Summary of the 8th Multi-Country Network Meeting

Southeast Asia Stigma Reduction QI Learning Network

November 6, 13, & 20, 2020
Virtual, via Zoom

Healthqual

UCSF

UCSF Institute for Global Health Sciences

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QI S+D NETWORK ASIA/PACIFIC

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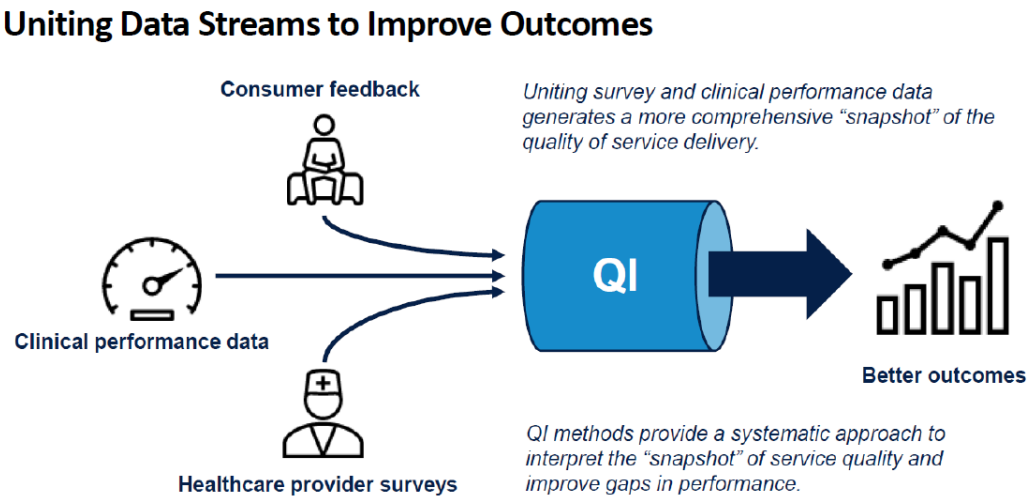
Executive Summary

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 **(QIS+D)** 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, Malaysia, Philippines, 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 into 2021. QIS+D is co-sponsored by UNAIDS and recognized as an activity of The Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination

How data are used for QI in the Network



Meeting Objectives

The 8th Multi-Country Network Meeting of the Southeast Asia Stigma Reduction QI Learning Network was convened on November 6, 13, and 20, 2020, virtually via Zoom, because of Covid-19 travel restrictions. Attendees represented 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 Myanmar (see **Appendix** for list of attendees). The objectives of the meeting were to:

- Present country-specific updates on the implementation of S+D QI activities, including successes and challenges, with a focus on how data, measuring HCW attitudes, patient experience and clinical literacy, are used to identify effective S+D QI interventions and approaches.
- Present an overview of the Global Partnership for Action to Eliminate all Forms of HIV-related S+D.
- Present and discuss ways in which HIV-related S+D disproportionately affects key populations (KPs) and to define areas to measure S+D experience in KPs for which specific interventions can be developed.

Meeting Themes/Highlights

- Presentations from Ministries of Health in Cambodia, Lao PDR, Thailand, Malaysia, Philippines, and Vietnam reported on progress of the programs and summarized findings from follow-up data collection and how results are being used to identify effective QI interventions. The Ministry of Health of Myanmar also presented an overview of their S+D activities.
- A presentation from Quinten Lataire, 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 Support Team Asia and the Pacific partnership with UCSF to scale-up initiatives like the SE Asia S+D Reduction QI Learning Network which aligns with the Global Partnership.
- S+D and key populations were a major theme of many of the country presentations as well as an overview of how S+D disproportionately impacts KPs presented by Taoufik Bakkali of UNAIDS, a presentation by Australian Federation of AIDS Organizations on the Sustainability of Key Population Services in ASIA project (SKPA), and an example of adapting a healthcare worker survey for key populations from New York State, presented by Dr. Bruce Agins.
- Small group discussion on how countries plan to adapt their HCW survey by including questions that are important to ask related to specific KPs to enable collection of more granular S+D data.
- As of November 2020, across the participating countries, 15 rounds of healthcare worker survey data have been collected, , with 26,784 respondents; 20 rounds of patient experience survey data collection (Cambodia uses a shorter data collection cycle) have been implemented, with 23,329 respondents; and 6 rounds of patient clinical literacy survey data in 4 countries, with 3,120 respondents. Please see the Implementation Progress charts in the Appendix for country-specific details.

Next Steps

The 9th Multi-Country Network Meeting will be convened virtually in May of 2021 and will focus on the review of workplans, continued discussion about activities focusing on stigma affecting key populations, and partnerships with community providers and PLWH to reduce stigma. Plans for S+D QI activities and expansion are being reformulated as we continue adaptation to the Sars-CoV-2 (Covid) pandemic.

Before the 9th Network Meeting, 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 to discuss implementation plans and provide technical support on S+D QI activities. Virtual meetings will be scheduled with country teams.
- Distribute Network Meeting summary report, including the summary of the breakout groups related to KP priorities.
- 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.
- Develop plans to integrate KP-specific stigma reduction interventions into their existing S+D QI activities.
- Continue to harvest successful interventions and implementation approaches for presentation at the Network's 9th Multi-Country Network Meeting.

Acknowledgements

QIS+D is supported in part by ViiV Healthcare and Gilead Sciences. The content is 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 on behalf of UCSF and UNAIDS to the Ministry of Health representatives and Network teams from Cambodia, Lao PDR, Thailand, Viet Nam, Philippines, and Malaysia, staff from Australian Federation of AIDS Organisations, CDC, WHO, Gilead Sciences, Malaysian AIDS Council, HAIVN, FHI 360, Myanmar Positive Group, Sustained Health Initiatives of the Philippines, Professional Society for Microbiology and Infectious Disease, and APN+, as well as delegates from Myanmar, now considering participation in the Network. He expressed regret of not being able to meet in-person due to the COVID restrictions, but thanked everyone for their flexibility regarding the virtual format of the meeting. Dr. Agins, commended the teams for advancing their S+D reduction activities in spite of the interruptions due to COVID. After a round of individual introductions, Quinten Lataire, from the regional office of UNAIDS, extended a welcome to the group and reiterated the commitment of UNAIDS to end S+D against PLWH and commended Lao PDR and Thailand for being early partners of the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination. Mr. Lataire stated that UNAIDS is delighted to co-convene the Network with UCSF-HEALTHQUAL. Dr. Agins then reviewed the agenda for Day 1.

The Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination

Presenter:
Quinten Lataire
Human Rights and Law Adviser
UNAIDS Regional Support Team Asia and the Pacific

- The **Global Partnership** for Action to Eliminate All Forms of HIV-related Stigma and Discrimination was launched on Human Rights Day, 10 December 2018 to build momentum to emphasize elimination of stigma and discrimination as key pillars of plans to end the HIV epidemic. The Global Partnership is co-convened by UNAIDS, together with UN Women, UNDP, GNP+, and most recently, the Global Fund.
- The goal of the **Global Partnership** is to support countries to translate human rights commitments into policy changes, programmes and practices that realize HIV-related rights. It aims to translate political and human rights commitments into action, revitalize partnerships among stakeholders to implement initiatives, and scale up programs. Countries are encouraged to support activities that generate and disseminate evidence-based data to inform policy and programming, measure progress, and promote accountability. The Global Partnership is focused on six settings: healthcare; workplace; education; justice; individual, household, and community; emergency and humanitarian.
- To join the Global Partnership, country governments must commit to 1) taking action on HIV-related S+D in 3 settings in the first year, and all six setting over 5 years; 2) assess their current state of HIV-related S+D; 3) partner with civil society, UN agencies, populations left behind, the private sector, and other stakeholders; 4) allocate resources to the work and its monitoring; and, 5) report annually on progress using existing and recommended indicators building on routine national reporting processes.
- Mr. Lataire noted that Lao PDR and Thailand were Early Adopter Country Partners. Globally, there are currently 16 countries have joined the Global Partnership. A technical support package, including tailored technical assistance, is available to all countries to support the implementation of their S+D activities.

Presentations

A shared Dropbox folder with all presentations from the 8TH Network Meeting can be found at:

https://www.dropbox.com/sh/azk4wa9x4i77moh/AABeLdauRyZ-b-7EesMySQBfa?dl=0

Country Presentations

Cambodia

Presenter:
Mr. Sophat Phal
Technical Advisor for Stigma and Discrimination
FHI 360 EpiC Cambodia

- Cambodia is now scaling up the Patient Satisfaction Feedback Survey (PSF) to 51 ART sites across the country following its experience with the 8 pilot sites and the new data collection tablet.
- From baseline to the last data collection round of the PSF survey (n=8,787) results continue to show satisfaction overall with points of service provision, however, some areas remain problematic in reproductive health, ANC and STI clinics. Services continue to be perceived and experienced as convenient and thorough, although it was noted that wait times should be shortened, at and that staff should refrain from speaking about the patients and their care in front of others.
- The participation rate for the PSF had remained consistent until April 2020 due to the COVID restrictions. At that time responses dropped significantly to 20+ per month vs. approximately 200-400 per month previously. Additionally, there is a concern about representativeness of the respondents. Some patients express concern about using the tablet- based PSF in the clinic due to possible COVID transmission; other methods are being considered.
- The fourth round of the healthcare worker (HCW) and non-HCW S+D survey had far fewer respondents than the third round (27 vs. 173). From round 3 to 4, responses to 3 of 4 questions focusing on fear of transmission during routine care given to PLWH showed an increase in concern, as well as increases in observed incidents of HCWs unwilling or providing poor quality of care to PLWH, although the number of respondents decreased.
- NCHADS has introduced dashboards for site, district, provincial, and national level data to monitor progress of retention, viral load suppression, and lost to follow-up to promote quality improvement. Additionally, PSF data is utilized to inform the QI coaching provided by NCHADS to address S+D issues that arise in participating ART sites, although coaching is curtailed during the pandemic due to travel and gathering restrictions.
- Next steps include establishing a technical working group (TWG) to monitor PSF and make changes based on the site-level data; continue regular in-person QI coaching when COVID restrictions are lifted; continue sharing PSF results with sites to inform their S+D QI work; use QR codes instead of tablets to link to patient and HCW survey tools; and, integrate PSF data into the national CQI and existing service delivery dashboards.

Viet Nam

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

Dr. Do Thi Phuong
HAIVN

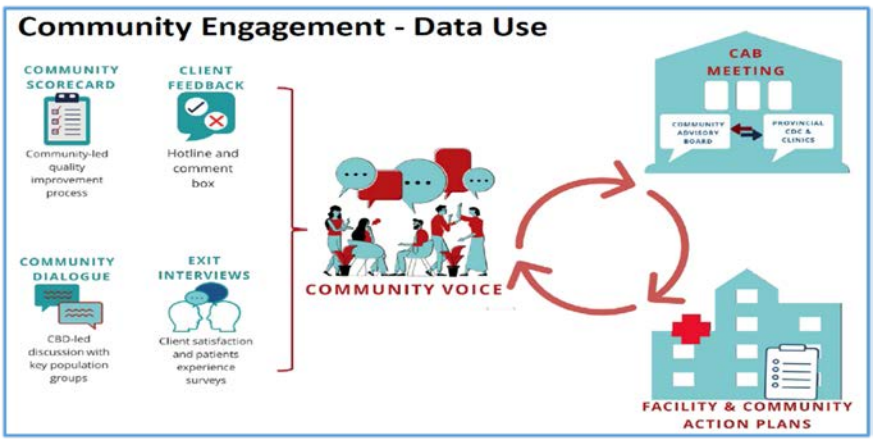
- Viet Nam is currently implementing its S+D QI work in 16 facilities located within 5 provinces.

Country Presentations (cont'd)

Viet Nam (cont'd)

- The client questionnaire was revised to include specific questions about services for PrEP, ART, and HTC, focusing on issues of satisfaction and S+D experience. The aim is to make results more relevant to the sites for prioritizing their QI interventions for S+D reduction.
- Questions were added to the HCW survey to address stigma related to KPs (MSM, PWID, TG, CSW). Results showed that about 50% of the staff feel they have received adequate training on how to effectively work with these specific KPs. Also, scores showed HCWs preferred not to provide health services to MSM, more than others, felt MSM, PWID, and CSW put them at higher risk of infection than TG, and that PWID and CSW engage in immoral behavior more so than MSM and TG.
- Data collection for the HCW survey was changed from a random sample of all staff in the entire facility to recruiting all staff in specific departments where staff are more likely to interact with PLHIV or at-risk populations (surgery and infectious diseases departments, and the outpatient clinic).
- Although results showed no difference between these departments, staff who work indirectly or not at all with PLHIV within each department were more likely to fear HIV infection than staff who work directly with PLHIV ($p<0.05$).
- Client feedback used in S+D QI activities is collected through exit interviews at the clinics after services, Community Advisory Board (CAB) meetings, a client hotline, and clinic comment boxes. Information collected is shared with the CAB, provincial, CDC, and clinic staff to address issues expressed by the clients through a QI process.
- In Binh Duong, with two completed rounds of data collection, improvement has been shown in all the HCW survey common indicators.
- At baseline In Thai Nguyen and Hanoi, HCWs reported high rates of fear of infection and use of unnecessary protection when caring for PLWH, as well as directly observing other HCWs providing poor quality care or unwilling to provide care to PLWH. The baseline survey also showed high rates of HCWs believed women living with HIV should be allowed to have babies if they wish, about 95% in both provinces, as well as believing that there are adequate infection control supplies at their facility. However, only 71% and 81% of HCWs in Thai Nguyen and Hanoi, respectively, believed their facility had written guidelines to protect PLWH.
- Baseline client S+D experience and satisfaction results showed scores of ≥ 90% across all indicators and provinces, except for privacy and confidentiality in Thai Nguyen. When differences between KPs were analyzed across all the indicators, MSM and TG scored privacy and confidentiality lower than CSW and PWID in all three provinces.
- Consumer satisfaction scores are generally high and do not yield information that is sufficiently specific for translation into improvement activities.
- Results from the treatment literacy questions showed a need for targeting improvement activities. Notably, viral load literacy was a focus for QI intervention in Binh Duong. The percentage of patients who knew their most recent VL results increased from 70% at baseline (May 2019) to 91% (Sept 2020), compared to Thai Nguyen and Hanoi where results were flat (VL literacy was not a focus of QI activities in these provinces). The increase in Binh Duong was achieved through a series of PDSA cycles where patients were given leaflets on VL testing, staff were provided counseling on how to discuss VL results and explain U=U to patients, and CAB members conducted follow up calls with patients a week after their clinic visit to determine if they remembered and understood their VL results.
- Viet Nam has adopted a multi-pronged strategy for involving PLWH in quality initiatives, including client feedback, CABs,

Methods of client feedback in Viet Nam



Country Presentations (cont'd)

Viet Nam (cont'd)

exit interviews and, more recently, community scorecard. Information from all of these activities are used for developing facility and community action plans.

- Hospital-based CABs are established in Binh Duong, Thai Nguyen, and Hai Phong provinces, with another to be set up in Hanoi. During the last quarter, CABs were able to help increase the percentage of clients aware of their VL results, increase client satisfaction with clinic waiting times and reduce that waiting time from 60 to 16 minutes, and launch facility PrEP services and client initiation of them during the COVID restrictions. Expansion plans for CABs include increasing community demand through routine meetings with DP network leaders, institutionalizing best practices for S+D reduction, and improve the quality of partner notification (PNS) and PrEP services.
- Results from the Community Scorecard (CSC) in Binh Duong informed actions which increased patient linkage to treatment from community agencies with 17 new ART patients in the previous 3 months compared to no new patients in the 5 months prior, increased use of multi-month dispensing of ART, and improved partner notification services. Other activities implemented based on the CSC results included creating private rooms for counseling sessions and establishing online support channels to promote friendly clinic services.
- Challenges encountered following the implementation of S+D QI activities include limited resources, competing priorities in facilities, the COVID epidemic, and issues related to client assessments. These include low number of PrEP responders, time and resource intensive exit interviews. Additionally, half of patients were not able to use the QR code independently and HCWs unable to adequately assist them. To address this, CBO members or clinic treatment supporters are enlisted to assist the patients with using the QR code, or lending them a cell phone to use if they do not have one.
- VAAC, in partnership with HAIVN, plans to expand S+D QI activities to Ba Ria-Vung Tau province, increase the number of PrEP clients in HCMC, expand the CAB model to three additional provinces, increase the use of CSC among sites, integrate S+D activities into the national U=U campaign.
- Innovations include collaborations between CDC and Hanoi Medical University to develop friendly clinic standards, and between the Department of Military Medicine, the Ministry of Defense, and PEPFAR to develop S+D trainings, and the development of community-led monitoring indicators. Through a partnership with UNAIDS, community experiences with COVID-19 and HIV will be reviewed.

Lao PDR

Presenter:
Dr. Khanthanouvieng Sayabounthavong
Deputy Director, Centre for HIV/AIDS and STIs
Ministry of Health, Lao PDR

- The three data collection rounds planned for May through December were postponed because of COVID, with the next round slated for December 2020.
- Although data collection could not be conducted, S+D QI activities continued in the sites, as well as QI coaching provided by CHAS.
- To protect the gains made in improvements in the HIV response during the COVID pandemic, government and partners implemented multiple strategies to engage patients such as multi-month dispensing, fast-track pick up at ART clinics, home or community-based delivery of ART by peers and HCWs, and refills by post for patients living in other countries (border crossing prohibition). As community points expand, S+D QI will be extended to them.
- CHAS conducted the first S+D QI Learning workshop for PLWH and HCWs in March, and an annual QI lessons learned meeting in May.
- As part of the Sustainability of Key Population Services in ASIA (SKPA) project of AFAO and funded by the Global Fund, CHAS, in collaboration with community service organizations (CSOs), conducted S+D trainings for peer counselors and HCWs from ART centers in four Northern Provinces to complement the current S+D activities, at the community level.

Country Presentations (cont'd)

Lao PDR (cont'd)

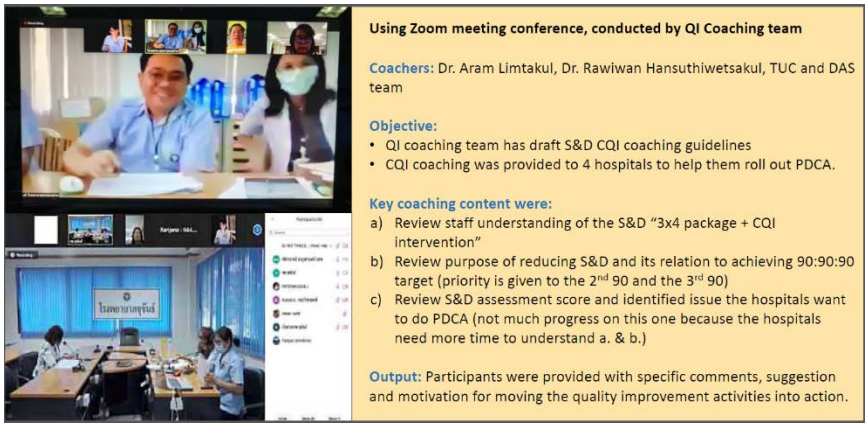
- Also, through SKPA, CHAS and the CSOs are planning Community Based Monitoring to secure consumer and KP feedback on their experience of S+D in prevention and testing service settings. There will be three components to the feedback: a Community Score Card, a Community Feedback and Response Mechanism, and a KP Beneficiary Perception Survey. S+D reduction has been integrated into the existing national HIV quality management plan, and also into the new National Strategic Action Plan 2021-2025.
- Next steps for the program are to conduct the next round of patient and HCW data collection, continue capacity building for S+D QI among CSOs and PLWH peers, implement community-based monitoring activities to assess the needs of the community, and to create a QI coaching group to share experiences, strategies, and foster peer learning to improve skills.

Thailand

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

Kriengkrai Srithanaviboonchai MD, MPH
Associate Professor, Department of Community Medicine, Faculty of Medicine
Deputy Director, Research Institute for Health Sciences
Chiang Mai University

- Thailand presented performance data from three rounds of survey results representing three 12-month intervals between October 2017 and June 2020 from 48 hospitals. As in previous rounds, all HCWs were surveyed in small hospitals and random samples were taken from large hospitals.
- In the third round 4291 HCWs and 4642 PLWH responded, somewhat less that in the previous round. Convenience sampling is used for PLWH surveys.
- HCW survey results were also stratified based on those who have received S+D training (65%) vs. those who have not.
- For the HCW survey results, trends for the QIS+D common indicators continued to show improvement.
- Patient survey results also showed improving trends, except notably among measures related to reproductive health. Among those surveyed, 7% reported experiencing discrimination related to reproductive health, including being advised not to have children or to have pregnancies terminated.
- Implementation of QI focusing on S+D has been challenging, prompting the development of a new strategy to coach facilities and strengthen QI capacity. Among challenges, the lack of contextual root cause analysis and problem identification has been observed.
- Thailand conducted a voluntary S+D QI workshop in March focused on QI methodology, invoking the 3 Ps process (Purpose-Process-Performance), QI plan development, connecting S+D to engaging patients in care (Thai model of RRTTR), and "deep listening" skills for staff, led by Samaritans Thailand. Nine hospitals drafted QI plans at the workshop for future finalization and submission to the Division of AIDS and STI. Some QI plans addressed S+D barriers to achieving care and treatment goals for epidemic control, including improving access for MSM and changing provider attitudes.



Country Presentations (cont'd)

Thailand (cont'd)

- Following the workshop areas were noted for improving the process for coaching and implementation of S+D QI. These include gathering sufficient information to investigate causes of S+D that are compromising access to services, time required to address S+D with QI methods, and the need for more support from coaches and DAS to implement S+D QI. Due to COVID-related restrictions, a virtual QI coaching conference was held via Zoom for four participating hospitals to provide direct coaching to the facilities on the use of PDCA for S+D QI reduction activities. Ongoing coaching visits conducted by S+D QI coaches via Zoom will be utilized, when necessary.
- Zoom coaching has been used successfully to facilitate development of priorities for improvement based on identification of causes
- Thailand is developing a **code of practice** for stigma-free care and services, together with an infographic. A more detailed survey via google sheets is being distributed to 48 hospitals to drill down actions related to privacy and confidentiality. Preliminary information suggests that both privacy and queuing remain challenging and are major areas for improvement. Examples of areas of concern related to privacy include history-taking and sharing of data.
- National program activities are moving forward with integration of S+D QI into the Disease Specific Certification program and HIV national standards. QI continues to be integrated into S+D coaching activities.
- Innovations implemented by Thailand for S+D reduction were highlighted:
    - An S+D e-Learning platform (sdelearning.ddc.moph.go.th) where HCWs (67% of participants) and support staff (33%) with 4 units and a post-test where participants can learn what S+D is and how it can be reduced in the healthcare setting. Over 14,700 HCWs have received certificates of completion.
    - An online S+D Crisis Response System (crs.ddc.moph.go.th), being piloted in 14 provinces with volunteer staff from 8 NGOs. Through the CRS, patients/clients or staff can report incidents of HIV-related stigma and human rights violations. Once an incident is reported, it is screened by staff and if accepted, the incident is investigated and a resolution reached, with reporting back to the person initiating the report and facility administration.
    - A self-stigma reduction program for both PWH and members of KPs.
- Next steps for further S+D QI implementation include conducting "lessons learned" workshops, developing an QI curriculum with S+D modules, developing S+D QI tools package, and to implement the patient experience tool in other hospitals.

Malaysia

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

- The Malaysian S+D QI initiative aims to reduce S+D among HCWs towards PLWH in targeted hospitals and clinics, and its model rests on a strong and unique partnership between the MOH HIV program, QI experts from the Institute of Health Systems Research (IHSR), and civil society through the Malaysia AIDS Council.
- Since the last Network meeting, Malaysia has accelerated their S+D QI activities: Design Meeting, QI Coaching, and 1st S+D QI Workshop (February 2020), Baseline Survey (July/August); 2nd S+D QI Workshop and continued QI Coaching (August); Facility Interventions Proposed and Virtual QI Coaching (November); Intervention Phase (Dec 2020 – May 2021); and Intervention Effectiveness Evaluation (June 2021).
- The baseline survey was conducted in 9 facilities (4 hospitals, 5 health clinics) in 5 states. All facilities are high-burden sites. Healthcare respondents from the hospitals included staff with direct contact with PLWH (doctors, pharmacists, nurses, medical assistants, registration clerks, and lab staff) from

Country Presentations (cont'd)

Malaysia (cont'd)

departments with PLWH contact (Medical, OB/GYN, and Pharmacy; Radiology to be included in the next cycle). In the health clinics, as the services are fully integrated, all categories of staff were included, excluding security guards and cleaners. A convenience sample was utilized for PLWH surveyed at both hospitals and health clinics, recruited at their clinic visits and drawn from those patients who had received care at the facility for at least the prior 6 months.

- The surveys include the 8 common QIS+D questions for HCWs and the 7 for PLWH used in the Network.
- The patient survey also includes 5 treatment literacy questions, and 3 open-ended questions: 1) Have you experienced any S+D in this facility? Explain. 2) What do you like about this clinic/hospital? 3) What don't you like about this clinic/hospital?
- The HCW survey includes 6 additional questions about opinions toward PLWH and KPs, however, questions focusing on TG were not included, but will be added for subsequent rounds.
- Surveys are conducted online via a website maintained by the Malaysia AIDS Council. HCWs are recruited via email or messaging app with a QR code link to the survey. Patients are recruited during their medical appointment or via a messaging app by an NGO case worker.
- An online dashboard offers real-time access to the data to all focal persons from each state, with benchmarking reports.
- Baseline results for the HCW survey included 3,457 total respondents for the 9 sites, with response rates >70% for all sites except one (55%). Fear of contracting HIV at work was very prevalent among staff at hospital and clinics: worried about drawing blood from PLWH, avoiding physical contact with PLWH, and wearing double gloves when caring for PLWH. Many HCWs who observed colleagues unwilling to care for PLWH (7.7% to 20.1%) or providing poor care to PLWH (9.5% to 27.0%). HCWs did believe their facility had standardized protocols to reduce workplace risk of HIV infection (>95% among all staff), but fewer staff believed their facility had written guidelines to protect PLWH from S+D (60.4% to 75.1%). One third to over half of HCWs responded that women living with HIV should not be allowed to become pregnant (33.1 % to 53.7%).
- Baseline results for the patient survey included 1,144 total respondents from the 9 sites. Results from the S+D experiential questions showed low rates of health information not being explained clearly, the clinic not being welcoming and friendly, and patients not being treated with respect, however, scores were higher in hospitals vs. health clinics for these three categories. Lack of privacy and confidentiality during clinic visits question was noted in many clinics, with rates ranging up to 9.6%.
- Higher rates were seen for experiencing discrimination from a HCW, patients not being involved with decision making, and inadequate time spent with the patient by the HCW.
- Responses to open-ended questions revealed issues of privacy and confidentiality due to shared consultation rooms, crowded clinics, and using patients' names in public settings instead of a queue number. Some patients also raised issues of unfriendly clinic settings and practices, and inexperienced, unempathetic, and unfriendly staff.
- QI coaches guided the health care facilities through root cause analyses of the baseline data to determine the best interventions and action plans to address issues at critical points where S+D can occur within the process of care.
- Additionally, MOH assisted all the health care facilities to utilize an online Knowledge, Attitude, and Practice survey about HIV (36 questions total) to further analyze the causes of S+D in the clinic settings. Facilities are also encouraged to target interventions based on these results.
- Interventions to address S+D issues are categorized into structural, process, and people interventions. Structural interventions developed include co-location of services, establishing an S+D committee/task force to oversee implementation of interventions, and improving patient communication systems to ensure confidentiality. Process interventions include ensuring appropriate criteria and standards are used at critical steps in the care process, removing disease identifying labels from lab forms, development of S+D-related policies, and updating SOPs for drawing blood. People interventions include improving content and modes of trainings, regular multi-media messaging about S+D, developing reward and appreciation programs for HIV "champions," strengthening adherence services
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Country Presentations (cont'd)

Malaysia (cont'd)

provided by pharmacists, improved S+D incident reporting and resolution systems, patient journey mapping, and engaging PLWH as volunteers in the clinic in partnership with an NGO.

- Challenges for the program include the need for QI capacity building among clinic staff, low response rate for S+D data collection especially for hospital settings, lack of support from some health facility leadership, and updates needed for the online survey website to address data collect issues. Interventions to address each of the challenges have been developed.

Philippines

Presenters:

Dr. Angelo Juan Ramos
Executive Director
Sustained Health Initiatives of the Philippines

Dr. Janice Caoili
Medical Director
Professional Society for Microbiology and Infectious Disease

- The S+D QI Network in Philippines has been designed as a unique model led by the Philippine Society for Microbiology and Infectious Diseases (PSMID) and managed through Sustained Health Initiatives of the Philippines (SHIP). PSMID provides expertise, their network of member physicians in partner hospitals and HIV/AIDS Core Teams (HACT), and will add QI coaching to HIV training provided to their partner hospitals. SHIP will provide management, logistics, and data collection for the S+D program. UCSF HEALTHQUAL will provide mentoring and technical assistance, with UNAIDS Philippines providing leadership support and additional TA. Gilead Sciences has provided start-up funding to SHIP for the Network.
- The overall objectives of the Network are: to raise awareness of HIV S+D among HCWs in geographically representative HIV Treatment Hubs and other treatment facilities; apply QI to S+D reduction; provide peer exchange opportunities for sites to learn implementation strategies from each other; inform program leaders and policy makers on how successful S+D reduction strategies can be integrated into routine processes to improve HIV service delivery; and to promote a model for public-private partnership to eliminate HIV S+D in the Philippines.
- After the core team planning session began in August 2020, a Design Workshop was held virtually over three Zoom sessions in October, with 60+ participants from the Department of Health and Regional Offices, public and private hospitals, multilateral agencies, professional organizations and NGO/community-based organizations from the private sector.
- A Declaration of Commitment was developed for the Network and signed by all participants, including the Department of Health.
- Thirteen partner HIV treatment sites are participating in the network. Community organizations, including those providing services to key populations were engaged from the beginning of the Network planning to provide input in its development and design.
- The Philippine Network will utilize the same surveys and questionnaires for HCWs and patients used by the broader S+D Network, translated into 5 languages for use in the Philippines. RIHES at Chiang Mai University is assisting with the set-up of RedCAP as the data collection platform. The first round (baseline) of data collection will be conducted Feb/March 2021.
- Implementation will proceed through July 2021, starting with a baseline data collection in January, subsequent QI activity and mentoring periods, punctuated by peer learning network sessions with all participating facilities. SHIP will use its established virtual platform to convene facilities for these sessions, and for coaching activities, as needed.
-

Country Presentations (cont'd)

Philippines (cont'd)

- To sustain the program, the Network core team plans to establish a community of practice among participating facilities. Plans are underway to involve other hospitals, HIV treatment facilities, local governments, and the private sector. A package of S+D interventions will be compiled for spread and scale-up.
- Following the first phase of implementation, S+D QI initiatives will ideally be integrated into Department of Health programs to improve HIV service delivery, including the addition of S+D indicators for the accreditation of HIV treatment hubs.

Myanmar

Presenter:
Dr. Htun Nyunt Oo
Director, National AIDS Program, Department of Public Health,
Ministry of Health and Sports, Myanmar

- In Myanmar, an estimated 240,000 people are living with HIV, accounting for a prevalence rate of 0.58%, concentrated mostly among KPs (34.9% among PWID, 8.8% MSM, and 8.3% FSW).
- Myanmar has a national Human Rights and Gender Technical Working Group which meets quarterly, and provides technical input on implementation of the National Strategic Plan (NSP), facilitates the availability of strategic information to decision makers, and promotes and supports effective HIV prevention interventions.
- Current S+D reduction activities include public awareness, surveys, trainings, laws, policies, and research.
- Results from the most recent Stigma Index survey conducted in 2016 reveal that 96% of PLWH self-reported that they never were denied health services due to their HIV status. However, only 61% of the general population agreed that PLWH should not be denied health services, and 70% believe PLWH should be separated from non-HIV patients when hospitalized. The same survey showed high rates of internalized stigma among PLWH across all KPs.
- In the 2019 Integrated Biological and Behavioural Surveillance (IBBS) survey, overall, 15% of MSM felt some level of fear seeking healthcare services in the last 12 months due to their KP status, while 50% of FSW reported the same. These findings represent an improvement from those shown in the 2015 IBBS.
- Actions taken in support of S+D reduction priorities in NPS-III include:
    - Community engagement:
        - Participation in high-level health sector decision-making bodies, and in national and sub-national HIV response planning processes.
        - Direct involvement in HIV services including provision of peer support by the Myanmar Positive Group (for 67% of total ART cohort), and reviewing the Rakhine State community-led prevention and linkage project (75% of KP clients linked to ART from positive test result).
    - Sensitization trainings throughout Myanmar in collaboration with UNAIDS, partners, and local key stakeholders on S+D reduction, social re-integration, human rights, and sexual orientation and gender identity (SOGI).
    - Open Door Day activities which provide a safe forum for marginalized and vulnerable populations to raise issues for collection by community leaders and discussion with the subnational AIDS team for resolution. If warranted, issues are elevated to the national Ministry level.
    - Advocacy meetings conducted at the township level reaching over 500 HCWs.
    - A community feedback mechanism, implemented by IPs and community networks, which handled ~800 cases of S+D experienced in health care, law/justice, employment, and social settings.

Country Presentations (cont'd)

Myanmar (cont'd)

    - Introducing new laws and policies aimed at ensuring access to services and protecting rights for KPs, and removing punitive laws, policies, and practices against SW in Myanmar.
- To ensure uninterrupted treatment services during the COVID pandemic, adaptations sought to reduce the frequency of visits and the maintenance of physical distancing at facilities. Interventions included expansion of 6-month multi-month dispensing (MMD) of ART and 14-day take home doses of methadone, with consideration for accessible overdose management at nearby health facilities. By the end of May 2020, 70% of all PLWH on ART were receiving MMD, and by the end of June, 90% of methadone maintenance therapy clients were receiving the take home dosing.
- Through NSP IV, Myanmar aims to eliminate HIV S+D in healthcare, education, and workplace settings by 2025; strengthen and expand gender-responsive and rights-based HIV service delivery models, community-led service delivery, community and civil society participation in policy and legal framework changes and community feedback mechanisms; and increase the number of KP and PLWH engaged in HIV prevention, testing, and treatment programs.

Topic Presentations

Key Populations and S+D

Presenters:
Taoufik Bakkali
Senior Strategic Information Adviser
UNAIDS Regional Support Team Asia and the Pacific

- New HIV infections in Asia and the Pacific disproportionately affect KPs. Mr. Bakkali presented data prepared by AIDS Data Hub based on 2020 estimates showing 98% of all new HIV infections in the region occur in KPs or their sexual partners (MSM, 44%; SW, 9%; Clients of SW and partners of KPs, 21%; PWID, 17%; TG, 7%).
- Data from the PLHIV Stigma Index from 14 countries in the region (2008-2014) showed stigma contributed to PLWH avoided or were denied access to HIV and health services, resulting in a late diagnosis of HIV in 32% of those surveyed. From these data, it was believed that multiple layers of S+D were experienced by KPs independently of the S+D experienced because of HIV.
- To determine the impact of S+D on accessing health care systems, specific to KPs, the Global AIDS Monitoring includes indicators which measure healthcare avoidance among SW, MSM, PWID, and TG due to S+D. Other indicators measure discriminatory attitudes towards PLHIV and HIV-related discrimination experienced by PLHIV, in general, in healthcare settings. A separate indicator measures the experience of HIV-related discrimination in health-care settings. These indicators are informed by population-based surveys that are not conducted regularly, and few countries report data; QIS+D offers a complementary strategy for measuring S+D on a frequent and regular basis.
- In Thailand, national S+D survey data reported by MOPH in 2014/15 and 2017 showed improvement in rates of PLWH avoiding or delaying healthcare because of fear of S+D (13% to 5.2), as part of overall improvement rates in 4 of 5 S+D indicators.
- The issues of provider denial of healthcare and people not engaging in care require that we not only measure whether stigma or discrimination is experienced by KPs in the healthcare setting, but also their perception of the healthcare provided and whether they experience self-stigma that may cause them to not access services. As we reduce S+D in healthcare settings, it is imperative that we tell consumers that action has been taken, what actions have been taken and that improvement is happening.

Topic Presentations (cont'd)

Sustainability of HIV Services for Key Populations in Asia (SKPA)

Presenters:
Greg Gray
Country Lead
Australian Federation of AIDS Organisations (AFAO)

Sanjeev Neupane
Monitoring, Evaluation and Learning Officer
AFAO

Harry Prabowo
Program Coordinator
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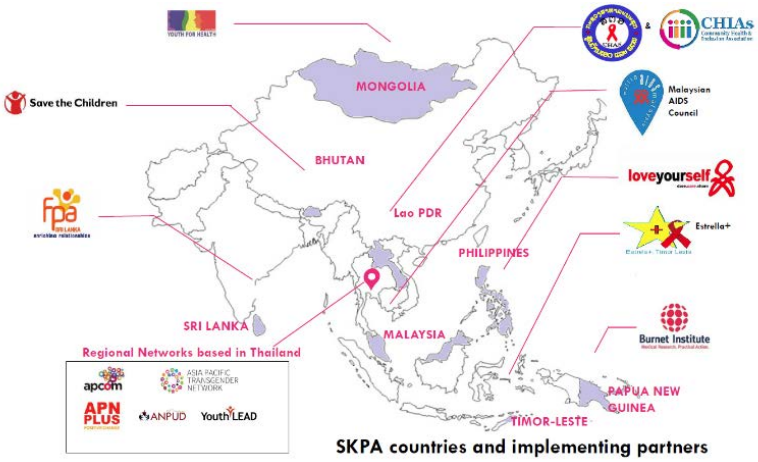
- The Sustainability of HIV Services for Key Populations in ASIA (SKPA) is a Multi Country Grant program funded by the Global Fund and managed by Australian Federation of AIDS service Organizations AFAO. The goal of the SKPA program is to promote sustainable services for KPs at scale to stop HIV transmission and AIDS-related deaths by 2030, by increasing financial stability, strengthening strategic information and community systems, mitigating service delivery gaps, and contributing to an enabling environment. SKPA began in January 2019 and will run through December 2021. It is funded by the Global Fund with AFAO as its principal recipient. There are 8 participating country sub recipient partners (SRs) and 4 implementing regional key population network sub-recipient partners.



SKPA countries and implementing partners

- Regional KP networks headed by implementing partners provide technical assistance for the implementation of the program in the 8 countries. The lead partners and topics for the networks are APN+ (S+D), APCOM (community-based monitoring and demand generation), APTN (TG-friendly services and related advocacy), and YouthLead (young KP advocacy). Sustainability planning for the regional KP networks to maximize impact is currently in progress and SKPA will fund activities based on recommendations emerging from these discussions.
- A table of program activities by country is provided in the Appendix.
- SKPA S+D reduction activities aim to establish a community-led feedback mechanism to strengthen community involvement in S+D reduction and align with QIS+D and the Global Partnership, among other initiatives. Activities are being conducted in Timor Leste, Lao PDR, Malaysia, Bhutan, and Mongolia.
- The strategy SKPA employs for S+D reduction is to create a community-owned program that complements existing S+D reduction efforts in the country, increases community participation, and creates a safe environment for sharing and discussion.
- Progress made in S+D reduction will be reported through existing reporting platforms for efficiency, allowing community stakeholders and policy to discuss successes and challenges.
- Recommendations for future efforts include addressing self-stigma, provision of opportunities for meaningful engagement of KPs in S+D activities, building capacity of the community to identify the root

Topic Presentations (cont'd)

SKPA (cont'd)

causes and drivers of key concerns, and to develop efficacious responses to address those concerns through a joint multi-stakeholder approach.

Adapting the healthcare worker survey for key populations: the view from New York

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

- In New York State, statewide healthcare worker survey to assess S+D in healthcare facilities was developed to include questions about HIV-related stigma, but also stigma associated with key populations (KPs). Stigma was often identified as a likely cause for lower rates of VLS lower among TG and young people. In this way, the survey addresses
- the multi-layered determinants of stigma and will facilitate targeting of improvement interventions to specific causes and populations.
- A joint subcommittee of the statewide provider and consumer quality committees determined which sub-populations to include in the survey. Those included TG, MSM, PWID, women, people of color (notable disparities in the US), and people living with a mental health diagnosis (PLMHD).
- Questions were added to elicit discriminatory and prejudicial attitudes among HCW towards KPs, whether providers had received training related to each KP, whether a facility has a discrimination policy, has a welcoming environment, if certain services are available to each KP in their facility, and if providers were comfortable discussing sexual history with MSM and TG, among other KP-specific questions.
- The scoring methodology for the adapted surveys utilized weighted averages, where any disagreeing response to a positive statement and any agreeing response to a stigmatizing statement was considered a "stigma strike." A "strong" response was weighted x2, while an agree/disagree response was weighted x1. For frequency response, the higher the frequency, the more weight was applied.
- Some selected results from the adapted survey include: not receiving training on S+D or KPs (35.5%); agreeing that HIV infection stems from irresponsible behaviors (26.1%); agreeing PLWH have many sexual partners (16%); and having a lack of comfort treating people with a mental health diagnosis (18.4%).
- While scores measuring observations of colleagues providing poorer care to KPs and speaking badly about them were highest in the PLMHD group (21.6% and 28.6%, respectively), they were also notable for PLWH in general (13.7% and 19.3%).
- A small group activity was conducted with Network participants to address the following questions:
    - Which patient key populations are important to include in your healthcare worker surveys?
    - Once you identify those groups, please identify the questions that are important to ask related to that group in your country?

A report back from the small groups is provided in the Appendix.

Appendix

Implementation Progress

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

Progress by Domain

Domain	Cambodia	Lao PDR	Thailand	Vietnam	Malaysia	Philippines
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 HCW survey data	✓	✓	✓	✓	✓	✓
2.2 Completion of baseline data collection - HCW	✓	✓	✓	✓	✓	**in progress**
2.3 Number of post-baseline data collection rounds – HCW	**2**	**3**	**3**	**2**	**0**	**0**
2.4 Formal protocol for collection of PLWH experience questions	✓	✓	✓	✓	✓	✓
2.5 Completion of baseline data collection - PLWH	✓	✓	✓	✓	✓	**in progress**
2.6 Inclusion of PLWH treatment literacy questions		✓	✓	✓	✓	✓
2.7 Number of post-baseline data collection rounds – PLWH	**N/A**	**1**	**3**	**2**	**0**	**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		✓		✓	✓	
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		✓		✓		

Appendix (cont'd)

Data Collection Summary

Domain	Cambodia	Lao PDR	Thailand	Viet Nam	Malaysia	Philippines	Total
Healthcare Worker Survey							
# of rounds	4	4	3	3	1	0	15
# of staff	372	3,570	18,119	1,266	3,457	N/A	26,784
Comments			48 hospitals	Revising approach to measurement, first new round Feb-April 2020	2nd round scheduled for June 2021	Baseline to be completed March 2021	
Patient Experience Questions							
# of rounds	15	2	2	3/4	1	0	20
# of patients	8,787	675	11,477	1,246	1,144	N/A	23,329
Comments	Use "Patient Satisfaction Survey" instead (n=8,787); data are collected more frequently		Use "PLHIV survey" instead (n=11,477)	Thai Nguyen & Hanoi completed round 3 with the revised tool applied; Binh Duong completed 4 rounds with the 2 recent rounds with the revised tool; HCMC piloted a QR code for 2 rounds (400 pts/round, excluded from the # of pts above)	2nd round scheduled for June 2021	Baseline to be completed March 2021	
Clinical Literacy Questions							
# of rounds	N/A	2	1	2	1	0	6
# of patients	N/A	675	251	1,050	1,144	N/A	3,120
Comments	Plans to implement in 2021		Will adapt questions	Hanoi, Thai Nguyen completed 2 rounds, BD completed 3 rounds	2nd round scheduled for June 2021	Baseline to be completed March 2021	

Appendix (cont'd)

SKPA Activities by Country

The activities in each country

Objectives	Activities	Bhutan	Lao	Malaysia	Mongolia	PNG	Philippines	Timor-Leste	Sri Lanka
Objective 1: Increase financial sustainability	Develop and implement action plans for achieving sustainable financing		X		X		X		X
Objective 2: Strengthen strategic information	Population size estimation (PSE)	X						X	
	Rapid assessment of PWID and TG		X		X				
Objective 3: Mitigate service delivery gaps:	Review of package of services for key populations (KPs)	X	X		X				X
	Implementation of community based testing	X	X		X	X		X	
	Implementation of HIV self testing and PrEP		X	X	X		X		
	Demand generation for HIV services through digital campaigns and social marketing		X		X	X	X		
Objective 4: Strengthen community systems:	Community based monitoring (CBM)		X		X	X			X
	Capacity building support for CBOs/NGOs	X	X	X	X		X		X
Objective 5: Contribute to enabling environment	Address stigma & discrimination in health care settings	X	X	X				X	
	Gender Review	X	X	X	X	X	X	X	X
	Advocacy for transgender friendly services					X	X		X
	Advocacy for engagement of young Key population		X					X	

Stigma and Key Populations: Small Group Report Back by Country

Country	Priority Key Populations	Survey Questions/Topics/Themes
Malaysia	MSM, PWID, SW TG (planned)	1. If I had a choice, I would prefer not to provide services to MSM. (*Same question format for all KPs, scored as strongly disagree to strongly agree. If agree or strongly agree, they also answer question 1a.)* 1a. I prefer not to provide services to MSM because (check all that apply): a. They put me at higher risk for disease. (Agree/Disagree) b. This group engages in immoral behavior. (A/G) c. I have not received training to work with this group. (A/G)
Philippines	MSM, TGW, IDU, Pregnant Women, Youth. MSM may need to be contextually subdivided, e.g., Seafarers, Incarcerated men.	Topics for the HCW survey may include: 1. Awareness of the situation of HIV in these KPs. 2. Personal and technical comfort treating or examining KP patients. a. Do you feel you have the training to provide services to KPs? What training do you need? 3. What are the available services in your facility for these KPs? 4. Are you aware of linkages you can access for referrals to NGOs
Lao PDR	MSM, TG, FSW	Questions would focus on awareness of KP issues, knowledge/skill for treating KPs, and willingness to provide services to KPs.
Thailand	MSM, TG, SW, migrant workers	As different KPs access care at different health facilities, questionnaires will be adapted to each site for particular KPs.
Cambodia	MSM, TG, entertainment workers (EW), PWID, PWUD	Patient Assessment (Cambodia's standard PSS) 1. Patient satisfaction of ART services (e.g., satisfaction with provider, receptionist, pharmacist, counselor) 2. Patient satisfaction of other services (waiting times, clinic hours, breaking privacy, reproductive health, lab, TB, STI. 3. Patient profile (how much time for the service) Health Facility Staff Self-Assessment 4. Facility and Staff profile 5. For KP (PLHIV, MSM, FEW, TG, PWID/PWUD)
Vietnam	MSM, TG, FSW, PWID	Same questions for all KPs; all scored as strongly agree to strongly disagree: 1. I prefer to not provide health services to MSM. 2. MSM put me at higher risk of HIV infection. 3. MSM engage in immoral behavior. 4. I have not received training to work with MSM.
Myanmar	MSM, TG, SW, PWID, prisoners and the incarcerated, migrant people, young KPs, KP pregnant women	• Delay health seeking of key populations in health care settings because of self- stigmatization • Measure self-esteem as inversely related to stigma • Perceived availability and satisfaction of services and support in health care settings • Attitude of the health care workers toward the key populations • Willingness to provide services for KPs and PLHIV • Willingness to work alongside with a colleague living with HIV/KPs • Concern about the quality of care to KPs • Any experience of HIV related discrimination among KPs • Self-reported use of unnecessary precaution when dealing with KPs and PLHIV • Barriers to receiving health care services for HIV-positive pregnant KP women. • Supportive laws and policies to provide stigma-free health care services

Appendix (cont'd)

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