Summary of the 9th Multi-Country Network Meeting

Southeast Asia Stigma Reduction QI Learning Network

August 20, 27, September 3
Virtual, via Zoom

Healthqual

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GILEAD

Ly Penh Sun, Director of the National Center for HIV/AIDS, Dermatology and STD (NCHADS), Phnom Penh, Cambodia, November 2020. Credit: UNAIDS

In Memoriam

It is with great sadness that we acknowledge the untimely death of our colleague Ly Penh Sun, Director of the National Center for HIV/AIDS, Dermatology and STD (NCHADS) Cambodia, who passed away on 9 November 2021.

Ly Penh Sun brought his open style, positive approach and commitment to ending the HIV epidemic to his work in Cambodia. We send condolences to our colleagues at NCHADS and Dr. Sun's family. We will miss him and his contributions to the QIS+D Network, as just one small part of those leading the effort to achieve maximal health-related quality of life to those living with HIV and to key populations.

Presentations and Recordings

A shared Dropbox folder with all presentations from the 9th Network Meeting can be found at:
dropbox.com/sh/ocw42dkur92yjc7/AAAPJIfz0iYo-IOIU8ws9SHSa?dl=0

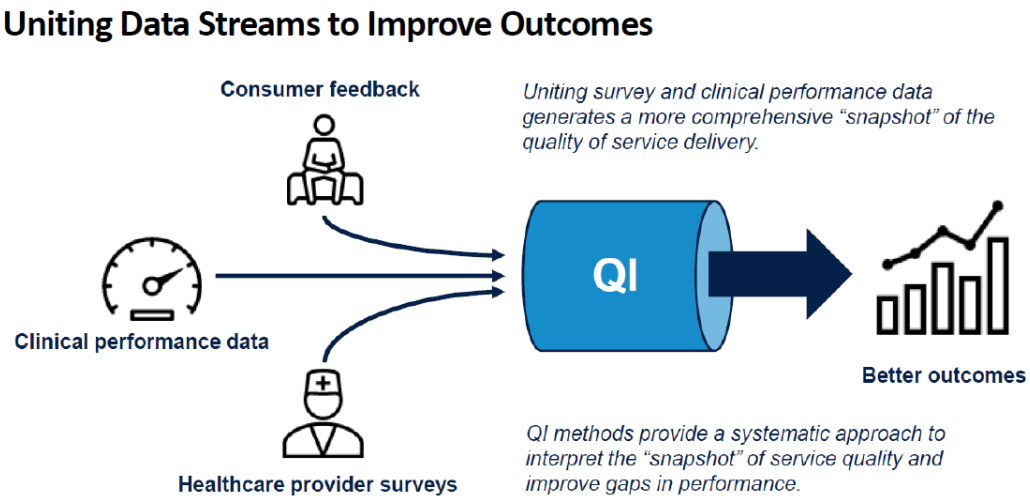
A public YouTube playlist with the video recordings of each day of the 9th Network Meeting can be found at:
youtube.com/playlist?list=PLd2cUKWXn63zXL1TeZLayPHwVpn5Mg_5a

Executive Summary

Background

HIV-related stigma and discrimination (S+D) in the healthcare setting remains a formidable barrier to achieving 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 UCSF-HEALTHQUAL, headquartered 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 Learning Network aims to accelerate the implementation of national- and facility-level HIV-related S+D reduction activities in Cambodia, Lao PDR, Malaysia, Philippines, Thailand, and Vietnam through routine measurement, quality improvement (QI) methods, and peer learning and knowledge exchange. By acting upon insights generated from routine analysis of healthcare provider survey data and patient feedback, anticipated outcomes of the initiative include the 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



The 9th Multi-Country Network Meeting of the Southeast Asia Stigma Reduction QI Learning Network was convened on August 20, 27, and September 3 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, Malaysia, Myanmar, Philippines, Thailand, and Vietnam (see **Appendix** for a list of attendees). The meeting was co-chaired by Harry Prabowo of APN+, Belice Odamna of UNAIDS, and Dr. Bruce Agins, Richard Birchard, and Charlie Ferrusi of UCSF HEALTHQUAL.

Executive Summary (cont'd)

Meeting Objectives

The objectives of the meeting were to:

- Present country-specific updates on the implementation of S+D QI activities, including successes and challenges, focusing on how data from how Network data, including health literacy assessments are used to identify effective S+D QI interventions and approaches.
- Present and discuss ways HIV-related S+D disproportionately affects key populations (KPs) and define areas to measure S+D experience in KPs for which specific interventions can be developed.
- Engage expert speakers in discussions focusing on **KP-Led Health Services** (KPLHS) model, **community-led monitoring** (CLM), and **mental health burden** among PLWH and LGBTQ populations.
- Engage attendees to in group discussions via breakout sessions to discuss the mental health issues embedded in addressing stigma and strategies to include self-stigma as a component of S+D programming in health facilities.

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 their follow-up data and how results are used to identify effective QI interventions.
- The challenges of S+D among key populations was a major theme of many of the country presentations.
- Quinten Lataire, UNAIDS Regional Support Team for Asia and the Pacific, shared a pre-recorded video detailing global advances in the field of HIV including a new UNAIDS political declaration focusing on human rights and S+D.
- Dr. Nittaya Phanuphak and Greg Carl from the Institute of HIV Research and Innovation (IHRI) presented on their innovative **KP-Led Health Services** Model, where task-shifting allows KP lay providers to deliver a package of services that are needs-based, demand-driven, and client-centered.
- Solange Baptiste and Nadia Rafif from the International Treatment Preparedness Coalition (ITPC) presented on "Citizen Science," and the activities and impact of their **community-led monitoring** efforts.
- Dr. Sunisa Suktrakul from Chulalongkorn University provided a pre-recorded presentation on the **Self-Stigma Program and curriculum** implemented in Thailand.
- Alex Keuroghlian, PhD from The Fenway Institute presented on mental health service delivery among PLWH and the unique mental health needs of LGBTQ populations.
- Attendees engaged in two breakout sessions focusing on reducing self-stigma and addressing mental health in service delivery among PLWH and KPs in their respective countries.

Next Steps

The 10th Multi-Country QIS+D Network Meeting will be convened virtually in April/May 2022. It will focus on the review of work plans, activities focusing on S+D affecting key populations, and partnerships with community providers and PLWH to reduce stigma. Additionally, there will be continued discussion about activities focusing on mental health, self-stigma, CLM, and the KPLHS model. Plans for S+D QI activities and expansion are being reformulated as we continue adaptation to the COVID-19 pandemic.

Before the 10th 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.

Executive Summary (cont'd)

- Coordinate follow-up discussions at future QIS+D Network meetings focusing on mental health, self-stigma, CLM, and the KPLHS model.
- Schedule virtual check-in meetings with country teams.
- Distribute Network Meeting summary report, including the summary of the breakout sessions and resources from guest presenters.
- Continue development and dissemination of Spotlights to showcase country and facility-level experiences implementing S+D QI activities.

Ministries of Health will:

- Continue implementing S+D QI activities according to their work plans, including ongoing measurement and documentation of improvement interventions.
- Measure network-wide indicators on treatment literacy and patient experience, and through HCW surveys.
- Scale-up and spread successful interventions and best practices that have been shown to reduce S+D.
- Develop plans to integrate KP-specific stigma reduction interventions into their existing S+D QI activities, addressing self-stigma and mental health when possible.
- Continue to harvest successful interventions and implementation approaches for presentation at the Network's 10th Multi-Country QIS+D Network Meeting.

Acknowledgments

The SE Asia Stigma Reduction QI Learning Network is supported financially by Gilead Sciences, Inc. and ViiV Healthcare. The contents are the responsibility of UCSF-HEALTHQUAL and do not necessarily reflect the views of Gilead Sciences, Inc. or ViiV Healthcare.

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 (AFAO), CDC, WHO, Gilead Sciences, Malaysian AIDS Council (MAC), HAIVN, FHI 360, Myanmar Positive Group, Sustained Health Initiatives of the Philippines (SHIP), Professional Society for Microbiology and Infectious Disease (PSMID), and APN+, as well as delegates from Myanmar. He thanked everyone for their flexibility regarding the ongoing virtual format of the meeting. Dr. Agins acknowledged the team that contributed to the organization and planning of the meeting, including Quinten Lataire and Belice Odamna of UNAIDS, Harry Prabowo of APN+, and UCSF staff, Richard Birchard and Charlie Ferrusi. Dr. Agins reviewed participating Network country COVID-19 data including daily new confirmed COVID-19 cases per million people, share of SARS-CoV-2 sequences that are the Delta variant, and daily new confirmed COVID-19 deaths per million. All rates continue to increase, and show the ongoing impact of the pandemic. On a positive note, the share of people vaccinated against COVID-19 has been increasing. Dr. Agins reiterated that although COVID-19 impacts our collective work, it does not diminish the urgency of addressing the root causes of S+D among PLWH. Dr. Agins, commended the teams for advancing their S+D reduction activities despite the interruptions due to the pandemic.

Quinten Lataire, UNAIDS Regional Human Rights and Law Advisor, provided a pre-recorded video presentation, welcoming the participants s on behalf of UNAIDS. Mr. Lataire noted global advances in the field of HIV including the new political declaration, *Ending Inequalities and Getting on Track to End AIDS by 2030*, which was adopted at the UN General Assembly High-Level Meeting on AIDS in New York on June 9, 2021. UNAIDS also adopted the *Global AIDS Strategy 2021-2026 – End Inequalities. End AIDS*, which is a bold new approach to use the lens of equity to close the gaps that are preventing progress towards ending AIDS. The Strategy was developed collaboratively based on data and involving stakeholders from country teams, communities, and partners. The Strategy sets forth evidence-based priority actions and bold targets to get every country and every community on-track to end AIDS by 2030. One of the three strategic priorities is to break down legal and societal barriers to achieve HIV outcomes, including the target of 10% for PLWH and KPs experiencing S+D, highlighting the importance of QIS+D as a strategy focusing on health care settings. UNAIDS will continue to strengthen its focus on human rights and S+D. Mr. Lataire stated that UNAIDS is delighted to co-convene QIS+D with UCSF-HEALTHQUAL and applauded the ongoing partnership that has been established.

Country Presentations

Cambodia

Presenter:
Dr. Ngauv Bora
Chief
Technical Bureau of the National Center for HIV/AIDS, Dermatology and STD (NCHADS)

- The National AIDS Program reported several major updates including updating of Standard Operating Procedures (SOP) for Patient Satisfaction Feedback (PSF) from PLWH. Over 170 HCWs attended a virtual PSF SOP dissemination session. Cambodia is scaling up the PSF to 60 ART sites to engage community workers as part of its Community Action Approach through refresher training on implementation procedures and data use.
- Site-based PSF QR codes for patients and providers are used to administer surveys and submit data to the PSF Database Server and PSF Dashboard. The PSF Dashboard has been updated and is used for site, district, provincial, and national level data to monitor key indicators and the ongoing progress of QI

Country Presentations (cont'd)

Cambodia (cont'd)

efforts, disaggregated by patient or HCW respondent group, KP group, age, provincial level, and hospital. The dashboard is managed by NCHADS with technical support from the EpiC/FHI360 project.

- As a result of COVID lockdowns, the number of patients providing feedback during the pandemic decreased from 1876 (FY20 Q4) to 1082 (FY21 Q1) to 643 (FY21 Q2).
- The number of providers participating in the PSF ranged from 45 (FY20 Q4) to 60 (FY21 Q1) without subsequent rounds at the time of presentation. Most providers continue to be only from ART units (72%). Provider feedback shows a decrease in the likelihood of HCWs being unwilling to care for KP, providing poorer quality of care to KPs, wearing double gloves when providing care to PLWH, and worrying about HIV transmission.
- U=U campaigns have been introduced in all ART clinics in 25 provinces.
- An example of the site-level documentation tool to track response to findings was shown which includes action steps for each facility based on areas for improvement which were identified through data and coaching sessions with NCHADS. Data are used at hospitals by directors during meetings of Group of Champions to plan PDSA cycles.
- Action areas identified were summarized and include: focus group discussions with patients with unsuppressed viral loads conducted by NCHADS and ART staff, emphasis on U=U messaging and its integration into the Health4All training, and both individual and group discussions to address misunderstandings and explain U=U.
- Cambodia's KP community feedback loop was described, including the role of partners and NGOs in delivering feedback from the community to the national level, additionally supported by the Global Fund.
- Implementation of Community Scorecard is led by PLWH and KP, focusing on domains of S+D, human rights, intimate partner violence, STI, prevention, care and treatment, and social protection. Findings are integrated into action steps during coaching sessions with providers.
- The current limitation on provider response to surveys has slowed progress of the S+D QI work, augmented by the inability of the PSF national team to conduct monitoring and coaching in person, although some virtual coaching sessions have been conducted.
- The next steps include the expansion of virtual technologies and social media to promote U=U and KP-friendly services; expand the use of QR codes to collect feedback from patients and HCWs; use e-monitoring tools for coaching, and to provide virtual TA, to continue to improve site-specific QI.

Vietnam

Presenter:
Dr. Do Huu Thuy
Vietnam Administration of HIV/AIDS Control (VAAC)
Ministry of Health, Vietnam

Ms. Do Thi Phuong
Project Coordinator
The Partnership for Health Advancement in Vietnam (HAIVN)

- Vietnam is currently implementing its S+D QI work within six provinces. Five provinces conducted S+D assessment rounds between October 2020 and April 2021, with data collection covering 22 sites. Multiple methods, including self-administered surveys via QR code or link, and facilitation by peers and HCW support, including interviews,) are used for assessment.
- The Covid response has challenged the health system, resulting in slowing of implementation of other activities. Hospitals and facilities are under lockdown restrictions, and travel restrictions have compromised access to medications.

Country Presentations (cont'd)

Vietnam (cont'd)

- Vietnam recently released guidelines on KP-friendly services adapted from Hanoi Medical University and CDC/PEPFAR. This includes ten standards for all HIV service providers. National guidance and advocacy for expanding CABs have been launched.
- Vietnam has expanded QIS+D to an additional 3 provinces beyond Binh Duong, Thai Nguyen and Hanoi. Emphasis has shifted away from well-performing sites to focus on high-need sites, given improvement in results from the former and demonstration of need in the latter. Use of a self-administered questionnaire using QR code has expanded to 3 provinces. The program has also expanded to PrEP sites.
- The focus of QI work has been to improve health literacy, following results that demonstrated a lack of knowledge of viral load test results and when the next test is due among a high proportion of patients. Although improvements were noted in Binh Duong, Hanoi and Thai Nguyen in client knowledge of the most recent VL test results, data show that VL literacy remains a persistent gap, particularly among sites conducting assessments for the first time.
- Despite the national campaign on U=U, the baseline assessment also confirms an ongoing need for universal U=U education. Of the respondents from Binh Duong (n=380), 42% were not familiar with U=U, and 52% did not hear about U=U from their healthcare provider. Of the respondents from Bà Rịa–Vũng Tàu Province (n=221), 39% were not familiar with U=U, and 39% did not hear about U=U from their healthcare provider. Site-level U=U and VL literacy is a QI focus and includes counseling for clients, CABs, and the design of educational materials
- Other interventions include sexual orientation and gender identity (SOGI) training, and facility policy development.
- Vietnam has expanded CABs to six provinces. In September 2021, the government endorsed CABs and is in the process of standardizing the model. CABs have successfully driven implementation of after-hours services, navigation assistance, flexible services, and access to SHI. They have also facilitated increased privacy in healthcare settings, enhanced space in clinics, and created web-based support channels.
- CLM brings the direct input of people to enhance the picture of S+D and quality of care. CLM has just begun in Vietnam, with data collection underway and initial results expected in September 2021. The first phase includes 30 PEPFAR sites. CLM data will be reported quarterly and shared with all IPs and will contribute to country-level QI initiatives.
- Data collection for the Stigma Index 2.0 was led by VNP+ and completed in January 2021 in seven provinces. Preliminary findings include 33% of MSM and 41% of transgender women reporting one or more S+D incidents in a healthcare setting in the last 12 months. Among the entire sample, high rates of self-stigma and mental health issues were reported, with 43% reporting anxiety or depression. Findings and recommendations will inform mental health and self-stigma interventions among YMSM.
- Early data from surveys among clients indicate high rates of stigma associated with PrEP, measured by reported experience of community stigma targeting PrEP.
- Next steps and future priorities include scaling up best practices and innovations and institutionalizing them within provincial health structures for sustainability but also for responsiveness, promoting data use and expand and grow these collaborations for mutual benefits and improved outcomes.
- Examples from the successes in the HIV program will be leveraged for Covid including use of CABs to provide friendly services for vaccination.

Country Presentations (cont'd)

Lao PDR

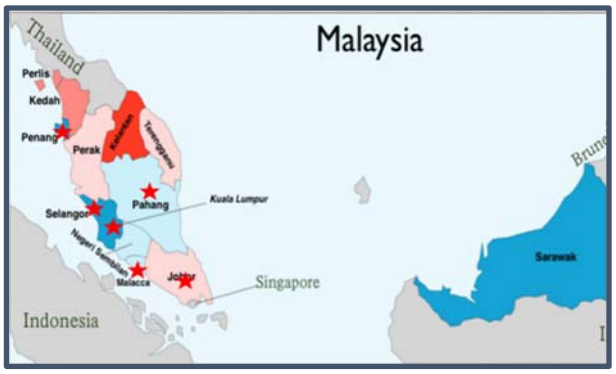
Presenter:
Dr. Ketmala Banchongphanith, MD, MPH
Head of Management on HIV/AIDS and STI Division
Center for HIV/AIDS/STI, Ministry of Health, Lao PDR

- S+D routine monitoring among HCWs was changed from quarterly to twice per year because of the covid pandemic. Lockdowns caused in-person QI coaching to pause after April 2021. Staff were deployed for COVID-19 efforts.
- A sixth round of HCW surveys was conducted in July 2021. Questions on COVID-19 vaccinations among PLWH were added during this round. A Google Form, accessible by QR code, was used for the survey and to analyze data. This round had the highest number of respondents, with 1686 HCWs completing the survey, an increase of 400 since the last round. Most respondents were nurses (53.7%) and doctors (28.9%). Respondents represented a variety of wards and units.
- When compared to the previous rounds, respondents in the sixth round showed improved rates for all the following common S+D questions regarding care provision to PLWH. The measures were disaggregated by sex, role, and service area, allowing for targeting of S+D reduction activities. Site-level variation is notable for some measures which will enable intensification of coaching to sites based on performance.
- The fourth round of the patient feedback survey included 536 respondents, a decline from 609 in the third round likely a result of travel restrictions that precluded clinic visits.
- Results indicated that 95.9% of patients thought information delivered was explained clearly, and 100% indicated that the clinic was welcoming and friendly; Nearly 100% of respondents indicated that they were treated with respect during their visit that privacy and confidentiality were observed, that they were involved with decision making about care, and that the provider spent enough time with the patient during the visit. Among the respondents, 5.2% reported that they experienced discrimination from a health provider or staff member.
- For the clinical literacy questions, 66.8% of patients knew which regimen they were taking, 68.7% knew what a VL test was, 58.6% knew their last VL test result, and 48.0% knew when their next VL test visit was, indicating a significant need to focus on HIV treatment literacy and consider its relevance for U=U messaging.
- FSW and MSM-specific results from the S+D questions from Lao IBBS 2020 were reviewed, highlighting specific focus areas and disparities. A high number of MSM reported delayed care-seeking because of fear or concern about stigma, and that they were denied services because of their sexual behavior. The plan is to add these questions to the next round of the patient feedback.
- The survey was also used to gather information about status of Covid vaccination among PLWH. Only 17.4% of respondents had received at least one dose, with the majority of those not receiving a dose (68%) citing fear of the vaccine as the reason.
- New activities include 1) an S+D feedback mechanism with community engagement that was developed through the community-based monitoring tool supported by SKPA, 2) developing a new S+D toolkit and training package for HCWs and PLWH being developed in collaboration with TUC (Thailand) and CSOs, and 3) strengthening QI implementation at all sites based on findings.
- The national-level strategy includes continued integration of S+D into the existing HIV QI program, revising health literacy efforts to include S+D and KPs, strengthening CSO engagement and involvement in QIS+D activities, improving S+D QI activities (e.g., PDSA), and conducting the Stigma Index Survey.
- Next steps include ongoing S+D reviews and dissemination of data, including additional questions about HIV stigma to the next round of the HCW survey, adding an index of engagement in HIV care to the patient feedback survey, on-site coaching, mentoring of hospital-based QI focal persons by CHAS to become QI coaches, reinvigoration of the QI coaches group to foster peer learning, and the development of a written change package of successful interventions.

Country Presentations (cont'd)

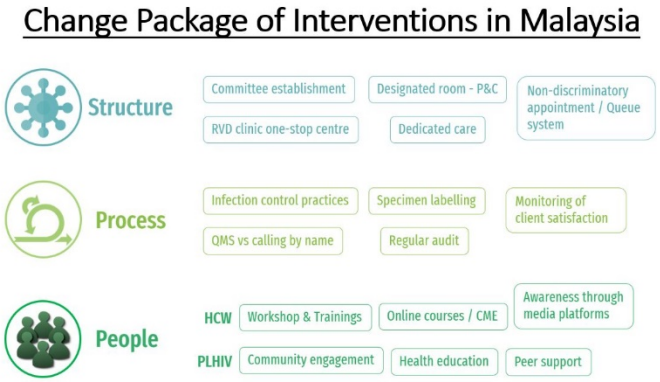
Malaysia

Presenter:
Dr. Izzatur Rahmi Mohd Ujang
Institute for Health Systems Research
Ministry of Health, Malaysia



- The Malaysia QI S+D project started in February 2020 with 11 facilities, and as of August 2021, ten facilities are participating in the second round of data collection. The COVID-19 pandemic necessitated the reprioritization of activities that resulted in the loss of some participating facilities. QI coaching and group meetings have been virtual and the intervention period was extended from 6 to 8 months.
- Both S+D surveys are accessible online. HCWs receive a recruitment message with a hyperlink or QR code to the online survey website. PLWH are recruited during their appointment visit at the facility or via messaging apps by an NGO case worker.
- For the HCW survey, there was a decline (54%) in the number of respondents from 3457 during baseline to 1598 in the follow-up round, in tandem with the loss of 1 facility and redeployment of HCWs. Additionally, the PLWH Survey decreased (46%) from 1144 respondents during baseline to 623 in August.
- Most facilities saw improvements in most indicators. The indicator regarding the absence of protocols to reduce the risk of HCWs acquiring HIV showed an increase. Although facilities may lack specific guidelines for reducing HIV infection risk among HCWs, national policies and procedures on infection prevention and control exist which will be used as reference at the sites.
- Notably, the data demonstrated a reduction in the number of HCWs preferring not to provide services to PWID, MSM, and FSW across all sites.
- Results from the PLWH survey were mixed across facilities and indicators. However, the indicator for PLWH experiencing discrimination from HCW improved across all sites.
- An increase in the number of PLWH not on ART (5/8 sites) and not knowing their ART regimen (4/8) was observed to a greater extent in hospitals than the clinics.
- An overview was provided of the various interventions (i.e., structure, process, people) that have been conducted throughout the project. Please see **Figure 1** for examples.

Figure 1



- QI interventions are tracked and reported using an Excel worksheet template to capture a description and explanation of the improvement intervention, when it started, where it was conducted, and who was involved. A compendium of successful S+D reduction interventions is being compiled for distribution to all healthcare facilities.
- Malaysia's incident reporting system was presented. Implemented by the Malaysian AIDS Council, this system permits PLWH and KPs to report any event that is discriminatory which is then investigated. MAC will help channel the complaint to the relevant parties for feedback and further action, if necessary. The government also manages a public complaint management system.
- QI coaching is conducted virtually, and supplemented by a monthly webinar discussing various QI topics.

Country Presentations (cont'd)

Malaysia (cont'd)

- The QI project at Clinic Selangor was highlighted: "Project Kasih" (facebook.com/watch/?v=1085897938512172). Building on its culture of client empowerment, HCW engagement and NGO participation in clinic activities, Project Kasih engaged HIV patients to co-design and implement strategies to adapt clinic services to pandemic conditions. Patients were engaged throughout the clinic to provide transport for disabled patients, and disinfect equipment to ensure that Covid precautions were followed. The clinic collaborated with Insaf Murni (NGO) and MAC to provide incentives and appoint clients as mentors to other clients so that a new cadre of workforce was developed. Regular trainings were held, vaccinations expedited, and PPE provided. Moreover, the clinic demonstrated improvements in every indicator for both the HCW and PLWH survey, except for the indicator regarding protocols to reduce the risk of HCWs acquiring HIV.
- Implementation challenges included recruitment and training of volunteers, patient safety issues, and an increase in COVID-19 cases.
- Malaysia Stigma Evaluation Survey (MYSES) 2021 was the first national study to establish a benchmark on S+D faced by PLWH in Malaysia. The survey was coordinated by the MAC and conducted January/February 2021. Preliminary results indicated a majority of respondents were part of a KP group (72%). This survey found that 47% of respondents had been advised by a healthcare provider not to have sex, with 2% indicating they were denied treatment. Despite these findings, over 90% of respondents were satisfied with the services provided.
- National level interventions based on the QIS+D results will be centered around providing short webinar sessions to HCWs to improve infection control knowledge, reinforce the code of ethics, promote awareness of U=U, treatment literacy, and sexual health.
- The S+D scale-up plan includes continued re-evaluation and cycle two of intervention activities, coaching, training, and peer-learning.

Thailand

Presenters:
Dr. Darinda Rosa, MD
Chief of Development of HIV/AIDS Treatment and Care Cluster
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

- COVID-19 has delayed implementation of S+D QI efforts. Five new hospitals were engaged in 2021 with virtual trainings.
- The national program has moved forward with plans to integrate S+D QI in routine work for sustainability and mobilizing resources to increase the comprehensive 3x4 intervention package coverage.
- Specific components of the national scale-up of S+D reduction in health care facilities include expansion to 71 provinces and 115 hospitals. Intervention is now being stratified into "new", "basic" and "advanced" levels.
- Since the previous Network meeting, two additional analyses using the same survey datasets were performed to assess baseline vs. long-term improvements. One analysis included a sub-group among KP PLWH, and the other assessed S+D towards KPs observed by HCW within the last 12 months. Sample sizes for migrant workers and IDU did not permit inclusion in this long-term analysis.

Country Presentations (cont'd)

Thailand (cont'd)

- Data on the HCW survey showed improvements among migrant workers, people who use drugs and sex workers in the indicator measuring whether poor quality was observed in provision of care towards KPs during the last 12 months *comparing baseline to long-term results, defined as baseline: October 2017-July 2018, 1-6 months before training; post-intervention: November 2018-April 2019, 3-6 month after training; long-term: December 2019-June 2020, 1.5 years after training.* However, for transgender women there was an increase from 9.5% baseline to 15.7% long-term, underscoring an area of focus for targeted improvement activities.
- Findings from the KP PLWH client survey results showed improvements in 4 key measures pertaining to MSM, TGW and SW, including status being disclosed without consent, records marked with HIV status non-confidentially, being informed to come back later or wait longer, and receiving less care than other patients.
- QI coaching has continued through virtual meetings and LINE groups.
- Almost all facilities have tools to collect patient satisfaction data, recommend improvements to the quality of services, and a system to receive clients' complaints. Examples of client satisfaction tools were presented.
- The S+D Innovation Storage Box includes Crisis Response, Self-stigma Reduction Program, the 3x4 package with QI, and S+D e-learning for HCWs. The SRP is being updated.
- The Self-Stigma Reduction Program (SRP) is implemented in six provinces This program is being continuously adapted with new activities including contextual adaptation for hospitals, development of a handbook for hospitals and introduction of specific content for the people who inject drugs. In September 2021, a virtual meeting was held to adapt the SRP in the context of COVID-19 with facilities, community members, and HIV/AIDS core group. It is in the process of becoming available through an app. See **page 16** for special presentation on the Self-Stigma Reduction Program.
- The Crisis Response System of event reporting, screening, investigation and reporting is now implemented in 14 provinces, with expanded operations and provides trainings.
- Priorities and next steps include the national expansion of the 3x4 package, linkages with KP communities and PLWH, creating a public awareness campaign to reduce HIV-related S+D, developing an S+D CQI implementation manual, and developing S+D pre-service e-learning programs for medical and nursing students.

Philippines

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

- The Philippines QIS+D Network began in October 2020, however, COVID-19 curtailed many planned activities, including in-person site visits for coaching and mentoring. Data collection and reporting periods were shortened, with only baseline data having been collected, and the second round scheduled for October 2021. The intervention period has been reduced to one within the first phase of implementation. Many HCWs have been detailed to COVID-19 duties,
- There have been five PH Network meetings since November 2020. The implementation period for QI interventions is occurring from May – September 2021. Communication is sustained via emails, Zoom meetings, and Viber groups. Eleven hospitals have initiated S+D reduction activities for patients and/or HCWs after the first round of the survey. Eight hospitals have existing QI teams or have started coordination for QI activities. The next survey round is scheduled for October 2021.

Country Presentations (cont'd)

Philippines (cont'd)

- Baseline HCW and staff surveys were conducted January – March 2021 and provided to all HIV treatment hub HCWs and staff (including security, reception, and cleaning staff, and other departments that have direct contact with PLWH, e.g., ophthalmology, surgery, dermatology). Surveys are accessible via QR code, but with backup options to use online Google forms or paper instruments.
- Twelve tertiary hospitals reported data with a total of 915 participants. Results indicated that 6% of respondents observed HCW unwilling to care for PLWH; 6% observed HCW providing poorer quality of care to PLWH; 19% avoided physical contact when providing care for PLWH; 77% were aware of written policies to protect PLWH from discrimination; and 78% were aware of written policies on preventing HIV transmission among HCWs.
- A small proportion of respondents disagreed with the statement that women living with HIV should be allowed to have babies, however, more than half reported being worried about HIV transmission if they drew blood from a PLWH. Overall, respondents agreed that there were adequate supplies to reduce their risk of HIV transmission.
- Areas for future development include disaggregation of service type and HCW cadre with separation by HIV-provider and non-HIV provider.
- Patient surveys were conducted through exit interviews or at the patient's convenience during January – March 2021. Convenience sampling aimed to capture at least 10% of the total HIV patients at the treatment hub. Online surveys were developed using RedCAP, accessed via QR code or link, as well as paper-based surveys and Google Forms. Twelve tertiary hospitals were engaged with 909 participants. The majority of respondents were male (91%), between 24-49 years old, and had been diagnosed four years or more. KP groups represented include MSM (81.5%), TG (3.6%), and PWUD (2.1%). Overall, patient survey results indicated a small number of respondents experiencing some form of S+D in healthcare settings. Of those who experienced S+D, the issues focused on interactions with personnel and the structure/organization of the facility.
- Aggregate data and individual hospital data sets from both surveys were sent to all hospitals. Limitations of the survey results include the lack of data collected on service areas, provider type, differentiation between HIV clinic providers and non-HIV providers, and LTFU clients. The plan is to add these additional questions to future surveys.
- An example from Jose B. Lingad Memorial General Hospital (Bahay LInGAD) was shared to demonstrate intervention design following analysis of baseline data results. A new workplace HIV policy was implemented and disseminated to eight other departments. The facility developed physical treatment hubs to improve confidentiality. Patient feedback is sent to the treatment hub monthly for monitoring, and HIV/AIDS Core Team (HACT) meetings are held to discuss survey feedback and next steps.
- Recently, the Philippines National AIDS Council crafted the HIV Human Rights Roadmap as the national vision for the country to address S+D. Additionally, Philippines is joining the Global Partnership to Eliminate S+D. Results of the Stigma Index helped to spur and inform national strategies and policies, including the 7th AIDS Medium Term Plan.
- Plans to scale-up S+D QI activities include the recently drafted M&E Toolkit for HIV Treatment Facilities, the development of an S+D training manual with WHO Philippines. Additionally, AFAO/SKPA is scaling S+D QI activities with CBO-led HIV primary care facilities, and FHI360/EpiC is integrating S+D QI across all supported programs in the country.
- The next steps for SHIP include coaching four hospitals, scaling up S+D QI with community-based HIV primary care facilities, and collaborating with WHO Philippines on developing the S+D training module for HCW. The next steps for PSMID include strengthening the capacity of member physicians for QI and mentorship, and engaging QI coaches. The Network aims to influence national policy on S+D through identification of successful interventions.

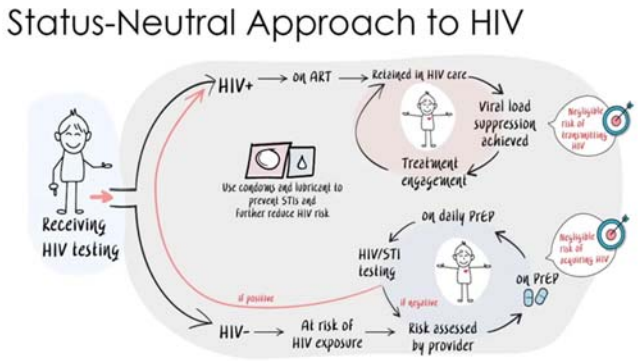
Topic Presentations

Key Population-Led Health Services Model (KPLHS)

Presenters:
Dr. Nittaya Phanuphak
Executive Director
Institute of HIV Research and Innovation

Greg Carl
Senior Capacity Building Supervisor
Institute of HIV Research and Innovation

- More than half of new HIV cases in Thailand are among MSM, transgender women, and sex workers. Started in 2015, the KPLHS model is a key strategy that offers accessible, available and acceptable services to key populations that are co-delivered by qualified lay providers who are often members of KP groups. Services are offered through flexible hours, one-stop services and hotspot locations and are designed to be stigma-free and gender-oriented. Services are designed and
- Quality improvement in IHRI-supported KPLHS is implemented through a multi-pronged approach that embeds measures that address stigma and includes: 1) training, practicum and certification assessment; 2) internal counselor supervision; 3) external assessment of counselor performance; 4) mystery clients and 5) client satisfaction surveys.
- The status-neutral approach is used to demonstrate an equal approach to service delivery regardless of HIV status, with the goal of reaching zero risk of HIV transmission or acquisition.
- Thailand's government has endorsed and committed to the KPLHS model. Domestic financing has been provided directly to accredited CSOs with trained/certified lay providers linked to affiliated hospitals. Previously supported entirely by PEPFAR, the government now funds over 50% of KP-led service delivery.



- MOPH regulations legalizing the roles of KP lay providers were endorsed by the Medical Council, Pharmacy Council, and Medical Technology Council, and was signed by the Minister.
- KP lay providers can provide services related to sample collection and point-of-care laboratory testing for HIV and STIs, dispense drugs as prescribed by health professionals to prevent and treat HIV and STIs. Referrals for further testing and care are made as needed.
- An overview of the capacity building and certification processes for KP lay providers developed by ENGAGE, a Capacity Building and Advocacy team of IHRI, was presented, with elements that include a multi-level training curriculum, certification exams and a practicum to achieve certification, and a final competency review.
- In total, 106 lay providers in 15 provinces have been certified by ENGAGE. These trained lay providers are responsible for delivering 50% of HIV testing and 60-70% of PrEP uptake in Thailand.

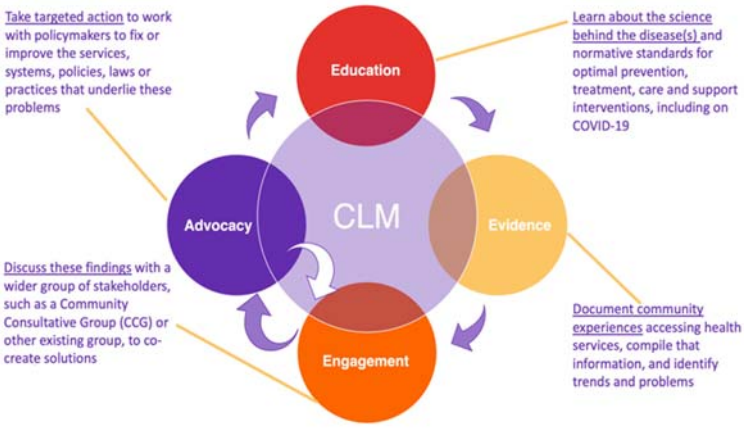
Topic Presentations (cont'd)

The Role of Communities in Measuring and Mitigating Against HIV-Related Stigma: Citizen Science

Presenters:
Solange Baptiste
Executive Director
International Treatment Preparedness Coalition

Nadia Rafif
Community-Led Monitoring and Advocacy Lead
International Treatment Preparedness Coalition

- Citizen Science is an initiative of ITPC that represents the demand side of quality improvement. It moves from models of 'data extraction' to 'data democracy', by combining community-led interventions including CLM, implementation science, and a novel methodology called Life Mapping, which uses collaborative and participatory visual media tools to effect advocacy. The process empowers participants and respects their expertise.
- CLM is a process through which communities lead routine monitoring; create indicators to routinely track those priorities; collect data; analyze the results; and share insights from the data with a larger group of stakeholders. Communities then work alongside policymakers to co-create solutions to appropriately design and target interventions, especially focusing on stigma.



ITPC Community-Led Monitoring Model 2021

- Key challenges include longer than anticipated lag times for orientation and implementation; balancing community-defined indicators with those required by donors; suboptimal data use, data ownership and security under CLM and harmonization of national and global indicators.
- Regional Community Treatment Observatories West Africa (RCTO-WA) was a 3-year Global Fund regional project on CLM and included 11 countries and 101 health facilities. CTOs collect and analyze data on availability, accessibility, acceptability, affordability and appropriateness of HIV care and services. Sub-analyses of RCTO-WA qualitative data showed that key populations have different reasons for not accessing ART than the general population. For young people, issues of confidentiality and privacy emerged as a top reason for not accessing ART, whereas for MSM, SWs, and PWID, fear of S+D was the key reason. Further findings and analyses can be found here: *Data for a Difference* and *They Keep Us on Our Toes*

Topic Presentations (cont'd)

The Role of Communities in Measuring and Mitigating Against HIV-Related Stigma: Citizen Science (cont'd)

- Results from the IPTC Global Treatment Access Survey reported that 64.6% of respondents experienced an instance of anticipated stigma in the previous 12 months, and 37.8% of respondents experienced an act of stigma in the previous year, including gossip and harassment. Members of KPs were especially vulnerable to stigma from HCWs and were twice as likely to be denied services.
- Community pandemic preparedness activities included CLM of COVID-19's effects on service delivery and lived experiences of PLWH in China, Guatemala, India, Nepal, and Sierra Leone.
- For CLM to be successful strong leadership is needed and the model must be embedded in the national response.
- ITPC resources (i.e., videos, fact sheets, reports) can be found at itpcglobal.org.

Thailand's Self-Stigma Reduction Program and Curriculum (Presentation)

Presenter:
Dr. Sunisa Suktrakul
Assistant Professor, Faculty of Nursing
Chulalongkorn University

- The Self-Stigma Reduction Program (SRP) has been active for six years in Thailand supported by the Global Fund. According to the Stigma Index, self-stigmatization affects accessibility to services including prevention, care and quality of life of people living with HIV.
- The curriculum was initated with the Foundation for AIS Rights (FAR), which consulted with the Faculty of Nursing, Chulalongkorn University, represented by Assistant Professor Dr. Phenpak Uthit and Assistant Professor Dr. Sunisa Suktrakul to join the Division of AIDS Services team to develop the program.
- The aim of the SRP is to help people address internalized stigma (e.g., guilt, blame, shame, self-esteem) related to their status (e.g., HIV, drug use) and regain power to better cope with S+D.
- Thailand's SRP an adapted 5-module structure for the curriculum based on the framework of internalized stigma developed by Livingston and Boyd, 2010. The framework addresses 1) internal stigma as well external public stigma, 2) how to address negative feelings about oneself, 3) identity transformation to instill value, 4) empowerment, and 5) taking action to stop self-stigma.
- The curriculum was tested in three pilot hospitals with 74 patients who are living with HIV and/or using drugs for five years or more. An assessment scale is used to measure self-stigma before and after program participation.
- SRP Version 2 includes 3 sessions. The sessions address 1) the thought processes that lead to self-stigma and management of negative thoughts; 2) coping skills and problem solving; and 3) discussion of positive aspects in life. Each activity is conducted for one hour.
- Instruments for data collection were presented including a self-stigma scale with questions to assess self-stigma and clinical outcomes. For a copy in English, please email richard.birchard@ucsf.edu.

Topic Presentations (cont'd)

Self-Stigma Reduction Program and Curriculum (Breakout Session)

Breakout Session Discussion Guidance and Responses: Participants were asked to discuss and answer the following questions:

1. ***What programs or services are available in your respective countries that address self-stigma among people living with HIV? Are any of these programs integrated within clinical healthcare programs and settings?***

    - Most attendees reported that there were no national efforts or programs to reduce self-stigma in their respective countries, and few services are offered at the facility-level.
    - Programs and services provided at the facility-level include the U=U strategy for patient empowerment; an HIV Human Rights Roadmap in the Philippines to address S+D and improve quality and accessibility of services; the Self-Stigma Reduction Program (SRP) in Thailand (see above) training modules; using community feedback mechanisms; hiring psychologists to enhance care teams; and embedding self-stigma management with mental health and case management services.

2. ***If you could design a program to address self-stigma within a healthcare setting, what would it look like?***

    - Several groups suggested conducting a baseline assessment of current initiatives and services being implemented before designing any new programs. One suggestion was to implement self-assessment among PLWH with CSOs and KPs to understand its extent and severity.
    - Potential program interventions could include:
        - *addressing self-stigma at all levels of the system (i.e., community, facility, national),*
        - *capacity building for HCWs to identify and address self-stigma*
        - *hiring and training peer counselors, cultural sensitivity trainings adapted to each country context,*
        - *counseling services,*
        - *employing life-coaching models,*
        - *involving community in identifying and addressing self-stigma,*
        - *on-site coaching,*
        - *support groups,*
        - *using a QI approach to develop interventions that address issues emanating from self-stigma,*
        - *involving influencers or celebrities who are living with HIV, and*
        - *utilizing social media platform and mobile applications.*
    - Attendees acknowledged that input from stakeholders, including CSOs, PLWH, and KPs, was crucial to the development of any program; adequate resources and political will from local and national funders is also needed to deliver sustainable services.

Topic Presentations (cont'd)

Self-Stigma Reduction Program and Curriculum (Breakout Session; cont'd)

3. ***How would this program address both HIV and reach key populations (i.e., sex workers, gay/bisexual/MSM, transgender women, people who use drugs) who are disproportionately affected by self-stigma?***

    - Programs should address KPs who are disproportionately affected by self-stigma. Some intervention strategies include:
        - *community-designed and -led initiatives,*
        - *involvement of KPs in programs,*
        - *addressing intersectionality for clients who identify with multiple KP groups,*
        - *developing programs broad enough to serve all KPs,*
        - *offering KP friendly services during individual case management,*
        - *offering peer support and demographic-specific support groups, and*
        - *intensive, client-centered case management services.*

4. ***How can we ensure that these strategies to address stigma are embedded in national HIV policy and programmatic responses to reduce self-stigma in healthcare settings?***

    - Emerging strategies should be embedded in national HIV policy and programmatic response to reduce self-stigma in healthcare settings. Early involvement of stakeholders and government buy-in is an essential step for sustainability.
    - Evidence and data justifying the need for self-stigma programs are needed. Examples include conducting research, using community data, administering assessments and surveys, drafting policy briefs and best practices, sharing success stories, and generating change ideas.

Mental Health Among PLWH (Presentation)

Presenter:
Dr. Alex Keuroghlian
Director, National LGBTQIA+ Health Education Center
The Fenway Institute

- Dr. Keuroghlian described the role that mental health plays as a mediator between stigma and HIV health outcomes, underscoring the bidirectional exacerbating effects of stigma and mental health problems, based on Hatzenbueler's framework of psychological mediation focusing on sexual minorities. He also reviewed literature from Southeast Asia focusing on the intersection of stigma and mental health, and the evidence linking both with poor HIV health outcomes.
- Data was shown demonstrating significant correlations between HIV and mood disorders, primarily anxiety, depression, and PTSD among patients retained in HIV care. Among PLWH, depression is the most common mental health challenge, leading to non-adherence to ART and routine medical care.
- Developing a plan to address depression could involve educating staff, integrating depression screening within client flow, training staff to use screening tools, understanding internal or external depression-related resources, and applying QI methods to facilitate implementation of this integration.
- The PHQ-2 (https://aidsetc.org/sites/default/files/resources_files/PHQ-2_English.pdf) is used to assess two main symptom categories of depression. If a client scores three or higher, a PHQ-9 (https://aidsetc.org/sites/default/files/resources_files/PHQ-9_English.pdf) is administered, which assesses all symptom domains of depression. The screening can be self- or staff-administered at each visit, and takes three minutes to complete. Proposed treatment actions based on severity were discussed.

Topic Presentations (cont'd)

Mental Health Among PLWH (Presentation; cont'd)

- Integrating mental health into HIV primary care involves coordinated, co-located, or integrated care. Coordinated care involves minimal collaboration or collaboration at a distance; co-located care involves close collaboration on-site with some system integration, and integrated care involves full collaboration in a merged integrated practice (Heath et al., 2013)
- Trauma and PTSD and their potential negative effects on treatment continuity were explained. PTSD can occur in people who have experienced a traumatic event or can occur because of chronic S+D.
- The co-occurrence of substance use disorders with PTSD is highly prevalent. Integrated treatments for substance use disorders and PTSD are well-tolerated and improve outcomes.
- Integrating trauma-informed care with treatment services focused treatment services is needed to achieve engagement in care and health outcomes in those who are affected. A trauma-informed approach to care should incorporate the identification of trauma and its mediators, education for patients about the connection between trauma and its negative outcomes, and linkage to suitable resources. Promoting resilience (the ability to cope with hardship and adverse events) is a desired goal for patients, including focusing on strengths. Questions assessing client resilience using a strengths-based approach were presented (SAMHSA, 2014).
- To address stigma and stress associated with being a sexual minority, principles include: facilitating emotional awareness and acceptance, empowering assertive communication, validating unique strengths, fostering supportive relationships, and affirming healthy expressions of gender.
- Responses from the mental health questionnaire that was sent to MOH leaders in the QIS+D Network were reviewed. The availability of mental health services was limited in most countries and only available in some facilities, such as tertiary and central hospitals. Mental health screenings are rarely routinely conducted in HIV care.

RESOURCES

PHQ assessment instrument:
www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health

All PHQs in various languages:
https://www.phqscreeners.com/select-screener
Roadmap: Routine Depression Screening
https://targethiv.org/library/roadmap-routine-depression-screening

Mental Health Readiness Assessment Tool:
https://aidsetc.org/resource/mental-healthsubstance-use-care-clinichealth-center-readiness-assessment-tool

SAMHSA-HRSA Integrated Center for Health Solutions, Trauma Resources:
https://www.integration.samhsa.gov/clinical-practice/trauma-informed

Learning to Address Implicit Bias Towards LGBTQ Patients: Case Scenarios *and* Strategies to Mitigate Clinician Implicit Bias Against Sexual and Gender Minority Patients*:*
www.lgbtqiahealtheducation.org

Mental Health Among PLWH (Breakout Session)

Breakout Session Discussion Guidance and Responses: Participants were asked to discuss and answer the following questions:

1. ***What mental health issues are you finding among key populations living with HIV?***

- Attendees reported seeing the following mental health issues among KPs living with HIV: depression, self-stigma, anxiety, suicidal ideations, self-harm, PTSD, bipolar disorder, multiple personality disorders, fear of rejection, fear of disclosure, grief, shame, and poor coping mechanisms.

Topic Presentations (cont'd)

Mental Health Among PLWH (Breakout Session; cont'd)

2. ***What mental health services would you like to have available in your facility?***
   a. How can these services be made KP-friendly?
   b. What resources would you need to provide these services?

- Countries reported limited KP- and HIV-specific mental health services and qualified staff, with a need for specialized counseling services for both groups. Mental health crisis management interventions are limited to hotlines in most countries, which are not always accessible due to communication issues.
- Access to affordable licensed clinical psychologists and psychiatrists is needed.
- Other mental health program strategies were described, including KP-led services, community-led "suicide watch," safe and objective support provided through a hotline, lay mental health counselors, trained community workers for mental health screening, peer-led initiatives, support groups, tele-mental health services, capacity building for providers to adequately diagnose and treat mental health issues..
- Services can be made KP-friendly through offering provider trainings on LGBTQ identity, sensitization on sex work and drug use, focus group discussions, client feedback mechanisms, and providing services by competent providers or providers who identify within a KP group.

3. ***What specific mental health interventions could be developed to support key populations?***

- Political and financial support from the government is needed for sustainability. Evidence-based data to advocate for necessary resources and inspire demand outside of government is another strategy.
- Resources are needed to provide mental health services for PLWH, including guidelines on delivering care and service flow, trainers and curriculum, and physical spaces for service integration between HIV and mental health.
- Expanded clinical mental health strategies that are useful include routine depression screening, trauma-informed care trainings for providers, cognitive behavioral therapy, and improved coordination of care and partnerships between CSOs and health centers.

4. ***What is the availability of crisis response interventions?***

- Lao relies on limited community-based services; Cambodia has few mental health centers and one KP-friendly service center, Malaysia has a hotline, Myanmar has a hotline run by CSOs, and Thailand has a crisis response team that addresses S+D.
- Philippines has robust telehealth hotline services and crisis management interventions through the HIV Access Network. The DOH-NASPCP has crisis intervention provisions in the new HIV adaptive plan for COVID. Psychological support, response centers, halfway houses, and rehabilitation centers are available.

Appendix

Implementation Progress

This section summarizes progress of S&D QI implementation by country as of August 2021.

Progress by Domain *(Please note: This chart has not been fully updated due to Covid disruptions to activities, but will be further updated after the next QIS+D Network Meeting.)*

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	✓	✓	✓	✓	✓	**Invited**
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	✓	✓	✓	✓	✓	✓
2.3 Number of post-baseline data collection rounds – HCW	**5**	**5**	**2**	**2**	**1**	**1**
2.4 Formal protocol for collection of PLWH experience questions	✓	✓	✓	✓	✓	✓
2.5 Completion of baseline data collection - PLWH	✓	✓	✓	✓	✓	✓
2.6 Inclusion of PLWH treatment literacy questions		✓	✓	✓	✓	✓
2.7 Number of post-baseline data collection rounds – PLWH	**N/A**	**3**	**2**	**2**	**1**	**1**
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	6	6	3	3	2	2	22
# of staff	535	6,535	18,119	1,922	5,215	1102	33,428
Comments				Revised approach to measurement; from Feb-April 2020 until Aug 2021: 3 rounds in Binh Duong, 2 rounds in Thai Nguyen, Hai Phong and 1 round in Hanoi, Ba Ria Vung Tau		915 (Baseline) 187 (End-line)	
Patient Experience Questions							
# of rounds	N/A	4	3	3	2	2	14
# of patients	12,516	1820	16,119	5,316	1,867	1105	38,743
Comments	Use "Patient Satisfaction Survey," NCHADS is in the process of scale up process. Data are collected more frequently and used on a quarterly basis. About 900 patients participate in every quarter, less than before because of wide implementation of MMD during COVID. Patients use of their smartphones and clinic QR code should increase participation.		Use "PLHIV survey" instead	Revised approach to measurement; from Feb-April 2020 until Aug 2021: 3 rounds in Binh Duong, 2 rounds in Thai Nguyen, Hai Phong and 1 round in Hanoi, Ba Ria Vung Tau		909 (Baseline) 196 (End-line)	
Clinical Literacy Questions							
# of rounds	N/A	4	1	4	2	0	11
# of patients	N/A	1820	251	5,414	1,867	N/A	9,352
Comments			Will adapt questions	4 rounds in Binh Duong, 3 rounds in Thai Nguyen, 2 in Hai Phong and Hanoi, 1 in Ba Ria Vung Tau		Baseline to be completed March 2021	

Appendix (cont'd)

Meeting attendees

Cambodia

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Ly Penh Sun
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Malaysian AIDS Council
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Penang State Health Department
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CDC
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Ei Ei Khin

Myanmar Positive Group
Min San Tun

Myanmar Positive Women Network
Kyae Mone Linn

Sex Workers Network (SWiM)
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UNAIDS
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Appendix (cont'd)

Meeting attendees (cont'd)

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Appendix (cont'd)

Meeting attendees (cont'd)

Philippines (continued)

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Clarence Salvador
Maria Cecilia Anonueyo
Stanley Roy Carrascal
Teresita Marie Bagasao

Bahay LInGAD, HACT
Sam Angelo Esteban

HIV & AIDS Support House
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Michael Joshua Santiago

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Jeremiah Saavedra

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Loyd Brendan Norella

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Aline Alindogan
Anna Maureen Dungca-Lorilla
Bernard Cruz
Menelyn Gastardo-Cabrillas
Jeffrey Garcia
Roldan Bucal
Carren Bocaling

Sail Clinic / SHIP
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SAIL Makati
Raymond Bugtong

Southern Philippines Medical Center
Nemfa Adorable

St. Luke's Medical City
Jorel Vallido

The Medical City (TMC)
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Vietnam

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Dr. Do Huu Thuy
Dr. Tran Thanh Tung
Tùng Trân

Appendix (cont'd)

Meeting attendees (cont'd)

Vietnam (continued)

HAIVN
Dang Thi Nhat Vinh
Dang Tra My
Do Thi Phuong
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Nguyen Hoai Linh
Dr. Todd Pollack

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Ha Noi Medical University
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PEPFAR
Hoang Thanh Hai

UNAIDS
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VNP+
Đông Đỗ Đăng

Other

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International Treatment Preparedness Coalition
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