Key population and local government-led social contracting in Vietnam: A pathway to expanding coverage of publicly-financed HIV services

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BACKGROUND

Social contracting (SC) can be an effective tool for sustaining key population (KP)-organization engagement in HIV service delivery as donor funding declines and domestic financing increases. International donor funding for Vietnam's HIV response decreased by approximately 20% from 2015 to 2018; this declining trend is expected to continue in coming years.[1] Therefore, exploring new options for publicly financing essential HIV prevention and control services is a high priority for the Ministry of Health's Vietnam Administration for HIV/AIDS Control.

A novel SC model was piloted in a high-HIV-burden province, Dong Nai (DN), by the local centers for disease control (DN-CDC) and a KP-led social enterprise (SE) with support from the USAID/PATH Healthy Markets (HM) project.

DESCRIPTION

DN-CDC and HM followed seven critical steps to pilot SC from April – October 2021.

01 Reviewed existing regulations on government of Vietnam (GVN) bidding, identified appropriate regulations to apply, and developed a pilot SC model.

02 Secured endorsement from the Vietnam Administration for HIV/AIDS Control (VAAC) for the proposed model.

03 Conducted rapid scoping of KP-SE clinics in DN to determine which had sufficient capacity to implement SC.

04 Identified Glink SE clinic as the sole group matching the requirements.

05 Held co-creation meetings between Glink and DN-CDC to agree on a service package, targets, budget and final contract aligning the capabilities of Glink with DN-CDC HIV service needs.

06 DN-CDC monitored performance and adapted targets as COVID-19 lockdowns were enforced from June – September.

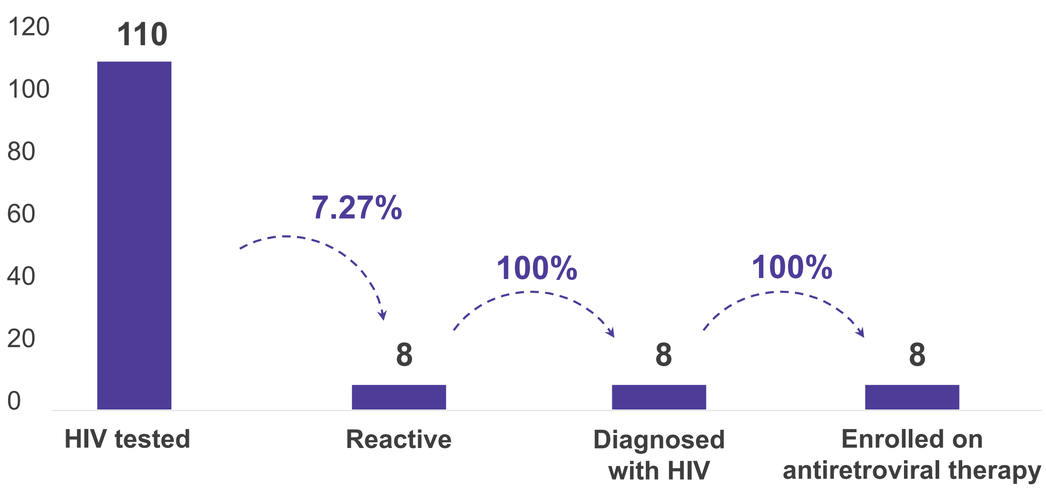
07 Identified key lessons to apply to national SC policy development.

LESSONS LEARNED

This pilot model showed strong results in terms of service delivery, demand generation, and health workforce capacity strengthening.

Service delivery: Glink reached 110 KPs for testing, with 8 newly diagnosed HIV positive (7.27% positivity yield) and 100% enrolled on antiretroviral therapy (ART) at public outpatient clinics (Figure 1).

Figure 1. HIV case finding and treatment cascade through social contracting model (June – October 2021).



Glink also delivered ART and adherence support to an additional 200 ART clients from the DN-CDC HIV treatment clinic.

Demand generation: Glink ran an online campaign on Google which generated 15,704 impressions and 1,804 clicks to service information on the search engine. Additionally, Glink organized 8 small group communications sessions on Zoom, reaching 240 attendees with information on HIV prevention and testing, self-care for sexual health, and guidance on how to use two HIV self-test products.

Capacity-strengthening: 14 public outpatient clinic health staff received training on effective communication with men who have sex with men and transgender communities.

Critically, this pilot generated a number of key learnings that are now being used to inform ongoing SC efforts. Key lessons learned include:

Glink clinic staff provides ARV drugs to client in quarantine. Photo: Glink Dong Nai.

- Securing strong VAAC and DN-CDC buy-in enabled rapid approvals and engagement.
- Identifying the right contracting mechanism up-front minimized implementation challenges.
- Focusing on trust generation between DN-CDC and Glink was essential for implementation.
- Enabling an adaptive approach by DN-CDC and Glink to rapidly respond to the lockdown helped change targets to meet real local needs, e.g., through increasing home/quarantine site delivery of ART and reducing reach and test targets.

> "We [Dong Nai CDC] have learned to use and allocate budget for the HIV/AIDS response, not only for public health facilities but also for private clinics and community-based organizations. This **will make service delivery more efficient and will support customers to have greater access to essential services** in the future."
>
> **– Dr. Vu Thanh Cong, HIV/AIDS Prevention Department, Dong Nai CDC**

CONCLUSIONS

This pilot provides essential learning to inform national HIV SC policies as a pathway for public-sector domestic financing of KP-led organizations. Key enablers for successful replication of this model in other contexts include strong interest, ownership, and openness to trying new things from the local government; endorsement from the Ministry of Health; respectful relationships between all stakeholders; and good capacity of the SE. Future efforts need to focus on securing ring-fenced domestic investment in SC and clear regulations for KP-organization SC.

References

[1] Ministry of Health, Vietnam Administration for HIV/AIDS Control. National Plan on HIV/AIDS Prevention and Control for the Period 2016-2020. Hanoi, Vietnam: 2015.
[2] PEPFAR/USAID/Sustainable Financing Initiative for HIV/AIDS. The sustainable financing initiative in Vietnam. Hanoi, Vietnam: 2018.