Summary of the 7th Multi-Country Network Meeting

Southeast Asia Stigma Reduction QI Learning Network

February 5-6, 2020
Bangkok, Thailand

Healthqual

UCSF

UCSF Institute for
Global Health Sciences

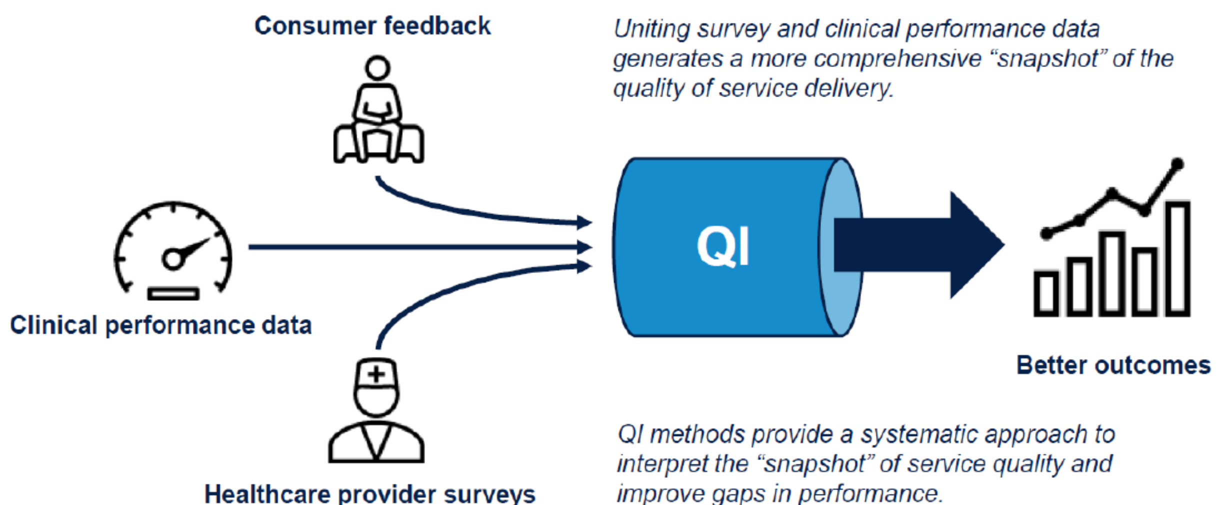
Executive Summary

Background

HIV-related stigma and discrimination (S+D) in the healthcare setting remains a formidable barrier to achievement of UNAIDS' 90-90-90 targets and optimal outcomes for people living with HIV (PLWH), and underscores a crucial need to develop and implement S+D-reduction interventions at scale. The Southeast Asia Stigma Reduction QI Learning Network was launched in 2017 by HEALTHQUAL in the Institute for Global Health Sciences at the University of California, San Francisco, initially with support from the Health Resources and Services Administration (HRSA) as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The aim of the Learning Network is to accelerate implementation of national- and facility-level HIV-related S+D reduction activities in Cambodia, Lao PDR, Thailand, and Viet Nam through routine measurement, quality improvement (QI) methods, and peer learning and exchange. By acting upon insights generated from routine analysis of healthcare provider survey data and patient feedback, anticipated outcomes of the initiative include creation of a regional community of practice in which implementation experiences are rapidly shared, generation and rapid scale-up of data-driven stigma-reduction interventions, reduction of HIV-related S+D in healthcare facilities, and improvements in care and treatment outcomes among PLWH. Funding through ViiV Healthcare and Gilead Sciences was secured to continue the work through 2020.

How data are used for QI in the Network

Uniting Data Streams to Improve Outcomes



Meeting Objectives

The 7th Multi-Country Network Meeting of the Southeast Asia Stigma Reduction QI Learning Network was convened on February 5-6, 2020, in Bangkok, Thailand, with attendees from national and provincial Ministries of Health, UNAIDS country offices, U.S. Centers for Disease Control and Prevention (CDC) country offices, civil society, and local implementing partners representing Cambodia, Lao PDR, Thailand, Vietnam, Malaysia, Philippines, and Indonesia (see **Appendix** for list of attendees). The objectives of the meeting were to:

- Present country-specific updates on implementation of S+D QI activities, with a focus on how results of are being used to identify effective S+D QI interventions and approaches.
- Discuss successes and challenges related to implementation of QI activities to reduce S+D.
- Report progress on use of Network's common suite of clinical questions to assess patient-level treatment literacy and linkages to UNAIDS' 90-90-90 targets.
- Introduce methods of measuring patient experience via Journey Mapping
- Present examples of Friendly Clinic models to reduce S+D and improve retention and health outcomes.
- Present examples of evaluation of S+D QI activities

Meeting Themes/Highlights

- A presentation from Eamonn Murphy, Director of the UNAIDS Regional Support Team for Asia and the Pacific, describing the importance of the UNAIDS Global Partnership For Action To Eliminate All Forms of HIV-Related Stigma and Discrimination (begun in 2018) and the UNAIDS Regional Office partnership with UCSF to scale-up initiatives like the SE Asia S+D Reduction QI Learning Network which aligns with the Global Partnership [to move the work forward]. Mr. Murphy underscored that S+D reduction is rooted in human rights, with the voice of the patient the most important input we have for our work.
- Dr Agins reviewed the areas of improvement discussed at the 6th Multi-Country Network Meeting.
- Presentations from Ministries of Health in Cambodia, Lao PDR, Thailand, and Vietnam summarized findings from follow-up data collection and how results are being used to identify effective QI interventions. Country presentations also considered plans for scale up of S+D QI activities, and how findings from patient feedback and surveys of treatment literacy are being applied to drive development and promotion of people-centered service delivery.
- Presentations by Malaysia (MOH), UNICEF (China & Philippines), and FHI360 LINKAGES (Thailand) introduced friendly clinic models that are being implemented for youth and key populations (KP). These presentations highlighted the components of successful friendly clinics, whether KP-led or not, as well as the importance of measuring levels of stigma to monitor the effectiveness of KP friendly care.
- Dr. Jittima Manonai Bartlett of Mahidol University/Ramathibodi Hospital presented on methods of measuring patient experience based on her work at Ramathibodi Hospital. Group work focused on describing how improving patient experience can reduce S+D and improve retention in care. Dr. Jittima detailed how to use journey mapping to better understand patient experience and find opportunities for QI interventions.
- Ms. Benjamas Baipluthong of CDC-DGHT Thailand and Dr. Todd Pollack of HAIVN presented two models of evaluation of S+D activities in the respective countries. For Thailand, the evaluation focuses on development and implementation of the “3x4 Participatory Training Program” and the success of implementation and outcomes of S+D QI activities in healthcare facilities. For Vietnam, results of a pre- and post-QI intervention evaluation conducted in 10 facilities were presented, as well as a new study protocol with the goal of utilizing QI methodology to reduce key populations- (KP) and HIV-related S+D in healthcare facilities (including HIV testing and outpatient clinics) and improve treatment outcomes for PLHIV.
- Dr. Supunnee Jirijariyavej of Thaksin Hospital presented the Thai Disease Specific Certification program for hospitals and how it incorporates stigma reduction standards, monitoring, and QI.
- Dr. Anita Suleiman from Malaysia and Angelo Ramos of SHIP (Philippines) presented overviews of their countries’ progress towards 90-90-90 goals and S+D activities. Both countries are planning a design meeting as part of participation in the Network.
- UNAIDS and community representatives from Indonesia presented an overview of their HIV epidemic, current levels and causes of S+D towards persons living with HIV (PLWH), and interventions to address S+D.
- Dr. Bruce Agins presented two studies from the US showing differing outcomes based on increased levels of internalized stigma among PLWH, along with limitations of stigma-outcome literature. Dr. Agins also presented a method of how to teach the PDSA cycle.
- As of February 2020, there have been 11 rounds of healthcare worker survey data collection, with 13,850 respondents; 19 rounds of patient experience survey data collection (Cambodia uses a shorter data collection cycle), with 21,048 respondents; and 4 rounds of patient clinical literacy survey data collection in 3 countries, with 1,520 respondents. Please see the Implementation Progress charts in the Appendix for country-specific details. Note that Lao PDR has integrated the patient experience questions formally. Adaptations are undertaken in other countries, with integration into more extensive patient surveys.

Next Steps

The 8th Multi-Country Exchange Meeting will be convened in Q4 of 2020, aligned with the convening of the Asia Pacific AIDS & Co-Infections Conference, and will focus on the review of workplans and partnerships with community providers and PLWH. In the interim, UCSF-HEALTHQUAL and participating Ministries of Health will continue implementation of S+D QI activities through the following next steps.

UCSF-HEALTHQUAL will:

- Follow up with Ministries of Health on their implementation plans and provide technical support on S+D QI activities. Virtual meetings will be scheduled with country teams.
- Continue development and dissemination of Spotlights to showcase facility-level experiences implementing S+D QI activities.

Ministries of Health will:

- Continue implementation of S+D QI activities according to their workplans, including ongoing measurement and documentation of improvement interventions.
- Measure network-wide indicators on treatment literacy and patient experience.
- Scale-up and spread successful interventions and best practices that have shown to reduce S+D.
- Continue to harvest successful interventions and implementation approaches for presentation at the Network's 8th Multi-Country Network Meeting.

Acknowledgements

The Southeast Asia Stigma Reduction QI Learning Network is supported in part by ViiV Healthcare and Gilead Sciences. The contents are the sole responsibility of UCSF-HEALTHQUAL.

Welcoming Remarks

The meeting was officially opened by Dr. Bruce Agins, Director of UCSF-HEALTHQUAL. Dr. Agins extended an official welcome to representatives from Cambodia, Lao PDR, Thailand and Viet Nam, and commended the Ministry teams for their progress in implementing S+D QI activities, as well as delegates from Philippines and Malaysia, who are ready to convene design meetings, guests from Indonesia, now considering participation in the Network, and staff from UNAIDS, Australian Federation of AIDS Organisations, CDC Atlanta, ViiV Healthcare, Legal Aid Institute and GWL-INA (Indonesia), Malaysian AIDS Council, Sustained Health Initiatives of the Philippines and Philippines Society for Microbiology and Infectious Diseases, HAIVN and Hanoi Medical University, and LINKAGES/FHI 360 and APN+ (Thailand)

Dr. Agins reviewed the areas for improvement for the countries discussed at the previous Network meeting in September 2019:

- Measurement
  - Following country workplan to regularly collect data
  - SOP with methods for data collection to guide facilities: adapt and adjust for facility context and variations (e.g. large v. small); formally describe sampling method; include non-HIV clinic staff; detail service areas to target interventions where stigma is most common and encounters most frequent; benchmarking reports to show range of results across facilities to showcase high performers and guide TA where needed; longitudinal reporting - with attention to changes in denominators and facilities; communicate results to stakeholders and participants
- Patient experience and patient literacy
  - Patient experience: routine capture, describe and train on methodology and how to use qualitative data for QI, identify national successes and issues by analyzing cross-facility data
  - Patient literacy: routine capture, use, and sharing of data
- Quality Improvement
  - Documenting and sharing of changes and improvements
  - Identifying and sharing best practices

    - Plans for additional training, including PDSA and data use
    - Knowledge management and communication: sharing work across sites and provinces/states; involving provider associations; publishing work in journals and at conferences (APACC, AIDS2020)
- Program
    - Scale-up and spread; engagement of subnational level (region; province; district) private sector, professional societies
    - Routine involvement of civil society: QI training, participation in QI activities, feedback from community about healthcare facilities and care

Dr. Agins reviewed the agenda for both days and ended his remarks by highlighting the collaboration with UNAIDS who will have a regular presence in the Network and participate in planning and management.

UNAIDS Presentation

Presenter:
Mr. Eamonn Murphy
Director, Regional Support Team for Asia and the Pacific
UNAIDS

- Mr. Murphy stated that historically, stigma has been a recurrent issue Addressing stigma from inside and outside the system is important. The Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination was launched in December 2018 to build momentum to address the issue. The Global Partnership is co-convened by UNAIDS, together with UN Women, UNDP and GNP+.
- Additionally, the UNAIDS Regional office is partnering with UCSF to support the Southeast Asia HIV Stigma Reduction QI Learning Network, an initiative that brings together stakeholders to work towards stigma elimination. Quinten Lataire, the Human Rights and Law Advisor for the UNAIDS Regional Office, is the liaison to UCSF for the Network
- As health services become integrated, it is necessary to educate the entire health workforce regarding HIV. Separate HIV services and training focused only on HIV providers will not change attitudes system-wide. For example, in Thailand, Chiang Mai University has been introducing widespread training, starting with clinic guards through to clinical staff. Everyone is included and many of the Network countries have goals to target all elements of the health system and workforce.
- The UNAIDS Global Partnership is founded in human rights. Although there are new national laws and policies regarding stigma and discrimination, the preparedness of the legal systems in many countries is still a question. Countries need to turn promises into action. Although commitments have been signed, institutional discrimination still exists.
- Part of the commitment to human rights is universal healthcare. The Global Partnership is galvanizing national programs to address this longstanding issue. Industry and private insurers are part of the equation, but there is much work to be done.
- Another key human rights component is eliciting patient/client input to inform the work, including the voices of key populations. A feedback loop from the patient/client to those conducting the S&D reduction activities is critical.
- Country-level work is contextual among all stakeholders, but it is important that countries come together here as a Network to share and learn from each other.
- S&D cuts across all segments of society. For example, MOH Malaysia is making great statements about stigma that are not specific to health sector, which is key.
- Mr. Murphy ended his remarks by stating that the Global Partnership is important to success, and UNAIDS looks forward to partnering with UCSF to help move the work forward and grow. He offered the support of UNAIDS to any country for their S&D reduction efforts.

Country Presentations

Cambodia

Presenter:
Mr. Sophat Phal
Senior Program Manager
FHI 360 LINKAGES, Cambodia

- The third round of the healthcare worker (HCW) and non-healthcare worker S+D included 178 respondents. Results showed an improvement in 3 out of 4 questions asked about concerns of becoming infected through routine care given to PLWH, however there was a decrease in the belief that women living with HIV should be allowed to have babies.
- The third round of the Patient Satisfaction Feedback (PSF) survey was completed (n=1,948). Results continue to show strong satisfaction that the services are convenient and thorough, although wait times at clinic should be improved, and that services remain confidential. However, there was a trend in decreased satisfaction among patients regarding the confidentiality of services. The response rate for the PSF has trended lower in October-December, with under 300 respondents each month, compared to 300, 435, and 357 for July, August, and September
- QI activities implemented at sites include: Heatlh4All Training of Trainers (TOT) to hospital clinical staff and a step-down training to healthcare workers; meetings at each clinic led by the hospital director to share patient satisfaction feedback with healthcare providers and healthcare provider experience with patients convened by NCHADS in which action plans based on survey findings are developed. Meetings are convened for sharing of experiences among virally suppressed patients with those who have detectable viral loads. QI coaching provided by the AIDS Care, Research, and Data Management Units of NCHADS continues with support from US-CDC and LINKAGES.
- Next steps include the development of a PSF data management system using an online platform (April 2020); PSF questionnaires to be embedded with audio which allows patients who cannot read to provide their feedback (April 2020); a real-time dashboard will be available for every health facility based on the scope of access of each user account. ~~The~~ DHIS2 will be used for data consolidation and generate interactive dashboards. A formal SOP for PSF will be developed and disseminated and scale-up of PSF S+D QI activities is planned this year to non-PEPFAR supported sites in four provinces
- (Kampong Cham, Kampong Chhnang, Tboung Khmum, and Pailin province), including private-sector health facilities.
- The National Program includes SOPs for PSF, QI mentoring at clinic level, data quality assurance, with data collection instruments for the PSF, a dashboard for each ART site, and ongoing S+D assessments to inform ongoing improvement activities.

Viet Nam

Presenter:
Dr. Do Huu Thuy
Viet Nam Administration of HIV/AIDS Control
Ministry of Health, Viet Nam

- A new approach to measuring S+D is planned for the next round of data collection (Feb-April 2020). Questionnaires will be revised, with the HCW instrument augmented to include questions focusing on key population (KP)-related S+D, and the patient instrument to focus on S+D experienced when receiving services at the health facility. The patient instrument will also include specific questions about the service received (e.g., PrEP, HTC, ART), a focus on patient experience and literacy, and a quality of life scale. There are plans to pilot an online, self-administered patient questionnaire through REDCap in HCMC.

Country Presentations (continued)

Viet Nam (continued)

- QI coaching continues, both in-person and virtually. Improvement in rates of consented HIV testing were noted in Thai Nguyen following a series of interventions including training, SOP development, supervision and reminders.
- The successful CAB model, initially implemented in Binh Duong, is expanding. Capacity-building includes comprehensive training that focuses on HIV-related laws and services, basic HIV knowledge, QI and teamwork.
- In addition to the consumer advisory board (CAB) in Binh Duong province, a new CAB was established in Thai Nguyen province in December 2019 which includes 15 members from MSM, PWID, PLHIV, and self-help groups. It will start to support outpatient clinics (OPC) in February 2020. Activities of the Binh Duong CAB include: collecting feedback from patients at OPCs; supporting QI plan implementation on patient VL literacy and reducing medication wait times. Another CAB in Hai Phong Province is being planned.
- A comprehensive training is being developed to build capacity of CAB members for HIV prevention, care and treatment, services, and laws; quality improvement; and development of teamwork and communication skills.
- Piloting of the Community Score Card (CSC) has begun in Binh Doung. In January 2020, MOH staff met with the Binh Duong PAC, CAB, and community and health facilities to develop the set of indicators for CSC to be used. Scoring of service quality began soon after the meeting and facility action plans will be developed.
- A QI plan in Binh Duong to improve patients' treatment literacy resulted in improvements to patients knowing their viral load test results (from 70% to 84%) and the proper VL testing interval (from 30% to 61%). The QI plan included multiple interventions conducted by both HCWs and CAB members.
- An example of reducing waiting time for receiving medicine was presented in which dedicated staff time for this activity was reinforced by leadership.
- Treatment literacy results in Binh Duong improved in domains of knowing VL results and frequency of testing. Improvement plans to improve VL literacy included recommendations from providers and patients to educate patients on the benefits of VLS, explaining results to patients as part of routine care, educational brochures, posters, U=U messaging (K=K), and leadership involvement through reminding staff in meetings about the issue.
- National QI activities include a campaign focused on U=U, continued implementation of the MOH Directive No. 10 on S+D, continued activities to improve HCW sensitization of KP issues, and piloting a Friendly Clinic model in 2 provinces (Thai Nguyen and Hai Phong).

Lao PDR

Presenter:

Dr. Ketmala Banchongpanith, MD, MPH
Head of Management of HIV/AIDS and STIs Unit
Centre for HIV/AIDS and STIs
Ministry of Health, Lao PDR

- The fourth round of S+D monitoring data was completed January 2020 in 11 ART sites (N=1,100). The number of HCWs surveyed has increased with each round, including both HIV and non-HIV clinic staff from the entire healthcare facility. Doctors and nurses comprise >85% of the respondents.
- Results indicate loss of improvement gains from the third round, most likely reflecting the expansion of the survey to staff outside of the HIV clinic, but most indicators still show improvement from baseline. Since the fourth round was just completed, these data will be used by clinics to inform QI activities that address their lowered performance.

Country Presentations (continued)

Lao PDR (continued)

- Key qualitative feedback from providers regarding how to reduce S+D toward PLWH in healthcare settings and the community includes: increasing HIV knowledge across healthcare settings, government sectors, and in the community; joint activities between health staff, PLWH, and communities; multi-media campaigns targeting HIV S+D; and the development of standard S+D guidelines for all HIV and non-HIV healthcare facilities.
- Paper data collection forms were used for the fourth round which created challenges to sampling, data collection, and data entry. For subsequent rounds, MOH will explore resuming data collection with the REDCap system or possibly develop a mobile application as an alternative to paper forms.
- The second round of the patient experience survey (9 ART sites; n=331) showed scores above 97% on all questions, an improvement from the first round. Data collection for patient experience assessments is facilitated by peer PLWH at each site.
- The second round of the patient survey on treatment literacy was also conducted (8 ART sites (N=311). Results showed that of patients on ARV, 82.1% know their regimen (vs. 74.4% first round), however only 64.3% know what VL testing is (vs. 74.5% first round), and only 48.9% know when their next VL test should be scheduled, with 20% of those claiming that they were not informed by staff.
- NATIONAL QI ACTIVITIES: In November 2019, one hospital ART site completed the HIV training workshop, with most hospital staff and some PLWH peers participating. Additionally, CHAS conducted an S+D reduction workshop for the ART sites in the north, with staff and PLWH peers participating, and conducted QI coaching visits to all ART sites in December 2019.
- Next implementation steps by CHAS for the program include: continue the quarterly schedule of HCW and patient S+D survey data collection with post-analysis dissemination to ART sites; expand S+D activities to new “point of care” sites (e.g., medication pickup community sites); develop a S+D national guideline with technical support from UCSF; conduct TOT for S+D reduction QI activities; develop a S+D reduction change package for dissemination and encourage peer sharing of successful strategies; continue QI coaching to sites, with a refresher on the PDSA cycle; and mentor hospital-based QI focal persons to become regional QI coaches with possible further training depending on resource availability.
- National strategy and policy for S+D QI include integration of these activities into the MOH quality strategy of 5 Goods and 1 Satisfaction, development of a national S+D reduction change package for healthcare facilities, encouragement of subnational leaders in provinces to spread best practices for S+D, continue quarterly data collection of the patient experience, and creation of a QI coaching group to share experiences, strategies and foster peer learning to advance skills.

Thailand

Presenter:

Ms. Parichart Chantcharas
Division of AIDS and STIs, Department of Disease Control
Ministry of Public Health, Thailand

- Thailand has scaled-up S+D reduction QI activities from 3 provinces and 6 hospitals in Phase 1 (2017) to 70 provinces and 110 hospitals in Phase 3 (2019).
- The second round of data collection was completed in November 2018-April 2019, post-intervention, as a follow up to baseline data collected October 2017-July 2018. In total, 6,411 HCWs and 5,317 PLWH were surveyed across 48 participating hospitals. All staff from small hospitals were included. In large hospitals, all ART-related services staff and a simple random sampling of other staff were included.

Country Presentations (continued)

Thailand (continued)

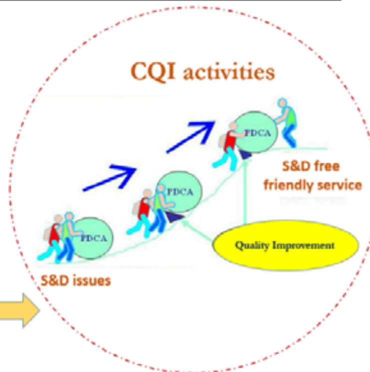
- Compared to baseline data, results of the second round showed decreases in the proportion of HCWs reporting fear of contracting HIV when drawing blood from a PLWH patient (57.1% vs. 50.2%), use of double gloves when providing care to PLWH (34.3% vs. 23.0%), observing colleagues providing poorer quality of care to PLWH (15.3% vs. 13.8%), and observing colleagues unwilling to care for PLWH (21.9% vs. 20.0%).
- Increases were shown in the proportion of HCWs agreeing that their facility has written guidelines to protect PLWH from discrimination (52.4% vs. 57.5%) and agreeing that women should be allowed to have babies if they wish (48.7% vs. 58.3%).
- Results showed larger improvements for all indicators in staff from small hospitals versus large, although the interventions did not necessarily target the entire staff, which affects the results.
- Findings from surveys of PLWH showed decreases in the proportion of respondents experiencing non-consensual disclosure of their HIV status in the last 12 months (14.6% vs. 9.1%), experiencing S+D related to sexual or reproductive health (11.0% vs. 7.3%), and experiencing any form of S+D in the healthcare setting (10.9% vs. 7.9%).

Graphic depicting Thai adaptation of QI methods to S+D Reduction

S&D CQI Intervention and Process in Health Facilities

S&D participatory training

1	increase S&D awareness & knowledge key drivers & its impacts.
2	challenge attitude towards PLHIV & KP understand feeling of being stigmatized
3	HIV transmission knowledge, fear of HIV-infection, Universal Precaution
4	identify existing S&D issues, analyses root causes, it's impact.
5	prioritize the identified S&D brainstorm on solution/ action plan



- A 7-point survey measuring patient experience of care provided in ARV clinics was conducted from August to November 2019 (n=333) in 4 hospitals. Although >95% of the patients responded "agree" or "strongly agree" to 6 of the 7 items asking if care was provided well in a welcoming, inclusive, and respectful manner, over 37% of the patients responded that they experienced some type discrimination from a HCW or staff member.
- 22 of 62 hospitals have completed a S+D participatory training with the aim of building capacity to initiate S+D reduction QI activities. The facilities which have completed the training have begun to address S+D issues in MCH and OR units, infection control practices, and confidentiality of HIV-specific patient information.
- An S+D QI TOT workshop planned for March 2020 in Samut Sonkram province. Objectives are to build capacity of the hospital team to use QI instruments for root cause analysis S+D and to facilitate and strengthen the QI infrastructure in health care facilities. The expected outcome is for participating facilities to become models for implementing and using QI instruments for S+D reduction. The workshop will focus on: 1) QI concepts and instruments for S+D reduction; 2) building capacity for "deep listening" as a tool for patient journey mapping and QI; 3) how to identify and prioritize S+D issues and move into the QI process; 4) developing a S+D QI action plan based on supporting data, with a clear timeframe, roles for staff, and an M&E plan.
- A review of 48 hospitals showed CQI activities had progressed to an advanced level in 7 facilities, with 19 at a basic level, and that 22 were just beginning. Analysis was conducted through review of progress reports, CQI storytelling in the hospital, documentation of lessons learned, phone interviews and Line group discussions.
- QI areas of focus have included infection control and prevention practices, avoidance of segregation of patients and beds, avoidance of labeling and heightened privacy.
- Phon Phisai Hospital (Nong Khai Province), one of the 48 participating hospitals, won first prize for Routine To Research 2019 for their research on improving health literacy among village health volunteers to reduce S+D towards PLWH in the community. The study was conducted among 16 villages in the Wat Luang Sub-district, Phon Phisai District, Nong Khai Province.

Country Presentations (continued)

Thailand (continued)

- Gaps for implementation that require further training include guidance on root cause analysis and how to independently identify QI projects based on local context. Strategies to improve QI implementation include integration of coaching with the DSC and HA systems, modification of the report forms, inclusion in the hospital report form and developing a “code of practice” of successful S+D QI interventions health care facilities can choose from, with a standardized template for documentation of the implementation process and results.
- Of note, the S+D CQI Implementation Report Form for Hospitals will be modified to document number of training participants, activities implemented by the hospital, and capturing implementation of patient experience assessments.
- To address uptake of S+D QI activities in all healthcare facilities, MOPH is implementing the national S+D QI strategy and policy that includes a monitoring plan, focused S+D QI coaching, revising survey forms, and developing an implementation manual and activity instrument for S+D QI. Other national strategies include integrating S+D QI in disease specific certification (DSC) and HIV national standards/guidelines, revision of health literacy guidance to include KP and S+D, launch an S+D e-learning platform, use M&E data for S+D program planning, and conduct an evaluation of S+D activities, including QI. Additional next steps include using patient journey mapping and self-stigma reduction activities to improve services, conduct the workshop to build capacity for S+D QI (March 2020), continued documentation of interventions and lesson learned (including hospital code of practice), continued data collection for long-term, post-intervention results, and conduct a S+D CQI Lessons Learned Workshop.

Malaysia

Presenter:
Dr. Anita Suleiman
Head of HIV/STI/Hepatitis C Section
Ministry of Health, Malaysia

- Malaysia is on track with the first and third 90s (86% and 96%), but behind on the second 90 (55%), with stigma experienced in health care facilities and internal stigma both contributing to the low ART rate.
- A formal expansion of S+D reduction activities, evolving from the Health Center and KP Friendly Clinic models and the HOPE Module, to specifically focus on the use of QI methodology with the aim of scaling up ART coverage is underway. Subsequent to Malaysia’s participation in the 6th Network meeting in September 2019, informal exploration talks between the Institute of Health systems Research (IHSR), the MOH unit which oversees the national quality program, CBOs, and state technical staff took place in late 2019 to design the structure of the initiative. In December, the team developed a concept note describing the methodology, identifying sites and collaborators.
- The Design Meeting will be conducted February 2020 with participation from UCSF and UNAIDS. 12 health facilities (a mix of clinics and hospitals) from six states have been identified to participate in the first phase. IHSR will conduct QI training to build capacity in the participating facilities.

From the Malaysia Design Meeting, Kuala Lumpur, February 2020

Country Presentations (continued)

Malaysia (continued)

- Data collection of HCWs and patient experiences will be conducted using the Network standard instrument on a semi-annual basis, with migration to a quarterly interval in the future. An online data collection interface is being developed (e.g., Survey Monkey) to facilitate responses to the instrument, with plans to eventually consolidate all data collection on an online dashboard.
- Development of a package of S+D QI interventions, with actionable drivers, from which sites can choose will facilitate the QI cycle for service delivery improvement.
- Regular sharing of findings through fora such as the online dashboard and the annual Malaysia QI conference will promote both peer exchange and healthy competition.
- A reward system for facilities demonstrating significant improvement will be built into the structure of the program.
- It is anticipated that the program will be fully implemented by April 2020. Expansion to all 14 states is planned by the end of 2021.

Philippines

Presenters:
Dr. Angelo Ramos
Sustained Health Initiatives of the Philippines (SHIP)

Dr. Janice Caoili
Philippine Society for Microbiology and Infectious Diseases (PSMID)

- Philippines has a daily HIV infection rate of 35 new cases per day, the highest in the world. If levels of prevention and ART coverage remain the same, this would translate to >46,000 new cases by 2030.
- Progress to meeting 90-90-90 goals has been difficult, with current rates of 72%, 62%, and 17%, respectively. Stigma is a major factor for gaps along the cascade.
- Since 1998, Philippine law has recognized there is discrimination of PLWH, but the language in the original law was vague and provided no penalties for those who discriminate. A 2018 replacement law added that private and public HIV service providers must deliver non-discriminatory services, and that the government must develop "redress mechanisms" for PLWH to ensure their rights are protected.
- The S+D QI program in Philippines is unique, as it will be privately led and funded by PSMID and SHIP. PSMID will provide their expertise, their network of member physicians in partner hospitals and HIV/AIDS Core Teams (HACT), and HIV training and QI coaching to their partner hospitals. SHIP will leverage their current and past work in the public sector and provide the management, logistics, and data collection for the S+D program. SHIP also has a videoconferencing platform using Zoom that can be adapted for some Network meetings.
- 17 hospitals and HIV treatment hubs (a mix of private and public) will participate in the program. These facilities are located in regions with the highest HIV burden, focusing on the cities of Metro Manila, Cebu, Bacolod, Legazpi, Davao, and multiple cities in central and northern Luzon. Many private facilities have conducted S+D activities already, but none have engaged in S+D QI activities.
- Next steps for implementation of the program include a PSMID strategic planning meeting, meetings with the Department of Health's (DOH) HIV and QA programs, establishing the program requirements for staffing, logistics, QI counselors, and REDCap, meetings with CBOs and KPs, baseline data collection, and QI capacity surveys of partner facilities.
- The official Design Meeting was planned for June 2020 (now postponed because of COVID-19).
- The goal for sustainability of the program is to institutionalize QI indicators for S+D as part of DOH policy, for treatment hub accreditation or license renewal, and included in all private facility HIV QI and QA initiatives.
- UNAIDS has been very involved supporting the S+D program in Philippines, and Gilead has provided some funding to support the activities.

Country Presentations (continued)

Indonesia

Presenters:

Yasmin Purba
Human Rights & Gender Advisor
UNAIDS, Indonesia

Wawa Reswana
Project Officer
GWL-Ina, Indonesia

Novia Puspitasari
Program Officer
Legal Aid Institute

- In Indonesia, there are currently 630,000 PLWH, with a prevalence rate of 0.33% among adults, with nearly 85% of the prevalence concentrated in KPs (PWID, 28.8%; MSM, 25.8%; TG, 24.8%; FSW, 5.3%). Annually there are 49,000 new infections and 39,000 deaths.
- Despite the recent improved availability of HIV-related health services, and a national Test and Treat policy being launched in 2017, Indonesia is still not on track to reach its 90-90-90 targets. Currently, rates are 52%, 18%, and 1%, respectively. One major factor impacting access to services is S+D.
- Since 2016, S+D towards LGBT has increased throughout the country, often supported by government officials and politicians.
- The prevalence of S+D towards KPs raises the distrust of healthcare providers and healthcare system, with concerns of maintaining confidentiality. These concerns lead to hesitation to be tested for HIV and subsequently starting treatment late, if infected.
- Research conducted by the Indonesian AIDS Council in 2017 found that 73% of human rights violations against PLWH took place in healthcare settings. The most common forms of S+D found were the refusal of services and unfriendly treatment by health staff.
- To reduce S+D, MOH has conducted a series of sensitization trainings to healthcare providers in 34 provinces since 2015. Currently, dedicated trainers in 25 provinces can deliver these trainings to their fellow healthcare providers.
- UNAIDS has facilitated the formation of a National CSOs Coalition against Stigma and Discrimination (consisting of 18 civil society organizations engaged in advocacy for PLWH and KPs, human rights, and legal aid), the development and publication of the first Indonesian Stigma Index (March 2020), and advocacy for a comprehensive anti-discrimination law. UNAIDS also collaborates with local partners to develop community-based monitoring and feedback which allows documentation of client satisfaction and human right violations.
- Community interventions for S+D include trainings to healthcare providers on sensitization to SOGIE-SC (sexual orientation, gender identity and expression, and sex characteristics) issues and providing safety and security to the LGBT community (an urgent need), providing mobile VCT services at local LGBT gathering places or CBOs, networking and partnering with legal aid institutions related to legal cases affecting the LGBT community, and documenting S+D cases occurring at CBOs when clients have accessed services.

Friendly Clinic Presentations

To achieve epidemic control, HIV testing and care & treatment services must be structured and provided in welcoming and friendly manner, especially for key populations who bear the weight of stigma and discrimination the most. Participants heard presentations from colleagues from Malaysia, Thailand, and the regional UNICEF office highlighting distinct approaches to providing HIV services through both a KP "friendly clinic" model and a KP-led health service model to improve accessibility and clinical outcomes.

Malaysia

Presenter:
Dr Nik Rubiah Nik Abdul Rashid, MD (UKM), MCGP (Mal)/ FRACGP (Aust), MPH (UKM)
Family Health Development Division (FHDD)
Ministry of Health, Malaysia

- Situational analyses of the state of adolescent health in Malaysia revealed many concerning trends. The rate of sexual activity among adolescents is increasing, the age of debut is decreasing, while rates of condom use remain low. Rates of depression, suicidal ideation, and drug and alcohol use are also increasing.
- In 1996, the national Adolescent Health Programme was launched, integrating adolescent health services into primary care settings. However, after > 20 years, adolescent-specific services still lacked visibility and priority among healthcare providers compared to other health services.
- In 2018, MOH Malaysia implemented Best Practice Adolescent Friendly Health Services (AFHS) in 38 government health clinics, based on WHO criteria and MOH guidelines, to increase access to care, strengthen adolescent services in primary care settings, increase HCW competency for adolescent health management, increase early intervention, and reduce morbidity and mortality among adolescents.
- Emphasis is placed on creating clinic environments that are welcoming, comfortable, and accessible; improving adolescent-sensitive communication skills among providers; ensuring efficient service delivery, confidentiality. Integration with other clinical services is promoted while providing adolescent health specific resources and trainings for healthcare staff.
- An assessment of AFHS was conducted in 2019 by Adolescent Health Sector (Family Health Division) and State Health Department clinical staff. Methods included observation of the adolescent friendly clinic environment work processes, and staff; review of policies, SOPs, register books, training records, and client satisfaction surveys, and interviews with clinical staff focusing on policy and processes, the importance of AFHS, and clinical management of sensitive and complex cases.
- A 5 tier scoring scale was used: Results showed 52.6% of clinics scoring 5, 36.8% scoring 4, and 10.5% scoring 3.
  Successes of the AFHS implementation include increased competency in adolescent health management among HCW; improved collaboration between adolescent health and other services; improved adolescent friendly work processes and clinic environment; creative and innovative approaches to health management involving peers the community, and social media; and a strong commitment from managers at the state, district, and clinic level.
- Implementation challenges include high staff turnover, limited space, incomplete data collection, and adolescent and parental support issues (self-stigma, transportation, school referrals, parental consents).
- Continuous monitoring and reassessment is planned for AFHS, with gradual expansion to other clinics, continued QI trainings, and sharing of best practices across various platforms.

Friendly Clinic Presentations (continued)

UNICEF: China and Philippines

Presenter:
Shirley Mark Prabhu
Regional HIV/AIDS Specialist (EMTCT, Adolescent Health and HIV)
UNICEF East Asia and the Pacific Regional

- In the East Asia/Pacific region, a 31% decline in HIV infections has been demonstrated among adolescent girls, but only 7% among adolescent boys. Many adolescents do not know their HIV status, and few who are diagnosed and on ART adhere to treatment. Adolescent-specific medical and mental health services are limited, and parental consent laws create significant barriers to HIV testing. Many adolescents do not access HIV prevention and treatment services due to fear of stigma, fear of a positive HIV test result, and clinics that are inconvenient due to distance or clinic hours.
- As part of the All-In initiative and supported by UNICEF China, the Chinese Association of STD/AIDS Prevention and Control (CASAPC) cooperated with Guangzhou CDC and Super Young, a peer network of adolescents, to pilot an online-to-offline (O2O) model to address the issues in adolescent HIV and sexual health services.
- In the O2O model, education activities are conducted regularly in middle schools and universities, complemented by online promotions via learning games, live-chats and crowd-sourcing on social media.
- Super Young created a core team of 11 staff and 35 trained volunteers, selected from peer educator networks, who provided demand creation activities, sexual health and HIV service referral, voluntary counseling and testing (VCT), and advocacy.
- HIV testing was provided in two models to the specific needs of adolescents. Model 1 complemented the current venue-based VCT network with online risk assessment and appointment booking, peer-assisted counseling, and testing performed in community settings, e.g., schools, MSM community centers. Model 2 applied a self-testing approach to address privacy issues and to serve those familiar with HIV testing. Post-test consultation was provided by trained peer counselors.
- The CASAPC and its provincial counterpart used national and subnational advocacy to share key findings from the pilot and engage partners in dialogue. In a 10 month period, over 240 adolescents with high-risk behaviors were tested, 80% of them for the first time. The satisfaction rate exceeded 90%; 93.4% were happy to recommend it to others, and 38.8% indicated a willingness to test regularly.
- In Philippines, UNICEF has worked with government to strengthen capacity for HIV counseling and testing services, and to facilitate access to integrated sexual and reproductive health services and the wider Service Delivery Network for HIV and Adolescent Health.
- Peer educators in schools, CSO/NGOs and youth organizations encourage adolescents to use SRH services, Referrals to legal, protective, financial, and psychosocial services are offered.

Friendly Clinic Presentations (continued)

KP-Led Health Services (KPLHS) in Thailand

Presenter:
Khun Thirdchai Sattyapanich (Oat)
Senior Technical Officer, Key Populations
LINKAGES Thailand, FHI 360

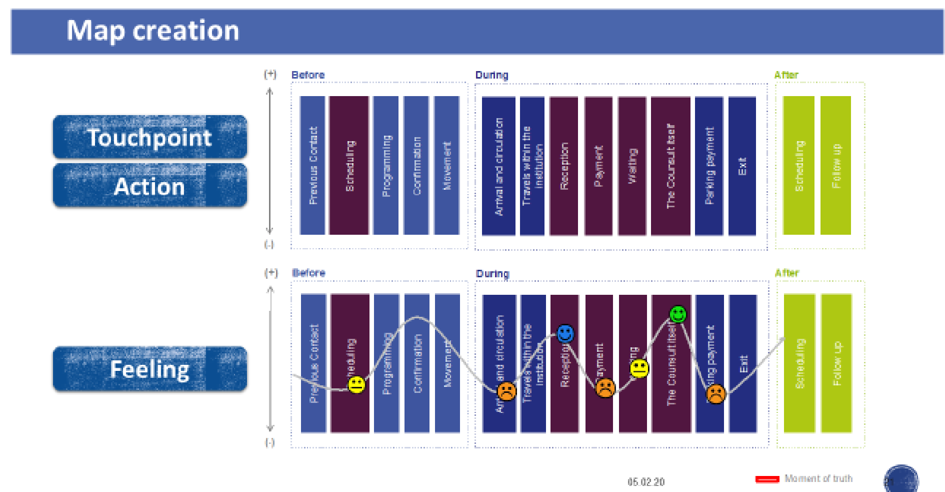
- KPLHS is a model of community-based, KP-led HIV service delivery developed by FHI 360 and TRCARC under the PEPFAR- and USAID-funded LINKAGES Project based on a differentiated service delivery model along the Thai Reach-Recruit-Test-Treat-Prevent-Retain cascade, focused on supporting KP clients around HIV testing and ART initiation.
- The delivery structure ensures accessibility by being located in hot spots with flexible service hours providing a one-stop service. KP-focused services include HIV testing, PrEP, PEP, STI screening, hormone monitoring, and legal consultation with staff from the community who provide services that are friendly and gender-oriented.
- KPLHS has been implemented in 9 community health centers in high HIV burden provinces. Nationwide, in 2018, 55% of all self-reported MSM and TG tested for HIV, 36% of all newly HIV diagnosed cases among MSM and TG, and 55% of all Thai PrEP users received services in these health centers.
- Services are aligned with national standards, and quality is monitored by both internal and external mechanisms. A QA/QI committee, which meets semi-annually, was established with members including the provincial Public Health Official, staff of the NHSO, DDC, Thai Red Cross AIDS Research Centre, LINKAGES, and the PEPFAR-USAID funded ENGAGE project.
- Post-intervention results from the client S+D survey showed lowered rates of S+D towards most KPs, but still remained high towards many, most significantly towards PLWH. Internalized stigma increased in 3 out of 7 KP groups, and may need separate interventions to address. Stigma also increased when KP clients became HIV-positive.
- The results highlight that measurement of stigma is vital to ensure services are truly KP friendly and that stigma may be targeted towards subpopulations within the clinic.
- Quality monitoring activities are conducted every 6 months and include the client Stigma and Discrimination Client Satisfaction instrument (completed via an online, self-administered LINK client feedback survey), staff training to become certified KPLHS providers, and use of mystery clients.
- Mystery clients (MC) access and assess KPLHS to observe staff behaviors and attitudes, ensure standard operating procedures are followed, and identify opportunities for improvement. The MC intervention will expand to all KPLHS sites, including online outreach services.
- Areas for improvement included expanding hours of availability and, in some clinics, to improve staff attitudes.

Topic Presentations

Measuring Patient Experience: An Introduction to Journey Mapping

Presenter:
Dr. Jittima Manonai Bartlett
Department of OB/GYN
Mahidol University and Ramathibodi Hospital, Bangkok, Thailand

- Dr. Jittima presented methods to measure patient experience – defined as the range of interactions patients have with the health care system - as part of routine quality improvement activities as part of her experience at Ramathibodi Hospital/Mahidol University: patient care experience observation, in-depth interviews, and patient journey mapping.
- **Patient experience observation** is a "fly on the wall" approach where trained staff (called "flies" at Ramathibodi Hospital) directly observe the real-time care experience from the patient's perspective in healthcare settings, and report on context, setting, and observed interactions between support staff, HCWs, and patients. The observation may uncover behaviors or routines previously unaware to both the patient and the providers. The data and reports are used to develop interventions to improve service delivery, policies, and patient outcomes.
- **In-depth patient interviews** are used to explore the experiences, feelings, and expectations of patients receiving services. Interviews can range from unstructured interviews, which elicit full, rich descriptions and data, to structured interviews, which elicit "rational" versus "emotional" responses. Interviewers are trained in active listening and how to utilize "probing" techniques to collect accurate and comprehensive responses from the patient. Transcripts of the interviews can be analyzed to identify themes to be used in the QI process leading to modification of policies and administrative processes.
- **Journey mapping** analyzes the patient's pathway as they visit the clinic, seen from their perspective, along the consecutive "touch points" of the complete service delivery cycle from diagnosis to post-care. The process goes through the 3 steps of actions, thoughts and feelings: What steps do your patients take to meet their needs? How do your patients perceive and evaluate their experience, and what do they expect? What emotions do your patients have during their journey?
- The steps involved include planning, data creation and map creation, followed by analysis to identify actionable key points.
- Through this in-depth study of the patient care process, a culture of ownership and accountability can be built among administrative, support, and clinical staff. A root cause analysis is conducted to develop QI interventions to address inefficiencies, gaps and issues in service delivery that can eliminate redundancy loops and long waiting times. The end product is a highly visual and understandable "process map."



Journey mapping process map

Topic Presentations (continued)

Journey Mapping (continued)

- Dr. Jittima facilitated a small group exercise on how to integrate the routine capture of qualitative patient experience, use these data for QI activities, and how to fold patient experience assessment into regular QI and S+D trainings. Report from the groups included ideas such as linking the patient experience activities with the improvement priorities of the clinic, utilizing comment boxes, exit interviews, and social media to routinely capture data, and collaborating with CABs to assist with training.
- Dr. Jittima voiced the importance of leadership support to enable these activities, and the need to figure out how to integrate these activities into routine care systems in order to mine this important information to improve quality of care and engagement of patients.

Disease Specific Certification (DSC) Model – Thailand: Stigma Standards, Monitoring, and Quality Improvement

Presenter:
Dr. Supunnee Jirijariyavej
Chief, Community Medicine
Thaksin Hospital, Bangkok, Thailand

- DSC standards for hospitals seeking certification include an outcome measurement for S+D for the Performance Outcome component.
- Dr. Supunnee highlighted QI interventions for S+D reduction conducted at Thaksin Hospital to meet this requirement, including capacity building among staff, patient journey mapping, participatory self-care planning with patients, and standardizing patient rights.
- When changes to the hospital healthcare delivery system are centered on the patient and made convenient, comfortable, and safe, and when staff capacity is built to better understand patients' medical and emotional needs, staff are able to be self-aware and more empathic, leading to improvements in both patient and personnel satisfaction scores and reduction of S+D.
- Performance rates for loss to follow-up and patients receiving ART within 7 days, suggesting reduced S+D, have improved steadily from 3.25% to 0.98% (LTFU) and from 16.2% to 100.0% (ART).

EVALUATION: What can we learn from our implementation of S+D QI to be sure we are achieving our goals?

Evaluation of Thailand's National Stigma Reduction Implementation Program in Healthcare Settings

Presenter:
Ms. Benjamas Baipluthong
Public Health Specialist, Monitoring and Evaluation
CDC-DGHT, Thailand

The evaluation of Thailand's national stigma reduction implementation program complements the focused assessment of enablers and barriers to QI implementation undertaken as part of the National Program. Formal pre- and post-assessments of the 3x4 Participatory Training Program (PTP) through measurement of the routine S&D indicators is planned together with a formal evaluation protocol proposal which is presented here.

Topic Presentations (continued)

Evaluation: Thailand (continued)

- PTP has been shortened to include 5 modules and scaled up to 48 additional hospitals. The training intervention under evaluation will include 5 modules: 1) increase HCW awareness of S+D, its key drivers, and the impact of not reducing S+D; 2) challenge HCW negative attitudes towards PLWH and KPs; 3) universal precautions and fear of HIV infection; 4) identification, as a team, of existing S+D issues in the facility through root cause analysis and application of QI methodology; 5) identification, as a team, solutions to address the identified S&D issues and prioritization of how the S+D issues will be addressed through a post-training action plan for improvement.
- An evaluation protocol has been developed to assess how the S+D reduction PTP intervention was implemented and if it achieved the planned outcomes. The PI will be the DDC –Division AIDS and STIs (DAS), Ministry of Public Health (MoPH). Co-investigators include Chulalongkorn University (external evaluator), RIHES of Chiang Mai University, and DGHT of US CDC Thailand. The evaluation will be funded through the Thailand MoPH-US CDC Collaboration (TUC) Cooperative Agreement and is pending US CDC Ethical Research Committee (ERC) approval.
- The objectives of the evaluation are: 1) To assess the development and implementation of PTP (both the original 10 module and revised 5 module versions); and 2) To evaluate the S+D outcomes and factors contributing to success of S+D QI implementation in health care facilities. Key study questions include: 1) Has S+D decreased in facilities after implementing the S+D reduction intervention? 2) How was the S+D intervention implemented? 3) How were S+D QI activities conducted?
- The evaluation methodology will include an analysis of pre- and post-intervention data, a desk review of the S+D program package, curriculum modules, and program reports, field observations at 3 pilot hospitals and 9 expansion hospitals, and in-depth interviews and focus group discussions with policy makers, key persons in the development of the curriculum, hospital administrators and clinical staff, the training teams and participants, and PLWH receiving services from the participating hospital (hearing the voices of clients is important).
- Other areas covered in the study include identification of policies and code of practices that were developed as part of S+D interventions, lessons learned and the enabling/hindering factors of implementation.
- It is hoped that approval for the evaluation will be received by May 2020, with completion of the evaluation by December 2020.

Evaluating Stigma Reduction Efforts in Healthcare Facilities in Viet Nam

Presenter:
Dr. Todd Pollack
Country Director
HAIVN, Viet Nam

- The first evaluation protocol was a pre- and post-intervention research study in 10 healthcare facilities in 3 provinces. The design included baseline data collection of HCW and PLWH surveys, post-survey implementation of a series of interventions, and subsequent data collection 9 months post-intervention.
- Questionnaires were built into REDCap and conducted in private rooms/space at each facility. The HCW survey was a repeated measure design. HCWs were randomly sampled, proportional to the number of their discipline in each facility (doctor, nurse, other HCW), with the same cohort completing a self-administered online survey pre- and post-intervention so that results were matched.

Topic Presentations (continued)

Evaluation: Viet Nam (continued)

- The PLWH survey was a repeated cross-sectional design. PLWH were invited by consecutive sampling at the clinic until the sample size was reached. PLWH had to have been a patient for at least 6 months in the facility to participate. Some patients may have been included in each of the cross-sectional samples, but results were not matched and identifiable information was not included. Interviews were conducted in a private room with a peer.
- The study was powered to show a difference in stigma (by domain) based on full sample of aggregated data at province level. Data from the original pilot conducted by UNAIDS in HCMC in 2016 was used to determine the sample size needed (HCW: 622. PLWH: 496). The sample size was then allocated proportionally at each clinic.
- The main intervention was a participatory training for HCWs, which all HCWs participating in the evaluation attended. Other interventions included: trainings for HCWs, community engagement, fostering champions, QI planning and activities, development of hospital regulations and policies, and development of communication materials.
- Measurement domains were adapted from the formal Thai evaluation with one to ten items per domain. Items were analyzed as composite measures which may skew the aggregated total for each domain.
- For the HCW survey, domains included fear of HIV infection, negative attitudes towards PLWH, health facility policy, over protecting oneself, observed discrimination towards PLWH and KPs, and discomfort working with PLWH staff.
- For the PLWH survey, domains included experienced discrimination, internalized stigma, disclosure of HIV status, and reproductive health.
- Based on multivariate analysis, results for the HCW survey showed statistically significant improvement on all items in all measurement domains. The results showed the same for the PLWH survey. Please refer to the presentation for data.
- Limitations of the study include: self-report subject to recall bias; interventions were inconsistently applied and therefore not able to be directly correlated with results (except for the participatory training); SOGI and KP status of PLWH were not well defined on the questionnaire; and results were based on a single assessment post-intervention leaving open the question of sustainability
- Although significant reductions occurred in all measured domains, certain issues remain problematic, specifically observed discrimination among health staff (31.8%) and experienced discrimination among patients (15.4%) Continued efforts are needed to address the actionable drivers of stigma.
- A specific protocol has been developed to evaluate the effect of QI methodology on S+D reduction which is undergoing approvals. The interventions will include actions to reduce KP- and HIV-related S+D in healthcare facilities, including HIV testing and PrEP sites, and to improve treatment outcomes. Study objectives include: 1) establishment of routine QI measurement and initiatives to reduce S+D, and 2) to describe changes in facility-level S&D measures, document facility level interventions to reduce stigma, and disseminate interventions implemented in facilities with improved S&D measures over time.
- The HCW domains were changed slightly from the first evaluation protocol, and include demographics, fear of infection, using unnecessary precautions, observed discriminatory practices towards PLHIV made by hospital staff, attitude and opinion of hospital staff towards PLHIV and KPs, and facility policies. Domains for PLWH were revised and include discrimination experienced at health services, privacy and confidentiality, patient experience / client satisfaction, treatment literacy, and quality of life (the fourth 90).
- Methodology processes include 1) forming and training a QI team at each facility to lead S+D reduction efforts, 2) conduct the questionnaire every 6 months (HCW, self-administered; PLWH, peer exit interview) for a duration of 2 years, 3) provide measurement data back to facilities for QI planning, 4) facility implementation of QI interventions supported by QI coaching, 5) quarterly online group videoconferences to share successes and challenges among all facilities.
- Coaching will be standardized and provided by HAIVN staff and HAIVN-trained provincial coaches. QI implementation will include standardized worksheets and reporting templates used by facilities and coaches.

Topic Presentations (continued)

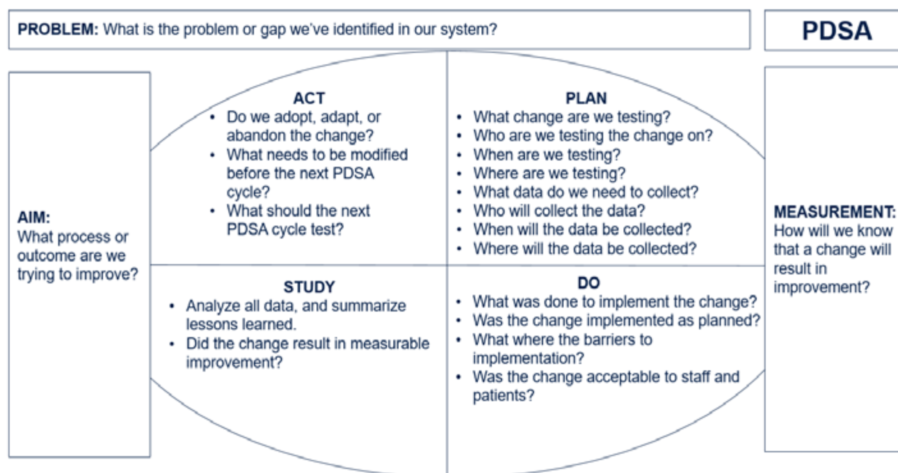
Evaluation: Viet Nam (continued)

- Facilities will be given their data to use for QI planning. A current quality of care dashboard will be adapted for evaluation data use, with data plotted longitudinally and disaggregated by subpopulations (e.g., age, gender, KP status). Results will be disseminated across facilities to share successful strategies and generate healthy competition. MOH will receive aggregated data from across sites to inform national level S+D reduction efforts.
- Following approvals, the evaluation is expected to begin in March 2020 and end March 2022.

Teaching Improvement: How to Travel Around the PDSA Circle

Presenter:
Dr. Bruce Agins
Director, HEALTHQUAL
University of California, San Francisco, USA

Dr. Agins presented a tool developed by MoHSS Namibia to teach the PDSA cycle to providers to facilitate implementation of QI activities. The PDSA cycle can improve systems to narrow the “know-do” gap, and ensure that implemented changes work and are understood in enough detail to spread to other facilities to replicate improvement.



Stigma and Clinical Outcomes: A Very Brief Tale of Two Studies

Presenter:
Dr. Bruce Agins
Director, HEALTHQUAL
University of California, San Francisco, USA

- Dr. Agins presented an overview of two studies focused on stigma and its impact on viremia which show different outcomes: *Internalize HIV Stigma Is Associated With Concurrent Viremia and Poor Retention in a Cohort of US Patients in HIV Care,* JAIDS Volume 82, Number 2, October 1, 2019; and *Lack of virologic suppression is associated with lower HIV-related disclosure stigma in people living with HIV,* AIDS CARE, https://doi.org/10.1080/09540121.2019.1679705
- The results of the first study showed higher rates of internalized stigma were associated with lower rates of viral suppression, with increased stigma levels among patients <50 years old, racial/ethnic minorities, cisgender females, and those identifying as heterosexual. In adjusted analyses, each unit increase in internalized HIV stigma increased the odds of a history of missed visits and concurrent viremia by 10%– 15% while a smaller effect was observed on retrospective 6-month visit constancy
- The results of the second study showed an opposite effect: an increase of one point on the stigma scale was associated with **reduced** odds of viremia. This inverse association was in contrast to other studies. The authors posit that stigma may lead people to better adherence to care and treatment to prevent disclosure from appearing sick because of their illness, which was supported through qualitative data.
- Limitations of stigma-outcomes literature include: studies measure different types of stigma and groups of patients, use different stigma scales, do not always address inter-sectional stigma, and successful treatment outcomes do not mean that stigma is not present.

Appendix

Implementation Progress

This section summarizes progress of S&D QI implementation by country as of February 2020.

Progress By Domain

Domain	Cambodia	Lao PDR	Thailand	Vietnam
1. Planning and coordination				
1.1 Site selection and sensitization completed	✓	✓	✓	✓
1.2 Formal plan to integrate S&D activities into national HIV quality plan		✓	✓	✓
1.3 Formal involvement of provincial/district health authorities	✓	✓	✓	✓
1.4 Formal plan for scale-up of S&D QI activities		✓	✓	✓
2. Performance measurement				
2.1 Formal protocol for collection of healthcare worker survey data	✓	✓	✓	✓
2.2 Formal protocol for collection of PLWH survey data/experience questions	✓	✓	✓	✓
3 Completion of baseline data collection—healthcare workers	✓	✓	✓	✓
2.4 Completion of baseline survey data collection—PLWH	✓	✓	✓	✓
2.5 Inclusion of clinical questions (e.g., viral load) into PLWH survey		✓	✓	✓
2.6 Number of post-baseline survey data collection rounds – healthcare workers	**2**	**3**	**1**	**1**
2.7 Number of post-baseline survey data collection rounds – PLWH	**N/A**	**1**	**1**	**0**
3. Quality improvement activities				
3.1 Formal protocol for documentation and reporting of site-level QI activities		✓	✓	✓
3.2 Formal plan for peer exchange among participating sites		✓	✓	✓

Domain	Cambodia	Lao PDR	Thailand	Vietnam
3.3 Formal plan for involving PLWH in site-level QI activities		✓	✓	✓
3.4 National QI curriculum with modules on S&D reduction		**Developed training slides on S+D.**	✓	
4. Quality improvement coaching				
4.1 Identification, training, and monitoring of QI coaches		✓	✓	✓
4.2 Formal timeline of QI coaching for S&D QI activities		✓	✓	✓
4.3 Formal protocol for documentation of QI coaching activities		✓	✓	✓

Data Collection Summary

Domain	Cambodia	Lao PDR	Thailand	Viet Nam	Total
Healthcare Worker Survey					
# of rounds	**3**	**4**	**2**	**2**	
# of staff	**178**	**3,672**	**13,828**	**672**	**18,350**
Comments			**48 Hospitals**	**Revising approach to measurement, first new round Feb-April 2020**	
Patient Experience Questions					
# of rounds	**14**	**2**	**2**	**1**	
# of patients	**8,244**	**675**	**11,477**	**652**	**21,048**
Comments	**Use "Patient Satisfaction Survey" instead (n=8,244); data are collected more frequently**		**Use "PLHIV survey" instead (n=11,477)**	**Use "Patient survey" instead**	
Clinical Literacy Questions					
# of rounds	**N/A**	**2**	**1**	**1**	
# of patients	**N/A**	**675**	**251**	**644**	**1,520**
Comments	**Plans to implement in 2020**		**Will adapt questions**		

Appendix (continued)

Meeting attendees

Cambodia

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Appendix (continued)

Thailand (continued)

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Appendix (continued)

Thailand (continued)

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Appendix (continued)

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