Vietnam
Country Operational Plan
COP 2022
Strategic Direction Summary
2 May 2022



Contents

1.0 Vision and Goal Statement	2
2.0 Epidemic, Response, and Program Context	3
2.1 Summary statistics, disease burden and country profile	3
2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Co	ntinuity
	14
2.3 Investment Profile	15
2.4 National Sustainability Profile Update	20
2.5 Alignment of PEPFAR investments geographically to disease burden	20
2.6 Stakeholder Engagement	21
2.7 Stigma and Discrimination	23
3.0 Geographic and Population Prioritization	23
4.0 Client-Centered Program Activities for Epidemic Control	25
4.1 Finding people with undiagnosed HIV and getting them started on treatment	25
4.2 Ensuring viral suppression and ART continuity	27
4.3 Prevention, specifically detailing programs for priority programming:	29
4.4 Additional country-specific priorities listed in the planning level letter	34
4.5 Additional Program Priorities	35
4.6 Commodities	36
4.7 Collaboration, Integration and Monitoring	40
4.8 Targets by population	40
4.9 Cervical Cancer Program Plans - Not applicable to Vietnam	43
4.10 Viral Load and Early Infant Diagnosis Optimization - Not applicable to Vietnam	43
5.0 Program Support Necessary to Achieve Sustained Epidemic Control	44
6.0 USG Operations and Staffing Plan to Achieve Stated Goals	47
APPENDIX A PRIORITIZATION	48
APPENDIX B – Budget Profile and Resource Projections	52
APPENDIX C – Tables and Systems Investments for Section 6.0	54
APPENDIX D– Minimum Program Requirements	55
APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epide	emic 65

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

				Ta	able 2.1	.1 Host (Country	Govern	ment Re	sults					
	Tota	ıl		<15	5			:	15-24			2	25+		Source, Year
			Fem	ale	N	1ale	Fen	nale	N	1ale	Fer	nale	Ma	ale	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	98,183,2 19		11,383, 810	11.6	12,4 59,2 40	12.6	654 883 6	6.7	6,931 ,002	7.1%	31,3 05,7 47	31.9	29,55 4,584	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	1,588,40 4														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	371 2	3.65	5476	5.38	2426 9	23.85	66615	65.47	NTP case report, 2019
% of TB cases that are HIV infected	2.841	2.81		23 (0.8	3%)			248	3 (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

	Та	ble 2.1.2 9	5-95-95 ca	scade: HIV	diagnosis	, treatment	and viral	suppressio	on²		
Epidemiologic Data						eatment an Suppressio			HIV Testing and Linkage to ART Within the Last Year		
	Total Populat ion Size Estimat e (#)	HIV Prevale nce (%)	Estimat ed Total PLHIV (#)	PLHIV diagno sed (#)	On ART (#)	ART Covera ge (%)	Viral Suppre ssion (%)	Tested for HIV (#)	Diagno sed HIV Positiv e (#)	Initiate d on ART (#)	
Total populati on	98,183, 219 ⁷	0.24	242,100	207,252 , ³	172.500	71.3	96 ⁵	2,898,6 61 ⁶	26,366 ⁶	16,306 ⁶	
Populati on <15 years	23,843, 050 ⁷	0.03	4,3008	4,000	3,9104	91	935	NA	NA	110 ⁵	
Populati on 15+ years	74,340, 169 ⁷	0.27	237,800	203,242	168,590	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	3.69	N/A	NA	NA	NA	NA	27,043 ⁶	135 ⁶	NA	
PWID	189,581	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

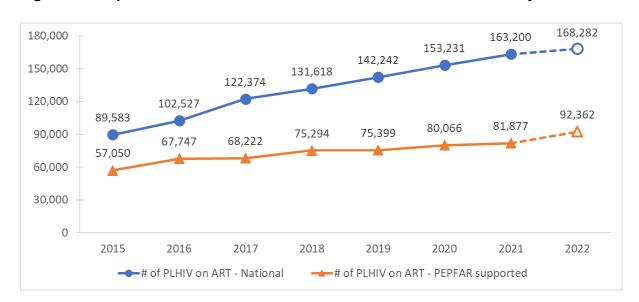


Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment

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

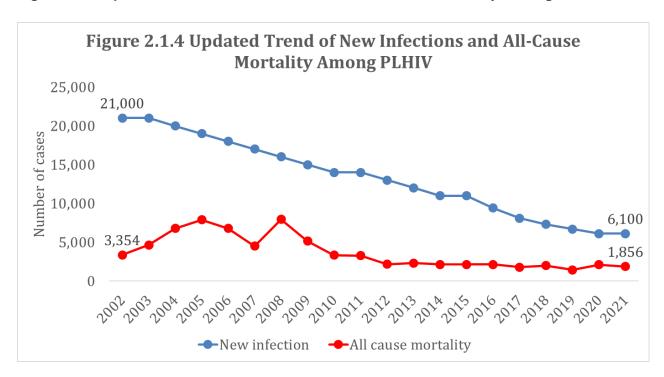


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

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

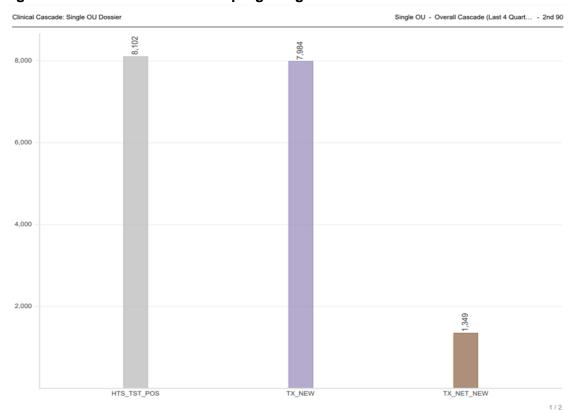


Figure 2.1.5 Assessment of ART program growth in FY21

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

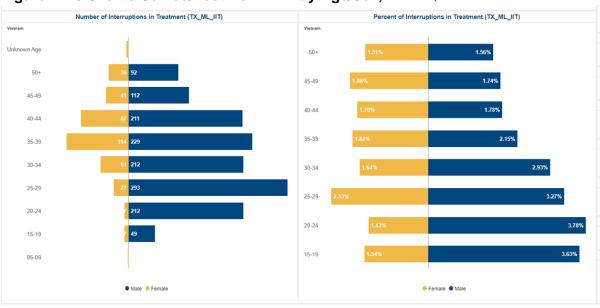
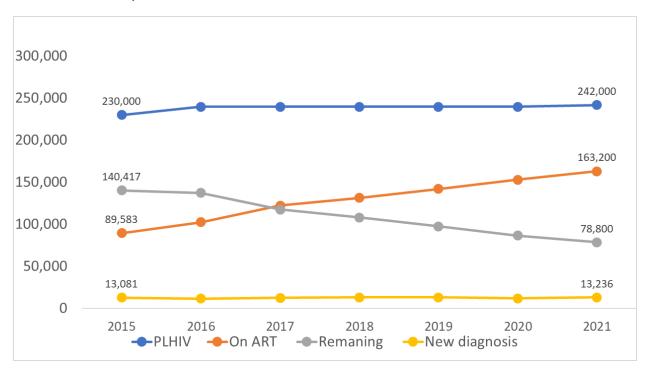


Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4

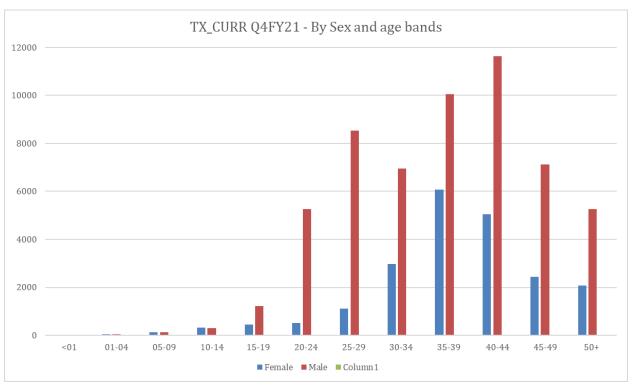
Source: Q4FY21 PEPFAR panorama clinical cascade: Treatment Single OU Dossier — download on April 04 2022

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 incountry – 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 casefinding, testing, and PrEP, only accounts for 20% of total public expenditure, and services are still primarily financed by donors.

Standard Table 2.3.1

I	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
Ì	\$	%	%	%	%	2018-2022
are and Treatment	\$52,409,693	76%	14%	10%	0%	
HIV Care and Clinical Services	\$10,578,947	0%	52%	48%	0%	1
Laboratory Services incl. Treatment Monitoring	\$1,925,062	0%	89%	11%	0%	
Care and Treatment (Not Disaggregated)	\$39,905,684	99%	0%	0%	0%	
IV 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%	
revention	\$17,112,405	20%	48%	32%	0%	
evenuon		22.2				
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%	_
ocio-economic (incl. OVC)	\$70,235	0%	100%	0%	0%	_
Case Management	\$0					1
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					
bove 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	\$05,247	0.8		100%	0.8	
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%	
rogram Management	\$26,240,477	71%	6%	23%	0%	
Implementation Level	\$26,240,477	71%	6%	23%	0%	
otal (incl. Commodities)	\$116,509,123	54%	18%	28%	0%	
ommodities 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.

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	\$	%	%	%	%	2018-2020
are 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%	
revention	\$21,434,019	39%	25%	21%	16%	
Community mobilization, behavior and norms change	\$4,567,769	0%	40%	60%	0%	
Voluntary Medical Male Circumcision	so					
Pre-Exposure Prophylaxis	\$2.611.456	0%	51%	49%	0%	
	\$329,366	0%	100%	0%	0%	
Condom and Lubricant Programming	\$2.912.578	35%	25%	0%	41%	
Opioid Substitution Therapy						
Primary Prevention of HIV & Sexual Violence	\$5,693	0%	100%	0%	0%	
Prevention (Not Disaggregated)	\$11,007,157	66%	10%	3%	21%	+
ocio-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					
bove 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%	-
Disease Ctri Programs Laws, Regulations and Policy Environment	\$670,120	0%	43%	57%	0%	
Above Site Programs (Not Disaggregated)	\$3,102,071	94%	0%	6%	0%	
rogram 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%	

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

		Domestic			Other	
	Total	Government	Global Fund	PEPFAR	Funders	Trend
	Current year	%	%	%	%	2018-2023
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					

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	\$	%	%	%	%	2018-2022
Antiretroviral Drugs	\$24,581,384	79%	16%	4%	0%	
aboratory 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. Invest	ment Profile (Expend	itures) for HIV Com	modities, 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 Ann	nual USG Non-Pl	EPFAR Funded Ir	nvestments 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

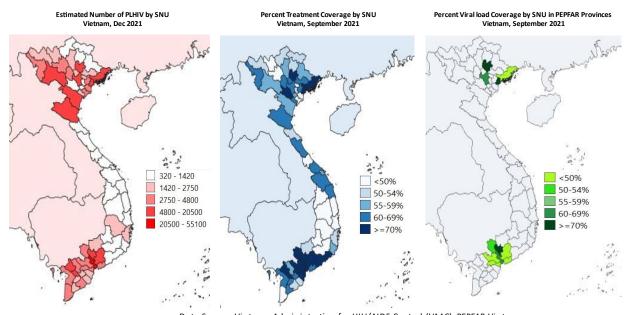


Figure 2.5.1 People living with HIV, Treatment coverage and VL coverage in Vietnam

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 law¹ 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.

¹https://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 S	Status of ART satura	ation		
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

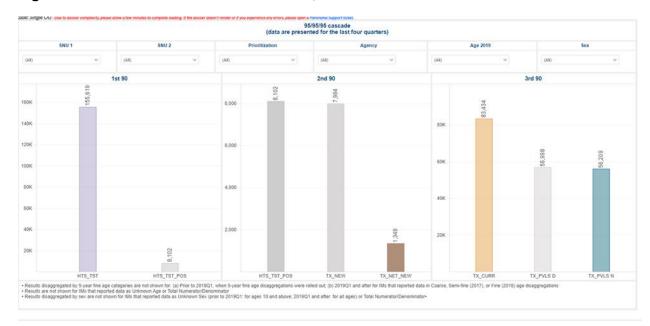


Figure 4.0.1 Overview of 95/95/95 Cascade, FY21

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.

■ HTS_TST_POS • Yield 3500 25 23.8 3000 Pos 17.8 16.9 TST 2000 E yield ō 1500 10 ₹ 1000 6.7 500 Community Other PITC Community Community Other PITC VCT Facility ICT Community ICT ICT Male Female HIV testing modality

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

19 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

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

Less Us. More Them

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

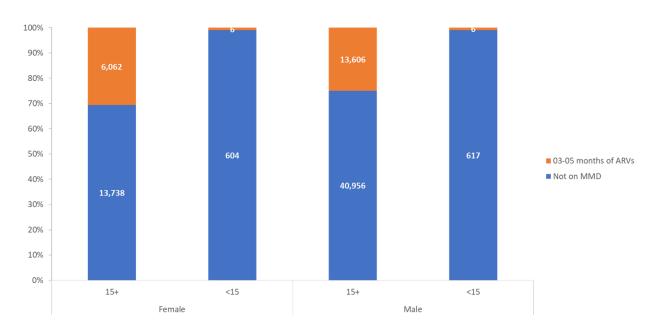


Figure 4.2.2 Viral Load Outcomes, FY21. PEPFAR MER indicators in 11 supported provinces



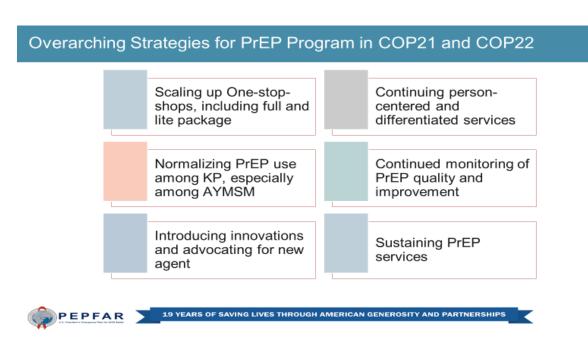
4.3 Prevention, specifically detailing programs for priority programming:

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, personcentered, 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.

Lesson Learned from OSS Implementation Plan for COP22

Lesson learned

- Stigma free for MSM/TG, especially young MSM
- Key demand creation message: OSS services available
- Pairing with CBOs or mobilize students to reach AYMSM
- Normalized PrEP: Events with KOLs, fun videos on social media, online access
- Regular monitoring of client satisfaction for continued quality improvement

Plan for COP22:

- Expand full/lite OSS services to current and new PrEP sites
- Add services to OSS: Tele -PrEP, mobile PrEP, facility-based, LA PrEP (i.e., CAB)





19 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

COP22: Actions to Sustain PrEP Service in Vietnam



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.

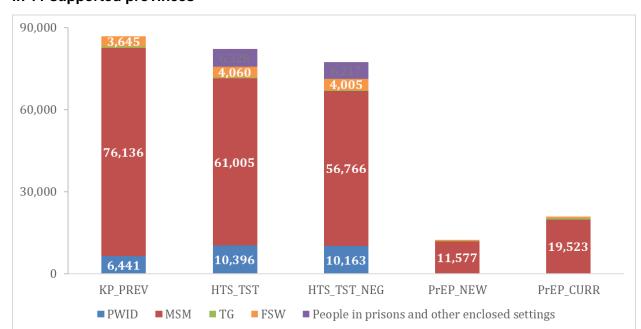


Figure 4.3.1 Prevention Continuum by Key Population Group -. PEPFAR MER indicators in 11 supported provinces

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 onestop 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.

Community Led Monitoring – Key Findings and Recommendations



Facilities

- OPCs should have a private and safe space for counseling.
- Staff should follow confidentiality principles strictly.
- Long waiting time vs. limited servicetime in some cases (could be sensitive).
- Preferred extended service hours for ART and PrEP.
- Transparency and visibility of all possible costs.
- Preferred an automatic reply or reminders system- via phone.
- Preferred an on-site feedback mechanism new or enhanced.



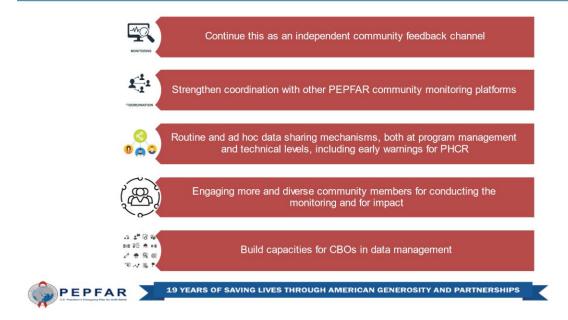
CBOs

- Overall, good client care services (PrEP and ART).
- Limited or shared space- waiting area, service room,
 CBO office in some cases in Hanoi.
- Need better SOPs for service delivery, particularly testing services.
- Clients mostly appreciated staff attitudes.



19 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

Community Led Monitoring – Strategy for COP22



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 bloodbased 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

Proposed PEPFAR Solutions - ongoing + COP22



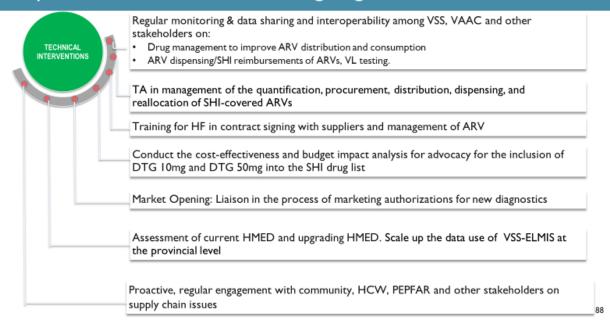
Complicated Policies: Development & roll out the implementation of the ARV Drug Security Plan

Address Poor Coordination - TA for coordination (such as organization of SHI drug council meetings + prep for meeting documents) + advocacy/coordination with multiple stakeholders (VAAC, DAV, NDCPC, DPF and VSS)

Policies Revision: I. Development of guidance for ARV dispensing and reallocation; 2. Revise circular to extend timing of Framework Agreement from 12 months to 36 months; 3. Allow VAAC to be the focal agency in consolidating demand and management of ARVs procured through price negotiation; 4. upgrade current procurement system to e-procurement; 5. Besides open bidding and prices negotiation - advocate with GVN for international pooled procurements for peds ARVS/2nd & 3rd line drugs.

87

Proposed PEPFAR Solutions - ongoing + COP22



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 A	RT 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.
- 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 ongoing 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 Prioritiza tion	Overal ITX Cover age (by APR 19)	COP19 Prioritiza tion	Overal ITX Cover age (by APR 20)	Cop20 Prioritiza tion	Overal ITX Cover age (by APR 21)	Cop21 Prioritiza tion	Overal ITX Cover age (by APR 22)	Cop22 Prioritiza tion	Overal ITX Cover age (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 Duon g	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 Phon g	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 %
Quan g 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 Nguy en	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 Supporte d	67%	Not Supporte d	72.70 %	Not Supporte d		Not Supporte d			
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²COP₂₀ surge provinces are highlighted in blue

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Yen Bai	Not Supporte d	44%	Not Supporte d	40.90 %	Not Supporte d	Not Supporte d		
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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

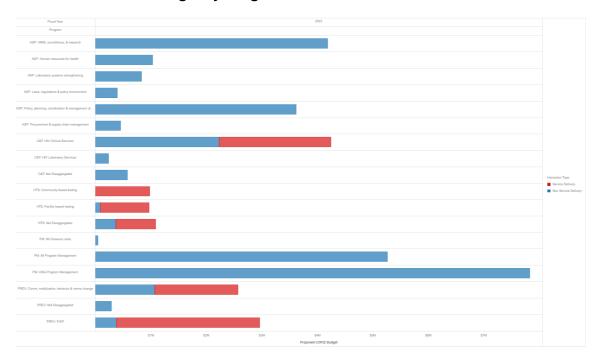


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Prop	osed COP22 Budget		Percent of Pro	posed 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	\$385,379	\$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	\$1,083,285	\$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	\$1,028,775		\$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 Plann	ing 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 Re	source Allocation	by Program and	Beneficiary						
Operating Unit	Metrics			Proposed 0	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	\$1,038,543	\$285,493	\$30,951	\$5,116,236	\$12,515,113	\$18,964,336	21%	9%	1%	49%	95%	51%
	Priority Pops	\$21,550	\$85,000	\$158,770	\$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, Re	elated SID Elements, Barrie	s to Local Responsibility)			Vietnam
Step 1: Select SID element	SID score (autopopula ted)	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	Comm ents
		KP-led CBOs/private clinics		Lack of capacity and legal status		-
		and civil society		among local organizations, including		
		organizations are legally		the private sector, to engage in the		
		included in the health		public health response, community		
		workforce for HIV service		monitoring and deliver innovative		
4. Private Sector Engagement	8	delivery	Legal, policy or regulatory constraint	HIV service.	4-5 years	
3.82	_	Increase in quality and		Lack of capacity and legal status	,	
		quantity of diverse		among local organizations, including		
		groups, including KP-led		the private sector, to engage in the		
		CBOs and civil society,		public health response, community		
		social workers, and law		monitoring and deliver innovative		
		enforcement, providing		HIV service.		
		HIV and drug treatment				
3. Civil Society Engagement	5.1	services.	Lack of technical capacity		6-9 years	
		Civil society, particularly		Lack of capacity and legal status		
		community-based		among local organizations, including		
		organizations actively		the private sector, to engage in the		
		monitor the HIV program		public health response, community		
		for a true public health		monitoring and deliver innovative		
3. Civil Society Engagement	5.1	response.	Lack of managerial capacity	HIV service.	6-9 years	
		Innovations in case		HIV service delivery systems lack		
		finding, HIV prevention,		innovative and client-centered		
		especially PrEP, and linkage to care are		models for an effective public health		
		institutionalized under a		response to reach, test, and retain		
		national public health		KPs and PLHIV across the HIV		
6. Service Delivery	6.9	response.	Lack of technical capacity	cascade.	4-5 years	
	0.3			HIV service delivery systems lack	,	
				innovative and client-centered		
				models for an effective public health		
		All PLHIV access client-		response to reach, test, and retain		
		centered differentiated		KPs and PLHIV across the HIV		
6. Service Delivery	6.9	care for viral suppression.	Lack of sufficient HRH	cascade.	4-5 years	

				HIV service delivery systems lack		
				innovative and client-centered		
				models for an effective public health		
		Sustainable viral load		response to reach, test, and retain		
		coverage through SHI for		KPs and PLHIV across the HIV		
6. Service Delivery	√ 6.	9 ART clients in two regions.	Legal, policy or regulatory constraint		2-3 years	
		Increase capacity of HIV		Access to HIV testing (including		
		confirmatory labs in NEZ		recency testing and VL) remains a		
		and HCMC/Metro to		challenge, resulting in limited use of		
		increase case finding and		routine VL and recency testing as an		
		access to early ART		essential part of the public health		
10. Laboratory	7.	6 initiation.	Lack of technical capacity	response.	2-3 years	
		Recency data used for		Access to HIV testing (including		
		better management and		recency testing and VL) remains a		
		coordination of public		challenge, resulting in limited use of		
		health response at		routine VL and recency testing as an		
		provincial and national		essential part of the public health		
10. Laboratory	7.	6 levels.	Lack of technical capacity	response.	4-5 years	
		Increase access to viral		Access to HIV testing (including		
		load testing to maintain		recency testing and VL) remains a		
		the third 95 and		challenge, resulting in limited use of		
		decreasing forward		routine VL and recency testing as an		
		transmission.		essential part of the public health		
10. Laboratory	7.	6	Legal, policy or regulatory constraint	response.	4-5 years	
		HIV case-based		Limited HIV case-based surveillance,		
		surveillance system		monitoring, and reporting systems to		
		components are linked		support the public health response.		
14. Epidemiological and Health Da	5.	<mark>.7</mark> and operational	Lack of technical capacity		4-5 years	
				Limited HIV case-based surveillance,		
		HIV/AIDS data		monitoring, and reporting systems to		
14. Epidemiological and Health		interoperability platform is		support the public health response.		
Data	5.	<mark>7</mark> established	Legal, policy or regulatory constraint		4-5 years	
		Surveillance and program		Limited HIV case-based surveillance,		
		data are used routinely to		monitoring, and reporting systems to		
		measure and monitor		support the public health response.		
		performance and inform				
		the HIV public health				
16. Performance Data	8.	7 response.	Lack of sufficient HRH		4-5 years	

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

				+	
			Nascent domestic capacity to rapidly		
			expand commodity procurement and		
			manage the supply chain, including		
8. Commodity Security and	Increased access t	o TLD	coordination efforts for the HIV		
Supply Chain	7.5 through SHI.	Lack of technical capacity	public health response.	4-5 years	
			Nascent domestic capacity to rapidly		
	Ensure access to e	ssential	expand commodity procurement and		
	HIV prevention		manage the supply chain, including		
	commodities thro	ugh	coordination efforts for the HIV		
13. Market Openness	9.4 diversified market	s. Underdeveloped private marl	ket public health response.	4-5 years	
			Limited capacity for provincial and		
	National Provincia	I HIV	national-level authorities to access,		
	managers in charg	e of HIV	aggregate and interpret data for		
	prevention, treatr	nent and	an evidence-based HIV public health		
	systems in can col	ect,	response.		
	analyze and interp	ret data			
	to provide approp	riate			
9. Quality Management	7.8 public health resp	onses Lack of technical capacity		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	Primary Barrier to Local Expected Outcome 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	Interventi on End	If ongoing from a previous year, i please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years	COP22 Baseline	COP22 Benchmark	Will the activity be continue once all benchmarks have been achieved?	d Notes
\$ 330,000	ASP: Laws, regulations	Non-Targeted Pop:	Program and data	16. Performance Dat	8.73	8.73	N/A	Civil society, particularly Lack of managerial capacit	Lack of Financial Resources		CSO Engagement Fora; Public and media engagement	COP20	Post	OGAC requirement	Community-led monitoring	res	Building on CLM results in COP20	At least 1,500 PLHIV and KP	Quarterly report Yes	Community-led monitoring
	& policy environment- NSD	Not disaggregated	quality management					community-based organizations actively			programs; Public programs addressing stigma and discrimination; Community-led monitoring		COP25		started in COP20 and interviewed over 1,000 clients		and COP21. Building on and continuing to	individuals interviewed for community led monitoring		
	HJD.							monitor the HIV program for			discrimination, community-red monitoring				from 30 sites in the 11 PEPFAR		build public diplomacy capacities	At least 6 CSOs granted directly		
								a true public health							provinces. The plan for COP21 is		for local CSOs through the HIV	and many more (CBOs and stakeholders) engaged in small		
								response.							to survey 1,500 clients from 40 sites. COP22 targets are built on		Public Diplomacy small grants. Building on existing relations	stakeholders) engaged in small grants activities:		
															this progress and also the		with media outlets and through	At least 20 media outlets briefed		
															strategy to build data collection.		them reaching out to the general	and trained on HIV/AIDS		
															analysis and presentation skills for community leaders and CBOs.		public.	services, and through them tens of thousand individuals in the		
															In recent years, 5-6 small grants were provided annually to local			general public are reached via		
															were provided annually to local CBOs in the HIV public diplomacy			traditional and social media; At least 40 sites monitored by		
															program. These grants served to			community		
															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 eathering hundreds to					
															thousands of participants, to					
															online communication campaigns with high views and					
															interactions. The grants also					
\$ 310,000	ASP: Human resources	Non-Targeted Pop: Not disaggregated	Civil society	3. Civil Society	4.25	5.08	3.5 Civil Society Enabling	Increase in quality and Legal, policy or regulatory	Lack of managerial capacity	Lack of information on costs	National/Provincial:	COP21	Post	Activity requires multiple years	Social contracts bid and	res	SC pilot preparation started in	1. Dong Nai province commits at	Annual report and financial data Yes	
	for health-NSD	Not disaggregated	engagement	Engagement			Environment: Are there laws,	quantity of diverse groups, constraint		and program requirements	National: Partner with USAID IPs and national social		COP25	to reach the goal	performed in HCMC, Tay Ninh,		Tay Ninh, Dong Nai and Tien	least 25% financial contribution	captures from provinces	
							policies, or regulations in place which normit CSOs to be	including KP-led CBOs and civil society, social workers.			contracting partners (US CDC, UNAIDS, GF) to strengthen				Tien Giang and one TBD province		Giang	in FY23 and has a financial marhanism in place to mobilize	IP progress report Provincial approved document	
- 1	l	1	1				funded from a government	and law enforcement,	1	1	implement, monitor, and effectively use data as part of a	1					l	local funding for social		
1	1		I				budget for HIV services	providing HIV and drug	1	1	phased transition plan. Provincial: Efforts will focus on provincial leadership while	1					l	contracting efforts in future		
	l	1	1				through open competition (from any Ministry or	WEST STREET	1	1	collaborating with partners working on community	1					l	years. 2.Tay Ninh agrees to contribute		
	1		I				Department, at any level -		1	1	strengthening efforts and national advocacy. Sustain	1					l	at least 25% of the costs of social		
1	1		I				national, regional, or local)?		1	1	efforts for social contracting in Tay Ninh, Dong Nai, and Tien Giang: expand to two additional provinces selected in	1					l	contracting agreements by end FY23.		
- 1	l	1	1				Note: This sometimes		1	1	consultation with the TWG: transition out of PEPFAR	1					l	•Nghe An mobilizes a 50%		
	1		I				referred to as "social		1	1	support for social contracting in Nghe An, documenting	1					l	contribution for social		
	1		I				contracting" or "social procurement."		1	1	lessons learned around provincial level GVN budgetary commitments and performance monitoring.	1					l	contracting by end FY23. 3.A sustainable financing plan is		
	1		I				,		1	1	and performance monitoring.	1					l	approved by the Provincial		
	1		I						1	1	1	1					l	Pennle's Council of Tien Giang by	1	
	l	1	1						1	1	1	1		1			l	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		
																		from Tay Ninh, Tien Giang, Dong Nai and Nghe An maintain at		
	1		I						1	1	1	1					l	least one full-time staff member		
- 1	l	1	1						1	1	I	1					l	dedicated to social contracting work in FY23.		
\$ 120,000	ASP: Policy, planning,	Non-Targeted Pop:	Program and data	16. Performance Dat	8.73	8.73	16.6 Quality of Service	Provincial program and HIV Legal, policy or regulatory	Lack of managerial capacity	1	Continuous quality improvement: Establish effective	COP20	COP24	TA requires multiple years	TA provided to HCMC, Dong Nai,	res	Community and facility CQI data	Expansion of provincial CQI	100% CBOs and facilities Yes	
	coordination &	Not disaggregated	quality management				Delivery Data: To what extent	data are regularly collected constraint		1	procedures for collecting and responding to community and facility CQI data (PEPFAR, Circular 03, PQM, and	1		1	Tay Ninh, Tien Giang and Quang		not collected or not pulled	model focused on the use of CO3	supported in USAID EpiC	1
- 1	management of disease motival	1	1				does the host country	and analyzed to track the	1	1	and facility CQI data (PEPFAR, Circular 03, PQM, and community feedback) & PQM dashboard. Work with nublic	1			Ninh		together for overall program quality review and CQI actions.	data to national in partnership with VAAC: continued support	provinces and sites use CQI data to improve service quality.	
	programs-NSD		I				implement policies,	- Tagana	1	1	sector facilities, community members, and private facilities	1					, review and cup actions.	for CQI and PHCR in all provinces	and the same same same same same same same sam	
	1		I				procedures and governance		1	1	where needed to address 1) Treatment interruption	1					l	with USAID DSD support.		
	1		I				structures that assure quality of HIV/AIDS service delivery		1	1	contributing significantly to attrition above the monthly threshold; 2) Deaths contributing significantly to attrition	1					l			
	1		I				data?		1	1	above threshold: 3) PrEP seroconversion and retention:	1					l			
	1		I						1	1	and 4) Index testing, HTC/PrEP uptake and treatment	1					l			
\$ 80,000	ASP: Policy, planning,	Non-Targeted Pop:	Program and data	16. Performance Dat	8.73	8.73	16.3 Comprehensiveness of	Provincial program and HIV Lack of technical capacity	1	l	initiation. PLHIV estimation & CS: Provide technical assistance to the	COP20	COP23	TA requires multiple years	EpiC LOE to the national TWG,	res	CS data pulled as national TWG	Updated reports for provinces	Quality CS data incorporated No	
	coordination &	Not disaggregated	quality management				Service Delivery Data: To	data are regularly collected	1	1	national CS TWG to support Case Surveillance and support	1			the new estimation for selected		requested. National HIS CS tool	Updated reports for provinces prioritized by the VAAC for	into the national CS system.	
1	management of disease control		I				what extent does the host	and analyzed to track the public health response.	1	1	CS implementation in Tay Ninh, Tien Giang, Dong Nai and Quang Ninh-based upon National CS guidelines with	1			PEPFAR provinces completed		to be rolled out and incorporated.	estimation in PY23.		
	programs-NSD	1	1				country government collect HIV/AIDS service delivery data	pours near or response.	1	1	National CS TWG support. Collaborate with other	1					morpotated.			
1	I		I				by population, program and		1	1	stakeholders to provide technical assistance to the GVN to carry out the next round of HIV size estimation and	1					l			
	l	1	1				geographic area? (Note: Full		1	1	carry out the next round of HIV size estimation and projections in HCMC and other provinces as determined by	1		1			l			1
							selecting all disaggregates.)				the VAAC.									
\$ 300,000	ASP: Policy, planning, coordination &	Key Pops: Not	Civil society	3. Civil Society	4.25	5.08	3.5 Civil Society Enabling Environment: Are there laws.	Increase in quality and Legal, policy or regulatory	Lack of information on costs and program requirements	Lack of managerial capacity	National: Social contracting advocacy and central policy	CO921	COP25	TA requires multiple years	1> HIV preventive services to be included in adhoc PM Decision	Partial	Pilot implementation plan in	1.SC pilot monitoring tool and	IP/VAAC SC progress update Yes	
1	management of	disaggregated	empagement	creagement			policies, or regulations in	quantity of diverse groups, constraint including KP-led CBOs and	and program requirements	1	Facilitate dialogues, consultations, and learning	1			as Public services		prace	biannual reports for national pilot is available	report Monitoring tool for SC	
1	disease control	1	1				place which permit CSOs to be	civil society, social workers.	1	1	quents to connect the development of a policy framework	1		1	2> Provincial sustainable plans in		l	Exchanged events (each per	MOH policy document	
1	programs-NSD	1	1				funded from a government budget for HIV services	and law enforcement, providing HIV and drug	1	1	enabling social contracting for HIV services in Vietnam Support MOH in the development and advocacy plan	1		1	targeted provinces include funding commitment for CSO led		l	quarter) are organized to allow provinces learning and sharing	Meeting minutes for event	
	l	1	1				through open competition	treatment services.	1	1	for the endorsement of HIV as a public service under the	1			services		l	provinces learning and sharing experience in social contracting		
	l	1	1				through open competition (from any Ministry or		1	1	revised Prime Minister Decision using generated evidence	1			3> Evidence on SHI and public		l	implementation.		
	l	1	1				Department, at any level - national, regional, or local)?		1	1	on social contracting implementation, results from the SC pilot for the two-year pilot and international best practices	1			funding eligibility for HIV prevention services		l	MOH Decision on HIV SC to be public health services		
1	1		I						1	1	and standardization of SC GVN cost norms	1			p					
1	l	1	1				Note: This sometimes		1	1	 Support national oversight trip during the pilot implementation and cross exchange/learning during COP 	1		1			l	working group to promote SC 3.HIV services in the MOH		
	l	1	1				referred to as "social contracting" or "social		1	1	22 for key GVN stakeholders (including GF) to travel to	1					l	3.HIV services in the MOH proposal to PM on public service		
1	1		I				procurement."		1	1	provinces to see how social contracting models are	1						for health		
	l	1	1						1	1	working Organize cross exchange/learning events for key GVN	1		1			l	4.oversight/monitoring trips are		1
1	1		I						1	1	stakeholders and provinces to share experience on the	1						- Ultramett		
1	1		I						1	1		1								
1	l	1	1						1	1	(supervision/TA trips) or TA or guidance on costing for HIV service packages to pilot provinces if required).	1		1			l			
	l	1	1						1	1	 Work with other IPs to support VAAC to monitor the 	1					l			
	l	1	1						1	1	implementation and gather lessons during the social	1					l			
	l	1	1						1	1	contracting pilot for HIV service provision at the national level. Contribute to the pilot evaluation/design and	1					l			
1	1		I						1	1	preparation of policy brief promoting SC	1								
\$ 350,000	ASP: Policy, planning,	Key Pops: Not	Program and data quality management	16. Performance Dat	8.73	8.73	16.5 Analysis of Service	Provincial program and HIV Legal, policy or regulatory	Lack of managerial capacity		Support coordination and data sharing and	COP20	COP24	TA requires multiple year and	HMED/eLMIS upgraded versions	res	HMED and EIMIS are ready to use	Regular (monthly alert) to VAAC	Regular report Yes	
	coordination &	disaggregated	quality management				Delivery Data: To what extent	data are regularly collected constraint		1	interoperability between VSS and VAAC on (1)	1		data exchange and triangulation	to meet the management			and PEPFAR team on the ARV		
	management of disease control	1	1				does the host country government routinely analyze	and analyzed to track the public health response.	1	1	ELMIS/HMED and (2) VSS Edaim and HIV info 1. Support regular monitoring and data sharing and	1		between two systems is not functioned as yet	requirements		l	drug consumption Quarterly Analysis on SHI		
	programs-NSD	1	1				service delivery data to		1	1	Support regular monitoring and data sharing and interoperability between VSS/ELMIS and VAAC/HMED on	1					l	reimbursement of ARV, VL		
1	l	1	1				measure program		1	1	drug management to improve ARV distribution and	1		1			l	testing and copays amount provided to VAAC, PEPFAR team		
	1		I				performance (i.e., continuum of care cascade, coverage,		1	1	consumption 2. Support regular monitoring of ARV dispensing/SHI	1					l	63 provinces have eLMIS		
1	l	1	1				retention. AIDS-related		1	1	reimbursements of ARVs, VL testing and S copays through ELMIS at the national level to support the continuity and	1		1			l	accounts to extract SHI data and		
	1	1	1				mortality rates)?		1	1	ELMIS at the national level to support the continuity and quality of HIV treatment service.	1					l	can use the data for improved drug management		
	1	1	1						1	1	3. Support VSS and MOH to scale up the data use of VSS-	1					l	Official GVN decision for data		
	1	1	1						1	1	ELMIS at provincial level through on the job training to	1					l	sharing between VSS and VAAC		
1	l	1	1						1	1	Provincial CDCs and HF staff to understand drug usage levels and inform provincial stock forecasting and decision	1		1			l	for HIV program management		
1	1		I						1	1	making	1					l			
	1		I						1	1	A Support VAAC to undate standard variables for rore	1					l			
	1		I						1	1	indicators for HIV program management and support data sharing mechanism for HIV indicators between VSS and	1					l			
											VAAC/MOH									

3 1300		Non Trensted Bon:	Overright technical	C Conside Polisson	2.20	6.00	£ 1 Beconscionance of facility	terrorred GNN conscitute Lack of technical conscitu	tack of managerial capacity		Strengthonian the Communication or necessary out on	come com	4 Those we still penning issues	11 DTG10ms registered in VM	fraction	1 one Mulas TI Danid Ti D	Circular 15 (2010 - Dover Biddies	A new Ballider Issuer Vos	
	supply chain	Not disaggregated	assistance, and	6. Service Delivery	7.20	0.83	based services to demand for	manage and coordinate HIV	Lack or managenal capacity		for ARV:	COP20 COP2	with the SHI ARV Procurement	Additional non-Mylan TLD and	ratual	cartonless registered in Vietnam	in public health	Report on national procurement	
	management-NSD		supervision to				HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	commodities procurement and supply chain from			1) Policies Revisions: Technical advice and support to the		and Supply Management that require technical	TLD cartonless registered in		cartonless registered in Vietnam 2) National PrEP sustainability	facilities/Finalization in COP22 Circular 15/2020 – List of	option	
			subnational levels				facilities respond to and generate demand for HIV	and supply chain from multiple sources.			revision process of * Policy to enable the appropriate procurement options		require technical connect/assistance from 9F9FAR	2) Proposal for pooled		plan in place	medicines procured in public	of evidences/study prepared for MA dossier and progress	
							services to meet local needs?				for ARV (Revision of Circular 15/2019 on procurement of drugs in public health facilities, including pooled						medicines procured in public health facilities/Finalization in COP22	report	
							(Check all that apply.)				drugs in public health facilities, including pooled			registered ped ARVs			COP22 Circular 22/2020 – Procurement		
											procurements, domestic or international procurement, including the procurement of special drugs categories (pediatric ARVs, 2nd line/3rd line drugs).			3) National PrEP sustainability plan in place					
											(pediatric ARVs, 2nd line/3rd line drugs).			prantin prace			Drugs/Finalization in COP22 Recommended National		
											* Policy related to drug bidding and procurement regulations/policy to enable particular ARV that was						Recommended National		
											regulations/policy to enable particular ARV that was excluded in the price negotiation list.						Procurement Options are		
																	developed Cost-effectiveness analysis (CEA)		
											* Provide support on coordination, advocacy and ad-hoc TA among VAAC, NDCPC, VSS during the procurement						and budget impact analysis (BIA)		
																	are available MA Dossiers for the long acting		
											* Support the MOH in the development of the						injectable ARV and PYEP and		
											Recommended National Procurement Options by expanding to the international pooled procurement rather						other ARVs (TLD, DTG10/50) submitted successfully to DAV		
											expanding to the international pooled procurement rather						submitted successfully to DAV		
											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								
											to GF/WAMBO for example) as needed								
											 Conduct the cost-effectiveness and budget impact analysis and work with MOH on the preparation of dossier 								
											* 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								
\$ 200,00		Non-Targeted Pop:	Supply chain	8. Commodity Security	6.86	7.49	8.8 Management and	Increased GVN capacity to Lack of technical capacity	Lack of managerial capacity	Legal, policy or regulatory	In COP22, the project will provide technical assistance to:	COP20 COP2	4 GVN just started their SHI	SOPs/Guidelines on SHI ARVs	Yes	SHI procurement for 2021 2022	GVN fulfilled the SHI	% drugs supplied according to Yes	
	supply chain	Not disaggregated	infrastructure	and Supply Chain			Monitoring of Supply Chain:	manage and coordinate HIV		constraint	1) Support regular monitoring, data sharing, effective use		management of ART so requires	Management SOPs for GVN Price		SHI procurement for 2021 2022 are finalized Stock status at facilities are available at national level for	procurement and supply for	the framework agreement	
	management-NSD						Does an administrative entity, such as a national office or	commodities procurement and supply chain based on			and interoperability between VSS/ELMIS and VAAC/HMED on drug management to improve ARV distribution and		some more years to be	SOPs for GVN Price Negotiation/Open Bidding		Stock status at facilities are	FY2023 Monitored and alerted stock	No stock-out Spatients on MMD	
							Bureau/s, exist with specific	data from multiple sources.			consumption and quantification. Its benchmark is Regular			ARV drugs security plan for 2022-		analysis and reviewed	status of ARV drugs to VAAC and		
							authority to manage - plan,				(monthly alert) to VAAC and PEPFAR team on the ARV drug			2026			PEPFAR which affects to the		
							monitor, and provide guidance - cumply chain				consumption and the early warning on the stock status						MMD implementation GVN implemented the ARV Drug		
							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				2) Provide technical assistance at the national level to						MMD implementation GVN implemented the ARV Drug Security Plan to ensure no treatment interruption		
							forecasting, stock monitoring,				related entities (VAAC, DAV, DPF and VSS) to roll out the						treatment interruption		
							logistics and warehousing support, and other forms of				implementation of the ARV Drug Security Plan (including all events/incidents in ARV drug supply and all scenarios in								
	1		1				information monitoring across		1		2) Provide technical assistance at the national level to nelated entities (PAAC, DAA, DPF and VSS) to roll out the implementation of the ARV Drug Security Plan (including all eventylincidents in ARV drug supply and all scenarios in ARV supply to secury/manage the continuum of HIV treatment) (this plan being developed with LHSS in CDP21)	1 1				l			
			1				information monitoring across all sectors? Select only ONE answer		1		treatment) (this plan being developed with LHSS in COP21)					l			
	1	1	1				answer.		1	l						l			
\$ 280,00	000 ASP: Policy, planning coordination &	g, Key Pops: Not	Assessing impact of	2. Policies and	6.38	6.33	2.4 User Fees for Other Health Services: Are HIV infected persons espected 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 constraint	Lack of managerial capacity		National & provincial adhoc TA on SHI ARV Copayment	COP19 COP2	4 GVN just started their SHI	Policies changed and modified to	Partial	44/63 provinces has financial	63 provinces have Sustainable Financial Plans for HIV approved and tocal 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	Approved provincial plans Yes	
	coordination &	disaggregated	Assessing impact of policies and regulations on HIV	Governance			bervices: Are HIV infected	parners for PLHIV to constraint	1		Subsidies Monitor the annual hydrox officeration and		4 GVN just started their SHI management of ART so requires some more years to be			44/63 provinces has financial commitment through approved provincial sustainable financing plan for 2022-2030	and Local burkets are approved	Approved provincial plans Evidence on 5 committed through provincial budget	
	management of disease control programs-NSD		regulations on HIV				be asked to pay user fees,	SHL	1		expenditure to SHI ARV copayment by funding source		functional	for SHI Regular update on SHI		plan for 2022-2030	allocated and tracked to HIV	annually	
	programs-NSD		1				either formal or informal, for		1		(Local budget, donor, others) and procurement method			reimbursement for HIV services		· · · · · · · · · · · · · · · · · · ·	program at the provincial level	OOP Assessment data and report	
	1	1	1				any non-HIV services in the		1		Provide technical assistance to MOH in the revision related policies on ARM on the revision					l	Increased number of provinces		
	1	1	1				MCH/SRH, TB, outpatient		1		22, Decision 2188) or development of financial evidance					l	funding, esp. local budget to		
	1	1	1				registration, hospitalizations,		1		on the implementation to ensure the equality in financial					l	subsidize PLHIV for SHI ARV		
	1		1				and others?		1		protection for HIV patients regardless of ARV procurement	1 1				l	copayment		
	1	1	1						1		mechous (public bidding or price negotiation). 3. Technical support to VAAC/MACH and 9595A.9					l	Posessment of OOP for PLHIV accessing SHI ART and VI coming		
	1	1	1						1		supported provinces to advocate for local budget increases					l	copayment Assessment of OOP for PLHIV accessing SHI ART and VL services and evidence on Impact of copay to PLHIV is available		
			1						1		National & provincial anime. The nits of ANY Copyment Con- location of the Conference of Conference						to PLHIV is available		
											premium and ARV copay.								
											review out-of-pocket payments and impact on MMD and								
											catastrophic health expenditures among antiretroviral								
											therapy (ART) patients in Vietnam when the primary								
											March 2019.								
\$ 200.00	000 ASP: Policy, planning	g, Key Pops: Not	Market openness	13. Market Openness	9.33	9.41	13.2 Requiring license or	Ensure access to essential Underdeveloped private	Lack of technical capacity	Lack of managerial capacity	National Level: Continue to support market expansion and	COP20 COP2	5 HIVST kit market is still limited	1. Facilitate at least 2 new HIV	Yes	1. TA to Abbott and OS on	One new HIVST product	Routine M&E tools Yes	
	coordination &	disaggregated					authorization: Do national	HIV prevention commodities market			entry for new HIV products including but not limited to:		and need to provide TA to the PS	test kits registered and sold in the Vietnam Markets		product registration; both Abboti	registered and available in VN	coi	
	management of disease control	1	1				government or donor (e.g., PEPFAR, GFATM, etc.) policies	through diversified markets.	1		Self-test kits (HIV, HCV, Syphilis) New ARV and PrEP drugs (eg CAB-LA)		to register in Vietnam. Long-acting cabotegravir (CAB LA) is still on discussion and need	the Vietnam Markets 2. Facilitate long acting &		product registration; both Abbott and OS have submitted dossiers to MOH for product review and approval	market with a market entry	Quarterly progress report	
	programs-NSD						PEPPAR, GPATM, etc.) policies establish a license, permit or				 New ARV and PrEP drugs (eg CAB-LA) Other point of care platforms and test kits (HBV, HBC, 		Long-acting cabolegravir (CAB LA) is still on discussion and need	Z. Facilitate long acting & Injectable (CAB) PrEP registered		to MOH for product review and	strategy in place (pricing, distribution and		
	p. 100 a						authorization process as a				duo HIV & syphilis, GN/CT) 4. Expand distribution platforms in USAID supported		to explore the potential for local	and available in Vietnam		2. Ongoing discussions with ViiV	marketing/demand generation) 2. CAB-LA registered in the local		
							requirement of operation?				4. Expand distribution platforms in USAID supported		registration of International	Markets 3. Support VAAC to pilot at least		2. Ongoing discussions with ViiV on LA-CAB registration 3. Draft TelePrEP protocol under	2. CAB-LA registered in the local		
											provinces for key products through pharmacies, e- commerce, tele-health, KP CBOs/SE, clinics		Partnership.	3. Support VAAC to pilot at least one new and innovative HIV		3. Draft TelePrEP protocol under final approval review	market with a TMA strategy in place (access and commercial		
											5. Pilot and expand bundled Self Test/self-care packages			related service delivery model		4. Regular National Forums on	pricing, distribution,		
											tailored to different normilations			and advocate for any policy/legal		demand gen and DSD	marketing/demand gen, post-		
											tailored to different normilations			documents changed /revised.		5. Agreement on inclusion of	pricing, distribution, marketing/demand gen, post- market surveillance); preliminary		
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5 200,00	management of disease control programs-145D		Опида видин	A. Private Sector Faggement A. Private Sector A. Private Sector Engagement	6.00	7.99	water people with a capability to support PM/ADG August PM	regressions are highly considered in the head of the h	Lack of Information on costs	Last of technical capacity	sationar to a different populations. 1. The NAMAC has been design procedure (cernman) and Procession designs of the Control o	COP19 COP2	saching on boliums description of pain in CO23. STR sentantion to reveal under the control of th	Social Medical Private And Company for Social Access of Social Private Annual Pri	Total	S. Agreement conscission of selection of the construction of the construction of the construction of the construction and freatment extends on the construction of the construct	modest enjoyacion of febCV/CV. modest in the popularie like hardcapper, liketorie and la hardcapper and la hardcapper, liketorie an	CO Meagress project report Pegers Applicating of the Control of t	
5 2000	management of disease control programs-145D		Private sector sepagement	A. Private Sector Engagement A. Private Sector A. Private Sector Engagement A. Private Sector Engagement	5.99	7.99	witch process the capability to support HV/MAD is subject to the support HV/MAD is subject to HV/MAD is support HV/MAD is subject to HV/MAD is subject	regressions are highly considered in the head of the h	Lack of Information on costs	iad affeithead capacity	National & Protestical Lewis Continue to build agazethy for Child Tan Wald Child and Child and Child Activation of Child Acti	COP20 COP2	saching on boliums description of pain in CO23. STR sentantion to reveal under the control of th	Assemble of the Company of the Compa	ros.	S. Agreement conscission of selection of the construction of the construction of the construction of the construction and freatment extends on the construction of the construct	modate expectation of MOCIVO-20 modates are producted in the September 18th and Company of Marcor and September 18th and Company, Marcor and Company, M	CO Meagress project report Pegers Applicating of the Control of t	
5 86,60	management of disease control programs-145D		Private sector single-private Private sector single-private single-private	A. Private Sector Coppignment A. Private Sector Coppignment	537	7.99	water people with a publish programme to be programmed. As A Provide Sactor Engagement Government of the Control of the Contro	regressions are highly considered in the head of the h	Lack of Information on costs	Code of Nechnical capacity.	sationes to a different populations. 1. The NAMA's based design procession (commanity of Procession design) and the Commanity of Procession designs of the Commanity of Procession designs of the Commanity of Procession designs of the Commanity of the Commanity of Procession designs of the Commanity of the Comma	COP19 COP2	saching on boliums description of pain in CO23. STR sentantion to reveal under the control of th	Assemble of the Company of the Compa	Ton.	S. Agreement conscission of selection of the selection of	modate experiencia on filosCV/cV. modate is missing periped in the benefactors in the propriete in the propriete in the benefactors in the propriete in the propriete in the benefactors in the propriete in the propriete in the benefactors in	CO Meagress project report Pegers Applicating of the Control of t	
5 250,00	management of disease control programs-145D		Private sector sequenced property of the sector sequenced private sector sequenced sequenced private sector sequenced sector sequenced private sector sequenced sector sequenced sector sequenced sector sequenced sector s	A. Privade Sactor Engagement A. Privade Sactor Engagement E	1.50	7.99	with or possible to appelling to support the MADA to support the M	regressions are highly considered in the head of the h	Lack of Information on costs	was affective at capacity.	science for a different populations. 6. The SWART has defined populations (6. The SWART has defined procedure Community of Processes and other removalation CoP and its 16.64 s.). When the second of the control of the SWART has defined a control of the SWART has defined a copy of th	COP20 COP2	saching on boliums description of pain in CO23. STR sentantion to reveal under the control of th	Assemble of the Company of the Compa	ro.	S. Agreement conscission of selection of the selection of	modate experiencia on filosCV/cV. modate is missing periped in the benefactors in the propriete in the propriete in the benefactors in the propriete in the propriete in the benefactors in the propriete in the propriete in the benefactors in	CO Meagress project report Pegers Applicating of the Control of t	
\$ 230,00	management of disease control programs-145D		Private sector sepagement	A. Private Sector Engagement A. Private Sector Engagement	6.00	7.99	wind proposes the capability to support HV/ADS t	regressions are highly considered in the head of the h	Lack of Information on costs	cuit of festiment capacity.	satisfaces for afficient populations. A Tax NAVAC beat disenting investions Community of Practice and other resources CoPs and as CASA. National and other resources CoPs and as CASA. Particles and other resources CoPs and as CASA. National and Propertical Levels. Continues to build appairing to focus of interpress CASA & Practice Practice Continues to build appairing to CASA. National Services Continues to build appairing to CASA & Practice Continues and Associated Continues CASA. National Services CASA & Practice Continues and Associated Continues CASA & Practice Continues and Associated Continues CASA & Practice CA	COP20 COP20	saching on boliums description of pain in CO23. STR sentantion to reveal under the control of th	Assemble of the Company of the Compa	Fee.	S. Agreement conscission of selection of the selection of	mounter expension of MOCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in MoCAVICA in MoCAVIC	CO Meagress project report Pegers Applicating of the Control of t	
5 200,00	management of disease control programs-145D		Private sector	E. Private Sector Federal Sector Edit Sector Edit Sector Federal Sector F	5.50	7.99	with or possible to appelling to support the MADA to support the M	regressions are highly considered in the head of the h	Lack of Information on costs	cod of technical capacity	science for a different populations. 6. The SWART has defined populations (6. The SWART has defined procedure Community of Processes and other removalation CoP and its 16.64 s.). When the second of the control of the SWART has defined a control of the SWART has defined a copy of th	COP18 COP2	saching on boliums description of pain in CO23. STR sentantion to reveal under the control of th	Assemble of the Company of the Compa	Tes.	S. Agreement conscission of selection of the selection of	modate experiencia on filosCV/cV. modate is missing periped in the benefactors in the propriete in the propriete in the benefactors in the propriete in the propriete in the benefactors in the propriete in the propriete in the benefactors in	CO Meagress project report Pegers Applicating of the Control of t	
5 2046	management of disease control programs-145D		Private sector wegap amount	A. Private Sector Engagement A. Private Sector Engagement	630	7.99	wind proposes the capability to support HV/ADS t	regressions are highly considered in the head of the h	Lack of Information on costs	Last of festivent capacity.	saltered to a different populations. 6. This No MACE has different populations of the Common of the	COP19 COP2	saching on boliums description of pain in CO23. STR sentantion to reveal under the control of th	Assemble of the Company of the Compa	7 os.	S. Agreement conscission of selection of the selection of	mounter expension of MOCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in MoCAVICA in MoCAVIC	CO Meagress project report Pegers Applicating of the Control of t	
5 200.00	management of disease control programs-145D		отната выполнения выс	A. Private Sector Faggement A. Private Sector A. Private Sector Engagement	130	7.99	wind proposes the capability to support HV/ADS t	regressions are highly considered in the head of the h	Lack of Information on costs	Cush of technical capacity	Saltered to Miller and Saltered populations. 1. The Na WALC based and entire formation (ceremonally and Previous and other removations Ceremonal to CASA). National & Frontenical Levels: Continues to basid capacity for the CASA and AND AND AND AND AND AND AND AND AN	COP19 COP2	saching on boliums description of pain in CO23. STR sentantion to reveal under the control of th	Assemble of the Company of the Compa	Total	S. Agreement conscission of selection of the selection of	mounter expension of MOCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in MoCAVICA in MoCAVIC	CO Meagress project report Pegers Applicating of the Control of t	
5 200,00	management of disease control programs-145D		Private sector sec	A. Private Sector Engagement 4. Private Sector Fragagement	150	7.99	wind proposes the capability to support HV/ADS t	regressions are highly considered in the head of the h	Lack of Information on costs	land of healthread capacity.	Section 1 to 1 different populations. 1. This No WALC has desired provision Community of Practice and other resolutions CoP and as CASA. Note that the Copy of t	COP19 COP2	saching on bolisses on displacement of the control	Assemble of the Company of the Compa	ros.	S. Agreement conscission of selection of the selection of	mounter expension of MOCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in MoCAVICA in MoCAVIC	CO Meagress project report Pegers Applicating of the Control of t	
5 200,000	management of disease control programs-145D		Private sector sing proper Private sector sing proper private sector	A. Private Sector Coppignment A. Private Sector Coppignment	5.50	7.99	wind proposes the capability to support HV/ADS t	regressions are highly considered in the head of the h	Lack of Information on costs	Code of Nechnical capacity.	Saltered to different populations. 1. The NAVAC to be and design procession Community of Previous and other resolutions CoF south as CASA. Navious and other resolutions CoF south as CASA. Navious and other resolutions CoF south as CASA. Navious and coffee of the CASA. Navious and CASA. Navious and CASA. Navious C	COP19 COP2	saching on bolisses on displacement of the control	Assemble of the Company of the Compa	Ton.	S. Agreement conscission of selection of the selection of	mounter expension of MOCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in MoCAVICA in MoCAVIC	CO Meagress project report	
5 200,00	management of disease control programs-145D		Private sector segge general	A. Privatile Section Engineement A. Privatile Section A. Privatile Section Engineement Engineement	5.50	7.99	wind proposes the capability to support HV/ADS t	regressions are highly considered in the head of the h	Lack of Information on costs	icad affectivest capacity	Section 1 to 1 different populations. 1. This No WALC has desired provision Community of Practice and other resolutions CoP and as CASA. Note that the Copy of t	COP20 COP2	saching on bolisses on displacement of the control	Assemble of the Company of the Compa	Ton.	S. Agreement conscission of selection of the selection of	mounter expension of MOCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in Months of the MoCAVICA in MoCAVICA in MoCAVIC	CO Meagress project report	

5 50,000 ASP: Policy, pt. coordinations in management disease content and programmed and program	of d	Overlight, technical assistance, and supervision to submational levels. Civil society engagement	G. Service Delivery 3. Civil Society Engagement	7.20	6.85	6.0 Sub-national Service Delivery Capacity: Do sub- national health authorities (i.e., district, provincial) have (i.e., district, provincial) have plan and menage HVI services sufficiently to achieve sustainable epidemic control? 3.4 Domestic Funding of Civil Society: To what estent are (iii) All Domestic Funding of Civil Society: To what estent are	Severation is care facility. Production of inflamental production of the production	not Lack of technical capacit (Lack of managerial capacit Lack of Financial Resource	A Provincial Level II Liddle province symbol P Audio engineeration to include public score partners/province in HP Provincial model (e.g. the HP, PACCES HP) within HP. (20), illustrated search careful HP, PACCES HP) within HP, (20), illustrated search careful HP, PACCES HP) the resources/farutures of public actor he resources/farutures of public actor in the resources/farutures of public actor within LASAD Provinces. Provide capacity building and within LASAD Provinces. Provide capacity building and whereviral assistance resiglement outpaths cold became several assistance and settings.	COP20	COP25	There are some new models needed to provide TA to PrEP into the some needed to provide TA to PrEP into the some needed to provide TA to PrEP into the some needed to provide the some needed to previous needed to provide the some needed to the some needed to provide the some needed to provide the some needed to t	1. Provide training to all public. PFS this is all LXAD supported PFS this is all LXAD supported PFS this is all LXAD supported PFS this all public OSS by public this all this all this all this all this PF-led OSS -10 CBCN and other IPS groups received quapitly building on Social contracting related	6	1. Innovative HIV self-feet and PVEP campaigns implemented of wind reinforced propagas for the propagas for	I. Ta package developed in how to design and implement inconsults in PD Models (see Tell-inconsults in PD Models (see Tell-in PD, PHZ/CIGS PEP, Models PPE), PHZ/CIGS PEP, Models PPE, PHZ/CIGS PEP, Models PPE, PPE, PPE, PPE, PPE, PPE, PPE, PPE	Temperature Temper	
programs-NSD S 253,000 ASP: Policy, pl	anning, Key Pops: Not	Civil society	3. Civil Society	425	5.08	demestically (either from government, private sector, or government, private sector, or and generated flunds)? (if exact or approximate nown pricontage income, or the percentage from the various demestic source, please note in Comments column) 3.5 Civil Society Enabling	and ta we inforcement, providing this and drug florationers services. Out todain, particularly, back of technical cap	city Legal, policy or regulator	/ Lack of Financial Resource	Signaturations (community hashed opinisations) and level controlled with high granted based opinisations and service controlled with high granted based opinisation level controlled production; published because the end opinisate good practices with VAX_CRIS, ADD and other partners to advocate for with VAX_CRIS, ADD and other partners to advocate for level produced produced by the process of a driving agents of the produced produced and of the agents. In Mandred, Provision, Community:	COP21	COP25	TA requires multiple year	At least 02 (among 12) CBOs contracted under social contracts with social contracts with GWV/grovinical agencies in the project sites. Tool to monitor and evaluate CBO's performance of social contracts developed and used	s	At least 02 (among 12) CBOs contracted under social contract with GWV/provincial agencies in the project sites — Tool to monitor and evaluate CBOs performance of social contracts developed and used CBOs performance of social contracts developed and used contracts developed and	-15 CBOs and other XP props received apacity building on social contracting related procedures -1.4 least 05 CBOs contracted under social contracts with GVM/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. National PMCR framework,	Notional to SCANA baseline secretaries Notional algorithm and SONs Notional algorithm and SONs	
coordination (coordination) configuration (coordination) configuration (coordination) coordination (coordination)	of å	опдаретеля.	Engagement			Environment: Are there laws, opticises, 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 focally Note: This sometimes referred to as "social contracting" or "social procurement."	community-based organizations extra programme and community or a strong policy as the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the programme and community or a strong policy to early the	constraint		Magazine (PMCR) Enemon A (algorithm is coordinated) in the material common and a contract of the second of the Contract of the common and a contract of the contract of the material common and contract seasons from the 2P contract common and contract seasons are contract or 1.5 Contract translational assessment of community seasons 1.5 Contract translational assessment of commonly seasons and co-devisite particles and mSPCR response with parties prices to chairs a set provide in earling with parties prices to chairs and provide in earling with parties prices to chairs and provide in earling contracting consistings. (A) Indian particle in the chair and parties are consistent as chairs and parties are chairs and contract and chairs are consistent and chairs are consistent as chairs are consistent as chairs are chairs and chairs are chairs and c				algorithm and SOPs are developed to incide community and civil organization orgagement.		algorithm and SOPs are developed to include community and child regardation engagement.	algorithm and SOPs are developed; and community-based PriCh is effectively implemented to control HIV cluster in fections. In the control HIV cluster in fections. If the control HIV program is the control HIV program in the control HIV cluster in fections. If the control HIV cluster is the control HIV cluster in the	mouther a service on Community mouther as service of the community mouther of the community mout	
5 149,500 KSP-Patiley, Discontinuation of management discontinuation discontinuation discontinuation discontinuation discontin	of å	Civil SOCHRY engagement	3. Civil Society Englagement	4.25		3.5 Cwil Society Enabling Environment: As there laws, policies, or regulations in piace which permit COst to be piace which permit COst to be budget for fift services through open competition (from any Menistry or Department, at any Iveal - national; regional, or focally Nete: This comment and or focally Nete: This comment referred to as "social contracting" or "social procurement." 34.1 Management and	Tencesarie in qualify and season of secherical cap conducting to the CEO season of secherical cap could receive a conducting to the CEO season of section	constraint	Lack of Financial Resource	Settorial & Community increase operational and finational users and little of many hashed organizations by a substantial profit of many hashed organizations by planning efforts and support graduated ECOs with aggregations in a figure graduated ECOs with aggregation are raised profit or an experimental profit of the collisional on with STEPS and other partners. In collisional on with STEPS and other partners. In collisional on with STEPS and other partners.	COPPI	COPES	TA requires multiple year TA requires multiple year	-terosising number of CBOs have legislatus. Now legislatus. -60 CBOs supported to have legislatus.	.	additional S nationally, lifer Operational sustainability! this will require a combined assessment of how domains governance, administration and operations' and Triancial management and sustainability for both we expect that year to date monitoring will show growth in these areas to reach at least a "5".4" on the SCANA tool —this will be done in tarch at least a STEPS/NVST as appropriate. —65 CBOs supported to have lega status	related services. - CBOs with formal legal status by GVN, 10 CBOs supported to have legal status. - CBO scored of 'S' on item 3.1.1 of the SCANA tool. With regards to operational and financial sustainability, organizations.	and flashfall states. The requested KEAN states for the requested KEAN states for the requested KEAN states for the requested KEAN states and operational states and operational states and requested for the requested KEAN states and the results and the r	
servitares, f. research-450			14. Epidemiological and Health Data			Monitoring of Surveillance, Martines Does in Admires Chee in A	nomegoardaling platforms on sonabilished street consistence of the construction of the	constraint		aum CHS of seed that has been but in COP21 looperand by Dos, I have ill recided a provincing sethinical section for PCCS or lovels and lovel file of the long designment to PCCS or lovels and long designment (looperand pCCS or lovels and long designment pCCS or looperand pCCS or lovels and long-lovel pCCS or looperand pCCS or lovels and long-lovel pCCS or looperand pCCS or lovels and long-lovel pCCS or looperand pCCS or lovels and articles to support community and montaining and PCCS in no Co. Note City. Explaint CHS conded to as at diffusion to support community and montaining about the lovels and long-lovels or point CHS model to point a province, Note will include 3) Pointing (Dreath days as a provincial community apple community again to point the lovels are pointing or lovels and lovels are pointing and PCCS and lovels are long-lovels and Dreath Lovels and Dreath Lovels Dreath			and the continued work is	Community (gild look) wherebyee and opinion characteristics and control of the co	o approach	(D. Health) has been upgraded to	operated in the Chi Minh Chy. Test Safa used on smooth Prick in the Chi Safa used on smooth Prick in the Chi Minh Chy. Test Smooth expended in Dong Nab by premoting D. Halbith spe play and pooling data from other community apps to create a provincial community spet to create a provincial community and builty on the community spet to create a provincial spet on the community spet to create a special specia	Ad-hot regarding (qualitative first	
3 284,545 APP Human no inch haalth-MCI	sources (Non-Targeted Pop Not disaggregate	Collectag guidelines, policies for service delivery delivery	e. Service Delivery	7.20		6.3 Responsiveness of Schizers (6.4 Responsiveness of Schizers derivated under the desirable for facilities respond to and promote demand for IIV and of the schizers promote demand for IIV and one of the schizers Charles of the depthy in	All Prefix across clevel- ter from the control of t	use of sufficient rities		3) The and support to entirous all earning ordereds for EP. And Varieties. Developed to visit to Competent case tools, post all, publishers bloosed on equity, accombing to Varieties. Developed to visit to Competent case tools, post all, publishers bloosed on equity, accombing the varieties of the varieties as with foundational bio-medical involvation agency and through collaborating with varieties of the varieties as within a varieties of the varieties and provide endersor based for the Varieties of the varieties of the varieties and provide endersor based for the Varieties and varieties and provide endersor based for Varieties the varieties of varieties and varieties of the varieties of varieties and varieties of varieties and varieties of varieties and varieties of va	1.09/20	L.GP23	Need for confined work in enemying Philosophic Philosophic Philosophic enemying Philosophic Philosophic enemy Philosophic Philosophic enemy Philosophic Philosophic enemy Philosophic enemy Philosophic enemy Philosophic en	At least 2 FTTS IN RYFAM and 3 May reside province in the control of the control		Last Tejerisation and MAD. Memory place resolution and MAD. Memory place resolution and properties the supply resource and possible variety and properties the supply resource and possible value of approximation and possible value of approximation and produced pr	GIAN and area transmant	AFT/QUEST text have recorded for formation of the procession have been processed by the processed have been processed by the	

and the same the	tiS, Non-Ta	Targeted Pop:	Program and data	16. Performance Data	8.73	8.73	16.5 Analysis of Service Delivery Data: To what extent	Surveillance and program Lack of technical capacity t data are used routinely to	1		Assure high-quality data collection system for program monitoring at all levels of the epidemic monitoring	CO918	Post I	Program monitoring provide	High quality data are collected and accessible in 90% of priority	Yes	Program Monitoring Data (MER)	Program Monitoring Data (MER) is collected regularly (monthly	Number of sites submitted Yes program data on time	
surveilla	ance, & Not dis h-NSD	disaggregated	quality management				Delivery Data: To what extent does the host country	t data are used routinely to measure and monitor					COP25	data to evaluate program quality and identify program gaps	and accessible in 90% of priority provinces		is collected regularly (quarterly) through multiple platforms and	is collected regularly (monthly and quarterly) through multiple	program data on time 2. Number of sites/ SNUs review	
Teasar Cr							government routinely analyze	performance and inform the			Collect program monitoring data at all levels to meet	1	l ľ	and returnly program gaps	provinces		accessible in CDC direct	platforms and accessible in CDC	data monthly and develop COI	
							service delivery data to	HIV public health response.				1					supported provinces. Data now is	direct supported and other	plan	
	1						measure program	1 1	1	1	2. Conduct data abstraction and reporting for monitoring	1					collected and prepare for data	prioritized for PHCR provinces.	3. Number of DQA visits from	
							performance (i.e., continuum				service quality and retention	1					use in 127 sites (HTS, TX and	Those MER data will be collected	VAAC to provinces	
1 1	1						of care cascade, coverage, retention AIDS-related	1		1	Conduct data review by site and SNU for program planning and intervention/remediation activities.	1					PrEP) in 6 CDC supported	monthly and quarterly in 150 sites in 3 DSD and 3 TA provinces		
							retention, AIDS-related mortality rates)?				planning and intervention/remediation activities. 5. Support and ensure program data quality nationally	1					provinces	Program data in at least 3 PHCR		
							more carriery rates y				through updating national DQA guideline, training of	1						provinces will be collected and		
											trainers and providing TA for DQA in selected high HIV	1						prepared for data use at both		
											burden provinces to meet requirement of data utilization	1						site and provincial level		
											for epidemic monitoring under National Responsive TA	1								
											framework	1								
											6. Monitor, strengthen and ensure program quality	1								
											through CQI TA to 7 CDC-supported provinces for provincial	L								
\$ 180,000 ASP: Pol	ation & Not dis	Targeted Pop:	Domestic resource mobilization	11. Domestic Resource	8.21	7.70	N/A	GVN ensures no financial Lack of Financial Resource harriers for PLHIV to	es Legal, policy or regulatory		TA to 7 CDC-supported provinces for provincial	CO919	COP25	Provincial financial sustainability plans do not currently fill in gaps	% uptake of VL testing through	Partial	Support VAAC and CDC Support of provinces to	All CDC-supported provinces submit provincial HIV	% of PLHIV on ART are covered by SHI and being reimbursed for	
	ment of	unaggregated	modification	MODIFEADOR				accessing treatment under	constraint		sustainability plans, treatment continuity, and civil society engagement in delivery of person-centered services:		1 1	in SHI co-payments and	Sri .		strengthen the private-public	sustainable plans, with plans to	services	
disease	control							SHI.			1) On-going support to social contracting in 2-3	1	1 [coverage. Social contracting is	Identified mechanisms/pathways		collaboration, promoting quality	cover SHI ARV co-payment gaps	% domestic contribution to	
program	ns-NSD										CDC/PEPFAR provinces 2) Provincial sustainability planning support-for financing	1		still under pilot phase.	for social contracting in CDC		of HIV services and national		spending on HIV program and	
											2) Provincial sustainability planning support- for financing	1			provinces		reporting in the private sector	Social contracting pilot	commodities	
											pathways to cover/address gaps for social contracting, VL	1					2. Promote the use of HIV self-	completed in two provinces	% and amount of \$\$ invested in	
											and ARV co-payments, and other financing needs	1					test among key populations,		social contracting	
											3) Align KP-competent HCW accreditation for compensation policies for provision of HIV-related services	1					especially those who never tested for HIV:			
											compensation policies for provision of HIV-related services	•					tested for HIV: 3. Marketing for self-test through			
												1					multiple channels including but			
												1					not limited to websites, dating			
												1					apps, Fanpages and other social			
												1					media			
												1					4. Expand partnership with			
	1						1	1		1	1	1					pharmaceutical system to	1	1	
	1						I	1	1	1		1					distribute self-test along with	1	1	
	1						I	1	1	1		1					linkage to other services	1	1	
	1						1	1		1	1	1					5. Maintain person-centered PrEI services to promote PrEP	1	1	
	1						I	1	1	1		1					initiation and continuation, with	1	1	
	1						I	1	1	1		1						1	1	
	1						I	1	1	1		1					burden CDC provinces.	1	1	
	1						I	1	1	1		1					burden CDC provinces. a. Develop PrEP sites to become	1	1	
	1						I	1	1	1		1					oss	1	1	
\$ 220,400 ASP: Pol	licy, planning. Key Pro	Pops: Not	Oversight, technical	6. Service Delivery	7.20	6.85	6.9 Sub-national Service	Provincial technical capacity Lack of technical capacity	Lack of sufficient HRH	1	1) On-going national oversight, coordination, tracking, and	COP19	COP24	Expansion of PTT technical	At least 12 PTTs in PEPFAR and	Partial	Multiple high-needs provinces	All clinics (in high-needs	% of Provincial TA teams that are Yes	
coordina	ation & disaggr	gregated	assistance, and	, , , , , , , , , , , , , , , , , , ,			Delivery Capacity: Do sub-	is standardized and		1	TA to high-needs PTTs to ensure HIV program quality and	1	[[capacity and institutional	high-needs provinces are		still in COVID and ARV supply	All clinics (in high-needs provinces and non-PEPFAR	conducting TA to sites for	
manage	ment of		supervision to				national health authorities	mandated to implement a	1	1	robust implementation of KP-competent innovations,	1	1 .	oversight into new high-needs	providing TA and support to		recovery' leading to gaps in HIV	supported sites) provide quality	program quality and/or PHCR	
disease	control		subnational levels				(i.e., district, provincial) have	robust provincial public		1	models and services.	1	1 6	provinces to support broader	program quality responses		program treatment and negative	of services and follow national	% of PTT members who are	
program	ns-NSD						the capacity to effectively	health response.		1	2) Responsive TA through Provincial Technical Teams	1	1 6	National Program and			impact on VN treatment cohort	guidelines including SDA, MMD.	capacitated to deliver TA for	
1 1	1						plan and manage HIV services	1	1	1	(PTTs); strengthening and deployment with focus on high-	1	1 -	sustainable epidemic control is			I	retention, and VLS	PHCR	
	1						sufficiently to achieve	1	1	1	burden provinces to ensure HIV program services meet	1	1 1	needed.			2. VAAC developed an algorithm	50% new patients start SDA	# of clinics receiving support	
	1						sustamable epidemic control?	1	1	1	GVN quality and technical standards.	1					using key program data to	95% patients retained on	# and % increase in clients who access DDM, SDA, tx continuity	
	1							1	1	1	 Focused technical assistance to maintain treatment quality in high-need provinces, utilizing existing systems- 	1					identify sites and provinces with needs and/or gaps	treatment RNS nations set a VI test and	access own, suA, tx continuity	
	1							1		1	quality in high-need provinces, utilizing existing systems- CS, PTTs- and promoting data alignment (e.g. Can Tho,	1					reeds and/or gaps	80% patients get a VL test and 95% of them having VL	1	
	1							1		1	CS, PTTs- and promoting data arignment (e.g. Can Tho, Kien Giang and Soc Trang. CDC/PEPFAR provinces)	1					3. TA events are documented and	suppression	1	
	1							1	1	1		1					 TA events are documented and monitored for on-going follow-up 	Patient level data system set up	1	
	1							1		1	1	1						for patient monitoring and	1	
																		reporting		
\$ 130,000 ASP: HM	tiS, Non-Ta	-Targeted Pop:	Surveillance	14. Epidemiological and Health Data	8.06	5.74	14.3 Who Leads Key	Expected outcome: Lack of sufficient HRH	Lack of Financial Resources	Lack of technical capacity	1. In the Northern region, provide technical assistance for	COP18	Post o	Case surveillance will be	Technical assistance provided	Partial	1. CS is primally established in	Advanced case reporting is	Number of provinces are able Yes	
	ance, & Not dis h-NSD	disaggregated		and Health Data			Population Surveys & Surveillance: To what extent	Strengthen the technical	1	1	the implementation of an advanced case reporting system	1	COP25	maintained in previous provinces	to implement new HSS+		Hai Phong, Thai Nguyen and part	estatrished in northern	to submit data to case reporting	
research	n-maD						Surveillance: To what extent does the host country	capacity for local staff to improve the quality of		1	for surveillance activities to monitor the epidemic. 2. Provide on-going technical assistance to Northern	1	1 1	and scale up in other prioritized provinces. Size estimation	sampling methodologies to measure disease burden and risk		of Hanoi 2. Size estimation of MSM	provinces. 2. CS is well function in NEZ	system 2. Number of TA visits to CS	
	1								1	1		1	1 1	provinces. Size estimation everyises will be even-infert to	measure disease burden and risk hehaviors in northern HSSs		A. ALM ESCITIATION OF MISM	A. C. I IN WHIT FUNCTION IN NEZ	A. PERMINER OF LA VISITS TO CS	
							envernment lead & manage	national curveillance system			nmvincial CS scaleum						nonulation available in Hanni			
											provincial CS scale-up 3. Implement a size estimation exercise amone MSM and		1 1		provinces (Ha Noi, Hai Phone)		population available in Hanoi, Thai Nauven and Hai Phone	PEPFAR provinces and surge northern provinces (Hangi, Hai	provinces 3. Number of provinces	
							planning and implementation of the HIV/AIDS portfolio of	national surveillance system to inform program planning and monitor epidemic			Implement a size estimation exercise among MSM and other KP googlations in other Northern high priority			other burden provinces. Sentinel surveillance will apply innovative	provinces (Ha Noi, Hai Phong). 2. High-quality KP size estimates		population available in Hanoi, Thai Nguyen and Hai Phong	northern provinces (Hanoi, Hai Phone, Thai Neuven)	provinces 3. Number of provinces completed KP PSE	
							planning and implementation of the HIV/AIDS portfolio of key population	to inform program planning			3. Implement a size estimation exercise among MSM and			other burden provinces. Sentinel surveillance will apply innovative	provinces (Ha Noi, Hai Phong). 2. High-quality KP size estimates		population available in Hanoi, Thai Nguyen and Hai Phong	northern provinces (Hanoi, Hai Phong, Thai Nguyen) 3. High-quality KP size estimates	completed KP PSE 4. Number of provinces	
							planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys	to inform program planning			 Implement a size estimation exercise among MSM and other KP populations in other Northern high priority provinces to inform provincial estimation and program planning. 			other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach	provinces (Ha Noi, Hai Phong). 2. High-quality KP size estimates in two provinces 3. Key indicators for epidemic		population available in Hanci, Thai Nguyen and Hai Phong	northern provinces (Hanoi, Hai Phong, Thai Nguyen) 3. High-quality KP size estimates are completed in another	completed KP PSE 4. Number of provinces completed HSS+.	
							planning and implementation of the HIV/AIDS portfolio of key population opidemiological surveys and/or behavioral	to inform program planning			Implement a size estimation exercise among MSM and other KP populations in other Northern high priority provinces to inform provincial estimation and program planning. A provide on prior technical assistance of HSSs fronting.			other burden provinces. Sentinel surveillance will apply innovative	provinces (Ha Noi, Hai Phong). 2. High-quality KP size estimates in two provinces 3. Key indicators for epidemic monitoring identified		population available in Hanci, Thai Nguyen and Hai Phong	northern provinces (Hanoi, Hai Phong, Thai Nguyen) 3. High-quality KP size estimates are completed in another selected northern province	completed KP PSE 4. Number of provinces completed HSS+. 5. Number of orovinces with CS	
							planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys	to inform program planning			Implement a size estimation exercise among MSM and other MP populations in other Northern high priority provinces to inform provincial estimation and program planning. Provide on-going technical assistance of HSS+ (routine and new method including web-based survey and mail		3	other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach	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 NEZ PEPFAR		population available in Hanoi, Thai Nguyen and Hai Phong	northern provinces (Hanoi, Hai Phong, Thai Nguyen) 3. High-quality KP size estimates are completed in another selected northern province 4. New HSS+ sampling	completed XP PSE A. Number of provinces completed HSS+. S. Number of provinces with CS implemented are able to	
							planning and implementation of the HIV/AIDS portfolio of key population opidemiological surveys and/or behavioral	to inform program planning			 Implement a size estimation exercise among MSM and other KP opoulations in other Northern high princity provinces to inform provincial estimation and program planning. A Provide on-going technical assistance of HSS+ (routine and new method including web-based survey and mail testing in Northern provinces. 		5	other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach	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 NEZ PEPFAR provinces and surse northern		population available in Hanei, Thai Nguyen and Hai Phong	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	completed KP PSE 4. Number of provinces completed HSS+. 5. Number of provinces with CS implemented are able to monitor senting levents for track	
							planning and implementation of the HIV/AIDS portfolio of key population opidemiological surveys and/or behavioral	to inform program planning			I. Implament a size estimation exercise among MSM and other XP opolations in other hornburn high priority provinces to inform provincial estimation and program planning. 4. Provide on-going technical assistance of PSS+ (routine and new method including web-based survey and mail testing) in Northern provinces 5. Ongoing support & triengthening of monitoring and		5	other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach	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 NEZ PEPFAR provinces and surge northern provinces (part of Ha Noi, Hai		population available in Hanoi, Thai Nguyen and Hai Phong	northern provinces (Hanol, 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	completed KP PSE 4. Number of provinces completed HSS+. 5. Number of provinces with CS implemented are able to monitor senting levents for track	
							planning and implementation of the HIV/AIDS portfolio of key population opidemiological surveys and/or behavioral	to inform program planning			 Implement a size estimation exercise among MSM and other 87 populations in other Northern high princity provinces to inflore productial estimation and program planning. Provide on-going technical assistance of 1655+ (routine and new method including web-based survey and mail testing) in Northern provinces Ongoing support & strengthening of emonitoring and surveillance systems (Benchmarks, key indicators, 509+ 		5	other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach	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 NEZ PEPFAR provinces and surse northern		population available in Hanoi, Thai Nguyen and Hai Phong	northern provinces (Hanol, Hai Phons, Thai Nguyen) S. High-quality KP size estimates are completed in another selected northern province 4. New HSS+ sampling methodologies is implemented in selected provinces S. Key indicators for epidemic	completed NP PSE A. Number of provinces completed HSS+. S. Number of provinces with CS implemented are able to monitor sentinal events to track PLHW from diagnose to death. S. Number of staff trained in HW	
							planning and implementation of the HIV/AIDS portfolio of key population opidemiological surveys and/or behavioral	to inform program planning			I. Implament a size estimation exercise among MSM and other XP opolations in other hornburn high priority provinces to inform provincial estimation and program planning. 4. Provide on-going technical assistance of PSS+ (routine and new method including web-based survey and mail testing) in Northern provinces 5. Ongoing support & triengthening of monitoring and		3	other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach	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 NEZ PEPFAR provinces and surge northern provinces (part of Ha Noi, Hai		population available in Hanoi, Thai Nguyen and Hai Phong	northern provinces (Hanol, Hai Phong, Thai Nguyen) 3. High-quality KP size estimates are completed in another salected northern province 4. New HSS+ sampling methodologies is implemented in selected provinces 5. Key indicators for epidemic monitorina are visualized and	completed KP PSE 4. Number of provinces completed HSS+. 5. Number of provinces with CS implemented are able to monitor senting levents for track	
							planning and implementation of the HIV/AIDS portfolio of key population opidemiological surveys and/or behavioral	to inform program planning			Is Implement a size estimation exercise among MSM and horse 79 populations in other Northern high printing provinces to inform provincial administors and program from the control of the		5	other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach	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 NEZ PEPFAR provinces and surge northern provinces (part of Ha Noi, Hai		population available in Hanoi, Thai Nguyen and Hai Phong	northern provinces (Hanol, Hai Phons, Thai Nguyen) S. High-quality KP size estimates are completed in another selected northern province 4. New HSS+ sampling methodologies is implemented in selected provinces S. Key indicators for epidemic	completed NP PSE A. Number of provinces completed HSS+. S. Number of provinces with CS implemented are able to monitor sentinal events to track PLHW from diagnose to death. S. Number of staff trained in HW	
							planning and implementation of the HIV/AIDS portfolio of key population opidemiological surveys and/or behavioral	to inform program planning			Integration and sectionation services among MSM and best PS populations in other Northern high priority provinces to Inform provincial estimation and program princing. In the provincial estimates of PSS (province princing). In the provincial estimates of PSS (province princing). In the provincial estimates of PSS (province princing). In the provincial estimates of PSS (province provincial estimates). In the provincial estimates of PSS (provincial estimates). In the provincial		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	other burden provinces. Sentinel surveillance will apply innovative method include web-based survey and mail testings to reach	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 NEZ PEPFAR provinces and surge northern provinces (part of Ha Noi, Hai		population available in Hanoi, Thai Nguyen and Hai Phong	northern provinces (Hanol, Hai Phong, Thai Nguyen) 3. High-quality KP size estimates are completed in another salected northern province 4. New HSS+ sampling methodologies is implemented in selected provinces 5. Key indicators for epidemic monitorina are visualized and	completed NP PSE A. Number of provinces completed HSS+. S. Number of provinces with CS implemented are able to monitor sentinal events to track PLHW from diagnose to death. S. Number of staff trained in HW	
\$ 195,000 ASP:HM	415, Non-Ta	-Targeted Pop:	Surveillance	14. Epidemiological	8.06	5.74	planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (to inform program planning and monitor epidemic and	es Lack of technical capacity	Lack of sufficient HRH	I Implement also estimation extracts among MSM and where Propulations on the Northern high principal propries to inform pronocial estimation and program planning. A Provide or pering studentical assistance of 1955 prostner planning. A Provide or pering studentical assistance of 1955 prostner assistance of 1	COP18	Post	other burden provinces. Sentinel unveilTance will apply innovative method include web-based unvey and mail testings to reach hidden KP.	provinces (Ha Not, Hail Phong). 2. High-quality Poize estimates in two provinces 3. Key indicators for egidemic monitoring identified 4. CSS scale-up in NEZ PEPPAR. provinces and surges northern provinces part of Ha Noi, Hail Phong, Thail Nguyen) 1. Technical assistance provided	Parti M	Thai Nguyen and Hai Phong Thai Nguyen thai Phong	northern provinces (Hanol, Hai Phong, Thai Hypyren) 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 sisualized and used in northern provinces 1. Advanced case reporting is	completed OP SE 1. Munified of provinces 5. Munified of provinces with CS 5. Munified of provinces with CS 6. Munified of provinces with CS 6. Munified to provinces with CS 6. Munified to provinces with CS 6. Munified of provinces with CS 6. Munified of provinces are ability 6. Munified of provinces are ability free 6. Munified of provinces are ability free	
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surveilla	tiS, Non-Ta ance, & Not dis	-Targeted Pop: disaggregated	Surveillance	24. Epidemiological and Health Data	8.06	5.74	planning and implementation of the HV/MDS portfolio of key population equidemiological aurweys and/or behavioral surveillance activities (14.3 Who Leads Key Population Surveys & Surveillance: both extent	to inform program planning and monitor epidemic and the second program and t	es Lack of technical capacity	Lack of sufficient HRH	Inspirents also estimation services among MSM price and their Populations in other Northern high price of properties in other provincial estimation and program provinces in oldern provincial estimation and program and new method including with based downey and mall method in program price and some provincial and and price and provincial and provincial provincial and provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial S. Provided straining on contraval hyrocognization for provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial provincial	COP18	Post COP25	other burden provinces, Sentials wavelindered lago yli mozative wavelindered will goly innovative method in dude web-based unavey and mail testings to reach hidden KP. Case surveillance will be maintained in previous provinces and scale up in order provinces and scale up in order provinces.	provinces (Ha Not, Ha illhough, 2. High-quality (Pole estimates) in two provinces 3. Key indicators for epidemic monitoring identified 4. CS Scale-up in 1872 Fe/PAR provinces and surga northern provinces (part of Ha Not, Hai Phong, Thai Nguyen) 1. Technical assistance provided to implement new WSS+ sampling methodologists to	Parti M	Thai Nguyen and Hai Phong L Implement new HSS+ sampling methodologies in selected southern province.	northern provinces (Hano), Hai Phong, Thai Nguyality MP tale estimates are completed in accompleted in sear completed in sear sear completed in sear completed in sear self-cetal provinces. A New HSS's sampling mathodologies is implemented in selected provinces. S. Key indications for epidemic comitoring are visualized and used in northern provinces.	completed OP ISE 4. Humber of provinces completed ISS. completed	
surveilla	ance, & Not dis	-Targeted Pop: disaggregated	Surveillance	14. Epidemiological and Health Data	8.06	5.74	planning and implementation of the HHV/MDS pertofile of the HHV/MDS pertofile of twp population epidemiological surveys and /or behavioral surveillance activities (M.3. Who Leads Key, Population Surveys & Surveillance: To what extent does the host codes the host codes the host codes of the MDS pertofile of the MDS pertof	to inform program planning and monitor epidemic Expected autonome: Coneglish to be schiolaid Expected autonome: Coneglish to be schiolaid	es Lack of technical capacity	Lack of sufficient H8H	I implement a size estimation services among MSM and privately obtained proposation in other Northern high privately appointed in officers provincial estimation of any program of the other provincial estimation and program of the other provincial estimation and program of the other provincial estimation and provincial estimation of the St. Provincial estimation and research and the other provincial estimation of the St. Provincial estimation and research and the other provincial estimation and research and the st. Provincial estimation and the	COP18	Post COP25	other burden provinces. Sentinal warvillance will apply innovative to unwillance will apply innovative menthod include web-based warview and mail testings to reach hidden KP. Can surveillance will be emailtained in previous previnces and scale up in other prioritisal convinces. Size up in other prioritisal.	provinces (Ha No, Has IProng), 2-tilliquality Object editarlass in two provinces. 3. key indicators for epidemic monitoring identified. 4. KS Scale- on Int AZE PEPAR provinces and surge northern provinces (part of Ha No, Hall Phong, Thai Nguyen). 1. Technical assistance provided to implement new IPSS sampling methodologies to mesture of severe new IPSS sampling methodologies to mesure disasse before nor in IPSS sampling methodologies to mesure disasse before new IPSS sampling methodologies to mesure disasse before the mesure disasse development of the IPSS sampling methodologies to mesure disasse before new IPSS sampling methodologies to mesure disasse before the methodologies to mesure disasse development	Partial	Thai Nguyen and Hai Phong 1. Implament onew HSSs sampling methodologies in selected one-water products of MSSA.	northern provinces (Hano), Hai Phong, Thai Ngayality NP case estimates are completed in another sale completed in another sale completed in another sale case of the complete sale sale case of the case of the case is a sale case of the case of the sale case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of t	completed OP SE 1. Munified of provinces 5. Munified of provinces with CS 5. Munified of provinces with CS 6. Munified of provinces with CS 6. Munified to provinces with CS 6. Munified to provinces with CS 6. Munified of provinces with CS 6. Munified of provinces are ability 6. Munified of provinces are ability free 6. Munified of provinces are ability free	
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\$ 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	HIV case- surveillance system components are linked and operational	Eack of Financial Resources	Lack of technical capacity	Lack of sufficient HRH	 Lead expansion of the national case surveillance syste by coordinating with all partners on development of the framework, e.g. standardizing minimum requirement. 	n COP18	Post COP25	Case surveillance will be maintained in previous provinces and scaled up in other prioritized	 CBS expanded to 11 PEPFAR and 4+ surge provinces (Can Tho, Soc Trans. An Gians. Kien Gians). 	Partial	 CS expanded to 6 CDC/PEPFAI provinces and 2+ surge province (Soc Trans and Can Tho). 	R 1. CS maintain in 6 CDC/PEPFAR is and expand 4+ surge provinces (Soc Trang, Can Tho and other	Case report system data analysed and used for development of the case-based	res	
			l				host country government conduct IBBS and/or size					endorsing adapted SOPs, etc. Complete all policy		1	provinces. Size estimation exercises will be expanded to	Soc Trang, An Giang, Kien Giang). 2. National CBS platform developed with minimum		(Soc Trang and Can Tho). 2. National CBS platform developed with minimum	two selected provinces). 2. National CS platform	surveillance system. Existing data		
							estimation studies for key and priority populations? (Note:					requirements to prepare for national roll-out. 2. Lead the expansion of sustainable HIV epidemic monitoring			other burden provinces and national size estimation will be	standards in place. 3. Complete SOP/policy for		developed with minimum standards in place. 3. Complete SOP/policy for	developed and preliminarily established.	platforms reviewed. Case surveillance system components established. KP sizes are		
												3. Institutionalize monitoring and surveillance systems			extra populated. Sentinel	epidemic monitoring. 4. Update provincial KP size		epidemic monitoring.	3. Use SOP/policy for epidemic	estimated. Advanced case reporting system is established		
							run score possione without selecting all disaggregates.) Please note most recent survey dates in comments					quickly identify public health issues for response 3. Update national KP size estimations utilizing			method include web-based survey and mail testings to reach hidden KP.	estimates		number of selected provinces is used for PLHIV estimation and	monitoring. 4. Update KP size estimates at national level	nationally.		
							section.					with global subject matter experts			hidden KP.			projection.	national level 5. National advanced case reporting system is established			
												Lead in design and development of a robust national HIV health information system to support epidemic							and well function.			
												monitoring and program management and improvement 5. Lead the implementation of advanced case reporting system nationally to support case verification process an	-									
													1									
\$ 187,200	ASP: Policy, planning, coordination &	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and	6. Service Delivery	7.20	6.85	6.9 Sub-national Service Delivery Capacity: Do sub-	Innovations in case finding, HIV prevention, especially	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	COP20	Post COP25	Pivot to a public health cluster response (PHCR) for sustainable	PMR successfully implemented in up to 3 provinces	Partial	PMCR successfully implemented in up to 3 provinces	National SOPs piloted, revised, finalized and disseminated	% increase in PrEP uptake % increase in ART linkage	res	
	management of disease control programs-NSD		supervision to subnational levels				national health authorities (i.e., district, provincial) have the capacity to effectively	PrEP, and linkage to care are institutionalized under a national public health				implementation, monitoring and documentation in PEPFAR and other high-need provinces under the directi of the VAAC/National HIV program:	in.		epidemic control requires on- going support to monitor and track alerts and respond at	Monitoring of key data in provinces with highest new infections in 2020 and latest data		Monitoring of key data in provinces with highest new infections in 2021-22 and latest	Routine TWG monitoring for	% increase in # of tests for target population		
	programs-NSD						plan and manage HIV services	national public health response.				 Ensure provincial capacity to monitor and implement 			national level and throughout	infections in 2020 and latest data		Infections in 2021-22 and latest data	alerts and conducting initial investigations	% decrease in recent infections		
							sufficiently to achieve sustainable epidemic control?					PHCR through training, guidance, and other technical assistance by national level 2) Coordination of national TWG to review alerts for			the 63 provinces				PHCRs successfully implemented			
												potential investigations and response; promote data use							in 2-3 provinces in Vietnam			
												and linkage across multiple platforms 3) Implementation of time-bound provincial/local responses based on an established core package and										
												responses based on an established core package and leveraging PTTs, rapid response teams, community exper and other provincial stakeholders and experts. Direct clo	ts									
												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										
												and the second s										
\$ 70,000	ASP: Laboratory systems strengthening-	Non-Targeted Pop: Not disaggregated	tab quality improvement and	10. Laboratory	7.79	7.61	10.4 Capacity of Laboratory Workforce: Does the host	Expanded Network of HIV VI. testing that able to	Lack of technical capacity	Lack of managerial capacity		 Provide technical assistance to implement continuous quality improvement for laboratories providing HIV testi 	COP20	COP25	This is an on-going activity to ensure high quality of all HIV-	At least 7 viral load labs links LIMS to existing hospital HIS	Yes	The national LQMS guidance ha been approved by MOH and	s - Legal framework to harmonize EQA providers	# of HIV testing labs maintaining 3 star level of LQMS	res	
	NSD		assurance				country have an adequate number of qualified	reimbursed through SHI to support better treatment				services 2. Update the national guidance/ requirements for	.1	1	related testing services	platforms to improve TAT and reduce reporting error of results		expand for national scale up	SHI to at least 2 labs	and able to reimburse through SHI mechanism		
			1				laboratory personnel (human resources [HR]) in the public	services for HIV patients			1	laboratory quality improvement, Decision 2429/ QD - BY 3. Expand the network of HIV VL labs able to be	1	1					clinical labs is endorsed and	2.# of HIV VL labs reimbursed through SHI		
			l				sector, to sustain key functions to meet the needs of PLHIV for diagnosis,					reimbursed through SHI (focus on central highlands)		1					implemented nationwide	through SHI 3.8 of labs receiving responsive TA from national team		
	1						monitoring treatment and							1	1				1			
\$ 143,720	ASP: HMIS,	Non-Targeted Pop:	Surveillance	14. Epidemiological	8.06	5.74	viral load suppression 14.3 Who Leads Key Population Suppress &	Surveillance and program	Lack of Financial Resources	Lack of technical capacity	Lack of sufficient HRH	Continue to provide support for the development, enhancement and implementation of point of service da	COP21	COP23	Case surveillance will be	Point of service information Systems for nonzerom monitoring	Yes	Point of service information systems for program monitoring	Point of service information systems for program monitoring	Point of service information systems functional and available	res	
	surveillance, & research-NSD	Not disaggregated		and neach Data			Population Surveys & Surveillance: To what extent does the host country	data are used routinely to measure and monitor performance and inform the				enhancement and implementation of point of service da collection to be interoperable with program monitoring and the case surveillance repository (upgrade EMIs) and testing/prevention data collection and reporting system	1	1	maintained in previous provinces and scale up in other prioritized provinces. Size estimation	systems for program monitoring and case surveillance for 15 high burden requiress developed		and case surveillance for 15 high	systems for program monitoring and case surveillance for 15 d supported provinces are	systems functional and available as per program requests 2. Key indicators among KPs such		
	1						government lead & manage	performance and inform the HIV public health response.				and the case surveillance repository (upgrade EMRs and testing/prevention data collection and reporting system in 15 high burden provinces.)	1	provinces. Size estimation exercises will be expanded to other burden provinces.	burden provinces developed 2. Timely technical assistance for national level in data analysis		burden provinces are developed 2. Guidance in data analysis and data use for epidemic monitorin	d deployed	as prevalence and incidence of		
			l				planning and implementation of the HIV/AIDS portfolio of key population					in 15 high burden provinces. 2. Continue to provide technical assistance at the nation		1	Jones parden provinces.					MV, STIs among MSM/PMD/FSW are available. 3. Size estimation of MSM in		
	1						key population epidemiological surveys and/or behavioral					 Continue to provide technical assistance at the nation level to create data collection tools, support data management and data analysis for epidemic monitoring 	1	1	1	monitoring provided 3. Knowledge sharing platform to host study and surveillance data,		understand the most appropriat	and data use for epidemic te monitoring is provided timely ng and accurately.	 Size estimation of MSM in selected provinces are available for epidemic monitoring and to 		
							surveillance activities (IBBS, size estimation studies, etc.)?					and program planning.				support data triangulation and		MSM population is identified	 Size estimation exercise 	inform program planning.		
							and elimination student, etc.)					 Implement and provide technical assistance to estima the size of the MSM population in selected surge 				sharing across programs developed for epidemic monitoring			province is available.	E-learning system establishment and operationalization progress.		
\$ 365,000	ASP: HMIS,	Non-Targeted Pop:	HMIS systems	14. Epidemiological	8.06	5.74	N/A	Provincial program and HIV	Lack of sufficient HRH	Lack of technical capacity	Lack of Financial Resources	provinces. 1. Provide support to GVN/VAAC for software	COP20	COP24	Implementation of HMED-	90% of PLHIV with presumptive	Not applicable	The HMED-ARVLogbook is in	Patient monitoring systems	Number of TA visits/ virtual	res	
	surveillance, & research-NSD	Not disaggregated		and Health Data				data are regularly collected and analyzed to track the public health response.				enhancements and implementation to ensure continuity of patient monitoring systems (HMED-ARVLogbook and OPC-Assist) and timeliness/puality of data collected for			ARVLogbook starts in FY22 with a plan to put the system in place	TB are successfully referred for TB work up			al (ARV logbook, OPC-Assist) are at maintained, enhanced as per	sessions to support the implementation of patient		
								public health response.				OPC-Assist) and timeliness/quality of data collected for program monitoring and case surveillance.			and complete user training for 52 provinces. Followed up effort is	SOP for private provider		is in use in 5 PEPFAR/CDC provinces.	requests from program, and users are supported to ensure high quality data are collected and submitted in a timely	monitoring system. 2. Number of facilities and users		
												2. Provide support for GVN/VAAC and HCDC/DOH in the			required to ensure use of the system for routine data	inclusion in CS		 Advanced case reporting system -HIV Info 4.0- is is used in 	high quality data are collected and submitted in a timely	trained to use HIVInfo 4.0 in HCMC; number of user requests		
												implementation of HIV Info 4.0 in HCMC to help create a unified national case reporting/surveillance data system			collection and reporting. OPC- Assist is in use in 5 PEPFAR/CDC	Development of an m-health platform for tracking and referral		all 63 provinces. 3. Point of service information	manner. 2 HN/Info 4 ft is denloyed user	received and number addressed 3. Number of documents		
												for all provinces in the country.			supported provinces, and maintenance continues in FY23.	of TB patients		systems for program monitoring and case surveillance for PEPFAI	training conducted for province it and district levels, MV case data in in HCMC are migrated into the	developed and training courses conducted regarding data		
												 Provide support to GVN/VAAC in establishing/adoptin and implementing standard protocols, policies and procedures for data management and use to ensure data 						and high-burden provinces are i place for data collection.				
												procedures for data management and use to ensure data privacy, security and confidentiality.						Technical assistance plan for CS and other surveillance and	using the system to submit case data.	visits, M&E trainings.		
												4. Data quality improvement and data use in the data life						M&E activities are developed	3. Data management for security and confidentiality is designed	5. Percentage completion of the e-learning system		
												cycle: Assure high-quality data collection system for program monitoring and data use enhancement at site							and deployed 4. M&E and data management			
												levels - Conduct data reviews by sites for program planning an							trainings with advanced content conducted			
												intervention/remediation activities. - Develop indicators to measure the background of data							5. The e-learning system is developed, piloted and integrated into the HIV Info 4.0			
												Organize provincial M&E and data management training to follow up previous trainings as well as provide new.	ε						system. The system is made available for use to facilitate			
\$ 30,000	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed	Institutionalization of	7. Human Resources for Health	7.54	7.76	7.6 In-service Training: To what extent does the host	Innovations in case finding.	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory	HTS quality and sustainability:	Prior to COP	Post copps	i) staff rotation and reassignment	All participating HTS facilities and schools attain a second fully-	Partial	60-70% of HTS facilities and schools having attained two full	100% of participating HTS	% of participating facilities having attained 01-02 fully- capable HTS trainers and actually	res	
		services					country government (through	PrEP, and linkage to care are institutionalized under a			l	Training and TA for military trainers/mentors in HMZ, NE and military medical schools to become the military	1	[military, requiring refreshed	ranable HTS trainer earh who		schools having attained two full- capable HTS trainers each but provide training and TA to own	second fully-capable HTS trainer	capable HTS trainers and actually provide training/TA to own		
			l				voluntary sectors) plan and implement HIV/AIDS in-	institutionalized under a national public health response.				and military medical schools to become the military system's own pool of TA trainers/providers (fully competent of all program services and recommendation		1	training/mentoring for staff newly on the roles. ii) programs evolve year on year	will provide training to own facility staff		provide training and TA to own facility staff is still limited	and their trainers will provide training and TA to own facility staff	provide training/TA to own facility staff.		
			1				consist training processors to				1	joining national efforts including especially recency and PHCR)	1	1	nequiring continuing technical support to integrate							
			1				equip health workers for sustained epidemic control? (if exact or approximate				1		1	1	nequiring continuing technical support to integrate updates/revisions of guidelines and rolling out changes.							
	1						percentage known, please note in Comments column)							1	(III) Covid-19 impacted program progresses delaying meeting				1			
\$ 77,000	ASP: Human resources for health-NSD	Priority Pops: Military	Institutionalization of	7. Human Resources	7.54	7.76	7.6 In-service Training: To what extent does the host	Innovations in case finding,	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory	HIV/STIs prevention for new military recruits:	Prior to COP	Post	benchmarks i) staff rotation and reassignment is the common norm in the military, requiring refreshed	100% of all 50+ participating	Partial	60 - 70% of participating military	y 100% of participating military	% of participating regiments and	res	
	for health-NSD	a other uniformed services	en-service training	nor Health			country government (through	Innovations in case finding, HIV prevention, especially PrEP, and linkage to care are			constraint	TA support for updating the national training material;	28	COP25	as the common norm in the military, requiring refreshed	schools attain 01-03 fully capable		regiments and military schools attain 01-03 fully capable traine	y 100% of participating military regiments and military schools attain 03 fully capable trainers	mintary schools having attained 01-03 fully-capable trainers who		
	1						public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-	institutionalized under a national public health				provide refresh training for military trainers in HM2, NE2 and beyond in line with all national guidelines/ recommendations and with emphases in especially		1	newly on the roles.	trainers each who will provide training for the military peer		each and these trainers have been providing training and TA a own facilities	each who will provide training at and TA for the program at own	actually provide training/TA to own staff/platoons		
			l				implement HIV/AIDS in- service training necessary to equip health workers for	response.				recommendations and with emphases in especially recency and PHCR.		1	ii) programs evolve year on year requiring continuing technical support to integrate	education program at own facilities		own racilities	racintiés			
			l				equip health workers for sustained epidemic control? (if exact or approximate							1								
	1						(if exact or approximate percentage known, please note in Comments column)							1	and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting				1			
\$ 20,400	ASP: HMIS,	Priority Pops: Military	Program and data	16. Performance Data	8.73	8.73	16.5 Analysis of Service	Surveillance and program	Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory	Quality data collection, analysis and use for PHCR:	Prior to COP	Post	benchmarks i) staff rotation and reassignment	1) 100% of in-charge staff are	Partial	i) 75% of in-charge staff are	i) 95% of in-charge staff are	i) # of military staff received	ries	
	surveillance, & research-NSD	& other uniformed services	quality management				Delivery Data: To what extent does the host country	data are used routinely to measure and monitor			constraint	Training and TA for military site staff on collecting, analy	18 is	COP25	is the common norm in the military, requiring refreshed	trained on training on data collection, reporting and analysis		trained on data collection, reporting and analysis based on	trained on data collection,	training on data collection,		
							government routinely analyze service delivery data to	performance and inform the HIV public health response.				and use of program data. SIMS and MER metrics; continu	•	1	training/mentoring for staff newly on the roles.	based on national and PEPFAR MER and SIMS requirements;		national and PEPFAR MER and SIMS requirements;	national and PEPFAR MER and SIMS requirements;	reporting and analysis and use data for responsive interventions		
			l				measure program performance (i.e., continuum					advocacy for and increase military HIV program data sharing to the national/provincial platforms for PHCR.		1	ii) programs evolve year on year	2) HIV/AIDS program data from		ii) HIV/AIDS program data from	ii) HIV/AIDS program data from			
	1						of care cascade, coverage, retention, AIDS-related							1	requiring continuing technical support to integrate updates/revisions of guidelines	select military sites continue to be shared with respective		select military sites continue to be shared with respective	select military sites continue to be shared with respective			
	1						mortality rates)?							1	and rolling out changes. iii) Covid-19 impacted program	provincial data portal.		provincial data portal.	provincial data portal.			
															progresses delaying meeting benchmarks				L			
\$ 130,989		Priority Pops: Military & other uniformed services	Lab quality improvement and assurance	au. Laboratory	7.79	7.61	10.4 Capacity of Laboratory Workforce: Does the host country have an adequate	Increase access to viral load testing to maintain the third 85 and decreasing forward	name or securical capacity	NAME OF SUFFICIENT HITH	nex or managerial capacity	Laboratory services TA, quality assurance and accreditation:	Prior to COP 18	Post COP25	staff rotation and reassignment sthe common norm in the military, requiring refreshed.	1) 03 additional military sites accredited to conduct confirmatory testing 1 VI fully				# of military labs accredited/approved by MOH and fully functioning as	***	
		VILES	- Contraction				country have an adequate number of qualified laboratory personnel (human	95 and decreasing forward transmission.				Continue TA support to improve military lab system capacity includine:		1	training/mentoring for staff	confirmatory beating, 1 VL fully function within the national program with continuing TA; 80% of eligible, recommended patients to be receive tested by		fully function within the nations program with continuing TA	nonpitals to estatish rive b confirmatory besting capacity, all with at least 03 additional military sites to be authorized; 1 VL lab fully function within the national program with	and fully functioning as confirmatory/VL testing/recency testing sites		
	1						laboratory personnel (human resources (HR)) in the public sector, to sustain key					capacity including: () HTV confirmatory, VL and recency testing; (i) proficiency testing mentoring and institutionalization		1	ii) programs evolve year on year requiring continuing technical	of eligible, recommended patients to be recent vacual by		referral for recency testing by	VL lab fully function within the national program with	testing sites ii) % of ISO (or national		
			l				functions to meet the nearly					across network;		1	support to integrate			taking place; advocacy continue	national program with ed continuing TA; 80% of eligible, recommended nations to be	equivalence) requirements met		
			1				of PLHIV for diagnosis, monitoring treatment and viral load suppression				1	content in pre-service/CME training curriculum of militar medical schools	,	1	and rolling out changes	military/national programs; first military site to conduct recency testing		recency testing;	referred for recency testing by	site assessment at end of a COP		
			l									content in pre-service/CME training curriculum of militar medical schools; iv) build military pool of proficiency testing traines/mentors for system's own self training/mentorir		1	progresses delaying meeting benchmarks	testing; 2) Lab quality management practices continue to be maintained in all ISO-accredited		practices continue to be maintained in all ISO accretinate	d continuing 1% also, or engote, recommended patients to be referred for recency testing by civilian labs to inform military/national PHCR; first military site to roll out recency testing;	accredited;		
			1								1	, , , , , , , , , , , , , , , , , , , ,	1	1		maintained in all ISO accredited labs: other priority labs in HM7		labs; other priority labs in HMZ and NEZ need to continue to	testing:	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 training from the service of the service of the training from the service of the servi		
			1								1			1		labs; other priority labs in HMZ and NEZ continue to improve scoring to 90% of checklist ISO (or		Improve scoring; Scoring of all labs against ISO or national	practices continue to be maintained in all ISO-accredited	system; Number of quality management training modules		
			1								1			1		the national equivalence); 3) National lab quality		quality checklist not yet done as planned for COP21.	labs; other priority labs in HMZ and NEZ to improve scoring by	included in pre-service training program at military medical		
			1								1			1		management checklist		iii) National lab quality management checklist	10% against previous year result per ISO checklist (or the national	s schools; iv) number of military members		Pa
	1													1	1	labs meet around 80% of checklist requirements; Training		management checklist embedded in military system bu scoring against the national quality checklist not yet done;	st equivalence); iii) National lab quality	fully competent as trainers/mentors;		г
		1	1					1			1	I .	1	1	1	of the approved quality		quality checklist not yet done:	management charklist	1	I	

\$ 25,000	ASP: Human resources	Priority Pops: Military	Institutionalization of	7. Human Resources	7.54	7.76	7.6 In-service Training: To	All PLHIV access client- Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory	Treatment services quality and sustainability:	Prior to COP	Post	i) staff rotation and reassignmen	t 1) 100% in-charge military staff	Partial	i) 80% in-charge military staff	i) 100% in-charge military staff	i) # of military medical staff that Yes	
	for health-NSD	& other uniformed	in-service training	for Health			what extent does the host country government (through	centered differentiated care for viral suppression.		constraint	Training and TA for military hospitals/OPCs and medical	18	COP25	is the common norm in the military, requiring refreshed	received refreshed training or mentoring on HIV/AIDS CTV		received refreshed training or mentoring on quality HIV/AIDS	received refreshed training or mentoring on quality HIV/AIDS	receive refreshed training/mentoring on quality	
		services					public, private, and/or	for viral suppression.			Training and TA for military hospitals/OPCs and medical schools, including implementation of all treatment MPRs			training/mentoring for staff	mentoring on HIV/AIDS CTX 2) 100% military OPCs follow the		mentoring on quality HIV/AIDS CTx and related MPRs	mentoring on quality HIV/AIDS CTx and related MPRs	training/mentoring on quanty HIV/AIDS treatment and related	
											and national guidelines: joining national efforts on receno				2) 100% military OPCs follow the updated national guidance on		ii) 100% military OPCs follow the	ii) 100% military OPCs follow the	HIV/AIDS treatment and related	
1	1	1	1				voluntary sectors) plan and implement HIV/AIDS in-	1	1	1	and national guidelines; joining national efforts on recency and PHCR; scaling up SHI reimbursements for military OPC:		1	newly on the roles. ii) programs evolve year on year	updated national guidance on HIV/AIDS treatment and scale up		updated national guidance on	updated national guidance on	ii) % of OPC sites following	
							service training necessary to				patients and linkages with civilian services/CBOs.			requiring continuing technical	Test and Start/TLD regimen/VL		HIV/AIDS treatment, TPT, and	HIV/AIDS treatment, TPT, and	national guidance on HIV/AIDS	
							equip health workers for				patients and images with deman services/caos.			support to integrate	tests for HIV patients		scale up MMD/TLD regimen/VL	scale up MMD/TLD regimen/VL	treatment	
							sustained epidemic control?							updates/revisions of guidelines	tests to the patients		tests for HIV patients.	tests for HIV patients.	a continuent	
							(if exact or approximate							and rolling out changes.						
							percentage known, please							iii) Covid-19 impacted program						
							note in Comments column)							progresses delaying meeting						
														benchmarks						
\$ 54,500	ASP: Human resources	Priority Pops: Military	Institutionalization of	7. Human Resources	7.54	7.76	7.6 In-service Training: To	To contribute to military Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory	Infection Prevention and Control (IPC) Strengthening:	Prior to COP	Post	i) staff rotation and reassignmen	t 90% of lead nursing staff working	Partial	75% of lead IPC staff working in	i) 85% of lead IPC staff working in	i) # of lead IPC staff working in Yes	
	for health-NSD	& other uniformed	in-service training	for Health			what extent does the host	medical system's capacity on		constraint		18	COP25	is the common norm in the	in HIV/AIDS at military and				HIV/AIDS at military and selected	
		services					country government (through				Training and TA on IPC and patient safety teaching and			military, requiring refreshed	selected civilian facilities and		civilian facilities and military	civilian facilities and military	civilian facilities and military	
							public, private, and/or	control (IPC) for quality			mentoring capacity for IPC lead staff and practitioners in			training/mentoring for staff	military medical schools receive		medical schools receive training	medical schools receive training	medical schools that receive	
							voluntary sectors) plan and	HIV/AIDS care and			HMZ and NEZ and military medical schools.			newly on the roles.	training and TA on infection		and TA on infection IPC (includin	and TA on infection IPC	training and TA on on IPC and	
							implement HIV/AIDS in-	treatment and other care services including						ii) programs evolve year on year	prevention and control (including TB/HIV), biosafety and		TB/HIV/COVID-19) and patient	(including TB/HIV/COVID-19) and	patient safety	
							service training necessary to equip health workers for	Services including TB/HIV/COVID-19)						requiring continuing technical support to integrate	(including TB/HIV), biosalety and waste management, patient		safety and are competent of providing peer-teaching back at	patient safety and are		
							systained enidemic control?	IB/HIV/COVID-19)						undates/revisions of quidelines	cafety and S&D: and are		their facilities	teaching back at their facilities.		
							(if exact or approximate							and rolling out changes.	competent of providing peer-		Dies lacilities.	ii) service linkages with civilian		
							percentage known, please							iii) Covid-19 impacted program	teaching back at their facilities.			system improved.		
							note in Comments column)							progresses delaying meeting	teaching back at their racinoes.			system improved.		
														benchmarks						
\$ 65.175	ASP: Human resources	Priority Pops: Military	Institutionalization of	7. Human Resources	7.54	7.76	7.6 In-service Training: To	All PLHIV access client- Lack of technical capacity	Lack of sufficient HRH	Legal, policy or regulatory	Patient care quality and sustainability:	Prior to COP	Post	i) staff rotation and reassignmen	90% of lead nursing staff working	Partial	75% of lead nursing staff working	i) 85% of lead nursing staff	i) # of lead nursing staff working Yes	
1	for health-NSD	& other uniformed	in-service training	for Health			what extent does the host	centered differentiated care	1	constraint		18	COP25	is the common norm in the	in HIV/AIDS at military and		in HIV/AIDS at military and	working in HIV/AIDS at military	in HIV/AIDS at military and	
		services					country government (through	for viral suppression.			Training and TA to build patient care teaching and			military, requiring refreshed	selected civilian facilities and		selected civilian facilities and	and selected civilian facilities	selected civilian facilities and	
1	1	1	1				public, private, and/or	1	1	1	mentoring capacity for continuous quality improvement,	l	1	training/mentoring for staff	military medical schools receive		military medical schools receive	and military medical schools	military medical schools that	
1	1	1	1				voluntary sectors) plan and	1	1	1	including rolling out innovative models and practices		ı	newly on the roles.	training and TA on HIV service		training and TA on quality	receive training and TA on	receive training and TA on	
1	1	1	1				implement HIV/AIDS in-	1	1	1	(QA/Q(/CQI).	l	1	ii) programs evolve year on year	quality assurance and CQI,		patient care and CQI and are	quality patient care and CQI and	quality HIV patient care and CQI.	
1	1	1	1				service training necessary to	1	1	1		l	1	requiring continuing technical	clients centered/friend services		competent of providing peer-	are competent of providing peer-	1 1	
1	1	1	1				equip health workers for	1	1	1		l	1	support to integrate	and S&D and are competent of		teaching back at their facilities.	teaching back at their facilities.	1	
1	1	1	1				sustained epidemic control?	1	1	1			1	updates/revisions of guidelines	providing peer-teaching back at			ii) service linkages with civilian	1	
1	1	1	1				(if exact or approximate nerrentage known nlease	1	1	1		l	1	and rolling out changes.	their facilities.		I	system improved.	1	
1	1	1	1				percentage known, please note in Comments column)	1	1	1		l	1				I		1	
							note in Comments column)							progresses delaying meeting						
c 22 401	ASP: Policy, planning,	Priority Pops: Military	Clinical guidelines,	6. Service Delivery	2.20	6.05	6.9 Sub-national Service	To contribute to military Legal, policy or regulatory	tack of tochoical conneits	Lack of managerial capacity	Infection Prevention and Control (IPC) Strengthening:	Prior to COP	Dect.	benchmarks ii) programs evolve year on year	1) 03 technical guidance on	descript	i) IPC guidance developed but	i) IPC guidance	i) IPC technical guidance Yes	
3 33,491	ASP: Policy, planning, coordination &	Priority Pops: Military & other uniformed	Clinical guidelines, policies for service	o. service Delivery	7.20	0.85	Delivery Capacity: Do sub-	medical system's capacity on constraint	or technical capacity	sans of managemai capacity	mecous revenuon and control (IPC) strengthening	18	COP25	 programs evolve year on year requiring continuing technical 	1) 03 technical guidance on infection prevention and control,		undates needed:	i) IPC guidance developed/updated:	developed (undated)	
	management of	services	delivery				national health authorities	infection prevention and			Support updating/revising technical guidelines and	10	CUFZS	support to integrate	biosafety and waste		ii) IPC modules used in CME	ii) Select IPC training modules	ii) # of technical IPC modules	
1	disease control						(i.e., district, provincial) have	control (IPC) for quality	1	1	CME/pre-service training curriculum on IPC and patient	l	1	updates/revisions of guidelines	management to be		trainings of military hospitals or	integrated into CME trainings of	integrated into CME trainings of	
1	programs-NSD	1	1				the capacity to effectively	HIV/AIDS care and	1	1	safety.	l	1	and rolling out changes.	developed/updated;		military medical schools but	military hospitals or military	military hospitals or military	
1		1	1				plan and manage HIV services	treatment and other care	1	1		l	1	iii) Covid-19 impacted program	2) 03 technical		updates needed	medical schools.	medical schools.	
1	1	1	1				sufficiently to achieve	services including	1	1			ı	progresses delaying meeting	modules/guidance on same		1	1	1	
							sustainable epidemic control?	TB/HIV/COVID-19)						benchmarks	above to be integrated into CME					
1	1	1	1					1 1	1	1			ı		trainings of military hospitals or			1	1	
															military medical schools.					
\$ 24,500	ASP: Policy, planning,	Priority Pops: Military	Clinical guidelines,	6. Service Delivery	7.20	6.85	6.9 Sub-national Service		Lack of technical capacity	Lack of managerial capacity	Patient care quality and sustainability:	Prior to COP	Post	ii) programs evolve year on year	1) 03 technical guidance on	Partial	i) HIV/AIDS patient care and	i) HIV/AIDS patient care and	i) HIV patient care and support Yes	
1	coordination &	& other uniformed	policies for service				Delivery Capacity: Do sub-	centered differentiated care constraint	1	1	L	18	COP25	requiring continuing technical	quality HIV/AIDS patient care		support guidance developed but	support guidance	guidance developed/updated;	
1	management of	services	detivery				national health authorities	for viral suppression.	1	1	Support updating/revising technical guidelines and	l	1	support to integrate	and support to be		updates needed; ii) Select technical modules used	developed/updated;	ii) # of technical modules integrated into CME trainings of	
1	disease control programs-NSD	1	1				(i.e., district, provincial) have				CME/pre-service training curriculum for continuous quality	1		updates/revisions of guidelines	developed/updated;			ii) Select technical modules		
							the capacity to effectively				improvement, including rolling out innovative models and			and rolling out changes.	2) 03 technical		in CME trainings of military	integrated into CME trainings of	military hospitals or military	
							the capacity to effectively plan and manage HIV services				improvement, including rolling out innovative models and practices (QA/QI/CQI).			and rolling out changes. iii) Covid-19 impacted program	modules/guidance on same		hospitals or military medical	integrated into CME trainings of military hospitals or military	military hospitals or military medical schools.	
							the capacity to effectively plan and manage HIV services sufficiently to achieve				improvement, including rolling out innovative models and			and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting	modules/guidance on same above to be integrated into CME		in CME trainings of military hospitals or military medical schools but updated needed	integrated into CME trainings of	military hospitals or military medical schools.	
							the capacity to effectively plan and manage HIV services				improvement, including rolling out innovative models and			and rolling out changes. iii) Covid-19 impacted program	modules/guidance on same above to be integrated into CME trainings of military hospitals or		hospitals or military medical	integrated into CME trainings of military hospitals or military	military hospitals or military medical schools.	
5 14 100		Princips Proc. Military	Clinical quintelines	6 Service Delivery	7.20	6.85	the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Innovations in case finding. Legal policy or residatory	lark of technical canacity	tark of managorial ranarity	improvement, including rolling out innovative models and practices (QA/QI/CQI).	Prior to COR	Dest	and rolling out changes. iii) Covid-19 impacted program progresses delaying meeting benchmarks	modules/guidance on same above to be integrated into CME trainings of military hospitals or military medical schools.	Partial	hospitals or military medical schools but updated needed	integrated into CME trainings of military hospitals or military medical schools.	medical schools.	
\$ 14,100	ASP: Policy, planning	Priority Pops: Military & other uniformed	Clinical guidelines, policies for service	6. Service Delivery	7.20	6.85	the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control? 6.9 Sub-national Service		Lack of technical capacity	tack of managerial capacity	improvement, including rolling out innovative models and	Prior to COP	Post COP25	and rolling out changes. ii) Covid-19 impacted program progresses delaying meeting benchmarks ii) programs evolve year on year	modules/guidance on same above to be integrated into CME trainings of military hospitals or military medical schools. TA to support continue rolling	Partial	hospitals or military medical schools but updated needed i) TA needed to support existing and additional sites on quality	integrated into CME trainings of military hospitals or military medical schools. (i) TA provided to 3 - 5 additional	medical schools. 3 # of sites provided with TA to Yes enhance HTS services cer the	
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\$ 44,000	Sor Pelos, gazanos, socialismos 8 management of disease control gazanos 6 management of disease control gazanos 6 management 6 manageme	A chief uniformed juricles of programmed juri	positives for service delivery General guidelines, positives for service delivery service delivery	Service Delivery Service Delivery Service Delivery Service Delivery De Laboratory	720	6.85	the capacity or effectively considerable specification of the capacity of effectively considerable specification of the capacity of effectively considerable specification of the capacity of effective of capacity confiderable specification of the capacity of effective of capacity confiderable specification of the capacity of effective of capacity confiderable specification of the capacity of effective of the effective of the capacity of effective of	modulous in case finding, lagar, policy or regulatory endough the second of the second	Case of technical capacity	Cuck of managerial capacity	improvement, including rolling out immovative models and sections (RVA/CIGN). 1013 quality and sectionability: 10. support for prevention for the ministration of the control of the con	Prisor to COP	Post COP2S	and colling out changes. In a colling out change, and colling out changes. In a colling out changes are considered to the colling out changes and colling out changes. The colling out changes are colling out changes. In a colling out changes, and colling out changes, and colling out changes. In a colling out changes, and colling out changes are colling out changes. In a colling out changes, and colling out changes are colling out changes. In a colling out change is colling out changes are colling out changes. In a colling out change is colling out changes are colling out changes are colling out changes are colling out changes are colling out changes. In a colling out changes out changes out changes are colling out changes out changes are colling out changes. In a colling out changes out changes out changes out changes out changes out changes out can be provided and particularly and pagins of the during out changes.	moduloup data can a same whose the interpretation for Markov the best interpreted into CMA sometimes making and the control of	Prestad	hospitals or written meetical socialities of the support entities of the support provided in a large broad and support provided in control and support provided in control and support provided in control and support provided in a support provided in provided in a support provided in provided in a support provide	Integrated into CMF training of models of the CMF training of models of the CMF training of models of the CMF training of the	medical schools. Set of stays provided with Tab. Set of stays provided with Tab. The second political school optical money of the second political school optical and school optical school optical political school optical	

\$ 985,000 ASP (reso.)	: HMS, entitles & enti	Key Popu. Net disaggregated	rektiš systems	24. Epidemiological and Health Data	8.06	5.74 N	ŲA.	interogeniality galdom is established	of Financial Resources	Ladi of technical capacity	Lack of sufficient HPH	It hmost be technical support to GNNAAC for rouses properties, offices and inflorationates maintenance, and properties, offices and inflorationates maintenance, and submissionates of the control of	COP19	COP23	mirror data overlinens is mentioned in province where the activity is in species model, the activity is in species model, the activity is in species model, and the activities provinces. The supprised of activities in PT22 incomes on finalizations of our facilities. The supprised of activities in PT22 incomes of the activities of activit	Exequence to 1.5 speriones. White Section of the S	artiil	1. The MYC System is in State and cross section developed and cross section developed and cross section developed and cross section developed and effective and cross-section developed and cross-section developed and cross or unioning depoting of the size of	Let VC Cyperan in nemerication with Indicationality produced as insended to support for assessment to support for assessment to support for assessment of City 11 Sp provinces (15 Lin 15 Sp provinces) and assessment of City 11 Sp provinces (15 Lin 15 Sp provinces) and assessment of City 11 Sp provinces (15 Lin 15 Lin	CS system to facilitate program implementation; Number of system users served; Number of user requests received and percentage of them addressed;	
	:HMIS, I	Non-Targeted Pop: Nor disaggregated	Service organization and management opstems Program and data	16: Performance Data	8.76	ir p m sa a p c c c	1.3 Performance Data of Oxidection and the for objection and the for improvement. Are PIV represented that yes an experiment of the yes managed to detail yes assigned to detail yes assigned to detail yes assigned to assigned the assigned to assigned the assigned to yes assigned to yes yes yes yes yes yes yes yes	Provincial program and HTV Lack co	of technical capacity	tack of managerial capacity tack of managerial capacity		Advancable and work with the VAAL to develop and citizen a man of the common of the c	COP22	COP23	Rufu Ta requires multiple year	N/A	tot applicable	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-S an online testing system,	system and social contracting MAE 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)	Described of provinces planting for securities and control of the control of the control of securities and control of the control of securities and control of the control of securities and control of postures. An experiment of the control of securities and control of securities and securities and securities securities securities securities securities securities s	
sunv rese	veillance, & I	Not disaggregated	Program and data quality management	16. Performance Data	8.73	Si wa co H br si si	envice Delivery Data: To what extent does the host ownerty government collect #IV/AIDS service delivery data ny population, program and seographic area? (Note: Full core possible without electing all disaggregates.)	data are regularly collected and analyzed to track the public health response.		Lack of managerial capacity		provinces to ensure high-quality information for program response. Continue to maintain and upgrade the provincial stathus/PQM. Ensure data automation for 1005 of PQM indicates. Strengthen provincial staff capacity on PQM data use to identify program quality issues and action through established CQI provincial teams. Integrate HS system PQM/CHSJ at provincial level teams or provincial level teams or provincial level teams or provincial level teams. Integrate HS system PQM/CHSJ at provincial level managing program quality, case surveillance and community performance.	0.0922	COP2S	interventions	N/A	es.	automated CHIS module is established in HCDC	system implemented in 03 provinces (Dong Nai, Tay Nish and Tien Gilang) and piloted in 01 province (HCMC). 2. 2PQM, CHS 2. PQM, CHS system piloted in HCMC	2.Number of provinces with integrated PQM and community etc.	
man dise prog	rdination & Inagement of lase control grams-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization Market openness	Domestic Resource Mobilization	9.33	vi er fc yv	1.7 Health Budget Execution: What was the country's execution rate of its budget or health in the most recent : ear's budget?	barriers for PLHIV to aconsting treatment under SHI. Ensure access to essential Lack c	policy or regulatory raint			Nevincial SHI Coverage and Copayments: Advocate for new, expanded, to sustained provincial commitments to cover SHI copayments for ARVI and viral load. Coordinate with the VAX. And INISC is ensers supportive policies and finances are in place at the national level and data systems uccessfully monitor SHI uptake and associated costs. Cover emergency copayment needs for ARVI and viral load for clients inelligible to receive provincial support. Demand generation: Promote services provided by social	CO921 CO922	COP24	Conflict of policies	USAID-supported treatment provinces have local commitments to cover ARV copayments and at least one province supports viral load copays.	tot applicable	no payment mechanism using local funding	FY23. 1. Increase in the number of	copayments 2. Number of USAID-supported transtrainet provincies that have local commitments to cover viral local copayments Pregular reports on: Yes	
coorman man dise prog	rdin ation & ragement of ragement of rase control grams-NSD	Not disaggregated				a (s a a a a	usticnal government or doron g., PIPAM, GNTA, etc.) officies limit the ability of control of the ability of the ability of the ability of control of the ability of the ability of the ability of control of the ability of the ability of the ability of the ability of control of the ability of control of the ability of the abi	HV prevention commodities through diventiled murfats.				enterprise, community based organizations, and public abundance of the control of						number of clinic conducting risk issuements and booking in state of a risk of the clinic production of the clinic production of the clinic like of the clinic like of the clinic production of the clinic like of the clinic like of the clinic production of the clinic like of the clinic like of the clinic country like of the clinic country production of the clinic country clinic country production production country production production country production production production production country production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production production produ	contine risk assessments and experience to be less by a 150 parent companied by P22. parent companied by P22, parent companied by P22, parent companied by P22, parent companied by P22, parent confidence to forestand and parent confidence for parent confidence for parent for profit forestand for profit forestand for profit forestand for profit forestand in finding forestand for forestand fo	A collect not advantage the control of the collect	
man dise prog	rdination & I nagement of sase control grams-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	D d 89 irr P sz o d	6.6 Quality of Service belivery Data: To what extent loss the host country overnment define and implement policies, rocedures and governance tructures that assure quality if HIV/AIDS service delivery lata?	data are used routinely to measure and monitor performance and inform the HIV public health response.		tegal, policy or regulatory constraint		National HIV MBE framework: Work with VAAC and relevant Stakeholders to review current national HIV MBE requirements inclining spidnoce, inclidances, and data collection systems and recommand revisions of indicators for CQ/ PQM activities.	COP22	COP23	N/A	N/A	fot applicable	•Bircular 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 	**Astional guidance on data* Pes sollection and too available for updated reporting requirements. 2.**Auruber of Estaining courses on the updated reporting requirement conducted	
man	: Policy, planning, Irdination & ragement of aspement of ase control grams-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	8.73	D d 87 in p s2	5.6 Quality of Service nelivery Data: To what extent lose the host country powerment define and repitement policies, protectives and governance tructures that assure quality of HV/AIDS service delivery sta?	Provincial program and HV. Lack of data are regularly collected and analyzed to track the public health response.	of technical capacity	Lack of sufficient HRH	tack of managerial capacity	Out a quality assurances (bydate the network of the Custom) assurances for foil for PLACES Frowthins and Custom lounced by the VAM.C and Encitates OVA. According is self-time to prove performing system and the OSC Association to the proper performing common and the OSC Association to the proper performing common and baseline assurances.	CO922	COP24	N/A	NJA	eot 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-PEPRAR- supported provinces, DQA has supported provinces, DQA has often been included with general menistroing trips and thus lacked in-depth DQA activities.	lapstated wereinn of national DQA tool released. At least two DQA tripp to assess provincial data quality in two non-project supported provinces	Exercised COA guestime yes developed and disconnected to provinces. Developed and disconnected to provinces Developed and disconnected to provinces Developed and Developed to provincial data quality	

\$ 172,500	ASP: HMIS, surveillance, &	Key Pops: Not disaggregated	Research	14. Epidemiological and Health Data	8.06	5.74	14.1 Management and Monitoring of Surveillance	Surveillance and program Lack of technical capacity data are used routinely to			KP evaluation study on HIV related care seeking behavior of clients in priority provinces (HCMC, Done Nai and 1-2	COP22	COP23	N/A	Protocol of KP study agreed upon N by authorized GVN partner and	iot applicable	Protocol of KP study agreed upon by authorized GVN partner and	Study completed with written report	- Complete raw dataset Yes - Final report findings shared	
	research-NSD						Activities: Does an	measure and monitor			provinces with increasing epidemics) to understand characteristics of clients that are seeking ART and PrEP				PEPFAR stakeholders and	ļ	PEPFAR stakeholders and		with '- VAAC, USAID, other	
		l	1				administrative entity, such as a national office or Bureau/s,	performance and inform the HIV public health response.			characteristics of clients that are seeking ART and PrEP services, and MMD outside of public facilities including			ļ	approved by IRB	,	approved by IRB		stakeholders in a study presentation	I
							exist with specific authority to	The passes response.			unmet needs, barriers and challenges to access and uptake services at public sector, as well as preference for services.				1	,	('		presentation	
							manage - plan, monitor, and provide guidance - for	1 '			services at public sector, as well as preference for services. The KP study will assess not only MSM, but also include				1	,	('			
							Les instrumentation 20141 VIII	1 '			other key populations groups who may be undeserved				1	,	('			
1		l	I				surveys and/or surveillance activities including, data	1 '			including female nartners of MSM sons-discondant			ļ	1	,	· '		1	
							activities including, data collection, analysis and	1 '			couples, transgender women, female sex workers, and people who inject drugs.				1	,	('			
							interpretation, and quality	1 '							1	,	('			
							assurance across all sectors. Select only ONE answer.	1 '							1	ļ	<i>i</i> '			
\$ 200,000	ASP: Policy, planning, coordination &	Key Pops: Not	Assessing impact of	2. Policies and	6.38	6.33		Ensure access to essential Lack of technical capacity HIV prevention commodities	Lack of sufficient HRH	Lack of Financial Resources	National & Provincial Levels: Provide TA to support	CO922	COP25	N/A	N/A	eot applicable	Preference among KPs	1. Demand among KPs for key	TA package developed Yes	
	coordination & management of	disaggregated	policies and regulations on HIV	Governance			Legislation: Are there policies or legislation that govern	HIV prevention commodities through diversified markets.			increasing the demand for HIV related goods and services: National Level:				1	ļ	(Consumer survey 2021) 2. Data on PrEP uptake among	HIV services including: PrEP (daily oral, event-driven and CAB-LA),	DQA and M&E CQI/satisfaction survey	
	disease control						HIV/AIDS service delivery or				1. Under VAAC's leadership, working with relevant				1	ļ	KPs	Self-Testing, STI screening, viral hepatitis, mental health care OSS	Progress annual report	
	programs-NSD						policies and legislation on health care which is inclusive	1 '			partners to update/revise the communication strategy to increase demand amone KPs for key HIV related services in				1	ļ	<i>i</i> '	hepatitis, mental health care OSS services and others (provincial		
							of HIV service delivery? Note:	1 '			increase demand among KPs for key HIV related services in the new context of VN				1	ļ	<i>i</i> '	services and others (provincial campaigns, etc) increased by at		
							If one of the listed policies differentiates policy for	1 '			Support VAAC to revise/adapt the training package, manuals & materials on how to do attractive events				1	,	('	minimum six campaigns targeting different audiences		
							specific groups, please note in	1 '			targeting different groups of audiences esp. young people				1	,	('	(young people, young MSM,		
							the Notes/Comments column	1 '			and young MSM 3. Support VAAC to coordinate and implement demand.				1	ļ	<i>i</i> '	(young people, young MSM, TGW), insights generated to inform specific needs of young		
								1 '			3. Support VAAC to coordinate and implement demand generation activities and provide TA to GFATM provinces through National Forum e.g. PYEP & tele-PYEP				1	,	('			
								1 '			through National Forum e.g. PrEP & tele-PrEP Provincial Level:				1	,	· '	2. TA provided to VAAC to		
								1 '			4. Support community partners in USAID supported				1	,	· '	develop communication strategy in the context of COVID19		
		l	1					1 1 '			provinces to scale-up online ordering/services through Self- Tout and Built plantages, and by technology (ALC by that) to				1	,	·	targeting young people and young KPs		1
								1 '			improve the quality of services				1	ļ	<i>i</i> '	3 Training manual/quideling on		
		l	I					1 '			improve the quality of services 5. Coordinate and support USAID/IPs to annually update KPs insights and refresh PrEP, HIVST messages and			ļ	1	,	· '	demand generation for all HIV related services to different	1	
1		l	I					1 '			campaigns 6. Coordinate and support USAID/IPs to organise periodic			ļ	1	,	<i>'</i>	groups of audiences esp young		
1		l	I					1 '			 Coordinate and support USAID/IPs to organise periodic online HIV services DG Forums among CBOs, SEs and KP-led 			ļ	1	,	<i>'</i>	people and young MSM, completed and delivered to		
		l	1					1 1 '			dinies				1	,	·	VAAC for roll-out		1
																	·	4. Online-to-Offline services		
\$ 150,000	ASP: Policy, planning, coordination &	Key Pops: Not disaggregated	Clinical guidelines, policies for service	6. Service Delivery	7.20	6.85	 Responsiveness of facility- based services to demand for 	Innovations in case finding, HIV prevention, especially			Pilot coupled with implementation study of integrated PrEP CAB-LA service delivery through private sector/KP-led	COP22	COP23	N/A	N/A	Not applicable	CAB-LA, is an injectable form of PrEP approved by the USFDA for	Pilot integrated PrEP CAB-LA service delivery through private	Study Protocol No Study report	
1	management of		delivery				HIV services: Do public	PrEP, and linkage to care are			dinics:			ļ	1	,	use as a prevention option. It is new to VN and there is no model	sector/KP-led clinics	Data set	
	disease control programs-NSD	l	I				facilities respond to and generate demand for HIV	PYEP, and linkage to care are institutionalized under a national public health			Secure VAAC approval of CAB-LA delivery pilot model and protocol designed to address key pragmatic			ļ	1	,	new to VN and there is no model available on the use of CAB-LA in	VAAC approval of CAB-LA delivery nilot model and	1	
- [programs-NSD	l	I				services to meet local needs?	national public health response.			implementation appetions (accountability feasibility				()	,	country	contaced decisioned to address how		
- [l	I				(Check all that apply.)	1 '			effectiveness, cost) 2. Develop service SOPs, training, demand gen				()	,	· '	pragmatic implementation		
- [l	I					1 '			tools/videos/social media/micro-events (awareness, how			ļ	1	,	· '	pragmatic implementation questions (acceptability, feasibility, effectiveness, cost)	1	
								1 '			CAB-LA works) and reporting systems in place				1	,	· '	secured 3. Service SOPs, training,		
								1 '			 Secure import of CAB-LA donations for study; support ViiV with product market entry (assessing market, pricing, 				1	ļ	<i>i</i> '	demand gen tools/videos/social		
								1 '			access and commercial distribution) 4. Innlement CAR-IA service delivery and study in				1	ļ	<i>i</i> '	media/micro-events (awareness, how CAB-LA works) and		
								1 '			 Implement CAB-LA service delivery and study in coordination with VAAC, PEPFAR and provincial partners 				1	ļ	<i>i</i> '			
								1 '			Preliminary results from pilot shared with VAAC/MOH,				1	ļ	<i>i</i> '	reporting systems in place 4. Import of CAB-LA for study		
								1 '			PrEP TWG quarterly and GFATM				1	,	· '	secured; support ViiV with		
								1 '			6. Assist VAAC/MOH to develop CAB-LA implementation plan to be developed & implemented (in COP23)				1	,	· '	product market entry (assessing market, pricing, access and		
								1 '							1	ļ	<i>i</i> '	commercial distribution) 5. CAB-LA service delivery and		
								1 '							1	,	· '	study being implemented in coordination with VAAC, PEPFAR		
								1 '							1	,	· '			
								1 '							1	ļ	<i>i</i> '	6. Preliminary results from pilot shared with VAAC/MOH, PrEP		
\$ 180,000	ASP: HMIS, surveillance, &	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	Surveillance and program Lack of technical capacity data are used routinely to			Implementation Study: Evaluation of acceptability, feasibility, effectiveness and program delivery cost of key	CO922	COP22	N/A	N/A	Not applicable	There is currently no asssement available for the new CAB-LA and	Monitor/compare HIV seroconversion and STIs among	Study Protocol No Study report	
	research-NSD						extent does the host country	measure and monitor			feasibility, effectiveness and program delivery cost of key population-led social enterprise clinic delivered long-				1	ļ	oral Prep among KP	oral PrEP and CAB-LA users and	Data set	
							government define and implement policies.	performance and inform the HIV public health response.			acting cabotegravir in Vietnam.				1	,	· '	factors associated with HIV seroconversion and STIs		
							procedures and governance structures that assure quality	1							1	ļ	<i>i</i> '	Quantify degree of switching between oral PrEP and CAB-LA at		
							structures that assure quality of HIV/AIDS surveillance and	1 '							1	,				
							survey data?	1 '							1	,	· '	with switching 3. Measure and compare		
								1 '							1	,	· '	Measure and compare willingness to pay for oral PrEP		
								1 '							1	,	· '	and CAB-LA		
								1 '							1	,	· '	Describe service delivery		
-1		l	I					1 '						ļ	1	,	<i>'</i>	preferences between different KP groups for oral PrEP and CAB-LA		
		l	1					1 1 '							1	,	·	5. Describe provider perceived barriers and facilitators of offering CAB-LA in addition to		1
-1		l	I					1 '						ļ	1	,	<i>'</i>	offering CAB-LA in addition to		
- [l	I					1 '						ļ	1	,	· '		1	
		l	1					1 1 '							1	,	·	Compare service delivery cost of different models of oral PrEP		1
		l	1					1 1 '							1	,	·	(TDF-FTC) and LAI-PrEP (CAB-LA)		1
\$ 150,000	ASP: HMIS,	Key Pops: Not	Research	14. Epidemiological	8.06	5.74	14.1 Management and	Surveillance and program Lack of technical capacity			National Private Sector Assessment Study: Market survey	COP22	COP22	N/A	N/A	Ant applicable	No market survey available on	Measure and compare	Study Protocol No	
	surveillance, & research-NSD	disaggregated	I	and Health Data			Monitoring of Surveillance Activities: Does an	data are used routinely to			to assess demand of private sector services for key populations and end users as a baseline measurement to			ļ	1	,	willingness to pay for HIV and PHC commodities and services	willingness to pay for HIV and PHC commodities and services in	Study report Data set	
		l	I				ariministrative entity such as	performance and inform the HIV public health response.			cusport the VAAC's National HB/ Brigate Cortes			ļ	1	,	among KPs	urban, peri-urban and rural		
		l	1				a national office or Bureau/s, exist with specific authority to	HIV public health response.			Engagement (PSE) Roll-Out Plan.				1	,	·	settings 2. Describe service delivery		1
		l	1				exist with specific authority to manage - plan, monitor, and provide guidance - for	1 1 '							1	,	·	2. Describe service delivery preferences between different KP		1
		l	1				provide guidance - for HIV/AIDS epidemiological	1 1 '							1	,	·	groups 3. Describe provider perceived		1
		l	1				surveys and/or surveillance	1 1 '							1	,	·	barriers and facilitators of		1
1		l	I				activities including, data collection, analysis and	1 '						ļ	1	,	<i>'</i>	accessing HIV and PHC commodities and services		
- [l	I				interpretation and quality	1 '						ļ	1	,	i .	4. Quantify total baseline	1	
		l	I				assurance across all sectors. Select only ONE answer.	1 '							()	,	i .	markets for a sub-set of HIV and		
		l	1				ment only one answer.	1 1 '							1	,	·	PHC commodities and services 5. Utilize study results to input		1
1		l	I					1 '						ļ	1	,	<i>'</i>	baseline figures and set benchmarks where relevant for		
								<u> </u>									·	the national HIV PSE Plan		<u> </u>
\$ 100,000	ASP: Policy, planning, coordination &	Key Pops: Not disaggregated	Clinical guidelines, policies for service	6. Service Delivery	7.20	6.85	6.2 Responsiveness of community-based HIV/AIDS services: Has the host country	Increased GVN capacity to manage and coordinate HIV	Lack of sufficient HRH	Lack of managerial capacity	NEW: Advocate for Community PrEP and nPEP drug	COP22	COP22	N/A	N/A	Not applicable	Community Prep/nPrep is not yet included as delivery model in	Proposal for Community	M&E tool No Result report	
	management of	n-militalisted	delivery				services: Has the host country	commodities procurement			distribution 1. Advocate for VAAC approval of Community PrEP/nPEP			ļ	1	,	national guidelines	PrEP/nPEP drug distribution developed and approved by	Property regions	
1	disease control	l	1				standardized the design and implementation of	and supply chain from			drug distribution service delivery model 2. Co-Develop demonstration activity with VAAC in Done			ļ	1	,		VAAC 2. Community PrEP to PEP store	1	
1	programs-reSD	l	1				community-based HIV	manageme additions.			Nai				1	,	·	distribution implemented in 2-3		1
1		l	I				services? (Check all that apply.)	1 '			Use evidence to advocate for the revision of the PrEP National Guidelines to include community PrEP & nPEP			ļ	1	,	i .	provinces in collaboration with Community Partner - LADDERS	1	
1		l	I				mbb.1-1	1 '			National Guidelines to include community PTEP & nPEP drug distribution.			ļ	1	,	i .	3. Community drug distribution	1	
		l	1					1 1 '							1	,	·	demonstration results will be shared with VAAC and other key		1
		ı	I					1 '						ļ	1	,	· '	stakeholders for revision of the	1	
															t		·	National PrEP Guidelines		1
		No. Verreit de	Fortune to a	44 Caldamiatesi	0.07	6.71	11/4													
\$ 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	Lack of sufficient HRH		NO Discours among MIN eligate in COC BEREAR necessions	COP22	COP22	One time only evaluation	N/A	Not applicable	6 CDC-PEPFAR provinces have CABs that collect client	Protocol approved, data collection completed, with	% increase in VL literacy/HIV No health literacy (K=K, testing	
\$ 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 sufficient HRH		NA Stormer AMAGES 2022 in CDC RESEAR negations	COP22	COP22	One time only evaluation	N/A		CARrish or collect clicat	collection completed, with	% increase in VL literacy/HIV No health literacy (K-K, testing interval, VL result, MMD, etc.)	
\$ 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	centered differentiated care	Lack of sufficient HRH		VL literacy, among HIV clients in CDC-PEPFAR provinces	COP22	COP22	One time only evaluation	N/A		6 CDC-PEPFAR provinces have CABs that collect dient satisfaction data, participate in QI and client outreach and support	collection completed, with	health literacy (K+K, testing	

\$ 71,	515 ASP: Human resources	Key Pops: Not	Civil society	3. Civil Society	4.25		Civil society, particularly	Legal, policy or regulatory	tack of technical capacity		Contribute to community Public Health Cluster Response	COP22	COP25	N/A	N/A	Not applicable	PHCRs implemented in Can Tho,	1/ community expert cadre	Yes	PHCR initiative includes person-centered, ethical
	for health-NSD	disaggregated	engagement	Engagement		Engagement: Does civil	community-based	constraint			nationwide. In collaboration with HSS and Program						Soc Trang and Kien Giang with	established and capacitated,	4s of national level community	and equitable standards with a robust
						society engagement	organizations actively				Services:						lessons learned and documente	d active participation in TWG	champions/experts actively	community response component
						substantively impact policy,	monitor the HIV program fo				In partnership with VUSTA:						for onward planning	2/ Active PHCR community	involved in TWG	
						programming, and budget	a true public health				- Establish a national cadre of community PHCR champions							learning network with routine	-Documentation & M&E of	
						decisions related to HIV/AIDS?	response.				as part of the national PHCR TWG, including engagement							meetings and knowledge	community PHCR responses	
											and design of core elements/standards for ethical and							platform for sharing best	As of CBOs/community experts	
											person-centered response package as part of the National							practices	actively engaged in learning	
											SOPs. Training and support for national-level community							3/Inclusion of person-centered		
											champions on PHCR approaches and practices to foster							standards in National SOPs and		
											their technical leadership.							guidelines		
											- Monitoring, documentation of provincial community							Г		
											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)									
\$ 75,	000 ASP: Human resources			3. Civil Society	4.25			Lack of technical capacity				COP22	COP25	N/A	N/A		CBO market analysis and	Roadmaps initiated for	# CBOs receiving support to meet No	
	for health-NSD	disaggregated	engagement	Engagement			quantity of diverse groups,				Epidemic Control:						mapping completed in 6 CDC-	community organizational	social contracting requirements	
							including KP-led CBOs and										supported provinces	support	#TA events provided by VNP+ to	
							civil society, social workers,				1) Organizational capacity building for CBOs in CDC-								the network and community	
							and law enforcement,				supported provinces to qualify for social contracting and							VNP+ develops and shares	organizations	
						decisions related to HIV/AIDS?					broader HIV program support and collaboration (with						VNP+ utilizes Stigma Index 2021			
							treatment services.				VUSTA)							rk support materials to network via		
																	priority plan	multiple fora and documents		
											With VNP+: science sessions on biomedical innovations,									
											treatment & health literacy including for aging + HIV, etc.,						S CDC-supported provinces are i	n		
1		I	I				i	1	1	1	community and stigma monitoring coordination, public	l	l	l	I		varying stages of readiness for	I		1
1		I	I				i	1	1	1	health messaging on status neutral, etc. (in collaboration	l	l	l	I		social contracting. VNP+ is national convener for Tx literacy	I		1
1		I	I				i	1	1	1	with HAIVN). Describe healthcare needs and existing gaps,	l	l	l	I			1		1
1		I	I				i	1	1	1	such as telemedicine literacy, among aging PLHIV to	l	l	l	I		and advocate for biomedical	I		1
											support person-centered care for this population						innovation			
							1													

4 Prior Yr SRE-E

COP21 Activity	Activity Description	Filter Here -	Activity Type	Activity Title	Primary evaluation or study questions	COP or	Activity Start	Activity End COP		COP20 Baseline	COP20 Baseline Status (detail)	How does this activity advance COP priorities?	SRE=1	All required fields completed?	Ongoing in	Additional Notes- Please explain if not ongoing in COP22
Budget		ONLY SIL	Турс	Title	or study questions	funded ?	COP Year	Year	activity (as of COP20)	Status (major)	Status (uetail)	Cor priorities:		completeus	(Yes/No)	ii not ongoing in cor22
\$15,000	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. 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	СОР	COP20	COP25	Propose d in COP	Data_collec tion	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 methologies 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 surveillan ce 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	СОР	COP18	COP22	Ongoing	Data_collec tion	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 methologies 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 surveillan ce 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	СОР	COP18	COP22	Ongoing	Data_collec tion	In progress	Strengthen the national surveillance system and improved surveillance data to monitor the epidemic		SRE details entered	yes	
\$227,500	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. 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			What are the appropriate methods to estimate KP and PLHIV and project the HIV motariity and mobility in Vietnam Establishing case based surveillance, using HIS system	COP	COP18	COP26	Ongoing	Data_collec tion	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.				Using program and HIV case reporting data to monitor and evaluate the cascade	СОР	COP18	COP20	Ongoing	Data_collec tion	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

	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	СОР	COP20	COP22	Propose d in COP	Data_collec tion	Not started	Strengthen capacity for authorities to access, aggregate and interpret data for an evidence- based HIV public health response	SRE details entered	yes	
	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		HIV surveillan ce system	What is the achivement of 90-90- 90 goal?	СОР	COP19	COP26	Ongoing	Data_collec tion	In progress	Strengthen the national surveillance system and improved surveillance data to monitor the epidemic	SRE details entered	yes	
1	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	of	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_Sc ope	Not started	Improve the quality of HIV treatment program	SRE details entered	no	The project will be ended in COP21 and no further activities being continued in COP22
	Size estimation method of Young MSM population in a number of high burden provinces	Surveillance	Population size estimation	Estimatio	What is appropriated method to estimate size estimation of young MSM populations?	COP	COP21	COP22	Ongoing	Protocol_Sc ope	In progress	Improve the estimation of PLHIV at province and national levels	SRE details entered	yes	
	Estimation of MSM population in a number of high burden northen provinces	Surveillance	Population size estimation		What is size estimation of MSM aged 18 year above in selected northen provinces?	СОР	COP21	COP22	Ongoing	Protocol_Sc ope	In progress	Improve the estimation of PLHIV at province and national levels	SRE details entered	yes	
	Estimation of MSM population in a number of high burden sourthen provinces	Surveillance	size		What is size estimation of MSM aged 18 year above in selected southern provinces?	COP	COP21	COP22	Ongoing	Protocol_Sc ope	In progress	Improve the estimation of PLHIV at province and national levels	SRE details entered	yes	
	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 surveillan ce	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_Sc ope	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	SRE details entered	yes	
	Ongoing support & strengthening the implementation of case based surveillance system in HCMC	Surveillance	1		What is the achievement of 95- 95-95 target in HCM?	СОР	COP20	COP26	Ongoing	Data_collec tion	In progress	Strengthen the national surveillance system and improved surveillance data to monitor the epidemic	SRE details entered	yes	

APPENDIX D- Minimum Program Requirements

Care and Treatment	Status
Adoption and implementation	Status
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) Panid antimization of APT by	On-going: TLD included in the Vietnam National Standard
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including	Treatment Guidelines since December 2017, with most recent
	Guidelines in November 2019 establishing TLD as a first-line agent
adolescents and women of childbearing potential), transition	for all PLHIV, including children≥10 years old and >20kg and
to other DTG-based regimens	adolescents and women of childbearing potential >30kg. Phasing
for children who are \geq 4 weeks of age and weigh \geq 3 kg, and	out NVP is prioritized in the Guidelines, with all NVP patients
removal of all NVP- and EFV- based ART regimens.	indicated to be transitioned to TLD. DTG 10 mg is currently being
based AKT Tegimens.	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 turnaround time for VL test results to the site and the client in addition to optimizing STI testing with TB testing using the GeneXpert platform.

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

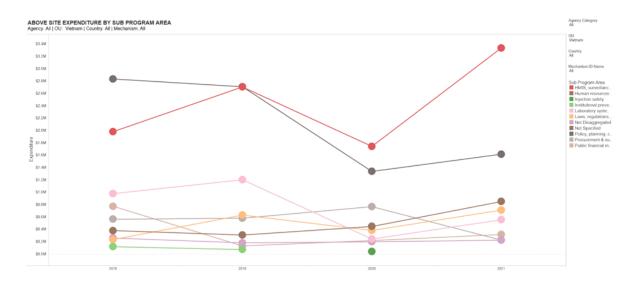
APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

Alignment of Sustainability Goals and PEPFAR Investments

E.1.1: SID Element Scores Over Time

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

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

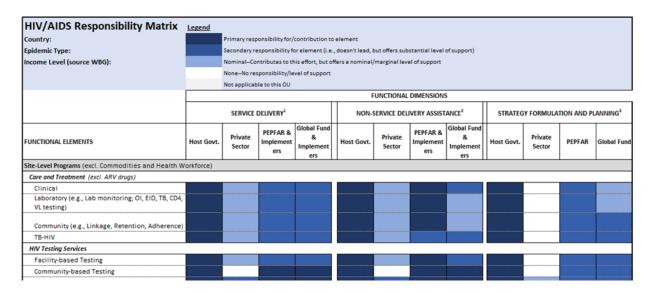


E.1.1 Above-Site Investments (Table 6) by SID Score

SID Score						COP20		
Domain	Element	2017	2019	2021	SID Budget Element	Activities	Budget	
Governance, Leadership & Accountability	Planning and Coordination Score:	9.00	8.29	8.07	Planning and Coordination	1	S178,500	
	2. Policies and Governance Score:	5.75	6.38	6,33	Policies and Governance	1	E \$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	E \$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	E \$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	A STATE OF THE STA			
	16. Performance Data Score:	7.63	8.73	8,73	4			
	17. Data for Decision-Making Ecosystem Score:	1000	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)



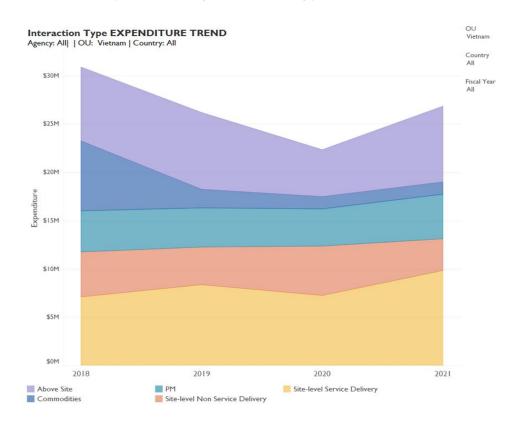
E.1.2 Responsibility for Above-Site by Stakeholder (v.2)

Tabulation of Responsibility Matrix Responses 2021*

	Но	st Govt.		PEPFAR			
			Nominal			Nominal or	
Functional Element	Primary	Secondary	or None	Primary	Secondary	None	
Total across elements	17	2 2	13	28	76	83	
Above Site (Systems) Programs	5	2 0	0	2	32	18	
Commodities	3	7 0	5	4	16	22	
Health Workforce	2	4 0	0	0	8	16	
Program Management		0 0	0	0	0	0	
Site-Level Programs (excl. Commodities and Health Workforce	5	9 2	8	22	20	27	
*Host country did not provide a Responsibility Matrix for 2021							
Host Government Responsibility	PEPFAR Responsibility						
■ Primary ■ Secondary ■ Nominal or NA			Primary I	Secondary	Nominal or NA		
Primary	No or NA	Nominal or NA		Secondary		Primary	

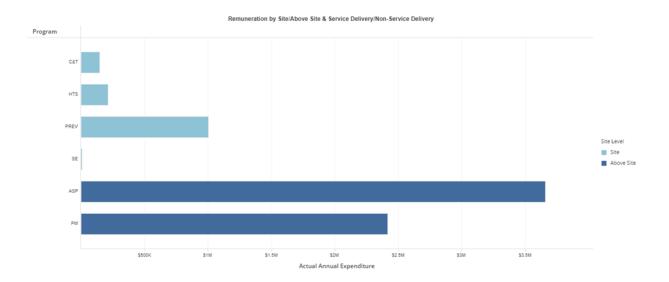
Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:

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.