Southeast Asia Stigma Reduction QI Learning Network

Reducing HIV-related stigma and discrimination in healthcare settings through peer learning and application of quality improvement (QI) methods

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What is the problem?

HIV-related stigma and discrimination (S&D) in healthcare settings is a major barrier to achievement of UNAIDS' 95-95-95 targets, discouraging people living with HIV (PLWH) and key populations (KP) at high risk of HIV acquisition from accessing treatment and prevention, engaging in care, and adhering to treatment (**Figure 1**).[1] In Southeast Asia (Cambodia, Lao People's Democratic Republic, Thailand, and Viet Nam), where the HIV epidemic is highly concentrated among KPs of men who have sex with men, sex workers, transgender people, and people who inject drugs, HIV-related S&D is further compounded by cultural, social, and institutional factors that discourage care seeking, undermine treatment self-efficacy, and normalize marginalization. Addressing S&D is critical to reaching these KPs and ensuring they receive HIV prevention and treatment services that are responsive to their unique identities, needs, and circumstances.

Validated tools and evidence-based interventions exist to measure and reduce HIV-related S&D, yet their incorporation into routine programming in Southeast Asia remains limited. Reasons for poor uptake of stigma-reduction activities are many, and reflect the inherent difficulty of scaling pilot projects to generate population-level impact. Previous initiatives to reduce S&D in Southeast Asia have assumed that training alone—and episodic rather than continuous measurement of its prevalence—is sufficient to eliminate S&D in healthcare settings. To be sure, training is necessary to remedy gaps in knowledge that may perpetuate S&D, but it does not address other factors through which S&D is produced and abetted, nor does it assure translation of gains in knowledge into practice. As the drivers of HIV-related S&D are multi-dimensional and highly contextual, so, too, must S&D-reduction interventions be multi-dimensional and sensitive to local context.

What is the solution?

The Southeast Asia Stigma Reduction QI Learning Network ("Network") was launched in 2017 by UCSF-HEALTHQUAL with support through HRSA's Quality Improvement Capacity for Impact Project to accelerate integration of S&D-reduction activities into routine HIV quality management programming in Cambodia, Lao PDR, Thailand, and Vietnam, through continuous measurement, QI methods, and peer-to-peer learning and exchange.

Continuous measurement

As part of Network activities, health facilities in participating countries measure HIV-related S&D among healthcare workers (HCW) on a continuous basis using common indicators from a validated survey tool (**Table 1**).[2] In addition, these facilities routinely collect data on patients' experience and treatment literacy through structured questionnaires, patient fora, and clinical encounters.

QI methods

Using data from HCW surveys, patient feedback, and clinical performance data, facilities apply QI methods (e.g., process mapping, plan-do-study-act cycles) to identify root causes of suboptimal outcomes and implement contextually tailored interventions to improve identified gaps. Through this process, a broader conceptualization of quality of care is forged in which S&D reduction activities and people-centered service delivery are explicitly aligned with 95-95-95 targets (**Figure 2**).

Peer-to-peer learning and exchange

To share successes and challenges and co-create implementation strategies, teams from participating Ministries of Health are convened on a quarterly basis by UCSF-HEALTHQUAL. During these meetings, participants discuss the translation of policy into data-driven practice at the facility level, and develop plans for scale-up and sustainability based on experiences from peers and content experts.

Figure 1. Linking S&D reduction to 95-95-95 targets[3]

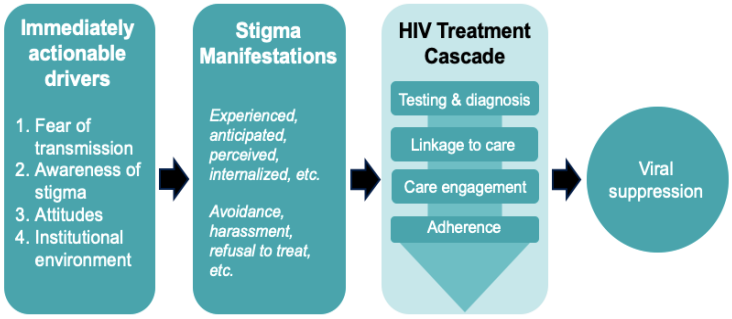
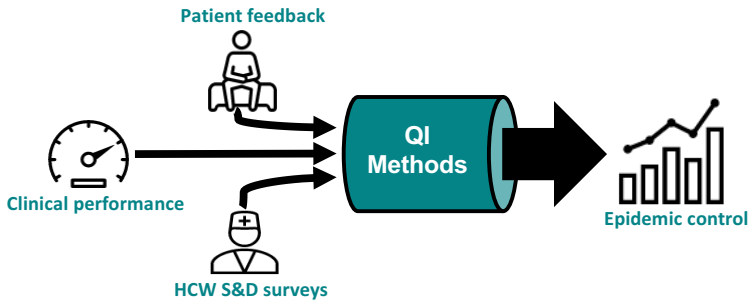


Table 1. Common S&D indicators

Indicators
1. Have you observed HCW colleagues unwilling to care for a PLWH in your health facility?
2. Have you observed HCW colleagues providing poorer quality of care to a PLWH in your health facility?
3. Do you typically wear double gloves when providing care to PLWH?
4. Do you typically avoid contact when providing care to a PLWH?
5. Do you strongly agree, agree, disagree, or strongly disagree that women living with HIV should be allowed to have babies?
6. Do you strongly agree, agree, disagree, or strongly disagree that there are adequate supplies in your facility to reduce your risk of being infected with HIV?
7. How worried are you about getting HIV if you drew blood from a PLWH?
8. Does your facility have written guidelines to protect PLWH from discrimination?

Figure 2. Uniting data sources to reach epidemic control



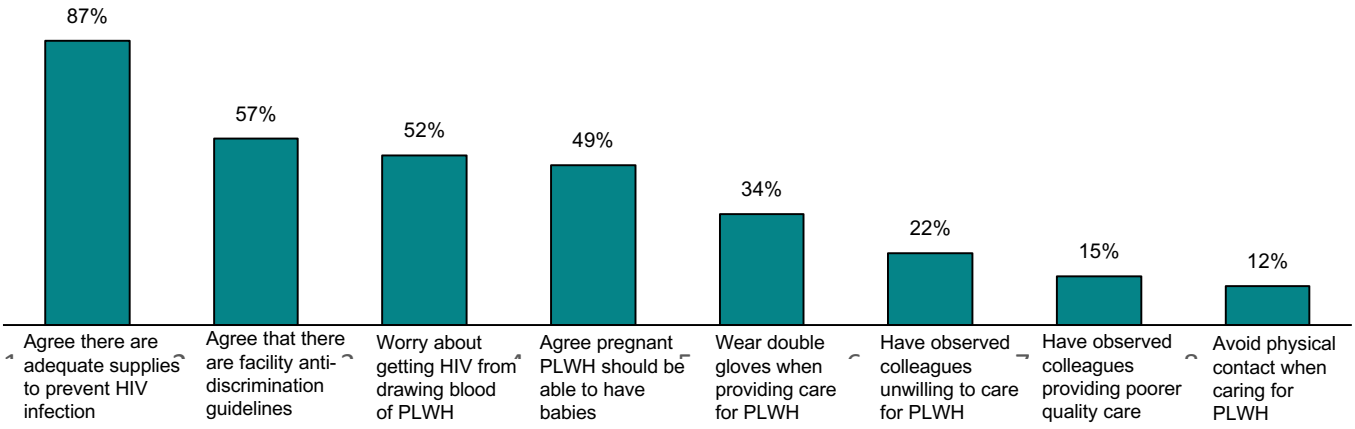
How does it work?

Network activities seek to accelerate progress toward achievement of UNAIDS' 95-95-95 targets in Cambodia, Lao PDR, Thailand, and Vietnam, by linking S&D reduction activities to routine quality improvement activities in healthcare facilities.

Progress and Impact

Implementation progress across participating countries is monitored by UCSF-HEALTHQUAL and shared with other Ministry teams as part of quarterly exchange meetings. Monitoring focuses on five broad domains: planning and organization, performance measurement, quality improvement, and coaching and support. Leveraging its expertise in HIV quality management programming, UCSF-HEALTHQUAL provides technical assistance on an as-needed basis to Ministries seeking mentorship on implementation of Network activities. To date, 83 facilities across the 4 countries have initiated S&D reduction activities, and over 8,000 HCW have completed baseline assessments (**Figure 3**). Activities to assess patient experience and treatment literacy through common indicators are currently being implemented, with the goal of routinely monitoring, and acting upon, these data as part of ongoing S&D reduction activities.

Figure 3. Baseline results of HCW S&D surveys (Cambodia, Lao PDR, Thailand, and Vietnam)

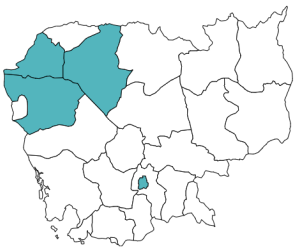


Scalability

Experiences from Thailand and Lao PDR, in particular, show the Network model to be highly scalable (**Figure 4**). As participating sites test, and implement, S&D reduction interventions through rapid-cycle tests of change, successful interventions are harvested and disseminated by Ministry teams to scale-up sites. Through a sequential approach in which the development, management, and spread of local knowledge is supported by Ministry teams through existing quality management activities, S&D reduction interventions are brought to scale at a rapid pace. QI activities to reduce S&D lead to the development of a continuously evolving "change package" of interventions that provide scale-up sites with a firm groundwork for implementation. At the multi-country level, UCSF-HEALTHQUAL facilitates curation and sharing of successful interventions and implementation strategies as part of Network knowledge management activities.

Figure 4. Implementing facilities

Cambodia
4 provinces, 8 facilities



Lao PDR
8 provinces, 11 facilities

Thailand
13 provinces, 50 facilities

Vietnam
4 provinces, 14 facilities

References

[1] UNAIDS. Confronting discrimination: overcoming HIV-related stigma and discrimination in healthcare settings and beyond. 2017.
[2] Srithanaviboonchai K, et al. Building the evidence base for stigma and discrimination-reduction programming in Thailand: development of tools to measure healthcare stigma and discrimination. *BMC Public Health.* 2017;17(1):245.
[3] Courtesy of Laura Nyblade, RTI International.