SMART TA

Sustainable management of the HIV/AIDS response and transition to TA project

FY14 Annual Report
(October 2013 – September 2014)

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Executive summary

The USAID *Sustainable Management of the HIV/AIDS Response and Transition to Technical Assistance Project* – or "SMART TA" – is a five-year, $45 million initiative managed by FHI 360 that strives to ensure the provision of quality, comprehensive and sustainable HIV services through a strengthened national response.

The project is designed to contribute directly to the targets identified in the *National Strategy on HIV/AIDS Prevention and Control in Vietnam* and the *Partnership Framework between the Government of the United States of America and the Government of the Socialist Republic of Vietnam for HIV/AIDS Prevention and Control.* SMART TA prioritizes programming that is aligned to PEPFAR's five key agendas – impact, efficiency, sustainability, partnership and human rights – to move us towards the 90-90-90 goals and an AIDS-free generation.

This document constitutes USAID/SMART TA's FY14/COP13 annual narrative report for the period 01 October 2013 to 30 September 2014.

The following sections outline:

- USAID/SMART TA's evolving program operating model
- Our vision of success
- Year 3 challenges, responses and results
- A project management and personnel overview

The USAID/SMART TA annual report also contains annexes that summarize Year 3 results against targets; highlight important success stories; and share key SMART TA tools.

Evolving models

Every drop we lose is a lost resource, effort, opportunity . . . life
SMART TA cascade video

The world has changed dramatically since 2003, when the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) launched an unparalleled response to combat the HIV epidemic. Through our global collective efforts, we are at a tipping point in the fight against HIV, where substantial reduction of HIV transmission is feasible. We have the tools – like the HIV cascade of care - that can help assess the outcomes and impact of programs and services. We've developed approaches that support enhanced coordination and leverage the unique capabilities of key stakeholders, including national institutions, funding agencies, implementing organizations, community supporters, and key populations. We have introduced innovations and programming improvements that take advantage of revolutionary new technologies and emerging evidence to improve cascade performance across the continuum of HIV prevention to care (CoPC) for key populations. We've tested strategies that increase program efficiencies, and align funder and government priorities for impactful interventions at local and national levels.

However, these promising global practices have been implemented unevenly and inconsistently. Innovative interventions have not become proven scalable solutions. Programs, even when effective, may not always be affordable or sustainable in the wake of declining funder resources. Those who bear a disproportionate burden of HIV – key populations and their intimate partners – continue to have difficulties accessing

and utilizing the products, services and other resources that will protect their health and improve their well-being.

Overcoming these challenges and moving - successfully and sustainably – towards Vietnam's AIDS-free generation demands unparalleled coordination and collaboration; world-class technical leadership; a comprehensive and intimate understanding of key populations and their needs; and the ability to move from evidence to action in rapidly changing environments.

USAID/SMART TA's evolving paradigm for action is designed to respond to the challenges that stand in the way of achieving the country's AIDS-free goals. Our operating model emphasizes three key, inter-related, components that form the foundation of our efforts: (a) the HIV CoPC cascade; (b) a provincial TA systems strengthening focus; and (c) a phased and managed transitioning approach that leverages national, provincial and community-based resources and promotes sustainable, local ownership.

HIV CoPC cascade framework

Although HIV will continue to be an important public health threat for years to come, strong evidence of the benefits of anti-retroviral therapy (ART) has ushered in an era in which we can envision an end to the disease and the suffering associated with AIDS. Focusing efforts on individuals at greatest risk; increasing uptake of HIV testing and counseling (HTC) among key populations; facilitating early diagnosis of HIV infection and initiation on ART; retaining PLHIV on treatment; and suppressing HIV viral loads are the hallmarks of a strong HIV response that achieves population-level impact.

To achieve ambitious AIDS-free goals, however, requires that implementers have tools that immediately discern service system gaps, help focus or prioritize programmatic interventions, and make the most strategic use of available resources.

The continuum of HIV prevention to care cascade of care is a way to show, in visual form, the numbers of individuals who are actually accessing CoPC services and receiving the services they need. At each step, the cascade assesses engagement in an HIV service system. It powerfully identifies "leaks" in the system, so that implementers at site, district, provincial or national levels can target limited resources on effective interventions that improve the health of HIV positive individuals, lower the amount of virus in vulnerable communities, and prevent new infections in the long term. Identifying where drop-offs are most pronounced is vital for knowing how, where and when to intervene to break the cycle of HIV transmission in Vietnam.

USAID/SMART TA has adapted the CoPC cascade specifically for the concentrated Vietnam epidemic context (Figure 1). This cascade model underlies all three SMART TA strategic objectives[1]:

1 *Deliver quality HIV services within the CoPC.* SMART TA supports cascade service approaches that (a) identify key populations; (b) prioritize combined prevention to those at highest risk; (c) test and identify HIV positive individuals; (d) immediately link PLHIV to HIV care and treatment services; (e) initiate timely ART; (f) sustain individuals on ART and (f) suppress viral loads to extend life and reduce HIV transmission.

2 *Strengthen GVN and CSO technical capacity to sustain quality CoPC services.* SMART TA assists national, provincial, district GVN and civil society organizations (CSOs) to understand and more effectively program their HIV response (and other health services) across the cascade. SMART TA technical assistance ensures that strategies are evidence-based, of good quality, and locally feasible and sustainable.

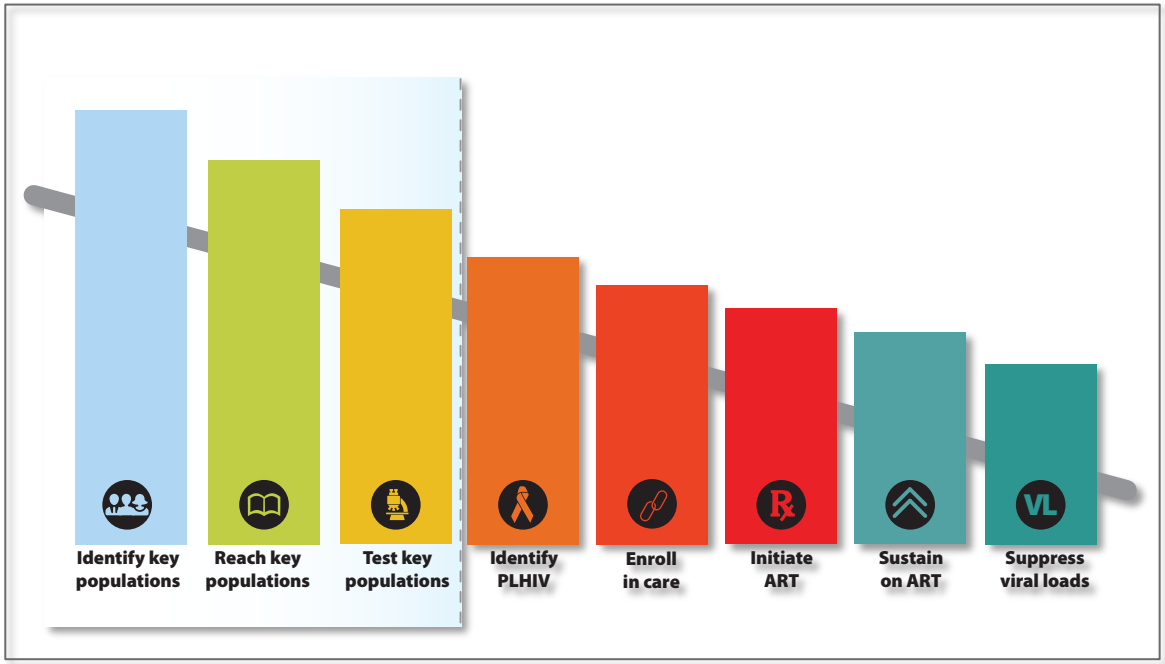


Figure 1 | **Continuum of HIV prevention to care (CoPC) cascade**

[1] Strategic objective wording has been slightly revised to reflect the nature of this iterative program. Objectives 2 and 3 also have been reordered.

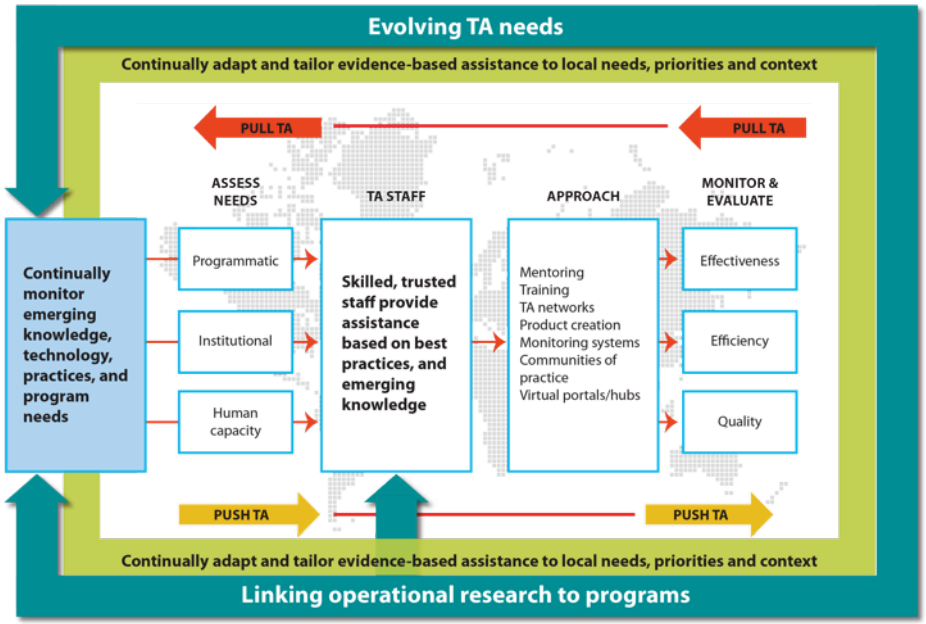


Figure 2 | **Vietnam TA Systems Framework**

3 *Transition financial support and administrative and technical ownership of CoPC services.* As implementers view the HIV response through the lens of the HIV cascade, they can optimize the use of limited resources (whether they be financial, human and technical) to work towards the USAID/SMART TA goal of "transitioning a minimum of 40% of USAID-supported CoPC interventions, partners and sites to GVN and local partners."

Systems-oriented TA focus

USAID/SMART TA utilizes a combination of complementary "*push*" (promoting new knowledge, findings and best practices) and "*pull*" (facilitating access to technical information and skills) TA to standardize individual or site-level competencies, maintain service quality, and build enduring TA networks and institutions. We continually monitor emerging knowledge and practice to identify relevant TA opportunities, and we utilize systematic tools/approaches – including the CoPC cascade framework, targeted operational research and CoPC SMART technical monitoring methodologies – to identify and act upon TA needs, challenges or priorities. Both push and pull TA will now be facilitated and monitored through our electronic TA tracking system, the national VAAC learning portal, and through innovative social media channels.

As Vietnam lays the foundations for an upper middle-income society, its individuals, programs and institutions must have the requisite capacity to overcome development challenges and advance socioeconomic growth. USAID/SMART TA works within a systems approach – particularly at the provincial levels – to ensure that TA is managed, delivered and monitored in effective, efficient, and ultimately sustainable, ways. We support the national methadone mentorship system, and are building trusted local TA networks and assisting designated TA institutions across the CoPC.

Rational, feasible transitioning approach

Progress towards full country ownership has been slow because: (a) CoPC service models are too expensive to sustain given the limited national funding allocations to the HIV program; (b) there are no currently available resources and systems for purchasing, procuring, distributing and managing antiretroviral drugs and methadone; (c) service systems in most provinces are fragmented across different donor-funded projects; (d) provinces lack important technical capacities for sustainability; and (e) strong governance and coordination of the HIV response is lacking. USAID/SMART TA employs a comprehensive transitioning approach that strives to achieve the following goal:

40% of CoPC interventions, partners and sites transitioned to the GVN and local partners with resources coming from the Government, other donor sources and efficiency gains.

With service sites as the primary unit of transition, USAID/SMART TA works to:

- Provide TA to improve service affordability
- Use strategic information and specialized tools to identify transitioning priorities, track progress and monitor quality
- Reduce unnecessary reoccurring operating costs
- Support the development and functioning of local TA networks; and
- Provide tailored TA to ensure the "effective" performance of CoPC sites before, during and after transition.

Visioning success

USAID/SMART TA's vision of success can be summarized in a single sentence: "effective programs that cost less, use local TA and decrease donor dependence" (Figure 3). For SMART TA:

Effective programs improve CoPC cascade performance and ultimately move us towards AIDS elimination. They continually monitor practice and generate/use data or scientific knowledge to ensure that programmatic focus is placed on interventions that will achieve population-level impact. Program enhancements and innovations are introduced to respond to constantly changing realities and different local contexts. A strong client-centered focus ensures service access and uptake of key populations, PLHIV and their intimate partners.

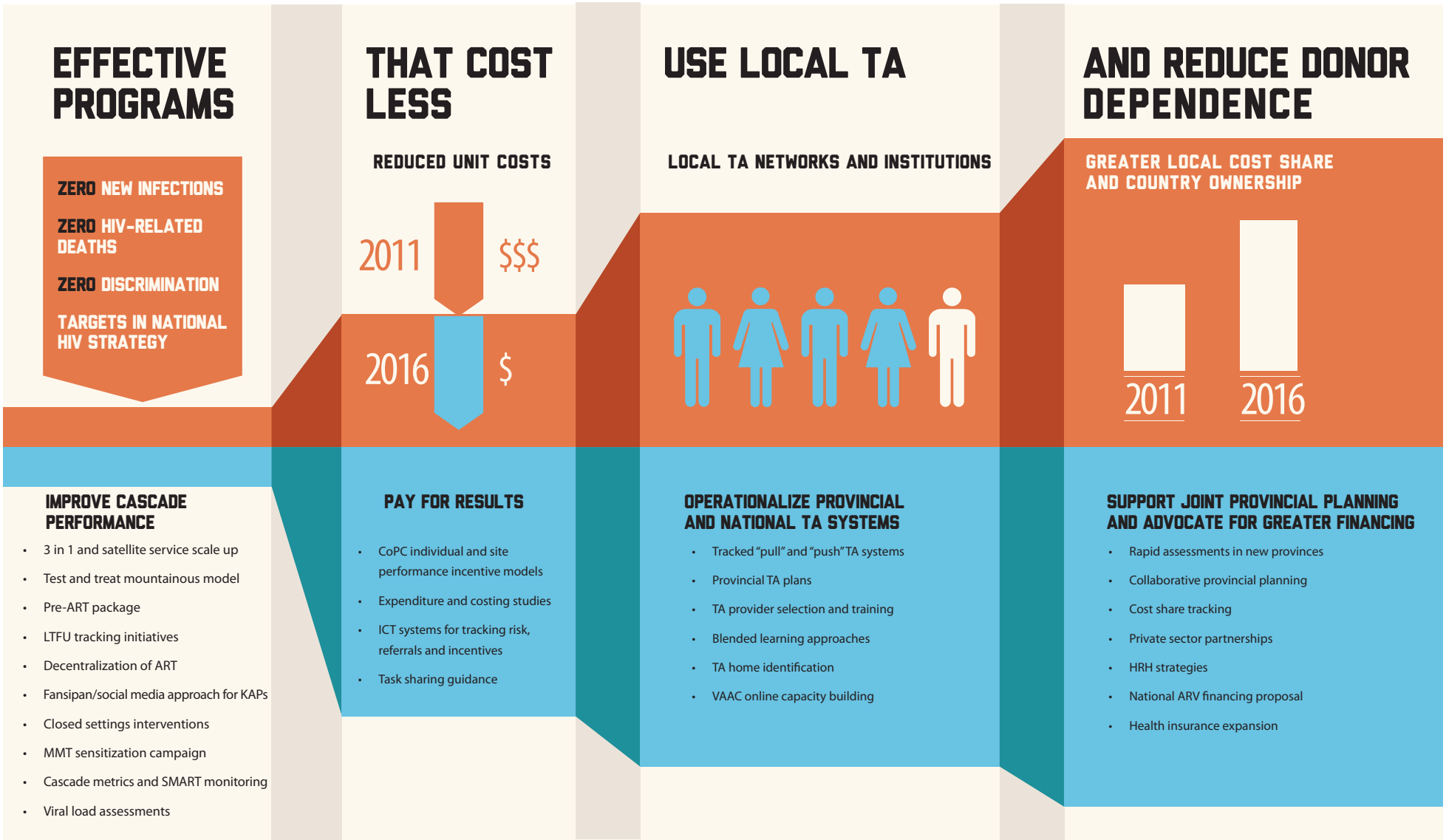
Programs that **cost less** emphasize effective use of resources and cost efficiencies in program design, implementation and scale up. They strategically use technology to reduce expensive – and largely unsustainable – human capital. They pay for performance and take advantage of the resources available, whether they come from the GVN, civil society and/or the private sector. They are conscious of their costs, link expenditures to key programmatic outcomes, and reduce unnecessary staffing and other direct expenses.

Trusted **local technical assistance providers** and institutions ensure the quality, effectiveness, efficiency and sustainability of an evolving response. TA approaches

follow a systematic process, use innovative tools and adapt a variety of push and pull methods that can be tracked and measured. USAID/SMART TA technical personnel support the burgeoning TA system and continually adapt or tailor evidence-based assistance as per local needs, priorities and contexts.

Direct service delivery is thoughtfully and rationally **transitioned** through a planned, managed approach that assesses service technical performance and GVN or CSO readiness, capability and resources. Site or intervention quality and client service access is closely monitored and remains stable following DSD graduation, as evidenced by post-transition monitoring.

Figure 3 | **SMART TA vision of success in Year 3**



Year 3 challenges, responses & results

USAID/SMART TA identifies a number of current **challenges** that stand in the way of a Vietnam AIDS-free generation:

- Substantial, local HIV epidemics are occurring in poorly or underserved areas across the country.
- PLHIV are often not seeking testing and, after testing positive, may not be linked into continuous care until they are ill.
- The rate and number of individuals newly initiating ART is not growing or declining in most service sites, and a significant proportion of clients are dying, dropping out of treatment or being lost to follow up.
- Coordination across provincial service systems remains fragmented and focused on "project-based" interventions.
- In country TA and capacity building strategies lack strategic focus, effort and coordination.
- Donor resources are declining and service system costs require continual monitoring and refinement to ensure that available resources are used most effectively and lead to sustainability.

In Year 3, we have focused our technical assistance and programmatic resources to effectively **respond** to these challenges and achieve **results** across the three SMART TA strategic objectives:

1. Deliver quality HIV services within the CoPC.
2. Strengthen GVN and CSO technical capacity to sustain quality CoPC services.
3. Transition financial, administrative and technical capacity of CoPC services.

Deliver quality HIV services within the CoPC

Quality HIV services are fundamental for moving the country towards its AIDS control goals. In year 3, USAID/SMART TA provided targeted and tailored assistance to:

- Respond to local epidemics in underserved areas
- Support key populations to test for HIV and assist PLHIV to enter care and treatment services
- Improve quality of care, reduce loss to follow up and support (re) engagement in the HIV service system

Our technical assistance was multi-faceted. We helped provinces analyse their epidemics and prioritize highest impact interventions; we established new service sites in underserved areas; we introduced innovative ways to deliver community-based outreach; we developed and tested information communications technology systems; we sought to better understand why PLHIV drop out of treatment or are loss to follow up; and we established mechanisms which pay for important cascade results.

These are our key achievements[2].

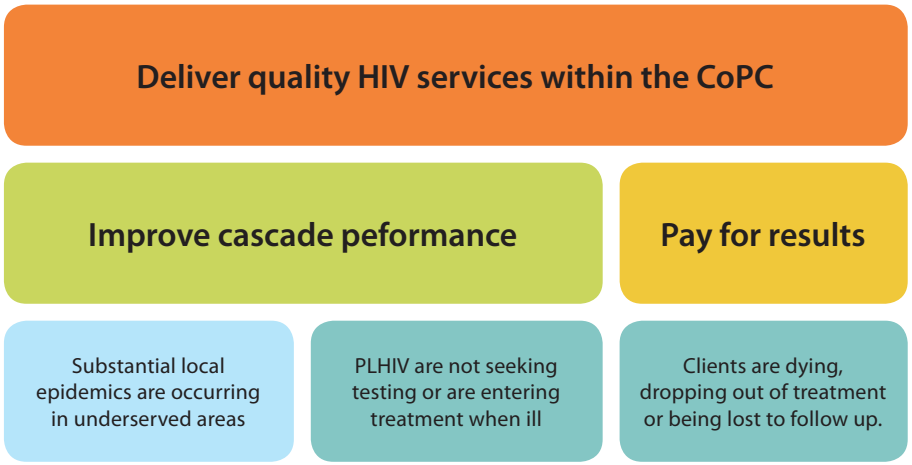


Figure 4 | **SMART TA strategic objective 1: challenges and key responses**

[2] A detailed listing of deliverables against SMART TA's original FY14/COP13 work plan priority activities is included in Annex 1.

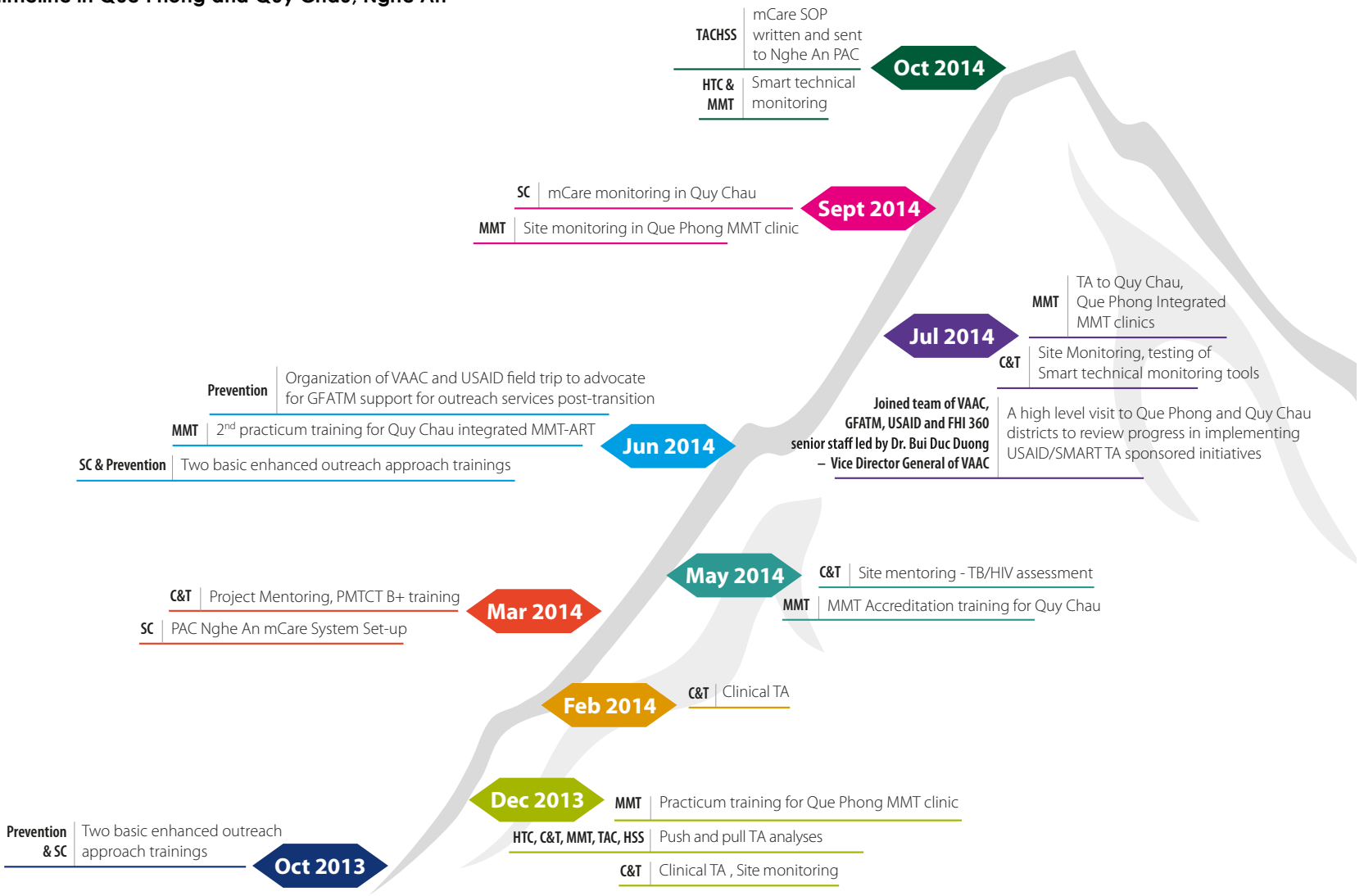
In Nghe An, 2 underserved districts identify 40% of all newly diagnosed PLHIV

Reaching the right people, with the right interventions, in the right places lies at the heart of high impact HIV programming. This year, USAID/SMART TA provided comprehensive, time-bound technical assistance to establish and implement CoPC services in Que Phong and Quy Chau, two underserved areas in Nghe An province. We established the basic enhanced outreach approach that mobilized hamlet health workers to identify high needs individuals, promote mobile HIV testing services, and find PLHIV who had been lost from the HIV service system. We helped to accredit MMT staff in newly integrated MMT facilities. We provided targeted capacity building for health providers to supply quality 3-in-1 services. Our technical experts delivered site monitoring and clinical mentoring assistance, and we introduced the information communications technology system, mCare, to help track PLHIV across the CoPC (Figure 5).

Que Phong and Quy Chau conducted 1755 HIV tests, and identified 19.3% positive cases in FY14. In contrast, 11,033 HIV tests conducted in all other areas of the province netted a 7.6% positivity rate. This means that 40% of all diagnosed PLHIV in the province hailed from either of these two districts.

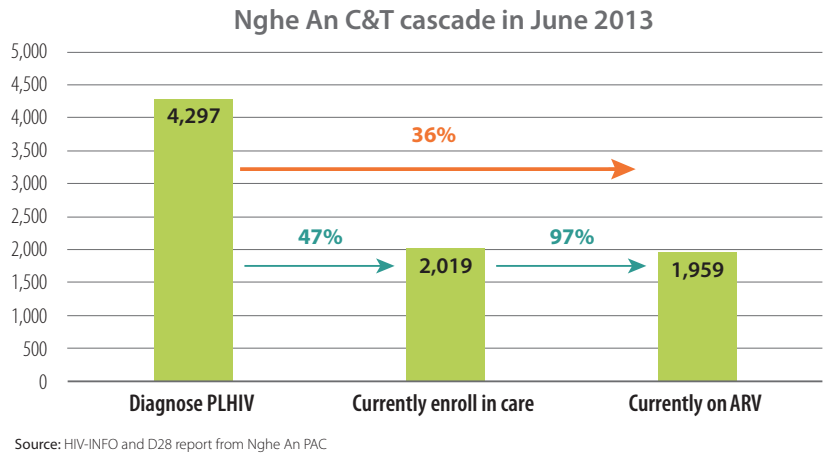
The value of targeted service programming extends past the local impact that they have for HIV positive individuals and vulnerable communities.

Figure 5 | TA timeline in Que Phong and Quy Chau, Nghe An



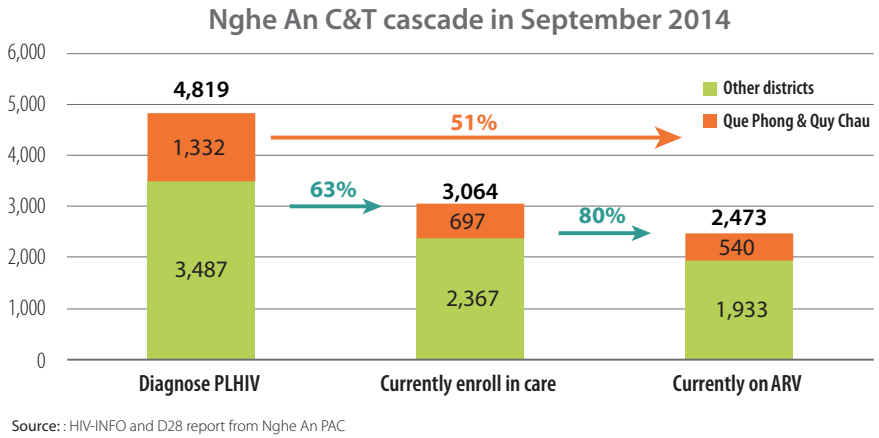
Every quarter

HTC | SMART TA HTC site monitoring and feedback



Source: HIV-INFO and D28 report from Nghe An PAC

Figure 6 | Nghe An care and treatment cascade, June 2013



Source: : HIV-INFO and D28 report from Nghe An PAC

Figure 7 | Nghe An care and treatment cascade, September 2014

Service provision in Que Phong and Quy Chau has actually improved the overall provincial cascade performance in just over one year. Figure 6 illustrates the Nghe An provincial cascade in June 2013, before the introduction of CoPC services in Que Phong and Quy Chau. Then, less than half of the total diagnosed PLHIV had enrolled in care and 36% were currently on ART.

By September 2014, 63% of all diagnosed PLHIV have been enrolled in care, and 51% are on ART (Figure 7).

USAID/SMART TA is currently working with the Nghe An PAC to fully transition these services, which will be financially supported through GFATM resources beginning in January 2015.

Ratio of females on ART climbs after gender assessment

After an USAID/SMART TA-commissioned gender assessment recommended that the program step up efforts to address gender issues in the program, we've emphasized the inclusion of gender breakdowns in all cascade analyses (Figure 8), and sought to improve the ways in which we reach key population (KP) intimate partners across the CoPC. Interventions like the enhanced outreach approach now include KP partners (particularly partners of PWID) as priority populations, and systematize partner referrals in outreach contacts. HIV testing and counselling technical staff are developing more rigorous partner notification strategies for newly diagnosed PLHIV, and *I Want* communications strategies are highlighting women in promotional materials about the benefits of early ART.

This year, the ratio of women newly enrolled on ART in USAID/SMART TA supported facilities climbed significantly, from 0.473 in FY13/COP12 to 0.545 in FY14/COP13 (Figure 9). The total ratio of females on ART also saw a slight increase – to 0.536 from the FY13 figures of 0.525.

This upward trend is encouraging. USAID/SMART TA will continue to develop and strengthen its gender sensitive programming in FY15 to ensure that all persons access the services they need at each step of the CoPC cascade.

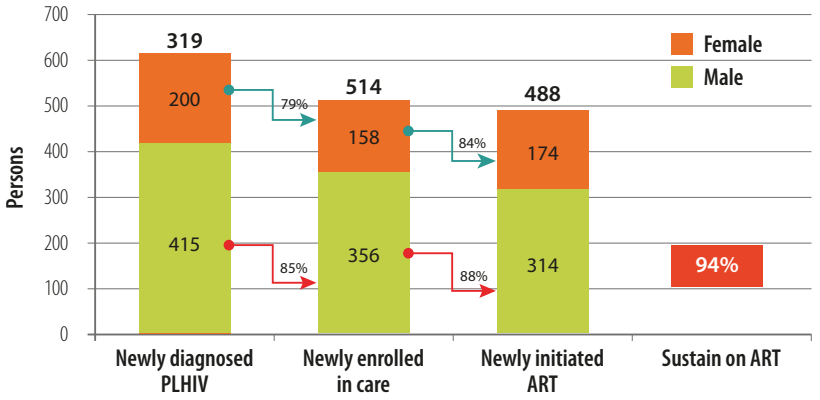


Figure 8 | HIV CoPC cascade, Province "A", January - December 2013

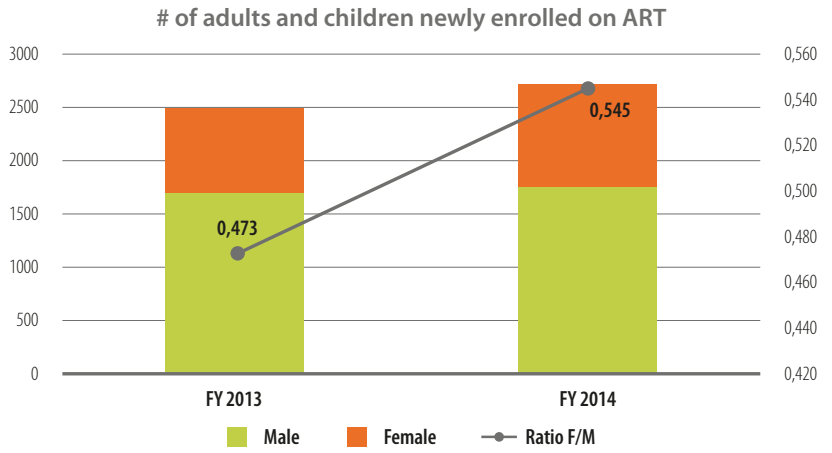


Figure 9 | Gender ratio, # of adults and children newly enrolled on ART

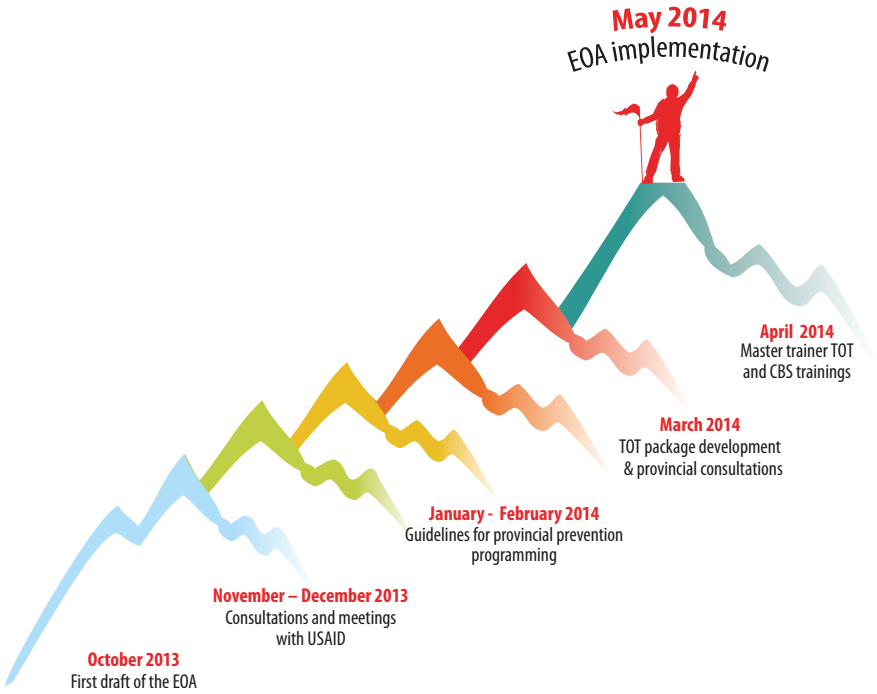


Figure 10 | EOA development timeline

Enhanced outreach approach closes diagnosis and enrolment cascade gaps

In Vietnam, as in many other countries, the biggest "leaks" in the HIV service system are found between outreach and HIV testing, and between HIV diagnosis and care and treatment enrolment. Traditional HIV prevention programs often struggle to increase HIV testing uptake, and HIV positive key populations – for a variety of personal and structural reasons[3] – may delay enrolment in HIV care.

This year, USAID/SMART TA has transformed traditional HIV prevention programming into the enhanced outreach approach, or EOA (Figure 10). The EOA is a series of complementary and mutually reinforcing community-based HIV interventions that help government, civil society organizations (CSOs) and community groups reach, test, treat, and retain key populations in the HIV service system, using available resources.

Over the fiscal year, USAID/SMART TA developed a variety of EOA job aides, communications/M&E tools, and enhancements that help implementers improve HIV cascade

[3] The "Risk factors for delayed entrance into care after diagnosis among patients with late stage HIV disease in Southern Vietnam – prepared by USAID/SMART TA and published in PLOS One – identified the following reasons for late entry: feeling healthy; fear of stigma and discrimination; time conflict; did not want to know if infected; and fear of confidentiality.

performance. Fifty-five GVN and CSO EOA master trainers – identified and supported by SMART TA – led capacity building efforts and monthly monitoring and mentoring of 189 community-based supporters and their first wave counterparts in nine provinces. From the initiation of EOA programming, the proportion of key populations testing for HIV has far surpassed traditional outreach results, from 38.5% between October 2013 and March 2014 (before the EOA), to 80% over five months of EOA programming. The gap between positive diagnosis and HIV care enrolment virtually disappeared in areas implementing the EOA, with all reported HIV positive individuals enrolling in care immediately after diagnosis.

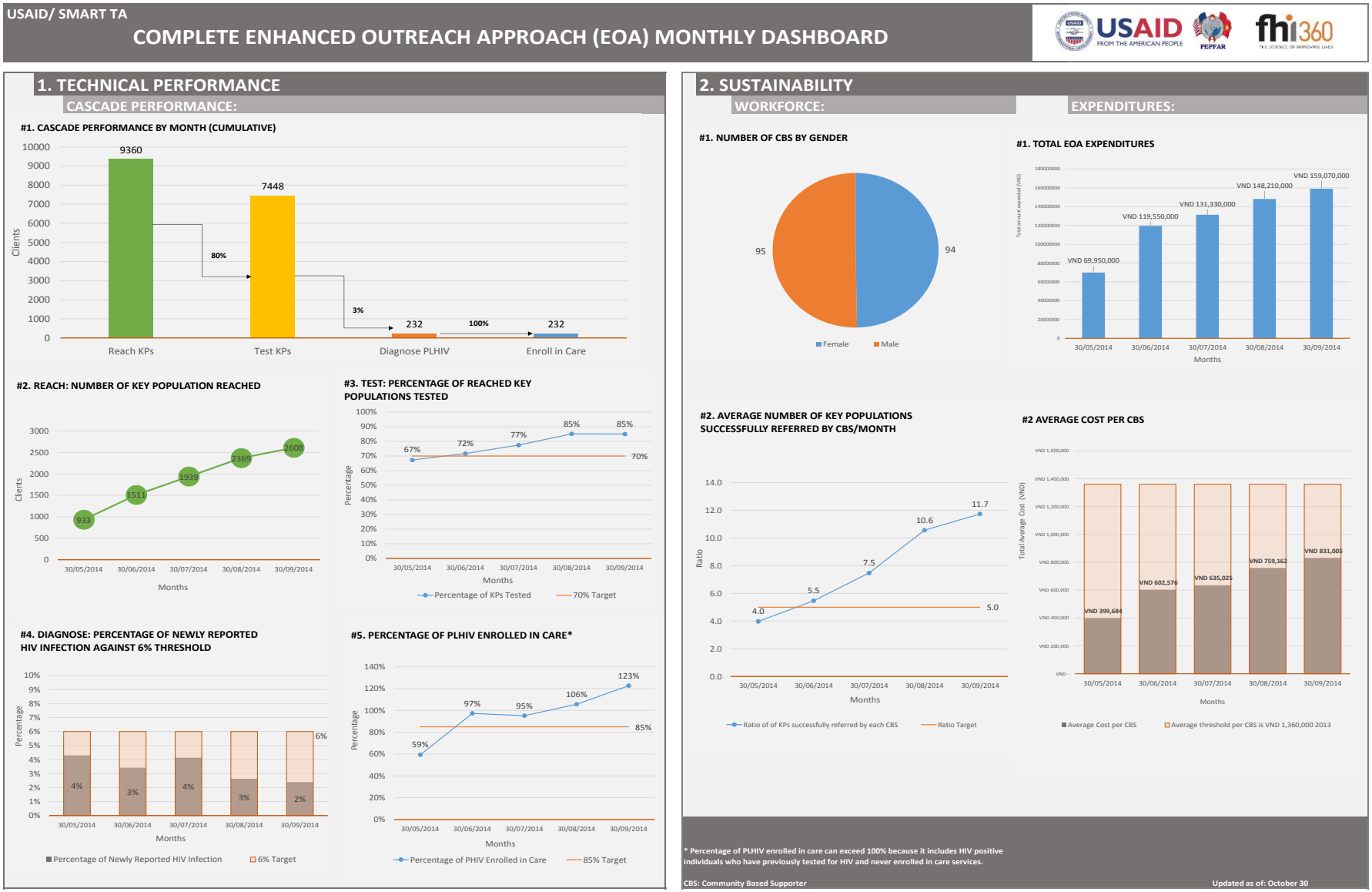
"The EOA promotes high risk groups to use HTC services, and motivates community based supporters (CBS) to reach and support clients across the CoPC," says Ms. Le Thi Ngoc Bich, an HTC counselor at Anh Duong, HCMC. "I have successfully referred 57 drug users to HTC and care and treatment services since June," adds Ta Quang Canh, a CBS in Le Chan district, Hai Phong. "And those 57 drug users referred another 39 PWID (mostly their friends and sex partners) to HTC. There are still many PWID who never get to services, so there are lots of people left to refer."

An overview of EOA cascade performance is detailed in Figure 11 and specific results are further described throughout the annual report. The EOA dashboard is included in Annex 5.

HTC-community linkages improve site performance

In An Duong, Hoc Mon and District 3 (HCMC), strong community and facility linkages have greatly improved HIV yield rates and facility-based referrals. An Duong – traditionally focused on FSWs – worked with EOA implementers in FY14 to expand utilization rates among other KPs, like MSM, and saw its HIV yield rates climb from 6.91% (FY13) to 9.6%. Almost 97% of HTC clients returned for their results, and 84% of PLHIV were successfully referred to care and treatment services. In District 3, KP client volume doubled during the reporting period – with HIV positivity at 9.7% -- and successful HTC-OPC referrals rose to 98%. Hoc Mon saw a 25% increase in KP customers, a 6% increase in return rates, and a 100% HTC-OPC referral rate over FY14/COP13.

Figure 11 | EOA cascade and sustainability performance, 9 provinces (May – September 2014)



ACIS breaks down CoPC service system barriers[4]

"The Access to Care Information System (ACIS) eliminates donor boundaries and involves all health facilities in the referral network," explains Dr. Khanh, the Director of Hai Phong Provincial Health Service. "This is why ACIS is so important."

ACIS is an open-source, SMS-based platform that provides automated referral tracking between HIV testing and care and treatment services. In so doing, ACIS helps health professionals systematically follow clients across key HIV service points, which ultimately assists patients to enter services more quickly and supports health providers to minimize loss to follow up.

In FY14/COP13, USAID/SMART TA worked closely with the Government of Vietnam and the Clinton Health Access Initiative (CHAI) to design and deploy ACIS across Hai Phong, Hanoi, An Giang, HCMC and most recently Can Tho and Quang Ninh provinces. We facilitated half-day ACIS training sessions for staff at 59 HTC facilities and 57 HIV outpatient clinics. We prepared SOPs for outpatient transfer procedures that utilize SMS messaging support. We provided ACIS set up and monitoring assistance throughout the deployment process.

Over the reporting period, 66% (Hai Phong), 71% (Hanoi) and 97% (An Giang) PLHIV were recorded by ACIS as successfully entering HIV care following a positive diagnosis. The median time between referral and presentation at the service ranges from 16.6 days in Hai Phong, to just 1.06 days in An Giang. While SMART TA-supported sites typically perform better than other facilities utilizing ACIS (e.g. lower median times between referral and presentation), evidence shows that all ACIS-equipped sites successfully refer PLHIV much more quickly than the national 90-day window.

ACIS has also been used to track transfers between outpatient clinics in HCMC. Between May and September 2014, ACIS confirmed that 84.9% of 219 patients arrived at receiving outpatient clinics within 11 days of referral. For clients that do not present at services, USAID/SMART TA is helping our partners activate the EOA and more aggressive clinic-initiated case finding strategies in all PEPFAR priority provinces.

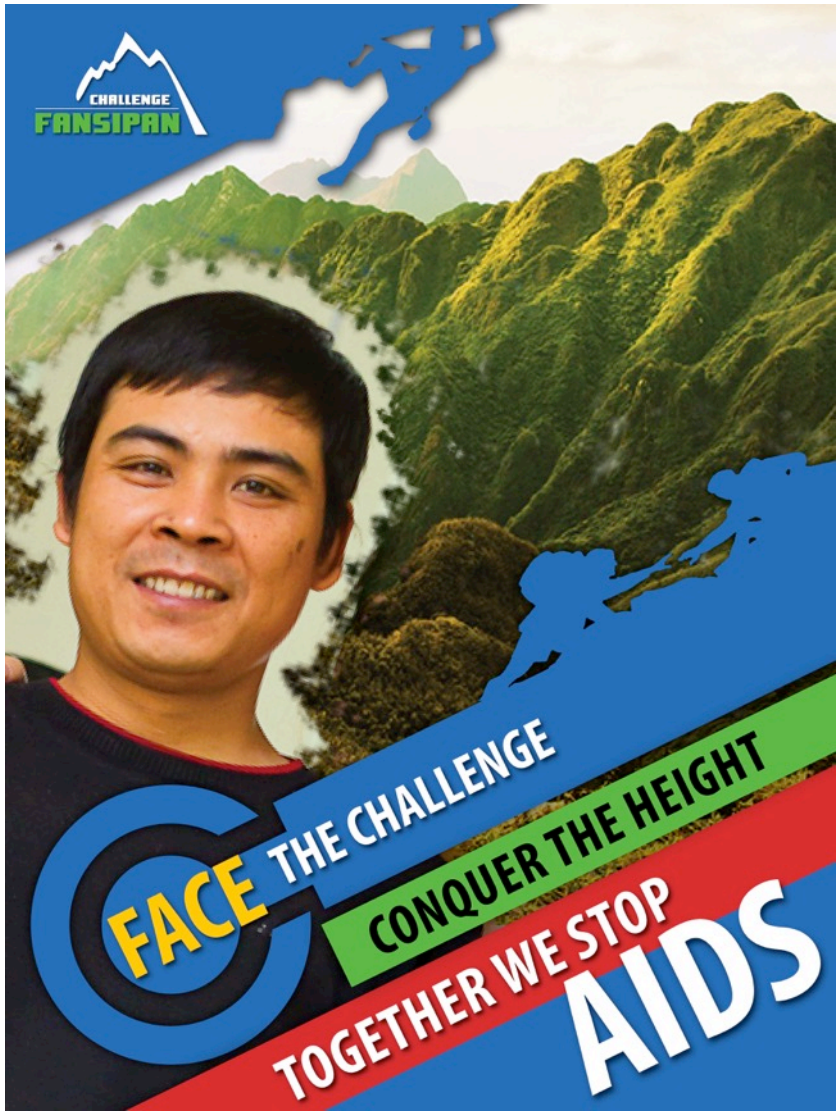
Injecting drug users in HCMC climb Fansipan

The Fansipan Challenge – a novel ARV-based prevention approach developed by USAID/SMART TA – uses peer-driven recruitment strategies, elements of gamification, and mobile technologies to increase HIV testing and enrollment in care

among people who inject drugs and their intimate partners. Over a six-month period (June – November 2013), 62% of 656 clients tested for HIV after a single contact. Approximately 71% of these individuals were first time testers; 17.8% were diagnosed as HIV positive and those who enrolled in care had higher than average CD4 counts.

Comparative expenditure analyses of USAID/SMART TA-supported outreach services show a dramatic reduction in costs associated with identifying an HIV positive person, from $132 USD (conventional outreach) to $72 USD (Fansipan Challenge).

The Fansipan Challenge was one of four finalists selected for USAID's Mobile Solutions in Asia Prize in January 2014, and has been featured in Huffington Post, Forbes Magazine, Tech in Asia, and Techonomy. It demonstrates that mobile technologies can maximize the benefits of HIV programs by effectively and efficiently reaching, testing, treating and retaining key populations. And it shows that game-oriented and social network-driven, cell phone-based recruitment strategies can link clients reached to HIV testing, with a high yield of HIV infected individuals in need of care, and a cost per case identified of less than half of conventional outreach approaches.



Technical assistance helps hundreds of PLHIV access ART in closed settings

USAID/SMART TA provides technical assistance to PACs in five provinces[5] to establish HIV testing and treatment services in targeted prison settings. This year, we prepared a closed settings service strategy and outlined community-based post release transfer procedures. We developed SOPs for prison-based HTC and ARV provision that is delivered through GFATM resources; prepared training materials that have been formally endorsed by VAAC; and technically supported provincial TA teams of PAC medical personnel and infectious department or outpatient clinic service providers to deliver, manager and monitor CoPC services. Over the year, 6816 prisoners tested for HIV, with HIV positivity rates ranging from 0.42% (Ninh Thuan) to 19.77% in Ha Nam. Of the 288 newly reported HIV infections, 285 were immediately enrolled in care and treatment services. A total of 360 inmates are now on life saving ART, and an additional 180 persons are accessing pre-ART services.

GFATM and the GVN have requested USAID/SMART TA technical assistance across an additional 18 prisons in FY15/COP14.

[5] Bac Giang, Ha Nam, Quang Ninh, Ninh Thuan, and Hau Giang provinces

TB/HIV service integration is a sustainability solution

Annex 6 includes a story on the TA efforts of USAID/SMART TA to strengthen TB/HIV integration. Integrated TB/HIV interventions not only improve the quality of care of PLHIV, they reduce loss to follow up, and promote the sustainability of services in Vietnam.

EOA case finding efforts pay off in Hoang Mai

Before introducing the enhanced outreach approach in Hoang Mai, Hanoi, 43% of PLHIV presenting at care and treatment services between December 2013 and April 2014 had CD4 levels of <100. Approximately 19% displayed CD4 levels of 100 to <250, while just 4.76% had CD4 levels from 250 to <350.

In the months following EOA initiation (May – September), the proportion of clients with CD4 levels of <100 dropped to 17.39% and the proportion of those with higher CD4 counts similarly rose to 21.74% (100 to <250), and 43.48% (250 to <350), suggesting that case finding through methods like the EOA has the potential to find PLHIV earlier in their infection.

HIVQUAL shows steady improvements in quality of care

Twenty-six USAID/SMART TA-supported care and treatment sites are now included under the national HIVQUAL system. Over five rounds of HIVQUAL, these sites (as they are incorporated into the system) have shown a steady improvement in key quality of care indicators:

Indicator	2012	2014
Proportion of patients newly registered at the OPC in last 6 months and tested for CD4 within 15 days of enrolment	66.67% (2011)	72%
Proportion of pre-ARV patients who visit the OPC regularly	33%	69%
Proportion of ARV patients visiting the OPC for reexamination and medication pick up according to scheduled appointment in the last visit	66.67%	80.77%

Five outpatient clinics (Dien Bien, Dong Hung, Hoc Mon, Thu Duc) further show substantial reductions in loss to follow up, death rates, and transfers out between 2012 and 2014.

"I really like this data feedback, it is so great. As a staff working at site levels, I find it difficult to spend time reviewing data. However, with this poster, it is very easy for me – as a chief of the unit, I now know exactly our situation and how many clients we are taking care of."

Dr. Thu Ba, Chief, Do Son OPC

Each quarter – and with each successive HIVQUAL round -- USAID/SMART TA reviews site-level data as a key means by which to tailor TA delivery and prioritization. Easy-to-follow data visualization dashboards (see Annex 5 and Figure 12) facilitate analysis and TA efforts.

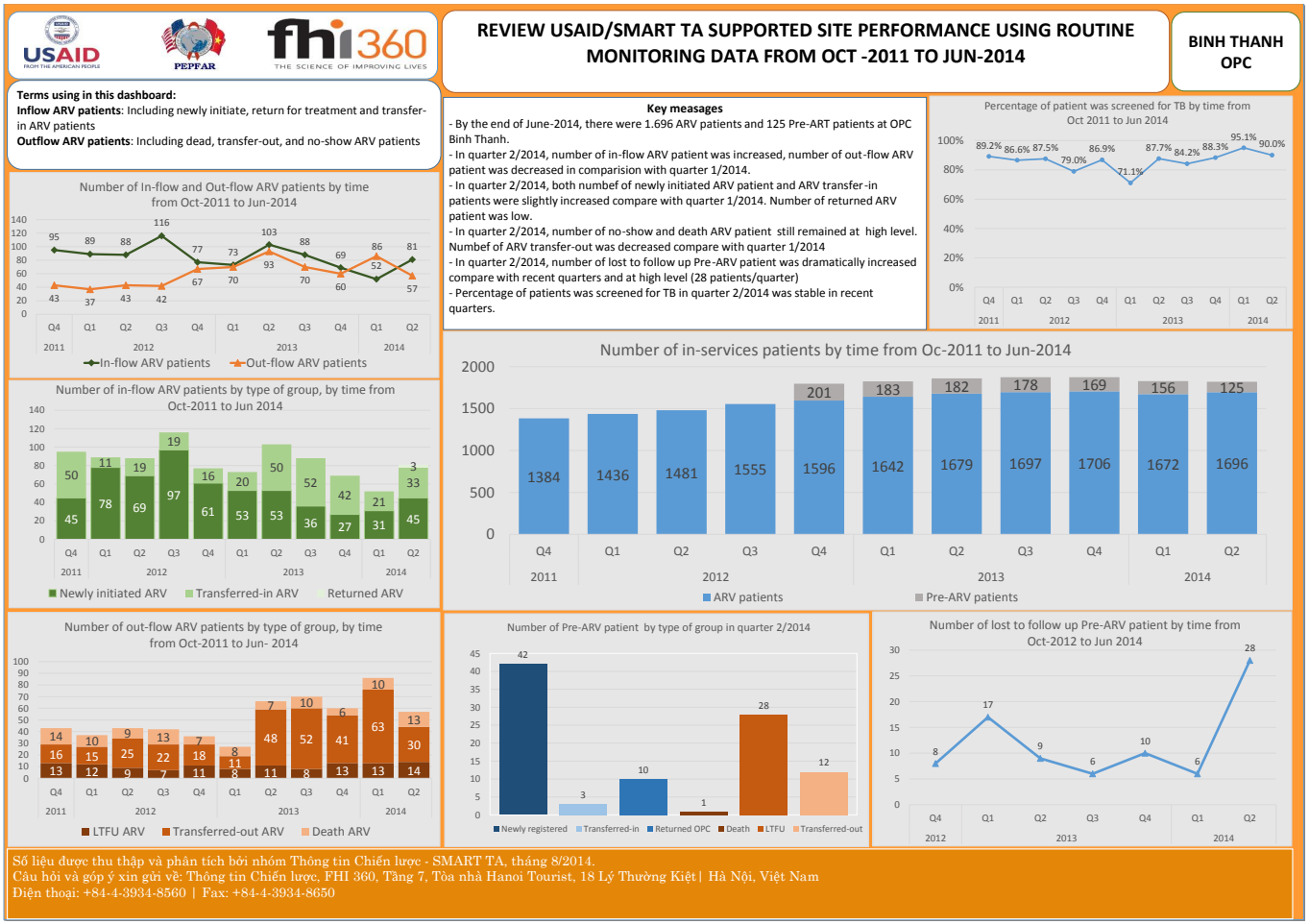
MMT services return HIV positive PWID to care

See Annex 6 to learn how USAID/SMART TA efforts are helping MMT service providers play instrumental roles in identifying loss to follow up PLHIV and returning them into care and treatment services.

Data feedback assists site quality improvement efforts

This year, USAID/SMART TA changed the way we provide data to PACs and the care and treatment sites we support. We asked our partners how and in what format data would be most useful: partners highlighted the need to have regular information updates that all staff could see and discuss. We now produce data feedback posters (Figure 12) that are provided each quarter to provincial and site partners.

Figure 12 | Binh Thanh OPC data feedback poster



Posters are displayed in high traffic areas such as staff meeting rooms, and form the basis for clinic monitoring discussions and actions. "This data feedback poster is great," says Dr. Hung from the Hai Phong PAC. "When I visit a site, I just need a quick look at this poster and I will know exactly about the current situation at this site. Without it, it is difficult to read all the detailed reports and identify the issues. Looking at this data feedback poster, I find it easy to understand the status of the OPC and the issues they have."

SMART TA conducts first cascade completion study in Vietnam

This year, USAID/SMART TA conducted a number of strategic programmatic studies that help the GVN place focus on interventions that will achieve population-level impact (Figure 13). One of these studies is the ART cascade completion study that we initiated in July 2014 across four urban (HCMC, Quang Ninh) and rural (An Giang, Dien Bien) provinces. The study is the first assessment of its kind in Vietnam that provides a complete picture of ART service performance. Previous studies in Vietnam that have examined viral suppression have been small and concentrated in infectious disease hospitals like Bach Mai and TDH. Other recent studies (e.g. WHO and CDC/WHO) have examined changes in the acquired and transmitted drug resistance over time in cohorts of patients.

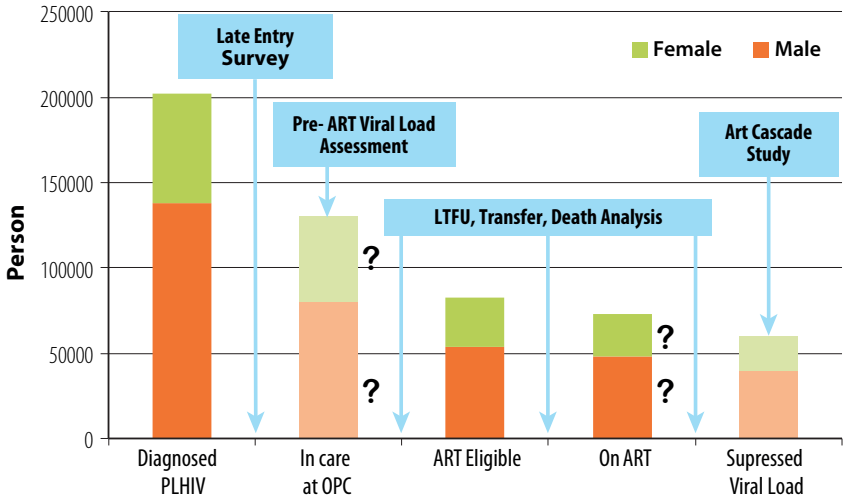


Figure 13 | High impact cascade of care studies

The ART cascade completion study, along with other key analyses such as the late entry survey and the pre-ART viral load assessment, form part of our strategic information TA to continually monitor practice and generate or use scientific knowledge for greatest programmatic effect.

OPC e-Logbook computes routine reports "in just a few clicks"

"It took me so long to calculate routine reports [with the paper-based logbooks]," explains one Hai Ba Trung OPC staff member in Hanoi. "Now I can do it with just a few clicks – not just the D28 and PEPFAR reports, but the HIVQUAL reports as well. It's amazing!"

In January 2014, USAID/SMART TA developed an electronic logbook tool to:

- Support OPCs to input and automatically export data for PEPFAR and D28 monitoring reports
- Support OPCs to input and automatically export data for HIVQUAL reporting and analysis
- Enable OPCs to easily export data for ARV and pre-ARV logbooks

We are trialing the e-logbook at the Hai Bai Trung OPC in Hanoi; after one quarter of implementation – where we checked and

verified e-logbook records with the paper-based versions – we found that all e-logbook entries were accurate. There are now plans to expand utilization of the e-logbook across targeted SMART TA-supported sites as an immediate data quality and time management tool that can be utilized by OPC staff until national solutions like e-clinica lite are rolled out.

DQA finds substantial data improvements in Dien Bien

USAID/SMART TA conducts routine data quality audits (DQAs) at its supported sites to ensure the quality of reporting data, particularly its completeness, accuracy and reliability. We review five key outreach indicators, six MMT indicators, five HTC indicators, and 11 care and treatment indicators when monitoring CoPC sites each annum.

In past DQA visits, completeness and reliability of client records, and therefore the accuracy of reports, have been problematic. USAID/SMART TA works with our partners to generate data quality action plans following every DQA exercise; this year we followed up with the Dien Bien PAC and compared the results of their previous DQA with the one conducted in FY14.

In the previous DQA, data variance for three outreach indicators was 29.5%, 22% and "cannot verify" in Dien Bien, and 19.8%, 45%

and 68.5% in Tuan Giao. This year, there was no data variance issues identified. Significant improvements were also found across all MMT indicators.

USAID/SMART TA plans to continue rigorous DQA exercises in FY15/COP14, and transfer DQA data verification and analysis responsibilities to members of the local TA networks. We also are helping VAAC finalize the national DQA guidelines so that data quality audits will be a routine part of all interventions within the HIV response.

Performance-based incentives (PBIs) improve performance, and save money

"I work hard, but I receive the same amount as other peer educators who do less," explained one peer educator at the start of the enhanced outreach approach (EOA). "This gives me less motivation to improve my work."

This year, USAID/SMART TA introduced performance-based incentives as an integral part of our EOA strategy for improving community-based outreach across the CoPC.

We get some bonus from the program, not much, fifty thousand VND, just enough for iced tea but I like to be a community-based supporter (CBS) as I have opportunities to attend the trainings, and the chit–chat meetings in the cafes. I have more friends now and that's pretty cool."

Nguyen Quoc Anh, CBS in Tay Ho, Hanoi

Over a five-month programming period, the ratio of successful service referrals per community-based supporter (CBS) has steadily increased, from four referrals in May 2014 to 11.7 in September. Incentives likewise have increased: September EOA expenditures across nine provinces totaled 159,070,000VND or 831,005 VND/CBS on average.

Despite these escalations, expenditures remain much lower than conventional outreach programming[6] in Vietnam, which spent an average of 1,360,000 VND/month per peer educator, irrespective of individual performance levels.

USAID/SMART TA will continue to test PBI systems in FY15/COP14 and incorporate care and support incentives within the EOA. We also will look at ways in which PBIs can be sustained within locally managed responses, either by the GVN or through innovative community and private sector partnerships, in collaboration with the newly initiated USAID Health Markets program.

Expenditure analyses provide important intervention baselines for sustainability efforts

USAID/SMART TA became the first Vietnam PEPFAR-supported implementer in FY14/COP13 to link expenditure analyses (EA) to site-level program outcomes. Our EA exercises were carried out to assist in our ROC reduction efforts; to inform strategies that help CoPC services become more affordable; and to provide baseline data for sustainability goals.

Two key indicators – the median unit expenditures to identify newly reported HIV infection and the median unit expenditures to sustain clients on ART (1st and 2nd year) (Figures 14 and 15) have been selected as one of the means by which we will track direct service delivery graduation progress. In particular, we are measuring the median % difference over time, as we strive to consolidate, integrate, and improve service site functioning for local sustainability.

[6] Peer education stipend average (USAID, CDC-VAAC and GFATM monthly expenditures)

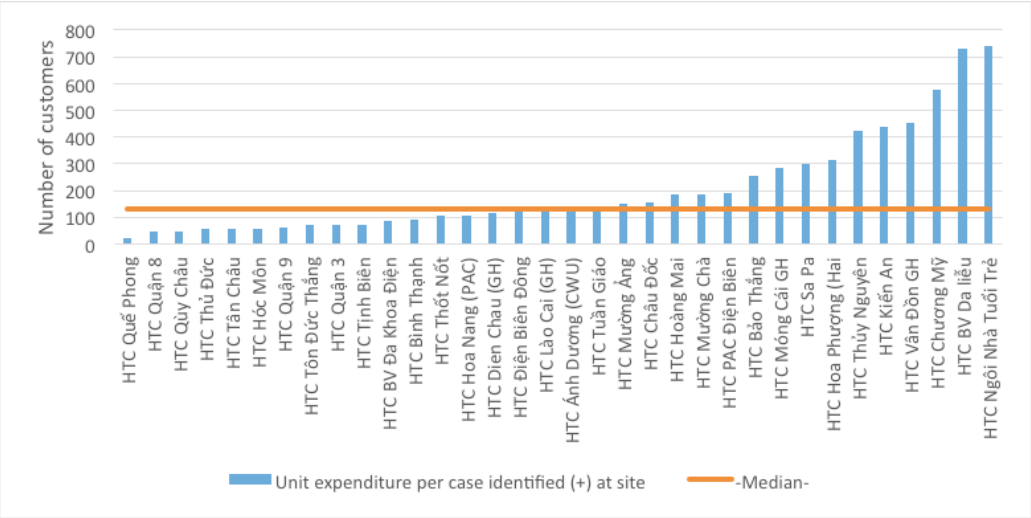


Figure 14| **Unit expenditure per case HIV positive (median $131.8 USD)**

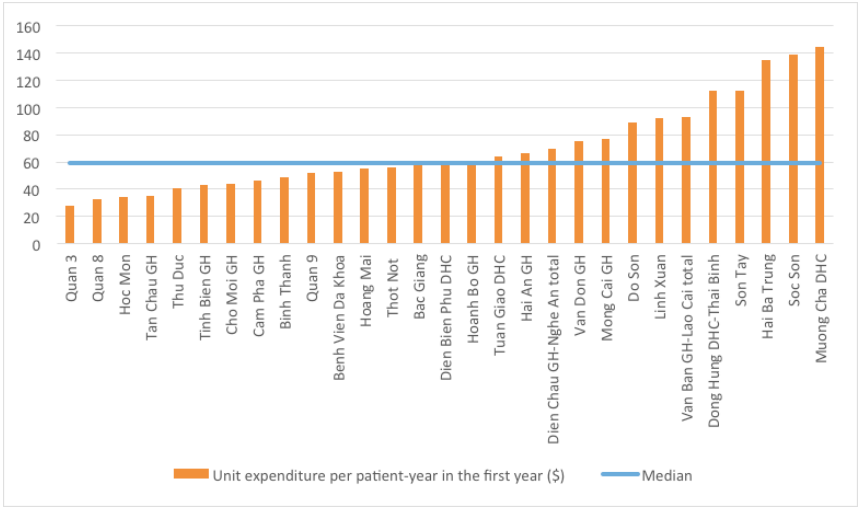


Figure 15| **Unit expenditure to sustain client on ART for 12 months in the first year (not including drugs) (median $59.1 USD)**

Strengthen GVN and CSO technical capacity to sustain quality CoPC services

Individual, site, provincial and national capacity is critical to the short-term success and long-term sustainability of effective CoPC programs and services in Vietnam. In fact, quality TA is the bedrock of the HIV response: good TA incorporates emerging science and knowledge to strengthen high impact interventions; it fosters the continuation of efforts that achieve results; it encourages changes in programming for greatest efficiency; and it assures the quality of CoPC services over time and space.

Like in many countries, however, TA services are fragmented and not well coordinated in Vietnam. Typically, an "expert" model of TA delivery is used with international or national subject matter experts traveling to the country or to provinces to lecture on various topics with little knowledge of current successes, capacities, challenges or service system achievements. Training is not systematic and curricula are often out of date. TA focus is project-based, with lack of TA coordination across different funded initiatives. Not surprisingly, there are few attempts to track and evaluate the impact of TA efforts.

At the end of SMART TA, trusted provincial and local providers and institutions will ensure the technical quality, effectiveness and sustainability of CoPC services. Our role is to prepare, support and strengthen these provincial TA networks to effectively respond to pull TA requests, implement push TA priorities, and assume responsibility and local ownership for routine monitoring and evaluation of CoPC services and capacity building of CoPC providers.

These are our key achievements in FY14/COP13.

I became a local mentor in 2013. In the beginning, I didn't have much experience or skills: SMART TA technical staff helped me do clinical mentoring and prepare TA plans. It's now 2014 and I feel confident to conduct TA trips by myself. I feel so much happiness that I can develop my career and make a contribution to Vietnam's MMT scale up, thanks to SMART TA.

Dr. Dang Minh Hieu, national MMT mentor

More than 50% of MMT TA delivered through local mentors

In Year 3, local mentors delivered 55% of site-level MMT technical assistance, up from 39% in Year 2 of SMART TA. An additional 21% of site TA was provided through the strategic pairing of USAID/SMART TA technical experts with local mentors.

Vietnam's national MMT mentorship system currently encompasses 37 doctors and 34 counsellors. USAID/SMART TA provides technical assistance to VAAC to operationalize the mentorship system, by co-facilitating mentor training sessions; developing mentorship training curricula and job aides; and providing individualized coaching. These on-the-job apprenticeships deepen mentors' technical knowledge and experience and provide critical opportunities for TA provider skills building. Local mentors are paired with USAID/SMART TA technical staff for a minimum of three TA visits before they deliver independent TA services. All mentors – whether paired or independent – provide written TA reports to USAID/SMART TA, which summarizes key findings and curates TA recommendations for VAAC, PACs, MMT clinics and local mentors.

In the coming year, USAID/SMART TA will increasingly transfer TA capabilities to the local mentorship system as part of our sustainability agenda. We also will continue to provide national TA

"I want to say thank you for everything. Although the [TA]training course is short, it has brought me a lot of emotion.

This is the first time after a training that the 'luggage' I brought home is all the knowledge I have been taught and learned."

Vo Duyen Trang, An Giang PAC

that strengthens the MMT TA coordination and knowledge management base for long-term country ownership.

VAAC endorses local TA networks in national TA plan

USAID/SMART TA believes that peer-driven TA systems that are grounded in findings from local needs assessments; use local peers as the main providers of TA; and are linked to effective knowledge management systems are much more likely to be successful in generating sustainable capacities and effectively introducing and integrating innovations, new technologies, and best practices at the service delivery levels.

This year, nine PAC partners identified 142 technical experts and programmatic specialists to staff each province's local TA network. All designated personnel are GVN staff to ensure the sustainability of TA delivery as external funder resources decline. To develop each individual's TA provider capacities – and to operationalize the new TA network concept – 80 (77 provincial and 3 national) persons participated in the first ever "How to be an effective TA provider in Vietnam" training course, developed and facilitated by USAID/SMART TA. The 3-day training program introduces participants to the science of technical assistance, from the social and behavioural theories that underlie TA to the methods by which TA is delivered. The

course also provides tailored communications training for handling pull TA requests and introducing innovations or emerging scientific knowledge. Participants were tasked with undertaking provincial cascade analyses and developing cascade TA plans. All training participants have also been linked to the "I love TA" social media community of practice platform as a means by which to continually and informally build their TA expertise. Half of the "I love TA" 81 members are actively involved in the forum, either by responding to forum posts or by sharing materials. "I always update myself to news and comments on the TA page", says Nam from the Hanoi PAC, " because I know for sure that there will always be useful information for me."

In April 2014, VAAC highlighted the institutionalization of these provincial TA networks in their "Strengthening the TA System in Vietnam" work plan. The plan outlines specific objectives to develop provincial TA systems and strengthen providers' responsibilities to receive and respond to TA requests, and to provide push TA to improve programmatic quality and coverage. The plan also advocates for financial sustainability of provincial (and national) networks through increased GVN resources.

The drafted work plan is in the process of finalization and will be sent to the MoH for review and endorsement in FY15/COP14.

Can Tho structures its 2014 provincial plan on the CoPC cascade

Push TA initiatives are truly successful when they are incorporated into the institutional planning, implementation, monitoring or management of the HIV response. In the case of the CoPC cascade – adapted for the Vietnamese context by USAID/SMART TA – Can Tho became the first province to utilize the cascade framework as a key tool in the development of its 2014 Provincial Plan, which was officially approved by the Can Tho People's Committee on January 2014. Following training and targeted support on how to construct cascades from USAID/SMART TA, Can Tho PAC officials undertook cascade analyses to identify programmatic gaps in HIV prevention, testing, care and treatment and MMT service uptake (Figure 16). Programmatic priorities focused on reducing leaks; performance will be measured annually and results used to frame the 2015 plan for the province.

5000 visitors access resources on the MMT forum each month

Since its launch in 2011, www.dieutrimmt.vn has become the recognized electronic knowledge hub for MMT and drug use-related information, resources, and training materials in Vietnam. More than 5000 members of the public, including those affected by drug use (people who use drugs and their families) and MMT service providers (counsellors, doctors and nurses) visit the website each month. This year, USAID/SMART TA continued its technical oversight of the forum. We developed 53 talking slides and video lectures to enrich the content of four online courses offered through the platform. We uploaded a set of five training curricula on social work principles for people who use drugs, developed collaboratively with the University of Labor and Social Affairs under the Atlantic Philanthropies project. New resources, such as a urine toxicology testing video, also were added to the MMT forum.

To further improve the user experience and sustain the online platform over the long-term, USAID/SMART TA is working in FY15/COP14 to redesign the interface and to incorporate the MMT forum under the augmented VAAC portal (described below).

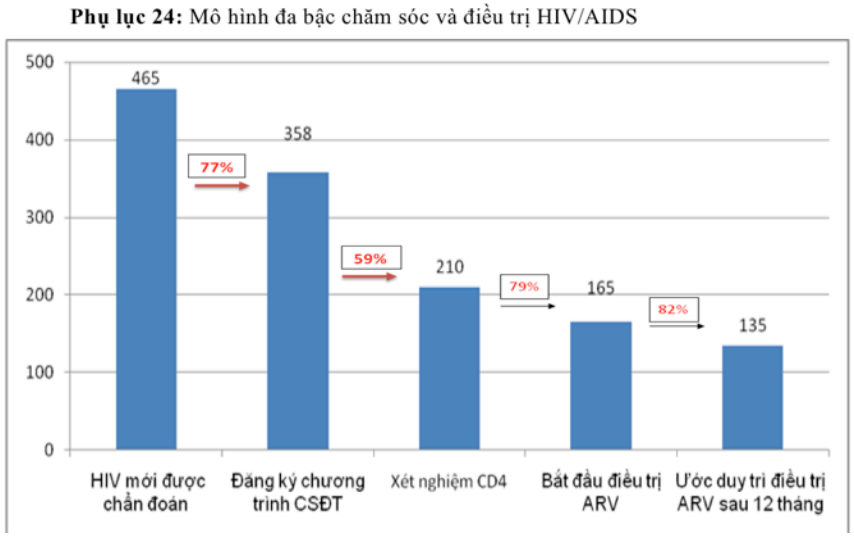


Figure 16 | **Can Tho cascade, 2014 provincial plan**

VAAC pledges financial support to sustain online knowledge portal

Charged with state management and nation-wide technical coordination of HIV prevention and control activities – including HIV/AIDS related information, education and communication – VAAC is currently best positioned to lead the coordinated effort and create needed linkages to different resources in order to improve the country's HIV knowledge management system.

This year, USAID/SMART TA has supported VAAC to develop its CoPC virtual learning hub or portal. The current website was created in April 2005 and upgraded twice in 2007 and 2010. However, data from www.alexa.com shows that its bounce rate is high at 56.4% - suggesting that over half of the site's visitors do not find it useful. The daily page view per visitor is low at 1.9 and the average time each visitor spends on the website is limited to 2.21 minutes. Graded by www.marketing.grader.com, the current VAAC website scores 27/100.

The new VAAC portal is being restructured to meet the needs of local TA providers, HIV health professionals, and service users. Among the new features include an interactive service map, links to the MMT forum and I love TA community of practice, and a central repository for CoPC learning and communications resources.

VAAC has now committed to taking over full financial and technical oversight of the portal after the first year of its implementation. "This portal is very important," explains Mr. Hoang Dinh Canh, Deputy Director of VAAC. "It is an effective tool and provides resources for health colleagues all over the country to use that they can access information fast and efficiently in this situation of external funding reductions. It is even affordable over the long-term."

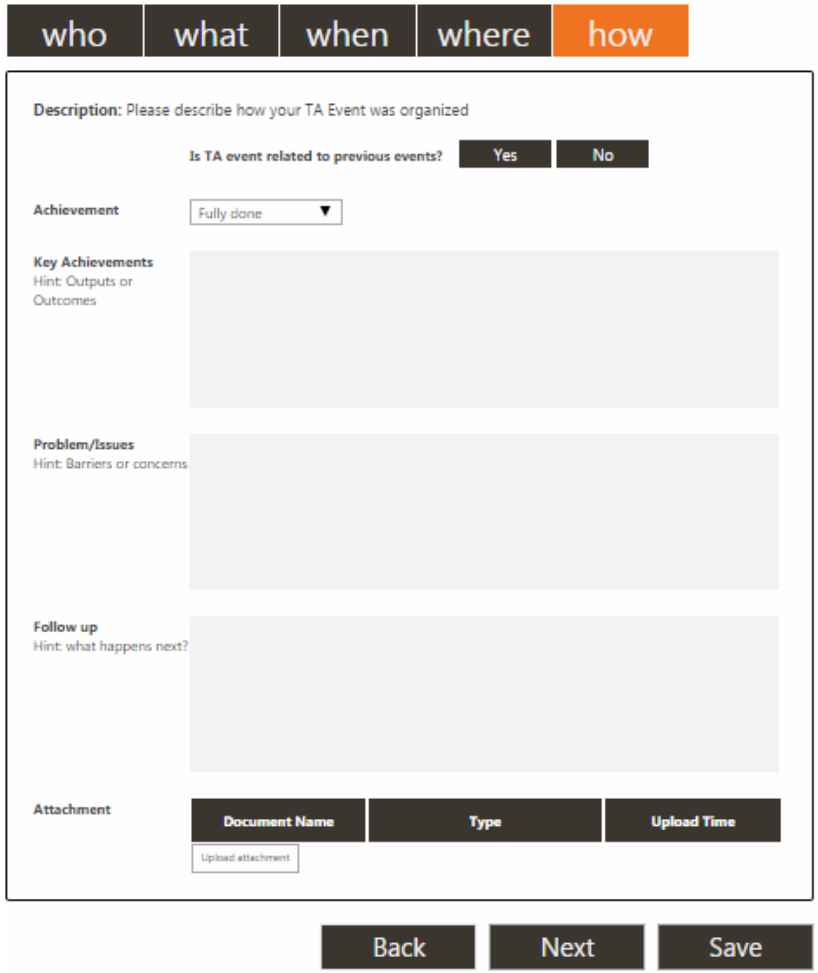


Figure 17 | **TAEM report creation page**

TAEM is ready for action!

USAID/SMART TA's internal Technical Assistance Events Management tracking software, or TAEM, was developed and finalized in Year 3 of the program. TAEM (Figure 17) makes it easy for USAID/SMART TA to:

- Track TA events over time, place and technical area
- Understand and assess the impact of our TA efforts
- Illustrate TA transfer to local TA providers
- Reliably report on MER TA indicators

TAEM will be fully utilized by USAID/SMART TA in Year 4 of the program.

GVN assumes technical ownership of MMT Basic, Accreditation and Advanced training programs

USAID/SMART TA has moved from playing a main training and facilitation role to that of a content TA provider for the MMT basic, accreditation and advanced national training programs. Our technical support includes the sharing of topic discussions for 41 advanced training participants; and providing technical content and lecture support for GVN facilitators of three MMT accreditation programs, reaching 400 participants from 49 MMT facilities across the country.

SMART TA technical assistance staff are recognized for CoPC technical expertise

Every year, SMART TA technical staff receive hundreds of pull TA requests, both within Vietnam and outside the country. Requests can range from document technical reviews, to guest lectures, to support for the development of key technical strategies, guidance and approaches. USAID/SMART TA expertise has also been featured in journal articles, blogs, symposia, and popular publications. Among the highlights this year include:

- SMART TA technical staff led three HAIVN webinars on outreach innovations and methadone maintenance treatment for hundreds of GVN clinical staff.

- FHI 360 Vietnam organized and facilitated the ICAAP IX Satellite Symposium on "Improving the HIV cascade of services: Advances in reducing loss to follow up between HIV testing, pre-ARV care and sustained adherence to ART," in partnership with the WHO Regional Office for the Western Pacific.

- USAID/SMART TA provided important technical guidance for the development of the WHO publication "Metrics for monitoring the cascade of HIV testing, care and treatment services in Asia and the Pacific."

- SMART TA technical experts gave plenary presentations on the integration of health systems and shared the benefits of MMT on televised broadcasts.

- Fansipan Challenge was recognized as one of four finalists (and the only USAID-funded initiative) for USAID's Mobile Solutions in Asia Prize.

- USAID/SMART TA published results on the "Risk factors for delayed entrance into care after diagnosis among patients with late-stage HIV disease in Southern Vietnam" in PLOS One.

- SMART TA was featured in Technomy, Huffington Post and Forbes Magazine for our HIV programming efforts in mobile health and the cascade approach.

- SMART TA has actively shared our technical approaches and tools with global HIV initiatives, such as the new USAID-funded LINKAGES project.

Transition financial, administrative and technical ownership of CoPC services

If donor resources are declining, how can implementers reduce service system costs and continually monitor and refine interventions to ensure quality and promote sustainability?

This was our main challenge in Year 3 of USAID/SMART TA. Over the programmatic period, we focused our efforts in reorienting the ways in which we work with our implementing partners; focusing on how we improve service affordability; preparing and tracking sites for DSD graduation; and advocating for increased financing of the HIV response.

Below are our key achievements[7]:

Transition for SMART TA means restoring responsibility and financial, technical and programmatic support for direct service delivery to the GVN and CSOs, while ensuring the quality and sustainability of services.

Provinces contribute more than $1 million USD to their local response

This year USAID/SMART TA modified the ways in which we work with 11 provinces across 14 sub-agreements. For the first time, provincial GVN partners shared their reported and monetized annualized provincial contributions to their local HIV responses. From a reported cost share of $359,784 USD in Year 1 of USAID/SMART TA, annualized contributions rose to $1,250,000 USD at the end of FY14/COP13. USAID/SMART TA's total annualized sub-agreement allocations similarly fell by 10% over the same period, from 3,742,286 USD (Year 1) to 3,379,723 USD (Year 3), suggesting that provinces are slowly assuming more of the financial responsibilities associated with HIV prevention and care provision.

[7] Transition achievements related to improving service affordability and preparing sites for DSD graduation are also highlighted in objectives 1 and 2 of the document.

ROC reductions help services operate more sustainably

USAID/SMART TA works with our partners to identify and reduce reoccurring operating costs that are unrelated to direct service delivery, or will not adversely affect service delivery outcomes. We provide tailored assistance to:

- Simplify program and service models
- Move contracted project staff positions to GVN-supported positions
- Reduce excessive management expenses
- Eliminate support for positions, like cleaners and guards, that are deemed to be the responsibility of the GVN
- Transition responsibility for financing of office supplies, utilities and building rental costs
- Increasingly transfer responsibility to the GVN for the purchase of selected DSD commodities, such as routine consumables

From Years 1 to 3 of the program, we have supported Provincial AIDS Committees to reduce their ROCs by 380,953 USD or 25%[8]. The number of contracted staff has declined substantially, from 734 persons at the beginning of SMART TA to the current totals of 296 individuals. A total of 333 positions have been transitioned or phased out over the course of the initiative.

[8] Adjusted after end-of-year financial reconciliation

SMART technical monitoring prepares and tracks sites for DSD graduation

USAID/SMART TA designates sites as the primary transition unit. We currently support 107 DSD CoPC sites across 11 provinces; ensuring that these sites can and do operate at "effective" levels before, during and after transitioning is the foundation of USAID/SMART TA's technical assistance strategy.

There are three main ways that site transition occurs:

External initiation is the direct transfer of a site to the GVN or an external donor, like GFATM, whereby the funder assumes all responsibilities for site functioning, either immediately or by a designated date. In these cases, SMART TA prepares sites for the transfer process and may or may not continue to provide TA following the transition. Nghe An CoPC sites in Quy Chau and Que Phong are examples of sites that will be transferred to the GFATM through an external initiation process.

Phase out or consolidation of a site may occur when programmatic analyses indicate service overlap or poor performance. As with externally initiated sites, USAID/SMART TA provides TA to ensure effective site performance, and may or may not provide TA following the consolidation process.

Managed transition is a process of phased DSD sustainability planning of a USAID-supported site. Here we classify sites on the basis of technical performance and provide tailored assistance to prepare them for DSD graduation. SMART TA provides assistance throughout the transitioning process.

No matter what kind of transition takes place, implementers need concrete classification criteria and practical transitioning/TA tools by which to assess site performance, track the transitioning process, and deliver quality, tailored TA. This year, USAID/SMART TA developed and/or introduced SMART technical monitoring toolkits for all CoPC interventions (outreach, HTC, MMT and HIV care and treatment). Our care and treatment SMART technical monitoring toolkit is included in Annex 4.

SMART technical monitoring uses existing quality standards (e.g. HIVQUAL), key cascade indicators, quality assurance instruments (e.g. SIMS) and routine GVN or MER-generated data to classify site performance into 3 main categories: effective, improving and stressed[9]. By systematically assessing technical performance, we can prioritize sites for transition and ensure that technical assistance plans are tailored to individual site needs. SMART technical monitoring criteria also is linked to provincial sustainability parameters – such as site

[9] MMT SMART monitoring further categorizes sites as sustainable when they meet 8 out of 8 standards.

SMART TA technical monitoring indicators, HIV care and treatment

CATEGORY	INDICATORS	MINIMUM STANDARD	TYPE
Gold indicators	1. Proportion of patients who are alive and retained in care after 12 months of registration	>=80%	SMART TA recommended
	2. Proportion of patients who still alive and retained in care after 12 months of ART initiation	>=85%	NGI/MER, D28
HIVQUAL indicators	3. Proportion of clients newly registered at the OPC in the last 6 months and tested for CD4 within 15 days of enrolment	>=75%	HIVQUAL
	4. Proportion of ARV patients visiting the OPC regularly and per appointment with doctor	>=75%	HIVQUAL
	5. Proportion of patients visiting OPC for medication pick-up according to scheduled appointment in the last visit	>=85%	HIVQUA
	6. Proportion of eligible patients initiating ART within 15 days during the past 6 months	>=65%	HIVQUAL
Future indicators	7. Proportion of clients who underwent early warning indicator (EWI) risk screening for LTFU in past 6 months	>=80%	SMART TA recommended
	8. Proportion of clients on ART for 12 consecutive months with suppressed viral loads < 1,000 cps/ml	>=85%	NGI/MER

Figure 18| **SMART technical monitoring indicators, HIV care and treatment**

Indicator 1 – Proportion of patients alive and retained in care after 12 months of registration (Gold indicator)

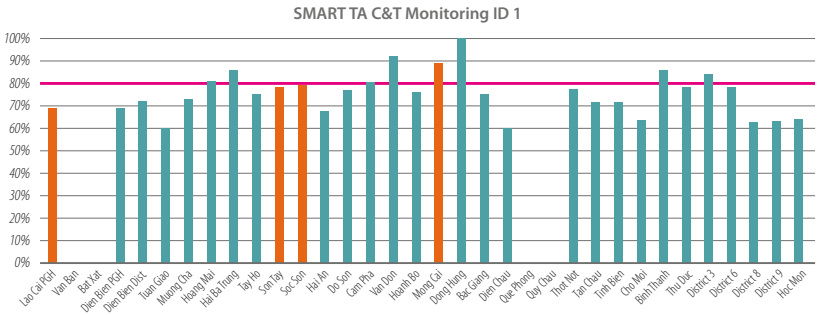


Figure 19| **Technical gold performance indicator, HIV care and treatment**

expenditure data and provincial preparedness – to indicate the degree of site transition "readiness" for full financial ownership.

We have reviewed 34 HIV care and treatment sites as per SMART technical monitoring criteria (Figure 18) in Year 3, with six attaining effective status, 27 designated as improving, and one in an unclassified category (Figure 19). A minimum of five effective sites will enter the managed transition process in FY15/COP14, while TA plans are now being implemented to enhance the performance of the 28 improving or unclassified sites.

SMART technical monitoring tools also have been developed and field-tested for HIV testing and counselling, methadone maintenance treatment, and most recently, HIV prevention or outreach. All SMART TA-supported DSD sites will be classified into SMART technical monitoring categories, and supported and tracked in FY15/COP14.

HIV testing and counselling site analyses carried out over the reporting period similarly highlighted overlapping services and poorly performing sites. In particular, 37% of 35 SMART TA-supported HTC sites identified just 8% of total HIV positive cases. Almost half of these services (49%) served just a quarter of identified key population clients, while 26% yielded 14% of the total testing volume (Figure 20).

USAID/SMART TA is now working closely with PEPFAR and the GVN to consolidate or phase out targeted low performing HTC sites, particularly those in the provinces of Nghe An, Hai Phong and Can Tho. Selected outreach services are also undergoing a review and consolidation/phase out process in an effort to help provinces focus their resources on highest impact interventions.

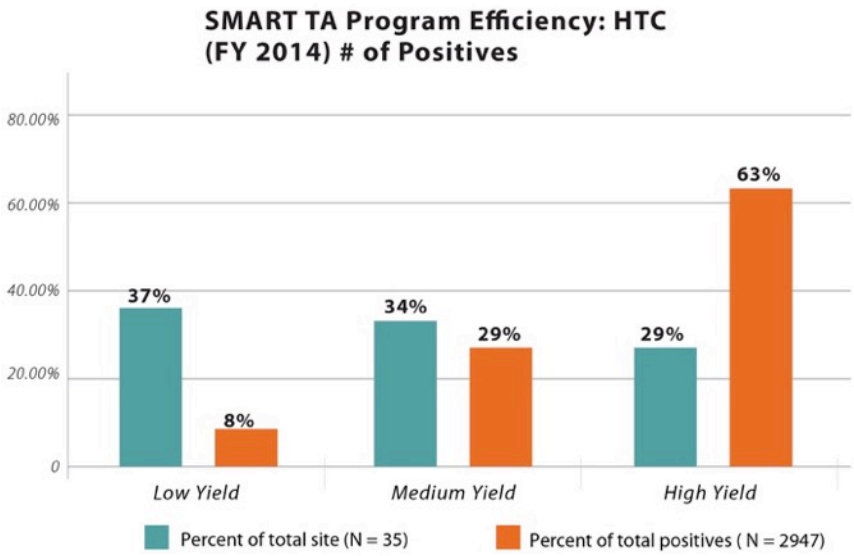


Figure 20 | **Technical performance, HIV testing and counselling**

MMT clients report satisfaction with Hai Phong co-pay services

In January 2014, Hai Phong assumed 100% of MMT clinic running costs, signaling the full withdrawal of USAID funding for methadone service delivery in the province. A co-pay structure – whereby MMT clients pay approximately 10,000 VND/day – has been applied across 11 service sites to sustain these services over the long-term.

USAID/SMART TA, together with the Hai Phong Department of Health, is conducting a series of surveys to ascertain the post-transitioning impacts of USAID funding withdrawal and the move towards direct patient payments. Are clients dropping out of co-pay services? Are they able and willing to pay the fees associated with methadone treatment? Are they satisfied with the services they receive from co-pay facilities?

The "Evaluating effects of the transition from a free service model to a co-pay service model in Haiphong" study follows patients at nine co-pay clinics over a one-year period, beginning in February 2014. More than 2000 clients have participated in each survey by filling out anonymous, self-administered questionnaires.

Almost half (44%) of participants state that they pay for MMT services with money that they earn from their jobs, while others indicate that they receive financial support from other sources, such as family members. Seventy four (74) percent believe that these payments are manageable (posing no difficulty to moderate difficulty).

Client data suggest that drop out rates have remained relatively steady over the transitioning process, with an average of 85 individuals falling out of MMT services each quarter. During the post-transition period, fewer individuals report being arrested or detained in 06 centers as a reason for dropping out, although reported deaths have slightly increased following transition.

Approximately 70% of patients say they are satisfied or very satisfied with the services they receive at co-pay facilities. The small proportion who report dissatisfaction highlight variable client interactions, like the counselling or reception experience, and overall clinic security and sanitation.

The Hai Phong study is an important way that USAID/SMART TA is using its technical expertise to track the quality of MMT services and ensure the sustainability of USAID investments in post-transitioning services.

50% of MMT DSD sites are transitioned to TA sites

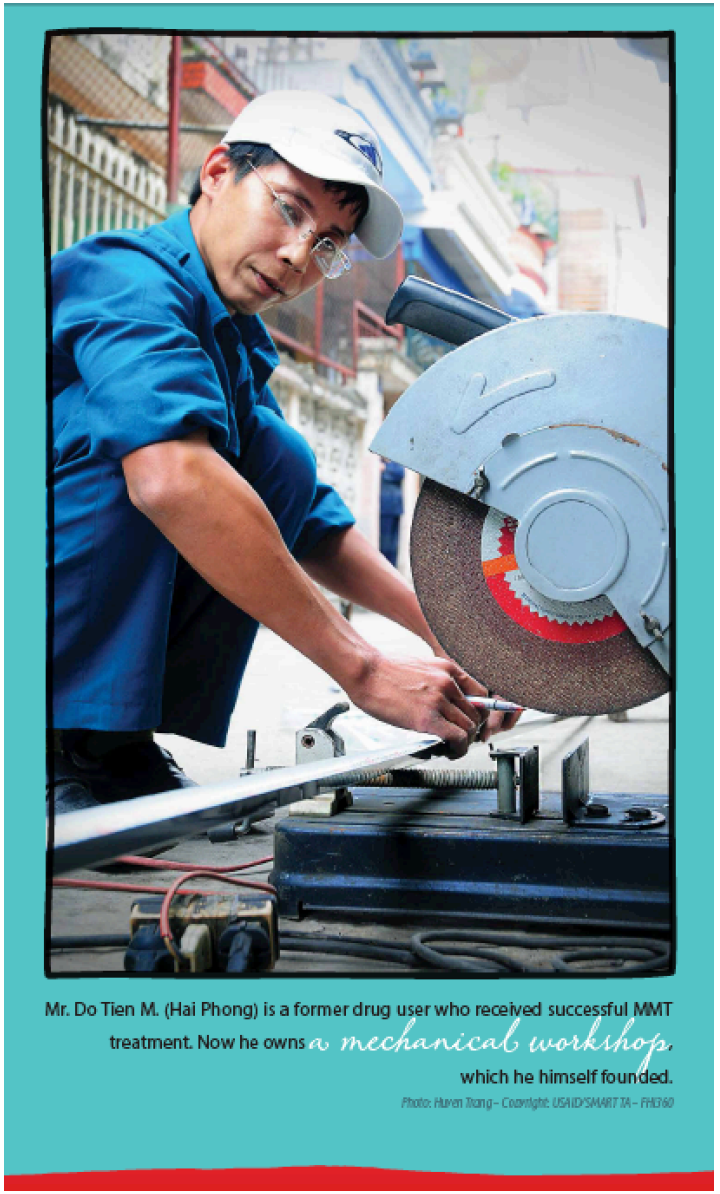
In Year 3 of SMART TA, 12 DSD MMT sites became TA sites, a 50% reduction in USAID/SMART TA direct service delivery support. The "external initiated" transition process was based on the following criteria:

- GVN commitment to assume 100% of ROCs
- Development and implementation of a provincial master MMT plan

Among these 12 sites are nine facilities in Hai Phong, two sites in HCMC, and one clinic in Can Tho. USAID/SMART TA now provides post-transition technical monitoring to ensure the effective implementation of MMT services and will work with the local mentorship systems in FY15/COP14 to transfer full technical oversight to those operating at effective or sustainable levels.

42 MMT clinics open after "Get Out and Go On" advocacy campaign

Developed by USAID/SMART TA, "Get Out and Go On" is the first multimedia campaign in Vietnam specially designed to sensitize the public about the benefits of methadone maintenance treatment and to advocate for increased GVN financing of MMT scale up.



Over a two-month period, more than 30 broadcasts, 46 articles and the Get Out and Go On TV spots highlighted methadone as a "smart solution" that provides health for patients, hope for families and safety for communities. The messages resonated with many members of the public: 3396 likes were recorded on the Get Out and Go On Facebook fan page and 500 individuals signed on to endorse the campaign messages.

On January 6, 2014, the Government Office facilitated a multisectoral GVN dialogue on solutions to expand and sustain MMT. Get Out and Go On materials provided the scientific data by which to highlight the benefits of MMT expansion. A VAAC follow up consultation on January 21, 2014 ensued with concrete decisions to:

- Accelerate the procurement of methadone to meet expansion requirements
- Approve guidelines for MMT satellite clinics
- Nominate additional local MMT mentors

Forty-eight new MMT clinics were opened between February and April 2014. And on June 20, 2014, Deputy Prime Minister Vu Duc Dam issued Decision 1008, establishing provincial quotas for the number of patients who must have access to methadone in each province.

The target of treating 80.000 drug users by methadone maintenance treatment must be accomplished with the highest determination.

Local governments must actively ensure the human resources.

Ministry of Health must ensure adequate sources of medication.

Involved departments must quickly issue legal frameworks to help overcome barriers for co-pay models.

Deputy Prime Minister, Vu Duc Dam

USAID/SMART TA is applying the lessons learned in Get Out and Go On to inform its ARV financing communications work that continues in FY15/COP14.

HCMC and An Giang call for national health insurance coverage for PLHIV

In HCMC and An Giang, more than 500 PLHIV across eight outpatient clinics and commune health stations now use health insurance to cover the costs associated with opportunistic infection and HIV care. USAID/SMART TA is helping both provinces document their experiences and recommendations to apply and scale up health insurance coverage for PLHIV across the country. Among the key recommendations are to:

- Include Cotrimoxazole and INH into the HI Medicine list
- Develop legal guidelines for PLHIV health insurance
- Implement PLHIV health insurance coverage in outpatient clinics located in hospital or commune health center settings

The report is now being reviewed by our provincial counterparts and will be submitted to national GVN authorities early in FY15/COP14.

Project management and personnel

To achieve Year 3 deliverables, USAID/SMART TA supported 74 FTE positions, up from 64 in Year 2, and 60 in Year 1 of the initiative. Staffing included 58 technical positions and 16 finance and operations personnel.

In the upcoming fiscal year, staffing will be reconfigured as USAID/SMART TA increasingly transfers routine TA roles to local TA networks and transitions sites to GVN ownership.

List of annexes

1. Annex 1, FY14/COP13 list of deliverables
2. Annex 2, FY14/COP13 results against targets
3. Annex 3, SMART TA glossary of important definitions
4. Annex 4, HIV care and treatment SMART technical monitoring toolkit
5. Annex 5, illustrative CoPC dashboards
6. Annex 6, SMART TA stories

Annex 1: FY14/COP13 list of deliverables

The chart below represents a summary of USAID/SMART TA's original work plan sub-objectives, priority activities and deliverables for the FY14/COP13 period.

Priority/Objective	Task Area	Result/Deliverable	Geographic Focus	Priority Activities	Deliverables
Priority I| Improve cascade performance **[Strategic objective: Improve CoPC service delivery systems]**					
1.1 Respond to local epidemics in under-served areas	1.1.1 Expand MMT, "3 in 1," satellite and mobile services in highest priority districts	(R) Substantially more PLHIV and MMT clients access services in areas where they live or reside (D) Improved cascade performance as per agreed upon provincial targets	Targeted mountainous provinces/districts	(a) Establish 8 new main MMT clinics and 12 new satellite MMT dispensing sites (Haiphong, HCMC, Dien Bien,Quang Ninh, Nghe An, Thanh Hoa, and lao Cai. (b) Incorporate recommendations and guidelines for 3-in-1 clinic startup procedures into SMART TA's TA services. (c) Develop protocols, SOPs and job aids to support 3-in-1 services and clinic management including integrating them into satellite and mobile service as feasible. (d) Confirm effectiveness and efficiencies gains of 3-in-1	• 16 new service sites established in Nghe An and Lao Cai • 2 additional MMT sites established • 7 MMT national SOPs developed

				clinics by comparing performance and productivity to single service sites. (e) Identify potential revisions in SOPs to streamline and reduce costs and delays in services.	
	1.1.2 Introduce test and treat mountainous model	(R) Test and treat model is endorsed by VAAC/GVN and implemented across NW region (D) 'Test and treat' strategy developed, implemented and monitored in selected provinces	Targeted mountainous provinces/districts	(a) Finalize concept paper with PEPFAR and VAAC. (b) Identify targeted areas and introduce concept to PACs and stakeholders. (c) Develop tools, training materials and plans (d) Monitor and revise strategy as per needs.	• Reach, test, treat and retain model developed; awaiting MoH approval • Commune level dispensing SoPs developed • Basic outreach approach developed and implemented in Nghe An, Dien Bien and Lao Cai
1.2 Increase the number / proportion of clients newly testing positive and immediately entering care and treatment	1.2.1 Explore gender and LGBT access issues	(R) Issues of gender are considered in the design of policies and programs and stigma/discrimination are reduced, and access to services for LGBT and other vulnerable populations is substantially increased (D) Gender/LGBT assessment with priority actions	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Develop a protocol to assess issues relevant to LGBT people, women, and other vulnerable populations accessing services, service barriers and other gender-related issues in SMART TA supported sites. (b) Implement the protocol and use findings to train and sensitize SMART TA staff and service provider staff on	• Gender analysis completed and disseminated • Gender cascades routinely generated and gender-specific programming introduced (e.g. targeting of intimate partners in EOA and

				gender issues, stigma and discrimination and related issues, particularly those that are barriers to or affect the quality of services. (c) Findings are incorporated into TA services and used to revise policies and design new or restructure existing services and practices.	HIV testing and counseling)
	1.2.2 Understand reasons for late entry to HTC and HIV care and treatment	(R) Service models directly respond to challenges or barriers that clients face (D) Completed assessment(s), dissemination and use of findings	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Disseminate findings from the assessment of reasons for late entry to HTC and care and treatment services, and revise SBC and program policies and marketing messages and efforts and service site policies as indicated. (b) Design innovative strategies for service promotion and demand generation including addressing common reasons for not seeking testing, treatment or dropping out of services such as "feeling healthy."	• Late entry findings PPT and poster disseminated; survey results published in PLOS One • Enhanced outreach approach/"I want" behavioral communications developed and implemented
	1.2.3 Introduce, strengthen and/or expand service models to increase HTC uptake and C&T	(R) The number of clients newly testing HIV positive and entering the CoPC is substantially increased (D) *60%* KAPs screened as	12 Provinces receiving SMART TA support, partner organizations and	(a) Expand Fansipan approach in 2 provinces. (b) Introduce social media and engagement strategies focused	• Fansipan implemented in 4 districts • MSM social media training conducted in

	enrolment	"high risk"; up to 40% increase in proportion of KAPs and partners testing for HIV; at least 50% of newly diagnosed PLHIV are first time testers; at least 70% newly diagnosed PLHIV are enrolled in care and treatment within 1 month of diagnosis; demand creation SBC package; community supporter roles/responsibilities, job aides, SOPs	national agencies	on combination prevention packages including individual and group led interventions for MSM, TG, women and other KAP in HCMC/Hanoi. (c) Design and provide TA for counseling and effective referral of sex and needle sharing partners to combination prevention services including care and treatment if already infected. (d) Introduce MSM group-level outreach approach, in partnership with iSEE and HCMC/Hanoi private establishment owners serving MSM based on SafeTalk methodologies. (e) Establish partnership with USAID Healthy Markets Project to promote private sector/socially marketed commodities for MSM. (f) Restructure IDU outreach model to focus on KAP including incentives for deliverables.	HCMC/Hanoi; social media strategy and RFP developed • HTC testing strategy for intimate partners developed • EOA approach developed and implemented for all KPs [MSM interventions put on hold by USAID; Healthy Markets not officially launched until FY15]
	1.2.4 Support CoPC service provision in	(R) A HIV service system for closed settings is	Closed settings in Vietnam approved	(a) Work with VAAC and MOPS to finalize the strategic	• 5 prison site assessments conducted

	closed settings	established and an increasing number of PLHIV in prison, jail or other closed settings receive HTC and ART services (D) Closed settings strategic framework and TA plan; prisoners tested for HIV and ART-eligible PLHIV receive anti-retroviral therapy in targeted closed settings	for TA	framework to provide TA to 18 GFATM supported service sites within prisons. (b) Expand SMART TA support to 5 new prisons for HTC and care and treatment services including ART. (c) Develop a plan for evaluation of the TA with acceptable indicators. (d) The TA is implemented and evaluated.	• HTC and HIV care and treatment technical model and SoPs developed and TA to PACs provided • 5 GVN sub-agreements prepared and implemented • TA provided for 5 closed settings
	1.2.5 Conduct advocacy and TA measures that have a major health impact	(R) Technical support leads to substantive changes in policies and practices for vulnerable populations and leads to substantial health impact (D) MMT campaign and feedback; FSW community-based harm reduction model strategy and roll out plan serving up to 1000 women	National	(a) Develop and implement MMT service sensitization campaign (b) Support piloting comprehensive community-based harm reduction model for FSWs in 1 province.	• Get Out and Go On methadone multimedia campaign developed and delivered • National harm reduction training package for FSWs developed, finalized and officially endorsed by MoLISA; 35 master MoLISA/DoLISA trained on how to train others to use package
1.3 Increase number/proportion of PLHIV initiating and adhering to ART and being retained	1.3.1 Systematize community-based supporter systems across all USAID-supported provinces	(R) Community supporters become essential members of service delivery teams at the provincial level and assist in referring KAP for HTC	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Introduce concept to provincial health authorities and pilot in enhanced service sites in 2 provinces (b) Based on pilot	• Complete EOA developed and implemented in 9 provinces; basic EOA developed and implemented in 3

		and retaining PLHIV in the CoPC. Retention in the CoPC is increased and lost to follow-up of ART clients is significantly decreased. (D) Phased community supporter systems strengthening strategy for 12 provinces; up to 40% increase in proportion of KAPs and partners testing for HIV; at least 50% of newly diagnosed PLHIV are first time testers; at least 70% newly diagnosed PLHIV are enrolled in care and treatment within 1 month of diagnosis; 80% of PLHIV are retained in care (do not miss appointments); CD4 levels upon HIV initiation increase by agreed % in targeted sites		experience and findings promote adoption and provide TA for the remaining provinces including: (i) finalizing M&E and communications plan and related tools; field test in targeted provinces; (ii) conducting provincial training for community-based, supporters across the 12 provinces using a phased training program.; (iii) setting up commodity/service social and commercial marketing system in collaboration with USAID Healthy Markets Project	provinces • Draft CBS+ strategy developed to incorporate care and support interventions [Health Markets partnership not activated as project did not officially launch until FY15]
	1.3.2 Apply SMART monitoring approach	(R) SMART TA monitoring systems appropriately classify sites and provide TA that improves sites with poor performance, sustains those that are effective, transitions sustainable sites for local	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Classify current sites using standard criteria into one of four categories: 1) Improving, 2) Effective, 3) Sustainable, or 4) Enhanced. (b) Introduce a standardized monitoring system tailored to	• SMART technical monitoring toolkits prepared and field tested for care and treatment; HTC; and MMT; toolkit prepared for outreach • 34 care and treatment

		ownership and management, and uses enhanced sites to pilot innovations and new technologies for Vietnam (D) SMART monitoring strategy implementation and mentoring plan; site classification upon baseline and at end of fiscal year; SMART monitoring reports and QI plans; level of effort of SMART TA staff commensurate with site classification needs		site classifications and actual needs with regular monitoring visits, contacts and performance reviews. (c) Transition those sites classified as sustainable to local management as feasible and PACs are willing. (d) Support enhanced sites to pilot innovative practices, interventions and service models. (e) Expand HIVQUAL system to all SMART TA supported sites and conduct QI exercises, document results in "improving" site performance or intervention success, and routinely monitor HIVQUAL system data.	sites classified as per SMART technical monitoring criteria (effective/improving/ stressed); site TA plans developed and implemented • Performance review of all HTC and outreach sites carried out, with accompanying consolidation or phase out recommendations • HIVQUAL expanded to 26 care and treatment sites
	1.3.3 Enhance pre-ART, early warning and LTFU responses	(R) The number of clients newly initiating ART significantly increases during year 3. An increasing percent of PLHIV on ART are adherent and retained in the service system (D) Pre-ART service package and approach; early warning system	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Routinely monitor trends in each supported site using the cascade framework and other tools. (b) Identify reasons for late entry, repeat positives, weak referral linkages, and high dropout rates during pre-ART and other relevant issues. (c) Enhance the pre-ART package	• Programmatic dashboards developed and utilized for each technical area and for priority provinces • Late entry survey finalized, disseminated and published • Pre-ART communications materials developed and disseminated to EOA

		operationalized as part of SMART monitoring approach; LTFU interventions review and strategy		of services to promote retention until ART eligibility. (d) Utilize early warning indicators for those at high risk being LTFU. (e) Recommend policy and procedural changes to reduce costs and delay in initiating ART (per Vietnam guidelines). (f) Reduce loss to follow-up and re-engage clients in care through adapting and implementing innovative practices.	implementers, HTC facilities and outpatient clinics • Retention and reengagement SoP; LTFU tool /early warning indicators developed • LTFU and death analysis protocol developed
	1.3.4 Field test referral system models	(R) The effectiveness of referral systems is substantially increased and an increased number of clients are able to receive the services they need. (D) Operationalized referral systems in targeted provinces	Sites in the 12 provinces receiving SMART TA support, Pilot systems in enhanced sites	(a) Establish and sustain effective linkages between CoPC service providers and services need by PLHIV particularly TB diagnostic, care and treatment and MMT services. (b) Identify which services are available from which sites are available within the catchment area. (c) For each potential referral site, identify terms of service, client eligibility, operating hours, quality of services available, fees, and	• ACIS system developed and deployed in Hanoi, Hai Phong, HCMC • mCare developed and deployed in Nghe An and Dien Bien • Subagreement with national TB program developed and implemented • TB/HIV services integrated in 2 sites • TB/HIV assessments carried out in Nghe An and Can Tho • Referral system

		willingness to accept referrals. (d) Establish agreements (formal or informal) for referral services and procedures for accessing them and communication systems with the sites to facilitate referrals and confirm clients came and received services. (e) Solicit feedback from referred clients to confirm services were received and learn about problems in gaining access. (f) Evaluate SMS and other electronic systems for reminding clients of referral needs, and appointments and facilitating communications with referral sites. (g) Support provinces in implementing effective SOPs for TB/HIV referrals. (h) Support integration of services as needed and feasible and effective in reducing costs, promoting retention and referral	agreements activated in all EOA districts • Integrated services introduced in all new expansion sites • OSCAR Phase 1 developed and completed • Care and treatment e-logbook developed and piloted in targeted outpatient clinics

				particularly for TB and drug use services. (i) Continue sub-agreement with the National TB Program to promote integration and referral services.	
	1.3.5 Conduct viral load assessments and provide TA on implementation of Testing Decision 1921	(R) Viral load testing is an integral part of the GVN CoPC system (D) Assessment findings and revised program strategies; defined TA role under Decision 1921	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Conduct viral load assessment among pre-ART clients in HCMC. (b) Develop concept paper for viral load assessment among ART clients sustained on ART (c) Provide TA for implementation of Viral Load Testing Decision 1921.	• Viral load assessment carried out among 1231 pre-ART patients • ART completion study developed and initiated
2.1 Provide TA to ensure that resources are directly tied to results; innovations and existing interventions are cost efficient; and expenditure/costing data aides GVN decision making and prioritization	2.1.1 Field test individual performance-based incentive models in all USAID-supported provinces	(R) Performance-based incentive systems help streamline costs and improve CoPC system performance (D) Operationalized individual performance-based systems in up to 12 provinces	12 Provinces receiving SMART TA support	(a) Compile and share examples of individual performance-based systems (b) Develop and implement coordinated individual performance-based systems in targeted areas.	• EOA and Fansipan PBI systems developed and introduced in 9 provinces • PBI scheme piloted for care and support in HCMC and Hanoi
	2.1.2 Explore feasibility of site performance incentive models	(R) Site-based performance incentive models are trialed in Vietnam	Targeted provinces/sites	(a) Develop site performance incentive strategy concept paper. (b) Pilot site performance	[Site based incentive models not developed, upon guidance of USAID]

		(D) Site performance incentive strategy and proof of concept plan		incentive model in targeted enhanced sites, as per guidance from VAAC and PEPFAR.	
	2.1.3 Establish private sector partnerships	(R) Private sector plays an increasingly important role in the GVN response (D) Private sector partnership agreements; amount/kind of support; collaborate agreement with Healthy Markets implementer	National	(a) Prepare private sector partnership advocacy materials. (b) Establish cooperative relationships with at least 2 private sector partners. (c) Collaborate with USAID Healthy Markets to expand private sector market share of critical commodities for KAPs	[Healthy Markets partnership not activated as project officially launched in FY15; other private sector partnerships were explored as part of MSM initiative, put on hold by USAID]
	2.1.4 Conduct and/or provide TA on analyses of service unit costs, expenditures and programmatic impact	(R) SMART TA economic assessments are invaluable to assessing and improving the efficiency of HIV/AIDS service delivery in Vietnam. (D) Expenditure data included in programmatic analysis reports; innovations strategies illustrate unit costs vis-à-vis conventional interventions; literature reviews; costing assessment(s)	National or provincial depending on the goal and type of analysis	(a) Identify questions and situations where economic analyses will substantially inform discussions and policy development. (b) Conduct reviews of relevant published literature, conduct costing studies or other types of assessments to generate economic information useful to SMART TA objectives and USAID and GVN goals and interests. (c) Continue support of human resources workload analyses	• Expenditure analyses -- using expenditure analysis data and site outcomes -- carried out across CoPC technical areas • Baseline data established for identifying newly reported HIV infection and sustaining patients on ART • MMT workforce efficiency study carried out and results disseminated

				in HCMC and other provinces.	
3.1 Design, implement and evaluate sustainable TA services / systems in Vietnam	3.1.1 Design and implement an effective "pull" TA system	(R) SMART TA pull TA systems are easily accessed by provincial and national level partners; are responsive to local/national needs; priorities and situations; and address common technical questions and challenges (D) Pull TA case management system; training and mentoring curricula; Pull TA reports and resources	All provinces, partner organizations and national agencies	(a) Design system to receive and assess, triage, and manage TA requests (b) Implement electronic tracking system to manage responses to requests and outcomes of TA (c) Identify common questions and issues and disseminate responses that are incorporated into training, blended learning, mentoring and other TA methods and activities	• TAEM TA tracking system developed
	3.1.2 Design and implement at least 5 "push" TA initiatives	(R) Push TA initiatives address national/provincial priorities and respond to common challenges. They lead to substantive improvements in provincial service system capabilities and performance, and increase the quality of services (D) Push TA strategies and implementation plans	All provinces, partner organizations and national agencies	(a) Design push initiatives based on cascade assessment findings; relevant best practices from in or outside of Vietnam; availability of new technologies; feasibility and suitability of implementation in Vietnam; and potential outcomes and impact of implementing new capabilities. (b) Disseminate information; host technical consultations;	• 5 push TA initiatives introduced and implemented in targeted sites • Cascade technical consultations organized and facilitated (cascade training sessions; ICAAP cascade satellite session)

				pilot test and evaluate "push" programming; facilitate training and blended learning strategies	
	3.1.3 Develop and implement blended and technology-mediated learning strategy tracked through the SMART TA database	(R) Blended learning offerings respond to training needs across GVN and SO agencies (D) Blended learning strategy documentation; 2 online platforms; SMART TA capacity building database; online training tools (e.g. 10 modules for drug use and MMT services)	All provinces, partner organizations and national agencies	(a) Develop blended and technology-mediated strategy for in-service mentoring, accreditation and CME (b) Identify subject matter experts, and procure software and IT contracts (c) Establish 2 VAAC service demand creation and online learning platforms (d) Strengthen MMT online learning platform (e) Create videos, job aids and other relevant tools for blended learning and/or technology mediated TA	• 53 talking slides and videos prepared for 4 online MMT courses • All existing care and treatment curricula and reference documents uploaded into VAAC portal • MMT forum and VAAC knowledge hub interface redesigned • I love TA social media community of practice developed and introduced • Videos and job aides created and deployed as part of I Want communications strategy
	3.1.4 Establish a sustainable network of well-trained, experienced provincial and national TA providers	(R) A well-trained, proficient and experienced network of TA providers in Vietnam provide TA on implementation issues within their own technical areas and geographic areas. They can be mobilized to assist other	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Identify TA network composed of 3 provincial representatives (each province) and 3 national representatives (each agency), as per standard criteria and assurances for TA sustainability	• Local TA networks established in all priority PEPFAR provinces • Local MMT mentorship system and EOA master trainers take on routine TA tasks • How to be an effective TA

		provinces when needed. They form a community of TA practice in Vietnam. The network is sustained beyond the duration of the SMART TA project. (D) TA network selection criteria and process documents; TA training Modules 1-3; TA reports; GVN documentation on TA roles/responsibilities/ sustainability		(b) Facilitate basic training course (Module 1) on "How to become an effective TA Provider in Vietnam" (c) Provide ongoing mentoring and advanced training (Modules 2-3) to TA network (d) Support TA network members to provide TA services; utilize SMART TA pull TA system; participate in push TA Initiatives; and join TA teams working outside their province or on national issues	provider training course developed and delivered • TA network members supported to carry out cascade analyses and develop cascade TA plans • Local TA providers paired with SMART TA in CoPC service delivery TA • I Love TA system implemented to establish community of TA practice across the nine provinces.
	3.1.5 Develop portfolio of CoPC service delivery and intervention models	(R) SMART TA provides TA on a range of service and intervention models that have been adapted and proven effective in Vietnam (D) New service models identified, assessed for utility, and disseminated through provincial/national TA networks	12 provinces receiving SMART TA support, partner organizations and national agencies	(a) Identify multiple service models and interventions potentially relevant to urban and rural situations (b) Adapt and pilot models and interventions to ensure feasibility, suitability and effectiveness in Vietnam (c) Provide TA on implementation of models and interventions in Vietnam and monitor actual performance	• EOA, closed settings TA model, PMTCT B+, ICT strategies developed and delivered in targeted areas • SI dashboards, DQAs, and cascade monitoring utilized for all CoPC interventions
	3.1.6 Identify sustainable homes for TA systems	(R) TA institutions are identified and operational at provincial and national levels for training, supporting and accrediting	12 provinces receiving SMART TA support, partner organizations and	(a) Assess current roles of national / provincial institutions In HIV CoPC services and their willingness, preparedness,	• National TA homes assessment protocol developed [National TA strategy revised

		CoPC TA providers (D) TA systems assessment, TA network membership roster, National Training Center operational plan and training materials, MoLISA training program strategy and tools, TA systems review	national agencies	capacities to lead all or major components of the TA system (b) Support TA systems development within designated national institutions and incorporate key representatives into national TA network (c) Establish National Training Centre for drug use and MMT services at NIMH/HMU/Bach Mai and provide 6 months intensive mentoring support (d) Provide ToT and mentoring support to HCMC Medicine and Pharmacy University for drug use and MMT service TA system strengthening (e) Support MoLISA TA network to conduct case worker training program on community-based FSW harm reduction (f) Evaluate progress within national institutions in implementing TA systems, gaining needed capabilities and supporting TA services	in Year 3 to focus on provincial TA system strengthening] [National Training Centre for drug use incorporated under PEPFAR/SAMHSA initiative] • MMT TA provided for national training program TA delivery • MoLISA master trainers ToT developed and delivered; national training package for FSW harm reduction finalized • VAAC national TA plan developed
3.2 Develop, support and evaluate local	3.2.1 Support capacity building and strategy development efforts for a	(R) Coordinated HIV response supported by well trained and capable GVN and SO implementers	All provinces, partner organizations and national agencies	(a) Develop and support classroom, practicum, and online training and	• Virtual and face-to-face training sessions carried out across CoPC

technical assistance efforts	coordinated and sustainable HIV response	(D) # health workers successfully complete an in-service training program; # community health and paraprofessional social workers successfully complete an in-service training program; Number/kinds technical inputs for policy documents, SoPs, master plans, etc		mentoring of community-based supporters, doctors, counselors and other professional staff (b) Provide TA for the development of CoPC guidelines, SoPs, policy documents, etc. (c) Provide TA for revising regulatory guidelines for MMT dispensing sites (d) Provide TA for APCB accreditation and integrated MMT-HTC-ART master plan	• CoPC guidelines, SOPs, and policy documents developed and implemented with SMART TA assistance • 7 MMT SOPs developed and awaiting MoH endorsement [Integrated MMT-HTC-ART master plan not prioritized by GVN in FY14]
3.3 Expand and enhance capabilities to provide strategic information, monitoring and evaluation, and research to improve services and systems	3.3.1 Strengthen "one" national M&E system	(R) GVN uses one M&E system, irrespective of funder support (D) Provincial cascades; GVN-supported M&E positions/departments; DQA/SMART monitoring plans and reports; M&E tools; quarterly feedback documents; QI strategies	12 provinces receiving SMART TA support, partner organizations and national agencies	(a) Provide TA to improve provincial M&E capacities, and streamline tools and systems (b) Support provincial partners to identify and support M&E position/department (c) Provide data quarterly feedback to implementing partners and provide TA to facilitate data use and QI across targeted provinces	• Technical assistance provided to update D28 indicators and reporting system • M&E personnel identified to be part of local TA networks • Data feedback provided to all PEPFAR priority provinces • DQAs carried out in all SMART TA-supported sites • Technical assistance provided to develop national DQA guidelines

				• Data collection tools simplified and streamlined • MMT M&E tools and national training package developed and finalized • HIVQUAL Round 5 indicators and data collection software revised
	3.3.2 Design and/or provide TA for research that leads to substantial improvements in service and intervention implementation	(R) SMART TA provides TA on research that improves program and service system outcomes (D) Number/kind/findings of research studies, protocols, assessments	All provinces, partner organizations and national agencies	(a) Upon request by USAID, support surveys and studies led by partner and national organizations (b) Provide TA on survey or research design, protocol development, data collection and analysis, and potential application of findings (c) Facilitate and assist in ensuring ethic review and IRB approval of proposed surveys and studies (d) Lead or participate in the authorship of scientific publications on program experience, surveys or studies	• National Outreach Assessment data collection completed and report drafted • MMT staff efficiency assessment study completed • Late entry survey completed and published • Viral load assessment studies in progress • Hai Phong co-pay serial survey in progress

4.1 Support national and provincial policies, planning and implementation for sustainability	4.1.1 Develop collaborative approach for the development, implementation and oversight of provincial sub-agreements	(R) SMART TA financial assistance is channeled through sub agreements that reflect provincial priorities, address gaps and barriers in the service system and promote local ownership and management (D) Sub-agreements finalized and operational by 1 January 2014. Sub-agreements illustrate GVN cost share, reflect HRH plans, respond to cascade leaks, and reduce administrative burden	12 provinces receiving USAID/SMART TA support	(a) Convene initial meetings with provincial representatives to discuss local needs, assess findings from cascade analyses and rapid assessments, and review local priorities. (b) Develop plans for use of available SMART TA resources. (c) Implement a monitoring and oversight process that reduces burden on provinces and SMART TA staff and increases flexibility of provinces to address local priorities. (d) Develop a sustainable strategy for HRH for each province receiving financial support from SMART TA.	• 14 provincial sub-agreements (with TA priorities, HRH plans, and cost share contributions) developed and implemented
	4.1.2 Conduct rapid assessments in 3 new provinces	(R) Rapid assessments will reveal priority gaps and leaks in the service systems that need to be addressed and provide	3 provinces	(a) Complete assessments in the 3 new provinces using a standardized protocol. (b) Develop short-term financial assistance and	• Rapid assessment carried out in An Giang • Sub-agreements with other RAR provinces developed with strategies

		evidence for planning and targeting resources (D) Rapid assessment plans and reports		TA plans that address gaps, issues and needs that are incorporated as scopes of work for sub agreements. (c) Complete follow-up on the implementation on assistance plans in the 6 provinces with completed initial assessments (d) Convene semi-annual provincial cascade performance reviews and consultations in the 12 provinces (SI). (e) Develop individualized approaches to strengthen services in HCMC/Hanoi using the cascade analyses and other tools.	for GVN handover • CoPC cascades developed for all priority provinces; cascade generation training conducted for all SMART TA-supported PACs • Cascade results used to inform SMART TA programmatic strategies in all provinces
	4.1.3 Track and monitor GVN financial contributions at all levels in provinces receiving USAID/SMART TA support	(R) SMART TA is able to estimate the amount of and trends in local investment in provincial HIV/AIDS programs (D) Proportion of GVN cost share/year	12 provinces receiving USAID/SMART TA support	(a) Document and track the amount/type of cost share in sub-agreements	• Provincial contributions collected and tracked in all sub-agreements
	4.1.4 Provide TA on the extension of health insurance coverage in targeted	(R) A clear plan is developed to increase access for PLHIV to health insurance that maximizes	12 provinces receiving USAID/SMART TA support	(a) Continue to pilot a health insurance model in HCMC. (b) Synthesize lessons learned from experience with	• Health insurance coverage for PLHIV trialed in HCMC and An Giang • Health insurance report of

	CoPC sites	allowable benefits to support their HIV/AIDS care and treatment (D) Health insurance programming expansion plan; health insurance provided to PLHIV in additional targeted sites		health insurance systems in An Giang, HCMC and other provinces. (c) Provide TA to scale up a health insurance model to other provinces.	scale up recommendations prepared
	4.1.5 Provide scientific evidence on global best practice and lessons learned to inform national and provincial policy discussions and decisions	(R) Policy discussions and decisions increasingly reflect the most up-to-date scientific evidence, research findings, global best practices and Vietnam program experience (D) Number/kind of literature reviews and policy papers	VAAC, MOLISA, MOH, PACs and other national and provincial Institutions and partners	(a) Identify critical information needs relevant to the goals of policy-making discussions and decisions. (b) Conduct literature reviews and surveys of practices around the world regarding high priority topics for Vietnam to identify case studies and relevant program experience and practices potentially feasible for Vietnam. (c) Summarize and present to national and provincial partners to support their discussions and decisions.	• Literature review on ART effectiveness prepared and disseminated • Policy papers developed for MMT expansion
	4.1.6 Continue advocacy efforts to support the	(R) Technical support leads to substantive changes in policies and practices and	National	(a) Advocacy meetings, workshops and forums	• Get Out and Go On broadcasts, articles, spots,

	renovation and conversion of compulsory 06 centers to open and voluntary addictions facilities	the emergence of science based policies and treatment programs for drug users in Vietnam (D) Number/kind/outcomes of advocacy efforts		focused on global best practices and scientific evidence and GVN policies and investment in MMT services. (b) Advocacy for revision of Decree #96/Article 21.2 (two-relapse equals termination policy) (c) Criminal offense and judicial clinical assessments prior to compulsory placements. (d) Development of communication materials for lay, government and judicial audiences.	presentations, public survey, and televised talk show materials developed and deployed
	4.1.7 Assist VAAC and other national institutions to advocate for increased ARV and methadone financing	(R) VAAC is able to make a compelling successful proposal for increased financial for funding and sustain HIV/AIDS programs and services in Vietnam donors reduce their financial support (D) National ARV financing proposal, number/kind/outcomes of ARV financing efforts	National	(a) Support VAAC to develop and finalize the national proposal to ensure financing of ARV drugs. (b) Research technical issues as needs arise to support planning and deliberations. (c) In collaboration with VAAC, organize and support meetings, workshops, and forums on ARV financing,	• ARV financing online dialogue aired on Vietnam Government portal • Benefits of ARV treatment video developed

		procurement and distribution. (d) Develop a communications campaign for sustainable financing for policy makers and the public.

Annex 2: FY14/COP13 results against targets

Objective 1: Deliver quality services within the CoPC

Component 1.1.Reduce acquisition and transmission of HIV

1.1.1. Improved identification and reach of key populations
1.1.2. Increased uptake of HTC services and enrollment into care and treatment
1.1.3. Achievement of MMT coverage targets

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Year 2	Year 3 Target		Year 3 Result	
						DSD	TA	DSD	TA
1. Number of key populations reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	Output	Quarterly	Program	59,717	47,774	45,100	0	30330	0
2. Number of people who inject drugs (PWID) on medication assisted therapy	Output	Quarterly	Program	3,606	5,500	4,580	10,874	1941	12,737
3. Number of individuals who received HIV Testing and Counselling (HTC) services for HIV and received their test results	Output	Quarterly	Program	50,380	50,000	60,450	5,000	56038	NA
4. Proportion of KPs reached by [EOA] community outreach workers who received HIV test results and post-test counselling	Outcome	Annually	Province/ district	N/A	N/A	70%	N/A	80%	NA
5. Proportion of KP individuals who received testing results and post-test counselling among HTC clients in province during reporting period	Outcome	Annually	Province/ district	65%	65%	65%	N/A	73.4%	NA

Objective 1: Deliver quality services within the CoPC

Component 1.1.Reduce acquisition and transmission of HIV

1.1.1.Improved identification and reach of key populations 1.1.2.Increased uptake of HTC services and enrollment into care and treatment 1.1.3.Achievement of MMT coverage targets									
Key Performance Indicators	**Level**	**Periodicity**	**Data Source**	**Baseline**	**Intermediate**				
				Year 1	**Year 2**	**Year 3 Target**		**Year 3 Result**	
						DSD	**TA**	**DSD**	**TA**
6. Proportion of newly identified HIV positive cases successfully referred from HTC to OPC	Outcome	Annually	Province/ district			85%	75%	97%	NA
7. % HIV positivity rate among KPs	Outcome	Quarterly	Program	6%	6%	6 %	N/A	5%	NA
8. Number of adults and children newly enrolled on ART	Output	Quarterly	Program	3000	2469	2500	450	2717	93
9. Number of adults and children currently receiving ART	Output	Quarterly	Program	12,479	13,950	16,000	450	16458	1705
10. Proportion of clients newly registered at OPC in last 6 months and tested for CD4 within 15 days of enrolment	Outcome	Annually	HIVQUAL	N/A	N/A	≥75%		84.2%	81.5%
11. CD4 level when initiating ARV treatment among PLHIV in the last 6 months	Outcome	Annually	HIVQUAL	41% (CD4 ≤ 100)	31.7% (CD4 ≤ 100)	28% (CD4 <= 100)	N/A	35.7%	55.2%
12. Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	Outcome	Annually	Program	88%	90%	90%	75%	86.4%	84.2%
13. Percentage of PEPFAR-supported ART sites achieving a 85% ART retention rate	Outcome	Annually	Program	N/A	N/A	N/A	N/A	86.8%	50%
14. Proportion of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit	Outcome	Quarterly	HIVQUAL	N/A	N/A	N/A	N/A	98.4%	100%

Objective 2: Strengthen GVN and CSO capacity to sustain quality CoPC services Component 2.1: Increased capacity of GVN and CSO individuals and institutions to manage, coordinate, deliver and monitor the HIV response at provincial and site levels							
Key Performance Indicators	**Level**	**Periodicity**	**Data Source**	**Baseline**	**Intermediate**		
				Year 1	**Year 2**	**Year 3**	
						Target	**Result**
15. Number/type of priority push TA initiatives	Output	Quarterly	Program	1 (transition)	3 (cascade, RAR, closed settings)	5 (cascade, EOA, ICT, TB/HIV, closed settings)	5
16. Number/ composition of local TA networks	Output	Quarterly	Program	0	0	80 (exclude MMT mentors)	81
17. Number of provinces with local TA networks	Output	Quarterly	Program	0	0	9	9
18. Number of TA sites supported by USAID/SMART TA	Output	Quarterly	Program	7	7	N/A	16 (+ 5 prisons and 60 MMT sites)
19. Proportion of SMART TA-supported provinces with annual TA plans	Outcome	Annually	Program	0	0	N/A	33%
20. Proportion of routine capacity building and M&E events carried out by local TA network members	Outcome	Annually	Program	N/A	N/A	N/A	55% (MMT); 60% (EOA)
21. Proportion of targeted provinces undertaking cascade analyses of the HIV response and implementing targeted service improvement action plans based on these analyses	Outcome	Annually	Program	N/A	44% (4 out of 9)	9	100% (9 out of 9)
22. Proportion of targeted SMART TA-supported provinces receiving push TA that adopt the intervention program approaches or integrate new technology	Outcome	Annually	Program	0	33% (RAR, 1 out of 3)	N/A	11% (EOA – Hai Phong); 11% (cascade/ Can Tho);

Objective 3: Transition financial, administrative and technical ownership of CoPC services Component 3.1: Achievement of transitioning targets with effective levels of service quality						
Key Performance Indicators	**Level**	**Periodicity**	**Data Source**	**Baseline**	**Intermediate**	
				Year 1	**Year 2**	**Year 3**
23. Total annualized financial allocations to sub-agreements	Output	Annually	Program	3,742,286 USD		3,379,723 USD
24. Total reported and monetized annualized provincial contributions	Output	Annually	GVN records	359,784 USD		1,250,000 USD
25. Total number of SMART-TA DSD sites	Output	Annually	Program	N/A	109	107
26. Total number of SMART TA partners	Output	Annually	Program	N/A	82 (total)/65 district	74 (total)/59 district
27. Percentage reduction of USAID/SMART TA sub-agreement financial allocations	Outcome	Annually	Program	N/A	N/A	10%
28. Percentage of reported provincial contribution (financial and in-kind)	Outcome	Annually	GVN records	N/A	N/A	30%
29. Percentage reduction of USAID/SMART TA supported ROCs	Outcome	Annually	Program	N/A	N/A	25% reduction
30. Median site expenditures to identify newly reported HIV infection or sustain clients on ARV (% difference)	Outcome	Annually	Program			$131.80 USD (newly reported infection); $59 (1st year)/$47 (2nd year) sustain clients on ART
31. Percentage of partners transitioned from PEPFAR DSD assistance	Outcome	Annually	Program	N/A	0%	10%
32. Percentage of sites transitioned from PEPFAR DSD assistance	Outcome	Annually	Program	N/A	0%	4%

Technical Assistance Glossary of Terms

TERM	DEFINITION/INTERPRETATION
Technical Assistance (TA)	Technical Assistance (TA) is a "A dynamic, capacity-building process for designing or improving the quality, effectiveness, and efficiency of specific programs, research, services, products or systems.
Community of TA Practice	TA providers are electronically linked to each other and to knowledge management services and share experience, solutions, case studies and technical information to continually improve the quality, coverage and effectiveness of TA services in Vietnam.
Diffusion Theory	Defines and explains the process through which innovations are disseminated over time among members of a social system. This theory is especially relevant to the structure and methodologies used in TA systems and services.
Knowledge management System	A knowledge management system continually monitors emerging knowledge, innovative practices, research findings and new technology to determine their relevance and potential impact on priority needs in Vietnam and it disseminates evidence through a TA system. Knowledge management services continuously review publications, research findings and report of best practices around the world which come from many sources.
I Love TA	"I love TA" was born during the first ever Vietnamese training in technical assistance in July 2014. It is an online community of practice forum that was designed for provincial TA provider networks to interact, exchange technical information, share experiences, and seek TA advice. "I love TA" aims to strengthen ownership of CoPC services to the GVN and enhance technical capacity to sustain quality HIV services in Vietnam as part of the SMART TA transitioning process.
Local TA Networks	Networks consisting of closely linked providers working at the provincial or district health levels that have been trained and mentored to be TA providers in Vietnam and are supported with KMS and the web-based communication systems.
Pull TA	Sometimes referred to as "market pull," it is the process of facilitating accesse to technical information that program implementers believe they need.
Push TA	Sometimes referred to as "Technology Push," it is a process that targets multiple programs or service systems to help them adopt specific best practices, gain needed capacities, introduce and integrate new technology, begin to use new treatment regimens or other innovations.
Readiness to Change Theory	Organizations, like individuals, will be at different stages of readiness to receive or apply TA. Assessing readiness to change can help TA providers identify the best methods and approaches to help an organization begin an incremental change process that leads to implementation of needed technology and other innovations.
Social Cognitive Theory	This social learning theory, with its core concept of self-efficacy predicts that confident, well prepared and supported TA providers that have and can serve as role models are most likely to be successful.
TA Evaluation	Like all other program practices and services, TA services must be routinely monitored and evaluated on at least four dimensions: 1) quality, 2) outcomes, 3) impact and performance, and 4) costs to provide effective services.
TA Events	Discrete TA services lasting one hour or longer, or site visits focused on improving the quality, effectiveness or efficiency of specific, programs, research, services or systems in Vietnam.
TA System	One time TA interventions or narrowly focused TA services are very unlikely to result in substantial results, or impact. Relevant social learning theories, experience, research and evaluation findings, and experience in Vietnam indicate that easily accessible, responsive systems that deliver needed services through trusted providers are more effective.
TA Tracking System	The Technical Assistance Events Management System (TAEM) tracks and provides a record of all TA "events" and determines the immediate outcomes of TA services. It forms the basis and provides data for more sophisticated evaluations of TA outcomes and impact.

Transition Glossary of Terms

TERM	DEFINITION/INTERPRETATION
Transition	Restoring responsibility and financial, technical and programmatic support for direct service delivery (DSD) to the Government of Vietnam (GVN) and civil society organizations (CSOs), while ensuring the quality and sustainability of services.
Interventions/ services	Defined package of core services for each CoPC programmatic element. *Community-based interventions* (prevention/care and support) emphasize case finding and management activities that (a) identify PLHIV and high needs KP; (b) support KPs to test for HIV and use prevention commodities; (c) enroll PLHIV in care and (d) help PLHIV be retained/reengaged in care and treatment services. *Facility-based interventions* include HTC, MMT, and C&T service packages, with strong links across the CoPC and between additional key services like TB.
Partners	National, provincial and district recipients of USAID/SMART TA financial assistance through subagreements, contracts or partnership agreements.
Sites	Provision of programmatic interventions at service delivery points. The district is the service delivery point for community-based programming (prevention/care and support), while the facility is the service delivery point for facility-based elements. *Note that, given the unique set of interventions for MMT, HTC and C&T, each is classified as an individual service delivery point, even in co-located or integrated sites.
Reoccurring Operating Costs (ROCs)	Routine direct service delivery (DSD) expenses that support CoPC interventions, services and TA. ROCs include HRH and site operating costs, including office supplies, rent and utilities.
Sustainability Planning	Provincial partners increasingly lead, coordinate, implement, manage and eventually finance site-level interventions.

REVIEW USAID/SMART TA SUPPORTED SITES PERFORMANCE USING ROUTINE MONITORING DATA FROM OCT -2011 TO JUN-2014

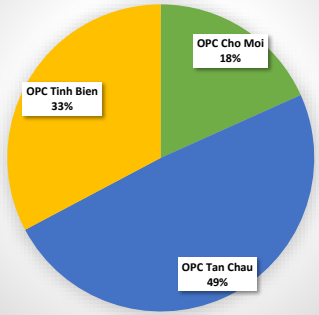
AN GIANG

Terms using in this dashboard:
Inflow ARV patients: Including newly initiate, return for treatment and transfer-in ARV patients
Outflow ARV patients: Including dead, transfer-out, and no-show ARV patients

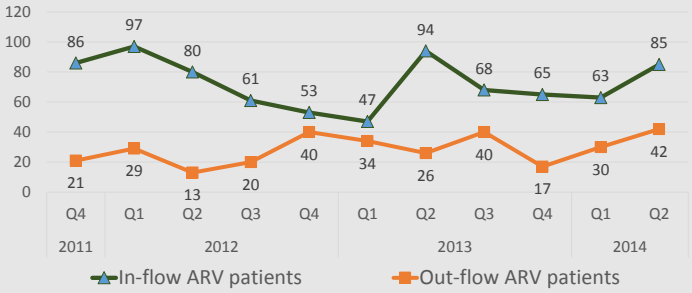
Key measages

- By the end of June-2014, there were 1.550 ARV patients and 184 Pre-ART patients at all SMART TA supported sites in An Giang. OPC Tan Chau had highest number of currently managed patients (49%).
- In quarter 2/2014, both of number of in-flow and out-flow ARV patient were increased compare with quarter 1/2014.
- Among in-flow ARV patients, numbef of newly initiated ARV patient was stable in recent quarters (55 patients /quarter in average). Number returned ARV patients was low in quater 2/2014.
- Among out-flow ARV patients, number of lost to follow up and transferred-out ARV patients were increased since quarter 4/2013. Number of death ARV patient was still at high level (15 patients in quarter 2/2014)
- Number of time miss appoinment of ARV patients was highest at OPC Tan Chau.
- Numbef of lost to follow up Pre-ARV patient was decreased dramatically at 3 USAID/SMART TA supported OPCs in An Giang

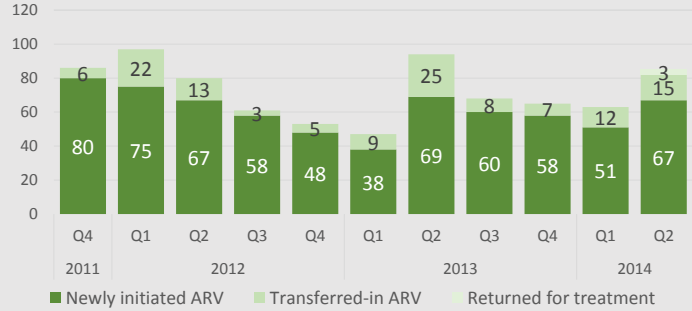
Number of currently managed patient (Pre-ART and ART patients) in quarter 2/2014



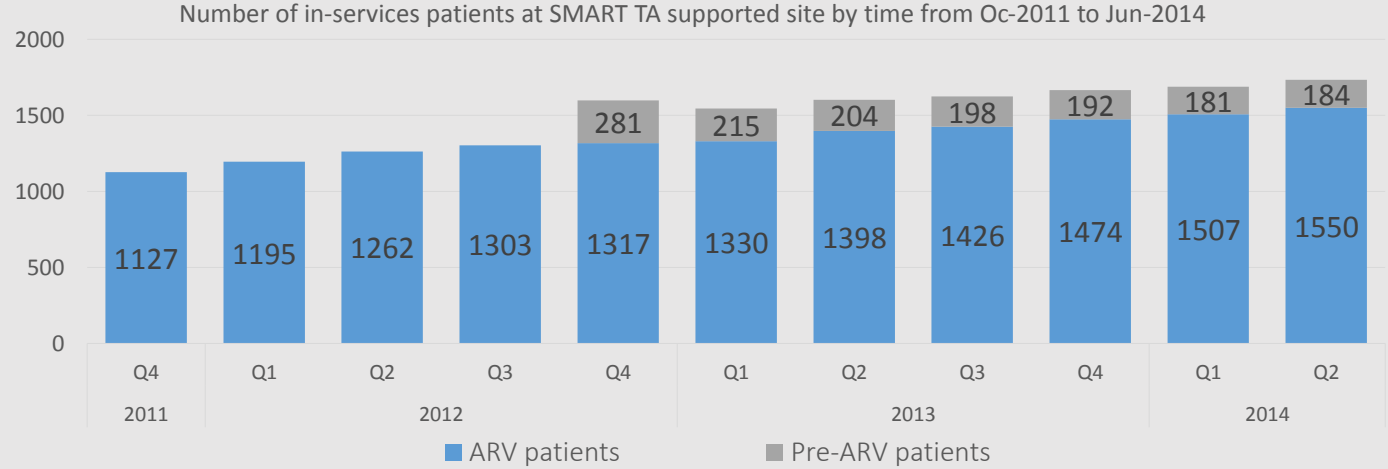
Number of In-flow and Out-flow ARV patients by time from Oct-2011 to Jun-2014



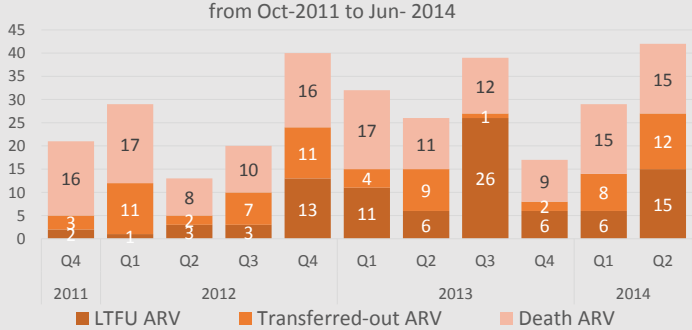
Number of in-flow ARV patients by type of group, by time from Oct-2011 to Jun 2014



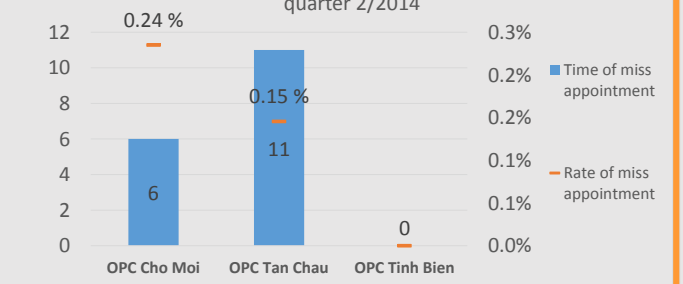
Number of in-services patients at SMART TA supported site by time from Oc-2011 to Jun-2014



Number of out-flow ARV patients by type of group, by time from Oct-2011 to Jun- 2014

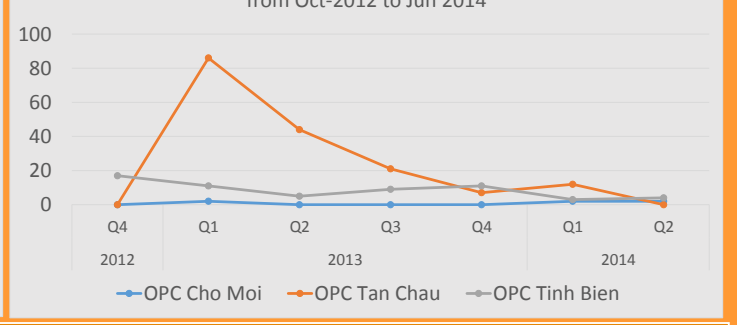


Number of time miss appointment of ARV patients by site in quarter 2/2014



Rate of miss appointment= Time of miss appointment/currently managed ARV patients

Number of lost to follow up Pre-ARV patient by time from Oct-2012 to Jun 2014



Prepared by SMART TA SI, Sept 2014
Further questions and concerns, please contact: Strategic Information Unit, FHI 360, 7th, floor, Hanoi Tourist building, 18 Ly Thuong Kiet street
Tel: +84-4-3934-8560 | Fax: +84-4-3934-8650

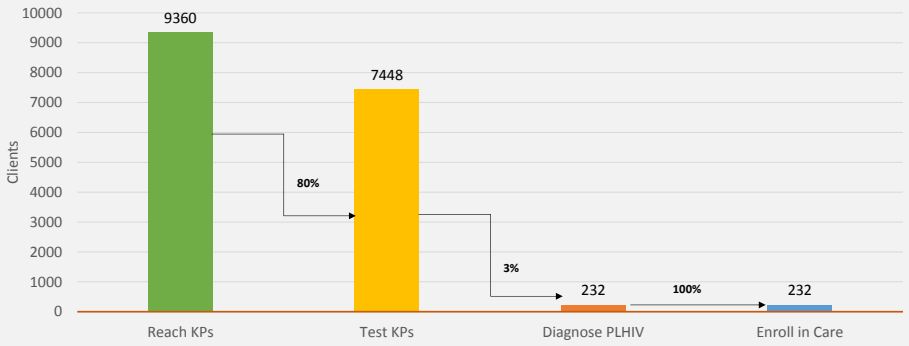
USAID/ SMART TA

COMPLETE ENHANCED OUTREACH APPROACH (EOA) MONTHLY DASHBOARD

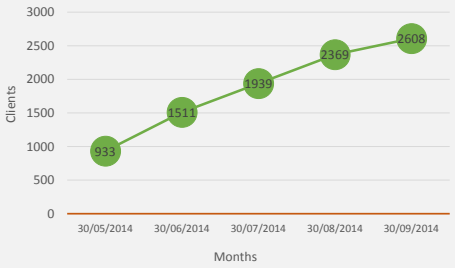
1. TECHNICAL PERFORMANCE

CASCADE PERFORMANCE:

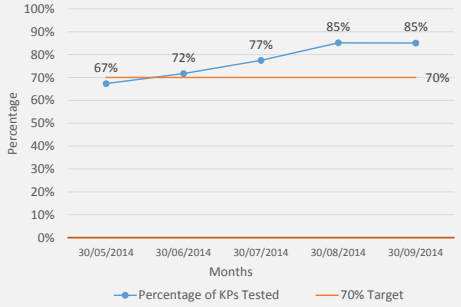
#1. CASCADE PERFORMANCE BY MONTH (CUMULATIVE)



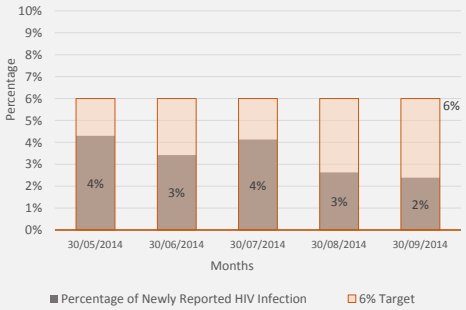
#2. REACH: NUMBER OF KEY POPULATION REACHED



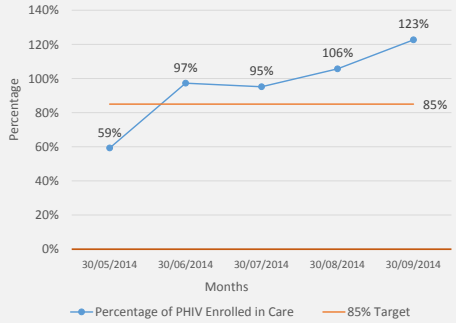
#3. TEST: PERCENTAGE OF REACHED KEY POPULATIONS TESTED



#4. DIAGNOSE: PERCENTAGE OF NEWLY REPORTED HIV INFECTION AGAINST 6% THRESHOLD



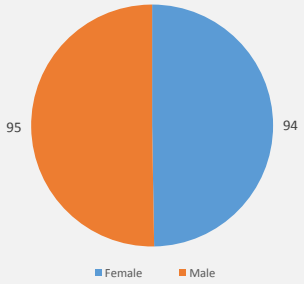
#5. PERCENTAGE OF PLHIV ENROLLED IN CARE*



2. SUSTAINABILITY

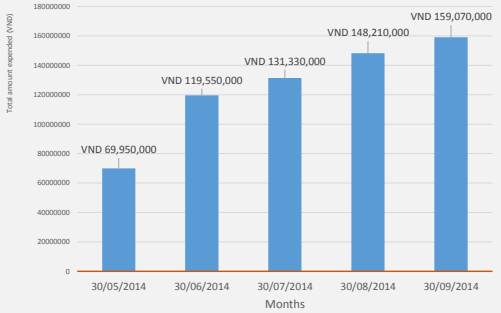
WORKFORCE:

#1. NUMBER OF CBS BY GENDER

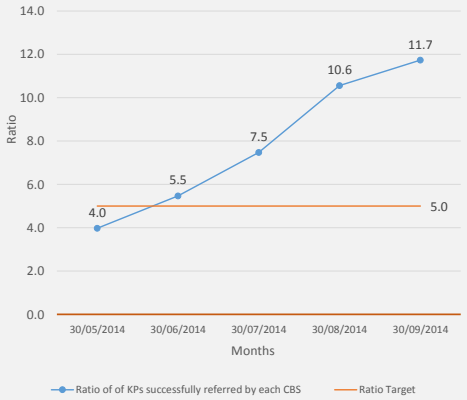


EXPENDITURES:

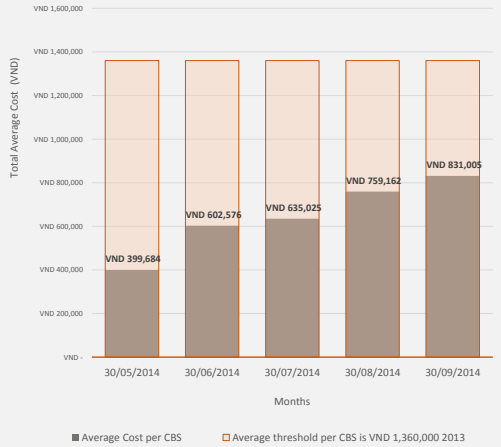
#1. TOTAL EOA EXPENDITURES



#2. AVERAGE NUMBER OF KEY POPULATIONS SUCCESSFULLY REFERRED BY CBS/MONTH



#2 AVERAGE COST PER CBS



* Percentage of PLHIV enrolled in care can exceed 100% because it includes HIV positive individuals who have previously tested for HIV and never enrolled in care services.

CBS: Community Based Supporter

Updated as of: October 30

Annex 6: SMART TA STORIES

Case management and MMT services in Vietnam reduce loss to follow-up in HIV care

Loss to follow up is too common in HIV care and results in delayed entry to treatment or potential resistance to antiretroviral treatment if interrupted. Recent research findings reported by the USAID/SMART TA project in Vietnam showing that injection drug users are more likely to enter HIV care later than other PLHIV.1 HIV epidemics that have high numbers of injection drug users, such as in Vietnam, need strategies to reduce delayed access and loss to follow up in the HIV prevention-care continuum. Now, the same USAID/SMART TA Project, managed by FHI 360, has found a partial solution: the introduction of case management services in a methadone maintenance therapy (MMT) program.

In MMT program, patients are seen on a daily basis and offer structured individual and group services such as periodic HIV re-testing, linkage to ART, and MMT services facilitate retention in HIV care and treatment services. In quest of assuring comprehensive care s, case managers seek HIV (-) patients and sex partners of MMT patients' sexual partners to facilitate HIV re-testing every six months, and find HIV positive cases who have been lost to follow-up.

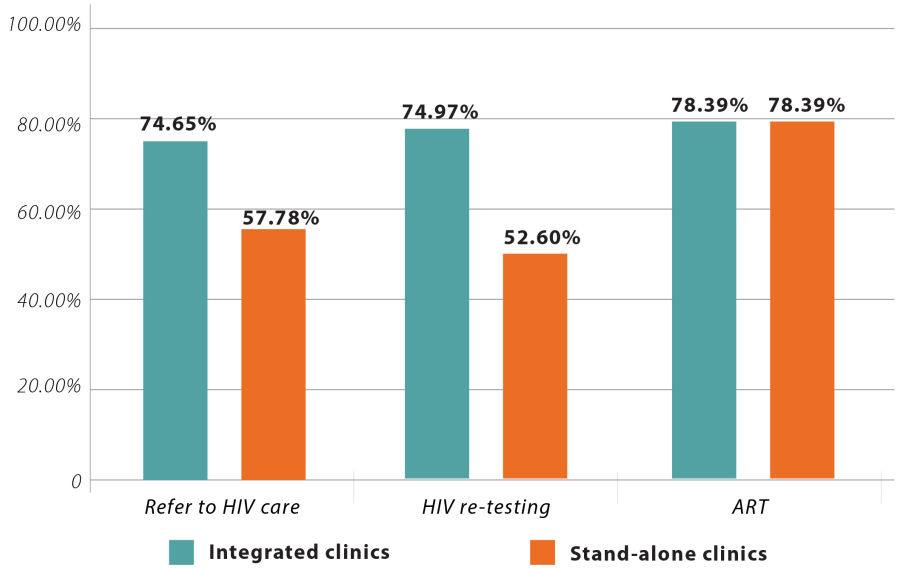
From April 15 – June 16, 2014, with the support from USAID/SMART TA, a systematic review of 5,795 client records was conducted by 21 MMT clinic case managers, with 1,255 of them found to be HIV positive patients. Case managers determined that 161 (12.8%) of HIV+ patients were either not enrolled in care or had dropped out of HIV care. This group was contacted by case managers and offered individual counseling focused on the benefits of early treatment and retention in HIV care. Key messages were on given on the need for periodic CD4 testing and early initiation of ARV treatment when symptoms or laboratory data indicated a need for medication.

[1] Rangarajan S, Tram HMB, Todd CS, et al. Risk Factors for Delayed Entrance into HIV care After Diagnosis of Patients with Late Stage HIV Disease in Southern Vietnam. PLoS One 9 (10): e108939.

These case management contacts resulted in 105 IDUs out of a total of 161 loss-to-follow-up persons (or 65.2%) to be enrolled or reengaged in HIV care. Among them, 16.8% (27 persons) were individuals who had enrolled but never entered to an HIV outpatient clinic or stopped using ARV and returned for full ART care; the remaining 48.4% (78 persons) were those who had been lost to follow up during the pre-ART period and returned to outpatient clinics for CD4 cell count and further intervention.

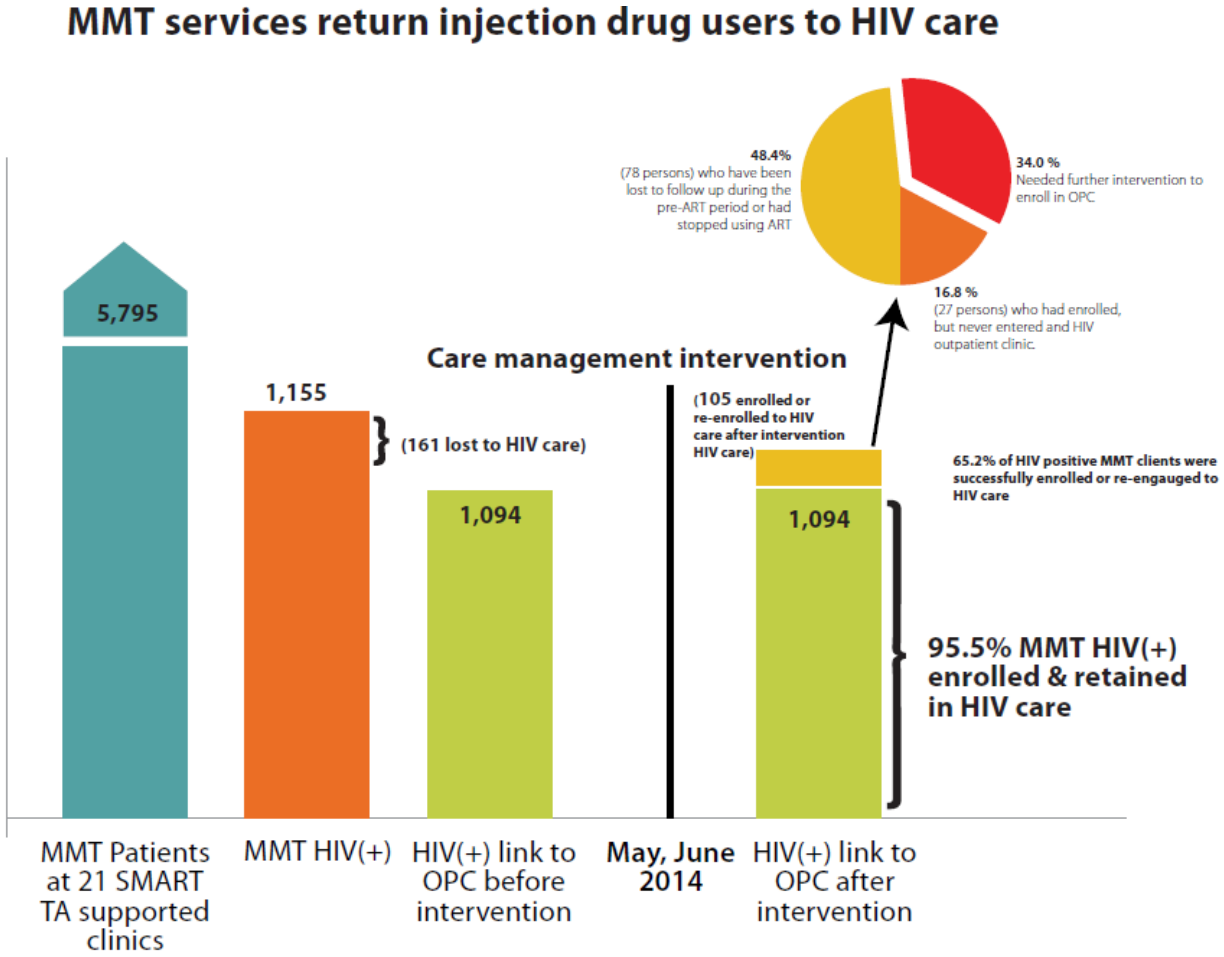
These encouraging results underscore the importance of case management and MMT services to facilitate, link, and re–engage IDUs in HIV care and treatment services. Indeed, the linkage between MMT case management and HIV services helps to ensure motivation and commitment from the case managers to follow-up and continuously support HIV positive patients. Case managers Thuyet, Giang, and Le from the Hanoi Son Tay and Hai Phong Le Chan clinics shared the following perspectives: *"If HIV positive patients don't get HIV treatment, methadone treatment will be very challenging because of complications caused by AIDS." They further noted, "Patients will get comprehensive care instead of addiction treatment only" and "Thanks to HIV care services I feel partially secure about health condition of my patients in the future, I am more motivated and hopeful to meet and provide counseling for patients who are still unwilling to enroll in HIV treatment."*

Comparison HIV linkage between Methadone integrated vs. Stand-alone clinics



In addition, an analysis is comparing success I in referral between integrated and stand-alone clinics. An integrated clinic is provides multiple services such as HTC, ART and MMT while stand-alone clinics only provide a single service such as methadone treatment service. Findings showed that there is a significantly higher rate of successful MMT patient referrals to HIV care and treatment, almost 74.7% in integrated clinics as compared to 57.8% in non-integrated ones (p=0.024). Significant difference was also seen in the rate of MMT patients returning every six month for re-testing. . Almost 75% or 1,219 MMT patients in integrated clinics came back for re-testing while only 52.6% or 1,031 patients in stand-alone clinics returned for re-testing, p value<0.001. These provides strong evidence that the integration of services model provides more benefits and greater efficiency in clinical practice, addresses gaps in the HIV Cascade gaps, and improves service performance.

In conclusion, evidence clearly supports use of an integrated service model. This type of Structural intervention can help ensure high coverage of HIV testing among MMT clients and their sexual partners, and strengthen linkages to critical HIV services that effectively plug HIV "cascade leaks." The cost to provide services is less and the integrated model is more affordable and sustainable.



ACIS eases patient referral process between clinics

Today, October 30, 2014, Hai, with his referral slip, visits and registers in his local out-patient clinic (OPC) in Binh Duong. From now on, he can continue with his ART at this site, closer to where he lives, and without travelling for hours to HCMC to receive the health care and medicine he needs. With a new patient tracking system established through collaboration between USAID/SMART TA and CHAI, health providers at local clinic, where Hai has now registered, can look up his treatment information and help him continue his ART without interruption. Using this system, provincial healthcare managers can now routinely monitor referral patients and confirm whether their referrals were successful in linking them to HIV/AIDS treatment nearer their homes. This was not the case only a few months ago.

As funding from international sources decline, big cities and heavily populated provinces do not have sufficient resources to provide treatment services to all PLHIV from other provinces who seek them. During 2013/14, 5761 ART and 4949 patients were reported to have been transferred out of HCMC to out-patient clinics in their home provinces. However, until recently, there has been very little information on whether these transferred patients have arrived and successfully linked to HIV/AIDS care and treatment services in their home provinces. The flow of ART patients voluntarily transferred back to their home provinces will increase as international funding declines. This trend underscores the need for a system that can track PLHIV referred and ensure they are successful re-engaged in treatment in their home province.

In response to the urgent need for a tracking system, USAID/SMART TA worked in collaboration with CHAI to develop an integrated, electronic tracking system and pilot it in 14 clinics (six in HCMC, six in Dong Nai, and two in Binh Duong). The system combines services from facilitators and family, peers and health workers with an automated SMS message built on an existing computer-based referral system for tracking referrals between local clinics called ACIS. This system, already tested, includes standard operational procedures (SOP) that define specific roles and responsibilities of stake holders, and community health workers.

Results from the pilot from May to Sept 30, 2014 is already showing that the proportion of successful referrals at OPC is high, 84.9% of referrals made. Among the 4.6% patients that have not arrived within the 30 days period, 4.6% most are still receiving are still receiving ART at the clinic that originally referred them. The system also allows managers to track the number of days that have elapsed when transferring from the original OPC to the other clinic, currently the average time is 11 days. More data is provided in the table below.

"*Since the system began operating, many referrals have been tracked and much useful data on the success of the system has been generated. This is the system we needed! Now we know whether our patients have been transferred successfully and how long it normally takes for them to make the move successfully. We will expand this project and implement in all clinics in HCM city*" said Mmd Nguyen Thi Hue, HCMC Provincial HIV/AIDS Committee.

	HCMC TRANSFER WITHIN HCMC OR TO BINH DUONG OR DONG NAI		BINH DUONG TRANSFER TO HCMC		DONG NAI TRANSFER TO HCMC		TOTAL OF TRANSFER	
	#	%	#	%	#	%	#	%
Number of transferred patients:	210		5		4		219	
Successful arrived at the Receiving OPC	180	85.71%	3	100.00%	3	75.00%	186	84.9
Average time from transfer date to receiving date:	11		16		4		11	
Have not arrived at receiving OPC but less than 30 days	9	4.29%	0	0.00%	1	25.00%	10	4.6%
Have not arrived receiving OPC, more than 30 days	20	9.52%	0	0.00%	0	0.00%	20	9.1%
Accepting SMS support:	154	73.33%	4	80.00%	4	100.00%		
Accepting family member support:	76	36.19%	3	60.00%	4	100.00%		
Accepting CHS staffs support:	20	9.52%	0	0.00%	1	25.00%		
Accepting OPC staffs support:	74	35.24%	2	40.00%	1	25.00%		
Transfer to Binh Duong	10							
Successfully arrived	9	90.00%						
Transfer to Dong Nai	11							
Successfully arrived	9	81.82%						
Transfer within HCMC	189							
Successfully arrived	162	85.71%						

TB/HIV service integration - a solution to facilitate access and retention in TB/HIV treatment

HIV services provided to patients

Since July 17, 2014, TB/HIV co-infected patients in Nho Quan district (Ninh Binh province) for the first time have been able to access treatments for both diseases at a "one single stop shop" – their local district hospital. Here, TB doctors and staff have provided integrated services, including HIV testing and counseling, HIV care and treatment, and TB care and treatment to HIV, TB, and TB/HIV co-infected patients. Patients now do not have to travel outside of the hospital to get essential lab testing or ARV and IO medicines as these services have been integrated into the relevant department within the hospital. At the same time, all HIV testing for TB patients at this site is now provided by the Government of Vietnam (GVN).

This integration of services is a fruitful outcome of a yearlong collaboration of local, national and international agencies, USAID/SMART TA, National TB program, VAAC, Ninh Binh PAC and Ninh Binh TB program. The USAID/SMART TA Project provided intensive technical assistance and cooperation across stakeholders, particularly in capacity building for the Nho Quan District Hospital medical staff on HIV testing and treatment and facilitated a consensus on to best integrate HIV services in the current TB and district hospital systems in Nho Quan.

Integration of HIV services into existing local health systems is key to achieving long term sustainability. Through integration, HIV services will become one element of the government-run system and efficiencies through reducing overlapping and parallel service systems will be achieved.

TB is a leading cause of death among PLHIV in Vietnam. PLHIV have a 30 times higher risk of becoming than those not infected with HIV. TB has been the cause of more than 40% of total deaths in this population.[1] The separation of HIV and TB treatment services has led to many challenges, most importantly a high rate of PLHIV dropping out of the services and then being lost to follow-up. It is hard "*for doctors to the adjust treatment regimen for HIV to fit with TB treatment regimen and vice versa since the two diseases are treated by different doctors who are not having direct information exchange*." said Dr. Do Thi Nhan, VAAC.
Current policies and practices result in too much time spent testing and confirming TB diagnoses and delays in PLHIV beginning TB treatment. "*In order to initiate and complete Insoniazid Preventive Therapy our patients might have to travel up to eight times between the clinics. It is too inconvenient, time consuming, and costly.* " Dr Eric Pevzner, CDC. Integrating HIV and TB treatment services will help PLHIV access TB services more rapidly and reduce drop outs before TB treatment can be completed.

After two month of operations, the new integrated site in Nho Quan has provided services for 33 HIV and 38 TB patients. All of the HIV patients are regularly tested for TB and 20 TB patients have received HIV testing supported by GVN. It is expected that this model will be replicated in other provinces in Vietnam.

[1] HIV and TB in Vietnam, Dr. Do Thi Thanh Nhan, VAAC.