

Clinton Health Access Initiative (CHAI) Vietnam: Phase III

DFAT Initiative INJ129

Mid-Term Review

August 2014

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Acronyms

ANC	Antenatal care
ARV	Antiretroviral drug
ART	Antiretroviral Therapy
AUD	Australian Dollars
CCIHP	Center for Creative Initiatives in Health and Population
CDC	US Centers for Disease Control and Prevention
CD4 test	Test of immune system function
CHAI	Clinton Health Access Initiative
C&T	Care and treatment
CPMU	Global Fund Central Project Management Unit
DFAT	Department of Foreign Affairs and Trade
EID	Early infant detection
EQAS	External quality assurance system
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAIVN	Harvard HIV/AIDS Initiative in Vietnam
HCMC	Ho Chi Minh City
HEBI	High-Energy Bar for Integrated Management of Acute Malnutrition
HMIS	Health Management Information Systems
IEC	Information, education, communication
IPT	Isoniazid Preventative Therapy (for TB prevention)
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTR	Mid-Term Review
NTP	National Tuberculosis Program
OPC	Outpatient clinic
PAC	Provincial HIV/AIDS Committee
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PHIM	Provincial HIV Integration Model
PICT	Provider Initiated Counselling and Testing
PPTCT	Prevention of Parent to Child Transmission
PMTCT	Prevention of Mother to Child Transmission
QASI	Quality Assessment and Standardization for Immunological Measures
SCMS	Supply Chain Management System
SMS	Short message service
TA	Technical assistance
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAAC	Vietnam Authority for HIV/AIDS Control
WHO	World Health Organization

Acknowledgements and disclaimer

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Executive Summary

Aid Activity Name	Clinton Health Access Initiative (CHAI)		
AidWorks initiative number	INJ129		
Commencement date	1 July 2012	Completion date	30 June 2015
Total Australian \$	\$4,650,000.00		
Total other \$			
Delivery organisation(s)	Clinton Health Access Initiative (CHAI), Vietnam		
Implementing Partner(s)	Vietnam Authority for HIV/AIDS Control (VAAC)		
Country/Region	Vietnam		
Primary Sector	Health		

Evaluation Criteria Ratings

Evaluation Criteria	Rating (1-6)
Relevance	5
Effectiveness	5
Efficiency	5
Sustainability	4
Gender Equality	4
Monitoring & Evaluation	5

Rating scale: 6 = very high quality; 1 = very low quality.

Below 4 = less than satisfactory.

Objectives

CHAI Phase III is a technical assistance (TA) and capacity development project with five objectives:

1. to expand the coverage and improve the quality and sustainability of the national HIV care and treatment system;
2. to enable the national pediatric program to identify and provide antiretroviral (ARV) treatment to 1,500 additional children living with HIV;
3. to support provincial partners to pilot an HIV integration model to optimise and integrate HIV interventions within the health system and inform a sustainable national approach;
4. to increase the efficiency, accuracy and sustainability of the national HIV laboratory system; and
5. to develop or improve HIV related policies and guidelines by supporting the Ministry of Health to adapt international best practices to the Vietnam context.

Effectiveness, quality and progress in delivering outcomes

After some delays in commencing provincial activities and work plan adjustments in Year 1, the project is progressing well against all objectives. CHAI responds to areas of unmet need, particularly focusing attention on pediatric issues neglected by other donors, and operates efficiently on a low-cost model so as to provide good value for money. National partners (particularly Vietnam Authority for AIDS Control (VAAC)) value CHAI's highly collaborative and flexible approach and the quality and accessibility of CHAI's technical staff.

Sustainability challenges include the rapid reduction in overall HIV funding from donors and Government of Vietnam and the short timeframe of provincial support. Sustainability was supported by: CHAI's focus on national and provincial partners (VAAC, MoH Maternal and Child Health (MCH) Department, National TB Program, (NTP), National Institute of Nutrition (NIN), Provincial AIDS Commissions (PACs), government hospitals and outpatient clinics (OPCs)); national policy development and national capacity development initiatives (training, tools and resources); training of local clinicians to assume leadership in capacity development, and ensuring training is followed up by mentoring. A targeted approach to areas of expertise, health systems orientation and strong local partnerships were key to effectiveness. CHAI is supporting national partners to address systemic issues that constrain sustainability, such as fragmented laboratory and supply chain management systems, and lack of service integration or linkages. A key contribution has been promotion of approaches that target gaps in the 'treatment cascade' from diagnosis to care to antiretroviral therapy (ART) by promoting early diagnosis, referrals, linkages and integration so as to increase the number of people who are detected, enrolled and retained in treatment.

The Phase III project proposal was over-ambitious in some areas. For example:

- (i) the initial aim of service 'integration' is now acknowledged to have been unrealistic in the timeframe of Phase III and has been modified to promoting 'linkages';
- (ii) there has been limited progress in supporting the MCH Department to provide leadership in integrating prevention of parent-to-child transmission into reproductive health care due to MCH capacity constraints and the need to transfer roles from Vietnam Authority for AIDS Control to the MCH Department;
- (iii) provincial activities have been delayed. In 2012, site support and mentoring were provided in only two provinces, rather than five provinces as initially proposed;
- (iv) implementation of provider-initiated testing and counselling (PITC) as yet has occurred in only a few sites;
- (v) relatively small numbers of children have so far benefited from the nutrition initiative;
- (vi) the proposal to pilot a harmonized multi-disease blood referral network has been abandoned; and
- (vii) some partners cautioned the need to be more modest in aspirations for national scale up of Health Management Information Systems (HMIS) software innovations given the Phase III timeframe.

Objective 1: Care and treatment

Provincial support focused on four Global Fund provinces where clinical mentoring and training was delivered (Yen Bai, Vinh Phuc, Thua Thien-Hue, and Tay Ninh). There are good indications of expanded coverage and improved quality and sustainability in these provinces. CHAI reports gradual improvements at OPCs in the quality of care and treatment services, although significant challenges remain in maintaining minimum standards in many of these areas due to high staff turnover. A key outcome is reduction of HIV testing turn-around times.

TA focused on OPCs in hospital settings to maximize sustainability. CHAI launched or strengthened pediatric services at adult OPCs in the four provinces. Reliance on international mentors is not sustainable in the long term and efforts have been made to establish pools of experts from Vietnam's three regions from which mentors can be sourced in the future.

Achievements in prevention of parent-to-child HIV transmission (PPTCT) have included TA to the MoH's MCH Department to include HIV indicators in the national reproductive health monitoring system, national trainings and inclusion of TA on PPTCT in site-level support. Provincial TA has been primarily focused on reviewing existing implementation arrangements and developing new operational procedures.

HMIS software innovations have been added to the workplan and are at early stages of implementation. Piloting of software in different urban and rural settings will be important to inform scale-up strategy. The SMS referral software (ACIS) is in use at over 100 sites,

demonstrating strong potential, and is already improving loss to follow-up rates at some sites.

A greater emphasis on HIV/TB is an important new approach. CHAI has increased its activities in HIV/TB by initiating a partnership with the National TB Program and National Lung Hospital. Pediatric Isoniazid Preventative Therapy (IPT) was introduced in Phase II and has been further supported in Phase III. With CHAI support 1,792 HIV-positive children have been initiated on IPT at 18 pediatric OPCs. CHAI found a 97 per cent reduction in TB incidence for children on ART and IPT. This finding is significant and will be disseminated internationally.

Nutritional needs of children are being addressed in partnership with the National Institutes of Nutrition (NIN). To date a very small number of children have benefited.

CHAI has assisted national partners to respond rapidly to drug stock outs to prevent treatment being interrupted. At local level OPCs confirmed that introduction of Excel tools at sites was beneficial to clinical management, drug management and tracking of needs. At the national level CHAI has advocated to ensure an ongoing supply of pediatric antiretroviral drugs (ARVs) and played a key role in ensuring fixed-dose combination ARVs have been made available in Vietnam. A particular challenge exists relating to ensuring a sustainable future supply of ARVs. The government increasingly prefers to source ARVs from national manufacturers, but pediatric commodities are not a priority for local manufacturers.

Objective 2: Pediatric treatment and care

Although there has been a decline in average monthly numbers of new children enrolled on ART, Vietnam is on track to achieve CHAI's target of 5,000 children receiving ART since commencement of Phase I. By March 2014, there were 4,263 children on ART, an increase in 697 since June 2012, and an increase in 4,018 since 2006 (from a June 2006 Phase 1 baseline of 245 children). The MoH's establishment of a national Early Infant Diagnosis (EID) program in 2009 was a key contribution of CHAI Phase II and during Phase III the program was consolidated and is currently available at 78 pediatric OPCs in 55 provinces, testing about 1,800 infants per year. Provider-initiated testing and counselling (PITC) has been implemented in Pediatric Hospitals No. 1 & 2 in Ho Chi Minh City and two hospitals in Yen Bai. PITC has reduced loss to follow-up between diagnosis and registration for OPC care. By the end of March 2014, a total of 2,953 children had been tested for HIV through PITC services.

Objective 3: Yen Bai Pilot of the Provincial HIV Integration Model (PHIM)

Progress of the PHIM pilot has been slow but good foundations have been built for the achievement of solid gains in remaining months. Delays were experienced in establishing the pilot while approvals were obtained. Implementation has occurred through a phased approach. Lessons emerging from PHIM include use of ACIS in addressing loss to follow-up, a phased approach initially focusing on 'linkages' rather than integration and involving DOH rather than just the PAC in policy development. However, the approach to applying lessons from the pilot to inform a sustainable national approach is unclear. Although a good basis for sustainability has been provided by the focus on SOPs and supportive policies, it is too early to assess whether improvements will be fully sustained independent of ongoing TA post-2015.

Objective 4: Laboratory systems strengthening

There has been good progress at the policy level but gradual progress at operational level. VAAC regards the adoption of the National Laboratory Master Plan as a significant milestone and is using the plan to guide its detailed work planning. Activities focused on implementing laboratory guidelines related to minimum laboratory standards for HIV serology and CD4 tests, quality assurance, and testing turn-around times through trainings, the national serology survey and SOP development. The External Quality Assurance System is constrained by resource issues. CHAI and VAAC conducted a national referral survey, which was a strategic contribution because it prompted a policy response to address turn around times.

Objective 5: National policies

CHAI made very good progress against this objective and there a high degree of certainty that CHAI will leave an enduring legacy. Partners appreciate CHAI as an advocate for evidence-based policy at the national level and CHAI has been an active participant in discussions regarding the national HIV Investment Case. CHAI participates in national policy and planning dialogue in forums such as the Steering Committee of the Investment Case and VAAC Technical Working Groups. CHAI worked collaboratively with VAAC and provincial authorities in development of policies and technical guidelines including CD4 and Viral Load Guidelines, Quality Assurance Guidelines in HIV Serology, and Policy on Care, Treatment and Support of HIV+ Pregnant women, HIV-exposed infants and HIV-positive infants, which meet international standards.

Gender and disability

Progress in implementing CHAI's Gender Action Plan has been constrained by resistance of national partners to proposals to include gender issues in clinical policies. Further, many health care workers who have received basic gender training lack skills, time or willingness to integrate gender considerations into their work. Whereas CHAI has made progress in identifying these constraints, the approach to addressing these factors is unclear. There have been no efforts to systematically address access issues of people with disabilities in training, policies or procedures.

Contribution to National Strategy on HIV/AIDS

CHAI's activities are strongly aligned with the National Strategy on HIV/AIDS Prevention and Control and CHAI's activities support achievement of targets that Government of Vietnam has set relating to prevention of mother-to-child transmission (PMTCT), access to early diagnosis, reduction in loss to follow-up and improved access to ARVs and TB treatments. CHAI has supported progress towards the goal of universal access to services including scale-up of pediatric treatment services. CHAI is contributing to reducing child illnesses and deaths, as indicated by data on patient retention and high child survival rates after initiation of ARVs. CHAI's focus on addressing gaps in the 'treatment cascade' from diagnosis to care to regular treatment also aligns strongly with the National Strategy. CHAI-supported sites report progress against national M&E reporting indicators. This includes reporting of retention rates on ART, with rates reported above national averages in project provinces.

Lessons learned

In Phase III, CHAI has adopted a more systematic approach to documenting lessons learned than in previous phases. Key lessons include:

- (i) Silos within the health system contribute to patients being lost to follow-up and create obstacles to quality HIV services for women and children. Moving to a more decentralized and integrated service model is a long-term vision that first requires improved horizontal and vertical health system coordination and linkages between HIV, VCT, MMT, TB, hepatitis C and ANC services and the reproductive health care system down to commune and village levels.
- (ii) When planning provincial activities, TA providers and their national counterparts (VAAC) should formally engage with provincial authorities outside of health at an early stage prior to commencement of provincial activities (People's Committee, Department of Investment and Planning). This is important to avoid delays.
- (iii) CHAI has demonstrated a comprehensive approach to its TA role, extending beyond training and mentoring to include piloting of new technologies and the strategic use of evidence. Examples include: for laboratories, the national sample referral survey showed that with strong evidence, it is possible to move government to action; the national EID study has provided an evidence-based for national partners to begin to address access barriers; piloting of HMIS software has provided evidence for scale up of innovations.
- (iv) The approach of using an NGO with national technical staff to provide targeted TA through intense engagement with national counterparts is very effective. Low reliance on international staff helps to increase local engagement, build national capacity and maximize local ownership. TA personnel avoided becoming involved in direct implementation or substituting for country partner personnel, contributing to institutional strengthening.

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- (v) As donor budgets decrease and Vietnam increasingly sources drugs from costly national suppliers, procurement and supply chain challenges will likely worsen. Vietnam faces a period of uncertainty as it transitions away from reliance on donor-funded commodities and access to TA in this area reduces.

Summary of recommendations

- (i) CHAI should continue to implement activities under the five Phase III objectives but with a greater emphasis on sustainability. A sustainability plan is required for the final 12 months that addresses the following priorities:
- a) More intense work with the regional pediatric committees on supporting transfer of skills to local mentors and trainers, identifying sources of funds (e.g. from provincial budgets) to sustain local capacity building activities and ensuring that systems are in place for clinicians to access local mentors and training.
 - b) More focused work with the MCH Department to integrate PPTCT into ANC services and the MCH system. Provide TA to the MCH Department to begin assuming HIV responsibilities as a phased approach commencing 2014 so that the MCH Department is able to provide leadership and fully manage PPTCT and related HIV responsibilities by 2016.
 - c) Documentation of lessons learned, particularly from the Yen Bai provincial pilot and PPTCT including blockages at national down to commune level, highlighting obstacles as well as progress. CHAI should aim for all data relevant to lessons to be captured no less than three months before completion date so that ample opportunity exists to disseminate lessons.
 - d) Consider contracting someone to focus on sustainability planning including documentation and dissemination of lessons to domestic audiences. Consider promotional activities such as an exit seminar, web-based promotion, or presentations at the Annual Meeting of the Vietnam Clinical HIV/AIDS Association.
 - e) With partners develop a roadmap for VAAC and MoH to improve technical capacity in international procurement particularly of pediatric commodities.
- (ii) TA to VAAC for preparing the Vietnam HIV Investment Case and proposal for the next Global Fund grant should proceed. Preferably this should be done by contracting a temporary expert who can work on a day-to-day basis in close collaboration with VAAC staff and the Global Fund CPMU team so that skills are transferred to local staff. Objective 5 should be amended to refer to planning as well as policy development and CHAI should include this as a planning activity.
- (iii) CHAI should discontinue national-level activities that are not of central relevance to exit planning for the four project objectives. For example, CHAI's involvement in the Estimates and Projections Project could be discontinued after the Global Fund concept note and proposal have been prepared.
- (iv) The final year of the Yen Bai PHIM pilot should include:
- a) a strong focus on PPTCT, including the case management approach to manage HIV-infected pregnant women and their babies until the infant's HIV status is determined;
 - b) piloting of the 'test and treat' approach including but not limited to pregnant women (consider also people who inject drugs to simplify treatment and to reduce transmission to their partners);
 - c) assessment of eClinica to compare uptake in a rural context with the results from Ho Chi Minh City;
 - d) M&E should be adjusted to measure and report progress on the linkages established through referral mechanisms, SOPs, software etc.;
 - e) work with PAC to identify alternative funding sources to maintain key activities including from national and provincial budgets.
- (v) eClinica will require careful handover to government partners at central level and regional levels to ensure capacity to maintain the system, particularly the rules relating to patient management that may require annual revision. The aim for Phase III should be to document experiences of simplified versus more complex versions so that lessons can be applied to adapt the system to national level and other health conditions.
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- (vi) For ACIS, SOP templates and standard training materials should be developed for use by government partners at regional and national levels. Experience in development and piloting of the eClinica and ACIS software should be documented in Vietnamese publications and opportunities explored for publication in a domestic medical journal and/or at a domestic medical conference. This will ensure that lessons learned are disseminated so that future HMIS initiatives can learn from CHAI's experiences (if use of the software is not sustained post-Phase III).
 - (vii) CHAI should assess the application of tools developed by WHO on gender and disability in HIV clinical services to the Vietnam context. Disability should be more explicitly recognised in CHAI training and materials to raise awareness of measures that can be taken to improve physical restrictions on access to clinical services. CHAI's TA and trainings should promote the principle that services should explore ways of providing 'reasonable accommodation' to the needs of people with disabilities.
 - (viii) A no-cost extension of CHAI Phase III is supported until 31 December 2015 as beneficial to maximize sustainability of provincial activities and capture lessons learned. This is particularly important for Yen Bai province (PPTCT and ensuring that service linkages are maximized), which has been significantly delayed. If this extension is approved, the Objective 2 target should be modified to read: "provide antiretroviral treatment to between 1,300 and 1,500 additional children living with HIV."
 - (ix) It is recommended that international clinical mentors not be used in the final six months of Phase III, to enable national staff to focus on capturing lessons learned and maximizing domestic capacity to lead the response.

Potential areas of work post-2015 if funds are available

Potential focus areas for new CHAI activities post-2015 include assistance to MoH and other national partners in TB/HIV or in a whole-of-system approach to medicines quality. If Australia seeks to continue to support gaps in Vietnam's HIV treatment and care response and Government of Vietnam requests ongoing HIV-specific support, there are good grounds for providing further funding to CHAI based on past performance and country needs.

1 Background

The purpose of the Mid-Term Review (MTR) of Clinton Health Access Initiative (CHAI) Phase III was to assess quality and progress against expected outputs and outcomes; challenges and their impact; sustainability; contribution to the National HIV/AIDS Strategy; actions to address disability and gender; and lessons learned (see Terms of Reference, Annex IV). On the basis of this assessment, the MTR was requested to recommend changes in project direction or design, to provide an opinion on whether a request for a no-cost extension should be supported, and to assess areas in which CHAI could be engaged after 2015 if further funds are available. The MTR was also requested to provide a draft Quality at Implementation Report (Annex I), including assessment and ratings against DFAT's standard evaluation criteria for Australian aid activities (relevance, effectiveness, efficiency, monitoring and evaluation, sustainability, gender equality, cross-cutting issues and risk management).

Australia has been funding CHAI in Vietnam to provide HIV-related technical assistance (TA) and capacity development support to country partners in three phases commencing 2006. Phase I ran from 2006-2009 and Phase II from 2009-2012. The Department of Foreign Affairs and Trade (DFAT) is providing AUD\$4,650,000 for Phase III (July 2012 to June 2015), which builds on the achievements of earlier phases in the areas of HIV care and treatment. In Phase III, CHAI is continuing to work in the niche area of HIV care and treatment with a particular focus on the needs of women and children.

Phase III objectives support the project's overarching goal: "To reduce HIV-related deaths among adults and children in Vietnam by 2015." The objectives relate to: (i) care and treatment including prevention of parent to child transmission (PPTCT); (ii) pediatric care and treatment including provider initiated testing and counselling (PITC); (iii) A pilot Provincial HIV Integration Model (PHIM); (iv) laboratory strengthening; and (iv) national policies.

2 MTR method

The MTR team reviewed background documents, including: annual reports; work plans; information, education and communication (IEC) materials; and national plans and guidelines. During the period 26 May – 4 June 2014, the team met with representatives of DFAT, CHAI and the following national implementing partners:

- (i) Vietnam Authority for HIV/AIDS Control (VAAC) and Ministry of Health (MoH) Global Fund Central Program Management Unit;
- (i) MoH Maternal and Child Health (MCH) Department;
- (ii) National Tuberculosis Program (NTP);
- (iii) Pediatric Hospital Number 1;
- (iv) Ho Chi Minh City (HCMC) Provincial AIDS Committee (PAC);
- (v) HCMC District 11 Outpatient Clinic (OPC);
- (vi) Tay Ninh PAC;
- (vii) Tay Ninh Provincial Hospital and OPC;
- (viii) Hue Central Hospital; and
- (ix) Yen Bai Department of Health and PAC; and
- (x) Yen Bai Provincial General Hospital and OPC.

The team also met with Centers for Disease Control (CDC, Government of USA); Supply Chain Management System (SCMS); FHI 360; Center for Creative Initiatives in Health and Population (CCIHP); World Health Organization (WHO); and the Joint UN Programme on HIV/AIDS (UNAIDS). A list of people consulted is at Annex II and documents reviewed is at Annex III.

An Aide-Memoire was presented to DFAT and CHAI on 4 June 2014 outlining initial MTR findings. A draft report was submitted to DFAT on 30 June 2014 for distribution to CHAI, VAAC and other stakeholders for comment prior to finalisation of the report.

3 Findings

3.1 Context

The major contextual challenge is the impact of the reduced overall level of HIV funding on the national care and treatment response. The reduction in funding has occurred at a time when the total number of people requiring HIV treatment services continues to increase as more people are tested and live longer. This is placing significant pressure on the health care workforce.

Over 90 per cent of funding for HIV in Vietnam is from the US Government's PEPFAR program and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). PEPFAR funding was USD\$69.8 million in 2011-2012 reducing to under USD\$55 million in 2013-2014 and is anticipated to be around USD\$50 million per annum for 2014-2015, with a phased withdrawal of support planned in coming years as PEPFAR transitions to a limited TA role.

The Global Fund's HIV budget for Vietnam was USD\$27 million in 2013 and significant cuts are being negotiated. In 2011 the Viet Nam National Assembly approved HIV as a standalone National Target Program with the expectation that resources would increase in the period 2012-2015. The Government of Vietnam had planned a USD\$168 million allocation over four years, but this was revised significantly downwards due to the financial crisis with only USD\$4.2 million allocated in 2014.

In terms of the alignment with Government of Australia's aid priorities, support to CHAI Phase III is consistent with DFAT's new international aid policy (*Australian aid: promoting prosperity, increasing stability, reducing poverty*, June 2014), which states that Australia will support partner governments to deliver better health for all, including to the poor, with a focus on cost-effective interventions to prevent communicable diseases such as HIV and TB, and to promote improved health outcomes through quality maternal and child health. Support to CHAI Phase III also aligns with DFAT's policy response to HIV presented at the International AIDS Conference in July 2014, which included commitments to support interventions with the following characteristics:

- support to cost-effective and socially inclusive interventions to prevent and treat HIV;
- work to integrate HIV testing and treatment within sexual and reproductive health, tuberculosis (TB), maternal and child health and chronic disease care services to maximise opportunities to reach all those in need;
- activities conducted in partnership with national governments, to innovate, build capacity, share expertise and lessons learnt.¹

DFAT's general policy direction at country level is that Australia is withdrawing support to the health sector in Vietnam. Hence HIV is not identified as a priority under the *Australia-Vietnam Joint Aid Program Strategy 2010-2015*. The Strategy notes that Vietnam is not meeting its Millennium Development Goal targets for HIV and that Australia may continue to provide support in relation to HIV as a trans-boundary issue. This has provided policy support for maintaining CHAI's HIV project until 2015 as a long-standing niche HIV investment. DFAT is drafting a new country strategy for endorsement in 2015, to be known as DFAT's Vietnam Aid Investment Plan 2015-2020.

Australian aid remains the primary source of funding to CHAI for activities in Vietnam. CHAI is also participating in a project funded by the Bill and Melinda Gates Foundation, focused on TB, which is addressing supply chain issues and supporting the Government's National TB Program to access new TB drugs especially for treating children. This additional activity has enabled CHAI to increase its engagement with the National TB Program, and the leadership of the National TB Program is keen to expand this partnership.

¹ *Australia's domestic and regional response to HIV: shaping the future, learning from the past.*
Ewen McDonald, Deputy Secretary, DFAT, 20th International AIDS Conference, Melbourne, 22 July 2014.

3.2 Overview of progress

Strengths

CHAI addresses gaps in the national HIV response agreed by the Vietnam Authority of HIV/AIDS Control (VAAC) in the areas of adult and pediatric HIV care and treatment services, laboratory system strengthening, supply chain management, policy development and building the capacity of the health care workforce in HIV treatment and care. CHAI provides support to government partners at all levels of the health system (central, province, district and commune).

CHAI's TA and capacity building activities align with National HIV/AIDS Strategy objectives and respond to areas of unmet need, particularly focusing attention on pediatric issues neglected by other donor activities. Sustainability has been supported through collaboration with VAAC, technical working groups and the leading hospitals in policy development, planning and in implementing capacity development activities. The national response to pediatric HIV needs has been supported by the improved policy framework and by CHAI's strengthening of key institutions to increase their capacity to provide ongoing technical leadership. A key contribution has been promotion of approaches that target gaps in the 'treatment cascade' (from diagnosis to care to ART) by promoting early diagnosis, referrals, service linkages and integration so as to increase the number of people who are detected, enrolled for ART and retained in treatment.

The TA that CHAI provides is not readily available from other sources. The Global Fund does not include a significant TA budget and most funds are allocated to ARV procurement costs. PEPFAR TA is focused primarily on PEPFAR provinces, and support at the national level to supply chain management. No other provider is offering site-specific support at OPCs and clinical mentoring. Some aspects of support are provided in collaboration with other TA providers, e.g. FHI 360 and CDC (for HMIS activities), and the Harvard HIV/AIDS Initiative in Vietnam (HAIVN) (e.g. adolescent to adult transition package, care and treatment IEC materials). CHAI's site-level activity focuses on provinces funded by the Global Fund to avoid overlap with PEPFAR activities, which are focused on PEPFAR priority provinces. HAIVN provide some mentoring services for adult treatment and care in PEPFAR sites.

National partners (particularly VAAC) value CHAI's highly collaborative and flexible approach. VAAC commented on the frequency of CHAI's technical inputs. Communication occurs on a daily basis on a range of issues. Technical partners also reported positive experiences in collaboration (e.g. WHO, CDC, FHI360 and SCMS in areas such as EID guidelines, transition package, drug forecasting meetings). CHAI was described as "nimble", willing to innovate and "push the envelope" more than other TA agencies. Partners value CHAI's clear focus on its niche areas with minimal overlap with other donor activities. National partners also value the staff makeup, which is largely national staff with periodic inputs from international technical experts. CHAI works with VAAC staff on a daily basis and six-monthly review meetings are convened to jointly review progress and adjust work plans.

CHAI's focus on support to national systems sets it apart from other TA providers. In addition to working in close collaboration with VAAC, CHAI has increased its engagement with the MCH Department and the National TB Program at national level and Departments of Health at provincial level. This is a positive development for sustainability. Sustainability is supported by:

- (i) CHAI's focus on national and provincial partners (VAAC, MoH MCH, NTP, Pediatric Hospitals No.1 and 2, PACs and OPCs);
- (ii) National policy development and national capacity development initiatives (training, tools and resources), training of experts to assume leadership in capacity development, and ensuring training is followed up by mentoring;
- (iii) IEC materials and tools do not display a CHAI logo. Government partners are encouraged to take ownership of these materials;

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- (iv) CHAI is supporting national partners to address systemic issues that constrain sustainability, such as fragmented laboratory and supply chain management systems, and lack of service linkages and integration of HIV OPCs with mainstream clinical services.

The MTR welcomes the inclusion of new approaches and activities introduced in Phase III building on Phase II achievements including in the following areas:

- a stronger focus on health system linkages and referrals to address patients lost between HIV diagnosis and entry to treatment (gaps in the ‘treatment cascade’);
- piloting of new Health Management Information Systems (HMIS) that are also addressing loss to follow-up, patient management and improved reporting;
- an increased focus on HIV/TB service linkages and co-infection treatment and care;
- a focus on the needs of adolescents transitioning from pediatric to adult treatment services;
- support to Global Fund proposals under the requirements of the new funding model;
- documentation of progress through programmatic / operational research, with findings to be presented at the AIDS2014 international conference; and
- nutritional needs of children addressed by partnering with NIN and promoting use of HEBI (a ready-to-use therapeutic food product developed by NIN).

Challenges

The main challenges have been contextual constraints including underfunding of the general (adult) treatment services, local resistance to innovation and deficits in health care workforce capacities. The diverse range of Phase III activities proved challenging for a small technical NGO to manage in the context of a national system increasingly constrained by funding reductions.

The Phase III project proposal was over-ambitious in some areas. For example:

- (i) the initial aim of service ‘integration’ is now acknowledged to have been unrealistic in the timeframe of Phase III given the rigidities of the health system and the siloed nature of HIV services – hence the aim of integration has been modified to promoting ‘linkages’;
- (ii) there has been limited progress in supporting the MCH Department to provide leadership in integrating PPTCT into reproductive health care due to MCH capacity constraints and the need to transfer VAAC roles;
- (iii) provincial activities have been slow to commence e.g. in 2012, site support and mentoring were provided in only two provinces (Thua Thien-Hue and Yen Bai), rather than five provinces as initially proposed;
- (iv) implementation of PITC has occurred as yet in only a few sites;
- (v) relatively small numbers of children have so far benefited from the nutrition initiative;
- (vi) the proposal to pilot a harmonized multi-disease blood referral network has been abandoned; and
- (vii) some partners cautioned the need to be more modest in aspirations for national scale up of Health Management Information Systems (HMIS) software innovations given the Phase III timeframe.

Progress has been slow in implementing PPTCT and the PHIM pilot, which were two of the key new activities of Phase III. Delays were due to complex factors relating to site selection and official permissions. However, after overcoming delays in these areas, Phase III is now making solid progress against all five of its Objectives. This late start suggests the need for more focused efforts in remaining months to ensure sustainability of activities by project completion, particularly at the provincial level.

A particular challenge exists relating to ensuring a sustainable future supply of antiretroviral drugs (ARVs). The government increasingly prefers to source ARVs from national manufacturers, but pediatric commodities are not a priority for local manufacturers due to the low level of domestic demand for pediatric drugs compared to adult formulations. There is an increasingly urgent task of improving the capacity of MoH in procurement and supply chain management, to ensure timely

procurement from international markets of the full range of essential pediatric drugs occurs independent of external TA post-2015.

3.3 Progress in achieving objectives, effectiveness and sustainability

3.3.1 Care and treatment

Objectives 1. To expand the coverage and improve the quality and sustainability of the national HIV care and treatment system.

The project is progressing well in supporting care and treatment activities. There are good indications of expanded coverage and improved quality and sustainability in the four mentoring provinces. ART coverage is better than the national average in the provinces of Yen Bai, Tay Ninh, Thua Thien-Hue and Vinh Phuc, with 100% of eligible pediatric patients now receiving ART. High retention rates are reported in Yen Bai, Thua Thien-Hue, and Vinh Phuc with 100% retention of patients at 12 and 24 months after ART initiation. For adults in Yen Bai, Thua Thien-Hue, Vinh Phuc and Tay Ninh province, retention rates were well above the national average.

Training and site support

CHAI support has focused on four Global Fund provinces where clinical mentoring and training was delivered as agreed by VAAC (Yen Bai, Vinh Phuc, Thua Thien-Hue and Tay Ninh), and is soon to commence in a fifth province, Dong Thap. Site support was slow to start as a result of delays in receiving official clearances, with only two provinces (Thua Thien-Hue and Yen Bai) receiving support in 2012. In Year 2, support expanded to four provinces and in addition CHAI supported the southern region's Pediatric Committee to provide support to an additional six provinces (Binh Phuoc, Kien Giang, Tien Giang, Bac Lieu, Tra Vinh and Hau Giang).

CHAI deliberately chose to work in challenging provinces. Progress has been slow for a range of reasons including delays in obtaining approvals from VAAC and local partners, conservative institutional cultures, poor infrastructure, and challenges created by contexts characterized by highly mobile patient populations, long travel distances to clinics and isolated, rural populations. Achievements are likely to be modest in Dong Thap province, where CHAI's site support activities were yet to commence at the time of the MTR.

TA focused on OPCs in hospital settings to maximize sustainability. CHAI launched or strengthened pediatric services at adult OPCs in the four provinces. Pediatric Hospital No.1 is supportive of CHAI's approach, emphasizing that it is their priority to improve capacity for pediatric HIV care at District OPCs.

Capacity building efforts have included mentoring, national trainings, training of technical working group members to become trainers and mentors, and development of IEC materials (posters, dosing wheel, flipcharts and tools on EID and infant care). Trainings for provincial, district and commune health workers addressed pediatric care and treatment, treatment adherence, drug management, Excel tools, referral support, HIV/TB, laboratory Quality Management Systems and EID. Health care workers commented favourably on trainings, IEC materials and tools e.g. dosing wheel, height charts. CHAI's data on pre and post-test scores of 514 health workers attending trainings and meetings confirmed overall improvement in knowledge relevant to performing health care roles. The MTR site visits confirmed that site support was comprehensive, addressing management of opportunistic infections, treatment failure, side effects, second line treatment, regimen switching, use of Excel tools for patient management and prescription printing, CD4 testing, HIV/TB and pediatric IPT, and management of HIV-exposed infants.

The support provided by international mentors is clearly highly beneficial to the limited number of local clinicians who receive mentoring. However, reliance on international mentors is not sustainable in the long term and efforts have been made to establish a pool of experts for the northern, central and southern region from which mentors can be sourced in the future, centred

around the pediatric sub-committees for the three regions. The aim is to support pools of local experts with capacity to offer mentoring and training after CHAI exits. For example the Director of Infectious Diseases Department, Pediatric Hospital No. 1 (Dr Khanh) has been supported by CHAI to visit Tay Ninh PAC. The sustainability of locally-led mentoring efforts will be largely dependent on the availability of National Target Program funding.

CHAI reports gradual improvements at OPCs in Hue, Yen Bai, Vinh Phuc and Tay Ninh for care and treatment services in the areas of clinical management, inter-facility linkages, OPC infrastructure and patient flow, documentation and reporting, laboratory services and supply chain management. While progress is reported by PACs and OPCs, it was clear to the MTR team that significant challenges remain in maintaining minimum standards in many of these areas, for example due to staff turnover and lack of a systematic program of continuing medical education. A key outcome for care and treatment is reduction of HIV testing turn-around times as a result of policy changes and site support.

The MTR observed a mentoring debriefing session in Tay Ninh and adolescent transition training for the southern region at Pediatric Hospital No. 1. Training on adolescent transition from pediatric to adult OPCs was conducted in partnership with CDC and HAIVN. CHAI led most of the technical development, including the baseline assessment, training curriculum, and transition package framework, consisting of local materials and materials adapted from Thailand and Canada. The MTR Team was impressed that the content emphasized the importance of adolescent peer support, sexual and reproductive health, attention to psychological and mental health needs, and recognition of young people's evolving capacities to advocate their own interests and make independent health choices. Although much of the training method was didactic, the last day of the three-day training program included small group work to develop plans for applying lessons learned to each province. Such a participatory approach is commendable.

PPTCT

In Phase III CHAI is promoting a more gender sensitive 'PPTCT' model that addresses the role of both parents in prevention, treatment and care rather than a more limited prevention of mother-to-child transmission ('PMTCT') model. CHAI estimates that 50 per cent of HIV-positive pregnant women still do not access PPTCT services although national policy requires universal implementation. Many women do not receive timely access to ARVs to prevent HIV transmission to children because they are only diagnosed with HIV at delivery. District antenatal care (ANC) facilities generally do not have ARVs for PPTCT.

Building on lessons from the CHAI PMTCT pilot conducted in Thai Nguyen in 2011, Phase III achievements have included TA to the MoH's MCH Department to include HIV indicators in the national reproductive health monitoring and evaluation system, two national TOT trainings and inclusion of TA on PPTCT in site-level support. TA has been primarily focused on reviewing existing implementation arrangements and developing new policies and operational procedures (e.g. in Yen Bai and Tay Ninh). Health care workers in Tay Ninh and Vinh Phuc have participated in trainings, and site-level TA activities will commence in coming months. Activities in Tay Ninh will be based on a provincial policy introduced in April 2014 and will expand training to ANC at commune level and integrate PMTCT indicators into the reproductive health reporting system.

The MoH MCH Department would like to assume lead responsibility for monitoring PMTCT scale-up as soon as practicable, however the role is still carried out by VAAC. VAAC and the MCH Department have been discussing a timeframe for handover through a phased approach from 2014 to 2016. The MCH Department requested that CHAI share more information on CHAI's provincial PPTCT activities so that MCH Department can be more actively engaged in its monitoring roles. The MCH Department is keen for more training opportunities to be provided for reproductive health staff (previous VAAC trainings have been targeted at HIV OPCs and PACs).

Prior to 2012 there had been very little TA provided to support PPTCT scale-up apart from CHAI's project and a district-level pilot implemented by FHI 360. UNICEF has been active on

policy development in some provinces and at national level, but has not provided the type of intense operational-level support that CHAI provides. UNFPA is also implementing a pilot project on linkages and PMTCT in another province.

Health Management Information Systems (HMIS)

HMIS development is playing a more prominent role in the CHAI work plan than anticipated in the Phase III project proposal requiring new outcomes to be added to the monitoring and evaluation (M&E) framework. The MTR team endorses the strengthened focus on HMIS given the challenges that Vietnam faces in managing the HIV patient load in the context of declining funding levels and the potential to provide models that can be used more widely in the health system. CHAI's introduction of open source, interoperable HMIS software to the Vietnam context is pioneering work not occurring elsewhere in the health system.

HMIS software has been developed in partnership with CDC and FHI 360. These partners acknowledge that CHAI has played a leadership role and CHAI technical inputs have been indispensable to these innovations. VAAC expressed enthusiasm for continued scale-up of the software products. There is national ownership in the software products introduced by CHAI and partners, and the systems are hosted on the VAAC server in Hanoi and the HCMC PAC server.

The eClinica software has been piloted in four OPCs in HCMC. On the basis of the pilot VAAC supports development of a national version. Questions have arisen over the degree of complexity of the system and whether maintaining the software will be sustainable without CHAI TA. CHAI and CDC are considering a 2.0 version of the software with clinical decision prompts. Clinicians at Pediatric Hospital No. 1 raised the concern that existing hospital software cannot merge data with eClinica. eClinica requires an investment in time upfront to load historical patient data but saves time and resources in the long run by generating comprehensive reports. A concern requiring resolution is the government requirement for hard copy reports to be completed and filed in addition to electronic copies, which creates additional work demands. A recently issued regulation on patient records may partly address this by allowing certain records to be kept electronically.

eClinica may not be appropriate for health care workers in provincial areas, e.g. nurses in mountainous areas, many of whom have limited computer skills or experience in computer databases. Given that HCMC is not representative of remoter provinces, piloting will be required in other settings. WHO and CDC raised the possibility of having different HMIS systems in operation concurrently – a more complex system for urban centres such as HCMC and a simplified system for other sites. WHO would prefer a priority be given to scaling up a simplified electronic patient register for national adoption. It would be useful for CHAI to assess eClinica in the specific context of PPTCT.

The site visit to HCMC District 11 OPC confirmed that the eClinica system is regarded as simple to use in terms of entry of patient data. Some initial steps have been taken towards sustaining the system within national systems e.g. HCMC PAC has taken on the role of providing TA for eClinica pilot sites.

The other main software innovation led by CHAI is the Access to Care Information System (ACIS) SMS referral software, which was developed by CHAI in Phase III and is already in use at over 100 VCT and OPC sites in seven provinces. This is appropriate technology for Vietnam given the widespread ownership of mobile phones and that the health system cannot afford to pay individuals to follow up patients personally. ACIS is already improving loss to follow-up rates at some sites. Piloting of additional ACIS features for treatment support is to be conducted in Yen Bai in the second half of 2014.

The evaluation of the ACIS pilot in Yen Bai found a modest improvement in referral success five months after ACIS was introduced. The system requires further assessment in Yen Bai and HCMC, and in other sites to determine suitability for national scale up. As it relies on willingness

of health care workers to adopt the system, ACIS roll out will have to be accompanied by efforts to either require or actively promote adoption. HCMC District 11 OPC pointed out that the limitations of the system include reliance on other referral districts to also be running and maintaining the same software and reliance on patients to provide accurate information. The success of the system ultimately will turn on the number of districts within each region that use the software. It would be valuable to further assess operation in high prevalence high population areas such as HCMC.

VAAC is supportive of the ACIS software being scaled up to OPCs nationally. HCMC PAC regarded ACIS as an important initiative for patient follow-up. During the HCMC District 11 site visit a problem was identified of automatic emails not being generated. This indicates that system errors are still occurring. At this stage of development the MTR team concluded that ACIS is more likely to be sustained than eClinica because it is low cost, less complex and has more tangible immediate benefits to clinical practice than eClinica. However, WHO raised concerns about the burden on VAAC to maintaining the system if it were rolled out nationally.

The VAAC M&E staff are confident that both software systems can be maintained by national IT staff. The MTR team is concerned that eClinica may become dated quickly. Clarification is required as to whose role it will be to monitor whether the clinical decision prompts remain current and to enter updates after the CHAI project ends. The MTR Team is supportive of CHAI continuing the HMIS focus, but with a stronger emphasis on documenting lessons learned and ensuring the systems can realistically be managed by national partners without reliance on CHAI TA post-2015. It is advisable to focus on simplified options rather than introducing complexities that may meet with resistance from some clinicians (e.g. some may perceive prompts as being over-prescriptive; in rural areas some clinicians may prefer to maintain well established hard copy systems). If CHAI proceeds with developing an eClinica version that includes clinical decision support it will need to be subject to thorough field testing prior to making a decision about appropriate sites for scale up.

HIV/TB

A greater emphasis on HIV/TB is an important new approach. CHAI has increased its activities in HIV/TB by initiating a partnership with the National TB Program and National Lung Hospital. CHAI conducted two national HIV/TB trainings to improve TB prevention and treatment among people living with HIV.

Pediatric Isoniazid Preventative Therapy (IPT) was introduced in Phase II and has been further supported in Phase III. With CHAI support 1,792 HIV-positive children have been initiated on IPT at 18 pediatric OPCs. The documentation of the effectiveness of IPT in HCMC is potentially of international significance and was presented at the International AIDS Conference in Melbourne in July 2014. WHO recommends IPT for TB prevention in children diagnosed with HIV, but this approach has been questioned as a result of data from South Africa. However the HCMC data supports the WHO recommended approach. CHAI found a 97 per cent reduction in TB incidence for those children on ART and IPT. This is a good example of how documenting achievements and disseminating lessons learned through publication can have wider benefits.

Nutrition

Nutritional needs of children are being addressed in partnership with the National Institute of Nutrition (NIN). This includes development of a practical training program, IEC materials and promotion of NIN's ready-to-use therapeutic food product (HEBI). Malnutrition treatment programs are being piloted at small scale in CHAI provinces and Pediatric Hospital No.1. To date a very small number of children have benefited. Data confirming thirteen children benefiting from nutritional support from Yan Bai, Vinh Phuc, Hue and Pediatric Hospital No 1 were provided to the MTR.

Supply chain management

CHAI's role in supply chain management has reduced at national level compared to earlier phases as it is no longer procuring pediatric commodities. The MoH's Global Fund project commenced procurement of pediatric drugs in 2013. CHAI has been focused on supporting VAAC and the Global Fund project staff to increase ownership and capacity in supply chain issues, which remains an area of need as evidenced by ARV stock outs in Hue and Yen Bai in 2013-2014. CHAI has assisted national partners to respond rapidly to stock outs so as to prevent interruption of patients' access to treatment. At local level OPCs at Yen Bai, Tay Ninh and Hue confirmed that introduction of Excel tools at sites was beneficial to clinical management, drug management and drug tracking needs. At the national level CHAI has advocated to ensure an ongoing supply of pediatric ARVs and played a key role in ensuring fixed-dose combination ARVs were made available in Vietnam, which is crucial to support adherence. Partners including the PEPFAR contractor SCMS value the role CHAI plays in participating in monthly and quarterly meetings at national level to assist with quantification to inform planning of ARV procurement and supply.

3.3.2 Pediatric treatment

Objectives 2. To enable the national pediatric program to identify and provide ART to 1,500 additional children living with HIV.

697 additional children were enrolled for antiretroviral therapy (ART) between July 2012 and March 2014. While this indicates progress, national partners will continue to face challenges in meeting the ambitious CHAI target of 1,500 additional children on ART. Pediatric ART services are provided at 60 of 63 provinces nationwide, with five new provinces commencing pediatric ART services since 2012.

Nationally there are an average of 33 additional children on ART per month. This is below the 42 per month required to reach the CHAI-defined target of 1,500 new children by mid-2015. CHAI explained that this shortfall has probably arisen as a combination of epidemiological trends (fewer registered HIV cases, possibly because primary HIV prevention programs are working) and budget cuts affecting adult HIV services. Also, some stakeholders have suggested that scale-up of PMTCT programs may be leading to fewer pediatric infections, although this is not confirmed.

An alternative explanation is that CHAI's TA in areas such as PITC, PPTCT and EID is failing to have its intended impact in ensuring services identify new cases. However, the MTR team believes it is more likely that funding cuts to PEPFAR, Global Fund and the National Target Program are constraining the capacity of the overall system to identify new cases. There should be continued efforts to explore the reasons for the shortfall and to support government partners to intensify case detection efforts.

The project's year 1 Annual Report indicates modification of the target of 1,500 to "at least 1,100 children", or a total of over 5,000 children since commencement of Phase I. Further, the target needs to be adjusted to take into account the recommendation of this MTR that Phase III be provided a six-month no-cost extension. If the average of 33 new children per month is sustained the total will be 1,386 by December 2015. The MTR therefore recommends modifying Objective 2 to read: "provide antiretroviral treatment to between 1,300 and 1,500 additional children living with HIV."

Early infant diagnosis (EID)

The MoH's establishment of a national EID program in 2009 was a key contribution of CHAI Phase II to the HIV response. TA to strengthen the program continues to be a significant contribution in Phase III. During Phase III the Dry Blood Spot (DBS) collection program was consolidated and is currently available at 78 pediatric OPCs in 55 provinces, testing about 1,800 infants per year. CHAI originally proposed to introduce SMS printing to reduce turn-around time for results and consequently increase retention of infants in care but this is yet to be introduced in the context of EID.

A significant contribution in Phase III was CHAI's collaboration with VAAC in a national EID study to provide evidence of barriers to access to EID and barriers to access to treatment for those children diagnosed with HIV. Barriers identified to accessing EID services included: late maternal HIV testing; low caregiver knowledge regarding importance of early infant testing and ART initiation; long travel distances to care; inadequate linkages between PMTCT services and HIV care; and maternal anxiety about stigmatization and family breakdown. Barriers to treatment accessibility included: delays in diagnostic testing, poor linkages between diagnostic and treatment services, maternal fears of stigmatization and family breakdown, and long distances for treatment services. The study found that a minority of HIV-exposed infants receive timely and complete EID testing. Only 63% of 312 HIV-infected children identified through EID were alive and known to be on ART. The results indicated an urgent need to improve accessibility to early diagnosis and treatment, particularly the linkages between prevention of mother-to-child transmission, EID, and treatment services. This study was a strategic contribution that confirms that much more work is required to ensure timely access to quality EID services. It is unclear as yet how national partners will respond to the data.

Provider-initiated testing and counselling (PITC)

PITC has been implemented in HCMC (Pediatric Hospitals No. 1 & 2) and two hospitals in Yen Bai using trainings and gender-sensitive counseling checklists. PITC has reduced loss to follow-up between diagnosis and registration for OPC care. Pediatric Hospital No. 1 informants stated to the MTR team that they need further PITC training and support to introduce PITC to new pediatric hospital departments and to pediatric clinics of district level hospitals.

PITC was introduced at Pediatric Hospital No.1 in Phase II. In Phase III, PITC has been expanded into two additional departments at Pediatric Hospital No.1 and seven departments at Pediatric Hospital No.2. The case management system is reducing the number of cases lost-to-follow-up. Referral success and referral time improved after PITC was introduced. By the end of March 2014, a total of 2,953 children had been tested for HIV through PITC services. It was clear to the MTR team that key lessons learned through the pilot phase were informing improvements to the program. For example, hospitals had accepted the importance of a case management approach and had taken action to ensure clinicians did not rely only on posters showing severe symptoms to inform a decision to test for HIV.

3.3.3 Pilot of the Provincial HIV Integration Model (PHIM)

Objective 3. Support provincial partners to pilot an HIV integration model to optimize and integrate HIV interventions within the health system & inform a sustainable national approach

Progress of the PHIM pilot in Yen Bai has been slow but good foundations have been built for the achievement of solid gains in remaining months. Delays were experienced in establishing the pilot while approvals were obtained and implementation has occurred through a phased approach. In 2012, CHAI provided clinical mentoring and built relationships with the PAC. The PHIM pilot started in 2013 with a focus on TA and trainings for commune, district and provincial-level health care workers. A PPTCT operational procedure and a draft provincial plan for implementing PPTCT have been developed, and there is enthusiasm to initiate site-level PPTCT activities in coming months.

Yen Bai is also participating in a VAAC/CDC national OPC quality assurance project, which is providing some site-level support at district level complementary to CHAI. Save the Children Fund provided some advice on establishing PPTCT in Yen Bai in 2012. However, no other provider has offered the hands-on, intensive technical and mentoring support that CHAI provides.

VAAC and Yen Bai PAC are supportive of CHAI's original long-term vision of a decentralized, integrated provincial HIV management model to inform longer term planning. However, in 2013-2014 the Yen Bai pilot has mostly focused on strengthening linkages rather than full service integration. The aim of 'integration' has been modified to promoting 'linkages', given for example that HIV testing is unavailable at ANC level so it is unrealistic to transfer PPTCT to

ANC services. Much of the support provided under the PHIM pilot has not been directed at integration *per se* but rather at improving quality of HIV treatment and care and technical proficiency of clinicians and laboratory workers. The M&E indicators are directed at quality of testing, treatment and care and require modification to also measure the implementation of strengthened service linkages (through referral mechanisms, software, SOPs, etc.) and integration that contributes to improved outcomes in areas such as loss to follow-up.

Yen Bai Department of Health (DOH) strongly welcomes the TA and the approach taken by CHAI staff. Yen Bai DOH recommended that, should CHAI seek to apply the model in other provinces, delays could be avoided by VAAC writing to provincial authorities prior to commencement (e.g. People's Committee, Department of Investment and Planning). The project proposal referred to establishment of a 'coordination unit' at the PAC but it appears that no new structures have been established and instead existing positions are assuming authority to manage implementation. This is advisable as a more sustainable approach than creating new structures.

There are some lessons emerging from PHIM of relevance to other provinces (such as use of ACIS in addressing loss to follow-up, a phased approach initially focusing on 'linkages' rather than full integration and involving DOH rather than just the PAC in policy development). However, the approach CHAI and VAAC will take to applying lessons from the pilot to inform a sustainable national approach is as yet unclear. Gains are still fragile and a stronger focus on sustainability will be required in remaining months. For example, operational guidelines in areas such as PPTCT and HIV/TB management have been introduced but monitoring of compliance and assessment of outcomes is yet to occur.

Notable achievements include:

- **Policy:** Yen Bai DOH's HIV and CD4 testing procedures and service linkages guideline led to a 70% reduction in HIV testing turn-around times. This is a clear demonstration of benefit of the linkages approach.
- **Standard operating procedures (SOPs):** The SOPs on patient referral at the Provincial General Hospital and Nghia Lo Hospital apply to all departments in the hospitals to address loss to follow-up. Other SOPs have been developed in relation to testing, patient management and drug management. The provincial hospital staff are enthusiastically applying lessons learned in relation to development of SOPs for a range of issues going beyond HIV. The challenge will be monitoring and enforcing implementation.
- **Training and TA** on clinical management including three day trainings on pediatric treatment and care for provincial and district level health care workers and on-site TA and case discussions. Testing of participants confirmed that training has increased knowledge.
- **ACIS pilot:** Use of software to generate automatic patient reminder SMSs has proved effective to reduce loss to follow-up and VCT-to-OPC time to arrival. The average time to successful referral has been reduced from 17 days to 10 days.
- **PITC** was implemented for adults and children at the Provincial General Hospital in March 2014 and Nghia Lo Hospital in April 2014.
- For **TB/HIV**, a cross referral guideline was developed with CHAI TA. Yen Bai DOH approved the Guideline of TB/HIV patient management in 2014, which links HIV and TB facilities and has improved access to diagnostic and treatment services. Health care workers have also received training in TB/HIV clinical management.
- **Laboratories:** 44 health care workers received training in HIV testing quality assurance; 18 received basic training on quality management systems; and TA was provided to three HIV and CD4 laboratories. The laboratories aim to meet the minimum standards in 2014. CHAI developed 12 custom SOPs covering sample collection, transportation, testing and management. Turn-around time for confirmatory testing decreased from 37 to 11 days from 2013-2014. CHAI engaged with the Yen Bai DOH to develop a 2013 Decision mandating testing procedures and maximum turn-around times to enable this reduction. Turn-around times for CD4 testing reduced from seven to three days by changing administrative procedures.

It was observed that some equipment that CHAI had purchased for the hospital OPC was not in use e.g. Ear Nose Throat diagnostic equipment (this was also the case in Tay Ninh). Access to medicines is constrained as a result of supply chain issues and affordability. Essential drugs to prevent opportunistic infections are not always available or are unaffordable. There was a recent stock-out of ARVs at one Yen Bai treatment centre and isoniazid to prevent TB was unavailable in 2013. CHAI is addressing drug supply issues by providing TA to the PAC and OPC on use of electronic tools.

The Yen Bai pilot has identified the importance of addressing health insurance to ensure equitable access to HIV-related medicines and services. The Yen Bai DOH indicated that this requires action at both the central level (to ensure ARVs and other required medicines are covered in relevant regulations) and provincial level (to ensure people living with HIV have Health Insurance Cards).

Yen Bai DOH requested that TA be provided for an additional five years. This is an indication of the timeframe that provincial authorities view as desirable in order to reach a point where they are confident in sustaining improvements to HIV care, PPTCT and associated systems independent of TA. Although a good basis for sustainability has been provided by the focus on SOPs and supportive policies, it is too early to assess whether improvements to quality of treatment and care will be fully sustained independent of ongoing training and TA post-2015.

3.3.4 Laboratories

Objective 4. Increased efficiency, accuracy and sustainability of national HIV laboratory systems

There has been good progress in addressing laboratory issues at the policy level but gradual progress at the operational level, with the exception of the dry blood spot (DBS) sample system which is operating effectively nationally. Progress at the national level built on Phase II achievements. VAAC regards the adoption of the National Laboratory Master Plan as a significant milestone and is using the plan to guide its workplan. VAAC indicated that CHAI is the only source of TA for the national laboratory network and was responsible for introducing EID through DBS. Activities focused on implementing laboratory guidelines related to minimum HIV and CD4 test laboratory standards, quality assurance, and testing turn-around times through trainings, the national serology survey and SOP development. Support at the national level for maintaining the QASI EQA system continued in Phase III including TA for a different evaluation methodology for CD4 test quality. The Quality Assessment and Standardization for Immunological Measures External Quality Assurance System (QASI EQAS) is providing effective quality assurance although resource issues contribute to problems such as lack of available reagents that create obstacles to some laboratories participating in the system.

TA for strengthening laboratory systems was also provided at site level. In Vinh Phuc and Tay Ninh support to laboratory systems was only provided through one or two on-site trainings to update knowledge for health care workers on specimen collection. Support was limited at these sites because samples are sent to Ho Chi Minh City and Hanoi for CD4 testing. In Hue and Yen Bai more extensive support was provided. In Hue and Yen Bai where CHAI support has entered the second year, there are improvements in CD4 testing practices as evidenced by higher percentages of patients receiving CD4 test results in the previous six months in 2013 as compared to 2012.

In 2013 CHAI and VAAC conducted a national survey of laboratories, OPCs, HIV voluntary counselling and testing (VCT) sites, and PMTCT sites in all provinces relating to HIV serology, CD4 and viral load testing. CHAI's analysis of survey responses identified problems with confirmatory testing turn-around times caused by factors such as geographic remoteness, funding for transport costs, administrative and laboratory systems challenges. VAAC responded to the finding by sending a letter to all provincial facilities outlining the testing procedures and requiring HIV confirmation results to be returned within seven days, the first VAAC official mention of

testing turnaround times. The national survey was a strategic contribution because it prompted this response from VAAC and because it provided data to support MoH to take steps towards the future introduction of HIV confirmation through rapid testing.

VAAC requested TA in the final year to ensure their high priority provinces and districts are complying with national guidelines for HIV confirmatory testing. VAAC stated that developing the laboratory network and implementing the Laboratory Masterplan were challenging and that quality assurance efforts had met with mixed results but they had learned from experiences. VAAC highlighted the success of EID as a significant CHAI contribution. FHI 360 emphasized that the focus of VAAC on CD4 testing needs to shift given that viral load testing is likely to be more significant tool for patient monitoring than CD4 testing in future years. CHAI acknowledges this but also needs to be responsive to TA requests for current tools.

As part of a WHO-led initiative CHAI purchased PIMA Point of Care CD4 machines for remote clinics in Can Tho and Dien Bien provinces and donated a machine to Thanh Hoa province. Sustainability issues have arisen however as replacement cartridges have not been provided in Can Tho and Thanh Hoa. Use of the machines has reduced the number of patients lost to follow-up, and turn-around times dropped in Can Tho and Dien Bien from a week or more to less than an hour after machines were introduced. Use of PIMA Point of Care CD4 machines has improved patient outcomes but is controversial because of the large number of different CD4 machines already provided by donors. Although CHAI provides TA to assist in use of the PIMA technology CHAI is not advocating for their scale up except in very limited circumstances where justified in remote locations.

VAAC confirmed that the TA on laboratory systems that CHAI provides is not readily available from other sources. VAAC also requested that a TA partnership with Australia's National Reference Laboratory (NRL) be explored. This would be beneficial to VAAC if NRL has access to international TA funds such that a partnership could be established for providing TA beyond 2015.

3.3.5 National policies

Objective 5. To develop or improve HIV-related policies and guidelines by supporting the MoH to adapt international best practices to the Vietnam context.

CHAI made very good progress against this objective and there is a high degree of certainty that CHAI will leave an enduring legacy. Achievements in policy development are likely to be more sustainable than other TA areas, and activities in this area are relatively low cost (accounting for less than 10 per cent of the project budget).

Partners appreciate CHAI as an advocate for evidence-based policy at the national level. For example, CHAI has been an active participant in discussions regarding the national HIV Investment Case and has contributed to the Estimates and Projections Project that provides data to inform policy. CHAI participates in national policy dialogue in forums such as the Steering Committee of the Investment Case and VAAC Technical Working Groups (Care and Treatment, Monitoring and Evaluation). WHO values CHAI's contribution to technical guideline development and UNAIDS values their role as strategically important partners in advocacy for a more rational investment response from national partners and donors. As CHAI does not receive Government of USA funding its representatives are able to speak more freely (e.g. on issues such as stock outs) than PEPFAR partners. To more accurately reflect the breadth of CHAI's role Objective 5 could encompass 'policy and planning' and M&E indicators for this objective could report TA work on the Investment Case and Global Fund proposal as key national planning activities.

CHAI worked collaboratively with VAAC and provincial authorities in development of policies and technical guidelines to meet international standards. The major policy achievements were activities commenced in Phase II that reached fruition in Phase III:

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- Laboratory Master Plan (2013);
 - CD4 and Viral Load Guidelines (2013);
 - Quality Assurance Guidelines in HIV Serology (2013), which enables earlier anti-retroviral treatment; and
 - Policy on Care, Treatment and Support of HIV-positive Pregnant women, HIV exposed infants and HIV-positive infants (2013), which enables early detection and treatment of children.

Three MoH decisions on TB and HIV collaborations were approved in 2012 with CHAI support. CHAI also provided TA in relation to National Circular 32 of 2013 on management and monitoring of HIV-positive patients; the MoH Decision in 2013 to pilot PMTCT using a ‘test and treat approach’ (continuing the mother on ART for life); national guidelines on counselling for children living with HIV; and inputs to MoH’s measles vaccination guidance to correct discrepancies relating to immunization of children living with HIV. Turn-around times for HIV tests were addressed through a VAAC Letter on HIV testing distributed to all provinces, which represented the first time national policy had provided an explicit statement requiring a turn-around time for HIV tests of less than a week. Although monitoring compliance will be challenging, issuing the Letter was an important first step in addressing loss to follow-up.

CHAI is also active on policy development at the provincial level e.g. Yen Bai DOH’s HIV and CD4 testing procedures and service linkages guideline that led to a 70 per cent reduction in HIV testing turn-around times; Yen Bai DOH’s HIV/TB patient management guideline to better link HIV and TB facilities; and Tay Ninh DOH’s PMTCT procedures to link testing and referral services.

Another technical agency reported a concern that the close collaboration between CHAI and VAAC meant that other agencies sometimes felt excluded from providing inputs to pragmatic aspects of national technical guidance. CHAI needs to be aware of this perception and consider options for improving its communications to partners so as to better explain its role in supporting VAAC to develop and improve policies and guidelines.

3.4 DFAT Safeguards: Gender, disability and child protection

3.4.1 Gender

Support to CHAI on gender mainstreaming was initiated in Phase II and continued in Phase III. A local NGO with gender expertise (Centre for Creative Initiatives in Health and Population, CCIHP) provided assistance to update and implement CHAI’s Gender Action Plan with a focus on integrating gender sensitivity into CHAI’s work through a mainstreaming approach.

Key achievements included:

- the conduct of a gender knowledge, attitudes and practices survey to assess needs at hospitals where the PITC program was being implemented and OPCs;
- training for CHAI and VAAC staff;
- integration of gender into PITC training;
- a three-day training program conducted in 2013 to introduce gender in HIV care to 30 health care workers from 16 provinces;
- development of cue cards for gender sensitive counselling in providing care and treatment to children and PITC, and gender-sensitive checklists for adherence counseling;
- presentations on gender issues as a part of two HIV trainings provided by MCH Department; and
- incorporating gender prompts in the eClinica software, e.g. bruising indicative of domestic violence.

Gender is also central consideration in the design of some key aspects of the project, particularly PPTCT, which focuses on the roles of both parents in HIV transmission and access to services, rather than a narrower approach just focusing on the role of the mother. Lack of involvement of male partners can present obstacles to women accessing PMTCT services. To address these issues CHAI is applying a gender-informed and evidence-based approach focusing on the role of both parents (PPTCT) including the involvement of fathers in HIV prevention and in antenatal and postnatal care.

CHAI uses gender disaggregated data in M&E e.g. gender distribution of patients on ART at CHAI supported sites, and in reporting against national M&E reporting indicators for CHAI-supported sites. CHAI reviews male and female attendance at trainings to ensure an appropriate balance and training sessions are facilitated to ensure males do not dominate discussion sessions. There is some also evidence of CHAI including gender sensitive images in IEC materials reviewed by the MTR (e.g. depicting a male person as the cook in a domestic care context in materials on nutrition care).

While CHAI has demonstrated capacity to apply a gender perspective across a range of its activities, there is still much scope for strengthening the gender response. According to CCIHP the training provided was “mainly basic knowledge to improve the awareness rather than to change the behaviour... the very initial step of the gender integration”. Although CHAI has made very good efforts to promote gender sensitive approaches, applying gender mainstreaming principles is clearly proving challenging for health care workers. CCIHP and CHAI conducted an evaluation nine months after the national training, which identified a range of constraints such as health care workers having inadequate time to provide gender-sensitive counselling, being reluctant to initiate discussion of gender issues with long-term patients, and lacking skills to explore problems such as domestic violence and child abuse. The evaluation found that just under one third of health care workers had not used the checklist after training. Barriers to using the checklist included high workload, limited time during patient encounters, and difficulty in explaining technical terms to patients. It will be important for CHAI to define strategies to address these constraints during remaining months of the project.

CCIHP provided advice on inclusion of gender factors in some national policy documents e.g. MoH policy on HIV testing and counselling and EID. However, MoH has reportedly been resistant to inclusion of non-clinical factors in policy. CHAI reported no success in adding gender issues to official clinical guidelines and limited success in garnering health worker interest during trainings.

In terms of CHAI’s provincial activities, the MTR mission confirmed that gender was included in counselling training in Hue and Yen Bai. However, training in gender sensitivity and use of gender checklists is yet to occur in Tay Ninh but will be included in the remaining year of the project.

The CCIHP evaluation of national training on gender sensitive counselling provides helpful recommendations for CHAI’s further activities. To supplement support from CCIHP, the CHAI staff team could also consider the application of international work in this area e.g. the WHO tool on *Integrating gender into HIV/AIDS programmes in the health sector*.²

3.4.2 Disability

Over the last decade there has been increasing recognition globally of the importance of addressing the needs of people with disabilities in HIV policies and programs.³ People with disabilities may be particularly vulnerable to HIV and people living with HIV may experience

² WHO (2009). *Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women’s needs*. Geneva: WHO.

³ See e.g. UNAIDS, Handicap International et al, (2011). *Framework for the Inclusion of Disability in National Strategic Plans on HIV and AIDS*, UNAIDS..

HIV-related disability either as a result of HIV, an opportunistic infection or as a side-effect of treatment. HIV can be a cause of temporary or permanent disability, particularly when people do not have access to quality health care and ART.

Prior to the MTR, CHAI had not given consideration to the need for disability factors to be specifically highlighted in training, mentoring or resource materials. Rather, CHAI staff have dealt with disability as an integral aspect of clinical care and patient management, given that most patients receiving HIV-related treatment and care experience some form of physical impairment related to late HIV diagnosis and many are co-infected with TB and/or hepatitis C virus. Many experience mobility restrictions that affect their physical access to services. The MTR team noted for example that the Yen Bai OPC was only accessible by stairs.

CHAI staff acknowledged the importance of clinical services responding to restrictions on access to services in a more systematic way e.g. through training materials and policy guidance. This aspect can be given greater consideration in the remaining year having regard to international work. For example, people with disabilities have been included as a key population in South African National HIV Strategy, and UN partners have published a policy brief to guide work in this area.⁴

Vietnam is a signatory to the *International Convention on the Rights of Persons with Disabilities* (2008). The Convention requires services to provide reasonable accommodation to the needs of people with disabilities. This means that health services are required to make necessary and appropriate modifications and adjustments, not imposing a disproportionate or undue burden on the service, to ensure that persons with disabilities can access their services. CHAI can support Government of Vietnam to comply with the Convention by integrating the principle of reasonable accommodation into its TA activities e.g. site support and training of health care workers. For example compliance with this principle might require access to treatment, care and support programs to be improved through:

- design and location of facilities such as the inclusion of ramps;
- specialised formats such as material and packaging in Vietnamese Braille, sign language interpretation and simplified information to compensate for intellectual challenges; and
- referral to rehabilitation and other disability services where they exist.

3.4.3 Child protection

CHAI has a comprehensive child protection policy that applies to its staff and volunteers in Vietnam, including expatriates, who work directly with children under the age of 18, as well as contractors, consultants, and sub-contracting NGOs funded by CHAI. The policy complies with DFAT requirements, was approved by a DFAT Child Protection Officer and was updated in March 2014.

3.5 Contribution to the National Strategy on HIV/AIDS

CHAI's activities are strongly aligned with the National Strategy on HIV/AIDS Prevention and Control. The Strategy's vision to 2030 is: "To strive for universal access, improved quality and sustainability of HIV/AIDS prevention and control; to strive for the United Nations' three-zero vision: zero new infections, zero AIDS-related deaths, and zero discrimination." CHAI's activities support achievement of the following targets that Government of Vietnam has set under the National Strategy's "Project for comprehensive HIV treatment, care and support" and the National Target Program on HIV/AIDS Prevention and Control:

ARVs

- Increase the percentage of eligible people living with HIV receiving treatment to 70% by 2015 and 80% by 2020.

⁴ UNAIDS, WHO, Office of the High Commission on Human Rights, (2009). *Policy brief: Disability and HIV*, Geneva: UNAIDS.

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- Increase the percentage of people living with HIV who continue ARV treatment after 12 months to at least 80% by 2015 and maintain this percentage until 2020.

HIV/TB

- Increase the percentage of people with HIV-associated TB who receive both ARV and TB treatment to 80% by 2015 and 90% by 2020.

PMTCT

- Reduce mother-to-child HIV transmission rate to less than 5% by 2015 and 2% by 2020.
- Increase the percentage of pregnant women with HIV and their infants who receive early ARV treatment to 90% by 2015 and 95% by 2020.

CHAI has supported progress towards the goal of universal access to HIV services, as ART coverage rose from 7% of adults in need in 2006 to 59% in 2012 and 63% in 2013. A key contribution to universal access has been scale-up of pediatric treatment services. By 31 December 2013, there were 4,204 children on ART. This represents ART coverage of 71 per cent of the total number of children living with HIV in Vietnam.

These outcomes also align with the ‘Vision to 2020’ for ongoing care and treatment of children under the *National Program of Action on Children Affected by HIV/AIDS*.⁵ CHAI is contributing significantly to reducing child illnesses and deaths, as indicated by data on patient retention and high child survival rates after initiation of ARVs, and CHAI’s role in introducing EID. 1,875 infants received DBS testing in 2013, of whom 146 were found to be HIV-positive.

CHAI’s focus on addressing gaps in the treatment cascade also aligns strongly with the outcomes set by the National Strategy’s “Project for comprehensive HIV treatment, care and support” in relation to achieving the following strategic outcomes:

- increase the number of people living with HIV who have access to early HIV diagnosis and timely HIV/AIDS treatment and care;
- reduce the number of people living with HIV who are lost to follow-up after diagnosis; and
- increase the number of people living with HIV who are maintained in HIV/AIDS treatment and care.

CHAI-supported sites report progress against the Government of Vietnam’s detailed national M&E reporting indicators (Decision 28). This includes reporting of retention rates on ART, with high retention rates above national averages reported in Yen Bai, Binh Phuc, Thua Thien-Hue and Tay Ninh.

3.6 Lessons learned for Governments of Australia and Vietnam

In Phase III, CHAI has adopted a more systematic approach to documenting lessons learned than in previous phases. The project’s Annual Reports document specific lessons from each of the activity areas, indicating that CHAI has integrated a greater emphasis on continuous learning into its planning and organisational culture. Some of the documented lessons have the potential to inform HIV responses of other countries, e.g. confirmation of the high degree of TB protection provided by IPT when given to HIV-positive children. Other lessons have implications to health systems in Vietnam beyond HIV and for health systems of developing countries more generally e.g. use of ACIS software to reduce loss to follow-up through SMS-generated patient reminders; building MoH capacity in drug forecasting using appropriate electronic tools.

Key lessons include:

⁵ *Decision of the Prime Minister No. 84/2009/QĐ-TTg on the National Program of Action on Children affected by HIV until 2010 with the Vision to 2020.*

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- (i) Silos within the health system contribute to patients being lost to follow-up and create obstacles to quality HIV services for women and children. Moving to a more decentralized and integrated service model is a long-term vision that first requires improved horizontal and vertical health system coordination and linkages between HIV, TB, VCT, MMT, hepatitis C and ANC services and the reproductive health care system down to commune and village levels. Silos can be addressed through moving to a hospital-based model of integration including integrated adult and pediatric HIV care and treatment and related laboratory services, with strengthened linkages to TB, ANC, MMT, and VCT services.
 - (ii) PPTCT requires improved coordination between HIV services (under VAAC), ANC services in hospitals (under the Vietnam Administration of Medical Services) and the reproductive health system (under MCH Department). At provincial level this requires coordination between the PAC, Provincial Hospital and Reproductive Health Centers. Better EID accessibility is associated with more effective PPTCT services. Therefore coordination and linkages between PPTCT services and EID services should be strengthened. Further, HIV testing is usually not available at commune level, limiting the effectiveness of HIV detection and therefore of PPTCT. Resolving health insurance blockages could provide a long-term sustainable solution to decentralized HIV test availability.
 - (iii) When planning provincial activities, TA providers and their national counterparts (VAAC) should formally engage with provincial authorities outside of health at an early stage prior to commencement of provincial activities (People's Committee, Department of Investment and Planning). This is important to avoid delays.
 - (iv) CHAI has demonstrated a comprehensive approach to its TA role, extending beyond training and mentoring to include piloting of new technologies and the strategic use of evidence. Examples include: for laboratories, the national sample referral survey showed that with strong evidence, it is possible to move government to action; the national EID study has provided an evidence-based for national partners to begin to address access barriers; piloting of HMIS software has provided evidence for scale-up of innovations.
 - (v) The approach of using an NGO with national technical staff to provide targeted TA through intense engagement with national counterparts is very effective. Low reliance on international staff helps to increase local engagement, build national capacity and maximize local ownership. Although CHAI's staff team members are easy for national partners to access and support for particular issues is often provided on a constant or daily basis, TA personnel avoided becoming involved in direct implementation or substituting for country partner personnel, contributing to sustainability and institutional strengthening.
 - (vi) MoH capacity in procurement and supply chain remains weak as evidenced by stock outs. As donor budgets decrease and Vietnam increasingly sources drugs from costly national suppliers, procurement and supply chain challenges will likely worsen. Vietnam faces a period of uncertainty as it transitions away from reliance on donor-funded commodities and access to TA in this area reduces. It is becoming increasingly urgent to ensure MoH has both the technical capacity and legal power to import affordable quality-assured drugs from global markets and is supported to access low cost HIV drugs through CHAI's Procurement Consortium. There is a high risk that Vietnam will not be able to access many pediatric ARVs post-2015 without TA. The government is encouraging local ARV production, but local manufacturers have quality assurance and formulation challenges, and they have no plans to produce pediatric ARVs.

4 Conclusions and recommendations

4.1 Priorities for 2014 – 2015

VAAC staff made several suggestions for future priorities during MTR interviews, including the following requests:

- (i) all current activities should continue for the remainder of Phase III;
- (ii) in addition, a priority should be given to TA to GoV for preparation of the HIV Investment Case and the proposal for the next Global Fund grant;

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- (iii) a greater focus on a standard training program for laboratory strengthening;
 - (iv) human resources to strengthen the regulatory framework for laboratory network issues;
 - (v) further support for linking testing and treatment services through ACIS software development and support for maintenance of software systems;
 - (vi) a study tour to the National Serology Reference Laboratory (NRL) in Australia, or support to develop a partnership relationship with NRL. (CHAI may be able to facilitate this and funds may be available from NRL who may have access to regional capacity building funds);
 - (vii) costing analyses to inform programming for pediatric treatment and care.

MTR Recommendations

- (i) CHAI should continue to implement activities under the five Phase III objectives but with a greater emphasis on sustainability. A sustainability plan is required for the final 12 months that addresses the following priorities:
 - a) More intense work with the regional pediatric committees on supporting transfer of skills to local mentors and trainers, identifying sources of funds (e.g. from provincial budgets) to sustain local capacity building activities and ensuring that systems are in place for clinicians to access local mentors and training;
 - b) More focused work with the MCH Department to integrate PPTCT into ANC and the MCH system. Provide TA to MCH Department to begin assuming HIV responsibilities as a phased approach commencing 2014 so that MCH is able to provide leadership and fully manage PPTCT and related HIV responsibilities by 2016.
 - c) Documentation of lessons learned, particularly from Yen Bai PHIM and PPTCT including blockages at national down to commune level, highlighting obstacles as well as progress. CHAI should aim for all data relevant to lessons to be captured no less than 3 months before completion date so that ample opportunity exists to disseminate lessons.
 - d) Consider contracting someone to focus on the sustainability planning including documentation and dissemination of lessons to domestic audiences. Consider promotional activities such as an exit seminar, web-based promotion, or presentations at the Annual Meeting of the Vietnam Clinical HIV/AIDS Association.
 - e) With partners develop a roadmap for VAAC and MoH to improve technical capacity in international procurement particularly of pediatric commodities.
- (ii) TA to VAAC for preparing the Vietnam HIV Investment Case and proposal for the next Global Fund grant should proceed. Preferably this should be done by contracting a temporary expert who can work on a day-to-day basis in close collaboration with VAAC staff and the Global Fund CPMU team so that skills are transferred to local staff. Objective 5 should be amended to refer to planning as well as policy development and CHAI should include this as a planning activity. (New Objective 5: *To develop or improve HIV-related policies, planning and guidelines by supporting the MoH to adapt international best practices to the Vietnam context*)
- (iii) CHAI should discontinue national-level activities that are not of central relevance to exit planning for the four project objectives. For example, CHAI's involvement in the Estimates and Projections Project could be discontinued after the Global Fund concept note and proposal have been prepared.
- (iv) The final year of the Yen Bai PHIM pilot should include:
 - a) a strong focus on PPTCT, including the case management approach to manage HIV-infected pregnant women and their babies until the infant's HIV status is determined;
 - b) piloting of the 'test and treat' approach including but not limited to pregnant women (consider also people who inject drugs to simplify treatment and to reduce transmission to their partners);

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- c) assessment of eClinica to compare uptake in a rural context with the results from Ho Chi Minh City;
 - d) M&E should be adjusted to measure and report progress on the linkages established through referral mechanisms, SOPs, software etc.;
 - e) work with the PAC to identify alternative funding sources to maintain key activities including from national and provincial budgets.
- (v) eClinica will require careful handover to government partners at central level and regional levels to ensure capacity to maintain the system, particularly the rules relating to patient management that may require annual revision. The aim for Phase III should be to document experiences of simplified versus more complex versions in sites such as HCMC so that lessons can be applied to adapt the system to national level and other health conditions.
- (vi) For ACIS, SOP templates and standard training materials should be developed for use by government partners at regional and national levels. Experience in development and piloting of the eClinica and ACIS software should be documented in Vietnamese publications and opportunities explored for publication in a domestic medical journal and/or at a domestic medical conference. This will ensure that lessons learned are disseminated so that future HMIS initiatives can learn from CHAI's experiences (if use of the software is not sustained post-Phase III).
- (vii) CHAI should assess the application of tools developed by WHO on gender and disability in HIV clinical services to the Vietnam context. Disability should be more explicitly recognised in CHAI training and materials to raise awareness of measures that can be taken to improve physical restrictions on access to clinical services. CHAI's TA and trainings should promote the principle that services should explore ways of providing 'reasonable accommodation' to the needs of people with disabilities.
- (viii) A no-cost extension of CHAI Phase III is supported until 31 December 2015 as beneficial to maximize sustainability of provincial activities and capture lessons learned. This is particularly important for Yen Bai province (PPTCT and ensuring that service linkages are maximized), which has been significantly delayed. If this extension is approved, the Objective 2 target should be modified to read: "provide antiretroviral treatment to between 1,300 and 1,500 additional children living with HIV."
- (ix) It is recommended that international clinical mentors not be used in the final six months of Phase III, to enable national staff to focus on capturing lessons learned and maximizing domestic capacity to lead the response.

4.2 Potential areas of focus post-2015

Future role in HIV and related diseases

CHAI has amply demonstrated that it can make an effective contribution to strengthening a country-led HIV treatment and care response. If Australia seeks to continue to support gaps in Vietnam's HIV treatment and care response, CHAI offers good value for money and is very well placed to play an ongoing role. VAAC indicated that it would welcome continued TA on PMTCT and pediatric treatment and care, and highlighted the importance of TA to address anticipated procurement challenges particularly for pediatric drugs. CDC and FHI 360 were supportive of CHAI maintaining a niche role in the HIV response including in HMIS particularly to address loss to follow-up, and to conduct costing analyses as an evidence base for policy. These agencies also noted that CHAI is well placed to play an expanded role in TA to the national TB response to fill gaps in areas such as testing and laboratory strengthening.

The MTR team discussed potential focus areas for new CHAI activities with CHAI staff and identified the following activity areas as potential new components of an HIV-related project:

- (i) TB and HIV, including co-infection issues;

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- (ii) Liver cancer, hepatitis C virus (HCV), and HIV/HCV;
 - (iii) Further development of an integrated primary care model (MCH, HIV, TB, SRH, HCV, MMT); and/or
 - (iv) TA on procurement and supply chain issues to ensure continuity in access to HIV and TB medicines in the context of new procurement arrangements.

Of the above options, should DFAT seek to engage CHAI in a further phase of an activity related to HIV the MTR team recommends that priority consideration be given to a focus on TB and HIV given the contribution of TB including HIV/TB to morbidity and mortality in Vietnam. This could encompass TA to strengthen both the national TB and HIV response including integration and linkages between services and procurement of commodities e.g. for pediatric testing and treatment needs, and TA to help innovate and implement programs on diagnostics / intensified case-finding and IPT, including looking at testing methodologies.

However, if Australia seeks to support gaps in Vietnam's HIV prevention response rather than a treatment and care focus, DFAT should consider a tender process. CHAI has expertise in PMTCT and CHAI's expertise in ART means that it could be well placed to contribute to an initiative focused on use of ARV treatment for HIV prevention. However, other providers may offer equal or better value for money in addressing other essential aspects of a comprehensive HIV prevention response, particular community mobilization of key populations and other social, behavioural and structural aspects of HIV prevention. If DFAT were to fund an HIV prevention initiative, it may be strategic to focus on areas of the response where PEPFAR has policy constraints e.g. needle and syringe programs with people who inject drugs and/or the empowerment of sex workers.

Future role in health systems strengthening

Discussions with CHAI also confirmed that it is well placed to contribute to broader health systems strengthening efforts not limited to HIV, for example in the following areas:

- (i) Medicines quality (all essential medicines, preferably as part of a regional initiative);
- (ii) Health Management Information Systems (comprehensive for prevalent diseases); and
- (iii) Continuing Medical Education through e-learning.

Of the above options, should DFAT seek to engage CHAI in a health systems strengthening activity the MTR team recommends that priority consideration be given to a focus on medicines quality. For example this may extend to TA to the national drug regulatory authority and other government departments to address counterfeiting and sub-quality medicines generally as part of a multi-country initiative for the Greater Mekong Sub-region or South East Asia. This could also include building in-country capacity at national laboratories to carry out quality control testing on drug samples and diagnostic tests with an initial prioritization to malaria drugs and diagnostics.

It would be advisable for DFAT to conduct further scoping and consultations with Government of Vietnam and other stakeholders prior to any final decision about the focus of any future activity should funds be available, informed by the principle that the design of activities be demand-led rather than supply-driven.



Draft Quality at Implementation Report for *Clinton Health Access Initiative Phase 3*

Summary

Investment Name	<i>Clinton Health Access Initiative</i>		
Initiative number	<i>INJ129</i>		
Start date	<i>1 July 2012</i>	End date	<i>30 June 2015</i>
Value	<i>\$AUD 4,650,000</i>	Expenditure to date	<i>\$AUD 3,000,000</i>
Report drafted by	<i>Mid-Term Review</i>	Date of draft	<i>June 2014</i>

Description	<p>Vietnam is unlikely to meet the HIV targets of the Millennium Development Goals by 2015. Many of the building blocks of the national care and treatment system such as policies, planning systems, operational protocols and guidelines and trained staff have been lacking or weak and programs have neglected the needs of women and children. The Government of Vietnam (GoV) is unable to fully finance HIV programming and over 90 per cent of the HIV budget is funded by international partners. The main sources of funding for the national HIV treatment response are Government of USA (PEPFAR) and the Global Fund to Fight AIDS, TB and Malaria. GoV implements the Global Fund's HIV project.</p> <p>Clinton Health Access Initiative (CHAI) is a technical assistance (TA) and capacity development project being delivered in three phases. DFAT's AUD\$4,919,993 support for Phase I (1 July 2006 - 31 July 2009) was launched to improve the quality of care and treatment for people living with HIV with a focus on children. DFAT's contribution of AUD\$3.2 million in Phase II (1 August 2009 - 31 May 2012) built on the successes of Phase I to further strengthen the GoV's capacity to deliver HIV care and treatment services for adults and children, strengthen laboratory systems and improve supply chain management for antiretroviral drugs. Phase III (July 2012 – June 2015) continues the focus on women and children, has a health systems strengthening focus that seeks to integrate HIV care within mainstream services, provides TA including policy development and capacity building support (training and mentoring) to government partners and works closely with government at national, provincial and district levels. All activities are approved by the Vietnam Authority for HIV/AIDS Control (VAAC), which coordinates GoV's national response to HIV.</p> <p>The overall aim of CHAI Phase III is that GoV is able to sustain quality pediatric care and treatment services, prevention of parent-to-child HIV transmission (PPTCT) services, laboratory systems strengthening, and policy development in HIV treatment and care to international standards by 2015.</p>
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Outcomes Summary	<p>CHAI Phase III has five objectives:</p> <ol style="list-style-type: none"> 1. to expand the coverage and improve the quality and sustainability of the national HIV care and treatment system; 2. to enable the national pediatric program to identify and provide antiretroviral treatment to 1,500 additional children living with HIV; 3. to support provincial partners to pilot an HIV integration model to optimise and integrate HIV interventions within the health system and inform a sustainable national approach; 4. to increase the efficiency, accuracy and sustainability of the national HIV laboratory system; and 5. to develop or improve HIV related policies and guidelines by supporting the Ministry of Health to adapt international best practices to the Vietnam context. <p>These objectives support the project's overarching goal: "To reduce HIV-related deaths among adults and children in Vietnam by 2015."</p>
Key Messages	<p>CHAI Phase III addresses the niche area of HIV care and treatment for women and children. CHAI is building human resource capacity to address HIV needs within Vietnam so that by the conclusion of the project GoV can transition from NGO technical assistance to GoV ownership and leadership in delivery of quality HIV treatment and care with a strengthened focus on the needs of women and children.</p> <p>CHAI is also providing TA to the Ministry of Health (MoH) in supply chain management, drug forecasting and support to improve distribution of antiretroviral drugs including pediatric formulations to ensure the needs of children are not neglected.</p> <p>CHAI is assisting GoV to reduce AIDS-related deaths. Reduction in AIDS-related deaths is an expected outcome of the Global Fund's HIV Project and the MoH National Target Program on HIV, which are supported by CHAI TA. By 2014, CHAI had assisted government services to diagnose over 4,000 children with HIV and to provide access to life-saving treatment. Without early detection and antiretroviral therapy (ART), 50 per cent of HIV positive children may die by age of two. CHAI is on track to assisting government services to place over 5,000 children on ART by 2015. By March 2014, there were 4,263 children on ART, an increase in over 600 since June 2012, and an increase in 4,018 since 2006.</p> <p>The increase in adults and children accessing ART contributes to fewer people progressing from HIV to AIDS and less reported AIDS-related deaths. Total reported AIDS cases have reduced from 13,010 in 2006 to 6,074 in 2013, and reported deaths have reduced from 6,785 in 2006 to 2,296 in 2013.</p> <p>CHAI Phase III has strengthened the capacity of Government-led health systems to provide effective HIV services, especially for women and children in four provinces that have been targeted for support (Tay Ninh, Hue, Yen Bai, Vinh Phuc). CHAI is contributing significantly to reducing child illnesses and deaths in these target provinces, as indicated by data on patient retention (higher than national averages) and high child survival rates after initiation of ART.</p> <p>CHAI also supports GoV's objectives to increase the percentage of eligible people living with HIV receiving treatment to 70% by 2015. Nationally, ART coverage has increased from 7% of adults in need in 2006 to 59% in 2012 and 63% in 2013.</p> <p>TB is a leading cause of death for HIV patients in Vietnam. Isoniazid Preventive Therapy (IPT) is the core strategy to reduce TB deaths among HIV patients, especially for children. Under Phase III, CHAI assisted 18 outpatient clinics to launch IPT programs. With CHAI support 1,792 HIV-positive children have been initiated on IPT at 18 clinics. CHAI's documentation of the effectiveness of IPT in HCMC, where CHAI found a 97 per cent reduction in TB incidence for children on ART and IPT, was presented at the International AIDS Conference, Melbourne, July 2014. World Health Organization Guidelines issued in 2010 recommend IPT for TB prevention in children diagnosed with HIV, but this approach</p>

	<p>has been questioned as a result of data from South Africa. However CHAI's data supports the WHO recommended approach.</p> <p>CHAI's role has largely been through TA for clinical management, policy development, laboratory systems and supply chain management through mentoring, training and capacity development. Given the crucial role CHAI has played in the national treatment response, the mid-term review (June 2014) concluded that it is making a significant and strategic contribution to reducing deaths alongside the much larger PEPFAR and Global Fund programs.</p>
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Australian Aid – Rated Quality Criteria

Criteria	Assessment (no more than 600 words per cell)	Rating (1-6)	Management response Be as precise as possible: what? how? who? when? (no more than 600 words per cell)
1. Relevance	<p>Although DFAT is withdrawing support from the health sector, the Australia-Vietnam Joint Aid Strategy 2010-2015 recognises that Vietnam is at risk of not achieving MDG HIV targets by 2015 and therefore identifies limited continued assistance for HIV.</p> <p>Support to national HIV responses is consistent with DFAT's new aid policy <i>Australian aid: promoting prosperity, reducing poverty, enhancing stability</i> (2014), which states that Australia will support partner governments to deliver better health for all, including to the poor, with a focus on cost-effective interventions to prevent diseases such as HIV and TB, and quality maternal and child health.</p> <p>CHAI Phase III is relevant to need and closely aligned with GoV's agenda. Over 250,000 people are living with HIV and approximately 40% of eligible patients are not accessing treatment. CHAI's activities strongly align with the GoV's 2012 National HIV/AIDS Strategy. The Strategy's vision to 2030 is to strive for universal access and the United Nations' goals of zero new infections, zero AIDS-related deaths, and zero discrimination. CHAI's activities support achievement of the following targets under the National Strategy:</p> <ul style="list-style-type: none"> • ARVs: Increase the percentage of eligible people living with HIV receiving treatment to 70% by 2015. Increase the percentage of people living with HIV who continue ARV treatment after 12 months to at least 80% by 2015 and maintain this until 2020. • PMTCT: Reduce mother-to-child HIV transmission rate to less than 5% by 2015 and 2% by 2020. Increase the percentage of pregnant women with HIV and their infants who receive early ARV treatment to 90% by 2015 and 	5	

Criteria	Assessment (no more than 600 words per cell)	Rating (1-6)	Management response Be as precise as possible: what? how? who? when? (no more than 600 words per cell)
	<p>95% by 2020.</p> <p>In 2011 the Viet Nam National Assembly approved HIV as a standalone National Target Program. GoV funding for HIV interventions overall remains low, with minimal investment on women and children's needs. GoV planned to allocate USD\$168 million over four years, but this was revised drastically downwards due to the financial crisis with only \$4.2 million allocated in 2014.</p> <p>TA to support GoV to sustain the HIV treatment and care response has become more urgent as international funding is withdrawn. Vietnam's achievement of middle-income status has resulted in decreasing international funds for HIV. World Bank, the UK and the Dutch Government have exited HIV support, while USG's PEPFAR has reduced support from USD\$97.8 million in 2010 reducing to under USD\$55 million in 2013-2014 and is anticipated to be around USD\$50 million per annum for 2014-2015, with a phased withdrawal of support planned in coming years as PEPFAR transitions to a limited TA role.</p> <p>The Global Fund's HIV budget for Vietnam was USD\$27 million in 2013 and significant cuts are being negotiated.</p>		
2. Effectiveness	<p>Good progress, after some delays & adjustments:</p> <p>Objective 1: Treatment and care</p> <p>Delays in official clearances meant only two provinces received support in 2012. In 2013, support expanded to four provinces with early evidence of improved quality (data confirms ART coverage better than the national average and high treatment retention rates and reduction of HIV testing turn-around times.). CHAI launched or strengthened pediatric services at adult OPCs in these provinces. CHAI also supported the southern region's Pediatric Committee to provide support to an additional six provinces.</p> <p>There are gradual improvements in clinical management, inter-facility linkages and supply chain, but challenges remain in maintaining minimum standards.</p> <p>For TB, 1,792 HIV-positive children have been initiated on IPT at 18 pediatric OPCs. CHAI found a 97 per cent reduction in TB incidence for children on ART and IPT.</p>	5	<p>Adjust Objective 2 to "provide antiretroviral treatment to between 1,300 and 1,500 additional children living with HIV." (assuming a 6 month no-cost extension)</p> <p>DFAT should monitor monthly trends in new patients; CHAI should further investigate causes for decline in additional children on ART per month.</p> <p>For Yen Bai PHIM pilot, CHAI should develop a systematic approach to documenting & promoting lessons to inform the national approach.</p> <p>The final year of the Yen Bai PHIM pilot should include:</p> <ul style="list-style-type: none"> - a strong focus on PPTCT including the case

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	<p>The CHAI/VAAC national study on Early Infant Diagnosis (EID) has defined the access issues required to improve the national EID program.</p> <p>Provider-initiated testing and counselling (PITC) reduced loss to follow-up in some sites; lessons learned from CHAI's PITC pilots are informing improvements to the program.</p> <p>For PPTCT, HIV indicators were inserted in the national reproductive health M&E, two national trainings were held and site-level support provided on new operational procedures.</p> <p>New software systems (eClinica and ACIS) are a significant innovation. ACIS is improving loss to follow-up and used at over 100 sites.</p> <p>Objective 2: Treat 1,500 additional children. By March 2014, there were 4,263 children on ART, an increase in over 600 since June 2012. There are an average of 33 additional children on ART per month, below the 42 per month required to reach 1,500. Funding cuts are constraining the capacity of the system to diagnose and retain children in treatment, suggesting the need to revise the target e.g. 1,300 to 1,500 additional children by December 2015.</p> <p>Objective 3: Provincial integration pilot. Progress has been slow particularly PPTCT but good foundations are in place. The pilot commenced 2013. Lessons for other provinces include ACIS software to address loss to follow-up, a phased approach initially focusing on 'linkages' rather than service integration, and engaging DOH for policy outcomes. Achievements:</p> <ul style="list-style-type: none"> • New standard procedures to address loss to follow-up. • Average time to successful referral reduced from 17 to 10 days. • Turn-around time for confirmatory testing decreased from 37 to 11 days and for CD4 testing reduced from 7 to 3 days. • Cross-referral guideline for TB/HIV patient management and TB training. • PITC at 2 hospitals. <p>Objective 4: HIV laboratory systems Good progress at the policy level but gradual progress at operational level. CHAI and VAAC conducted a national survey of laboratories. This identified problems with testing turn-around</p>		<p>management approach;</p> <ul style="list-style-type: none"> - piloting of 'test and treat' approach for pregnant women and consider also people who inject drugs; - assessment of eClinica in rural context ; - amend PHIM M&E to measure service linkages established through referral mechanisms, software, SOPs, etc. to inform national learning; - work with PAC to identify funding sources to maintain activities from national / provincial budgets; - Assess eClinica in the context of PPTCT. If CHAI proceeds with developing an eClinica version incorporating clinical decision support this will need to be subject to thorough field testing. - Pilot ACIS in high prevalence high population areas such as HCMC <p>CHAI should document experiences of simplified versus more complex versions of eClinica in different rural / urban settings so that lessons can be applied to adapt the system to national level and other health conditions.</p> <p>For ACIS, an SOP template and standard training materials should be developed for use by government partners at regional and national levels.</p> <p>Experience in development and piloting of the eClinica and ACIS software should be documented in Vietnamese publications and opportunities explored</p>

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	<p>times. The survey prompted a swift policy response from VAAC. TA focused on implementing laboratory guidelines related to minimum standards and testing turn-around times through trainings and SOP development, and assisting national partners to maintain EID and a national quality assurance system. Implementing the Laboratory Masterplan remains challenging for national partners and quality assurance efforts have met with mixed results.</p> <p>Objective 5: National policies Partners appreciate CHAI as an advocate for evidence-based policy. CHAI participates in national planning on Global Fund proposals and policy dialogue in forums such as the Committee on the Investment Case. Achievements include:</p> <ul style="list-style-type: none"> • CD4 and Viral Load Guidelines; • Quality Assurance Guidelines in HIV Serology; • Policy on Treatment of HIV+ Pregnant women, HIV exposed infants and HIV+ infants • Circular 32 on management of HIV patients; • MoH Decision to pilot PMTCT using a test and treat approach; • MoH's measles vaccination guidance relating to immunization of children living with HIV; • HIV test turn-around times addressed by a VAAC Letter for all provinces. 		<p>for publication in a domestic medical journal and/or at a domestic medical conference.</p> <p>Explore VAAC request for a partnership with Australia's National Serology Reference Laboratory.</p> <p>TA for preparing the Vietnam HIV Investment Case and proposal for the next Global Fund grant should proceed.</p> <p>Objective 5 should be amended to refer to 'policy and planning' and M&E indicators for this objective should report work on the Investment Case and Global Fund proposal as planning activities.</p>
3. Efficiency	<p>The Program delivers value for money as CHAI is a relatively low-cost, flexible and responsive implementer. There is adequate investment in M&E with over 10% of the budget allocated to M&E.</p> <p>CHAI meets accountability and reporting requirements with regular reporting to VAAC and DFAT.</p> <p>The budget is underspent as a result of delays and the strong Australian dollar exchange rate. In year 1 actual expenditure was AUD\$1,125,054, which represented an underspend of \$424,946; in year 2 actual expenditure at 9 months was again tracking under the budgeted amount. CHAI has requested a no-cost extension. The MTR supported the extension as helpful to ensure sustainability particularly as there had been</p>	5	<p>A no-cost extension is supported until December 2015 as beneficial to maximize sustainability of provincial activities and capture lessons learned. This is particularly important for prevention of parent-to-child transmission (PPTCT) and Yen Bai pilot, which have been significantly delayed.</p>

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	<p>delays in commencing provincial activities in Year 1.</p> <p>Reliance primarily on national technical staff rather than international advisors keeps costs down. Staffing levels are appropriate with 14 in-country staff, and technical staff are well qualified having a range of highly relevant experience with other technical agencies and multilaterals e.g. WHO. International contractors include globally respected HIV pediatricians. At the time of the MTR one international mentor was being used (based in Hong Kong) and another international staff member was providing training (Part-time Clinical Advisor). Support is also provided by CHAI regional staff. The staff team are highly motivated and there is strong leadership from the Country Director.</p> <p>Objective 1: Treatment and care Implementation arrangements such as provincial workplans fully align with and support partner systems (VAAC, provincial hospitals, and Provincial AIDS Committees). Delayed permission to commence provincial activities impeded efficiency in Year 1.</p> <p>While most of CHAI's activities are implemented independent of other external TA providers, in the area of Health Management Information Systems (eClinica) CHAI has achieved efficiencies by working with FHI 360, CDC, and International Training & Education Center for Health.</p> <p>Within the project budget, CHAI has added two new outcomes: (1) eClinica software to support clinical and programmatic management of HIV care and treatment to run in pilot sites; and (2) an SMS Referral and Reminder Tool to run between at least 5 facilities. There has been rapid progress in developing and piloting these products in 2013-2014.</p> <p>Objective 2: Treat 1,500 additional children. Nationally there are an average of 33 additional children on ART per month, below the 42 per month required to reach the target of 1,500. The MTR found that this shortfall is not due to inefficiencies in areas such as CHAI support to PITC and EID but rather is due to the impact of funding cuts on health service capacity to detect new HIV cases across all provinces (PEPFAR, Global Fund and the National Program).</p>		

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	<p><u>Objective 3: Provincial HIV integration pilot.</u> Delayed permission to commence provincial activities impeded efficiency in Year 1. Vietnam's vertical model of HIV services, political constraints and logistical issues contributed to delays in agreement with provincial partners on the pilot. CHAI adjusted the model as a phased approach to strengthening linkages in Yen Bai province.</p> <p><u>Objective 4: HIV laboratory system.</u> CHAI's efforts to support government partners to maintain the external quality assurance system faced resource constraints e.g. restricted access to reagents, broken machines.</p> <p><u>Objective 5: Policies and guidelines.</u> CHAI is generally more efficient than larger development partners in supporting government to develop policies and guidelines. CHAI has secured close engagement with GoV partners built on mutual cooperation, and long-term working relationships. MoH views CHAI as a trusted partner in policy-related work as well as clinical matters. Activities in this area are relatively low cost (accounting for less than 10% of the project budget) and directly strengthen national systems.</p>		
4. Monitoring and Evaluation	<p>The current M&E framework is sufficient for performance reporting including providing the required information for QAI criteria.</p> <p>CHAI and VAAC conduct six-monthly review meetings to jointly review progress and adjust work plans. External independent evaluations have been conducted for each Phase. There is also regular engagement of CHAI management with the DFAT activity manager.</p> <p>The framework inherited the previous phases M&E work, with substantial improvement in integrating the indicators to the national M&E system. The current M&E framework is therefore highly regarded by VAAC and the MoH. The M&E framework is robust and captures a range of data required for project assessment and for policy making purposes such as survival rate, rate of retention on treatment, per cent of HIV-positive infants born to HIV-positive mothers, number of</p>	5	<p>An activity completion report and QAI-Final should be conducted in 2015.</p> <p>Adjust M&E indicators relating to Objective 1 (to monitor and report service linkages, referral systems etc), the Objective 2 target (1,300-1,500 new children by Dec. 2015), and Objective 5 (to report planning activities as well as policy).</p>

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	<p>children on ART, average turnaround time for CD4 laboratory to return test results. These M&E arrangements ensure accountability, enhance decision-making and promote learning.</p> <p>M&E indicators require adjustment relating to Objective 1 (to monitor and report service linkages, referral systems etc), the Objective 2 target (1,300-1,500 new children by Dec. 2015), and Objective 5 (to report planning activities as well as policy).</p>		
5. Sustainability	<p>Delayed commencement of provincial activities, & domestic financial and human resource constraints impede sustainability. CHAI has worked towards building sustainability by providing training and mentoring to health care workers to assume leadership roles, and initiating linkages and service integration e.g. locating pediatric treatment services in hospital OPCs.</p> <p>Sustainability is supported by:</p> <ul style="list-style-type: none"> (v) CHAI's focus on national and provincial partners (VAAC, MoH MCH, NTP, Pediatric Hospitals No.1 and 2, PACs and OPCs); (vi) Supporting the GoV to access Global Fund resources; (vii) National policy development and national capacity development initiatives (training, tools and resources), training of local experts to assume leadership, and ensuring training is followed up by mentoring; (viii) Supporting national partners to address systemic issues that constrain sustainability, such as fragmented laboratory and supply chain management systems, TB-HIV linkages and lack of integration of HIV OPCs with mainstream pediatric clinical services. (ix) An HMIS design that reports core national indicators. <p>For Yen Bai, although a good basis for sustainability has been provided by the focus on operational policies, it is too early to assess whether improvements to quality of treatment and care will be fully sustained independent of ongoing training and TA post-2015.</p> <p>Reliance on international mentors is not sustainable in the long term and efforts have been made to establish pools of experts for the northern, central and southern regions. The aim is to support local experts with capacity to offer</p>	4	<p>DFAT to work with CHAI in confirming a Sustainability Plan and Exit Strategy for the final year. A Sustainability Plan is required for the final 12 to 18 months that addresses:</p> <ul style="list-style-type: none"> a) More intense work with the regional pediatric committees on supporting transfer of skills to local mentors and ensuring systems in place for clinicians to access local mentors and training; b) More focused work with the MCH Department to integrate PPTCT into ANC and the MCH system. Provide TA to MCH Department to begin assuming HIV responsibilities as a phased approach commencing 2014 so that MCH is able to manage PPTCT by 2016. c) Documentation of lessons learned, particularly from Yen Bai and PPTCT including blockages at national down to commune level, highlighting obstacles as well as progress. CHAI should aim for all data relevant to lessons to be captured no less than 3 months

Criteria	Assessment (no more than 600 words per cell)	Rating (1-6)	Management response Be as precise as possible: what? how? who? when? (no more than 600 words per cell)
	<p>mentoring and training after CHAI exits. Sustainability of locally-led mentoring efforts will be largely dependent on the availability of national targeted program funding.</p> <p>WHO raised concerns about the burden on VAAC to maintain software systems rolled out nationally. The MTR team is concerned that eClinica may become dated quickly. Clarification is required as to whose role it will be to monitor whether the clinical decision prompts remain current and to enter updates after the CHAI project ends.</p>		<p>before completion date so an opportunity exists to disseminate lessons.</p> <p>d) Consider contracting someone to focus on the sustainability planning including documentation and dissemination of lessons to domestic audiences. Consider promotional activities such as an exit seminar, web-based promotion, or presentations at the Annual Meeting of the Vietnam Clinical HIV/AIDS Association.</p> <p>e) With partners develop a roadmap for VAAC to improve capacity in international ARV procurement. This is critical otherwise drug costs may place unsustainable pressures on domestic budgets.</p> <p>CHAI should continue the HMIS focus, but with a stronger emphasis on documenting lessons and assessing simplified options that can realistically be managed by national partners without reliance on CHAI TA post-2015.</p>
6. Gender Equality	<p>Progress in implementing the Gender Action Plan has been constrained by resistance of national partners to proposals to include gender issues in clinical policies. Further, many health care workers who have received basic gender training lack skills, time or willingness to integrate gender considerations into their work. Whereas CHAI has made progress in identifying these constraints, the approach that will be taken to addressing these factors is unclear.</p> <p>Achievements included gender training for health care workers, CHAI and VAAC staff; integration of gender into PITC training; development of cue cards for gender sensitive counselling, and gender checklists for adherence counseling; incorporating gender prompts in the eClinica software; considering gender in the design of</p>	4	<p>Clarify actions to be undertaken in Year 3 to address constraints to implementation of Gender Action Plan e.g. further encouragement of policymakers to consider gender factors; further support to health care workers to integrate gender sensitivity into counselling and other aspects of care.</p> <p>CHAI should implement recommendations provided by CCIHP in its evaluation of national training on gender sensitive counselling.</p>

Criteria	Assessment (no more than 600 words per cell)	Rating (1-6)	Management response Be as precise as possible: what? how? who? when? (no more than 600 words per cell)
	<p>PPTCT, to addresses the involvement of fathers in HIV prevention and in antenatal and postnatal care; use of gender disaggregated data in M&E e.g. gender distribution of patients on ART at CHAI supported sites, and in reporting against national M&E reporting indicators for CHAI-supported sites.</p> <p>CHAI reviews male and female attendance at trainings to ensure an appropriate balance and training sessions are facilitated to ensure males do not dominate discussion sessions.</p> <p>There is still much scope for strengthening the gender response.</p> <p>Applying gender mainstreaming principles is challenging for health care workers. An evaluation nine months after the national training, identified constraints such as health care workers having inadequate time to provide gender-sensitive counselling, being reluctant to initiate discussion of gender issues with long-term patients, and lacking skills to explore problems such as domestic violence and child abuse. Just under one third of health care workers had not used the checklist after training. Barriers to using the checklist included high workload, limited time during patient encounters, and difficulty in explaining technical terms to patients.</p> <p>A local NGO CCIHP provided advice on inclusion of gender factors in some national policy documents e.g. MoH policy on HIV testing and counselling and EID. However, MoH was reportedly resistant to inclusion of non-clinical factors in policy. CHAI reported no success in adding gender issues to official clinical guidelines and limited success in garnering health worker interest during trainings.</p> <p>Training in gender sensitivity and use of gender checklists is yet to occur in Tay Ninh but will be included in the remaining year of the project.</p> <p>Gender disaggregated data is being collected from CHAI supported sites to track the ratio of boys to girls receiving care and treatment. CHAI has been recording data on gender of attendees of training and mentoring visits.</p>		<p>To supplement support from CCIHP, CHAI could also consider the application of international work in this area.</p>

Other Key Issues

Criteria	Assessment (no more than 600 words)	Management Response Be as precise as possible: what? How? Who? When? (no more than 600 words)
7. Cross-Cutting Issues and Commitments	<p>CHAI has a comprehensive Child Protection Policy in place as the nature of work involves children. The Child Protection Policy is in line with DFAT Child Protection Compliance Standards and was approved by a DFAT Child Protection Officer.</p> <p>There have been no efforts to systematically address disability issues such as service access rights in training, policies or procedures. Prior to the mid-term review, CHAI had not given consideration to the need for disability factors such as physical access needs to be specifically highlighted in training, mentoring or resource materials. Rather, CHAI staff have dealt with disability as an integral aspect of patient management, given that most patients receiving HIV-related treatment and care experience physical impairment related to late HIV diagnosis. Many experience mobility restrictions that affect their physical access to services. Some OPCs are only accessible by stairs.</p> <p>Responding to restrictions on access to services for people with disabilities in a more systematic way (e.g. through training materials and policy guidance) can be given greater consideration in the remaining year, having regard to international work.</p> <p>No adverse climate change or environmental impacts were identified.</p>	<p>CHAI should assess the application of WHO tools on gender and disability in HIV clinical services to the Vietnam context.</p> <p>Disability should be more explicitly recognised in training and materials particularly as it relates to measures that can be taken to improve physical restrictions on access to clinical services.</p> <p>CHAI should introduce the principle of ‘reasonable accommodation’ of services to the needs of people with disabilities in TA and training activities e.g. promoting understanding of partners that access to services can be improved through:</p> <ul style="list-style-type: none"> • design of services such as the inclusion of ramps; • specialised formats such as material and packaging in Vietnamese Braille, sign language interpretation; • referral to rehabilitation and other disability services where they exist; • measures to address HIV and disability-related stigma and discrimination within health services.
8. Risk Management	<p>The risk register is maintained by CHAI and updated at least semi-annually. Risks are being discussed with DFAT on a monthly basis.</p> <p>The major identified risk of reduction in external funding is discussed quarterly by DFAT and CHAI.</p> <p>Current and ongoing risks identified during</p>	<p><i>Green</i></p>

Criteria	Assessment (no more than 600 words)	Management Be as precise as possible: what? How? Who? When? (no more than 600 words)	Response
	<p>the MTR included:</p> <ul style="list-style-type: none"> • Efforts to sustain quality HIV services with a focus on women and children are being undermined by a reduction in external funding from PEPFAR and the Global Fund. Fewer numbers of children diagnosed with HIV per month is symptomatic of funding constraining health services as less staff are available for HIV despite growing demands on health services. • The 2014 measles epidemic has placed additional demands on resources of pediatric and infectious disease departments. • GoV's commitment to maintain its National Target Program on HIV/AIDS Control beyond 2015 is uncertain. • Lack of MoH capacity in drug procurement means there is a high risk that MOH will lack capacity to procure pediatric ARVs after CHAI exit. 		

Scale for ratings against Quality Criteria

Satisfactory		Less than satisfactory	
6	Very high quality; needs ongoing management and monitoring only	3	Less than adequate quality; needs work to improve in core areas
5	Good quality; needs minor work to improve in some areas	2	Poor quality; needs major work to improve
4	Adequate quality; needs some work to improve	1	Very poor quality; needs major overhaul

Annex II People interviewed

Name & Position	Organization
Van Duong, Senior Program Manager	DFAT
Dang Ngo, Country Director Thuy Cao, Associate Director Thu Nguyen, Program Manager Tuan Luu, Program Manager	CHAI
Government of Vietnam partners	
Dr. Long, Director General Dr Bui Duc Duong, Deputy Director Dr. Do Thi Nhan, Head of C&T Dr. Phan Thi Thu Huong, Deputy Director Dr. Vo Hai Son, Head of M&E Dr. Nguyen Viet Nga, Deputy Head of M&E	VAAC
Dr. Nguyen Viet Nhung Director of National Lung Hospital & Manager of Vietnam NTP	National TB Program
Dr. Luu Thi Hong, Director of MCH Department	MCH Department, MoH
Dr. Tieu Thi Thu Van, Head of the Standing Office Mr. Nguyen Van Tam, Strategic Intelligence Manager Tran Doan Trang, Pediatrics Officer	HCMC PAC
Dr. Truong Huu Khanh, Director, Infectious Disease Department, OPC Head Dr. Le Minh Thuong, Deputy Director of Outreach Medical Services Secretary of Southern Pediatric Subcommittee	Pediatric Hospital No. 1
Dr. Na	HCMC District 11 OPC
Dr. Bien Van Tu, Director, PAC and his staff Dr Nguyen Thi Yen Nga, Deputy Director Dr Le Hoang Loc, Head of IEC and Treatment Dept.	Tay Ninh PAC
Dr Nguyen Ngoc Mung, Deputy Director Dr Nguyen Van Khuong, Infectious Diseases Dept. Ms Pham Thi Kim Dung, Infectious Diseases Dept.	Tay Ninh Provincial Hospital
Dr. Nguyen Duy Thang, Deputy Director Dr. Pham Hoang Hung, Director, Pediatrics Dept Dr. Phan Trung Tien, Director, Infectious Disease Dept Dr Pham Huu Tri, Head of Planning Dept. Dr Nguyen Thi Nhu Ly, Chief of Pediatrics OPC	Hue PAC
Dr. Nguyen Van Tuyen, Deputy Director of Dept of Health Dr. Phan Duy Tieu, Director of PAC and staff	Yen Bai Department of Health and PAC
Dr. Dam Thi Minh Hien, Deputy Director Dr. Pham Thi Hoa, Head of OPC Dr. Hoang Thi Ha, Head of ARV treatment team Dr. Do Thi Kim Dung, Head of Microbiology Dept. Dr. Le Tien Hanh, Head of Microbiology Dept.	Yen Bai General Hospital
Technical agencies and multilateral partners	
Suresh Rangarajan, Acting Director of Care and Treatment	FHI360
Kristan Schoultz, Country Director Christopher Fontaine, Partnerships Adviser	UNAIDS
Masaya Kato, Medical Officer – HIV Care and Treatment	WHO
Michelle McConnell, Country Director Nguyen Thai Binh, Head of Pediatrics and PMTCT; Nguyen Tuan Anh & Patrick Nadol, Head of Strategic Intelligence	USA CDC
Ha Thuy Huong, Country Director	SCMS
Tran Hung Minh	CCIHP

Annex III Documents reviewed

Government of Vietnam Documents

National Strategy on HIV/AIDS Prevention and Control to 2020 with a Vision to 2030 (Decision of the Prime Minister 608/QĐ-TTg).

Decision of the National Committee for AIDS, drug and prostitution prevention and control approving four Projects for implementing the National Strategy on HIV/AIDS Prevention and Control till 2020 with a vision to 2030 (Decision No.: 4548/QĐ-UBQG50 of 2012).

Decision on the National Program of Action on Children affected by HIV until 2010 with the vision to 2020 (Decision of the Prime Minister No. 84/2009/QĐ-TTg).

Ministry of Health & VAAC policies and procedures:

- Circular 32 on C&T operational procedures
- Decision 872 - National Guideline on management of HIV pregnancies and their children
- Decision 909 - Laboratory Master Plan
- Decision 1098 - HIV serology testing guideline
- Decision 1099 - CD4 regulations
- Decision 1921 - Viral Load testing guidelines
- Decision 2495 - ICF & IPT Guidelines
- Decision 2496 - TB & HIV collaboration mechanism
- Decision 2497 - TB & HIV collaboration framework
- Decision 4126 on pilot program of option B+ in PMTCT
- VAAC letter No 1356 on enhancing HIV testing activity
- Decision 153 on counseling for children living with HIV
- Circular 15 - HIV testing quality assurance

CHAI Documents

Child Protection Policy, updated 2014

CHAI Annual Report July 2013 - June 2014

CHAI Annual Report July 2012 - June 2013

CHAI Child Protection Policy, updated 2014.

CHAI Data on ART cohort retention rates for Hue, Tay Ninh, Vinh Phuc and Yen Bai

Report on gender integration into counseling at OPCs, Jan 2013

Cue card for Gender Sensitive Counseling at OPC

Report on reviewing gender cue card use 2014

Abstract submissions to AIDS2014 International AIDS Conference:

- Introducing Gender Sensitive Counseling into HIV Care in HIV Outpatient Clinics in Vietnam
- SMS-based Referral Support Between Voluntary Counseling & Testing and HIV Care Sites in Vietnam
- SMS-based Support for Successful OPC Referrals in Yen Bai Province
- National Assessment of Treatment and Retention Outcomes of HIV-infected Infants Identified by Early Infant Diagnosis in Vietnam
- National Assessment on Accessibility and Outcomes of HIV Exposed Infants in the Early Infant Diagnosis Program in Vietnam
- Transition Needs of Children and Youth Living with HIV in Vietnam
- Survey of the Sample Referral System for HIV Serology in Vietnam
- Results of the Introduction of a Hospital-based Pediatric Provider-Initiated HIV Testing & Counseling Program in Vietnam
- The Impact of Isoniazid Preventive Therapy and Antiretroviral Therapy on TB Incidence in Children Living with HIV in Vietnam

Procedure for patient transfer among HIV Out-patient clinics in the 3 provinces of Ho Chi Minh City, Binh Duong and Dong Nai

SMS Pilot Implementation in Yen Bai

Intensive Case Finding & Isoniazid Prevention Therapy Procedure for People living with HIV

Isoniazid Prevention Therapy Logbook and Reporting Excel tool
Survey of sample referral
CD4 indicator summary
CD4-EQA Excel tool
Guideline on laboratory assessment
Proposal on conducting the survey of sample referral system for HIV serology, CD4, viral load test and service linkages
Combined list of malnourished HIV-positive children
PITC indicators for Peds 1 & 2 March 2014
Baseline PITC in Yen Bai March 2014
Supply chain management indicators on fixed dose combination optimization
VAAC CHAI TRIP Reports to CHAI sites
Site reports for Yen Bai, Tay Ninh, Hue, and Vinh Phuc provinces.

Other

UNAIDS, Handicap International et al, (2011). *Framework for the Inclusion of Disability in National Strategic Plans on HIV and AIDS*, UNAIDS.
UNAIDS, WHO, Office of the High Commission on Human Rights, (2009). *Policy brief: Disability and HIV*, Geneva: UNAIDS.
WHO (2009). *Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs*. Geneva: WHO.

Annex IV Terms of reference

MID-TERM REVIEW CHAI Vietnam Phase III

1. Introduction

The purpose of this Mid-Term Review (MTR) is to assess the performance of the Clinton Health Access Initiative (CHAI) Vietnam Phase 3 against the goals and objectives as outlined in the funding agreement between CHAI and the Department of Foreign Affairs and Trade (DFAT), formerly the Australian Agency for International Development (AusAID).

2. Background

In 2006, DFAT (formerly AusAID) entered in to a Memorandum of Understanding (MOU) with CHAI (formerly Clinton Foundation HIV/AIDS Initiative) to support access to HIV treatment, particularly for children, in the Asia Pacific region, including Papua New Guinea (PNG), China and Vietnam. In Vietnam, DFAT provided funding for a three-year Phase 1 (AUD 4,799,435) from 2006 to 2009 which resulted in a significant increase (200 to 1300) in the number of positive children receiving life-saving antiretroviral (ARV) treatment.

Building on gains made in Phase 1, DFAT funded Phase 2 (AUD 3,100,000) with the purpose to strengthen capacity in Vietnam to sustain treatment systems for HIV positive women and children. Phase 2 was completed at the end of June 2012 and made impressive gains in: improving quality of HIV treatment in Vietnam and clinical training and mentoring for health staff working on HIV, strengthening capacity of laboratories, improving antiretroviral drugs supply chain management, providing technical assistance in developing the national pediatric HIV treatment guidelines and providing policy advocacy to the central level government.

As a result, DFAT provided additional AUD 4,650,000 (from July 2012 to June 2015) for Phase 3 with the focus on building sustainability. In Phase 3, CHAI continued to work in the “niche area” of HIV care and treatment and address gaps identified by Vietnam Authority of HIV/AIDS Control (VAAC) in the national HIV response to pediatric HIV, by providing access to ARV therapy and building the capacity of the health care workforce to address maternal and child needs. By developing national government’s ability to expand, lead and implement national

HIV/AIDS program, CHAI will assist Vietnam to achieve universal coverage and global commitment of “getting down to zero: zero infection, zero discrimination and zero AIDS related death”.

3. Project Goal and Purpose

CHAI Phase 3 has five objectives:

- to expand the coverage and improve the quality of sustainability of the national HIV care and treatment system;
- to enable the national pediatric program to identify and provide antiretroviral treatment to 1,500 additional children living with HIV;
- to support provincial partners to pilot an HIV integration model to optimise and integrate HIV interventions within the health system and inform a sustainable national approach;
- to increase the efficiency, accuracy and sustainability of the national HIV laboratory system; and
- to develop or improve HIV related policies and guidelines by supporting the Vietnam Ministry of Health to adapt international best practices to the Vietnam context.

CHAI’s work will support a government-led, strengthened health system that provides effective HIV services, especially for women and children. The outcome is expected to be increased access to quality HIV services in a system where the government ultimately has the capacity to manage these services.

4. Key Issues

Key issues include but are not limited to the following:

DFAT Strategic Directions

The Australia-Vietnam Joint Aid Strategy 2010-2015 recognises that HIV/AIDS is one of the Millennium Development Goal (MDG) targets that Vietnam is at risk of not achieving by 2015 and therefore identifies limited continued assistance for HIV/AIDS.

The Strategic Assessment on Australia’s investment is being finalised and preliminary findings need to be considered in the assessment of CHAI’s activities in Vietnam.

Regard should be given to fact that DFAT has withdrawn from the health sector in Vietnam due to changes in the strategic priorities of the Vietnam program and budget constraints within the aid program as a whole. Disengagement from the health sector is being achieved on a progressive basis as there are existing commitments to new and on-going health activities including HIV/AIDS (CHAI), health system strengthening, pandemics, and disability.

Australia’s limited support to HIV/AIDS beyond 2015 remains uncertain.

External Environment

The external environment has changed significantly since the MOU between DFAT and CHAI was signed in February 2006. Not only has the scale of the HIV/AIDS epidemic changed in Vietnam (mainly attributed to an increase in incidence among mainly young, male injecting drug users and their sexual partners), but the responses of other donor agencies, for example, the Presidents Emergency Fund for Aids Relief (PEPFAR), have also adjusted their focus and modes of support. These factors may affect the specific ‘niche’ role that CHAI has played in Vietnam, particularly in terms of supply of ARVs to HIV-infected mothers and children.

Domestic funding

The Government of Vietnam (GOV) is implementing its USD \$168 million over four (4) years National Targeted Program (NTP) on HIV/AIDS to reduce the HIV infection ratio in communities to less than 0.3% (currently estimated at 0.47%) where Prevention of Mother To Child Transmission (PMTCT) is a substantial component.

Sustainability

CHAI's principal collaborating partner within the GOV is the Ministry of Health's VAAC. The effectiveness of this collaboration is critical for the sustainability of CHAI outputs across all components of its program while technical capacity of VAAC and Provincial AIDS Centres remain weak. The extent to which VAAC is willing to take up this work upon the completion of CHAI activities in Vietnam is a key factor to the success or otherwise of this program.

5. Objectives of the Mid-Term Review

The objectives of the MTR are to:

- Access the sustainability of the CHAI activities.
- Assess the quality and progress in delivery of the project against the expected output and outcomes of the current funding agreement.
- Assess any project/challenges and their impact.
- Assess changes (or impending changes) in the project external and domestic environment that could have implications for project implementation and/or achievement of objectives.
- Recommend changes in strategic direction and/or refinements in project design/approach for project implementation and increased sustainability if required.
- Identify and highlight lessons/achievements that may have wider implications/interest for the Government of Vietnam or the Australian Government.
- Assess the contribution of CHAI's project in Vietnam to achievement of objectives under Vietnam's National HIV/AIDS strategy.
- Recommend area of work that Australia could be engaged beyond 2015 depending on aid budget availability.
- Provide assessment on DFAT safeguard issues including gender, climate change and disability.

The objectives are to be addressed while taking into account the Key Issues listed in the preceding section.

6. Scope of Service

Desk-based

The MTR team will initially make a thorough review of all MTR background documentation including:

- Funding Proposal
- Quality of Implementation Report
- Annual Report and Workplan

In-country

In Vietnam, the team will hold meetings and discussions with DFAT officials, counterpart and stakeholder agencies, staff and management of CHAI Vietnam and key development partners actively supporting the GOV in responding to the HIV/AIDS epidemic.

The individual members of the MTR team will provide advice and written inputs to the Team Leader, as instructed by the Team Leader, in order for the Objectives and Reporting Requirements of the MTR to be met. Guiding responsibilities of MTR team members are set out below, which in the interests of flexibility may be further refined during the MTR team discussions.

The MTR team will conduct provincial site visits to Yen Bai, Hue, and Tay Ninh provinces and to Ho Chi Minh City to see implementation arrangements and to assess CHAI's provision of technical assistance.

Guiding responsibilities for MTR team members

Team Leader and HIV Specialist

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- Act as the Team Leader for the MTR mission and for the management of team inputs, liaison and production of an aide memoire and MTR review report;
 - Provide an overall assessment of the performance of CHAI against the requirements of the funding agreement;
 - Provide an overall strategic assessment of the project relevance within the context of the evolving environment in Vietnam and internationally and with regard to relevant DFAT policies;
 - Provide overall assessment of the effectiveness of CHAI, the quality of the technical support, and the issues of GOV ownership and sustainability of project interventions and outcomes;
 - Identify, assess and highlight lessons/achievements that may have broader relevance; and
 - Highlight key gaps and opportunities in the HIV sector that DFAT may want to consider funding if there is an available aid budget.

Senior Vietnamese HIV/AIDS Expert

- To act as Deputy Team Leader and assist the Team Leader in the management of team inputs, liaison and production of an aide memoire and MTR review report;
- To assess the impacts of the changing external environment in Vietnam in terms of the effectiveness of the CHAI in Vietnam;
- To assess the ability of the key local stakeholder within the GOV (VAAC) to sustain CHAI outcomes once the project is completed;
- To liaise with other Vietnamese stakeholders in the HIV/AIDS area in terms of providing information and perspectives relevant to the MTR; and
- To provide interpretation when required.

DFAT (Senior Program Manager, Hanoi Post)

- To provide guidance, oversight, and the broader context to the MTR team through regular feedback during the review process; and
- To attend the provincial site visits.

7. Duration and Timing

In-country mission will commence on 25 May 2014 and conclude on 3 June 2014.

8. Reporting Requirements

The MTR team is required to provide the following reports to DFAT:

- An Aide Memoire for the MTR debriefing session in Hanoi – maximum of ten (10) A4 pages in length.
- A first-draft MTR review report, submitted electronically to DFAT Hanoi within 10 days of the completion of the mission, in a format compatible to DFAT's IT system.
- A second-draft MTR review report, submitted electronically to DFAT Hanoi within 10 days of receiving DFAT's comments on the first draft, for distribution to GOV agencies and to other relevant stakeholders for their comments.
- A final MTR review report, 20 pages submitted electronically within 10 days of receiving consolidated comments from DFAT, GOV and other stakeholders – which should include an executive summary with a summary list of recommendations.