MINISTRY OF HEALTH
VIETNAM AUTHORITY OF HIV/AIDS CONTROL

# MID-TERM ASSESSMENT REPORT

# Pilot Implementation of Social Contracting with Social Organizations in HIV Services Delivery in Vietnam from 2022–2024

Technical and financial assistance by:
UNAIDS and USAID/Local Health System Sustainability Project

Hanoi, June 2024

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# ACKNOWLEDGEMENTS

On November 29, 2021, the Minister of Health issued Decision No. 5466/QD-BYT approving the " Pilot Implementation of Social Contracting with Social Organizations in HIV Services Delivery in Vietnam from 2022-2024", assigning the Vietnam Administration of HIV/AIDS Control under the Ministry of Health to coordinate with relevant stakeholders to pilot the implementation of social contracting with social organizations for HIV/AIDS services delivery for the 2022- 2024 period.

In order to provide information and evidence after more than a year of social contracting pilot implementation, the Vietnam Administration of HIV/AIDS Control has organized a mid-term assessment, conducted by a team of independent experts with extensive experience.

Firstly, we thank the assessment team comprised of Dr. Nguyen Duc Thanh and Dr. Le Bao Chau from the Health Personnel Training Institute, Hanoi University of Public Health, MD. Kieu Huu Hanh, and Ms. Marie Ryan, Public Health Experts, for their dedicated efforts and expertise in compiling this report.

Special thanks are due to the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Viet Nam and the Local Health System Sustainability Project (LHSS) funded by USAID for their invaluable technical and financial support throughout the assessment process.

We also express our sincere appreciation to the leaders and staff of provincial Departments of Health, various divisions under provincial Centers for Disease Control, and participating social organizations across Nghe An, Tay Ninh, Dong Nai, Tien Giang, Can Tho, Kien Giang, Binh Duong, Hai Phong, and Dien Bien provinces. Their support during site visits, provision of comprehensive feedback, and participation in in-depth interviews and focus-group discussions greatly enriched our assessment.

Furthermore, we acknowledge the valuable contributions of our technical assistance partners and international development collaborators, including USAID/EPIC, US. CDC/EPIC, UNAIDS, USAID/LADDERS, US. CDC/ECLIPSES, and members of the Social Contracting-Technical Working Group, whose feedback and insights were instrumental in the data collection and finalization of this report.

We are pleased to present this Mid-term Assessment Report to all stakeholders interested in the progress and outcomes of the pilot implementation of social contracting in HIV services delivery in Vietnam.

**Vo Hai Son, MD. MA.**

**Deputy Director of Vietnam Authority of HIV/AIDS control**

## ACRONYMS

| | |
|---|---|
| ARV | Antiretroviral |
| CBO | Community-based organization(s) |
| CDC | (Provincial) Center for Disease Control |
| DOH | (Provincial) Department of Health |
| FGD | Focus group discussion(s) |
| IDI | In-depth interview(s) |
| MMT | Methadone Maintenance Treatment |
| MOH | Ministry of Health |
| OW | Outreach worker(s) |
| PrEP | Pre-exposure prophylaxis |
| SE | Social enterprise(s) |
| SO | Social organization(s) |
| TA | Technical assistance |
| TWG | Technical working group |
| SC | Social contracting |
| SC-TWG | Social Contracting-Technical Working Group |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| USAID | United States Agency for International Development |
| USAID/EpiC | USAID/Meeting Targets and Maintaining HIV Epidemic Control Project |
| USAID/LADDERS | USAID/Local Assistance to Develop and Deliver Excellence, Resilience, and Sustainability in Vietnam |
| USAID/LHSS | USAID/Local Health System Sustainability Project |
| U.S. CDC | United States Centers for Disease Control |
| U.S. CDC/ECLIPSES | Enhancing HIV Program Collaborations, Linkages, and Intelligence to Progress towards Sustainable Epidemic Control |
| U.S. CDC/EPIC | Enhancing (HIV) Program Innovations and Collaboration (in Vietnam) |
| VAAC | Vietnam Administration of HIV/AIDS Control |

## DEFINITIONS

SO Social Organization(s) (SO) used in the context of this social contracting pilot refers to social enterprises (SE) and/or community-based organizations (CBO).

SC Social Contracting means public financing of community-led service delivery and is defined in this pilot intervention as the procurement of HIV service packages from SO through contracts issued by the Provincial Departments of Health (DOH)/Provincial Centers for Disease Control (CDCs) in nine target provinces in Vietnam.

## LAWS, DECREES, AND DECISIONS REFERENCED IN THIS DOCUMENT

| | |
|---|---|
| **Government of Vietnam (GOV)**<br>**No.43/2013/QH13**<br>**November 2013** | Law on Bidding<br>Law No. 43/2013/QH13 dated November 26, 2013, of the National Assembly on Bidding |
| **Government of Vietnam (GOV)**<br>**Decree No. 32/2019/ND-CP**<br>**April 10, 2019** | Prescribing the assignment of tasks, purchase orders, or bidding for provision of public products and services funded by the State Budget's Regular Expenditures |
| **Ministry of Planning and Investment (MPI)**<br>**Decree 63/2014/ND-CP**<br>**June 2014** | Detailing the Implementation of Several Provisions of the Law on Bidding Regarding the Selection of Contractors |
| **Minister of Health**<br>**Decision No. 5466/QD-BYT**<br>**November 2021** | Approval granted by the Minister of Health to implement the pilot project for procurement of HIV/AIDS prevention and control services provided by social organizations 2022–2024 |
| **Vietnam Administration for AIDS Control (VAAC)**<br>**Decision No. 40/QD-AIDS**<br>**March 2023** | Guidelines for a pilot project for procurement of HIV/AIDS prevention and control services provided by social organizations 2022–2024 |
| **Government of Vietnam**<br>**Prime Minister's Decision 1387/QD-TTg dated July 13, 2016** | Decision 1387/QD-TTg promulgating the List of Public Services using the state budget in the field of Health—Population |

# EXECUTIVE SUMMARY

International funding to support the HIV response in Vietnam has been declining in recent years, and social contracting is considered one of the important solutions to increase domestic financing to help reach a sustainable HIV response in Vietnam. While the social health insurance scheme has become the main financing agent for HIV treatment since 2019, the funding for HIV prevention still depends on external sources. The Vietnam Ministry of Health (MOH) approved a three-year social contracting pilot in 2021 and the Vietnam Administration of HIV/AIDS Control (VAAC) began the roll-out of the pilot in June 2022 with funding from international development partners including the United States Agency for International Development (USAID), the United States Centers for Disease Control and Prevention (U.S. CDC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The pilot was designed to explore the use of a social contracting model to be delivered by non-government partners that conforms with the standard government procurement conditions applying to public funding.

The Social Contracting Technical Working Group (SC-TWG) was established in 2018 by the VAAC with membership comprising MOH and international development. Local community partners helped to develop and support the implementation of the pilot including developing the VAAC pilot implementation guidelines. By September 2023, the pilot covered 13 social organizations in nine provinces with a total of 20 contracts signed.[1] Pilot implementation in eight of these provinces was linked to either the U.S. CDC/Enhancing HIV Program Innovations and Collaboration in Vietnam (U.S. CDC/EPIC) or the USAID/Meeting Targets and Maintaining HIV Epidemic Control Project (USAID/EpiC) projects, both of which are engaged in the same type of HIV prevention activities and help support the implementation of the pilot in their respective locations. Pilot implementation in Dien Bien province was funded through UNAIDS and not linked to an established HIV prevention project; Dien Bien was the only province to implement harm reduction services. Of the 13 SO selected to participate, 10 were in the U.S. CDC/EPIC or USAID/EpiC-supported provinces and held formal registration as social enterprises, while the three SO in Dien Bien province did not have legal status.

The four HIV service packages that formed the basis of the pilot included: (1) Providing harm reduction commodities and referral to methadone treatment; (2) Providing community HIV testing and referring reactive cases to confirmation testing; (3) Linking to antiretroviral therapy; and (4) Linking to pre-exposure prophylaxis (PrEP).

From September 2023 to March 2024, USAID's Local Health System Sustainability Project (LHSS) and UNAIDS supported the VAAC in conducting a mid-term assessment of the implementation of the social contracting pilot. The assessment was undertaken by a team of experienced consultants in cooperation with LHSS and UNAIDS.

The mid-term assessment had three objectives:

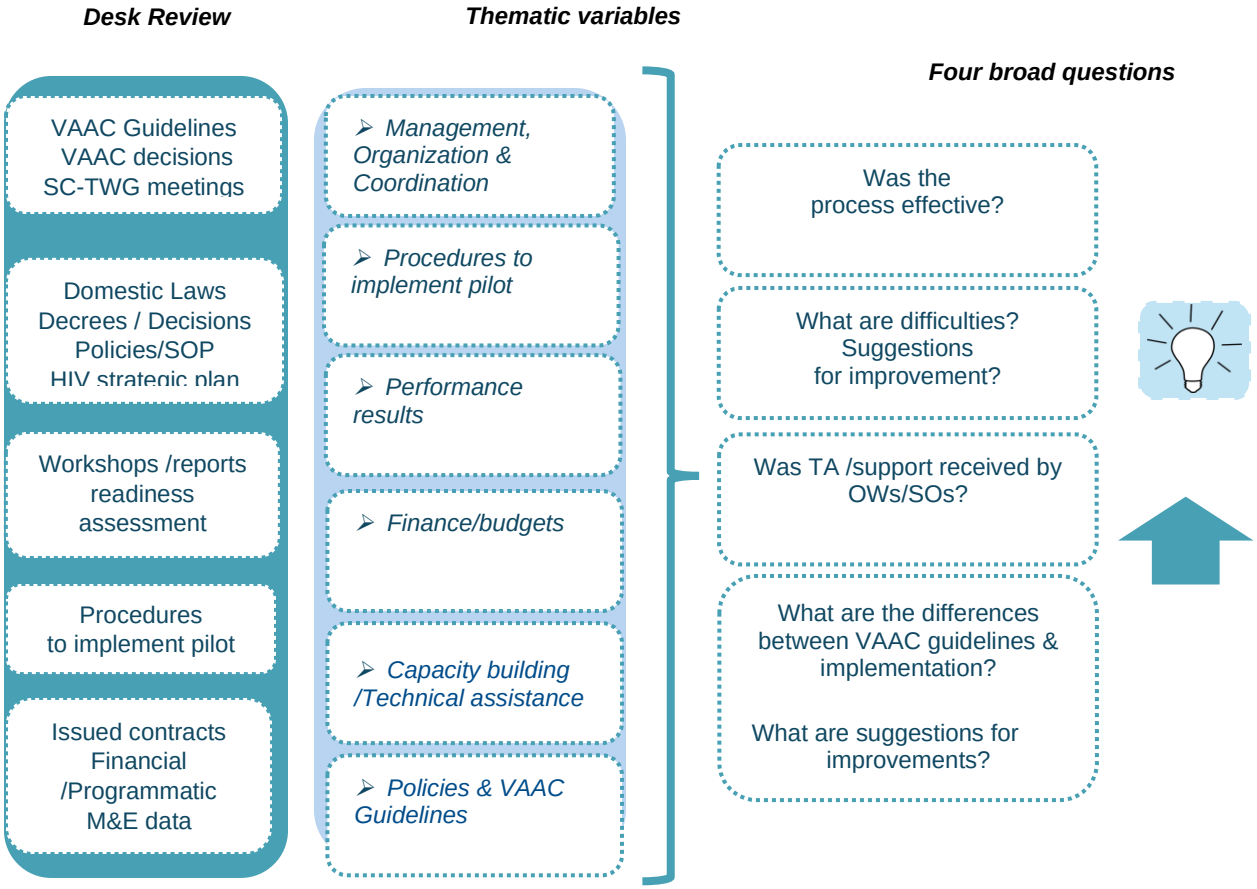
1. To assess the social contracting pilot progress and the results of the pilot up to September 2023 (subsequently extended to March 2024).
2. To explore advantages and challenges in the process in the nine provinces and provide recommendations for improvement in the remaining implementation period to December 2024.

1 Nghe An province had begun social contracting in an earlier period with two social organizations, concluding in September 2023. Where possible the process and outcomes in Nghe An province were also reviewed as part of this pilot assessment.

3. To assess the feasibility and appropriateness of the pilot implementation guidelines issued by VAAC.

The assessment team developed a logical framework in consultation with VAAC and SC-TWC. To meet the objectives, the SC-TWG agreed on four broad questions that were examined using a series of interview questions according to six thematic variables to generate feedback from participants and to develop recommendations for improvement for the remaining pilot period (Figure 1).

**Figure 1. Mid-term assessment logical framework**




The study design combined qualitative and quantitative methods, including:

- Desk review: secondary data reviewed from reports on the readiness assessment of provincial agencies and capacity of social organizations (SO, progress monitoring and evaluation, payment progress between SO and the provincial CDCs, documents on the bidding and procurement process, contracts, and contract liquidation.
- Twenty-four in-depth interviews (IDI) and 23 focus group discussions (FGD) with representatives of VAAC, technical assistance (TA) agencies/partners/donors, provincial DOHs, provincial CDCs, and 13 social organizations participating in the pilot.

- Anonymous questionnaires were completed by 46 community outreach workers (OW) from the SO who directly provided services to key population groups. Respondents were also able to supply comments as they saw fit.

## KEY FINDINGS

### IMPLEMENTATION PROCESS, RESULTS, ADVANTAGES, AND CHALLENGES IN THE PILOT IMPLEMENTATION

The findings are organized according to the six thematic variables described in the logical framework:

#### 1. Organization, management, and coordination

VAAC was the central coordinating body at the national level providing technical support and consultation. The Provincial DOHs were responsible for reporting to the Provincial People's Committee, obtaining consensus from relevant agencies and sectors in the province, assigning tasks to the provincial CDCs, approving the pilot implementation plan, and providing guidance and support to the provincial CDCs during the implementation process. Feedback collected from the interviews revealed good involvement and active participation of all stakeholders from the central level (the VAAC) to the provincial level (the provincial DOHs and CDCs, and the SO).

After more than two years of preparation and following up with pilot implementation, all participants demonstrated an improvement in their capacity for programmatic management, coordination, and implementation, ranging from VAAC at the central level to those at the provincial level. Provinces with the most active involvement—leaders in the DOH and CDC and close engagement with SO— demonstrated an easier implementation process and achieved positive results.

Given the complex nature of the bidding process, seven out of the nine participating provinces used purchase orders for procurement. Only two provinces used the bidding method (Nghe An and Binh Duong provinces). The preparation process to issue a contract using a bidding method (limited online competitive bidding) in Binh Duong province was four times longer than the purchase order method (167 days versus 40 days). Prolonged preparation time for contract signing led to shortened times for contract implementation and affected the time available to achieve contract targets.

A late start to implementation in some provinces was affected by the extended approval process for the USAID/EpiC and U.S. CDC/EPIC projects at the central level. In addition, late procurement of harm reduction commodities, HIV test kits, or lack of clarity as to which provincial agencies were responsible for approval of the procurement also delayed the start of implementation. The VAAC issued Decision No. 40/QD-AIDS, dated March 10, 2022, that allowed entities without legal status to participate in the pilot, including three SOs in Dien Bien province, while the 10 SO implementers in the other eight provinces were already legal entities (social enterprises). On this basis, all provinces followed the VAAC guidelines and complied with legal procedures and regulations for procurement including the bidding process. Pilot implementation in eight provinces was linked to either U.S. CDC/EPIC or USAID/EpiC projects while one province (Dien Bien supported via UNAIDS) was not linked to an established project.

In total, there were 20 contracts signed with 13 SO in nine provinces. VAAC guidelines did not provide suggestions or examples of specific clauses for controlling risk (e.g., specifications for HIV tests or commodities, taxes, bonus/penalty clauses) and as a result, the signed contracts

were not consistent in detailing these terms. For example, the contracts of Dong Nai and Kien Giang provinces did not mention any tax obligations.

Three locations (Can Tho city, Dong Nai, and Tien Giang provinces) used the terms “targets” and “maximum targets.” Targets were used as the basis for either reward or to trigger penalty provisions. Maximum targets were used in these contracts to ensure payments were kept within the available budget.

Three locations (Hai Phong city, Can Tho city, and Binh Duong province) used lump-sum contracts, while the remaining six provinces used fixed-price contracts. The use of lump-sum contracts was problematic if the social organization failed to achieve the specified targets that in turn would affect contract payment or liquidation.

Contracts issued in Dien Bien province were able to apply an advanced payment (30 percent), but the remaining provinces could not offer advanced payments because of the financial policies of either U.S. CDC/EPIC or USAID/EpiC projects supporting pilot implementation in these locations.

### 2. Pilot implementation procedures

Regarding the delivery of the four service packages specified in the pilot, most OW were experienced in providing similar services due to their involvement in either U.S. CDC/EPIC or USAID/EpiC projects. Results from the anonymous questionnaire completed by 46 OW showed there was a high level of understanding in relation to the six thematic variables (>84 percent) with a slightly lower average score for questions related to Organization, Coordination; and Management (75 percent).

Based on their practical experience, OW proposed additional hours for three out of the four service packages. No additional time was requested for package 4b (PrEP treatment adherence support in the first three months). Most OW proposed increased hours for service packages 1–3 with an additional two to five hours for the following:

- Service package 2a: Two additional hours for community-based testing (without re-active results)
- Service package 2b: Five additional hours for community-based testing (with reactive results) and referral for confirmatory tests
- Service package 3a: Two additional hours for referral for ARV treatment.

For aspects related to monitoring (M&E), supervision, and reporting, the CDCs and SO in all provinces fulfilled the monitoring items for contract implementation according to VAAC guidelines, although Dien Bien CDC completed online data on behalf of their SOs.

SO completed monthly reports using standard forms that were supplied to all CDCs. The CDCs reviewed the reports, provided feedback to amend or update as necessary, and approved the reports as the basis for payment.

However, undertaking supervision activities by the CDC described in the VAAC guidelines was lacking. Required supervision activities detailed in the VAAC guidelines spanned the on-site review of the service delivery process, the quality-of-service provision, and client satisfaction. The CDC generally provided limited on-site supervision and did not always supervise the components according to the VAAC guidelines. Apart from Dien Bien province, there was no formal supervision

plan in other provinces for the pilot, because there was usually a lack of funding or time for on-site supervision exercises.

A review of reported data on VAAC's web-based reporting system showed some inconsistencies for some provinces between the data in the web-based system and the paper-based reports forwarded by CDCs to the VAAC.

In all contracts, payment was scheduled in monthly installments, triggered by the submission by the SO of both a payment request and a monthly performance report to be verified by the CDC. However, this approval process could extend for more than two months from submission of the payment request, often because of complicated procedures and/or complicated payment forms causing delays either because SO were requested to re-submit paperwork, or in some locations, multiple levels of approval were needed before payments could be authorized.

## 3. Performance results

For this assessment, it was not appropriate to make direct comparisons of achievements between different provinces. This was because of the different start times and duration of contracts, different targets and target groups, and different management support from the U.S. CDC/EPIC and USAID/EpiC projects.

Overall, the targets were found to be appropriate. Results varied among provinces depending on contract duration, ranging from 20 percent to more than 100 percent against individual targets. Of the 16 contracts reviewed (excluding four earlier contracts in Nghe An province), 14 contracts achieved greater than 50 percent of the set targets, of which 10 of these had achieved greater than 70 percent. Two contracts achieved less than 50 percent of the set targets (Tay Ninh Pride's second contract in Tay Ninh province, and Six Colors in Hai Phong city). A second contract issued by Tay Ninh province for three service packages had low achievement (40 to 58 percent) as the targets were set for 12 months, but because of a delay from the CDC in issuing the contract, this meant the contract had only a six-month duration. Hai Phong city achieved less than 20 percent for each of the three service packages for the same reason as Tay Ninh province, and the late delivery of HIV tests from the U.S. CDC/EPIC project added to the delay.

Prior to and during pilot implementation, training opportunities were available for both CDCs and SO to improve capacity and feedback from the CDC and SO during interviews stated they had become more proactive, SO also requested or received additional support to gain legal status. Feedback and ratings in the OW questionnaire showed appreciation of the technical support (90 percent) and that performance payments were considered adequate (79 percent). OW' perception of client willingness to supply personal information to receive services had a rating of 69 percent, while OW' written comments also stated clients expected confidentiality as part of service delivery.

## 4. Finance and budget

Regarding contract payments to March 29, 2024, locations with disbursement rates of more than 90 percent included Can Tho city, and the provinces of Binh Duong, Tien Giang, and Dong Nai (Xuan Hop Contract). The remaining contracts also had high disbursement rates up to 86 percent. Hai Phong city had the lowest disbursement rate, reaching only 14.8 percent by the conclusion of their contract for the reasons mentioned earlier. Tay Ninh province disbursement reached only 50.5 percent that matched their achievement rate, also for the reasons described earlier.

The assessment reviewed achievements and payments until March 29, 2024. The intended time was extended from the end of November 2023 to the end of March 2024 because not all the 20 contracts under review ended by September 2023; three concluded in November 2023, two in

December 2023, and the final contract ended in March 2024. VAAC guidelines included a method to calculate costs in the contracts. Most CDCs and SO understood the cost estimation method used to calculate unit costs by the CDC. Although some SO felt the unit costs in the pilot were low and impractical, and proposed including additional or higher rates for salary, travel, communication for demand generation, and operational costs.

In most provinces, the time taken to process a payment request exceeded two months because approval was first needed from the CDC and/or DOH as well as the U.S. CDC/EPIC and USAID/EpiC project. As Dien Bien province was not linked to an external development project, their processing time was shorter.

Despite having the longest preparation time and a very short implementation time, Binh Duong province had a fast approval time once a payment request was received.

HIV test kits were provided by the U.S. CDC/EPIC project in Hai Phong city and Binh Duong, and by the CDC in Dien Bien province. In other provinces, SO had to purchase HIV test kits according to market price and be reimbursed using the unit prices stated in the contract. In practice, because of low volumes and/or repeat purchases by the SO, the unit price allocated was often lower than the market price. In this situation, the SE paid the difference in price from its own (non-pilot) funds.

Feedback from the anonymous questionnaire showed OW gave high scores (greater than 76 percent) agreeing that both salary and travel allowance incorporated into the unit costs were adequate.

### 5. Capacity building / Technical assistance

During the preparation and pilot implementation, the provincial CDCs and SO received ongoing technical support from VAAC and international partners (UNAIDS, U.S. CDC/EPIC, USAID/EpiC, USAID Local Assistance to Develop and Deliver Excellence, Resilience, and Sustainability in Vietnam (LADDERS), and the U.S. CDC Enhancing HIV Program Collaborations, Linkages, and Intelligence to Progress towards Sustainable Epidemic Control (ECLIPSES).

Building capacity in provincial CDCs and SO followed a pilot preparation plan. Provincial CDCs and SO appreciated capacity-building activities and technical assistance but expressed a need for further capacity-building because social contracting was a new experience, particularly the bidding process, organizational management, and taxes.

### 6. Relevance and feasibility of the VAAC pilot implementation guidelines

The OW respondents to the anonymous questionnaire rated highly (greater than 80 percent) for both the understanding of the steps for the service provision process (86 percent) and the ability to follow the steps according to the VAAC guidelines (88 percent).

Questions with a lower average rating (less than 80 percent) include: Ability to use the supplied materials (76 percent), Having no difficulty with planning and reporting (74 percent); Achieving the assigned outputs/targets (75 percent); and Completing the prescribed forms (79 percent).

Many SO and OW commented that the VAAC guidelines required the completion of too many forms/reports. SO also proposed the need to adjust some content in the guidelines.

Suggested revision for the VAAC pilot implementation guidelines:

- Revise the technical process for delivery of harm reduction commodities for maintenance clients. Currently, the VAAC guidelines only provide guidance for new clients.

- Update and include a technical process for ARV and PrEP treatment adherence support packages in the first three months.
- Standardize client referral forms to PrEP treatment clinics.
- Consider adjusting economic-technical norms to align with practical experience (to increase the scheduled time (or level of effort/LOE for service delivery) and add economic-technical norms/guidance for the harm reduction commodities (syringes and condoms) for maintenance clients.

Regarding the possibility of using the local budget for social contracting activities, all provincial DOHs and CDCs agreed it was feasible to absorb the costs for social contracting into the provincial/local budgets. However, for implementation, there needs to be a legal basis and detailed guidance from the central government beginning with an updated list of public services, including HIV services, allowable under the state budget (PM Decision 1387) as well as supplying economic-technical norms and a pricing framework. OW gave a high rating to their expected continued participation if it is funded through the state budget (85 percent). However, the lack of legal status (registered organization) for some SO, the lack of experience in financial management and reporting, and limited procurement capacity are barriers to scaling up services using SO for social contracting in the future.

**RECOMMENDATIONS**

Detailed findings used as evidence for the following recommendations are located in Annex O.

FOR VAAC

- Continue to support provinces in implementing the pilot.
- Consider adjusting and updating economic-technical norms detailed in VAAC's current guidance to match actual implementation (for example additional time for service delivery).
- Standardize case verification procedures and update the templates provided in the VAAC guidelines (especially for the harm reduction service package and non-resident HIV+.)
- Consider introducing a Unique Identifier Code (UIC) to encourage KP to use HIV/Testing and Support Services.
- Request provinces to use and update the web-based reporting system, and to closely monitor the pilot implementation progress to identify issues early for more timely support.
- Consider updating or revising the VAAC guidelines for the suggestions made in the section, *Suggested revision for the VAAC's pilot implementation guidelines*.
- Based on interviews with SO considerations for the final assessment:
  - Consider the potential for conflict of SO that are concurrently involved in social contracting together with either U.S. CDC/EPIC or USAID/EpiC project activities for the same interventions and the same target population groups, as it may adversely affect the achievement of pilot targets.
  - Given that the pool of OW are usually sourced from projects run in parallel with the pilot, give more attention to the recruitment and retention of OW and the employment practices of SO partners to retain experienced OW.

- Examine the method by CDC or by SO for procurement of HIV test kits and commodities and examine the reasons for using this method.

### FOR THE PROVINCIAL CDCS

- Continue capacity building for CDCs and SO staff in services procurement, particularly using the bidding process.
- Focus on supervision of the quality-of-service delivery in addition to monitoring the achievement of targets.
- Consider adding clauses in contracts, for example:
  - Tax obligations, penalties (minimum target setting); obligation to provide commodities, fixed price contracts; options for advanced payments to SO.
- State the specifications for HIV tests and commodities and review the products to verify that they meet the specifications.
- Consider including single targets in contracts and state the contingency available in the target is exceeded, rather than specifying a maximum target.
- Ensure consistency between reporting systems—the web-based reporting system and other systems.

### FOR SO

- Provide support for SO without legal status to achieve legal status so they are able to apply for bids (such as service delivery) according to public procurement regulations.
- Ensure OW follow VAAC guidelines for service delivery and monitor the quality of their work and achievements.
- Improve capacity in bidding, contract negotiation, reporting, and understanding of financial and tax regulations.

### FOR INTERNATIONAL DEVELOPMENT PARTNERS

- Continue providing financial and technical support to the CDCs and SO to participate in the pilot. Technical assistance includes capacity building for CDC staff on procurement and the bidding process, assistance for SO to participate in the bidding, technical support to CDCs and SO in the pilot implementation and improving management capacity and organizational development for SO.
- Provide support to undertake the final assessment of the pilot.

# INTRODUCTION

As external funding for HIV health financing declines, social contracting through social organizations (SO) that are contracted by the government to provide HIV prevention services is an important strategy to increase domestic investment and help move toward sustainable HIV programming.

In Vietnam, social organizations (SO) have developed an extensive community-level network, particularly with key populations among whom the HIV epidemic is concentrated. Therefore, leveraging the unique position of SO is a critical part of accelerating HIV prevention and control efforts to achieve Vietnam's goal of ending AIDS by 2030 (Quang Hai, 2023), (Xuan Thuy, 2023). However, a review by UNAIDS on social contracting in Vietnam found that the government does not have all the financial mechanisms, regulations, or policies in place to effectively contract SO to undertake this role (Tran Kim Chung and Ho Cong Hoa, 2019), (Ministry of Health [MOH]/ Department of Legislation, 2020).

On November 29, 2021, the MOH issued a Decision 5466 approving *The pilot to procure HIV/AIDS services through SO, 2022-2024* (Ministry of Health, 2021). This pilot was funded through international development partners (IDP). Following this Decision, the Vietnam Administration of HIV/AIDS Control (VAAC) issued pilot implementation guidelines (Decision No. 40/QD-AIDS dated March 10, 2022) (VAAC, 2022) and a gradual roll-out of the pilot followed, beginning in June 2022.

In 2018, the Social Contracting Technical Working Group (SC-TWG) was established by the VAAC in the MOH. With membership comprising MOH and international development and local community partners, the SC-TWG has helped to develop and support the implementation of the pilot.

Because of the restrictions contained in the Bidding Law (Law No. 43/2013/QH13 dated November 26, 2013) and procurement policies (Decree 32/ND-CP dated April 10, 2019) in using the state budget, organizations wanting to respond to government bids must have formal registration and a legal basis, such as a company or SE (Government, 2014), (Government, 2019). The use of purchase orders is normally restricted between government agencies.

For these reasons, to set up the pilot, the VAAC issued guidance No. 40 dated March 10, 2022 to allow purchase orders to be used with SO and those without legal status (such as unregistered SO) to participate in the pilot (VAAC, 2022).

As a result, 10 social organizations that already had legal status (SE) were selected and had concurrent contracts through USAID/EpiC or U.S. CDC/EPIC development projects for HIV prevention. Three unregistered SO from Dien Bien province were selected to participate with support from UNAIDS.

The implementation of the pilot has two goals:

1. Piloting service procurement methods using purchase orders or a bidding process for SO to provide HIV services, following the state budget procurement mechanism.
2. Create evidence and propose recommendations on policies and specific roadmaps for contracting SO to provide HIV services using the state budget in Vietnam.

The services provided through the social contracting pilot include four service packages (and sub-packages listed below) with modalities for direct service provision, supporting treatment, and modalities focused on referral.

Listed below are the four service packages (and sub-packages) implemented through the pilot:

- Package 1. Distribution of needles, condoms, and lubricants to people with risky behaviors and referral of people in need of methadone treatment (MMT)
- Package 2a: Community-based HIV testing
- Package 2b: Community-based HIV testing and referral of reactive HIV (+) to a health facility for confirmatory testing
- Package 3a: Referral of people with positive HIV results to an ARV treatment facility and treatment adherence support
- Package 3b: ARV treatment adherence support in the first three months
- Package 4a: Referral of people with negative HIV test results and who are eligible for a PrEP treatment facility
- Package 4b: PrEP treatment adherence support in the first three months

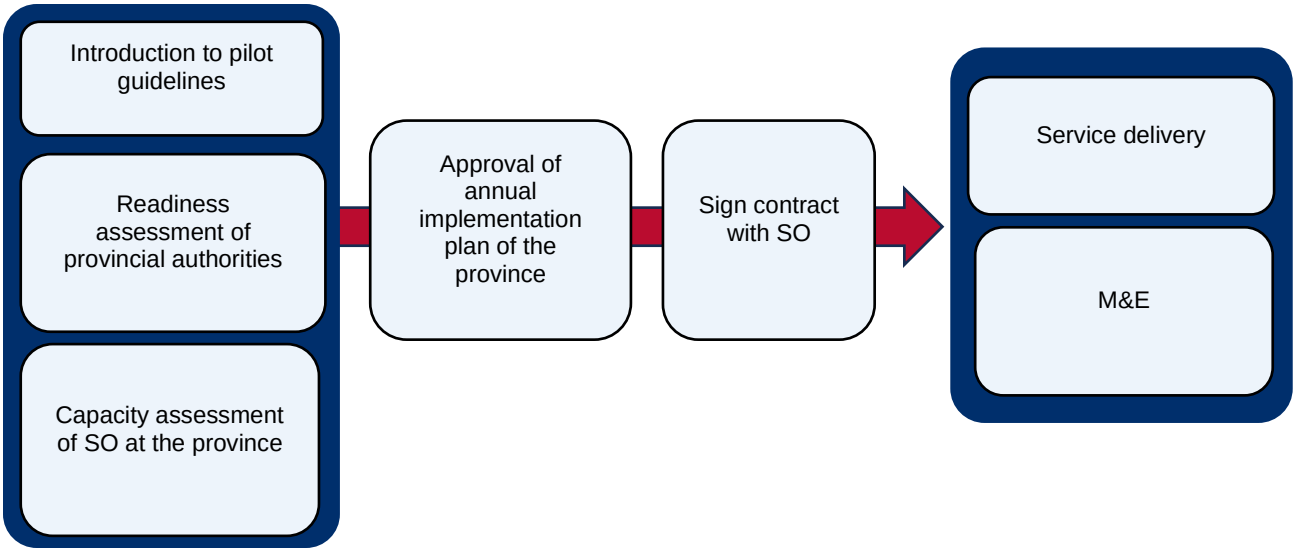
By October 2023, the pilot had covered 13 social organizations in nine provinces with financial and technical support via PEPFAR and UNAIDS (Table 1).

**Table 1: International development partners supporting the social contracting pilot**

| Implementing province/city | Funding source | Technical support |
|---|---|---|
| Nghe An*<br>Tay Ninh<br>Dong Nai<br>Tien Giang<br>Can Tho city<br>Kien Giang | PEPFAR Program<br>through the USAID/EpiC Project under FHI360 | USAID/EpiC<br>U.S. CDC/EPIC<br>UNAIDS<br>USAID/LADDERS<br>IRD<br>USAID/LHSSU.S. CDC/ECLIPSES |
| Binh Duong<br>Hai Phong city | PEPFAR Program<br>through the U.S. CDC/EPIC Project | |
| Dien Bien | Joint United Nations Program on HIV/AIDS (UNAIDS) in Vietnam | |

** Nghe An province commenced the social contracting pilot in 2018 and ended in September 2023, prior to the mid-term assessment*

**Figure 2: Pilot implementation steps at the provincial level**




The mid-term assessment took place after two years of pilot preparation and implementation.

## OBJECTIVES OF THE MID-TERM ASSESSMENT

1. To evaluate the operational and service delivery progress and results of the SC pilot implementation from June 2021 to September 2023 (extended to March 2024).
2. To identify challenges and recommend interventions to improve the pilot implementation and results for the remaining period (ending September 2024).
3. To assess the relevance and feasibility of the pilot implementation guidelines issued by VAAC.

## METHODOLOGY

### ASSESSMENT DESIGN

The assessment used both qualitative and quantitative approaches to collect data. An assessment framework was developed based on a desk review of documents related to the pilot proposal and discussions with VAAC and the SC-TWG. The assessment framework covered three objectives and four broad questions across six thematic variables.

**Figure 3. Assessment framework**

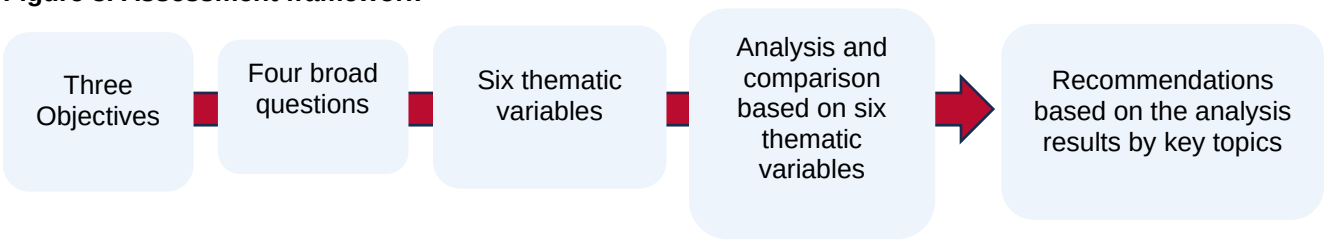



**Table 2: Assessment content**

| Four questions | Six thematic variables | Definition of variables |
|---|---|---|
| 1. Was the process effective?<br>2. What were the challenges faced and what are suggestions for improvement?<br>3. Did you receive TA to improve processes?<br>4. What is the difference (if any) between the regulations and/or guidelines compared with implementation? | 1. Organization, Management, and Coordination | The role, management, and processes for all stakeholders to participate in the pilot |
| | 2. Results /Outcomes | Expected deliverables from the pilot<br>e.g., targets achieved compared to VAAC historical data, application of guidance or information materials |
| | 3. Training /Support and TA | TA, training, or support received or supplied needed to implement the pilot and expand in the future using the State budget |
| | 4. Procedures to implement pilot | Procedures necessary to enable smooth implementation of the pilot |
| | 5. Finance /Budgets | Current sources of financing to implement pilot, the feasibility of options for future financing of expanded pilot, and use of State budget |
| | 6. Policies/Guidelines | Materials, instructions, and authorizations needed to enable the implementation of pilot and future expansion under the State budget mechanism |

The assessment reviewed primary and secondary data and collected responses from in-depth interviews (IDIs), focus group discussions (FGDs), and an anonymous questionnaire with a total of 31 questions completed by OW. The OW were directly involved in service delivery to key population (KP) clients, where a written response from an OW was requested for 7/31 of these questions.

## RESEARCH METHOD AND RESEARCH SUBJECTS

### DESK REVIEW

Secondary data was collected from VAAC, CDCs in nine pilot provinces, and from the 13 SO that had signed contracts. Documents reviewed were:

- Reports on readiness assessment/checklist of provincial authorities and capacity assessment of SO
- Reports, statistics, M&E data on progress, results of service delivery, and payment of social contract implementation from SO, CDCs, VAAC, and partners
- Purchase orders/bidding documents and SO selection procedure
- Contracts signed with SO by September 2023 in the nine pilot provinces.

### QUALITATIVE DATA

The study used IDIs and FGDs to collect information from the informants.

Twenty-five IDIs were undertaken. Each IDI lasted for approximately 40 to 60 minutes. The interviewees were:

- Representatives of the provincial Department of Health
- Leaders of provincial CDCs

- Group leaders/accountants of SO (one IDI/SO)
- Representatives of TA agencies/partners/donors: USAID/EpiC, U.S. CDC/EPIC, UNAIDS, USAID/LADDERS, and IRD
- Leaders of VAAC and heads of related departments under VAAC.

Twenty-three FGDs were undertaken. Each FGD took between 90 to 120 minutes. Participants of the FGDs were categorized into two groups:

- Staff at the provincial CDCs: Heads or Deputy heads of HIV/AIDS departments, staff in charge of social contracting implementation, staff in charge of procurement and bidding, staff in charge of planning, staff in charge of finance and accounting, and some other staff related to the pilot (one FGD/province)
- SO: leads, accountants, and OW directly providing service packages (one FGD per SO).

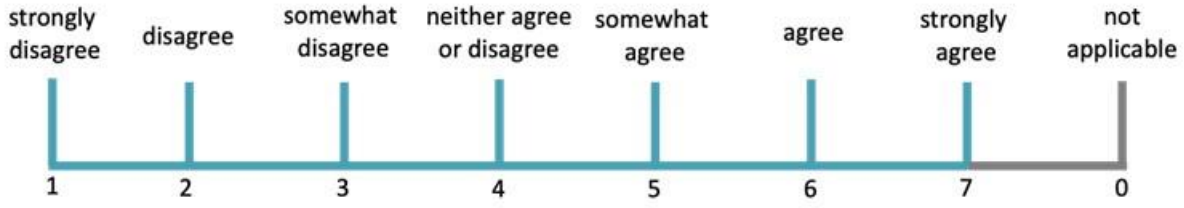
Details of the number of participants by province and a summary of key findings from respondents are in Annex A and B.

### QUANTITATIVE DATA

Feedback obtained from OW was grouped into three parts:

- Part 1: general information about participants (OW)
- Part 2: feedback for time allocation assigned for steps in service delivery and suggested adjustments (if any)
- Part 3: an anonymous questionnaire comprised of 31 questions to assess the practical implementation according to six thematic variables. Thirteen scaled questions (1–7) assessed the level of feasibility/appropriateness. Five scaled questions related to the perception of OW of client satisfaction with service delivery. Seven open questions collected narrative comments/responses from OW (Annex B, C, D). Respondents rated questions on a scale from (1–7), and results from all respondents were averaged and expressed as a percentage for individual questions, or group of questions (Figure 3).

**Figure 4: Scaled questions (1–7)**




A total of 46 full-time OW in eight provinces (excluding Nghe An province) participated in this process. The same OW also participated in the FGDs.

Eighty-one part-time OW participated in the pilot intermittently under the same performance criteria as full-time OW. However, because of difficulties in accessing these people, only full-time OW were included in the assessment.

Because of the relatively low number of OW respondents (46), a simple average of questionnaire scores was calculated without any further statistical analysis. Results, therefore, should be considered indicative of the pilot experience by OW participants.

Nghe An province implemented a social contracting process with two SO in a different period to the formal pilot. Their activities concluded in September 2023, before the assessment protocol had been finalized.

Where possible, data from Nghe An province is included or stated otherwise.

**Table 3. Research participants**

| Province | MOH | DOH | Provincial CDC Leader | Provincial CDC Staff | SO | OW | Questionnaire | FGD | IDI |
|---|---|---|---|---|---|---|---|---|---|
| Hai Phong city | | 0 | 1 | 4 | 1 | 3 | 3 | 2 | 2 |
| Can Tho city | | 1 | 1 | 6 | 1 | 8 | 7 | 2 | 3 |
| Kien Giang | | 0 | 1 | 4 | 1 | 3 | 3 | 2 | 2 |
| Tay Ninh | | 1 | 0 | 6 | 1 | 4 | 3 | 2 | 2 |
| Tien Giang | | 1 | 1 | 4 | 1 | 6 | 6 | 2 | 3 |
| Binh Duong | | 1 | 1 | 4 | 1 | 6 | 4 | 2 | 2 |
| Dong Nai | | 1 | 1 | 5 | 2 | 8 | 6 | 3 | 4 |
| Dien Bien | | 1 | 1 | 6 | 3 | 15 | 14 | 4 | 2 |
| Nghe An | | 0 | 1 | 3 | 2 | 8 | 0 | 3 | 0 |
| VAAC | 4 | | | | | | | 1 | |
| USAID/EpiC | 1 | | | | | | | | 1 |
| U.S. CDC/ECLIPSES | 1 | | | | | | | | 1 |
| USAID/LADDERS | 1 | | | | | | | | 1 |
| UNAIDS | 1 | | | | | | | | 1 |
| **138** | 8 | 6 | 8 | 42 | 13 | 61 | **46** | **23** | **24** |

**RESEARCH PERIOD AND LOCATION**

- Data collection: October–November 2023
- The assessment reviewed achievements and payments until March 29, 2024. The time was changed from the end of November to the end of March 2024 because not all the 20 contracts ended in November; two ended in December 2023 and the final contract ended in March 2024.
- Locations:
  - Nine pilot provinces/municipalities: Nghe An, Tay Ninh, Dong Nai, Tien Giang, Can Tho city, Kien Giang, Binh Duong, Hai Phong city, and Dien Bien.
  - Hanoi: Representatives of VAAC and international development partners supporting the pilot.

## DATA COLLECTION AND ANALYSIS

- Quantitative data: Excel software was used for data entry and analysis corresponding to feedback from OW and the OW questionnaire. Frequencies and percentages were used to analyze quantitative data to answer research questions and objectives.
- Qualitative data: Excel software was also used to transcribe responses from participants to research questions according to six thematic variables and four broad research questions. Audio of the interviews was recorded using iPhone software.

## LIMITATIONS OF THE ASSESSMENT

- Within the framework of this mid-term assessment, several limiting factors were not reviewed. These included (1) the impact of the pilot on the HIV program in the pilot provinces and at the national level; (2) the capacity of SO including human resources, equipment, funds, time, organizational structure, and operation; and 3) On-site supervision by CDC of service delivery by OW to demonstrate the VAAC guidelines were followed regarding the quality of services.
- This assessment did not collect information directly from clients receiving services due to resource and time constraints. The assessment collected feedback from OW as a proxy. As the number of OW respondents (46) was not enough to allow a full statistical analysis to account for bias or confounders, and because feedback about clients was based on OW' perception, all scored responses from the questionnaire should be considered indicative. A comprehensive picture of the quality-of-service delivery will be part of the final assessment using direct client feedback.
- Similar HIV activities were implemented concurrently through other donor-supported projects (e.g., Global Fund). While there was supposed to be no overlap with these projects this was sometimes unclear during interviews with SO partners.
- SO employ both full-time and part-time OW who work for the pilot and projects concurrently. The overall number of full-time OW engaged for the pilot was 53 and the number of part-time OW was 81. Forty-six out of the 53 full-time OW participated in this assessment, responded to the questionnaire, and participated in the FGD (Annex E). The assessment collected data from all full-time OW directly involved in service delivery for each participating SO but during on-site data collection, some OW were unavailable or absent. Part-time OW were paid on the same performance basis as the full-time OW. Because of the difficulty in accessing the part-time OW, the assessment team did not include part-time OW for feedback or interviews.
- Given that this assessment focused on the implementation process, the findings on effectiveness were addressed according to six thematic variables to answer four broad questions. Future assessments should more clearly define "effectiveness" and expand and adapt the related questions.

# RESULTS

## IMPLEMENTATION PROCESS, RESULTS, ADVANTAGES, AND CHALLENGES IN IMPLEMENTING THE PILOT

This results section aims to answer assessment Objectives 1 and 2 and categorized by thematic areas:

- Objective 1. Evaluate the implementation process and results of the pilot project until February 2024
- Objective 2. Identify difficulties and advantages in the process of implementing procurement of HIV/AIDS prevention services in nine pilot provinces and propose recommendations for improvement in the remaining phase (end), September 2024

### ORGANIZATION, MANAGEMENT, COORDINATION

The VAAC is the national coordinating body for the pilot, delivering technical support and advice during implementation. The provincial Department of Health is responsible for reporting to the Provincial People's Committee obtaining consensus from other government departments in the province, assigning tasks to the CDC, and approving the pilot implementation plan for the social contracting pilot as well as giving instructions and support to the CDC during implementation.

After more than two years of pilot planning and implementation, all participating organizations in the pilot have shown improved capacity in management, coordination, and implementation of the pilot, from the central level (VAAC) to the provincial level (Provincial Department of Health and CDC) and SO. Provinces with proactive CDC leadership and well-established relationships with SO were more successful with contract implementation.

> *"After two years of implementation, the first year CDC encountered many difficulties due to a lack of experience. However, in the second year (2023), the implementation is much more convenient because CDC staff clearly understand the process and implementation steps, and the capacity of SO has also improved. Coordination between CDC, the USAID/EpiC project, and SE during contract implementation is also more effective." (IDI with a representative from CDC G)*

> *"In general, the role of the VAAC is very important in managing, coordinating, and supporting provinces during the implementation of pilot activities. From discussion to issuance of VAAC's Decision in the past two years show the great effort the VAAC brings to this pilot. Without the VAAC guidance, the provinces would not be able to implement it." (IDI with a representative from an IDP project)*

#### Procurement methods and contracting methods

Twenty contracts were signed from the pilot's start between provincial CDCs and SO to September 2023. According to VAAC guidelines, two general procurement methods were available: bidding (including open bidding and online limited competitive bidding) and purchase orders.

Nghe An province completed its social contracting process in September 2023 prior to the start of this mid-term assessment and was the only province that used full competitive bidding. Binh Duong province was the only location that used online limited competitive bidding.

The remaining seven provinces used purchase orders to issue contracts to social organizations (SO).

**Table 4. Comparison of procurement methods used in the pilot**

| | Procurement method | Provinces | Requirements | Comments |
|---|---|---|---|---|
| 1 | Bidding | | | |
| | Open bidding | Nghe An | • SO with legal status<br>• Independent accounting<br>• Offline bidding: Minimum 3 bidders<br>• Online bidding: no required minimum number of bidders | • Requiring CDC and SO capacity<br>• The process is complicated and lengthy<br>• Strictest, most competitive and transparent |
| | Online limited competitive bidding | Binh Duong | • SO with legal status<br>• Independent accounting<br>• Online bidding: No minimum number of bidders | • Requiring CDC and SO capacity<br>• The process is complicated and lengthy<br>• Stricter, more competitive and transparent |
| 2 | Purchase orders | Remaining seven provinces | • Only available to public administrative units (according to Decree 32/2019/ND-CP) (Government, 2019) | • Only applicable for the pilot phase<br>• Less competitive compared to the bidding method<br>• Simple, easy, timesaving<br>• SO are not eligible because this method is restricted to public administrative units. |

VAAC Decision No. 40/QD-AIDS allowed two exemptions: (1) non-registered SO could participate in the pilot and (2) CDCs were able to issue purchase orders to contract SO (VAAC, 2022), this procurement method is normally restricted to public administrative units (Government, 2019).

To ensure SO have legal status according to current government policies, only registered entities can apply for government procurement. Secondly, from 2025 online e-bidding will be compulsory for all government procurement, and only legal entities will be able to access this platform.

Provincial CDCs prefer to use purchase orders to select SO for several reasons: (1) SO without legal status are not eligible to participate in bidding (Dien Bien province); (2) purchase orders are simpler and more efficient to process; (3) the purchase order process saves time; and (4) some provinces have only one SO with legal status.

VAAC Decision No. 40/QD-AIDS allowed non-legal entities to participate in the pilot. For example, three unregistered SO participated in Dien Bien province, and while SO in other provinces were also interested, they felt they were too inexperienced to participate.

With only one site to compare (Binh Duong province), the average preparation time for purchase orders compared to the bidding process was four times faster (40 days versus 167 days) beginning from the approval of the pilot procurement plan to contract signing. The preparation time for online limited competitive bidding in Binh Duong province was 167 days (Table 5). Meanwhile, Can Tho city had a very efficient approval time using purchase orders (14 days). The time taken to issue second contracts to the same three SO by Dien Bien CDC was also very efficient (17 days).

**Table 5. Approval time vs. duration of contracts**

| Provinces | Contracts | Purchase Order | Online Limited Competitive Bidding | Duration of contract | Approval /duration |
|---|---|---|---|---|---|
| | | (days) | (days) | (days) | % |
| Hai Phong city | Six Colors | 66 | | 154 | 43% |
| Kien Giang | The Sun Kien Giang | 26 | | 315 | 8% |
| Can Tho city | Glink Can Tho | 14 | | 196 | 7% |
| Tien Giang | Faith in Tien River | 74 | | 365 | 20% |
| Tay Ninh | 1st Tay Ninh Pride | 34 | | 105 | 32% |
| | 2nd Tay Ninh Pride | 30 | | 182 | 16% |
| Dong Nai | 1st Hung Vu | 40 | | 196 | 20% |
| | 2nd Hung Vu | 70 | | 189 | 37% |
| | 1st Xuan Hop | 70 | | 182 | 38% |
| Dien Bien | 1st Flower White Board | 43 | | 161 | 27% |
| | 2nd Flower White Board | 43 | | 161 | 27% |
| | 1st Sunrise | 43 | | 161 | 27% |
| | 2nd Sunrise | 17 | | 280 | 6% |
| | 1st Sunflower | 17 | | 280 | 6% |
| | 2nd Sunflower | 17 | | 280 | 6% |
| Binh Duong | Youth Link | | 167 | 70 | 239% |
| Average | | **40** | **167** | | |

**Average time for purchase order: 21%**
**Average time for bidding: 239%**

The assessment team did not review four contracts in Nghe An because Nghe An province had prepared a pilot implementation plan, completed the bidding process, and issued contracts in the period before the VAAC had formally issued the pilot implementation guidelines.

Approval time affects the time available to implement the contract in this pilot. The average time using purchase orders to prepare a contract compared to the duration of the contract was 21 percent. The preparation time for the process of online limited competitive bidding in Binh Duong province was 167 days, corresponding to 239 percent compared to the contract implementation time to fit within the same fiscal year (70 days).

**Comparison of the contracts**

**Legal status of SO**: CDCs issued 20 contracts to 13 SO. Three SO in Dien Bien province were community groups without legal status, and for this case, the CDC signed a contract with individuals representing the group. This method posed a risk for the CDC, for example, the CDC recouping an advanced payment.

*"One concern is that some provinces and cities sign with organizations that do not have legal status. However, I'm concerned about my personal responsibility because when something goes*

*wrong, the CDC is responsible, so I must wait for an organization with legal status to do it even though there are many SO. I simply think what will happen if I can't find them after signing the contract, and an advanced payment has been made?" (Representative from CDC A)*

**Comparison of issued contracts:** Table 6 show that the 20 contracts all complied with Form 3 Article 1 of the pilot guidelines (Decision No. 40/QD-AIDS) issued by the VAAC (VAAC, 2022). All contracts include parts "a" to "k." Only Dien Bien contracts used part "l" through adding a reporting template (Annex F).

**Table 6. Comparison of issued contracts**

| **Provinces = 9** | **SO = 13**<br>**Contracts = 20**<br>**Purchase Orders = 15**<br>**Bidding = 5**<br>**1st or 2nd contracts indicated where applicable** | **Service Packages I-II-III-IV** | | | | **Standard contents Form 3 Article 1 *parts (a-l)*** | | **Key Population** *legend for 'other' below* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Purchase orders* | | I | II | III | IV | a -k | l | MSM | FSW | PWID | other |
| Hai Phong | Six Colors | | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ |
| Kien Giang | The Sun Kien Giang | | ✓ | ✓ | ✓ | ✓ | | ✓ | | | |
| Can Tho | Glink Can Tho | | ✓ | ✓ | ✓ | ✓ | | ✓ | | | |
| Tien Giang | Faith in Tien River | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ |
| Tay Ninh | Tay Ninh Pride (1st) | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ |
| | Tay Ninh Pride (2nd) | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Dong Nai | Hung Vu (1st) | | ✓ | ✓ | ✓ | ✓ | | ✓ | | | |
| | Hung Vu (2nd) | | ✓ | ✓ | ✓ | ✓ | | ✓ | | | |
| | Xuan Hop | | ✓ | ✓ | ✓ | ✓ | | ✓ | | | |
| Dien Bien | Flower White Board (1st) | ✓ | ✓ | | | ✓ | ✓ | ✓ | | | |
| | Flower White Board (2nd) | ✓ | ✓ | | | ✓ | ✓ | ✓ | | | |
| | Sunrise (1st) | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| | Sunrise (2nd) | ✓ | ✓ | | | ✓ | ✓ | ✓ | | ✓ | ✓ |
| | Sunflower (1st) | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| | Sunflower (2nd) | ✓ | ✓ | | | ✓ | ✓ | ✓ | | ✓ | ✓ |
| *Bidding* | | | | | | | | | | | |
| Binh Duong | Youth Link | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| Nghe An | Glink (1st) | | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| | Glink (2nd) | | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| | Green Club (1st) | | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| | Green Club (2nd) | | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ |

***Other target populations:***

- Tay Ninh, Tien Giang provinces: transgender people, sex partner of HIV (+) or high-risk
- Hai Phong city, Nghe An provinces: sex partner of HIV (+) or high-risk population
- Dien Bien province: In the second contract FSW received condoms / PWID sex partner received HIV RDT

Table 6 shows MSM were targeted in all contracts, but fewer contracts targeted FSW or PWID. Some contracts mentioned "other target population" but did not define these groups, for example, contracts of Tay Ninh, Tien Giang, Nghe An provinces, and Hai Phong city. This may lead to potential contract disputes if tests or commodities are provided to unspecified groups.

**Controlling Risk**

VAAC guidelines did not suggest or recommend standard clauses to be included in contracts to control risk. Contracts should be beneficial to both parties and clearly state who is responsible for what should something go wrong. As a result, the issued contracts did not include, for example, penalty clauses. Contracts using the state budget often have clauses for late performance, and in some cases, penalties applying to the procurer for overdue payments.

Contracts should consider easier access to some key population groups (such as MSM) when calculating targets and not set targets too low, particularly when payments are based on a fixed unit price.

**Tax and others**

The VAAC guidelines do not suggest or recommend standard clauses for taxes, accidents, occupational health and safety, or labor law. Tax obligations were not included in the contracts of Dong Nai and Kien Giang provinces, leading to a lack of clarity about the parties' tax obligations, including whether VAT for example is included (or not) in unit prices. Most contracts stated all taxes were included in the contract value.

**Contract targets:** Three locations (Can Tho city, Dong Nai, and Tien Giang provinces) stated both targets and maximum targets to encourage higher performance within the available budget. If targets were appropriate, it is suggested that a maximum target is not needed. The use of a minimum (single) target is recommended,

**Lump-sum and Fixed unit price contracts:** Three locations including Hai Phong city, Can Tho city, and Binh Duong province issued lump-sum contracts. Kien Giang, Dong Nai, Dien Bien, Tay Ninh, and Tien Giang provinces issued contracts without specifying either type. For lump-sum contracts (Binh Duong province) payment was made on reaching 100 percent of the target. If 100 percent of targets are not met, the parties would have to negotiate prior to final payment and contract liquidation. With lump-sum contracts, payments and liquidation cannot be made if targets are not achieved. For contracts not identified as lump-sum or fixed unit price, payment was settled as for fixed unit price contracts.

**Advanced payment:** Only contracts issued by Dien Bien CDC were able to offer an advanced payment (30 percent). The remaining provinces were not able to offer advanced payments according to the financial policies of either U.S. CDC/EPIC or USAID/EpiC projects supporting the pilot.

**Definition of key population:** Contracts issued in Tay Ninh, Tien Giang, Nghe An provinces, and Hai Phong city stated "key population" without a definition for this term. This could lead to potential disputes if HIV tests or commodities are provided to undefined groups (Annex G).

**Procurement of HIV RDT and commodities**

Dien Bien Province was the only province in which CDC procured HIV RDT and commodities. In Hai Phong and Binh Duong, HIV RDT and commodities were provided by the U.S. CDC/EPIC project supporting the pilot. In Can Tho city, Kien Giang, Tien Giang, Tay Ninh, and Dong Nai provinces, procurement of HIV RDT was completed by the SO. Unit prices for these products were based on prices determined for procurement using the bidding process. This price was often lower than the market price because of the much lower volumes purchased by SO which affected the budget available for performance payments.

Verifying quality assurance of HIV RDT and commodities purchased by social organizations was not defined in the contracts. For the five provinces that issued contracts where the SO completed this procurement, there were no specifications stated for these products. (Table 7).

**Table 7. HIV RDT / commodities procurement**

| Province | CDC procurement | | SO procurement | | Supplied via project procurement | |
|---|---|---|---|---|---|---|
| | HIV RDT | Commodities | HIV RDT | Commodities | HIV RDT | Commodities |
| Hai Phong | | | | | ✓ | ✓ |
| Kien Giang | | | ✓ | ✓ | | |
| Can Tho | | | ✓ | ✓ | | |
| Tien Giang | | | ✓ | ✓ | | |
| Tay Ninh | | | ✓ | ✓ | | |
| Dong Nai | | | ✓ | ✓ | | |
| Dien Bien | ✓ | ✓ | | | | |
| Binh Duong | | | | | ✓ | ✓ |
| Nghe An | | | | | ✓ | ✓ |
| **Cost** | Potentially lower cost for bulk volume | | Potentially higher cost for lower volume | | | |
| **Quality Assurance** | Quality assurance standards met | | Quality assurance of products purchased by SO not checked by CDC | | | |
| **Human Resources** | CDC has experienced procurement staff | | SO may not be experienced in procurement | | | |
| **Processing Time** | CDC using bidding method folllowing government procedures | | Usually fast procurement faster time than CDC | | Delayed procurement in Hai Phong | |

## PILOT IMPLEMENTATION PROCEDURES

The assessment of the pilot implementation process focused on the following procedures:

1. The pilot preparation plan and approval
2. Bidding and purchasing orders
3. Technical guidance of the four service packages
4. Monitoring and supervision
5. Payment and settlement.

### *(1) The pilot preparation plan and approval procedure*

During the preparation process, provincial CDCs, with support from the VAAC coordinated with projects to develop pilot preparation plans submitted for approval. This process includes the following steps:

- Assess the readiness of provincial management agencies and the capacity of SO in the province.
- Build capacity for staff of CDC and SO.
- Select procurement methods, and service packages, develop targets for service packages, calculate prices, and prepare budget estimates.
- Complete the pilot implementation plan.
- Submit the pilot preparation plan for approval.

As this was the first time this pilot activity had been implemented there were many difficulties in the early stages, taking from three to fourteen months to prepare and approve the pilot implementation plans (Table 8). The average time for approval was six and a half months. However, excluding Hai Phong city and Binh Duong province where both experienced significant delays, the average time for approval of pilot implementation plans was around four months. The longer approval time in Hai Phong city was a result of unrelated delays in approval at the central level of the U.S. CDC/EPIC project supporting the pilot in this location. The lengthy delay in Binh Duong province was because of the use of limited competitive bidding to select SO, and uncertainty by local government authorities about who should be responsible for approval of the plan.

**Table 8. Duration to approve the provincial pilot implementation plan**

| Province | Start of readiness assessment for CDC | Approval | Duration (days) |
|---|---|---|---|
| **Dong Nai** | 3/2022 | 5/2022 | 3 months |
| **Tay Ninh** | 1/2022 | 5/2022 | 5 months |
| **Tien Giang** | 3/2022 | 7/2022 | 5 months |
| **Dien Bien** | 5/2022 | 6/2022 | 2 months |
| **Hai Phong city** | 3/2022 | 4/2023 | 14 months |
| **Binh Duong** | 3/2022 | 2/2023 | 12 months |
| **Can Tho city** | 1/2023 | 6/2023 | 6 months |

| | | | |
|---|---|---|---|
| **Kien Giang** | 1/2023 | 5/2023 | 5 months |

*Note: Duration applies to first contracts.*

For provinces that had more active participation from the Department of Health and Provincial CDC and technical support from UNAIDS, or USAID/EpiC projects, the preparation and approval of the plan was faster (Dien Bien, Dong Nai, Tay Ninh, Tien Giang, Kien Giang provinces and Can Tho city). Two locations with preparation and approval time of more than one year were Hai Phong city caused by the delay in the approval of the U.S. CDC/EPIC project at the central level, and Binh Duong province, where it was unclear what government agency would be responsible for approving the pilot implementation plan.

> *"Because in the early stages, the authority to approve the plan has not yet been identified, so the CDC submitted it to the Department of Health who submitted it to the Provincial People's Committee for approval. However, the Provincial People's Committee then assigned the Department of Health with the authority to approve, so the CDC had to resubmit it to the Department of Health for approval, which took a lot of time." (Representative from CDC D)*

### *(2) Bidding and purchasing order procedure*

According to the VAAC guidelines, procurement methods to issue contracts to SO are either the bidding process (full competitive bidding, limited online competitive bidding) or through purchase orders. Seven out of eight provinces used the purchase order method because they reported it was faster and less complicated and both CDCs and SO were also more familiar with this procedure. However, according to Decree 32, the use of purchase orders is normally restricted to public administrative units, making SO ineligible (Government, 2019). An exemption was made by the VAAC to allow purchase orders to be used for the pilot (VAAC, 2022).

Procurement using purchase orders has fewer steps (Table 9) resulting in a faster process compared with the development, review, and approval under the bidding process. The evaluation of the capacity of the SO is less complicated compared to the evaluation process for bidding documents. Procurement using either method (purchase orders or bidding) was implemented by all CDCs according to the VAAC guidelines.

**Table 9. Procedure for Bidding and Purchase Order steps according to regulations**

| | Bidding (limited competitive bidding) | Purchase Order |
|---|---|---|
| 1 | Prepare cost estimation and procurement plan | Prepare cost estimation |
| 2 | Review and approve cost estimation and procurement plan | Review and approve cost estimation |
| 3 | Prepare bidding document (E-bidding document for shortened competitive quotations) | |
| 4 | Review and approve bidding document (e-bidding quotes for limited competitive bidding) | |
| 5 | Extend invitation for bid | Invitation for EOI submission |
| 6 | Prepare and submit the bid | SO prepares and submits the capacity profile and quotation |
| 7 | Evaluate bid: the procurement package of HIV/AIDS prevention and control services with SO (single-stage, single-envelope method) | Evaluation of the capacity profile and quotation |
| 8 | Negotiate Contract | Negotiate Contract |
| 9 | Review and approve the procurement application | |

| | | |
|---|---|---|
| 10 | Sign Contract | Sign Contract |

Binh Duong province used online limited competitive bidding, which took considerable time because of the complicated bidding procedures and the lack of experience of the CDC. This caused delays in implementation and reduced the time to achieve targets. This negative experience meant that SO in Binh Duong province do not want to bid for a future contract using this method.

Other provinces used purchase orders, although they will face more challenges in the future as they did not gain practical experience from the bidding process during this pilot.

> *"The bidding implementation time is long because CDC has to organize many steps: the Bidding Team meeting to gain consensus; CDC invited SO to submit a quotation (3 times but only 2 SO submitted a quotation); preparation of bidding process; approve the technical list, decision to establish a technical expert team; develop and approve cost estimation; approve and post the contractor selection plan; develop a competitive bidding document, and evaluation of the bid." (Representative from CDC D)*

Only Dien Bien province provided an advanced payment. Advanced payments were not available through U.S. CDC/EPIC or USAID/EpiC projects supporting the pilot in other provinces, and SO in these locations faced some difficulty and had to use their own (non-pilot) resources to purchase HIV tests or pay for OW and related expenses during the start-up phase.

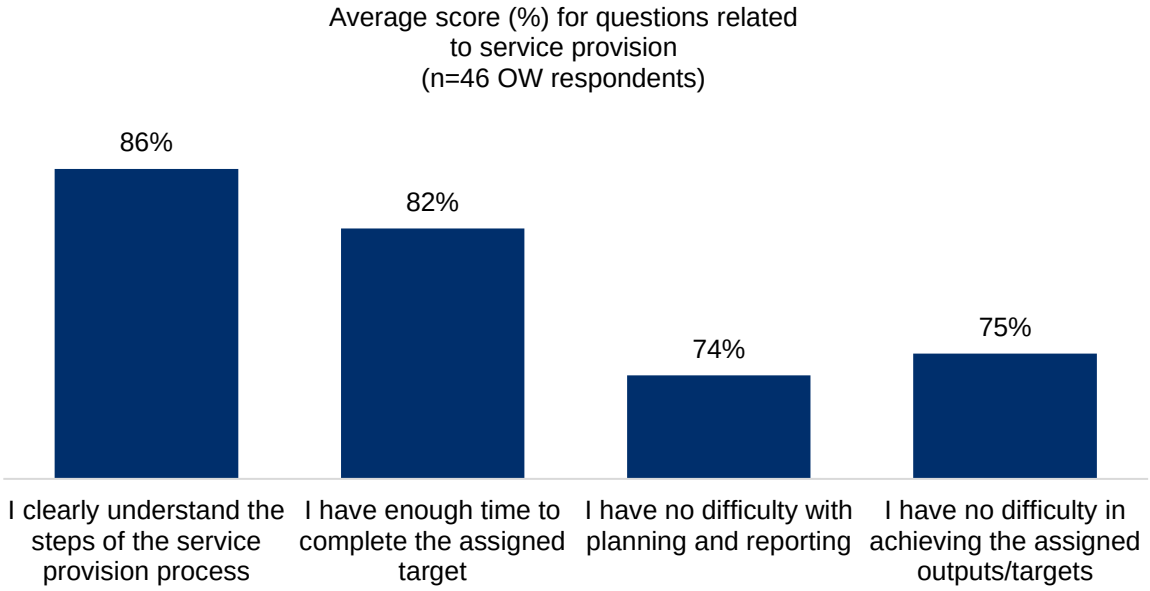
Three second contracts were issued to the same three SO in Dien Bien province, and had a very short approval time, as they were new contracts but based on the already completed contracts.

***Service provision process according to the four service packages***

The results of group discussions with SO and OW on the process of providing four service packages showed that most OW had experience implementing similar activities supported by either U.S. CDC/EPIC or USAID/EpiC projects. According to VAAC guidelines, SO must have at least two years of experience for SO managers in providing HIV prevention services. Of the 46 OW responding to the questionnaires, eight had one or fewer years of experience.

The OW questionnaire comprised 24 out of 31 questions requiring a score (1–7) and 7 out of 31 questions requiring a written response. The average score (expressed as a percentage) for questions related to service provision, gave a score of 86 percent for a clear understanding of the steps of the service delivery process, 82 percent for having enough time to complete assigned targets, 74 percent for having no difficulties in planning or reporting, and 75 percent for having no difficulty in achieving outputs or targets. (Figure 5).

**Figure 5. OW self-assessment of service provision**




Regarding the implementation time of the service provision, based on practical experience, OW proposed to increase the assigned time to deliver the service packages (except for package 4 PrEP treatment adherence support package within three months) ranging from one to five hours as shown in Table 10.

**Table 10. The additional time requested by OW per package and per province**

| No. of OW respondents | 3 | 4 | 6 | 6 | 3 | 14 | 7 | 3 | Current time allocation (hours) | suggested additional allocation (hours) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Packages** | **Tây Ninh** | **Bình Dương** | **Đồng Nai** | **Tiền Giang** | **Hải Phòng** | **Điện Biên** | **Cần Thơ** | **Kiên Giang** | | |
| | **(minutes)** | | | | | | | | **(hours)** | **(hours)** |
| 1 | N/A | N/A | N/A | N/A | N/A | 50 | N/A | N/A | 1.7 | 1 |
| 2a | 120 | 150 | 195 | 80 | 0 | 65 | 30 | 180 | 3.5 | 2 |
| 2b | 120 | 350 | 665 | 295 | 70 | 140 | 105 | 240 | 8.6 | 5 |
| 3a | 0 | 270 | 110 | 30 | 0 | 0 | 180 | 200 | 6.7 | 2 |
| 3b | 0 | 300 | 80 | 20 | 20 | 0 | 0 | 0 | 10.0 | 1 |
| 4a | 0 | 135 | 35 | 25 | 0 | 0 | 15 | 35 | 2.8 | 1 |
| 4b | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4.0 | 0 |

**Dien Bien Province was the only province that provided Package 1 Harm Reduction*

Three packages had the highest proposed increase in allocated time:

- 2a. Client community testing (non-reactive): two additional hours
- 2b Client community testing (reactive) and referral to HIV confirmatory testing: five additional hours.

- 3a Referral to ARV treatment: two additional hours

Some reasons for OW requesting an increased time allocation were related to large catchment areas, extra time to verify documents, long waiting time for test results, additional counseling after receiving test results, and having to travel long distances to health facilities.

**Monitoring, supervision, and reporting**

CDCs and SO conducted monitoring activities on the implementation of service procurement contracts in accordance with VAAC guidelines. These included reviewing monthly reports from SO to CDCs for implemented activities. Also included were CDCs' review, feedback, and signing off the SO reports and for payment requests, cross-checking achievements with related units such as ARV treatment facilities, PrEP providers, and laboratories.

According to the VAAC guidelines, components to be supervised include service provision methods, compliance with procedures, service quality, clients' satisfaction, number of services provided, and quality of services provided. However, CDCs did not supervise all these components and were mainly limited to their review of paper-based reports from SO.

*"Currently there is no funding for direct supervision activities, CDC is conducting supervision in combination with other activities once per quarter." (Representative of CDC province H)*

A web-based reporting system for social contracting was developed for the VAAC and provinces to monitor progress of the pilot, data management, and reporting, and seven out of eight provinces had been trained in its use. A review of the system showed that data for achievement was not consistent with data in the hardcopy reports sent to VAAC by the provinces. Some specific issues included:

- Hai Phong city and Binh Duong province had not entered data into the web-based reporting system. At the time of this assessment, Binh Duong province had not been trained in this system.
- Dien Bien province had inconsistencies between the narrative and data tables supplied by the CDC in the November 2022 interim report.
- SO in Dien Bien province did not directly enter data into the system. The CDC entered the data on their behalf.
- Can Tho city set maximum targets instead of (single) targets, which was not a method consistent with other provinces.

**Payment procedures**

The payment process varied across provinces because the U.S. CDC/EPIC or USAID/EpiC-supported projects had their own financial policies. Dien Bien province, however, had an efficient payment system because they were not attached to an external project and therefore had fewer steps for approvals. According to all contracts, payments were scheduled each month after submission of a monthly report and a payment request by the SO. Payment was confirmed once the monthly report had been verified by the CDC.

However, there were two primary reasons the payment process usually lasted more than two months from the date SO submitted the payment request. First, the payment forms were complicated, and the SO often had to revise the forms multiple times. Second, apart from Dien Bien province, the payment request from the SO had to pass through many levels. It went to CDC for review. Once accepted, it was then forwarded by the CDC to either the U.S. CDC/EPIC or

USAID/EpiC-supported projects for verification, acceptance, and payment transfer to CDC's account before the payment was made to SO.

There were also cases where the SO submitted a late payment request and because the requested amounts were small, then the CDC approved payments for multiple months (Can Tho city). Dien Bien province was the only province where advanced payments were made for start-up expenses. In other provinces, the lack of an advanced payment usually caused financial problems for the SO in the start-up phase as they had to advance their own (non-pilot) resources to buy HIV tests or pay travel expenses for OW.

> *"The payment process is similar to other projects, but the forms are different, and social contracting has more forms." (Representative of province A)*

> *"Disbursement is a bit slow, the unit price is a bit low because it is increasingly difficult to find positive cases, the positive rate of 5% is high compared to the fact that positive cases are becoming less and less, while payment requires a lot of paperwork." (Representative of CDC province I)*

## PERFORMANCE RESULTS

The assessment team collected and analyzed data according to three aspects: (1) Implementation results compared to targets, (2) Feedback from OW, and (3) Perceptions of OW as a proxy for client feedback.

**Implementation results compared to targets.** Nghe An province had concluded four contracts by the end of September 2023, and the other eight provinces concluded 16 contracts by March 29, 2024.

Due to differences in service packages, implementation time, and client groups, the comparison of results between contracts was not the specific focus of the assessment, the assessment examined if the contract process was efficiently managed, if target-setting was appropriate, and if targets were reached within the timeframe.

Note: Direct comparison of results between provinces is not appropriate in this assessment, because of the following issues:

- Duration of contracts varied
- Staggered implementation of pilot in different locations
- Different managing agencies
- Different funders and/or development projects supporting the pilot
- Different key population client groups.

From June 2022 to November 2023, six provinces issued single contracts, while three provinces (Dong Nai, Tay Ninh, and Dien Bien) also issued second contracts.

Annex H shows the target and achievement data for all contracts signed with the SO to March 29, 2024.

Twenty contracts were signed by the provincial CDC with social organizations to provide HIV prevention services. Overall, targets were found to be appropriate. Results varied among provinces depending on contract duration, ranging from 20 percent to more than 100 percent

against targets. Of the 16 contracts reviewed (excluding four earlier contracts in Nghe An province), 14 contracts achieved greater than 50 percent of targets, of which 10 contracts had achievable targets (greater than 70 percent). Two contracts achieved less than 50 percent of the set targets (Tay Ninh Pride's second contract in Tay Ninh province and Six Colors in Hai Phong city). The second contract issued by Tay Ninh province for three service packages had low achievement (40 to 58 percent). The targets were set for 12 months, but a delay by the CDC in issuing the contract left only six months for the duration of the contract. Hai Phong city achieved less than 20 percent for each of the three service packages for the same reason as Tay Ninh province, combined with the late delivery of HIV tests from the U.S. CDC/EPIC project. This experience shows that a short contract implementation time affects the time available to meet targets.

Other challenges reported by all provinces were complex requirements for reimbursement and case verification, and reimbursement rates for HIV tests/commodities were low compared with the actual market price.

The SE in Can Tho city exceeded the contract targets (125–137 percent) for service packages 2, 3, and 4 (community testing, referral to confirmation testing, link to ARV and PrEP treatment). This contract had included a maximum target as a performance incentive but also to keep expenditure within the available budget.

Dong Nai, Tien Giang, Binh Duong, and Kien Giang provinces issued contracts with a 100 percent achievement necessary to trigger payment for service packages 2, 3, and 4. Although in Binh Duong province where limited competitive bidding was used, the lengthy approval process (167 days) left a contract of only 70 days (about two and a half months) issued to the SE but retaining the same (12-month) target period approved in the provincial pilot implementation plan. (Table 5). However, with the cooperation and assistance from the provincial CDC, 100 percent was achieved in the short time frame, allowing the contract to be finalized and liquidated on time. However, this result might also suggest the 12-month target set in Binh Duong province was already too low.

As service packages 3b and 4b (ARV and PrEP treatment adherence support within the first 3 months), most provinces (except for Can Tho city) did not reach these targets, because there was no accounting for the possibility of clients moving to another treatment facility or changing their place of residence.

In the case of Hai Phong city, the results were low due to a short implementation time, targets were set too high, and delays in the supply of HIV test kits.

Notably, the CDC and SO reported they were able to improve their capacity to manage the contract process and were more proactive. Some SO also reported they felt they had good support to be able to reach legal status.

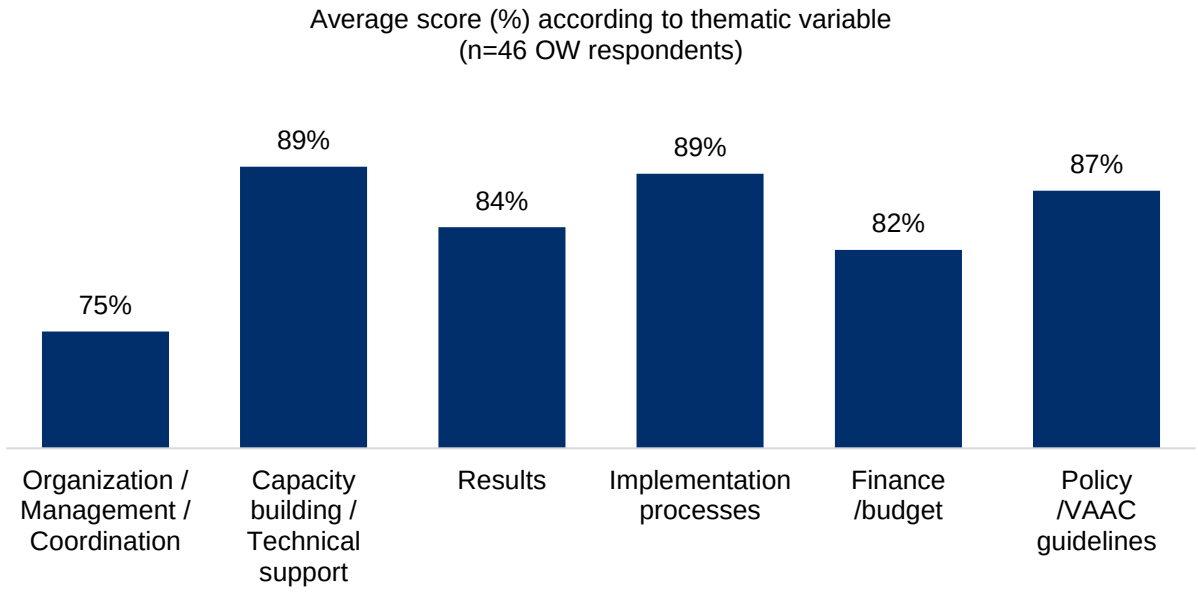
**Feedback from OW to thematic variables**

Feedback from 46 OW directly involved in providing the service packages was collected using an anonymous questionnaire on the feasibility and appropriateness of the pilot implementation, and the OW perception of the level of satisfaction of clients with service delivery. The questionnaire had 24 out of 31 scaled questions (1–7) and 7 out of 31 questions required a narrative response.

Dien Bien province had the highest number of OW (14) respondents while other provinces had between three to seven OW respondents.

The overall number of full-time OW engaged for the pilot was 53, and the number of part-time OW was 81. Forty-six out of 53 full-time OW participated in this assessment, responded to the questionnaire, and participated in FGD (Annex E). Because of the difficulty in reaching part-time OW, they were not contacted for feedback or interviews.

**Figure 6. OW average score according to thematic variables**




According to the average scores for thematic variables supplied by OW (Figure 6), all were above 80 percent except for Organization, Management, Coordination which was rated slightly lower (75 percent).

Together the scores for thematic variables, and for the service delivery process (Figures 4 and 5) show the feasibility and appropriateness of pilot activities were rated highly by OW (Annex I).

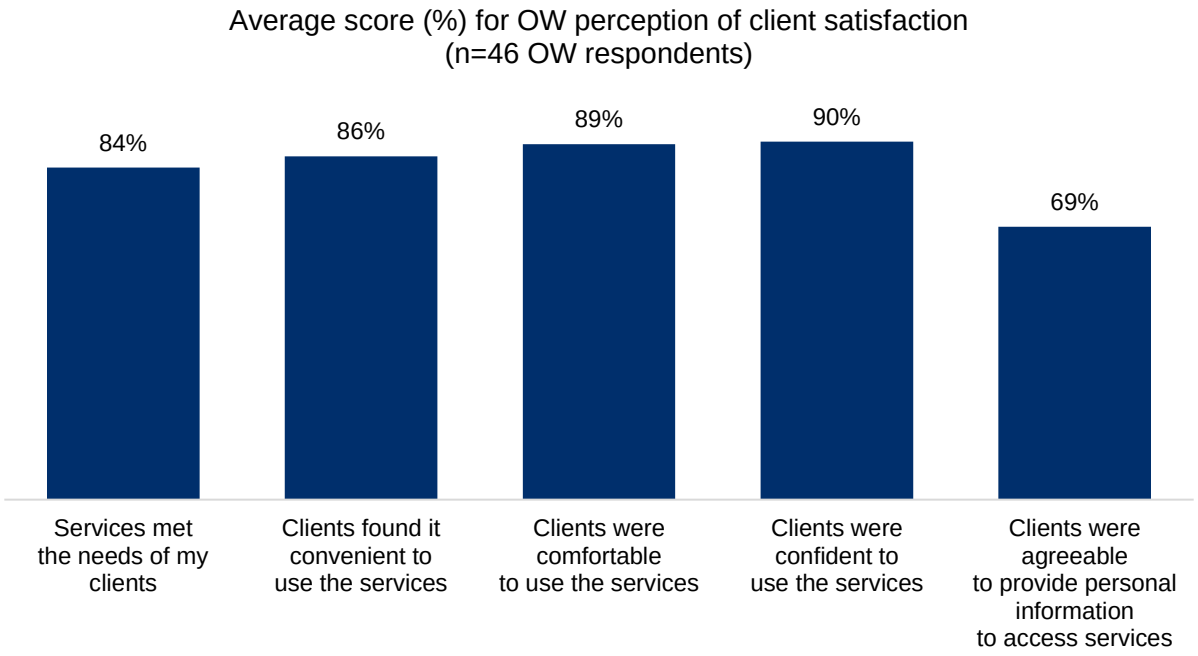
***Some Feedback From OW:***

- Long payment time causes difficulties, especially for social organizations that cannot receive an advanced payment.
- Request additional training and capacity building.
- Expect to offer more types of services (PrEP, tests for HCV, syphilis, etc.).
- Reduce paperwork to be more efficient.
- Support for demand generation activities.
- OW are concerned about job security, so they propose positions with monthly salaries rather than pay based on performance.
- Allow after-hours access to health facilities.

**OW perception of client satisfaction**

The mid-term assessment did not collect direct client feedback but indirectly through OW. OW' feedback on their perception of client satisfaction was based on five questions in the questionnaire: (1) Did the services meet the client's needs? (2) Clients felt it was convenient to access services provided by OW, (3) Clients feel comfortable using the services, (4) Clients feel confident receiving services, and (5) Clients were agreeable in providing personal information (Figure 7).

**Figure 7. OW perception of client satisfaction**




The five specific questions for OW perception of client satisfaction was rated highly overall for convenience, access, and reliability. However, the willingness of clients to provide personal information was rated lower (69 percent). For example, clients who received harm reduction commodities or HIV testing services did not want to provide personal information and did not want their personal details shared with third parties such as health center staff who were responsible for verifying SO case reports and contacted clients directly.

SO also had difficulty verifying HIV+ cases, particularly for non-resident cases, leaving the CDC to contact the VAAC for confirmation. The VAAC did not supply official documentation for case verification, leading to difficulties because according to the contract issued, signed original documents are required.

> *"Clients wish not to disclose personal information except to OW so that no one knows they are receiving HIV/AIDS services. When the client provided their personal information to OW, then the health center called to verify, the client felt uncomfortable. If the verification cannot be done, the payment won't be made/rejected." (IDI from OW in province B)*

## FINANCE/BUDGET

### Disbursements

Disbursement was high for most provinces (Table 11). By March 29, 2024, disbursement rates of more than 90 percent included Can Tho city, Binh Duong, Tien Giang, and Dong Nai provinces (Xuan Hop Contract). The remaining contracts had disbursement rates of up to 86 percent. Hai Phong city had the lowest payment/disbursement rate reaching only 14.8 percent at the end of the contract, while Tay Ninh province had a low disbursement rate of around 51 percent—both because of low achievement of targets. As described earlier, reasons for poor achievement for both locations are related to delays in contract approval and subsequently shortened implementation periods

**Table 11. Summary of disbursement**

| Province | SO | Total (VND) | | |
|---|---|---|---|---|
| | | Contract value | Disbursement | % |
| Dien Bien | Hoa Ban Trang group | 200.397.494 | 152.074.332 | 75.9% |
| | Huong Duong group | 193.180.368 | 130.532.112 | 67.6% |
| | Binh Minh group | 134.102.508 | 85.295.617 | 63.6% |
| Can Tho city | Glink | 190.866.490 | 190.507.000 | 99.8% |
| Binh Duong | Youth Link | 81.110.000 | 79.870.000 | 98.5% |
| Hai Phong city | Six Colors | 203.401.366 | 30.193.935 | 14.8% |
| Dong Nai | Xuan Hop | 72.874.332 | 68.868.671 | 94.5% |
| | Hung Vu | 142.083.916 | 115.280.760 | 81.1% |
| Kien Giang | The Sun Vietnam | 152.731.595 | 132.330.252 | 86.6% |
| Tay Ninh | Tay Ninh Pride | 362.069.320 | 182.820.387 | 50.5% |
| Tien Giang | Niem tin Song Tien | 160.823.952 | 158.442.970 | 98.5% |

*Source: Data from Provincial CDCs to March 29, 2024. Details are in Annex J.*
*Disbursement results do not include Nghe An province.*

### Feedback from SO and OW on unit costs

Most CDCs and OW understand how to calculate unit costs. Some SO believed that the unit costs were low and not consistent with reality and suggested a higher allocation for performance payment, travel allowance, demand generation, and operational activities. The allocation for HIV test kits calculated for the unit cost contained in the contract for example, was generally lower than the actual market price because of the lower volumes bought by the SO.

SO often compared unit costs between the U.S. CDC/EPIC and USAID/EpiC projects with the pilot, particularly the unit cost allocated for case finding, as the projects operate concurrently with the pilot, and implement the same activities using the same pool of OW.

Meanwhile, OW gave high scores (greater than 76 percent) agreeing that both salary and travel allowance incorporated into the unit costs were adequate.

> *"The unit costs are a bit low because SO also has to pay for other costs such as stationery, office renting, and demand generation. The cost for purchasing test kits with the market price is higher than the reimbursement cost in the social contract which used the same price as the bidding process (for bulk procurement)." (Representative of SO I)*

> *"It is necessary to adjust the economic-technical norms because the unit cost under social contracting is much lower than other projects. The total contract value is 83 million for 24 positive cases and 46 PrEP cases, while we have to pay 1.8 million VND for OW for 1 positive case and 400,000 VND for 1 PrEP case." (Representative of SO H)*

> *"The social contracting unit costs are quite low compared to the actual cost, as well as there is no funding support for demand generation activities. It is hard to attract the OW participation with low funding support." (Representative of SOI)*

> *"Currently, the SO is still receiving support from the EpiC project to pay for activities such as communications, office, electricity, and water. These low unit costs and late settlement lead to difficulty in implementation. In addition, there is no advanced payment mechanism in social contracting. In the future, we expect to have a mechanism for advanced payment " (Representative of SO I)*

**Possibility of using the local budget for social contracting**

The provincial DOHs and CDCs believe it is possible to use provincial budgets to pay for social contracting. However, a strong legal framework is needed along with detailed guidance from the central government.

> *"There is the possibility of using local budgets to implement social contracting. However, legal basis and guiding documents from the Government/Ministry of Health are needed." (Representative of DOH of province D)*

> *"The provincial vice president in charge of culture and social affairs is a medical doctor so he understands and supports this activity very much. After the pilot ends, an assessment on the program effectiveness will be conducted to have evidence to convince the provincial leaders to allocate funding for this activity" (Representative of DOH of province B)*

> *"It will be very difficult to use the local budget to implement social contracting. It is necessary to prove the effectiveness of the pilot." (Representative of DOH of province G)*

## CAPACITY BUILDING/TECHNICAL SUPPORT

During the pilot preparation and implementation process, provincial CDCs and SO received regular TA from VAAC and supporting projects (UNAIDS, U.S. CDC/EPIC, USAID/EpiC, USAID/ LADDERS, U.S. CDC/ECLIPSES). During the preparation phase of the pilot, a readiness assessment of provincial agencies (USAID/EpiC, 2022) and a capacity assessment of SO (USAID/LADDERS, 2022) were completed in all nine provinces. The outcome of these activities was shared with all the provincial CDCs and SO and after further meetings with the related stakeholders, capacity-building plans were developed (Annex K). The assessment confirmed that capacity-building activities were implemented and followed these plans. The provincial CDCs and SO highly appreciated the capacity-building activities and TA received from the IDPs.

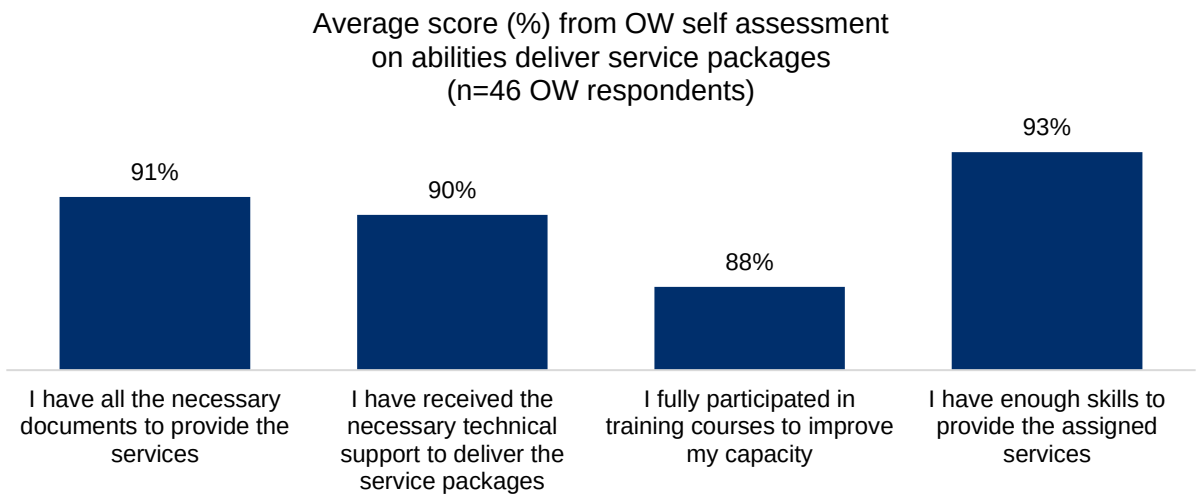
*"After the readiness assessment, there were recommendations for training with an implementation plan. Basically, the project conducted training for CDC and the SO as planned. The project also provided very useful technical support during the pilot implementation." (Representative of CDC, province H)*

*"Every year before contract renewal, there was an assessment, followed by recommendations and a training plan. With training support from the project, the capacity of CDC staff and the SO improved, particularly in terms of reporting, and disbursement which was improved considerably compared to the first phase of the pilot." (Representative of CDC province E)*

However, some new OW did not receive training on community outreach and testing (Dien Bien, Dong Nai provinces) or were trained but still without official certificates (Hai Phong city). The CDCs were also unable to issue OW cards to some OW due to their lack of personal identity papers (Hai Phong city, Tien Giang province). Because OW in Tien Giang province had difficulty retrieving official documents, the SE issued their own OW cards. While in Dien Bien province, new OW did not receive official OW cards.

Self-assessment scores by OW rated familiarity with all the necessary documents to provide the service packages was 91 percent, having received technical support for service delivery was 90 percent, participation in capacity-building activities was 88 percent, and having the relevant skills to provide the services was 93 percent (Figure 8).

**Figure 8. OW self-assessment of their skills to deliver services**




The provincial CDCs and SO requested further capacity building, stating that social contracting was a new experience, particularly for the bidding process, organizational management, and taxes.

***Further capacity building and TA requested during IDI/FGD:***

- Further capacity building and TA requested during IDI/FGD:
- Hai Phong city: training on “bidding and taxes” for the CDC and resource mobilization, proposal writing, organizational management skills, and corporate law for SO.
- Can Tho city: training for OW on client psychology, client motivation counseling, PrEP and ARV treatment, and training for the CDC on preparation steps for service provider selection plan and online bidding.
- Kien Giang: training on HIV counseling and testing, PrEP treatment, ART, client encouragement, demand-generation communication events.
- Tay Ninh: improving capacity in data analysis for CDC SO requested training in communications and bidding.
- Tien Giang: Improving SO’ capacity in financial management, and for CDC in managing payments.
- Dong Nai: Training in counseling for OW, media handling, and human resource management for SO.
- Dien Bien: Training to strengthen skills in dealing with clients and maintenance, improving reporting skills of OW, and needing support for SO to transition to SEs..

## RELEVANCE AND FEASIBILITY OF THE PILOT IMPLEMENTATION GUIDELINES

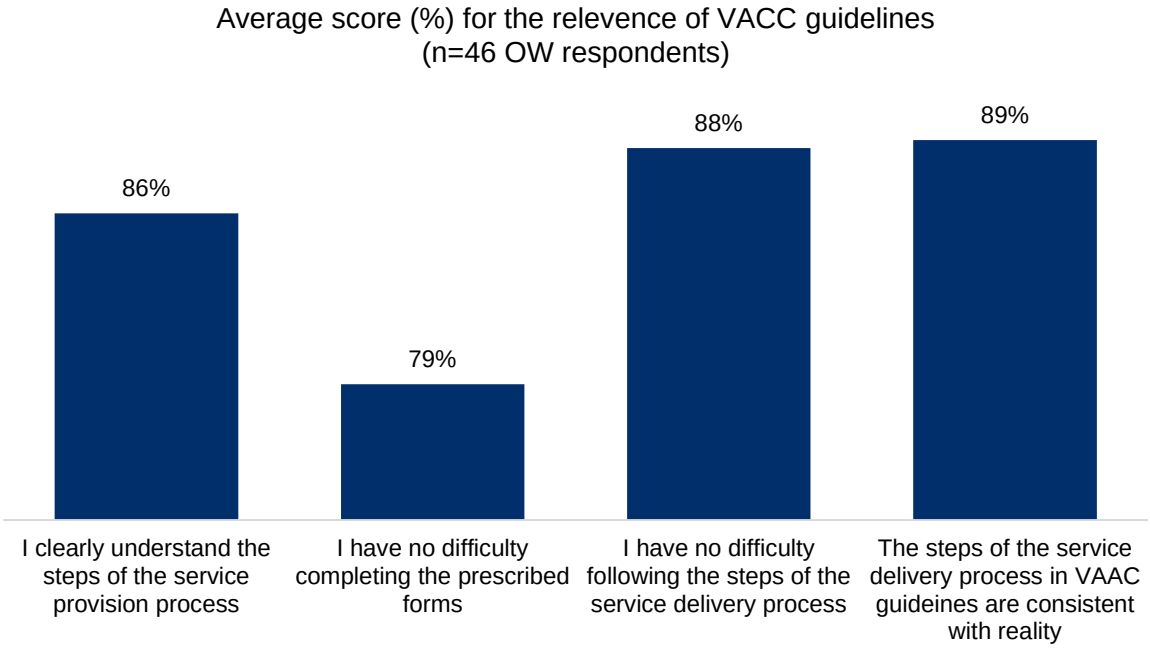
*This section aims to answer:*

*Objective 3. To assess the relevance and feasibility of the pilot implementation guidelines issued by VAAC for revision, as necessary.*

### RELEVANCE OF THE GUIDELINES

The relevance of VAAC's pilot implementation guidelines was rated highly by OW in the questionnaire (greater than 85 percent over the 4 questions) apart from completing forms which had a lower average score (79 percent). Most OW supplied high scores for having a good understanding of the VAAC guidelines, but also made additional (contradictory) written comments that they either had not read the guidelines or that the guidelines were too long. (Figure 9).

**Figure 9. OW assessment of the relevance of the VACC pilot implementation guidelines**




*"I think, in general, the guidelines cover sufficient items, but there are still some practical situations not being mentioned there. Guidance on service package prices and calculations of the prices should be there. Hopefully, in the near future, there will be more specific and detailed instructions." (Representative of CDC province A)*

*"VAAC guidelines considered too long and were not read or read but not remembered." (Representative of SO)*

SO and OW also commented that there were too many forms and reports required in the VAAC guidelines, for example: (1) seven to eight forms for a new client, four forms for a regular client (Dien Bien province); (2) some forms require up to three to four "original signatures" (Tay Ninh, Tien Giang provinces); (3) the counseling form is handwritten, leaving less time for counseling (Dien Bien province); and (4) reporting forms from Provincial CDCs requested clarification of the VAAC guidelines, for example, the patient referral form requiring the signature of the SO director, although this was not stated as a requirement in the VAAC guidelines (Annex L).

As a result of this assessment, the following are suggested revisions for the VAAC pilot implementation guidelines:

- Supplement technical process for delivery of harm reduction commodities for maintenance clients. Currently, the document only includes guidance for new clients.
- Supplement the technical process for ARV and PrEP treatment adherence support packages in the first three months.
- Amend the client referral forms for PrEP treatment clinics. "PrEP treatment facility" should replace "HIV/AIDS treatment facility," and "HIV diagnosis date" should be removed (Annex M).
- Consider adjusting technical-economic norms to align with practical implementation (mainly for additional hours for service delivery). Add technical-economic norms/guidance on the

basis for service delivery payment for delivery of harm reduction commodities (syringes and condoms) to maintenance clients.

- Consider issuing a standard contract form with suggested clauses to minimize risk during implementation. This will help CDCs in the process of contract preparation, negotiation, and signing.

### SCALING UP THE SOCIAL CONTRACTING MODEL USING THE STATE BUDGET

Provincial respondents felt it was possible in most locations to scale up the social contracting model using the state budget, with the following provisions:

- At the central level, a revision of the Prime Minister's Decision on the use of local budgets for contracting SO for HIV service delivery is needed. The Prime Minister's Decision No 1387/2016/QĐ-TTg specifies the list of services allowable using the state budget but does not currently include the HIV service packages used in this social contracting pilot (Government, 2016).
- The SO should confirm its eligibility to participate in public procurement (bidding) according to Article 5 of the Law 22/2023/QH15 (Government, 2023) on bidding.

A bidder that is an organization shall be deemed to be eligible if meeting the key following requirements:

- A domestic bidder or investor must be an enterprise, cooperative, cooperative union, cartel, public sector entity that is duly established and operating under the law of Vietnam.
- It must keep independent accounting records.
- Its name is registered on VNEPS before the grant of approval for contractor or investor selection result.
- Decree No. 32/2019/ND-CP (April 10, 2019): The assignment of tasks, purchase orders, or bidding for public products and services funded under the state budget (regular expenditure) only applies to public administrative units. SO are therefore not eligible. Also, in this Decree, the procurement of preventive health services procurement is only available through task assignment or purchase orders, and bidding is not allowed.

Therefore, it is proposed to amend this Decree 32/2019/ND-CP to (1) expand the scope of eligibility to include non-public administrative units (e.g., SO) and (2) allow the application of bidding method for procurement of preventive and primary health care services.

- A Decision issued by MOH is needed that details the technical and economic norms/unit prices for each HIV service package.
- CDCs requested detailed guidelines for the selection process for the SO providers of HIV services.

> *"The state budget can be used to implement social contracting activities. But currently, these services have not been included in the list of public services, so there is no basis to use state budget resources to deploy the activities. In addition, to use the state budget, there needs to be a clear legal framework." (Representative of CDC province H)*

*"If this model uses the state budget in the future, it will definitely have to be managed more strictly and there will have to be technical norms on prices and service packages prescribed by the Ministry of Health." (Representative of CDC province A)*

The anonymous OW questionnaire gave high scores for the willingness (85 percent) to participate in social contracts in the future under the state budget. However, issues such as legal status, financial resources, and capacity are likely to be barriers for SO to participate in the future. Procurement skills of provincial CDCs and SO especially using the bidding process, need improvement. SO also need to gain legal status to participate in bidding, submission of profiles, and make reports/payments according to the Budget Law.

*"I am not sure if the SO without legal status can participate when this activity switches to use the state budget and how to have legal status. Therefore, we have not thought about participating in this scenario." (Representative of SO D)*

*“If there is financial support and we are allowed to participate, our group will participate.” (Representative of SO C)*

*“We will try to participate, but the enterprise must have its own financial resources to pay for activities. If the state budget is too low, we don't know how to afford it." (Representative of SO C)*

*“Emotionally, we support this activity in the coming year and want to participate, but economically, we have to consider the prices and time. Because we have not yet paid for personnel and operating expenses.” (Representative of a SO H)*

*“SO will participate if the prices remain unchanged.” (Representative of a SO in Province A)*

# CONCLUSIONS AND RECOMMENDATIONS

## CONCLUSIONS

### ***Objectives 1***

*To assess the social contracting pilot progress and the results of the pilot from June 2021–March 2024*

#### WAS THE PROCESS EFFECTIVE?

The assessment found the management by the CDC of HIV prevention services delivered through contracted SO providers followed the rules for public procurement and were effective, indicating that social contracting could be a viable option to channel domestic funding for HIV prevention services with SO as implementers.

Target setting for most contracts was appropriate and achievable, but delays in some locations happened because of slow approval of pilot implementation plans and increased scrutiny levelled at government procurement activities. A more complicated bidding process meant that the CDC preferred to use purchase orders for procurement (15 out of 20 contracts).

Because SO (apart from Dien Bien province) were also engaged in either U.S. CDC/EPIC or USAID/EpiC projects with similar HIV prevention activities, there may have been potential for conflict between these projects, such as the engagement of community OW (full or part-time), and reporting on the achievements specific to the pilot.

### ***Objectives 2***

*To identify challenges and recommend interventions to improve the pilot implementation and results for the remaining period (ending September 2024)*

#### WHAT WERE THE CHALLENGES FACED AND WHAT ARE SUGGESTIONS FOR IMPROVEMENT?

While the development of policy frameworks for social contracting continues, challenges for procurement, bidding, and payment must be addressed prior to scaling up the model.

Challenges for improvement include the addition of HIV prevention services to the approved list of public health activities[2] and amending inconsistencies in relevant policies, such as eligibility criteria, procurement methods, and tax implications for the SO that receive financing through the state budget.[3] Greater efficiencies for procurement, bidding, and payment are needed, but both the CDC and SO partners indicated that the model is viable, if guidance from the central to provincial levels is in place, the legal status of SO is obtained, and ongoing financing is assured.

The process of preparing and establishing the pilot was very challenging, and considerable support was supplied in the preparation and initiation phases to select SO partners. This was to ensure both SO and CDC had the requisite level of skills to participate in the pilot, especially if

2 Prime Minister's Decision No 1387/QĐ-TTg (2016)

3 UNAIDS: 2019 Tran Kim Chung et al Overview of the legal and policy framework for implementation of Social Contracting in Vietnam's national response to HIV

the interested SO were not legal entities, as this posed a variety of practical problems to ensure accountability.

Apart from three SO in Dien Bien province, 10 SO in the other eight provinces were engaged under the U.S. CDC/EPIC or USAID/EpiC projects running concurrently with this pilot. The VAAC Decision No. 40/QD-AIDS (March 2023) allowed purchase orders by the CDC (normally restricted to procurement from public administrative units) and an exemption for non-legal entities to participate in the pilot. Non-legal SO will not be allowed to participate if the pilot moves to become a formal policy option, and therefore encouraging prospective SO to gain legal status should continue to be a priority. Further, public procurement is intended to be fully online by 2025, and unregistered or non-legal organizations are not eligible to use this platform with the bidding process as the only available procurement option.

Only two provinces used the bidding method during the pilot. Nghe An province used full competitive bidding to issue four contracts prior to the formal start of this pilot (concluding September 2023). As a result, not all the contracting information from Nghe An province was available to be reviewed or compared with other procurement methods. Binh Duong province used limited competitive bidding but had an excessive delay in approval of the pilot implementation plan by local authorities (167 days) resulting in a very short contract duration to coincide with the end of the fiscal year (70 days). All other locations used purchase orders for procurement of providers, but this meant there has been limited experience gained by CDC or the SO through the pilot in the bidding process.

Forty-six out of fifty-three full-time community OW participated in focus group discussions and completed an anonymous questionnaire about their involvement in the pilot. According to the questionnaire and related comments, the community OW had a good understanding of the pilot and delivery of service packages and were agreeable to continue their involvement in the future through public procurement. Based on feedback from the SO or community OW most considered the forms/copies needed for payment could be simpler and the payment process more efficient. Practical experience suggests more time would benefit counseling of key populations, especially for Service Packages 2 and 3.

A further 81 part-time OW had been engaged intermittently during the pilot in the eight provinces supported through the U.S. CDC/EPIC or USAID/EpiC projects. The role and extent of these part-time OW in pilot activities was unclear to the assessment team, and these OW did not participate in the assessment.

Because clients were not interviewed directly, feedback from community OW in the questionnaire found the practice of clients having to supply personal contact details can affect the willingness of key populations to use HIV testing services, and that clients also expected privacy and confidentiality when accessing services. This applies, for example, when third parties (health center staff) are involved in verifying services delivered to clients.

The internal financial policies for the U.S. CDC/EPIC or USAID/EpiC projects meant that advanced payments were not available to the SE supported via these projects. Dien Bien province was not linked to any external project and was able to offer advanced payments under the public procurement mechanism that proved invaluable to SO partners in the start-up phase.

Payment methods linked to either U.S. CDC/EPIC or USAID/EpiC projects had more steps and were less efficient than in Dien Bien province where payments were directly between the CDC and SO partners. Late procurement of HIV RDT and commodities hampered implementation in

Dien Bien province, and similarly in Hai Phong city. Delays in payments were often also due to incomplete reports that had to be resubmitted to the CDC.

The procurers (CDC or provincial units) issued various contracts that set different requirements for payment. For example, some contracts required 100 percent achievement, while others specified maximum targets as a means of keeping within the assigned budget. Both options posed difficulties for implementers such as Binh Duong province where 100 percent had to be achieved in a very short timeframe to trigger payment. The maximum targets used in three provinces were not consistent with other contracts and could be better expressed as a budgetary condition in contracts.

### DID YOU RECEIVE CAPACITY BUILDING OR TECHNICAL ASSISTANCE TO IMPROVE PROCESSES?

CDC and SO are familiar with procurement and payment schemes using the state budget and the CDC has become more competent in managing the procurement process.

Considerable support has been provided in all aspects of procurement including planning, implementing, and reporting for this pilot. SO were pleased with the support received for capacity building and TA. Most recommendations from readiness or capacity assessments of CDC and the SO were implemented, although regular capacity strengthening for the SO in organizational management, using the bidding process, tax obligations, and how to gain legal status is still warranted, as well as training in developing communication strategies to encourage demand.

## ***Objective 3***

To assess the relevance and feasibility of the VAAC guidelines for implementing the social contracting pilot to inform and necessary adaption.

### WHAT IS THE DIFFERENCE BETWEEN THE PILOT GUIDELINES COMPARED WITH IMPLEMENTATION?

The VAAC guidelines to implement the social contracting pilot were found to be feasible and relevant. There was good compliance with the VAAC guidelines for all participating locations, although if using the state budget, more detailed guidance would be necessary to shield CDC/DOH procurers from risk. The economic-technical norms for the service packages could be adjusted to better reflect the actual need.

Monitoring and evaluation components in the VAAC guidelines were completed by the CDC and (apart from Dien Bien province) focused on the review of supplied reports without on-site supervision, because of a lack of budget or time in these locations.

Although included in the VAAC guidelines, there was limited attention given to the quality of services delivered by SO/OW (including OW counseling delivered using online apps). Monitoring was focused on the achievement of targets and desk review of reports. Some inconsistencies were noted in a few locations between pilot reports supplied in hardcopy and the online reporting system, which suggests more attention to detail is needed.

Specifications for HIV RDT and /or commodities were not included in any contracts, and so verification of product quality (DAV registration, expiry dates, etc.) was not undertaken by the CDC.

A comparison of the twenty contracts showed all conformed with parts (a-l) in *Form 3, Article 1* supplied in the VAAC guidelines, and all contracts targeted MSM, with fewer targeting FSW or

PWID, however, contracts were uneven in supplying clauses to reduce risk. For example, suggested clauses could be offered in the VAAC guidelines to be used by the CDC to simplify the contracting process and help account for key risks.

The VAAC guidelines did not have clear instructions for Service Package 1 (maintenance clients) or for Service Package 2 (non-resident reactive clients) both of which caused difficulty when it came to verifying results and authorizing payments. The addition of standardized case verification procedures in the VAAC guidelines would make this process consistent across participating provinces.

**RECOMMENDATIONS BY AGENCIES**

**VAAC**

- Advocate to revise Decree 32/2019/ND-CP to (1) expand the scope of eligibility to include non-public administrative units (e.g., SO) and (2) allow the application of bidding method for procurement of preventive and primary health care services.
- Continue to support provinces in implementing the social contracting pilot.
- Consider adjusting technical and economic norms to match actual implementation.
- Consider developing recommended clauses for contracts, for example:
  - Taxes obligations, bonus/penalty terms (minimum quota), obligations in providing harm reduction commodities and test kits, contracts use fixed unit price and not lump-sum, and to offer terms for advanced payment.
- Standardize the case verification process, especially for harm reduction packages and HIV+ clients that relocate from other provinces.
- Standardize the PrEP referral form (HIV treatment facility information, date of HIV diagnosis).
- Consider use of a Unique Identifier Code (UIC) because a UIC should not require the use of a national ID number. The use of a UIC could help encourage clients to receive HIV testing and use support services.
- Request provinces to update data on the web-based reporting system so that VAAC can closely monitor the progress of pilot implementation and offer timely support.
- Propose revision of the VAAC pilot implementation guidelines to include:
  - Additional information for ARV and PrEP treatment adherence and harm reduction information for MMT adherence.
  - Revision of the PrEP referral form (HIV treatment facility information, date of HIV diagnosis)
  - Additional guidance on monitoring service delivery processes and quality for online services
  - Additional guidance on the standard of quality for HIV service delivery.

- Suggestions for the final assessment:

- There could be a potential conflict for SO or OW implementing either U.S. CDC/EPIC or USAID/EpiC projects concurrently with the activities of the social contracting pilot, because is it unclear how the SO assigns target achievements to either pilot or project.
- Review the choice of procurement method and procurer of HIV RDT and commodities and how quality assurance is verified.
- Collect direct client feedback.

**Provincial CDC**

- Continue to improve the capacity of CDC and social organizations on service procurement (especially for the bidding process).
- Provincial CDC should monitor service quality in addition to monitoring the achievement of targets.
- Consider adding standard clauses in contracts, for example:
  - Taxes obligations, bonus/penalty terms, HIV prevention services to be delivered, procurement responsibilities (e.g., harm reduction commodities and test kits), specify the fixed unit price (not lump-sum), and terms for advanced payment, etc.
- Align procurement of HIV RDT/commodities by social organizations with CDC specifications and provide evidence for verification.
- Do not include maximum targets in the contract and instead specify budget ceilings.
- Ensure the reporting system is consistent between the web-based reporting system and other systems (e.g., hardcopy report, presentation).

**International development partners**

- Continue to provide financial and technical support to for the social contracting pilot. Technical support includes organizing capacity-building training for CDC staff on procurement processes, guiding social organizations to participate in bidding, and providing technical support to CDC and social organizations during implementation.

**Social Organizations**

- For social organizations without legal status, it is necessary to build capacity to finalize registration in accordance with regulations, so that social organizations are eligible to participate in future social contracting exercises financed via the state budget.
- OW must provide service packages according to VAAC guidelines.
- Capacities should be improved in bidding, negotiating contracts, reporting, and financial and tax regulations.

# ANNEX A. DETAILS OF PARTICIPANTS IN FGD, IDI, AND RESPONDENTS TO THE OW QUESTIONNAIRE

Eight OW from Nghe An province did not participate, as this province had already concluded their contracts before the assessment had begun.

| Province | MOH | DOH | Provincial CDC Leader | Provincial CDC Staff | SO | OW | Questionnaire | FGD | IDI |
|---|---|---|---|---|---|---|---|---|---|
| Hai Phong city | | 0 | 1 | 4 | 1 | 3 | 3 | 2 | 2 |
| Can Tho city | | 1 | 1 | 6 | 1 | 8 | 7 | 2 | 3 |
| Kien Giang | | 0 | 1 | 4 | 1 | 3 | 3 | 2 | 2 |
| Tay Ninh | | 1 | 0 | 6 | 1 | 4 | 3 | 2 | 2 |
| Tien Giang | | 1 | 1 | 4 | 1 | 6 | 6 | 2 | 3 |
| Binh Duong | | 1 | 1 | 4 | 1 | 6 | 4 | 2 | 2 |
| Dong Nai | | 1 | 1 | 5 | 2 | 8 | 6 | 3 | 4 |
| Dien Bien | | 1 | 1 | 6 | 3 | 15 | 14 | 4 | 2 |
| Nghe An | | 0 | 1 | 3 | 2 | 8 | 0 | 3 | 0 |
| VAAC | 4 | | | | | | | 1 | |
| USAID/EpiC | 1 | | | | | | | | 1 |
| U.S. CDC/ECLIPSES | 1 | | | | | | | | 1 |
| USAID/LADDERS | 1 | | | | | | | | 1 |
| UNAIDS | 1 | | | | | | | | 1 |
| **138** | 8 | 6 | 8 | 42 | 13 | 61 | 46 | 23 | 24 |

# ANNEX B. SUMMARY OF IDIS AND FGDS—RESPONSES ACCORDING TO THEMATIC VARIABLES

| Organization, Management Coordination | Results /Outcomes | Training /Support & TA | Procedures to implement the pilot. | Finance/Budgets | Policy /Guidelines |
|---|---|---|---|---|---|
| **Findings: Strengths** | | | | | |
| All stakeholders contributed to the development of VAAC guidelines /regulations.<br><br>Some DOH were more active and had greater support (USAID/EpiC; UNAIDS).<br><br>Good co-operation ranging from national to provincial level.<br><br>SO were satisfied with the negotiation of contracts/ communication. | CDC/SO gained experience and became more proactive.<br><br>Targets varied and most did not reach 100%.<br>Can Tho city & Tien Giang province met the highest targets.<br><br>End-user clients were satisfied with the services. | CDC/SO completed the assessment with COSA/SCANA tools and most recommendations were implemented.<br><br>SO and OW received adequate training.<br><br>Good TA received during implementation, e.g., both online/offline<br><br>Support was provided to SO to become a legal entity. | Contract preparation:<br>Seven out of nine provinces used purchase orders.<br>Uncomplicated but time-consuming due to their lack of experience.<br><br>Service delivery:<br>Most SO/OW have prior experience with outreach services and understand the importance of gaining the trust and satisfaction of clients.<br><br>Good supervision from VAAC/donor to CDC, and from CDC to SO.<br><br>M&E<br>USAID provinces<br>KP eLog software was used for the EpiC project.<br>• Case data entered by SO.<br>• CDC to central level also used the web-based reporting system.<br>Remaining provinces<br>SO reported to the CDC, and the CDC collated and entered on the web-based reporting system.<br><br>Payment<br>SO and CDC are familiar with the state budget for payment. | Unit cost calculations:<br>• Unit cost calculations were well understood.<br>• Unit costs were adequate.<br><br>State budget:<br>• All DOH and CDC will continue if the appropriate legal framework is in place.<br><br>• Most SOwould participate but have some concerns about unit costs and delayed payments. | Appropriate and useful |
| ***Findings:* Limitations** | | | | | |
| Several concurrent projects supporting HIV/AIDS activities in pilot provinces: EpIC, | The short duration of contracts:<br>10-52 weeks | USAID provinces: assessment prior to contracts. | Binh Duong (Youth connection) was awarded under competitive bidding but will not bid for the next contract because the process was complicated. | SO:<br>• Insufficient allowances for travel and increased counseling time. | CDC:<br>VAAC guidelines<br>• Package 1 new client vs. |

| | | | | | |
|---|---|---|---|---|---|
| GF, VUSTA, LADDER, LIFE, and IRD, but poor collaboration /communication and sharing of implementation /results.<br><br>Apart from Dien Bien province financed via UNAIDS, all contracts were signed by legal entities as SE/company. | Packages 3 & 4<br>VAAC guidelines lack technical procedures for three-month adherence support.<br><br>Packages 3 & 4<br>VAAC guidelines lack technical procedures on three-month follow-up.<br><br>• Duration of contract and access to payments should accommodate the duration of three-month follow-up of clients.<br>• Some provinces allowed payment after the end of the contract (Tien Giang, Tay Ninh) while Hai Phong province has not. | *UNAIDS /Dien Bien province—also one assessment.*<br><br>*Some SOs did not receive assessment results or they were poorly understood.*<br><br>New OW were sometimes not trained (Dien Bien, Dong Nai) or trained but did not receive PE certificates. (Hai Phong)<br><br>Official PE card not issued:<br>• CDC did not issue a card.<br>• (Hai Phong, Tien Giang).<br>• SO in Tien Giang issued their own card.<br>• No card for new OW (Dien Bien).<br><br>Several development partners supply concurrent support to SO.<br>e.g.,<br>Hai Phong<br>Can Tho<br>Kien Giang | SO said that on the website, the Purchase Order process was straightforward.<br><br>Targets not met:<br>• Delays in procurement of commodities (Dien Bien).<br>• Lack of RDT (Hai Phong).<br><br>KP refused HIV testing services:<br>Dien Bien:<br><br>• National ID requirement.<br>• Phone call to client from DHC/CHC/CDC for verification of new KP clients.<br><br>Indicators:<br>• The web-based reporting system does not disaggregate data by KP and does not cover all indicators of Package 1.<br>• Target by KP but results were not disaggregated by KP provided (EpiC CDC and UNAIDS).<br>• Dien Bien: data on maintenance clients were not supplied by SO as VAAC guidelines were not clear.<br><br>Payment:<br>USAID provinces:<br>Contracts have standard and advanced targets.<br><br>• No payment if the advanced target was exceeded.<br><br>Excessive supporting documents required for payment (all provinces)<br>• New clients—seven to eight forms<br>• Maintenance clients—four forms (Dien Bien).<br>• Three to four copies for each form (Tay Ninh, Tien Giang).<br>• PrEP forms were incorrect (Hai Phong, Binh Duong).<br>• Manual reporting for pilot.<br>• The counseling form is too complicated for OW (Dien Bien).<br>• No advanced payment except Dien Bien. | • Fixed budget needed for communications, and office overheads.<br><br>CDC:<br>• Misinterpretation of unit costs for some CDCs.<br>• Too much responsibility.<br><br>VAAC:<br>VAAC to advocate to amend PM Decision 1387/2016 to include HIV/AIDS in the list of public services in the health and population sector access to the state budget.<br><br>• Evidence needed of model effectiveness.<br>• Legal framework and clear guidelines/policy including cost calculation from GOV and MOH for provincial authorities.<br>• Able to mobilize the local budget if the Government has the policy approval.<br><br>SO without legal status:<br>Clear guidelines needed on eligibility for social contracting (Dien Bien).<br>A minimum of three SO as legal entities is necessary for Competitive Bidding (3 legal SO unavailable in Tay Ninh, Tien Giang, and Kien Giang). | maintenance clients<br>• Package 3 and 4: requirements for three-month follow-up<br><br>*SO:*<br><br>• VAAC guidelines were considered too long and were not read or read but not remembered. |

- Payment delays after approval (Tay Ninh, Tien Giang, Dong Nai, Kien Giang).

Verification process:

Non-active cases:

- Dien Bien: verify by phone call.
- Other provinces: no verification (Kien Giang).
- Long distances for verification from OPC (Kien Giang, Tien Giang).

# ANNEX C. BACKGROUND OF OW BY PROVINCE

| | | Hai Phong | Tien Giang | Dien Bien | Dong Nai | Kien Giang | Can Tho | Binh Duong | Tay Ninh | Nghe An |
|---|---|---|---|---|---|---|---|---|---|---|
| **Number of OW** | 46 | 3 | 6 | 14 | 6 | 3 | 7 | 4 | 3 | |
| **Age-range** | 18–61 | 25–28 | 20–41 | 18-61 | 18-28 | 20-36 | 20-25 | 25-33 | 21-26 | |
| **Male** | 34 | 3 | 5 | 9 | 4 | 1 | 6 | 4 | 2 | |
| **Female** | 10 | | 1 | 5 | 1 | 1 | 1 | | 1 | |
| **Other** | 2 | | | | 1 | 1 | | | | |
| **University / higher** | 10 | 1 | 0 | 2 | 1 | 1 | 1 | 2 | 2 | |
| **College** | 14 | 1 | 3 | 5 | 2 | 1 | 2 | | 0 | |
| **High school** | 16 | 1 | 2 | 5 | 3 | 1 | 1 | 2 | 1 | |
| **Secondary school** | 4 | | 1 | 2 | | | 1 | | | |
| **Primary school** | 1 | | | | | | 1 | | | |
| **Illiterate** | 1 | | | | | | 1 | | | |
| **Years of employment as OW** | 1-20 | 5-10 | 1-20 | 1-12 | 1-5 | 1-6 | 2-4 | 1-12 | 1-5 | |
| **Years of employment with SO** | <1 to 3 | <1 | 1-3 | < 1 | 1-2 | 1-4 | 1-2 | 1-2 | 1-3 | |

*Eight OW in Nghe An province did not complete the questionnaire because their participation ended in September 2023.*

*SO Administrators not directly delivering service packages did not complete the OW questionnaire but participated in an IDI or FGD.*

# ANNEX D. OW NARRATIVE COMMENTS IN THE QUESTIONNAIRE—KEY POINTS SUMMARY

*Questionnaire responses (7,18,19,22,26,27,31)*

| | |
|---|---|
| 7 | What support do you need in the future to be able to do your job better? |
| 18 | What can be done to increase client satisfaction? |
| 19 | Do you have any suggestions on implementing communication to create demand? |
| 22 | What can increase your satisfaction? |
| 26 | How does the level of financial support from this pilot contract compare with other projects? |
| 27 | What changes should be made to improve the pilot? |
| 31 | How could policies or guidelines be improved? |

| **7. What support do you need in the future to be able to do your job better?** | **22. What could increase your satisfaction?** |
|---|---|
| Provide training to improve personal capacity<br>Add training on how to motivate clients<br>Encourage learning from other organizations<br>Improve knowledge of HIV and how to advise on PrEP<br>Supply training to complete reports<br>Ensure training for new OW | Continue support and guidance from VAAC and CDC<br>Increase travel expenses to reach more clients.<br>Reduce the number of forms to be completed.<br>Offer additional service packages including PrEP<br>Provide access to out-of-hours services from health facilities<br>Ensure financing to maintain the ongoing running of SE |
| **18. What can be done to increase client satisfaction?** | **26. How is the level of financial support from this pilot contract compared to other projects?** |
| Ensure clients' information given to OW will be confidential<br>Maintain security of clients' information<br>Provide additional free services; treatment and testing (e.g., PrEP, HCV, syphilis)<br>Provide additional harm reduction services<br>Offer different brands of commodities (condoms, lubricants, etc.)<br>Open PrEP and ARV clinics on weekends / after-hours<br>Increase promotion of services | Show that costs are considered equivalent or lower than other projects<br>Fund additional communication activities to create demand<br>Offer salaries for OW |
| **19. Do you have any suggestions on implementing communication to create demand?** | **27. What changes should be made to improve the pilot?** |
| Supply funding to organize events and communication activities<br>Ensure coordination between PHD, CDC, and Social Enterprises to create demand | Reduce paperwork and make it more efficient<br>Offer support to create SE as a legal enterprise<br>Increase communication activities to increase demand<br>Offer salaried positions<br>Increase payment norms |
| | **31. How could policies or guidelines be improved?** |
| | Adjust targets (if necessary) at contract signing |

| | |
|---|---|
| | Make policy guidelines clearer and more concise<br>Offer salaried OW to provide job security/commitment<br>Increase out-of-hours services from medical facilities (e.g., PrEP /ARV)<br>Offer more support for office space/equipment<br>Maintain training program for service providers /OW |

# ANNEX E. NUMBER OF FULL-TIME AND PART-TIME OW

| No | Province | SO | Number of OW | | Number of full-time OW participating |
|---|---|---|---|---|---|
| | | | Full-time | Part-time | |
| 1 | Dien Bien | Hoa Ban Trang | 6 | | 6 |
| | | Huong Duong | 5 | | 5 |
| | | Binh Minh | 3 | | 3 |
| 2 | Cần Thơ | Glink | 13 | 14 | 7 |
| 3 | Bình Dương | Kết nối trẻ | 1 | 8 | 4 |
| 4 | Hải Phòng | Six Colos | 6 | 2 | 3 |
| 5 | Đồng Nai | Xuân Hợp | 2 | 15 | 3 |
| | | Hưng Vũ | 7 | 5 | 3 |
| 6 | Kiên Giang | Công ty TNHH DNXH The Sun Việt Nam | 3 | 15 | 3 |
| 7 | Tây Ninh | Công ty TNHH Xã Hội Tây Ninh Pride | 4 | 15 | 3 |
| 8 | Tiền Giang | Công ty TNHH Xã Hội Niềm tin Sông Tiền | 3 | 7 | 6 |
| **Total** | | | **53** | **81** | **46** |

## ANNEX F. FORM 3, ARTICLE 1, PARTS "A" TO "L"VAAC GUIDELINES

Article 1. Content of ordering contract

1. Service category name

a) Order quantity and volume.

b) Product quality.

c) Implementation time and completion time.

d) Unit price and order price according to the decision of the competent authority.

đ) Contract value, details from the following sources:

- State budget sources for ordering (according to prices that include full costs) or state budget funds to support costs not yet included in public service prices and fees (in cases where prices do not include full costs).
- Fees are left to be spent on service provision activities and fee collection according to the law on fees and charges.
- Revenue from public administrative services is based on public administrative service prices determined by the State.
- Other sources (if any).

e) Payment and settlement methods.

g) Method of acceptance and product handover.

h) Rights and obligations of the order-receiving unit.

i) Rights and obligations of ordering agencies and organizations.

k) Responsibilities of the parties due to breach of contract; solution method.

l) In addition, the parties may add a number of other contents that are not contrary to the provisions of the law.

2. In addition to the contents of the ordering contract in point 1, localities can add a number of other contents to the ordering contract to suit the management requirements for each specific field or according to the contract form. contract according to the provisions of specialized laws (if any).

Article 2. Responsibilities of each party

Article 3. Other provisions

# ANNEX G. COMPARISON OF CONTRACTS (FORM 3, ARTICLE 1)

*Form 3, Article 1* in the VAAC guidelines. The form includes parts (a-l) but does not supply any examples of narrative clauses for inclusion in contracts.

| | Part | ***Findings*: Comparison of contracts** |
|---|---|---|
| **a** | Quantity and volume of public service services ordered | USAID/EpiC<br>• Data disaggregated by KP supplied in reports<br>• Some contracts have a target and maximum target for payment (Tay Ninh, Tien Giang, Can Tho, Dong Nai)<br>The U.S. CDC/EPIC<br>• Contract specifies target by KP (Binh Duong, Hai Phong)<br>• Data disaggregated by KP not supplied in reports<br>UNAIDS (Dien Bien)<br>• Results by KP available for 1st contract, 2nd contract not supplied<br>• Results on maintenance clients for 2nd contract not supplied<br>• Units for maintenance clients need clarification (case vs. time) |
| **b** | Quality of public service services | According to guidelines/regulations of MOH |
| **c** | Implementation time and completion time | All contracts state the duration of the contract<br>• Some contracts state the schedule for the final invoice<br>Package 3 and 4 (ARV and PrEP)<br>Verification of three months of client adherence is needed before payment<br>The U.S. CDC/EPIC- Hai Phong<br>• Cases that did not meet three-month follow-up were rejected<br>The U.S. CDC/EPIC–Binh Duong<br>• Contract permits bank guarantee to allow payment<br>• U.S. CDC/EPIC: did not state this provision but allow payment<br>USAID/EpiC - Glink Can Tho city<br>• Contract allow extra time for liquidation to allow for verification of 3-month follow-up |
| **d** | Unit price and order price according to the decision of the competent authority | Based on the unit cost calculations from VAAC, UNAIDS, CDC, and other development partners. All contracts had unit prices and order prices/total value in Annex B: Detailed Budget for Service Delivery |
| **đ** | Order cost estimate, with details from the following sources:<br>• - Project source supported by<br>• - Other sources (if any) | Single source<br>• Pilot SC project |
| **e** | Payment and settlement methods and type/form of contract | The U.S. CDC/EPIC- Binh Duong |

| | | |
|---|---|---|
| | | • Contract requires exact quantity/volume of services (100% or 0% payment) |
| **g** | Method of acceptance and product handover | USAID/EpiC<br>• Forms/documents required for payment for each package stated in the contract |
| **h** | Rights and obligations of the service provider | All contracts include the rights and obligations of the service provider (SO) |
| **i** | Rights and obligations of ordering agencies and organizations | All contracts have rights and obligations of ordering agencies (CDC/municipal authority)<br>• Excluding Nghe An province, 1st contracts signed with three parties |
| **k** | Responsibilities of the parties due to breach of contract; solution method | All contracts stated actions to follow up non-adherence to contract terms except for contracts issued in Dien Bien and Nghe An provinces where this obligation was not clear. |
| **l** | In addition, some other contents may be added not contrary to the provisions of the law | UNAIDS<br>• Dien Bien province contracts included an Annex for reporting requirements. |

**Form 3 is ordered according to the Vietnamese alphabet.*

# ANNEX H. IMPLEMENTATION RESULTS: TARGETS AND ACHIEVEMENTS ACCORDING TO INDICATORS

| No | Province | SO | | Service Package | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 1a+1b+1c | 1d | 2a | 2b | 3a | 3b | 4a | 4b |
| | | | | Package 1. # of clients received condoms, lubricants, needles, and syringes | Package 1d # of clients receiving needles and syringes and sent for MMT treatment | Package 2a. # of clients tested for HIV (non-reactive) | Package 2b. # of HIV-reactive clients successfully referred to confirmation testing | Package 3a. # of HIV-positive cases successfully referred to ART | Package 3b. # of clients received ART treatment adherence support within the first three months | Package 4a. # of negative testing clients successfully referred to PrEP treatment | Package 4b. # of clients received PrEP treatment adherence support within the first three months |
| 1 | Dien Bien | Binh Minh | **Package 1 + Package 2** | | | | | | | | |
| | | | **1st Contract: Contract Duration: 09/13/2022–02/13/2023** | | | | | | | | |
| | | | Contract Target | 81 | 4 | 69 | 1 | - | - | - | - |
| | | | Result | 46 | 7 | 48 | 5 | - | - | - | - |
| | | | % Target Achieved | 56.8 | 175.0 | 69.6 | 500.0 | - | - | - | - |
| | | | **2nd Contract: Contract Duration: 03/01/2023–11/30/2023** | | | | | | | | |
| | | | Contract Target | 64 | 18 | 82 | 4 | - | - | - | - |
| | | | Result | 46 | 19 | 66 | 6 | - | - | - | - |
| | | | % Target Achieved | 71.9 | 105.6 | 80.5 | 150.0 | - | - | - | - |
| | | Hoa Ban Trang | **Package 1 + Package 2** | | | | | | | | |
| | | | **1st Contract: Contract Duration: 09/13/2022–02/13/2023** | | | | | | | | |
| | | | Contract Target | 58 | - | 58 | 2 | - | - | - | - |
| | | | Result | 53 | - | 53 | 1 | - | - | - | - |
| | | | % Target Achieved | 91.4 | | 91.4 | 50.0 | - | - | - | - |
| | | | **2nd Contract: Contract Duration: 03/01/2023–11/30/2023** | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Contract Target | 98 | - | 138 | 6 | - | - | - | - |
| | | | Result | 75 | - | 82 | 7 | - | - | - | - |
| | | | % Target Achieved | 76.5 | | 59.4 | 116.7 | - | - | - | - |
| | | **Huong Duong** | **Package 1 + Package 2** | | | | | | | | |
| | | | **1st Contract: Contract Duration: 09/13/2022–02/13/2023** | | | | | | | | |
| | | | Contract Target | 69 | 4 | 69 | 1 | - | - | - | - |
| | | | Result | 63 | 7 | 63 | 1 | - | - | - | - |
| | | | % Target Achieved | 91.3 | 175.0 | 91.3 | 100.0 | - | - | - | - |
| | | | **2nd Contract: Contract Duration: 03/01/2023–11/30/2023** | | | | | | | | |
| | | | Contract Target | 114 | 20 | 96 | 4 | - | - | - | - |
| | | | Result | 64 | 17 | 52 | 5 | - | - | - | - |
| | | | % Target Achieved | 56.1 | 85.0 | 54.2 | 125.0 | - | - | - | - |
| **2** | **Hai Phong** | **6 Colors** | **Package 2+3+4** | | | | | | | | |
| | | | **Contract Duration: 05/04/2023–09/30/2023** | | | | | | | | |
| | | | Contract Target | - | - | 700 | 26 | 24 | 24 | 180 | 120 |
| | | | Result | - | - | 135 | 5 | 5 | 3 | 3 | 1 |
| | | | % Target Achieved | - | - | 19.3 | 19.2 | 20.8 | 12.5 | 1.7 | 0.8 |
| **3** | **Binh Duong** | **Youth Link** | **Package 2+3+4** | | | | | | | | |
| | | | **Contract Duration: 07/24/2023–09/30/2023** | | | | | | | | |
| | | | Contract Target | - | - | 250 | 26 | 24 | 24 | 46 | 46 |
| | | | Result | - | - | 250 | 26 | 24 | 24 | 46 | 19 |
| | | | % Target Achieved | - | - | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 41.3 |
| **4** | **Kien Giang** | **The Sun Vietnam** | **Package 2+3+4** | | | | | | | | |
| | | | **Contract Duration: 05/23/2023–03/31/2024** | | | | | | | | |
| | | | Contract Target | - | - | 475 | 25 | 25 | 25 | 40 | 40 |
| | | | Result | - | - | 402 | 25 | 25 | 25 | 40 | 19 |
| | | | % Target Achieved | - | - | 84.6 | 100.0 | 100.0 | 100.0 | 100.0 | 47.5 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **5** | **Can Tho** | **Glink Can Tho** | **Package 2+3+4** | | | | | | | |
| | | | **Contract Duration: 06/19/2023–12/31/2023** | | | | | | | |
| | | | Contract Target | - | - | 380 | 20 | 20 | 20 | 55 | 55 |
| | | | Result | - | - | 522 | 27 | 26 | 25 | 72 | 71 |
| | | | % Target Achieved | - | - | 137.4 | 135.0 | 130.0 | 125.0 | 130.9 | 129.1 |
| **6** | **Dong Nai** | **Hung Vu** | **Package 2+3+4** | | | | | | | |
| | | | **1st Contract: Contract Duration: 06/20/2022–12/30/2022** | | | | | | | |
| | | | Contract Target | - | - | 138 | 12 | 12 | 12 | 30 | 30 |
| | | | Result | - | - | 126 | 12 | 10 | 10 | 30 | 30 |
| | | | % Target Achieved | - | - | 91.3 | 100.0 | 83.3 | 83.3 | 100.0 | 100.0 |
| | | | **2nd Contract: Contract Duration: 03/27/2023–09/30/2023** | | | | | | | |
| | | | Contract Target | - | - | 207 | 18 | 18 | 18 | 24 | 24 |
| | | | Result | - | - | 200 | 18 | 18 | 18 | 24 | 22 |
| | | | % Target Achieved | - | - | 96.6 | 100.0 | 100.0 | 100.0 | 100.0 | 91.7 |
| | | **Xuan Hop** | **Packages: 03 (Package 2+3+4)** | | | | | | | |
| | | | **Contract Duration : 03/20/2023–09/30/2023** | | | | | | | |
| | | | Contract Target | - | - | 207 | 18 | 18 | 18 | 24 | 24 |
| | | | Result | - | - | 191 | 18 | 17 | 17 | 24 | 24 |
| | | | % Target Achieved | - | - | 92.3 | 100.0 | 94.4 | 94.4 | 100.0 | 100.0 |
| **7** | **Tay Ninh** | **Tay Ninh Pride** | **Package 2+3+4** | | | | | | | |
| | | | **1st Contract: Contract Duration: 06/20/2022–09/30/2022** | | | | | | | |
| | | | Contract Target | - | - | 247 | 20 | 20 | 20 | 20 | 20 |
| | | | Result | - | - | 267 | 20 | 20 | 20 | 30 | 18 |
| | | | % Target Achieved | - | - | 108.1 | 100.0 | 100.0 | 100.0 | 150.0 | 90.0 |
| | | | ***2nd Contract: Contract Duration: 04/01/2023–09/30/2023*** | | | | | | | |
| | | | Contract Target | - | - | 640 | 60 | 60 | 60 | 60 | 60 |
| | | | Result | - | - | 312 | 28 | 25 | 24 | 35 | 26 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | % Target Achieved | - | - | 48.8 | 46.7 | 41.7 | 40.0 | 58.3 | 43.3 |
| **8** | **Tien Giang** | **Niem tin song Tien** | **Package 2+3+4** | | | | | | | | |
| | | | **Contract Duration: 10/01/2022–09/30/2023** | | | | | | | | |
| | | | Contract Target | - | - | 468 | 36 | 36 | 36 | 36 | 36 |
| | | | Result | - | - | 484 | 36 | 36 | 29 | 36 | 28 |
| | | | % Target Achieved | - | - | 103.4 | 100.0 | 100.0 | 80.6 | 100.0 | 77.8 |

**1a /*1b /*1c (new clients recorded).*

*CDC in Dien Bien province were asked to review their results, as numbers supplied by the CDC in interim reports were inconsistent between narrative and tabled data, however, no update was received by the evaluation team.*

*Source: CDC data.*

*Results to March 29, 2024.*

*Nghe An province data not included.*

*Binh Duong province was last to commence implementation in July 2023, and Hai Phong City in May 2023.*

# ANNEX I. RESULTS OF OW QUESTIONNAIRE BY VARIABLE FOR INDIVIDUAL PROVINCES (% ROUNDED UP)

| OW per province (46) | 3 | 4 | 6 | 6 | 3 | 14 | 7 | 3 |
|---|---|---|---|---|---|---|---|---|
| **Variables** | **Tay Ninh** | **Binh Duong** | **Dong Nai** | **Tien Giang** | **Hai Phong** | **Dien Bien** | **Can Tho** | **Kien Giang** |
| Organization /management/ coordination | 67% | 86% | 88% | 76% | 71% | 86% | 41% | 43% |
| Capacity building /Technical support | 68% | 85% | 85% | 80% | 79% | 91% | 91% | 99% |
| Results/outcomes | 61% | 83% | 89% | 74% | 73% | 88% | 88% | 74% |
| Implementation processes | 57% | 86% | 90% | 79% | 86% | 95% | 86% | 95% |
| Finance /budget | 65% | 70% | 89% | 67% | 76% | 90% | 80% | 81% |
| Policy/Guidelines | 57% | 77% | 91% | 81% | 70% | 93% | 86% | 92% |

## ANNEX J. DISBURSEMENT BY PROVINCE / SOCIAL ORGANIZATION (3/29/2024)

Nghe An provincial data is not included.

| | Province | SO | First contracts(VND) | | | Second contracts ((VND) | | | Total (VND) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Total contract value | Disbursement | % | Total contract value | Disbursement | % | Total contract value | Disbursement | % |
| | Dien Bien | *Hoa Ban Trang* | 61.026.696 | 40.225.734 | 65.9% | 139.370.798 | 111.848.598 | 80.3% | 200.397.494 | 152.074.332 | 75.9% |
| 1 | | *Huong Duong* | 71.890.368 | 52.770.408 | 73.4% | 121.290.000 | 77.761.704 | 64.1% | 193.180.368 | 130.532.112 | 67.6% |
| | | *Binh Minh* | 59.408.326 | 34.505.231 | 58.1% | 74.694.182 | 50.790.386 | 68.0% | 134.102.508 | 85.295.617 | 63.6% |
| 2 | Can Tho | *Glink* | 190.866.490 | 190.507.000 | 99.8% | | | | 190.866.490 | 190.507.000 | 99.8% |
| 3 | Binh Duong | *Youth Link* | 81.110.000 | 79.870.000 | 98.5% | | | | 81.110.000 | 79.870.000 | 98.5% |
| 4 | Hai Phong | *6 Colors* | 203.401.366 | 30.193.935 | 14.8% | | | | 203.401.366 | 30.193.935 | 14.8% |
| 5 | Dong Nai* | *Xuan Hop* | 72.874.332 | 68.868.671 | 94.5% | | | | 72.874.332 | 68.868.671 | 94.5% |
| | | *Hung Vu* | 69.209.584 | 47.917.712 | 69.2% | 72.874.332 | 67.363.048 | 92.4% | 142.083.916 | 115.280.760 | 81.1% |
| 6 | Kien Giang | *The Sun Vietnam* | 152.731.595 | 132.330.252 | 86.6% | | | | 152.731.595 | 132.330.252 | 86.6% |
| 7 | Tay Ninh | *Tay Ninh Pride* | 129.021.140 | 80.265.837 | 62.2% | 233.048.180 | 102.554.550 | 44,0% | 362.069.320 | 182.820.387 | 50.5% |
| 8 | Tien Giang | *Niem tin song Tien* | 160.823.952 | 158.442.970 | 98.5% | | | | 160.823.952 | 158.442.970 | 98.5% |

*Source: Provincial CDCs combined monthly reports*

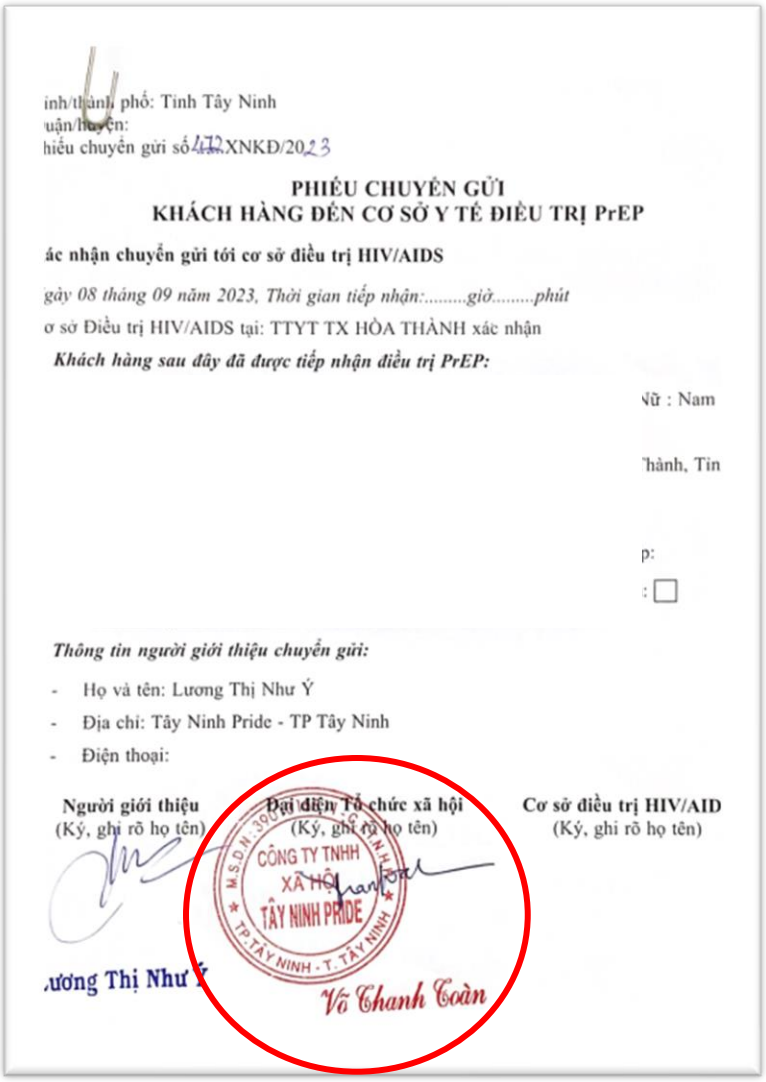
# ANNEX K. CAPACITY BUILDING OF CDC AND SO

| No | Training needs | | Status |
|---|---|---|---|
| | Topics | Participants | |
| Can Tho | Orientation workshop | CDC leaders, focal officers, technical and financial officers<br>Representatives of relevant departments | Completed |
| | Meeting to agree on procurement steps and support procurement implementation<br>Management | CDC staff | Completed |
| | Training on Monitoring, Evaluation, and Contract Management | CDC staff and SO | Completed |
| | Training on KP-Elog | CDC staff and SO | Completed |
| | Workshop on updating the revised HIV/AIDS Law | CDC staff and SO | Completed |
| Dong Nai | Workshop on updating the revised HIV/AIDS Law | CDC staff | Completed |
| | Integrate gender communication for students at secondary schools, high schools, and vocational schools | CDC, students at secondary schools, high schools, and vocational schools | Completed |
| Tay Ninh | Workshop on updating the revised HIV/AIDS Law | CDC staff | Completed |
| | Training on Gender and Inclusion | CDC staff | Completed |
| | Training on Planning Skills | Leader and staff of HIV/AIDS Dept | Completed |
| | Epidemiological data analysis skills | Leader and staff of HIV/AIDS Department | Completed |
| | Training in HIV Testing, Counseling, and Methadone Treatment | CDC's Staff | Completed |
| | Training on Bidding | Procurement staff | Completed |
| Tien Giang | Training on Gender and Inclusion | Staff of CDC | Completed |
| | Training on Accounting | Staff of HIV/AIDS Department | Completed |
| | Training on Bidding | Leader of CDC, staff in charge of social contracting and procurement | Completed |
| Kien Giang | Orientation workshop | Leader of CDC, staff in charge of social contracting and finance.<br>Representatives of Provincial Departments | Completed |
| | Meeting to agree on procurement steps and support procurement implementation | Staff of CDC and SO | Completed |
| | Training on Monitoring, Evaluation, and Contract Management | Staff of CDC and SO | Completed |
| | Training on KP-Elog | Staff of CDC and SO | Completed |
| | Training on Gender and Inclusion | Staff of CDC and SO | Completed |
| | Workshop on updating the revised HIV/AIDS Law | Staff of CDC and SO | Completed |
| | Training on Continuous Quality Management | Staff of CDC and SO | Completed |
| Binh Dương | Support two SEs in bidding, writing technical proposals, and financial reports | SO | Completed |

| | | | |
|---|---|---|---|
| Hai Phong | Support TCSO to establish legal status for | SO | Completed |
| | Training on Bidding and Taxes | SO | Completed |
| Đien Bien | Training for CDC staff on steps to implement social activities | CDC staff | Completed |
| | Training on Capacity Building and Service Delivery Processes | SO | Completed |
| | Training on updating the revised HIV/AIDS Law | CDC and SO | Completed |
| | Organize study tours | CDC | Completed |
| | Workshop to share experiences, advantages, and disadvantages of units: | CDC | Completed |
| | Accompany and guide the province whenever encountering difficulties in implementation—the project supports guidance on the web-based reporting system construction | CDC | Completed |

## ANNEX L. PATIENT REFERRAL FORM REQUIRING THE SIGNATURE OF THE SO DIRECTOR

This is not a requirement in the VAAC guidelines



inh/thành phố: Tỉnh Tây Ninh
uận/huyện:
hiếu chuyển gửi số 472/XNKĐ/2023

**PHIẾU CHUYỂN GỬI**
**KHÁCH HÀNG ĐẾN CƠ SỞ Y TẾ ĐIỀU TRỊ PrEP**

**ác nhận chuyển gửi tới cơ sở điều trị HIV/AIDS**

*gày 08 tháng 09 năm 2023, Thời gian tiếp nhận:.....giờ.....phút*

ơ sở Điều trị HIV/AIDS tại: TTYT TX HÒA THÀNH xác nhận

***Khách hàng sau đây đã được tiếp nhận điều trị PrEP:***

ữ : Nam

hành, Tin

p:

:

***Thông tin người giới thiệu chuyển gửi:***

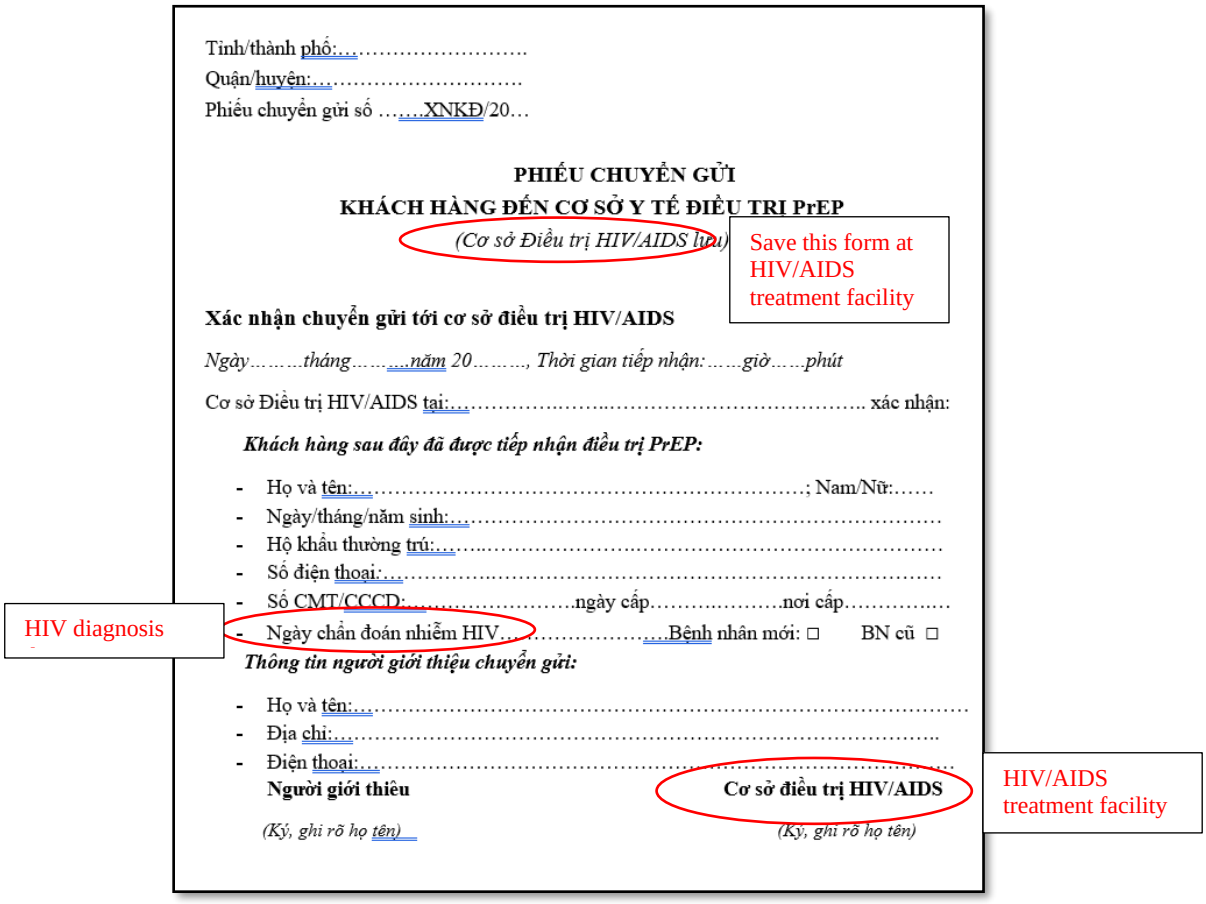
- Họ và tên: Lương Thị Như Ý
- Địa chỉ: Tây Ninh Pride - TP Tây Ninh
- Điện thoại:

| Người giới thiệu | Đại diện Tổ chức xã hội | Cơ sở điều trị HIV/AID |
|---|---|---|
| (Ký, ghi rõ họ tên) | (Ký, ghi rõ họ tên) | (Ký, ghi rõ họ tên) |
| ương Thị Như Ý | CÔNG TY TNHH XÃ HỘI TÂY NINH PRIDE<br>M.S.D.N: 3900...<br>TP. TÂY NINH - T. TÂY NINH<br>Võ Thanh Toàn | |

# ANNEX M. CLIENT REFERRAL FORM TO PREP TREATMENT CLINICS

According to VAAC guidelines.

*Recommend "HIV/AIDS treatment facility" to be replaced with "PrEP treatment facility;" "HIV diagnosis date" should be removed.*



Tỉnh/thành phố:…….

Quận/huyện:…….

Phiếu chuyển gửi số ……XNKĐ/20…

**PHIẾU CHUYỂN GỬI**

**KHÁCH HÀNG ĐẾN CƠ SỞ Y TẾ ĐIỀU TRỊ PrEP**

*(Cơ sở Điều trị HIV/AIDS lưu)*

Save this form at HIV/AIDS treatment facility

**Xác nhận chuyển gửi tới cơ sở điều trị HIV/AIDS**

*Ngày……tháng……năm 20……, Thời gian tiếp nhận:……giờ……phút*

Cơ sở Điều trị HIV/AIDS tại:…….. xác nhận:

***Khách hàng sau đây đã được tiếp nhận điều trị PrEP:***

- Họ và tên:…….; Nam/Nữ:……
- Ngày/tháng/năm sinh:……
- Hộ khẩu thường trú:……
- Số điện thoại:……
- Số CMT/CCCD:……ngày cấp……nơi cấp……
- Ngày chẩn đoán nhiễm HIV……Bệnh nhân mới: ☐ BN cũ ☐

HIV diagnosis

***Thông tin người giới thiệu chuyển gửi:***

- Họ và tên:……
- Địa chỉ:……
- Điện thoại:……

**Người giới thiệu**

*(Ký, ghi rõ họ tên)*

**Cơ sở điều trị HIV/AIDS**

*(Ký, ghi rõ họ tên)*

HIV/AIDS treatment facility

## ANNEX N. INTERVIEW ASSESSMENT SCORES FROM PROVINCIAL RESPONDENTS

Assessment questions

1. Did you receive the questions for the interview/discussion at least 24 hours prior to the interview?
2. Did the interview/discussion take place as announced /kept within the timeframe?
3. Do you understand what this assessment is about?
4. Were the discussions helpful?
5. Were the questions appropriate?
6. Is it better to do online interviews/discussions (e.g., via Zoom, teams, etc.)?
7. Is it better for face-to-face interviews/discussions?
8. Did you provide the review team with the information they requested in advance?

| 114 | 8 | 11 | 22 | 15 | 8 | 16 | 12 | 10 | 12 | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Question** | **Hai Phong** | **Tien Giang** | **Dien Bien** | **Dong Nai** | **Kien Giang** | **Can Tho** | **Binh Duong** | **Tay Ninh** | **Nghi An** | **Average** |
| 1 | 9.13 | 8.45 | 9.91 | 9.33 | 7.38 | 9.44 | 8.92 | 8.90 | 9.25 | 8.97 |
| 2 | 9.63 | 8.73 | 9.82 | 9.40 | 10.00 | 9.69 | 9.17 | 9.90 | 9.42 | 9.53 |
| 3 | 9.63 | 8.91 | 9.82 | 9.53 | 9.75 | 9.69 | 9.25 | 9.80 | 9.75 | 9.57 |
| 4 | 9.63 | 9.09 | 9.82 | 9.47 | 10.00 | 9.75 | 9.17 | 9.80 | 9.75 | 9.61 |
| 5 | 9.50 | 9.18 | 9.68 | 9.53 | 9.75 | 9.38 | 9.17 | 9.90 | 9.67 | 9.53 |
| 6 | 6.75 | 7.27 | 5.27 | 6.93 | 6.00 | 5.13 | 6.75 | 8.00 | 6.67 | 6.53 |
| 7 | 9.50 | 9.09 | 9.86 | 9.53 | 9.75 | 9.75 | 9.25 | 9.80 | 9.67 | 9.59 |
| 8 | 9.75 | 8.45 | 9.18 | 7.67 | 8.13 | 6.31 | 7.83 | 9.00 | 9.58 | 8.43 |

**Evaluation forms from central (MOH and development partners) not supplied.*

# ANNEX O. SUMMARY OF FINDINGS AND RECOMMENDATIONS

| Findings | Recommendations |
|---|---|
| **Objective 1: To evaluate the operational and services delivery progress and results.** | |
| CDC and SO benefited from the procurement process, and CDC became more competent in managing the government procurement process to engage SO.<br>Current situation<br>• SO must be legal entities (social enterprises) before they can apply for and access government procurement.<br>• Purchase orders can only be used between government agencies.<br>• The pilot has an exemption for CDC to use purchase orders to engage SO, including SO that are not legal entities.<br>• For this period, this applied to three non-legal SO in Dien Bien province only. | • VACC: Advocate to revise Decree 32/2019/ND-CP to<br>o Expand the scope of eligibility to include non-public administrative units (e.g., SO);<br>o Allow bidding method to be used for procurement of preventive and primary health care services.<br>• VAAC: Continue to support provinces in implementing the social contracting pilot.<br>• International development partners: Continue to provide financial and technical support for the social contracting pilot.<br>• CDC: Focus the procurement process on the government bidding process as this will be the required method in the future.<br>• CDC: Improve the capacity of CDC and SO on service procurement (e.g. bidding) |
| CDC and SO are familiar with procurement and payment schemes using the state budget, particularly in the use of purchase orders.<br>Only two locations used the government bidding process to engage SO: Nghe An* and Binh Duong provinces but there were considerable implementation delays.<br>* Nghe An province commenced the social contracting pilot in 2018 and ended in September 2023, prior to the mid-term assessment | • CDC: Increase familiarity with the government bidding process to engage SO.<br>• SO: Build capacity to finalize registration in accordance with regulations, to be eligible to participate in future social contracting exercises financed via the state budget.<br>• SO: Improve capacity in bidding, negotiating contracts, reporting, and financial and tax regulations. |
| Fewer steps for approval using the government system (Dien Bien Province) made the payment process more efficient compared to other provinces. | • CDC: Maintain efficiencies in verification and processing of payments |
| **Objective 2: To identify challenges and recommend interventions to improve the pilot implementation and results for the remaining period (ending September 2024)** | |
| Multiple forms needed to be completed to report on activities delivered. | • VAAC: Standardize the case verification process, especially for harm reduction packages and HIV+ clients that re-locate from other provinces.<br>• CDC: Reduce paperwork for verification and reporting.<br>• CDC: Ensure the reporting system is consistent between the web-based reporting system and other systems. |
| Supply of a national ID is necessary to receive government funded services in Viet Nam however interpretation of this requirement by CDC can affect recruitment of key populations for HIV testing and support services.<br><br>Clients expect confidentiality and did not want their personal details supplied to third parties (e.g. health center staff who contact them directly as part of the verification process). | • VAAC: Consider using a UIC to encourage clients to use HIV testing and support services.<br>• VAAC: Review verification methods by third parties.<br>• |
| Procurement of HIV RDT and commodities was completed by CDC (only Dien Bien province) or by SO.<br><br>HIV tests and commodities were not verified by CDC for quality (DAV registration, expiry dates etc.)<br><br>Dien Bien province experience an extended delay in procuring HIV RDT and commodities because the | • CDC: Ensure SO procurement of HIV RDT and commodities are according to CDC specifications and provide evidence for verification.<br>• CDC: Improve efficiency of planning and approval processes for CDC procurement of commodities.<br>• CDC: Ensure adequate stockpiling of RDT and commodities. |

| | |
|---|---|
| CDC used the government (online) bidding process to respond to bid. | |
| Advanced payments under the government procurement system were helpful to SO<br><br>Inexperienced SO in Dien Bien province appreciated the advanced payment (30%) to cover start-up costs to begin delivering services.<br><br>Advanced payments could not be used in other provinces as part of US.CDC/EPIC or USAID/EpiC supported projects. | • VAAC: Consider advanced payments in the future. |
| The process for issuing PE certificates to OW was inconsistent across all provinces. | • CDC: Streamline and make consistent, the provincial policies to issue PE certificates to OW |
| Clients were not always aware of the services available through the pilot. | • CDC: Establish communication strategies within the pilot to encourage demand |
| CDC used purchase orders to engage SO because they were easier and faster than the bidding process, although this means most SO and CDC have not gained any experience during the pilot in the government bidding process. | • VAAC: Ensure ongoing training in government bidding process to SO and CDC.<br>• SO: Improve capacity in bidding, negotiating contracts, reporting, and financial and tax regulations. |
| SO requested support to become legal entities and training in business management. | • VAAC: Continue with capacity building and TA supplied by UNAIDS/VAAC and other partners as part of training plan. |
| Data inconsistent in reports supplied to pilot and to VAAC | • CDC: Give greater attention to detail in M&E verification and compiling reports as this is critical to making correct payments. |
| Targets were generally achievable but should be increased as SO become more experienced. | • VAAC: Request provinces to update data on the web-based reporting system so VAAC can closely monitor the progress of pilot implementation and offer timely support.<br>• CDC: Consider not including maximum targets in the contract and instead specify budget ceiling.<br>• CDC: Review achievable target to meet 80 percent within the duration of the contract and recommend not to use maximum targets in contracts. |
| **Objective 3 To assess the relevance and feasibility of the VAAC guidelines for implementing the social contracting pilot to inform and necessary adaption** | |
| The VAAC guidelines supplies information to new clients but not for maintenance clients, which can impact the M&E and payment.<br>• | • VAAC: Standardize the PrEP referral form (HIV treatment facility information, date of HIV diagnosis)<br>• VAAC: Provide additional information for ARV and PrEP treatment adherence clients, and maintenance information for harm reduction /MMT adherence clients |
| CDC completed desk review on achievements of SO activities but did not consistently review the quality of services delivered on-site by SO. | • VAAC: Ensure guidelines are explicit on how to assess quality-of-service delivery.<br>• CDC: Strengthen the monitoring of service quality in addition to monitoring achieved targets.<br>• SO: Require outreach workers to provide service packages according to quality standards described in VAAC guidelines. |
| Contract type and contents varied across all provinces, but all were without standard clauses to reduce risk.<br><br>The contracts conformed with the contract outline (Form 3 Article 1) in the VAAC guidelines (according to Decree 32) but were inconsistent in content because there was no template, and clauses were left to individual CDC. | • VAAC: Consider developing recommended clauses for contracts, for example:<br>• Include taxes obligations, bonus/penalty terms (minimum quota), obligation to provide harm reduction commodities and test kits, contract based on fixed unit price not lump-sum, and to offer terms for advanced payment.<br>• CDC: Include standard clauses in contracts |

| | |
|---|---|
| Process related to adherence (HIV /PREP /MMT) was not included in VAAC guidelines and caused issues for payment.<br><br>PrEP form incomplete.<br><br>Limited details in guidelines to assess quality of service delivery by SO<br><br>SO reported extra time needed for service delivery. | VAAC: Provide guideline amendments<br>• VAAC: Provide additional information for ARV and PrEP treatment adherence, and harm reduction information for MMT adherence.<br>• VAAC: Revise the PrEP referral form (HIV treatment facility information, date of HIV diagnosis)<br>• VAAC: Provide additional guidance on monitoring service delivery processes and quality for online services.<br>• VAAC: Consider adjusting technical and economic norms to match actual implementation. |
| HIV tests and commodities were not verified by CDC for quality (DAV registration, expiry dates etc.) | VAAC: For final assessment<br>• Review the choice of procurement method and procurer of HIV RDT and commodities and how quality assurance is verified. |
| Key population clients were not contacted for feedback or interview. | VAAC: for final assessment<br>• Collect direct client feedback. |
| Potential conflict for SO or OW implementing either US.CDC/EPIC or USAID/EpiC projects concurrently with the activities of the social contracting pilot, because it is unclear how the SO assigns target achievements to either pilot or project. | VAAC: for final assessment<br>• Confirm how SO assigns achievements by OW in pilot and if SO are also linked to a concurrent HIV prevention project |

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