5) On-going review of PHCR implementation for lessons and sharing experiences for regional and national expansion	COP20	Post COP25	Pivot to a public health cluster response (PHCR) for sustainable epidemic control requires on-going support to monitor and track alerts and respond at national level and throughout the 63 provinces	Partial	PHR successfully implemented in up to 3 provinces Monitoring of key data in provinces with highest new infections in 2020 and latest data	PHCR successfully implemented in up to 3 provinces Monitoring of key data in provinces with highest new infections in 2021-22 and latest data	National SOPs piloted, revised, finalized and disseminated Routine TWG monitoring for alerts and conducting initial investigations PHCRs successfully implemented in 2-3 provinces in Vietnam	%-increase in PrEP uptake %-increase in ART linkage %-increase in # of tests for target population %-decrease in recent infections	Yes	
$ 70,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	7.79	7.63	10.4 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources (HR)) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression	Expanded Network of HIV VL testing that able to reimbursed through SHI to support better treatment services for HIV patients	Lack of technical capacity	Lack of managerial capacity		1. Provide technical assistance to implement continuous quality improvement for laboratories providing HIV testing services 2. Update the national guidance/ requirements for laboratory quality improvement, Decision 2429/ QD - BYT 3. Expand the network of HIV VL labs able to be reimbursed through SHI (focus on central highlands)	COP20	COP25	This is an on-going activity to ensure high quality of all HIV-related testing services	Yes	At least 7 viral load labs links LIMS to existing hospital HIS platforms to improve TAT and reduce reporting error of results	The national LQMS guidance has been approved by MOH and expand for national scale up	- Legal framework to harmonize EQA providers - Expand HIV VL testing through SHI to at least 2 labs - Updated guidance on LQMS for clinical labs is endorsed and implemented nationwide	1. # of HIV testing labs maintaining 3 star level of LQMS and able to reimburse through SHI mechanism 2.# of HIV VL labs reimbursed through SHI 3.# of labs receiving responsive TA from national team	Yes	
$ 143,720	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	8.06	5.74	14.3 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	Surveillance and program data are used routinely to measure and monitor performance and inform the HIV public health response.	Lack of Financial Resources	Lack of technical capacity	Lack of sufficient HRH	1. Continue to provide support for the development, enhancement and implementation of point of service data collection to be interoperable with program monitoring and the case surveillance repository (upgrade EMRs and testing/prevention data collection and reporting systems) in 15 high burden provinces. 2. Continue to provide technical assistance at the national level to create data collection tools, support data management and data analysis for epidemic monitoring and program planning. 3. Implement and provide technical assistance to estimate the size of the MSM population in selected surge provinces.	COP21	COP23	Case surveillance will be maintained in previous provinces and scale up in other prioritized provinces. Size estimation exercises will be expanded to other burden provinces.	Yes	1. Point of service information systems for program monitoring and case surveillance for 15 high burden provinces are developed 2. Timely technical assistance for national level in data analysis and data use for epidemic monitoring provided 3. Knowledge sharing platform to host study and surveillance data, support data triangulation and sharing across programs developed for epidemic monitoring	1. Point of service information systems for program monitoring and case surveillance for 15 high burden provinces are deployed 2. Technical assistance for national level in data analysis and data use for epidemic monitoring is developed and accurately. 3. Qualitative study to understand the most appropriate method to estimate size of Young MSM population is identified	1. Point of service information systems functional and available as per program requests supported provinces are deployed 2. Technical assistance for national level in data analysis and data use for epidemic monitoring is provided timely and accurately. 3. Size estimation exercise among MSM in other selected province is available.	1. Point of service information systems functional and available as per program requests 2. Key indicators among KPs such as prevalence and incidence of HIV, STIs among MSM/PWID/FSW are available. 3. Size estimation of MSM in selected provinces are available for epidemic monitoring and to inform program planning. 4. E-learning system establishment and operationalization progress.	Yes	
$ 365,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	8.06	5.74	N/A	Provincial program and HIV data are regularly collected and analayed to track the public health response.	Lack of sufficient HRH	Lack of technical capacity	Lack of Financial Resources	1. Provide support to GVN/VAAC for software enhancements and implementation to ensure continuity of patient monitoring systems (HMED-ARV/Logbook and OPC-Assist) and timelines/quality of data collected for program monitoring and case surveillance. 2. Provide support for GVN/VAAC and HCDC/DOH in the implementation of HIV Info 4.0 in HCMC to help create a unified national case reporting/surveillance data system for all provinces in the country. 3. Provide support to GVN/VAAC in establishing/adopting and implementing standard protocols, policies and procedures for data management and use to ensure data privacy, security and confidentiality. 4. Data quality improvement and data use in the data life cycle: Assure high-quality data collection system for program monitoring and data use enhancement at site levels - Conduct data reviews by sites for program planning and intervention/remediation activities. - Develop indicators to measure the background of data use - Organize provincial M&E and data management training to follow up previous trainings as well as provide new	COP20	COP24	Implementation of HMED-ARV/Logbook starts in FY22 with a plan to put the system in place and complete user training for 52 provinces. Followed up effort is required to ensure use of the system for routine data collection and reporting. OPC-Assist is in use in 5 PEPFAR/CDC supported provinces, and maintenance continues in FY23.	Not applicable	90% of PLHIV with presumptive TB are successfully referred for TB work up SOP for private provider inclusion in CS Development of an m-health platform for tracking and referral of TB patients	1. The HMED-ARV/Logbook is in place in 53 provinces (52 national + 1 PEPFAR province); OPC-Assist is in use in 5 PEPFAR/CDC provinces. 2. Advanced case reporting system -HIV Info 4.0- is is used in all 63 provinces. 3. Point of service information systems for program monitoring and case surveillance for PEPFAR and high-burden provinces are in place for data collection. 4. Technical assistance plan for CS and other surveillance and M&E activities are developed	1. Patient monitoring systems (ARV logbook, OPC-Assist) are maintained, enhanced as per requests from program, and users are supported to ensure high quality data are collected and submitted in a timely manner. 2. HIVInfo 4.0 is deployed, user training conducted for province and district levels, HIV case data in HCMC are migrated into the system and the province start using the system to submit case data. 3. Data management for security and confidentiality is designed and deployed 4. M&E and data management trainings with advanced content conducted 5. The e-learning system is developed, piloted and integrated into the HIV Info 4.0 system. The system is made available for use to facilitate	1. Number of TA visits/ virtual sessions to support the implementation of patient monitoring system. 2. Number of facilities and users trained to use HIVInfo 4.0 in HCMC; number of user requests received and number addressed 3. Number of documents developed and training courses conducted regarding data management for security and confidentiality 4. Number of DQA and M&E TA visits, M&E trainings. 5. Percentage completion of the e-learning system	Yes	
$ 30,000	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	Institutionalization of in-service training	7. Human Resources for Health	7.54	7.76	7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (If exact or approximate percentage known, please note in Comments column)	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health response.	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory constraint	HTS quality and sustainability: Training and TA for military trainers/mentors in HMZ, NEZ and military medical schools to become the military system's own pool of TA trainers/providers (fully competent of all program services and recommendations, joining national efforts including especially recency and PHCR)	Prior to COP 18	Post COP25	i) staff rotation and reassignment is the common norm in the military, requiring refreshed training/mentoring for staff newly on the roles. ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	Partial	All participating HTS facilities and schools attain a second fully-capable HTS trainer each who will provide training to own facility staff	60-70% of HTS facilities and schools having attained two fully-capable HTS trainers each but will provide training and TA to own facility staff is still limited	100% of participating HTS facilities and schools attain a second fully-capable HTS trainer and their trainers will provide training and TA to own facility staff	% of participating facilities having attained 01-02 fully-capable HTS trainers and actually provide training/TA to own facility staff.	Yes	
$ 77,000	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	Institutionalization of in-service training	7. Human Resources for Health	7.54	7.76	7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (If exact or approximate percentage known, please note in Comments column)	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health response.	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory constraint	HIV/STIs prevention for new military recruits: TA support for updating the national training material; provide refresh training for military trainers in HMZ, NEZ and beyond in line with all national guidelines/ recommendations and with emphases in especially recency and PHCR.	Prior to COP 18	Post COP25	i) staff rotation and reassignment is the common norm in the military, requiring refreshed training/mentoring for staff newly on the roles. ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	Partial	100% of all 50+ participating military regiments and military schools attain 01-03 fully capable trainers each who will provide training for the military peer education program at own facilities	60 - 70% of participating military regiments and military schools attain 01-03 fully capable trainers each and these trainers have been providing training and TA at own facilities	100% of participating military regiments and military schools attain 01-03 fully capable trainers each who will provide training and TA for the program at own facilities	% of participating regiments and military schools having attained 01-03 fully-capable trainers who actually provide training/TA to own staff/platoons	Yes	
$ 20,400	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	Program and data quality management	16. Performance Data	8.73	8.73	16.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	Surveillance and program data are used routinely to measure and monitor performance and inform the HIV public health response.	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory constraint	Quality data collection, analysis and use for PHCR: Training and TA for military site staff on collecting, analysis and use of program data, SIMS and MER metrics; continue advocacy for and increase military HIV program data sharing to the national/provincial platforms for PHCR.	Prior to COP 18	Post COP25	i) staff rotation and reassignment is the common norm in the military, requiring refreshed training/mentoring for staff newly on the roles. ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	Partial	1) 100% of in-charge staff are trained on training on data collection, reporting and analysis based on national and PEPFAR MER and SIMS requirements; 2) HIV/AIDS program data from select military sites continue to be shared with respective provincial data portal.	1) 75% of in-charge staff are trained on data collection, reporting and analysis based on national and PEPFAR MER and SIMS requirements; ii) HIV/AIDS program data from select military sites continue to be shared with respective provincial data portal.	1) 95% of in-charge staff are trained on data collection, reporting and analysis based on national and PEPFAR MER and SIMS requirements; ii) HIV/AIDS program data from select military sites continue to be shared with respective provincial data portal.	i) # of military staff received training on data collection, reporting and analysis and use data for responsive interventions	Yes	
$ 130,989	ASP: Laboratory systems strengthening-NSD	Priority Pops: Military & other uniformed services	Lab quality improvement and assurance	10. Laboratory	7.79	7.63	10.4 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources (HR)) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression	Increase access to viral load testing to maintain the third 95 and decreasing forward transmission.	Lack of technical capacity	Lack of sufficient HRH	Lack of managerial capacity	Laboratory services TA, quality assurance and accreditation: Continue TA support to improve military lab system capacity including: i) HIV confirmatory, VL and recency testing; ii) proficiency testing mentoring and institutionalization across network; iii) introduction /enhancement of proficiency testing content in pre-service/CME training curriculum of military medical schools; iv) build military pool of proficiency testing trainers/mentors for system's own self training/mentoring.	Prior to COP 18	Post COP25	i) staff rotation and reassignment is the common norm in the military, requiring refreshed training/mentoring for staff newly on the roles. ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	Partial	1) 03 additional military sites accredited to conduct confirmatory testing, 1 VL fully function within the national program with continuing TA; 80% of eligible, recommended patients to be recency tested by civilian labs to inform military/national programs; first military site to conduct recency testing; 2) Lab quality management practices continue to be maintained in all ISO-accredited labs; other priority labs in HMZ and NEZ continue to improve scoring to 90% of checklist ISO (or the national equivalence); 3) National lab quality management checklist embedded in military system, all labs meet around 80% of checklist requirements; Training of the approved quality management modules in select military school fully delivered;	1) 07 military sites accredited to conduct confirmatory testing, 1 VL fully function within the national program with continuing TA; 80% of eligible, recommended patients to be recency tested by civilian labs to inform military/national programs; first military site to roll out recency testing; ii) Lab quality management practices continue to be maintained in all ISO-accredited labs; other priority labs in HMZ and NEZ to continue to improve scoring; Scoring of all labs against ISO or national quality checklist not yet done as planned for COP21. iii) National lab quality management checklist embedded in military system but scoring against the national quality checklist not yet done; Advocacy continued on development of quality	1) Military directive to push for hospitals to establish HIV confirmatory testing capacity, with at least 03 additional military sites to be authorized; 1 VL lab fully function within the national program with continuing TA; 80% of eligible, recommended patients to be referred for recency testing by civilian labs to inform military/national PHCR; first military site to roll out recency testing; ii) Lab quality management practices continue to be maintained in all ISO-accredited labs; other priority labs in HMZ and NEZ to improve scoring by 10% against previous year results per ISO checklist (or the national equivalence); iii) National lab quality management checklist embedded in military system but pilot training of the approved	1) # of military labs accredited/approved by MOH and fully functioning as confirmatory/VL testing/recency testing sites ii) % of ISO (or national equivalence) requirements met by participating labs through on-site assessment at end of a COP year; Number of labs being ISO accredited; iii) National lab quality checklist embedded in the military system; Number of quality management training modules included in pre-service training program at military medical schools; iv) number of military members fully competent as trainers/mentors;	Yes	

$ 25,000	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	Institutionalization of in-service training	7. Human Resources for Health	7.54	7.76	7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (If exact or approximate percentage known, please note in Comments column)	All PLHIV access client-centered differentiated care for viral suppression.	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory constraint	Treatment services quality and sustainability: Training and TA for military hospitals/OPCs and medical schools, including implementation of all treatment MPRs and national guidelines; joining national efforts on recency and PHCR; scaling up SHI reimbursements for military OPCs patients and linkages with civilian services/CBOs.	Prior to COP 18	Post COP25	i) staff rotation and reassignment is the common norm in the military, requiring refreshed training/mentoring for staff newly on the roles. ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	i) 100% in-charge military staff received refreshed training or mentoring on HIV/AIDS CTx 2) 100% military OPCs follow the updated national guidance on HIV/AIDS treatment and scale up Test and Start/TLD regimen/VL tests for HIV patients	Partial	i) 80% in-charge military staff received refreshed training or mentoring on quality HIV/AIDS CTx and related MPRs ii) 100% military OPCs follow the updated national guidance on HIV/AIDS treatment, TPT, and scale up MMD/TLD regimen/VL tests for HIV patients.	i. 100% in-charge military staff received refreshed training or mentoring on quality HIV/AIDS CTx and related MPRs ii) 100% military OPCs follow the updated national guidance on HIV/AIDS treatment, TPT, and scale up MMD/TLD regimen/VL tests for HIV patients.	i.# of military medical staff that receive refreshed training/mentoring on quality HIV/AIDS treatment and related MPRs ii) % of OPC sites following national guidance on HIV/AIDS treatment	Yes	
$ 54,500	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	Institutionalization of in-service training	7. Human Resources for Health	7.54	7.76	7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (If exact or approximate percentage known, please note in Comments column)	To contribute to military medical system's capacity on infection prevention and control (IPC) for quality HIV/AIDS care and treatment and other care services including TB/HIV/COVID-19)	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory constraint	Infection Prevention and Control (IPC) Strengthening: Training and TA on IPC and patient safety teaching and mentoring capacity for IPC lead staff and practitioners in HM2 and NEZ and military medical schools.	Prior to COP 18	Post COP25	i) staff rotation and reassignment is the common norm in the military, requiring refreshed training/mentoring for staff newly on the roles. ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	90% of lead nursing staff working in HIV/AIDS at military and selected civilian facilities and military medical schools receive training and TA on infection prevention and control (including TB/HIV), biosafety and waste management, patient safety and S&D; and are competent of providing peer-teaching back at their facilities.	Partial	75% of lead IPC staff working in HIV/AIDS at military and selected civilian facilities and military medical schools receive training and TA on infection IPC (including TB/HIV/COVID-19) and patient safety and are competent of providing peer-teaching back at their facilities.	i) 85% of lead IPC staff working in HIV/AIDS at military and selected civilian facilities and military medical schools receive training and TA on infection IPC (including TB/HIV/COVID-19) and patient safety and are competent of providing peer-teaching back at their facilities. ii) service linkages with civilian system improved.	i) # of lead IPC staff working in HIV/AIDS at military and selected civilian facilities and military medical schools that receive training and TA on IPC and patient safety	Yes	
$ 65,175	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	Institutionalization of in-service training	7. Human Resources for Health	7.54	7.76	7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (If exact or approximate percentage known, please note in Comments column)	All PLHIV access client-centered differentiated care for viral suppression.	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory constraint	Patient care quality and sustainability: Training and TA to build patient care teaching and mentoring capacity for continuous quality improvement, including rolling out innovative models and practices (QA/QI/CQI).	Prior to COP 18	Post COP25	i) staff rotation and reassignment is the common norm in the military, requiring refreshed training/mentoring for staff newly on the roles. ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	90% of lead nursing staff working in HIV/AIDS at military and selected civilian facilities and military medical schools receive training and TA on HIV service quality assurance and CQI, clients centered,friend services and S&D; and are competent of providing peer-teaching back at their facilities.	Partial	75% of lead nursing staff working in HIV/AIDS at military and selected civilian facilities and military medical schools receive training and TA on quality patient care and CQI and are competent of providing peer-teaching back at their facilities.	i) 85% of lead nursing staff working in HIV/AIDS at military and selected civilian facilities and military medical schools receive training and TA on quality patient care and CQI and are competent of providing peer-teaching back at their facilities. ii) service linkages with civilian system improved.	i) # of lead nursing staff working in HIV/AIDS at military and selected civilian facilities and military medical schools that receive training and TA on quality HIV patient care and CQI.	Yes	
$ 33,491	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	Clinical guidelines, policies for service delivery	6. Service Delivery	7.20	6.85	6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	To contribute to military medical system's capacity on infection prevention and control (IPC) for quality HIV/AIDS care and treatment and other care services including TB/HIV/COVID-19)	Legal, policy or regulatory constraint	Lack of technical capacity	Lack of managerial capacity	Infection Prevention and Control (IPC) Strengthening: Support updating/revising technical guidelines and CME/pre-service training curriculum on IPC and patient safety.	Prior to COP 18	Post COP25	ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	1) 03 technical guidance on infection prevention and control, biosafety and waste management to be developed/updated; 2) 03 technical modules/guidance on same above to be integrated into CME trainings of military hospitals or military medical schools.	Partial	i) IPC guidance developed but updates needed; ii) IPC modules used in CME trainings of military hospitals or military medical schools but updates needed	i) IPC guidance developed/updated; ii) Select IPC training modules integrated into CME trainings of military hospitals or military medical schools.	i) IPC technical guidance developed/updated; ii) # of technical IPC modules integrated into CME trainings of military hospitals or military medical schools.	Yes	
$ 24,500	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	Clinical guidelines, policies for service delivery	6. Service Delivery	7.20	6.85	6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	All PLHIV access client-centered differentiated care for viral suppression.	Legal, policy or regulatory constraint	Lack of technical capacity	Lack of managerial capacity	Patient care quality and sustainability: Support updating/revising technical guidelines and CME/pre-service training curriculum for continuous quality improvement, including rolling out innovative models and practices (QA/QI/CQI).	Prior to COP 18	Post COP25	ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	1) 03 technical guidance on quality HIV/AIDS patient care and support to be developed/updated; 2) 03 technical modules/guidance on same above to be integrated into CME trainings of military hospitals or military medical schools but updated needed	Partial	i) HIV/AIDS patient care and support guidance developed but updates needed; ii) Select technical modules used in CME trainings of military hospitals or military medical schools but updated needed	i) HIV/AIDS patient care and support guidance developed/updated; ii) Select technical modules integrated into CME trainings of military hospitals or military medical schools.	i) HIV patient care and support guidance developed/updated; ii) # of technical modules integrated into CME trainings of military hospitals or military medical schools.	Yes	
$ 14,100	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	Clinical guidelines, policies for service delivery	6. Service Delivery	7.20	6.85	6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health response.	Legal, policy or regulatory constraint	Lack of technical capacity	Lack of managerial capacity	HTS quality and sustainability: TA support for: i) revising/updating the service guidelines, introduction,Rolling out of the revised/updated guidelines with emphasis on recency and PHCR, ii) development/refinement of HTS core content in pre or in-service training at military medical schools; iii) technical support for critical military communication campaigns to raise HIV/AIDS awareness, prevention, case identification and treatment (activity cutting across several technical programs).	Prior to COP 18	Post COP25	ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks iv) the limited quantity of support that can be provided a year against the sheer number of participating sites in need	TA to support continue rolling out/implementation of the Military HTS Guidelines.	Partial	i) TA needed to support existing and additional sites on quality HTS provision per the military revised guidelines. ii) Core HTS content in pre/in-service training at military medical schools not yet included/updated. iii) technical support provided to campaigns at select sites in COP20-21 and need to continue for other sites in coming COP years (activity cutting across several interventions).	i) TA provided to 3 - 5 additional sites on refinement of HTS services per the revised guidelines and updated recommendations. ii) advocacy made towards inclusion of HTS core content in pre/in-service training at military medical schools iii) technical support provided to campaigns at 7 - 10 sites (activity cutting across several interventions).	i) # of sites provided with TA to enhance HTS services per the revised guidelines and updated recommendations iii) # of awareness/demand creation campaigns that received technical support	Yes	
$ 44,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	Clinical guidelines, policies for service delivery	6. Service Delivery	7.20	6.85	6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health response.	Legal, policy or regulatory constraint	Lack of technical capacity	Lack of managerial capacity	HIV/STIs prevention for new military recruits: TA support and advocacy for: i) expanding the program into military schools and integration into the national training package for new military inductees; ii) support supervision and mentoring by military program leaders/managers to select sites; iii) technical support for critical military communication campaigns to raise HIV/AIDS awareness, prevention, case identification and treatment (activity cutting across several technical programs). vi) advocacy for development of e-learning platform on all topics for use by a larger pool of beneficiaries.	Prior to COP 18	Post COP25	ii) programs evolve year on year requiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks iv) the limited quantity of support that can be provided a year against the sheer number of participating sites in need	TA to support continue rolling out/implementation of the Military Peer Education Guidelines and supporting tools. Continue advocacy for the program to be integrated into the national military inductee training package at GVN's own costs and TA support only from PEPFAR.	Partial	i) Select military schools have participated in the program, more schools are expected; advocacy on institutionalization of the program conducted but needs to continue; ii) quality assurance mentoring visits conducted on a small number of participating regiments each year. To continue each year on other regiments. iii) technical support provided to campaigns at select sites in COP20-21 and need to continue for other sites in coming COP years (activity cutting across several interventions). iv) E-learning platform idea received positively by the military	i) 2-3 additional military schools participate in the program; advocacy conducted for institutionalization of the program into the national training package for new military inductees. ii) 10-12 quality assurance mentoring visits made by military supervisors and/or program leaders/managers; iii) technical support provided to campaigns at 2 - 3 sites (activity cutting across several interventions). iv) advocacy kicked-off and maintained for development of e-learning platform.	i) 2-3 additional military schools participate in the program; advocacy conducted for institutionalization of the program into the national training package for new military inductees. ii) 10-12 quality assurance mentoring visits made by military supervisors and/or program leaders/managers; iii) # of awareness/demand creation campaigns that received technical support	Yes	
$ 60,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and strategic plans	10. Laboratory	7.79	7.61	10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	Recency data used for better management and coordination of public health response at provincial and national levels.	Lack of sufficient HRH	Lack of managerial capacity	Lack of technical capacity	1. Provide technical assistance to the GVN on recent HIV responses, including the risk network, transmission clusters, and the molecular cluster response	COP20	COP24	This is an on-going activity	1. SOP and guidance for public health response is endorsed 2. Transmission clusters and molecular clusters are identified and responded in timely manner 3. Data from recency dashboard is responsively generated and used for planning public health cluster responses	Yes	- The SOP for PHCR finalized by end of COP22 - A training package on data use for PHCR is finalized	1. National authorities able to respond to any identified clusters, molecular clusters 2. National authorities understand how to analyse and interpret molecular clusters for PHCR	# of provinces trained on using recency data as alert for PHCR and molecular clusters # of molecular clusters identified and response	Yes	

$ 985,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	8.06	5.74	N/A	HIV/AIDS data interoperability platform is established	Lack of Financial Resources	Lack of technical capacity	Lack of sufficient HRH	1. Provide technical support to GVN/VAAC for routine operation, software and infrastructure maintenance, and software functionality/server and network infrastructure enhancements/optimization for the national HIV CS system to ensure interruption-free implementation of the case surveillance activities. 2. Identify and upgrade additional point-of-service systems to connect to and feed data into the established national case data repository, particularly testing data from laboratories. 3. Provide support for GVN/VAAC to develop and implement data exchange between the HIV CS system and the national social health insurance, and census data system upon availability of data sharing policies and utilize records matching algorithms developed to better facilitate the HIV case verification process and create a more sustainable data source for case surveillance. 4. Provide support for HCMC DOH/CDC to complete the upgrade and pilot of the ART data management system (eClinica), make it ready for roll out province-wide to better support for both ART patient management and disease surveillance activities.	COP19	COP23	- HIV case surveillance is maintained in provinces where the activity is in operation mode, and will be scaled up in prioritized provinces. The upgrade of eClinica in FY22 focuses on finalization of business requirements, selection ofstack technologies and development of core functions, the development and pilot continues into FY23. Development and implementation of the m-health platform is carried out using a phased approach with the basic features established in FY22 for pilot and small scale implementation. More advanced features will be added and implementation will be scaled up in FY23. Establishing and institutionalizing a national HIV	CS expanded to 15 provinces including PEPFAR supported and high-burdened provinces. The national CS data platform is established and ready for testing. A minimum functional m-health platform for CS established. Core national standards and guidelines for the national electronic health profile system (V20) including HIV case data are established.	Partial	1. The HIV CS system is in place and case sentinel events data are collected routinely from different data source systems. 2. An advanced case reporting system (HIV Info 4.0) will be deployed and user training conducted for 62 provinces (except HCMC). 3. Business requirements finalized and core functions of the eClinica system are developed. 4. The mobile app with basic features is available and piloted.	1. HIV CS system is maintained with functionality enhanced as needed to support for implementation and expansion of CS in 15 provinces. 2. Additional identified point of service systems are interoperable with the HIV CS system to pull data for CS. 3. Upon availability of data sharing policies, linkage between HIVinfo 4.0 and SHI, household/census data systems developed. 5. The eClinica system development is completed and piloted, ready for roll out. 6. The patient mobile app implementation is scaled up, selective advanced features will be added in the app. 7. Consensus for data sharing between the national HIV CS and the national eCDS (e communicable disease surveillance system) systems is	1. Uptime/% of the national HIV CS system to facilitate program implementation; Number of system users served; Number of user requests received and percentage of them addressed; 2. Number of POS systems identified and upgraded for interoperability with national HIV CS system; 3. A Minimum Viable Product (MVP) for the linkage between HIV Info 4.0 and SHI/census data system developed upon a data sharing policy; 4. Number and percentage of eClinica system functions completed and tested; Number of users participating during system pilot; Number of feedbacks/requests received during system pilot and number addressed; 5. Number of patients opt-in for the patient mobile app; Number of clinics implementing the app;	Yes		
$ 110,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Service organization and management systems	9. Quality Management	8.70	7.76	9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	Provincial program and HIV data are regularly collected and analyzed to track the public health response.	Lack of technical capacity	Lack of managerial capacity		Advocate and work with the VAAC to develop and utilize a national outreach and testing health information system and support to connect it with the new HIVInfo. Support to develop a social contracting monitoring dashboard system into the PQM system to monitor the performance of the social contracting model	COP22	COP23	N/A	N/A	Not applicable	There are several testing system in place such as: 1) HTC-Elog is an testing system. It is upgraded to online version and added a community component. It is currently implementing at all testing sites in Ho Chi Minh, Dong Nai, Tay Ninh, Tien Giang 2) IMS: an online testing system, currently is implementing at testing sites that not having donor supports in Dong Nai, Tay Ninh, Tien Giang	National outreach and testing system and social contracting M&E systems in place: 1) Develop social contracting dashboard and integrated and pilot in at least 6 provinces (4 USAID provinces and 2 non-project supported provinces). 2) VAAC site visits in to access the use of testing systems (HTC Elog/IMS…) and social contract monitoring system in PQM. 2) VAAC led workshop with relevant stakeholders to brainstorm the use of HIS systems in non-project supported sites. 3) TA to pilot the national testing systems in at least two non-project supported provinces.	1.Number of provinces piloting the SC dashboard to monitor SC activities 2.Number of site visits by VAAC to assess the use of the SC monitoring and HIV testing systems 3.Number or VAAC-led workshops on the use of HIS system nationally 4.Number of TA trips to support piloting of the national testing system by VAAC	Yes		
$ 200,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	8.73	16.3 Comprehensiveness of Service Delivery Data:: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Provincial program and HIV data are regularly collected and analyzed to track the public health response.	Lack of technical capacity	Lack of managerial capacity		Strengthen the Health Information System at four USAID provinces to ensure high-quality information for program response. Continue to maintain and upgrade the provincial datahub/PQM. Ensure data automation for 100% of PQM indicators. Strengthen provincial staff capacity on PQM data use to identify program quality issues and actions through established CQI provincial teams. Integrate HIS system (PQM/CHIS) at provincial level into one provincial level system to support provinces in managing program quality, case surveillance and community performance.	COP22	COP25	TA requires multiple year interventions	N/A	Yes	80% PQM indicator data flow are automated CHIS module is established in HCDC	1.Provincial datahub and PQM system implemented in 03 provinces (Dong Nai, Tay Ninh and Tien Giang) and piloted in 01 province (HCMC). 2.PQM, CHIS system piloted in HCMC	1.Number of provinces with provincial datahub and PQM systems upgraded and used for program pivots. 2.Number of provinces with integrated PQM and community HIS.	Yes		
$ 100,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	11. Domestic Resource Mobilization	8.21	7.70	11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?	GVN ensures no financial barriers for PLHIV to accessing treatment under SHI.	Legal, policy or regulatory constraint			Provincial SHI Coverage and Copayments: Advocate for new, expanded, or sustained provincial commitments to cover SHI copayments for ARVs and viral load. Coordinate with the VAAC and LHSS to ensure supportive policies and finances are in place at the national level and data systems successfully monitor SHI uptake and associated costs. Cover emergency copayment needs for ARVs and viral load for clients ineligible to receive provincial support.	COP21	COP23	Conflict of policies	USAID-supported treatment provinces have local commitments to cover ARV copayments and at least one province supports viral load copays.	Not applicable	no payment mechanism using local funding	All six USAID-supported treatment provinces commit to cover ARV copayments and three of these provinces have commitment to cover viral load copayments from SHI schemes in FY23.	1. Number of USAID-supported treatment provinces that have local commitments to cover ARV copayments 2. Number of USAID-supported treatment provinces that have local commitments to cover viral load copayments	Yes		
$ 115,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Market openness	13. Market Openness	9.33	9.41	13.16 Patient choice: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of patients to decide which providers or products to use?	Ensure access to essential HIV prevention commodities through diversified markets.	Lack of technical capacity			Demand generation: Promote services provided by social enterprises, community-based organizations, and public health facilities focused on outreach, testing, ART and PrEP linkage, psychosocial support, and ART retention support in all USAID provinces and social contracting provinces. Provide HIS for the management of clients at private and community-based clinics that receive project or social contracting support. Partner with existing healthcare booking platforms to promote services at public, private, and community sites. Work with other USAID IPs including STEPS and LADDERS to co-organize joint digital marketing forums, and provincial campaigns to promote HIV-related services provided by social enterprises and community-based organizations.	COP22	COP24	N/A	N/A	Not applicable	•Current data indicates that the number of clients conducting risk assessments and booking HIV-related services (HTS, PrEP, and self-risk assessment) via the online reservation application is low (FY22), accounting for approximately 10% of previous FY21 appointments. This is due to limited online and offline demand generation activities, COVID-19 restrictions, and a lack of collaboration with other stakeholders, including potential community and private sector partners. •EpiC's online booking system is missing advanced features that would enable clinics, outreach workers, and case managers to manage clients more effectively online.	1. Increase in the number of online risk assessments and appointment bookings by 150 percent compared to FY22. 2.Five offline events and three online campaigns conducted to increase demand for PrEP and HIV testing in all provinces supported by EpiC. 3.Increased online promotional efforts through social media in order to reach at least 10 million clients with 500,000 engagements on Facebook and 50,000 clicks to the online reservation application. 4.Co-organization of at least 1-2 joint campaigns to generate demand for PrEP in collaboration with other USAID IPs and community partners/social enterprises. 5. Development of key assets and tools to promote PrEP and HIV testing, which will be shared with community partners/social	3P regular reports on: -# online risk assesement -# online/offline event; campaigns -# of clients reached through those online/offline events/campaigns -# of tools developed	Yes		
$ 100,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	8.73	16.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	Surveillance and program data are used routinely to measure and monitor performance and inform the HIV public health response.	Lack of managerial capacity	Legal, policy or regulatory constraint		National HIV M&E framework: Work with VAAC and relevant stakeholders to review current national HIV M&E requirements including guidance, indicators, and data collection systems and recommend revisions of indicators for CQI/ PQM activities.	COP22	COP23	N/A	N/A	Not applicable	•Circular 03 for HIV/AIDS reporting was issued in 2015. VAAC is planning to submit the draft of revised Circular 03 for HIV/AIDS to MOH for approval in September 2022	•National guidance on data collection and tool developed and training for provinces on the updated reporting requirement conducted in COP22	1.National guidance on data collection and tool available for updated reporting requirements. 2.Number of training courses on the updated reporting requirement conducted	Yes		
$ 55,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	8.73	16.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	Provincial program and HIV data are regularly collected and analyzed to track the public health response.	Lack of technical capacity	Lack of sufficient HRH	Lack of managerial capacity	Data quality assurance: Update the national Data Quality Assesment Tool for HIV/AIDS Prevention and Control issued by the VAAC and facilitate DQA activities at facilities with poor-performing systems and low DQA scores, and less frequently at facilities with good scores from the baseline assessment.	COP22	COP24	N/A	N/A	Not applicable	DQA document was issued by VAAC 7 years ago (as of April 2022). Since then, there have been updates to the data collection system and requirements, but DQA guidance document has not been updated. In addition, in non-PEPFAR-supported provinces, DQA has often been included with general monitoring trips and thus lacked in-depth DQA activities.	Updated version of national DQA tool released. At least two DQA trips to assess provincial data quality in two non-project supported provinces	1.Revised DQA guideline developed and disseminated to provinces 2.Number of DQA-intensive trips conducted to access provincial data quality	Yes		

$ 172,500	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Research	14. Epidemiological and Health Data	8.06	5.74	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	Surveillance and program data are used routinely to measure and monitor performance and inform the HIV public health response.	Lack of technical capacity			KP evaluation study on HIV related care seeking behavior of clients in priority provinces (HCMC, Dong Nai and 1-2 provinces with increasing epidemics) to understand characteristics of clients that are seeking ART and PrEP services, and MMD outside of public facilities including unmet needs, barriers and challenges to access and uptake services at public sector, as well as preference for services. The KP study will assess not only MSM, but also include other key populations groups who may be underserved including female partners of MSM, sero-discordant couples, transgender women, female sex workers, and people who inject drugs.	COP22	COP23	N/A	Protocol of KP study agreed upon by authorized GVN partner and PEPFAR stakeholders and approved by IRB	Not applicable	Protocol of KP study agreed upon by authorized GVN partner and PEPFAR stakeholders and approved by IRB	Study completed with written report	- Complete raw dataset - Final report findings shared with ' - VAAC, USAID, other stakeholders in a study presentation	Yes	
$ 200,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.38	6.33	2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery? Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column	Ensure access to essential HIV prevention commodities through diversified markets.	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources	National & Provincial Levels: Provide TA to support increasing the demand for HIV related goods and services: National Level: 1. Under VAAC's leadership, working with relevant partners to update/revise the communication strategy to increase demand among KPs for key HIV related services in the new context of VN 2. Support VAAC to revise/adapt the training package, manuals & materials on how to do attractive events targeting different groups of audiences esp. young people and young MSM 3. Support VAAC to coordinate and implement demand generation activities and provide TA to GFATM provinces through National Forum e.g. PrEP & tele-PrEP Provincial Level: 4. Support community partners in USAID supported provinces to scale-up online ordering/services through Self-Test and PrEP platforms, apply technology (AI/Chatbot) to improve the quality of services 5. Coordinate and support USAID/IPs to annually update KPs insights and refresh PrEP, HIVST messages and campaigns 6. Coordinate and support USAID/IPs to organise periodic online HIV services DG Forums among CBOs, SEs and KP-led clinics	COP22	COP25	N/A	N/A	Not applicable	1. Preference among KPs (Consumer survey 2021) 2. Data on PrEP uptake among KPs	1. Demand among KPs for key HIV services including: PrEP (daily oral, event-driven and CAB-LA), Self-Testing, STI screening, viral hepatitis, mental health care OSS services and others (provincial campaigns, etc) increased by at minimum six campaigns targeting different audiences (young people, young MSM, TGW), insights generated to inform specific needs of young MSM. 2. TA provided to VAAC to develop communication strategy in the context of COVID19 targeting young people and young KPs 3. Training manual/guideline on demand generation for all HIV related services to different groups of audiences esp. young people and young MSM, completed and delivered to VAAC for roll-out 4. Online-to-Offline services	TA package developed DQA and M&E CQI/satisfaction survey Progress annual report	Yes	
$ 150,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Clinical guidelines, policies for service delivery	5. Service Delivery	7.20	6.85	6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are institutionalized under a national public health response.	Lack of technical capacity			Pilot coupled with implementation study of integrated PrEP CAB-LA service delivery through private sector/KP-led clinics: 1. Secure VAAC approval of CAB-LA delivery pilot model and protocol designed to address key pragmatic implementation questions (acceptability, feasibility, effectiveness, cost) 2. Develop service SOPs, training, demand gen tools/videos/social media/micro-events (awareness, how CAB-LA works) and reporting systems in place 3. Secure import of CAB-LA donations for study; support ViiV with product market entry (assessing market, pricing, access and commercial distribution) 4. Implement CAB-LA service delivery and study in coordination with VAAC, PEPFAR and provincial partners 5. Preliminary results from pilot shared with VAAC/MOH, PrEP TWG quarterly and GFATM 6. Assist VAAC/MOH to develop CAB-LA implementation plan to be developed & implemented (in COP23)	COP22	COP23	N/A	N/A	Not applicable	CAB-LA, is an injectable form of PrEP approved by the USFDA for use as a prevention option. It is new to VN and there is no model available on the use of CAB-LA in country	1. Pilot integrated PrEP CAB-LA service delivery through private sector/KP-led clinics 2. VAAC approval of CAB-LA delivery pilot model and protocol designed to address key pragmatic implementation questions (acceptability, feasibility, effectiveness, cost) secured 3. Service SOPs, training, demand gen tools/videos/social media/micro-events (awareness, how CAB-LA works) and reporting systems in place 4. Import of CAB-LA for study secured; support ViiV with product market entry (assessing market, pricing, access and commercial distribution) 5. CAB-LA service delivery and study being implemented in coordination with VAAC, PEPFAR and provincial partners 6. Preliminary results from pilot shared with VAAC/MOH, PrEP	Study Protocol Study report Data set	No	
$ 180,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Research	14. Epidemiological and Health Data	8.06	5.74	14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	Surveillance and program data are used routinely to measure and monitor performance and inform the HIV public health response.	Lack of technical capacity			Implementation Study: Evaluation of acceptability, feasibility, effectiveness and program delivery cost of key population-led social enterprise clinic delivered long-acting cabotegravir in Vietnam.	COP22	COP22	N/A	N/A	Not applicable	There is currently no assement available for the new CAB-LA and oral Prep among KP	1. Monitor/compare HIV seroconversion and STIs among oral PrEP and CAB-LA users and factors associated with HIV seroconversion and STIs 2. Quantify degree of switching between oral PrEP and CAB-LA at baseline and factors associated with switching 3. Measure and compare willingness to pay for oral PrEP and CAB-LA 4. Describe service delivery preferences between different KP groups for oral PrEP and CAB-LA 5. Describe provider perceived barriers and facilitators of offering CAB-LA in addition to oral PrEP 6. Compare service delivery cost of different models of oral PrEP (TDF-FTC) and LAI-PrEP (CAB-LA)	Study Protocol Study report Data set	No	
$ 150,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Research	14. Epidemiological and Health Data	8.06	5.74	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	Surveillance and program data are used routinely to measure and monitor performance and inform the HIV public health response.	Lack of technical capacity			National Private Sector Assessment Study: Market survey to assess demand of private sector services for key populations and end users as a baseline measurement to support the VAAC's National HIV Private Sector Engagement (PSE) Roll-Out Plan.	COP22	COP22	N/A	N/A	Not applicable	No market survey available on willingness to pay for HIV and PHC commodities and services among KPs	1. Measure and compare willingness to pay for HIV and PHC commodities and services in urban, peri-urban and rural settings 2. Describe service delivery preferences between different KP groups 3. Describe provider perceived barriers and facilitators of accessing HIV and PHC commodities and services 4. Quantify total baseline markets for a sub-set of HIV and PHC commodities and services 5. Utilize study results to input baseline figures and set benchmarks where relevant for the national HIV PSE Plan	Study Protocol Study report Data set	No	
$ 100,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Clinical guidelines, policies for service delivery	5. Service Delivery	7.20	6.85	6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)	Increased GVN capacity to manage and coordinate HIV commodities procurement and supply chain from multiple sources.	Lack of technical capacity	Lack of sufficient HRH	Lack of managerial capacity	NEW: Advocate for Community PrEP and nPEP drug distribution 1. Advocate for VAAC approval of Community PrEP/nPEP drug distribution service delivery model 2. Co-Develop demonstration activity with VAAC in Dong Nai 3. Use evidence to advocate for the revision of the PrEP National Guidelines to include community PrEP & nPEP drug distribution.	COP22	COP22	N/A	N/A	Not applicable	Community Prep/nPrep is not yet included as delivery model in national guidelines	1. Proposal for Community PrEP/nPEP drug distribution developed and approved by VAAC 2. Community PrEP/nPEP drug distribution implemented in 2-3 provinces in collaboration with Community Partner - LADDERS 3. Community drug distribution demonstration results will be shared with VAAC and other key stakeholders for revision of the National PrEP Guidelines	M&E tool Result report	No	
$ 50,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Evaluations	14. Epidemiological and Health Data	8.06	5.74	N/A	All PLHIV access client-centered differentiated care for viral suppression.	Lack of technical capacity	Lack of sufficient HRH		Evaluation of health literacy, in particular treatment and VL literacy, among HIV clients in CDC-PEPFAR provinces that have Community Advisory Boards and QI facility reduction programs to document the effectiveness of CABs in improving health literacy and client outcomes.	COP22	COP22	One time only evaluation	N/A	Not applicable	6 CDC-PEPFAR provinces have CABs that collect client satisfaction data, participate in QI and client outreach and support	Protocol approved, data collection completed, with preliminary findings and drafting of report begun	% increase in VL literacy/HIV health literacy (K=K, testing interval, VL result, MMD, etc.)	No	

$ 71,515	ASP: Human resources for health-NSD	Key Pops: Not disaggregated	Civil society engagement	3. Civil Society Engagement	4.25	5.08	3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	Civil society, particularly community-based organizations actively monitor the HIV program for a true public health response.	Legal, policy or regulatory constraint	Lack of technical capacity		Contribute to community Public Health Cluster Response nationwide. In collaboration with HSS and Program Services: In partnership with VUSTA: - Establish a national cadre of community PHCR champions as part of the national PHCR TWG, including engagement and design of core elements/standards for ethical and person-centered response package as part of the National SOPs. Training and support for national-level community champions on PHCR approaches and practices to foster their technical leadership. - Monitoring, documentation of provincial community response efforts into a national repository for continued learning and resolution of technical and programmatic gaps, in collaboration with LADDERS, VAAC and other National TWG members. Share lessons and foster community PHCR learning network through quarterly meetings, an online knowledge platform, and other documentation & dissemination. - National-level TA to VAAC on SOP revisions, guidelines, PHCR planning. - Support community PHCR in CDC/PEPFAR provinces (within the 11 priority provinces)	COP22	COP25	N/A	N/A	Not applicable	PHCRs implemented in Can Tho, Soc Trang and Kien Giang with lessons learned and documented for onward planning	1/ community expert cadre established and capacitated, active participation in TWG 2/ Active PHCR community learning network with routine meetings and knowledge platform for sharing best practices 3/ Inclusion of person-centered standards in National SOPs and guidelines	#s of national level community champions/experts actively involved in TWG #Documentation & M&E of community PHCR responses #s of CBOs/community experts actively engaged in learning network	Yes	PHCR initiative includes person-centered, ethical and equitable standards with a robust community response component
$ 75,000	ASP: Human resources for health-NSD	Key Pops: Not disaggregated	Civil society engagement	3. Civil Society Engagement	4.25	5.08	3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	Increase in quality and quantity of diverse groups, including KP-led CBOs and civil society, social workers, and law enforcement, providing HIV and drug treatment services.	Lack of technical capacity			Community-focused initiatives to meet Sustainable Epidemic Control: 1) Organizational capacity building for CBOs in CDC-supported provinces to qualify for social contracting and broader HIV program support and collaboration (with VUSTA) 2) With VNP+: science sessions on biomedical innovations, treatment & health literacy including for aging + HIV, etc., community and stigma monitoring coordination, public health messaging on status neutral, etc. (in collaboration with HAVN). Describe healthcare needs and existing gaps, such as telemedicine literacy, among aging PLHIV to support person-centered care for this population	COP22	COP25	N/A	N/A	Not applicable	CBO market analysis and mapping completed in 6 CDC-supported provinces VNP+ utilizes Stigma Index 2021 findings to advocacy and network priority plan 5 CDC-supported provinces are in varying stages of readiness for social contracting. VNP+ is national convener for Tx literacy and advocate for biomedical innovation	Roadmaps initiated for community organizational support VNP+ develops and shares treatment/health literacy support materials to network via multiple fora and documents	# CBOs receiving support to meet social contracting requirements # TA events provided by VNP+ to the network and community organizations	No	

4 Prior Yr SRE-E

COP21 Activity Budget	Activity Description	Filter Here - ONLY SRE	Activity Type	Activity Title	Primary evaluation or study questions	COP or HOP funded ?	Activity Start COP Year	Activity End COP Year	Current Stage of activity (as of COP20)	COP20 Baseline Status (major)	COP20 Baseline Status (detail)	How does this activity advance COP priorities?	SRE=1	All required fields completed?	Ongoing in COP22? (Yes/No)	Additional Notes- Please explain if not ongoing in COP22
$15,000	1. Potential deployment of focused TA for HIV public health response through on-going and routine monitoring of key clinical indicators. Response based on established decision points via a standardized national algorithm, e.g. telephone follow up, data mining, cluster investigation, etc. 2. Support client transition to SHI through provincial and site level coordination with PSS, on-going monitoring of key SHI services, and site-level TA	Surveillance	Other	Public Health Response	HIV public health response through on-going and routine monitoring of key clinical indicators	COP	COP20	COP25	Proposed in COP	Data_collection	Not started	Strengthen capacity for authorities to access, aggregate and interpret data for an evidence-based HIV public health response	1	SRE details entered	yes	
$347,400	In the Northern region, implement novel methdologies for new KP size estimates and PLHIV estimations, e.g. network analysis in high-burden provinces to inform rvised National estimated and the HIV public health response. 2. Support development of benchmarks for key indicators to quickly identify public health issues, set up the alert system and develop SOPs for response 3. Monthly data review through EOC platform for identification of hotspots for public health response 4. On-going technical assistance to northern provincial CBS scale-up and new sampling methodologies for MSM and FSW for HSS+.	Surveillance	Recency	HIV surveillance including recency testing	What are the prevalence, level of recent transmission rate and viral load among KP populations What is the best and appropriate sampling methods for HSS+ in Vietnam	COP	COP18	COP22	Ongoing	Data_collection	In progress	Strengthen the national surveillance system and improved surveillance data to monitor the epidemic	1	SRE details entered	yes	
$341,100	In the Southern region, implement novel methdologies for new KP size estimates and PLHIV estimations, e.g. network analysis in high-burden provinces to inform revised national estimates and the HIV public health response. 2. Support the development of benchmarks for key indicators to quickly identify public health issues, set up the alert system and develop SOPs for response 3. Monthly data review through EOC platform for identification of hotspots for public health response 4. On-going technical assistance to northern provincial CBS scale-up and new sampling methodologies for MSM and FSW for HSS+.	Surveillance	Recency	HIV surveillance including recency testing	What are the prevalence, level of recent transmission rate and viral load among KP populations What is the best and appropriate sampling methods for HSS+ in Vietnam	COP	COP18	COP22	Ongoing	Data_collection	In progress	Strengthen the national surveillance system and improved surveillance data to monitor the epidemic	1	SRE details entered	yes	
$227,500	1. Lead expansion of the national case-based surveillance system by coordinating with all partners on development of the CBS framework, e.g. standardizing minimum requirement, endorsing adapted SOPs, etc. Complete all policy requirements to prepare for national roll-out. 2. Lead development and dissemination of national HIV public health response 3.Endorse benchmarks for key indicators to quickly identify public health issues, set up the alert system and develop SOPs for response 3. Update national MSM size estimations utilizing internationally-endorsed methodologies in conjunction with global subject matter experts	Surveillance	Case surveillance	HIV surveillance system	What are the appropriate methods to estimate KP and PLHIV and project the HIV motarlity and mobility in Vietnam Establishing case based surveillance, using HIS system	COP	COP18	COP26	Ongoing	Data_collection	In progress	Strengthen the national surveillance system and improved surveillance data to monitor the epidemic	1	SRE details entered	yes	
$150,000	1. Support HCMC to develop benchmarks for key indicators to quickly identify public health issues, set up the alert system and develop the SOPs for response 2. Collect program monitoring data at site/district levels to meet PEPFAR MER requirements 3. Conduct data abstraction and reporting for monitoring program performance, service quality and coverage 4. Conduct data review by site for quality improvement, intervention/remediation activities. 5. Continue to support implementation of individual electronic medical record (eClinica) system at all district level OPCs to serve as important component for HIV case-based surveillance and for monitor treatment program. 6. Upgrade to online system for data capture and report of HIV-testing program. 7. Continue to strengthen HCRS at district and communal levels.	Surveillance	Case surveillance	HIV surveillance system	Using program and HIV case reporting data to monitor and evaluate the cascade	COP	COP18	COP20	Ongoing	Data_collection	In progress	Strengthen the surveillance and mornitoring and evaluation system to monitor and evaluate the effectiveness of program.	1	SRE details entered	no	The continuation in COP21 is described in line 20

$45,000	Potential deployment of focused TA for HIV public health response through on-going and routine monitoring of key clinical indicators. Response based on established decision points via a standardized national algorithm, e.g. telephone follow up, data mining, cluster investigation, etc.	Surveillance	Other	Public Health Response	HIV public health response through on-going and routine monitoring of key clinical indicators	COP	COP20	COP22	Proposed in COP	Data_collection	Not started	Strengthen capacity for authorities to access, aggregate and interpret data for an evidence-based HIV public health response	1	SRE details entered	yes	
$900,000	Develop CBS framework potentially adapting the NBS US Federal model: 1. Translating minimum standards to VN 2. Development of SOPs 3. Incorporating best practices for client-centered CBS 4. Data protection methods/confidentiality standards 5. Establishment of unique IDs 6. Design national CBS data warehouse and analytic visualization platform 7. Update input legacy systems for interoperability with CBS	Surveillance	Case surveillance	HIV surveillance system	What is the achivement of 90-90-90 goal?	COP	COP19	COP26	Ongoing	Data_collection	In progress	Strengthen the national surveillance system and improved surveillance data to monitor the epidemic	1	SRE details entered	yes	
$157,800	Assessment of feasibility and accessibility of novel antiretrovirals; TWG agreement CDC work on PrEP and novel ARV at national level; AID will do self test and tele-PrEP demand nationally. Demand in Hanoi, HCMC and for other national topics TBD at interagency prior to any development.	Research	Other	Feasilility of applying new ARV drugs	How client/PLHA accept LA-CAB and how this drug can be applied for HIV treatment and prevention in Vietnam?	COP	COP21	COP21	Ongoing	Protocol_Scope	Not started	Improve the quality of HIV treatment program	1	SRE details entered	no	The project will be ended in COP21 and no further activities being continued in COP22
$107,987	Size estimation method of Young MSM population in a number of high burden provinces	Surveillance	Population size estimation	Size Estimation	What is appropriated method to estimate size estimation of young MSM populations?	COP	COP21	COP22	Ongoing	Protocol_Scope	In progress	Improve the estimation of PLHIV at province and national levels	1	SRE details entered	yes	
$200,000	Estimation of MSM population in a number of high burden northen provinces	Surveillance	Population size estimation	Size Estimation	What is size estimation of MSM aged 18 year above in selected northen provinces?	COP	COP21	COP22	Ongoing	Protocol_Scope	In progress	Improve the estimation of PLHIV at province and national levels	1	SRE details entered	yes	
$180,000	Estimation of MSM population in a number of high burden sourthen provinces	Surveillance	Population size estimation	Size Estimation	What is size estimation of MSM aged 18 year above in selected southern provinces?	COP	COP21	COP22	Ongoing	Protocol_Scope	In progress	Improve the estimation of PLHIV at province and national levels	1	SRE details entered	yes	
$130,000	1. TA for data use and data sharing for recent HIV infection response 2. Enhanced Site-level Response for Recent Infection by establishing and training for Rapid respond team with/within PTT 3. Detecting and responding to HIV Tranmission clusters 4. Develop policy and guidance framework to monitor closely the implementation of recency testing and analysis of national level data for recent HIV infection response and PHR	Surveillance	Recency	HIV recency surveillance	Where are HIV infection cluster, new/recent infection hotspots? What is the trends and target group of HIV recent infections?	COP	COP20	COP26	Ongoing	Protocol_Scope	In progress	This activity will significantly contribute to the 95-95-95 achivement in Vietnam, recency surveillance helps authorities to understand where the active transmission happened and how to response to those cluster to stop the transmission	1	SRE details entered	yes	
$50,000	Ongoing support & strengthening the implementation of case based surveillance system in HCMC	Surveillance	Case surveillance	HIV surveillance system	What is the achievement of 95-95-95 target in HCM?	COP	COP20	COP26	Ongoing	Data_collection	In progress	Strengthen the national surveillance system and improved surveillance data to monitor the epidemic	1	SRE details entered	yes	

APPENDIX D– Minimum Program Requirements

Care and Treatment	Status
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	**Completed**: Vietnam endorsed Test & Start in July 2017. In 2018, Vietnam developed SOPs for rapid/same-day ART in conjunction with MMD.PEPFAR supports the expansion of HIV confirmatory labs in a one-stop shop model to enable access to same-day start, in addition to leveraging strong collaborations with CBOs for linkage and site-level monitoring of treatment initiation data.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	**On-going**: TLD included in the Vietnam National Standard Treatment Guidelines since December 2017, with most recent Guidelines in November 2019 establishing TLD as a first-line agent for all PLHIV, including children≥10 years old and >20kg and adolescents and women of childbearing potential >30kg. Phasing out NVP is prioritized in the Guidelines, with all NVP patients indicated to be transitioned to TLD. DTG 10 mg is currently being procured by the Global Fund and will arrive in-country by late 2022.
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	**On-going**: MMD SOPs approved in 2018. Three-month MMD coverage through SHI successfully launched in 2019. Due to unstable ARV supply, as of Jan 2022, a large majority of ART clients were not receiving 3-month MMD. Recovery will begin in Q3 FY22. 6 month MMD is planned for pilot in COP22–a few remaining policy barriers need to be addressed. The stability of ARV supply which has been impacted by COVID19, including GVN procurements and procurement planning, is a critical concern. DDD has been a critical piece of COVID adaption, and PEPFAR will work in COP21 and 22 to ensure that it remains an on-going solution.
4) All eligible PLHIV, including children and adolescents, - should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	**On-going:** Both national TB and HIV Guidelines recommend TPT for all PLHIV who do not have active TB and/or contraindication to TPT medication. After COP21, PEPFAR will no longer support medications, with a majority to be picked up by SHI in 2022. Currently 88% of PLHIV have completed TPT. In COP22, PEPFAR implementing partners will continue to provide technical assistance to ensure that SHI will be the primary financing mechanism for INH and TPT, with strategic stop-gap support from the Global Fund until SHI reimbursement is normalized.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	**Completed**: PEPFAR Vietnam monitors the scale up of VL testing and coverage- VLS for PEPFAR patients is currently 98.6%--, while ensuring monitoring and improvement of the gaps related to morbidity and mortality, particularly in key populations. The laboratory team is working on innovative strategies to reduce turn-around time for VL test results to the site and the client in addition to optimizing STI testing with TB testing using the GeneXpert platform.

Case Finding	Status
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	**Completed**. Index testing included in the national MOH community-based testing Guidelines in April 2018. PEPFAR Vietnam developed robust SOPs on confidentiality, IPV detection/QI/M&E, and first-line services for IPV and certified sites to ensure high-quality, person-centered, safe ICT services.
Prevention and OVC	**Status**
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	**On-going**. PEPFAR Vietnam initiated PrEP in 2017 with scale-up to 11 PEPFAR provinces in mid-2019. The majority of clients are KP/MSM. Access to direct, same-day PrEP will be further enhanced by a one-stop shop model with integrated HIV testing and PrEP service delivery through tele-PrEP and other person-centered modalities.
8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	n/a
Policy & Public Health Systems Support	**Status**
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations,	**On-going**. In 2019, PEPFAR supported Vietnam to join the Southeast Asia Regional S&D QI Collaborative and implements stigma elimination programs at facility level. The initiative measures 8 common regional S&D indicators and some specific to the Vietnam program, with documented reduction of HIV-related stigma and improved person-centered services. In addition to collecting site-level S&D elimination measures, the Vietnam Network of PLHIV completed the Stigma Index in 2021, providing relevant and complementary data from the community level perspective. VNP+ and PEPFAR are using those findings for advocacy with the GVN and stakeholders on institutionalizing an S&D indicator in the HIV reporting system. For COP22, PEPFAR

adolescent girls and young women, and other vulnerable groups.	VN will continue to expand explicit S&D programming addressing PrEP-related stigma and designing equitable, person-centered standards of care.
10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	**On-going**. Vietnam reimburses for HIV treatment services through SHI. No user fees for SHI HIV treatment. Support for SHI ARV co-payments and social health insurance is possible through provincial resources. Prevention services, including PrEP, are not yet covered by domestic resources. PEPFAR Vietnam continues to work with GVN for sustainability planning for these services and medications.
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	**On-going.** PEPFAR Vietnam supported initial national policies and implementation of a CQI system (HIVQUAL) which ensures program standards are being met. As part of the sustainable epidemic control strategy, PEPFAR Vietnam will continue to advocate for CQI across the HIV cascade and other program areas to ensure the relevant indicators and reporting frequency are in place.
12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	**Complete**: Vietnam is a leader within PEPFAR on the U=U movement, with 1. Early National endorsement 2. An internationally recognized campaign, including print, radio/TV, and social media, for both community and providers 3. U=U seed grants for CBOs to spread messaging. PEPFAR Vietnam evolved U=U messaging to an ARVs for Prevention/Status Neutral approach targeting key populations to use ARVs- PrEP, HIV treatment- as the foundational pathway to end HIV and HIV-related stigma.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	**On-going**. The direct funding of local partners remains a priority for PEPFAR Vietnam. This also reflects the U.S. Embassy's priority on engagement with locally registered organizations and the specific barriers they face, such as complex budget approvals (for government entities) and gaining legal recognition (for community-based organizations). PEPFAR Vietnam has a good Social Contracting roadmap that should lead to increased funding of KP-led organizations, but this plan needs to be executed with more urgency
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	**On-going**. The Government of Vietnam covers HIV treatment under SHI scheme with planning for prevention services sustainability under-way. PEPFAR works with provincial governments to develop and monitor sustainable financing plans for HIV and is supporting the pilot period for social contracting, which is a critical game-changer for CBO participation in HIV service delivery activities and program sustainability. Full-scale social contracting is expected in 2025.
15) Monitoring and reporting of morbidity and mortality	**On-going:** The PEPFAR Vietnam team paid close attention to the restructuring of Vietnam's health system and roll out of SHI. While

outcomes including infectious and non-infectious morbidity.	supporting case finding and linkage activities, the team has ensured the monitoring and reporting of morbidity and mortality outcomes, including infectious and noninfectious morbidity. These sentinel events will be captured in the case surveillance system.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	**On-going**. PEPFAR Vietnam is supporting GVN to build a robust case surveillance system in line with international standards on data quality, confidentiality, and use of unique identifiers- with expansion to 15 provinces by the end of COP22. PEPFAR Vietnam will ensure all relevant data streams are interoperable and harmonized with CS. Case surveillance will be deployed for public health cluster response and data-to-care purposes.
Vietnam –Specific Technical Directives (PLL)	**Status**
Overall	
1. While many MPRs have been completed, site-level implementation should continue to be monitored with a CQI approach, particularly in cases where COVID19 and associated lockdowns may have impacted implementation.	PEPFAR Vietnam programming aligns closely with CQI principles, which are applied through multiple approaches and mechanisms: ● HIVQUAL and PrEPQual indicators are used in PEPFAR sites to identify program gaps for remediation ● Clinical mentoring to PEPFAR sites includes CQI ● S&D QI Community Advisory Boards use CQI approaches for site level improvements for stigma elimination, scale up of person-centered service delivery, and provision of COVID or other health system disruption (e.g. unstable ARV supply) relief support. ● C2P community-facility linkage model incorporates client feedback and program data as a core component for site level improvement. C2P was also deployed to provide site level relief and support during COVID response and other health system disruptions (e.g. unstable ARV supply). ● Program Quality Management (PQM) platform and other data systems track key program indicators for real-time response (ex. also PDMA).
2. To support sustainable health systems while transitioning to increasing technical, managerial and financial ownership by the Government of Vietnam (GVN), PEPFAR Vietnam should continue to capacitate Ministry of Health, the private sector, and indigenous community-based organizations, with a focus on increasing the quality of public sector HIV service delivery across the full cascade and expanding key population-integrated primary healthcare models.	A key cornerstone of PEPFAR Vietnam COP22 strategy is sustaining HIV impact through indigenous technical leadership within the GVN, public and private sectors and community-based organizations. Initiatives that support GVN capacity include clinical technical assistance focused on biomedical innovation at the central level; national coordination of public health cluster response with complementary provincial and community responses; and scaling up HIV provincial technical teams in high-burden, high-needs provinces to provide expert assistance to sites providing clinical HIV services. In COP22, social contracting and private sector engagement expansion will create opportunities for indigenous community organizations and KP-led service providers to collaborate and work with public sector health providers to ensure ethical, person-centered services.
3. PEPFAR Vietnam should continue to support the Government of Vietnam's resilient and capacitated country public health system, specifically: to support MoH and indigenous community organizations, including those	As Vietnam progresses towards HIV epidemic control, VAAC/MOH will lead a public health cluster approach to identify, characterize, and interrupt time-space clusters of HIV throughout the country. VAAC will ensure that provincial responses are adequately resourced technically, and financially through deployment of technical expertise and coordination of existing local resources for HIV. In COP22, leading indigenous community organizations will also be formally activated to respond to PHCR alerts and provincial

which are KP-led, to effectively respond in geographic areas where case surveillance observes active HIV transmission, e.g., through signals such as time-space clusters of recent cases. This support should be funded through mechanisms that allow for nimble responses not limited to the 11 current DSD supported PEPFAR provinces.	responses through close coordination and engagement with the VAAC and the HIV system at national and provincial levels. PEPFAR Vietnam will ensure technical integrity and sufficient deployment of resources for time-bound responses in non-PEPFAR provinces sending PHCR alerts.
4. To continue progress made, the team should focus on increasing Government of Vietnam funding for HIV prevention service delivery, including HTS and PrEP, which could occur through the expansion of the benefits package in SHI and/or increasing domestic government resources by creating a budget line item for HIV prevention services and social contracting of local CBOs that provide these services.	Sustainable financing for HIV prevention is the priority of PEPFAR Vietnam. In 2021, PEPFAR Vietnam successfully advocated for the pilot implementation of the Social Contracting in 7 provinces as the foundation and pathway to sustain case finding provided by CBOs. PEPFAR VN was also successful in gaining the approval of the GVN to revise policies to allow local CBOs to provide and generate income from HIV testing services. In COP22, PEPFAR VN will accelerate this work by scaling social contracting for case finding in 2-3 additional PEPFAR supported provinces. In addition, we will work for domestic resources to support community-based and self-testing; innovative PrEP service delivery models in the private sector; and leverage provincial budgets for a co-pay PrEP model that ensures access regardless of income level. Also, we will continue to advocate to GVN to extend the preventive medicine package to include key HIV prevention interventions e.g., PrEP and HIV testing in the upcoming revision and update of the new Social Health Insurance Law.
5. Key populations, especially MSM, continue to face barriers such as stigma and discrimination when attempting to access HIV prevention and treatment services, particularly in the public sector. To be aligned with COP22 guidance to build the strength of KP-led service delivery and to improve the long-term friendliness of all facility and community staff throughout Vietnam. Specific activities relevant to Vietnam are: revising/scaling gender and sexual diversity (GSD) training required for all PEPFAR staff and PEPFAR IPs; scale trainings and other interventions that support KP competent client-centered services in all facility and community healthcare settings serving KPs; fund organizational capacity strengthening for KP-led CSOs – financial reporting,	PEPFAR Vietnam is committed to scaling up effective models for friendly service provision in public and KP-led settings. In COP22, PEPFAR Vietnam will scale up the Community Advisory Boards (CAB) and C2P models, One-Stop Shops, and other diversified service delivery initiatives to ensure KP-competent care and standards and promote KP leadership. Flagship KP community partners will develop person-centered codes of conduct and checklists to confirm friendliness of HIV health providers. A HCW policy for additional incentives for HIV service provision will be revised to be tied to KP-competent skills and affirmations of stigma-free and friendly care. A KP health literacy network will be established to foster community-to-community technical support, collaboration, and organizational capacity strengthening.

management, governance, including strategic information, reporting and usage; and invest in KP leaders as public health professionals.	
6. VLC for KPs in FY21 was 42% (though significantly impacted by COVID), with high VLS at 99%. The Vietnam team should continue to focus efforts on ensuring KPs are accessing VL testing, and that IPs are reporting KP disaggregates with MER PVLS results.	As of March 2022, 67% of ART clients at PEPFAR sites have accessed viral load testing, with 98.6% viral suppression, indicating recovery of viral load testing access. Current challenges to viral load testing, monitoring, and reaching viral load suppression are related to access to testing and to ARV medications. COVID waves have disrupted the availability of routine viral load testing due to lockdowns and restrictions. Testing pauses occurred during the last 18 months and may continue to be disruptive in COP22. COVID lockdowns and unstable ARV supply also affected client ability to routinely access ARV drugs, including current regimens and for multi-month dispensing, as well as prompted migration of ART clients to their home provinces. Mitigation strategies are in place to understand and address those who are unable to access VL testing, with initial data analysis showing that the majority are males aged 25-49 years. Outside of PEPFAR, more work needs to be done by GVN and stakeholders, including PEPFAR, to ensure universal viral load access and to address gaps in testing and VL suppression in Global Fund and non-donor provinces (the other 50% of the HIV epidemic).
HIV Prevention Services	
1. PrEP for KP and AGYW: In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to Vietnam's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), and other identified higher-incidence populations.	KPs -- especially adolescent and young MSM -- are the targeted groups of the PEPFAR Vietnam PrEP program. Based on our MER data, MSM accounts for more than 80% of our PrEP clients. Our PrEP program mainly serves the MSM between 20-29 years and we see gaps in younger MSM under 20 and TGW. In COP22, we will address these gaps by tailoring attractive PrEP campaigns with evocative messages targeting hidden adolescent and young MSM/TGW in schools, universities and industrial zones to normalize PrEP use. We also will scale the effective One-Stop Shop (OSS) model from 26 in COP21 to 36 in COP22 to provide a comprehensive service package to increase PrEP uptake and meet the needs of these populations. PEPFAR will continue dismantling PrEP stigma through community-led collaborations and will build on in-country formative work done in COP21 to advocate for long - acting agents known to be of interest to MSM in Vietnam.
2. PEPFAR/Vietnam should continue to be a leader in PrEP programmatic innovations, and explore additional differentiated service delivery models for PrEP in COP22 that strengthen community partner capacity to deliver PrEP, ensuring quality control standards and compliance in line with updated national guidelines (e.g., online and mobile PrEP), while also advancing the WHO KP guidelines and PEPFAR's	PEPFAR Vietnam will continue to be a leader in PrEP programmatic innovations. In COP22, besides scaling OSS, mobile-, tele- and pharmacy-based PrEP, we will help the VAAC to scale tele-PrEP for PrEP initiation. This was just approved by the GVN for pilot implementation in March 2022, as this model is currently approved for continuation visits. Furthermore, we will build off our initial successes with mailing ARVs during COVID disruptions and work with GVN to codify decentralized drug distribution outside the facility by providing TA on national guidelines. We will continue to advocate for enabling long-acting injectable PrEP (CAB-LA) to be piloted and registered into VN's markets. PEPFAR supported national PREPQUALr guidelines approval in COP21, and in COP22 we will continue working to ensure sites are implementing best practices. All these innovative

principles for building local KP community and CBO ownership, implementation, and sustainability in the response. We applaud the innovations in Vietnam to date, particularly during the COVID-19 pandemic, including through the use of telehealth and virtual platforms for service delivery, and increased service delivery in the community to make PrEP accessible to clients. PEPFAR/Vietnam should make sure they are working on the policies to enable new PrEP delivery models (e.g., injectables) available.	PrEP delivery models will help us to achieve provision of quality PrEP services for 18,000 new clients and ensure almost 16,000 clients remain on PrEP by Q4 FY2023.
Other Government Policy, Systems, or Programming Changes Needed	
1. Structural barriers for KP: COP22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g., DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected	Through consultations with community stakeholders, we identified 4 primary barriers that KP face: S&D, intersectional needs, COVID impact (health, economic, employment, movement), and limited KP engagement. To address these structural barriers, PEPFAR VN is scaling up a range of KP-focused interventions. For stigma, we will continue to implement facility QI, work with KP networks to identify a range of effective community-level interventions, and continue targeted public health campaigns promoting biomedical (PrEP, U=U, Status Neutral) messages to address HIV-related stigma. To address intersectional needs, PEPFAR VN will scale up One–Stop Shops to offer a range of services including mental wellness and other sexual health needs. We are also working to scale up person-centered care and holistic services in both private and public sectors, including supporting policies to accredit HCWs with KP-competent skills and an enabling environment that promotes equitable service delivery. To mitigate COVID-19 negative impacts on the economic and social well-being of key populations affected by HIV, we will continue to promote and institutionalize flexible health services that meet KP needs where they are, including tele-health & tele-medicine, with decentralized drug dispensing, catalyze social contracting for sustainable financing for community organizations that provide services to key populations, and expand diversified care models. Finally, for limited KP engagement, we will scale up innovations that promote KP-leadership in public and private health sectors, including CABs, Community Scorecards, C2P, social contracting and private sector expansion. We will empower KP communities and service providers through a health literacy & KP learning network, and finally, ensure that CLM plays a central role in empowering KPs to monitor KP-friendly health service provision.

to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP22 planning meetings	
2. Continue to invest in differentiated, client-centered ways to reach the highest risk MSM through STI screening and treatment, social network testing through digital platforms, including client segmentation to target more hidden MSM, such as older MSM in the NEZ, using SNS and HIVST to supplement Index testing of MSM partners; and PrEP demand creation, including new agents such as long-acting injectables which has been documented to be of interest to younger MSM. Be sure to offer Safe and Ethical Index testing to all newly diagnosed PLHIV as well as those with unsuppressed viral loads.	Adolescent and young MSM/TGW under 25 years is our priority in COP22. We will continue to explore and use multiple popular social media channels, employ innovative case finding approaches, and create demand for key related services such as syphilis/HIV testing with duo test, ED & daily PrEP or nPEP, CAB-LA when it is available, mental health support, substance use/chemsex counseling, hormone counseling, and other health related services. We will scale self-testing for PrEP monitoring. We will make sure that 100% of our supported HIV testing sites remain compliant with and offer Safe and Ethical Index Testing to all newly diagnosed PLHIV as well as those with unsuppressed viral loads. These requirements will be enhanced with updated trainings in addressing IPV and providing trauma-informed care, and services will be reviewed bi-annually via a CQI approach.
3. Continue to work with the GVN to create an enabling environment for indigenous community-based organizations to become social enterprise organizations, to participate as appropriate in SHI reimbursement, and to enable the overall social contracting roadmap.	Community-based organizations are the backbone of the National HIV response. PEPFAR Vietnam has built the capacity of CBOs for more than a decade. The important role of community organizations have been recognized by the GVN in the revised AIDS Law, National Strategy to End AIDS by 2030, and especially in the new Social Contracting road-map, which PEPFAR is providing technical and financial support to GVN to pilot and test using GVN mechanisms and cost norms to fund CBOs to deliver HIV services. In COP22, PEPFAR VN will accelerate these successes by scaling social contracting in 2-3 additional PEPFAR supported provinces and to develop and institutionalize capacity building strategies, tools and training materials to support CBOs to become social enterprises (SEs) and be ready and eligible to bid for GVN funds. In addition, PEPFAR VN will continue to strengthen the capacity of mature SEs to become independent businesses that can operate KP-led clinics and tap in different funding resources from other social impact investors. In collaboration with the VAAC, PEPFAR VN will also expand and institutionalize community support packages that can be delivered in the community and by the community.

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

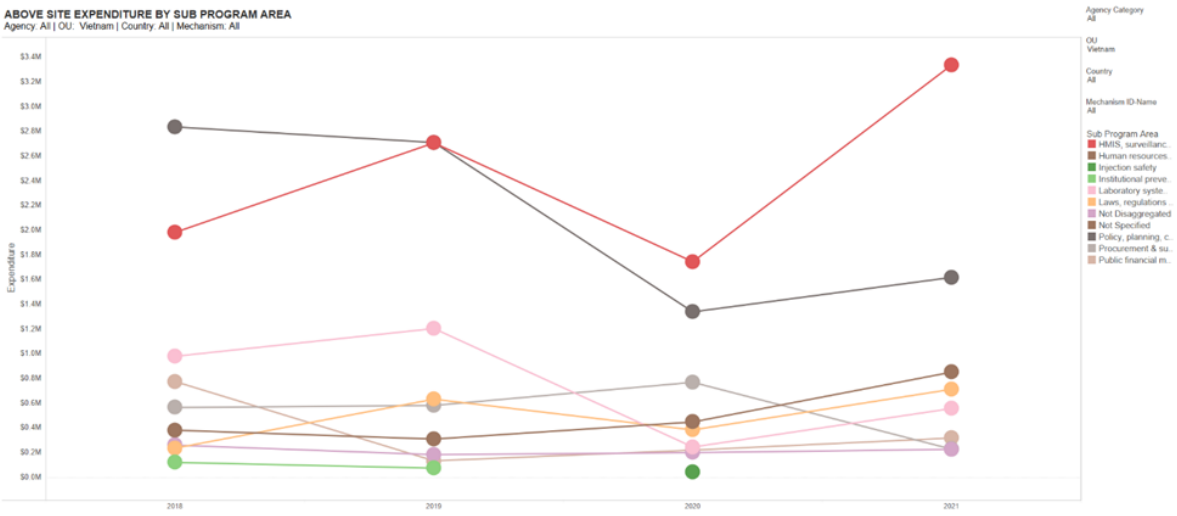
Alignment of Sustainability Goals and PEPFAR Investments

E.1.1: SID Element Scores Over Time

SID

Domain	Sum of SIDweighted_answer SID Element	FY2017	FY2019	FY2021	Score Over Time
Governance, Leadership & Accountability	1. Planning and Coordination Score:	9.00	8.29	8.07	
	2. Policies and Governance Score:	5.75	6.38	6.33	
	3. Civil Society Engagement Score:	4.04	4.25	5.08	
	4. Private Sector Engagement Score:	6.14	6.99	7.99	
	5. Public Access to Information Score:	5.00	6.11	6.11	
National Health System & Service Delivery	6. Service Delivery Score:	5.79	7.20	6.85	
	7. Health Workforce Score:	7.22	7.54	7.76	
	8. Commodity Security and Supply Chain Score:	5.90	6.86	7.49	
	9. Quality Management Score:	6.43	8.76	7.76	
	10. Laboratory Score:	7.92	7.79	7.61	
Strategic Financing & Market Openness	11. Domestic Resource Mobilization Score:	7.65	8.21	7.70	
	12. Technical and Allocative Efficiencies Score:	9.10	8.66	9.30	
	13. Market Openness Score:		9.33	9.41	
Strategic Information	14. Epidemiological and Health data Score:	5.18	8.06	5.74	
	15. Financial/Expenditure data Score:	8.33	9.17	8.33	
	16. Performance Data Score:	7.63	8.73	8.73	
	17. Data for Decision-Making Ecosystem Score:		3.67	5.83	
	SID element scoring criteria	< 3.50	3.50-6.99	7.00-8.49	8.50-10.00

E.1.1 Above-Site Expenditures by Sub-Program Area Over Time



E.1.1 Above-Site Investments (Table 6) by SID Score

SID Scores Reported in Table 6					Above Site Activities and Budget Reported in Table 6		
		SID Score				COP20	
Domain	Element	2017	2019	2021	SID Budget Element	Activities	Budget
Governance, Leadership & Accountability	1. Planning and Coordination Score:	9.00	8.29	8.07	Planning and Coordination	1	$178,500
	2. Policies and Governance Score:	5.75	6.38	6.33	Policies and Governance	1	$300,000
	3. Civil Society Engagement Score:	4.04	4.25	5.08	Civil Society Engagement	3	$390,000
	4. Private Sector Engagement Score:	6.14	6.99	7.99	Public Access to Information	2	$300,000
	5. Public Access to Information Score:	5.00	6.11	6.11	Service Delivery	8	$966,100
National Health System & Service Delivery	6. Service Delivery Score:	5.79	7.20	6.85	Human Resources for Health	7	$1,043,555
	7. Health Workforce Score:	7.22	7.54	7.76	Commodity Security and Supply Chain	3	$230,000
	8. Commodity Security and Supply Chain Score:	5.90	6.86	7.49	Quality Management	1	$105,000
	9. Quality Management Score:	6.43	8.76	7.76	Laboratory	7	$959,890
	10. Laboratory Score:	7.92	7.79	7.61	Domestic Resource Mobilization	2	$46,619
Strategic Financing & Market Openness	11. Domestic Resource Mobilization Score:	7.65	8.21	7.70	Technical and Allocative Efficiencies	1	$320,000
	12. Technical and Allocative Efficiencies Score:	9.10	8.66	9.30	Market Openness	2	$360,000
	13. Market Openness Score:		9.33	9.41	Epidemiological and Health Data	15	$4,247,368
Strategic Information	14. Epidemiological and Health data Score:	5.18	8.06	5.74	Performance Data	5	$583,603
	15. Financial/Expenditure data Score:	8.33	9.17	8.33			
	16. Performance Data Score:	7.63	8.73	8.73			
	17. Data for Decision-Making Ecosystem Score:		3.67	5.83			

Figure E.1.2. Percent Primary Responsibility Ratings from Responsibility Matrix

E.1.2 Responsibility for Above-Site by Stakeholder (v.1)

HIV/AIDS Responsibility Matrix

Country:
Epidemic Type:
Income Level (source WBG):

Legend
- Primary responsibility for/contribution to element
- Secondary responsibility for element (i.e., doesn't lead, but offers substantial level of support)
- Nominal–Contributes to this effort, but offers a nominal/marginal level of support
- None–No responsibility/level of support
- Not applicable to this OU

	FUNCTIONAL DIMENSIONS											
	SERVICE DELIVERY[1]				NON-SERVICE DELIVERY ASSISTANCE[2]				STRATEGY FORMULATION AND PLANNING[3]			
FUNCTIONAL ELEMENTS	Host Govt.	Private Sector	PEPFAR & Implementers	Global Fund & Implementers	Host Govt.	Private Sector	PEPFAR & Implementers	Global Fund & Implementers	Host Govt.	Private Sector	PEPFAR	Global Fund
Site-Level Programs (excl. Commodities and Health Workforce)												
Care and Treatment *(excl. ARV drugs)*												
Clinical												
Laboratory (e.g., Lab monitoring; OI, EID, TB, CD4, VL testing)												
Community (e.g., Linkage, Retention, Adherence)												
TB-HIV												
HIV Testing Services												
Facility-based Testing												
Community-based Testing												

E.1.2 Responsibility for Above-Site by Stakeholder (v.2)

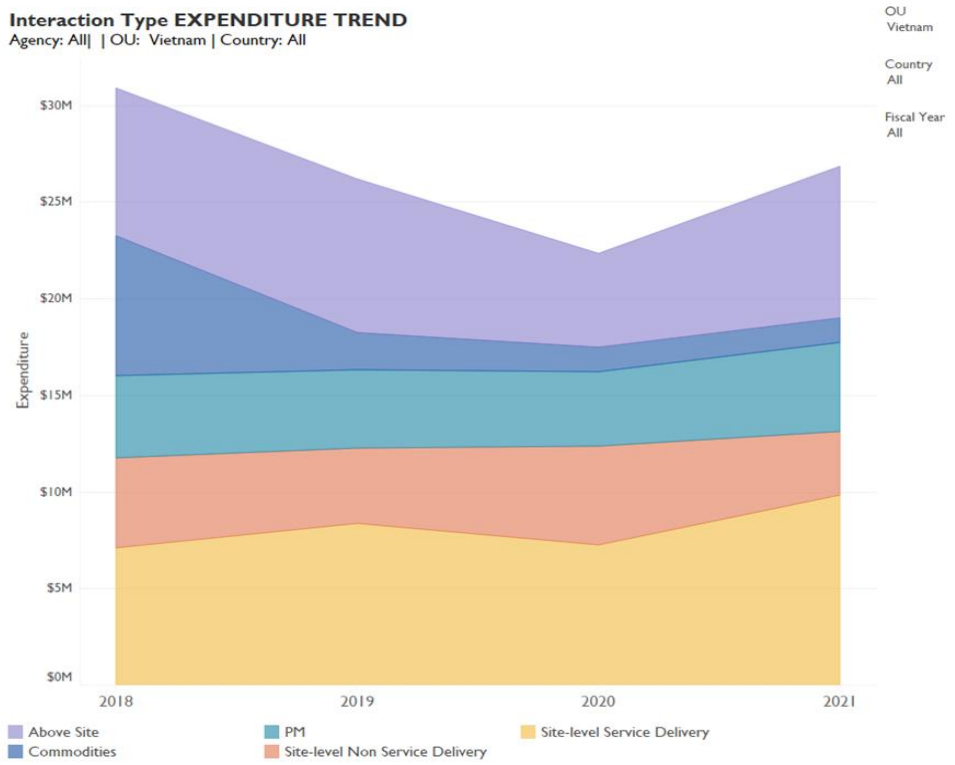
Tabulation of Responsibility Matrix Responses 2021*

	Host Govt.			PEPFAR		
Functional Element	**Primary**	**Secondary**	**Nominal or None**	**Primary**	**Secondary**	**Nominal or None**
Total across elements	172	2	13	28	76	83
Above Site (Systems) Programs	52	0	0	2	32	18
Commodities	37	0	5	4	16	22
Health Workforce	24	0	0	0	8	16
Program Management	0	0	0	0	0	0
Site-Level Programs (excl. Commodities and Health Workforce	59	2	8	22	20	27

*Host country did not provide a Responsibility Matrix for 2021

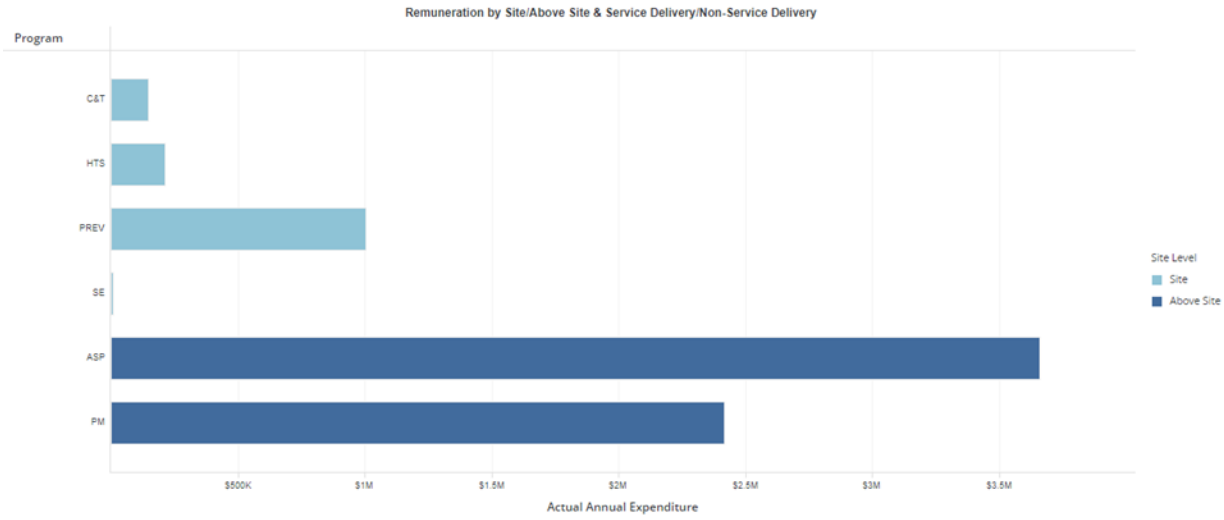
Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:

E.1.3 Total Expenditures by Interaction Type Over Time



HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:

Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



2. Areas for Transition

Three areas that could be considered “low hanging” fruit for GVN to take on include:

a) Financial responsibility including co-pays for ART and VL and support for prevention (e.g., PrEP and HIV test kits). In COP21, PEPFAR maintained minimal support for ARV co-pays whereas in COP22, treatment cost norms no longer contain this component, transferring support completely to provincial governments. Risks may include delay in provincial government support and/or client drop out. PEPFAR is prepared to mitigate these risks by providing site and provincial level TA on supporting ARV co-pays. In addition, PEPFAR will continue monitoring pertinent MER indicators (e.g., TX ML, IIT) closely, with timely responses should a signal indicating loss to follow up at the site level be raised. PEPFAR supports a total market approach to prevention commodities including PrEP; the transition roadmap indicates a stepwise transition down to 20% donor support by 2026, with the gap being partially filled by SHI.

b) PHCR. As discussed above in detail, PHCR is a locally-owned approach. In COP22, PEPFAR will institutionalize recency-driven PHCR as CS is being expanded, operationalizing monitoring and evaluation and updating national SOPs based on initial experiences in COP21. Updated SOPs will contain detailed implementation guidance; coupled with on-going PEPFAR technical assistance and PHCR field experiences in COP21 and 22, GVN will take an increasing leadership role in all phases of the response – from real-time data collection and monitoring to programmatic response, stakeholder and community coordination, and, finally, evaluation and close-out – with a lighter touch from PEPFAR moving forward.

c) TB/HIV. PEPFAR ceased procuring TB commodities in COP21. For the first time, GVN has committed to covering INH for TPT starting in July 2022. Using data from a PEPFAR supported in-country demonstration of 3HP – a shorter, person-centered TPT regimen – PEPFAR will advocate for inclusion of this regimen in SHI. Anticipating that SHI approvals may take time to process (e.g., possibly FY26), PEPFAR will mitigate the risk of treatment interruption by working closely with GF to procure sufficient 3HP to close the gap until SHI financing is available.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

Key areas on which PEPFAR is planning to engage with the GVN in COP22 to help achieve sustainable epidemic control include:

a) ARV supply chain. PEPFAR is committed to supporting the GVN to mitigate treatment interruption or regimen switches due to stock outs. Fundamental to the technical assistance is coordination with multiple stakeholders (VAAC, DAV, NDCPC, DPF and VSS) and revision of key policies. An early warning system for potential ARV stock-outs will be adopted, in which PEPFAR, VAAC, drug supply partners, and other stakeholders will proactively meet monthly or more to communicate on ARV supply status, drug dispensing/SHI reimbursements, and drug management/consumption.

b) Financing and growing local community organizations. PEPFAR remains committed to increasing the role of local organizations in the HIV response. To improve financing for CBOs, PEPFAR is supporting the VAAC and provincial governments to scale up social contracting in COP22, with full implementation using a policy framework anticipated in 2025. Key steps in COP21 and 22 towards this goal include finalizing pilot models and

policies along with ongoing capacity building of both provincial governments and CBOs. By 2024, the GVN will be increasingly financing social contracts, with PEPFAR TA. Alongside social contracting, PEPFAR will prioritize CBO development into social enterprises. Key technical assistance components include strengthening technical and business skills – including partnership building – and diversifying the portfolio to maximize income potential.

c) Sustainable financing for PrEP services. PEPFAR remains committed to supporting a multi-pronged approach to PrEP sustainability which includes advocacy for inclusion of PrEP into SHI and supporting the GVN to develop and pilot the public co-pay model to leverage the provincial budget to cover for PrEP services. In addition, PEPFAR Vietnam will scale innovative and differentiated PrEP service delivery models in KP-led and private clinics targeting clients who are willing to pay for PrEP services.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting). PEPFAR does not assign central support to SNUs. The GVN owns data in health information systems, the expanding CS system, and HIV sentinel surveillance, including patient-level MER data. Data use and sharing will be per GVN regulations; PEPFAR does not have routine access to any protected health information. Existing agreements (e.g., CS protocol, IP agreements) allow for sharing of de-identified aggregate data with PEPFAR for monitoring purposes. Most key sentinel data are available in different sustainable information systems that are hosted and operated by GVN such as the National Social Health Insurance system, national census data system, etc. The country team is working with relevant GVN stakeholders to achieve the HIV data sharing agreement. For other studies outlined in SRE, data sharing agreements are outlined in respective protocols, though PEPFAR makes every effort for local ownership of data in funded scientific endeavors.