Summary of the 11th Multi-Country Network Meeting

Southeast Asia Stigma Reduction QI Learning Network

November 23-25, 2022
Bangkok, Thailand

Healthqual

UCSF

UCSF Institute for Global Health Sciences

UNAIDS

APN PLUS POSITIVE CHANGE

QI S+D NETWORK ASIA/PACIFIC

Presentations and Recordings

A shared Dropbox folder with all presentations and video recordings of each day from the 9th Network Meeting can be found at:

https://www.dropbox.com/sh/k5p62hia4zzbgxo/AACNPj2AI038HuMpriQ8U1kZa?dl=0

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

ViiV Healthcare

GILEAD

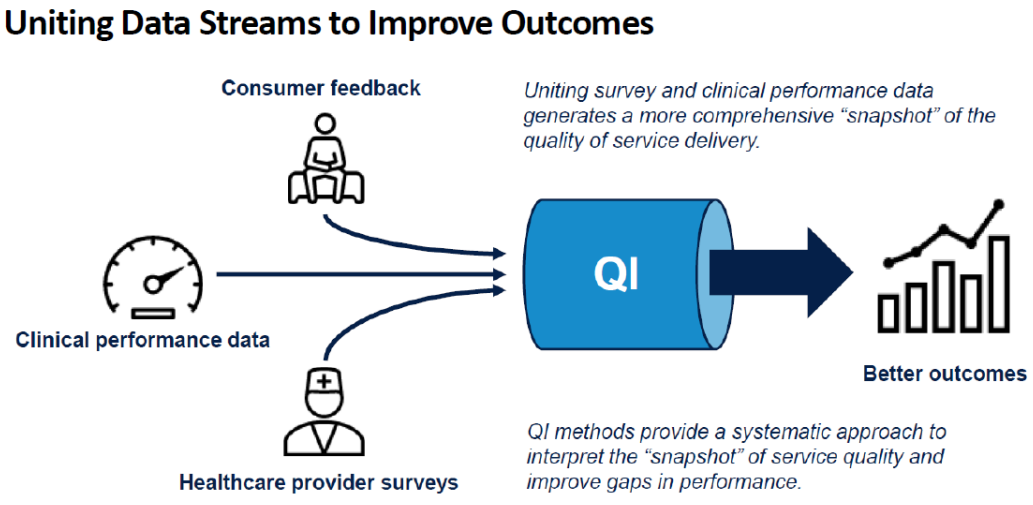
Executive Summary

Background

HIV-related stigma and discrimination (S+D) in the healthcare setting remain a formidable barrier to achieving UNAIDS' 95-95-95 targets and optimal outcomes for people living with HIV (PLHIV) and underscore 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).

As a community of practice, the QIS+D Learning Network aims to accelerate the implementation of national- and facility-level HIV-related S+D reduction activities in participating countries - 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, interventions are developed by facilities in each country through national programs to reduce S+D and shared at Network meetings leading to improvements in care and treatment outcomes among PLHIV and key populations. Funding through ViiV Healthcare and Gilead Sciences was secured to continue the work through 2022. QIS+D is implemented in partnership with UNAIDS and APN+, and is recognized as an activity of The Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination. A new major area of focus for the Network is the integration of data from community-led monitoring and other civil society initiatives to inform improvement interventions.

How data are used for QI in the Network



Executive Summary (cont'd)

The 11th Multi-Country Network Meeting of the Southeast Asia Stigma Reduction QI Learning Network was convened November 23-25, 2022, in Bangkok, Thailand with virtual participants joining via Zoom. 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+, Quinten Lataire and Belice Odamna of UNAIDS, and Dr. Bruce Agins, and Jackson Lee of UCSF HEALTHQUAL.

Meeting Themes/Highlights

- Presentations from Ministries of Health in Cambodia, Lao PDR, Thailand, Malaysia, Philippines, and Vietnam reported on progress of their programs and summarized their follow-up data and how they are being used to identify effective QI interventions
- While many countries are resuming and expanding in-person activities with the relaxing of COVID restrictions, high rates of staff turnover in health facilities persist. Turnover presents challenges in sustaining QI initiatives and requires sensitization of new personnel to S+D reduction efforts.
- Some countries also noted increases in fears among healthcare workers related to transmission of HIV, purportedly triggered by generally heightened fears related to COVID transmission. At the same time, expansion of the PSF surveys has expanded in Cambodia, treatment literacy has improved in Lao PDR, Malaysia has expanded to all states in Phase 2, Philippines is preparing to launch a new QIS+D Network, Thailand is advancing initiatives on many fronts as part of its National S+D Package, Viet Nam has added PrEP questions to its surveys, and most countries are expanding the use of peers and community health workers to implement their QIS+D activities.
- Carla Treloar of Centre for Social Research in Health of UNSW presented on a **universal precautions approach** to S+D reduction in health systems. This universal precautions approach eliminates focus on different populations or conditions by emphasizing provision of stigma-free care as a routine component at all levels of service provision.
- Jemma Samitpol of IHRI presented on transgender-associated stigma and health inequities, showcasing how the Tangerine Clinic, as a transgender-led clinic, creates a destigmatized healthcare environment for their clients. A breakout session followed on the status of transgender healthcare and related stigma in the network countries. Among other issues, participants noted that a lack of standardized transgender health information and practice guidelines about transgender care can lead to stigmatizing attitudes and poorer quality of care. Existing transgender health services are most often provided in specialized private clinics, creating financial barriers to accessing care.
- Rena Janamnuaysook of IHRI presented on the integration of peer-led depression screening and linkage-to-mental health services at the KP-led Tangerine Clinic in Bangkok. Screening is conducted with standardized Patient Health Questionnaires and demonstrates high rates of depression and need for either on-site mental health services or referrals specialized mental health care.
- Representatives from TLF Sexuality, Health and Rights Educators Collective (TLF Share) and Forum of Networks of People living with HIV and Most at Risk Populations (FoNPAM) from Philippines and Cambodia, respectively, presented on their countries' community-led monitoring activities. Network members then discussed barriers and

facilitators for implementing CLM in a breakout session. While CLM activities are ongoing in various stages across the network countries, many are reliant on external funding and have yet to be integrated into the national healthcare system.

- Bruce Agins of UCSF-HEALTHQUAL presented on PrEP stigma and strategies health providers can utilize for destigmatizing PrEP use and initiation.

Country Presentations

Cambodia

Presenter:
Dr. Ngauv Bora
Deputy Director
National Center for HIV/AIDS, Dermatology and STD **(**NCHADS)

- Cambodia has developed a national management strategy for reduction of S+D, which includes patient satisfaction feedback (PSF) SOP, an SOP for KP-friendly services (available here), CQI for HIV care and treatment, PSF dashboard, and national CQI management groups and meetings.
- PSF is implemented in 70 of 71 ART facilities representing all 25 provinces (up from 56 facilities in 2021) with an online dashboard that is available to all sites to measure progress (see Figure 1). In facilities, patients can use a provided tablet or QR code to complete feedback surveys. PSF data is reviewed at least quarterly at the facility level to inform quality improvement activities. Of the 70 sites implementing PSF, 47 have sufficient data for analysis whereas only 22 are using PSF for QI and action planning. The national program monitors these data to champion successful improvements and provides technical assistance to sites experiencing poor performance. Refresher trainings are being conducted to enhance participation.

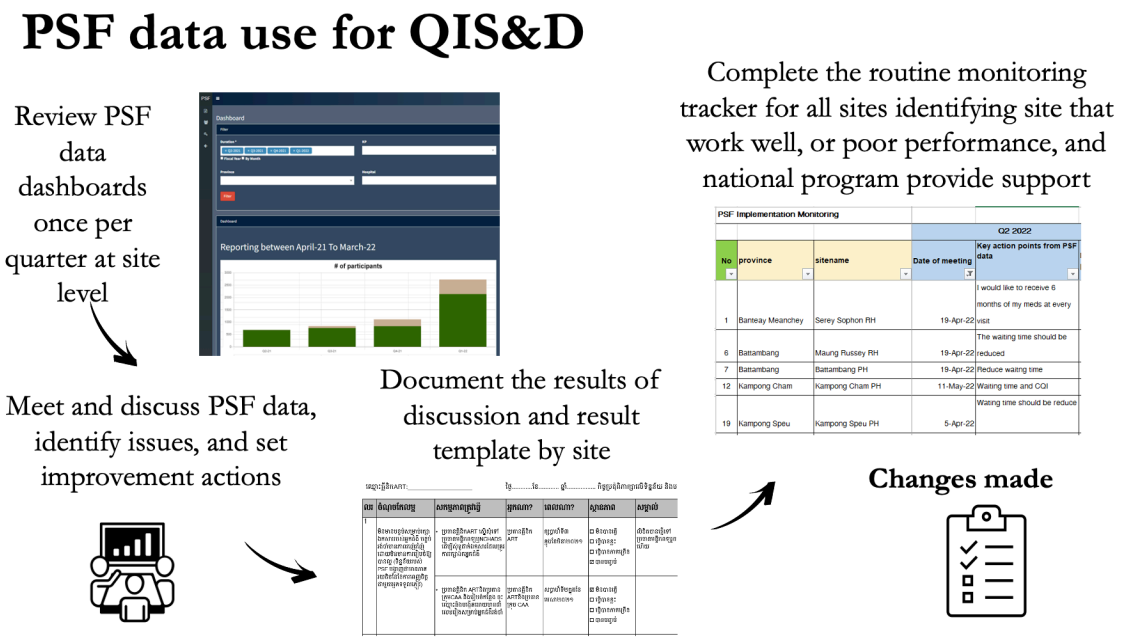


Figure 1, PSF data use for QIS+D

- PSF utilization by facilities and external stakeholders is supported by workshops on PSF data for QI and action planning. In 2022, the number of PSF respondents grew from 2,778 respondents in Q1 to 4,054 respondents in Q3, however the current system does not thoroughly capture KP and demographic information for disaggregating data. Overall patient satisfaction with ART services remains high and clients report feeling safe while receiving care (all >95%).
- Top suggestions from patients in 2022 Q3 include 6-month dispensing of medications, improving of wait times, facility cleanliness, HCW availability during scheduled clinic hours, and provider friendliness.
- Actions taken by facilities have included improving KP-friendly services (KPFHS), captured in the new KPFHS SOP, and shortening of waiting times by improving patient flow at triage.
- The number of provider feedback respondents fell in 2022 Q3 from 158 to 143. The percentage of providers who indicated observing a HCW being unwilling to provide care to PLHIV (8.5%) or providing poorer care to PLHIV 10.6%) rose slightly in 2022 Q3. Rates of double-gloving fell slightly in the same quarter. Provider evaluations of their facilities' services for PLHIV and KPs remained relatively unchanged, with 91% reporting their facility as providing high quality service to these populations.
- Additional efforts are needed to encourage ART sites to engage clients to complete the PSF and to use PSF data for QI. Additional efforts are also needed to encourage providers to respond through PSF, and facilities to address trends from provider data. New Community Action Approach (CAA) workers, non-medical health service providers, are not yet trained in PSF.
- Priorities for NCHADS include promoting KP-friendly services and better HIV care outcomes for KP, continued coaching of low performing sites, capacity building for community health workers on utilizing PSF data for QI, development of an instructional and promotional video for PSF, and engaging providers to strengthen the response to PSF data.

Lao PDR

Presenter:
Vixay Bounyavong
Technical staff
Centre for HIV/AIDS and STIs, Ministry of Health

- The 8th round of HCW surveys with 1,160 respondents and the 6th round of patient surveys were conducted in November 2022 using a Google Form accessible via link and QR code. All 11 ART sites and two point of care (POC) sties were assessed. The majority of HCW respondents were nurses (53.8%) and doctors (28.4%). Respondents represented a variety of wards and units.
- Rates of S+D among HCW in the 8th round were lower than the 7th round and many of the previous rounds. Observations of HCW unwilling to care for PLHIV fell from 13.4% to 9.5% and observations of HCW providing poorer care to PLHIV fell from 18.9% to 10.3%. Many clinics held internal workshops reviewing data about these HCW behaviors during the last action period, which may have contributed to the improvement in survey scores.

Country Presentations (cont'd)

Lao PDR (cont'd)

- Stigmatizing beliefs among HCW declined slightly with 56.5% (down from 60.7%) believing people get infected with HIV because they engage in irresponsible behavior and 42.6% (down from 45.5%) believing people with HIV do not care if they infect other people. Variation in scores was notable between sites for most of the HCW survey questions.
- Suggestions for reducing S+D from HCW include increasing HIV S+D knowledge among HCW; joint activities between HCW, PLHIV, and communities; additional educational materials on HIV S+D; expanding S+D outreach to other media like TV, radio, and Facebook; and a standardized S+D reduction package for facilities.
- The 6th round of patient feedback saw a drop in respondents from 647 to 326 at the time of presentation. The percentage of patients responding as satisfied with their care ranged from 97-100% across the survey.
- The 6th round of patient clinical literacy questions was collected using peers through a separate Google Form at ART sites and POC sites. The percentage of ART clients who did not know which regimen they were receiving dropped from 22.6% to 10.6%, while the percentage of clients who knew their last viral load (VL) result increased from 54.4% to 65.9%. Notably, VL literacy had been identified as an area of focus for improvement activities after the last survey round.
- Results from the recent rounds of S+D surveys will be shared with sites and internal workshops to review results will occur in early 2023. S+D reduction will be integrated into existing QI activities at ART sites accompanied by coaching; community-led monitoring data will be integrated with the S+D data to inform improvement activities.
- The MOH plans to develop a national S+D reduction package for implementation in facilities and communities. Provincial health leaders and ART sites will be encouraged to champion S+D reduction best practices. QI focal persons in hospitals will be coached to become regional QI coaches and a resource for other clinics. A coaching group will be created to foster peer learning and advancement of skills.

Malaysia

Presenter:
Dr Nur Ezdiani Mohamed
Institute for Health Systems Research

Dr Noor Harzana Harrun
Pandamaran Selangor Health clinic
Ministry of Health Malaysia

- Malaysia's QI model for S+D reduction is based on a partnership between the HIV/STI/Hepatitis C Sector (MOH HIV program lead), Institute for Health Systems Research, IHSR (MOH QI lead), and the Malaysia AIDS Council, MAC (case workers & civil societies lead).

Country Presentations (cont'd)

Malaysia (cont'd)

- Phase 2 for Malaysia's S+D reduction plan started in 2022 and represents scale-up from the initial QIS+D cycle from 2020 – 2021. Participation has expanded from 10 sites in six states to 55 sites in all 15 states and federal territories. The baseline S+D survey was conducted in March and April, followed by site-level identification of contributing factors to S+D, presenting intervention strategies, and developing support teams.
- Ongoing QI coaching, implementing in sequential phases, early engagement of top managers, and standardized QI tools and presentation templates were instrumental to the scale-up process.
-
- S+D data continue to be captured following improvement activities through an online platform accessible by hyperlink or QR code for both HCW and PLHIV surveys
- The Phase 2 baseline survey included 6,215 HCW and 1,499 PLHIV respondents. Baseline results indicated that 72% of HCW are worried about drawing blood from PLHIV, 68% indicating that they wore double gloves when attending PLHIV, and 7% having observed another HCW providing poor care to PLHIV.
- Only 6% of PLHIV reported that they had ever experienced discrimination when accessing health services (compared to the baseline of Phase 1 facilities in 202012%).
- Treatment literacy indicators revealed that 28% of PLHIV did not know their ART regimen, 14% did not know their VL and 25% did not know about U=U, all signifying areas for improvement.
- QI interventions from Phase 1 had been compiled into a compendium (available here), categorized by domains of structure, process, and people. Facilities in Phase 2 were encouraged to adapt and apply practices from the compendium. Peer sharing from Phase 1 facilities was also facilitated through workshops, National QA convention, and the Innovative and Creative Circle (KIK) convention. Innovation awards incentivize states to compete in generating and implementing interventions.
- Examples of compendium strategies modified by Phase 2 facilities include altering content of S+D training modules, pairing HCW and PLHIV in an herbal garden project, and localizing a community awareness day for PLHIV.
- Phase 2 will continue in 2023 with continued monitoring, continued QI coaching, and developing a S+D training module for HCW caring for PLHIV at primary care clinics.

- The challenge of the PLHIV survey response rate is being addressed through assistance from NGO case workers, use of paper-based surveys, cell phone reminders, home visits

Malaysia: Lessons Learned During Expansion Process

- Involve at least one district in all states to maximize peer learning and representativeness
- Engage sites through mutual agreement
- Use region-based QI coaching and staggered implementation approach
- Seek leadership support and engagement at facilities with strong support of state director
- Ongoing QI coaching with an organized support team that includes both QI and SMEs and NGOs
- Whole facility involvement (e.g. dental, lab etc.) including leadership

by healthcare workers, and database flagging for follow-up. The time for completion of HCW surveys was also lengthened to improve response rates. An official directive from state officers helped to gain cooperation from services that do not fall directly under the public health purview such as dental services.

- Recruitment of PLHIV sometimes remains challenging because of concerns about disclosure, or the lack of peers in some rural areas to facilitate their participation.
- In Selangor State, Project Kasih (Spotlight available here, video presentation available here) is an example of a successful intervention from Phase 1 that was developed and implemented through QI methodology.

Philippines

Presenter:
Dr Kate Leyritana
Medical Director
Sustained Health Initiatives of the Philippines (SHIP)

- QI stigma reduction activities in the Philippines have been funded mostly through grant-funded projects and not through central government initiatives. Most hospitals do not have HIV QI teams. SHIP is the primary implementer, through funding from UCSF-HEALTHQUAL via HRSA/PEPFAR for their QIS+D Network.
- The SHIP research team followed up with the twelve hospitals that participated in the initial QIS+D initiative, conducted as a study, in 2021 to assess the degree to which S+D QI practices were sustained in the absence of external funding. The team found that implementation of S+D surveys was rare, QI leads had shifted priorities, and interventions generated from the original QI action period were not sustained or measured. Some best practices remained in place such as regular HIV orientations for new employees with biyearly refresher orientations, and patient experience questionnaires.
- A follow up with the CBO-led clinic network participants revealed that two clinics had continued S+D QI practices. These clinics had continued two interventions generated from the initial action period: de-identified registration forms and patient feedback surveys that evolved to address larger process improvements in the clinics beyond S+D.
- The SAIL Clinic in Makati was one of the clinics that continued implementing the S+D survey. Areas for improvement identified through patient feedback included: more confidential waiting areas, improved wait times for simple visits like refill appointments, timeliness of doctor visits, and faster record retrieval. QI projects undertaken by the SAIL Clinic include:
    - The clinic began opening on Sundays to increase client access to services.
    - The Sustaining and Enhancing Customer Service Experience (SECS-E) initiative arose throughpatient feedback which suggested staff wear name tags to allow clients to foster personalization and trust, creating a more welcoming environment. SECS-E also involved a training led by a corporate customer service consultant to improve the communication and personal interaction skills of HCW.

Country Presentations (cont'd)

Philippines (cont'd)

- Sustainability of QI implementation in both hospitals and CBO-led clinics without external funding remains a challenge given that activities are implemented currently as "projects." To sustain QI activities, hospitals without QI departments require QI mentoring and CBO-led clinics need basic QI training. Support from the national HIV program is lacking.
- In partnership with UCSF-HEALTHQUAL, SHIP is supporting a quality improvement learning network focusing on stigma reduction that will engage 20 facilities.

Thailand

Presenter:
Darinda Rosa, M.D.
Division of AIDS and STIs, Department of Disease Control; Ministry of Public Healt

- The 2021 bi-annual S+D National Surveillance survey, which gives a national snapshot of the state of stigma among HCWs and patients, was delayed due to COVID and completed in 2022. The survey was completed in 69 hospitals.
- Fear of contagion in the workplace among HCWs remains high (83.9%) with corresponding reports of overprotection (68.9%). These data are utilized for M&E at national, regional, provincial, and hospital levels to inform national stigma program activities.
- S+D reduction training, started in 2017 has been scaled to 151 hospitals in 71 provinces. Cumulatively, 20,481 people (67% HCW, 33% other) from a total of 620 organizations have completed the national S+D e-learning course. Staff turnover and budget remains a problem for scaling and sustaining QI interventions.
- QI interventions are captured through a standardized template included in the 3 x 4 package and integrated with Self-Stigma Reduction Program (SRP).

Thailand Highlight: Chiangdao Hospital

Chiangdao hospital in Chiang Mai started S&D QI activities in 2019. The facility identified four areas to address with continuous QI: overprotection, inappropriate service behavior and communication, knowledge gaps regarding HIV/AIDS and universal precautions, and the disclosure of blood results. Facility QI teams used root cause analysis to identify the primary drivers of S+D to inform improvement strategies, which included trainings to address knowledge deficits, ensuring private space for discussing test results, canceling of identifying codes, and enabling layered data privacy protocols of results that reveal diagnosis of HIV.

Self-stigma was identified as a primary driver affecting care of PLHIV, which was triggered by inappropriate service behaviors and communication. Areas for interventions involved HCW training and group support for patients. Community interventions included at-home education and care, family involvement, and training of community leaders. Following these interventions, rates of PLHIV reporting avoidance of care due to self-stigma fell from 29.6% to 17.4%.

Country Presentations (cont'd)

Thailand (cont'd)

- Peer exchange to disseminate QI interventions was conducted at the national and sub-national level. Under COVID restrictions, participating sites were convened virtually and also participated in a messaging group. The exchange was conducted in-person in November 2022 and will be expanded to include QI training and coaching for participants.
- National Policy Interventions: The Department of Disease Control has started a collaboration with the Department of Corrections to target S+D among wardens, HCW, and prisoners. The intervention will be comprised of Acceptance and Commitment Therapy (ACT) modules. The project will be piloted in four prisons including one female prison and one correctional institution for drug users.
- POKPONG is a web-based crisis response system for reporting S+D and human rights violations in Thailand. Event reports are screened and investigated by government or CSO point persons who then direct assistance to help resolve the event. The most common type of human rights violation reported through the system is discrimination related to being a member of a vulnerable population (251 out of 331 cases). Violations to human rights originate from individuals in 60.7% of cases and their most common cause (41.4% of cases) is a lack of knowledge of relevant discrimination law. CSOs/CBOs help victims in accessing the system and reporting events.
- Consumer feedback on HIV counseling is collected routinely from clients using a standardized form. Clients can anonymously report on whether they feel their counselor was friendly kept their personal information confidential. Client satisfaction is aggregated at the clinic level to evaluate the quality of service provision.
- Next steps include:
    - The national S+D package, (3x4 approaches, SRP and POKPONG) will be scaled to cover 80% of clinics nationwide by 2026 and will include scale-up of QI activities.
    - The S+D e-learning platform will be expanded and modules integrated into medical curricula through collaboration with the Ministry of Education.
    - 110 hospital teams will receive refresher trainings on S+D CQI
    - A S+D CQI implementation manual with KP and TB topics will be developed.

Vietnam

Presenters:

Nguyen Quynh Mai
Officer
Vietnam Authority of HIV/AIDS Control

Dang Tra My
Project Officer
HAIVN

Asia Nguyen
Health Systems Strengthening Advisor
CDC

Country Presentations (cont'd)

Vietnam (cont'd)

- Vietnam facilitates S+D reduction at facility, community, and national levels, with QI as a major strategy. The QI component expanded to six provinces from its initial three, and in this fiscal year, the program has consolidated to implementation in four key provinces including expansion to new sites in each province.
- S+D data collection includes the health care worker survey, patient experience questions, and clinical literacy questions. Surveys are administered every six months with action periods in between. Surveys are administered through QR codes with members of Community Advisory Boards (CABs) assisting clients who may have trouble with the technology. PrEP questions have been added to the QI survey which also includes questions focusing on key populations (KPs).
- The seventh round of data collection was completed July – August 2022 in 14 sites across three provinces.
    - The percentage of HCW reporting fear of infection while drawing blood of PLHIV increased across the last four rounds of surveys (from 41% to 54%) with the highest rates reported in surgery departments. Observations of HCW unwilling to care or providing poorer care to PLHIV also increased over the same period, with the highest rates reported in surgery departments. High staff turnover due to COVID may offer a partial explanation for these findings.
    - The rates of HCWs reporting to have had sufficient training to work with KPs (MSM, TG, PWID, and FSW) appear to be associated with rates of reporting confidence in caring for these KP groups. Ba Ria-Vung Tau province had the lowest rates of confidence in round 7 with large declines from round 6. This province also had the highest rate of HCW turnover during this time.
    - ART client satisfaction and comfort remained high. Five cases of discrimination (0.44% of respondents) were reported during this round, matching the similarly small rates of previous rounds. Reports included being ignored by staff, prolonged waiting time, and unfriendly attitudes of HCW when providing medication.
    - Increasing from 11.2% and 18.1% in previous rounds, 30% of respondents identified experiences of negative judgement from the community because of PrEP use, indicating how community stigma is a key barrier to improving PrEP initiation.
- Thai Nguyen is being piloted as a **stigma-free province** with expanded S+D interventions in 7/11 ART sites. These facilities receive intensive refresher trainings on stigma reduction and Sexual Orientation, Gender Identity and Expression (SOGIE). Provincial CDC monitored activities with mobilization of CABs to support them. HCW reporting fear of infection when treating PLHIV and KP dropped in five of the seven sites in 2022.

Vietnam: QI Interventions

- One clinic in Ba Ria-Vung Tau increased client literacy of VL testing intervals from 8% to 98% in 2022 through information leaflets and posters, CAB personnel outreach in waiting rooms, follow up calls with clients, and standardized information from HCW during visits.
- In response to feedback captured through community scorecards, leadership at one site in Hai Phong province relocated HIV services to a private room to increase privacy. Client ratings of confidentiality and privacy improved from 5/10 to 9/10 after the change.

Country Presentations (cont'd)

Vietnam (cont'd)

- QI interventions are informed and monitored through an intersection of data from the S+D reduction program (including advocacy and QI), CLM, community scorecards, and CAB monitoring. Changes are implemented through advocacy, QI methodology, and KP-led design. Three key areas of improvement have been identified: fear of HIV infection, access to condoms and lubricants, and health literacy.
    - CABs use KP S+D data to identify gaps that affect health equity and develop tailored interventions for each group. CABs will work with sites to design new models of care to respond to KP needs, especially for MSM and TGs.
    - In June 2022 one site experienced three months of ARV stockouts. CABs quickly mobilized to navigate ART clients to transfer their care to new clinics. For clients who couldn't transfer their care, the CAB worked with other sources to procure ARV and ensure treatment continuity. Clients were tracked and received follow-up contact to ensure they did not miss appointments.
- The percentage of clients who knew the results of their most recent VL test increased by 16 points over two years. Clients have also grown more familiar with the concept of U=U through awareness campaigns.
- Three S+D indicators are included in the National HIV Strategy and M&E framework: 1) HIV stigma among general public, 2) PLHIV who avoid care due to anticipated stigma, and 3) reports of S+D in healthcare settings. The national survey is conducted every five years.
- National monitoring of PrEP, through PrEPQUAL, began in January 2022 with quarterly reporting across all 210 PrEP providers in 29 provinces. In Q3 of 2022, 96% of clients initiated PrEP on the same day as their assessment and 99% received PrEP medication within 2 hours. Results show that only 62% of clients are assessed for new HIV infection at the clinic visit, an identified area for improvement. The top reasons for PrEP users to stop their medication include moving, pregnancy, change in need, and lost to follow up.
- Eight community organizations received small grants to develop interventions to address PrEP stigma. These included: education sessions, mobile PrEP promotion, outreach to students, and external and internal stigma frameworks. PrEP and HIV knowledge increased for participants, anticipated PrEP stigma dropped, and 150 clients were enrolled in PrEP.
- In the next year the S+D reduction program will be expanded to one additional province. Currently four provinces implement community scorecards with additional province joining within the year. S+D indicators will be revised to include health literacy and status neutral goals. The CAB model will be evaluated to demonstrate effectiveness. Best practices from a KP learning network will be scaled up with the addition of new standards and tools for KP-friendly services and MH integration. Equity will be the central principle for the S+D program moving forward.

Topic Presentations

Trial of a universal precautions approach to stigma reduction in the Blood-borne viruses/Sexually Transmitted Infections field

Presenter:
Carla Treloar, PhD, FASSA, GAICD
Director
Centre for Social Research in Health; Social Policy Research Centre

- Since stigma remains pervasive as a key determinant of poor health outcomes across all levels of care, **a Universal Precautions approach to stigma reduction in healthcare settings is crucial for improving quality of care**. Elimination of stigma and its impact on health is a part of the Australian National Strategy which includes targets for stigma reduction across the health system.
- Stigma indicators have been established by the Centre for Social Research in Health and monitored through surveys conducted in 2018 and 2021. Notably, 2021 results showed that stigma directed towards people who inject drugs (PWID) is significant:
    - 70-75% of PWID experienced stigma from HCW and 56-69% of HCW responded that they would behave negatively towards other people because of their injecting drug use. A majority of PWID have delayed accessing health care to avoid being treated negatively by HCW.
- The decision to develop a universal precautions approach to stigma arose out of the practical need to improve patient experience no matter what combination of attributes an individual may have. This approach as described in Treloar et al. (2022) offers an opportunity to create a sustainable, system-wide methodology that does not silo stigma reduction programs to particular areas of care or particular patient attributes, similar to universal precautions for infection control to prevent bloodborne infections.
- The Centre is in the initial phase of universal precautions interventions and is funded to investigate their effectiveness over the course of four years. The research team aims to create scalable plans and toolkits for policymakers and provide workforce development in stigma reduction.
- The universal precautions approach will be tested along with KP-specific approaches to ensure that the universal approach does not create substandard outputs for any specific group.

Topic Presentations (cont'd)

Integration of a peer-led depression screening and linkage-to-care intervention at a transgender-led health clinic in Bangkok, Thailand

Presenter:
Rena Janamnuaysook
Program Manager (Implementation Science)
Institute of HIV Research and Innovation (IHRI)

- Despite the frequency of depression reported among transgender individuals (48% - 62% across global contexts), quantitative information about its occurrence in Thailand is lacking. In Thailand, mental health screening tailored for transgender clients is not commonplace. IHRI has tested the implementation of peer-led depression screening and linkage to mental health care for transgender clients at the Tangerine Clinic in Bangkok. The Consolidated Framework for Implementation Research (CFIR) was used to assess the implementation of a depression screening intervention for this study.
- Following training by a psychiatrist, transgender staff began screening clients using Patient Health Questionnaires, first with PHQ-2, followed by PHQ-9 if the first screening is positive. The majority (92%) of clients accepted the initial PHQ-2 screening. Those who refused screening did so due to a lack of interest, being currently on psychiatric treatment, or being too busy. Further qualitative study revealed that clients' decisions were informed by societal stigma towards those who receive mental health care and privacy concerns. These results emphasize the issue of intersectional stigma and the importance of mental health literacy interventions for clients.
- Of the transgender women assessed by PHQ-2, 53% had a positive result. All of those who screened positive accepted a subsequent PHQ-9 screening. Results from the PHQ-9 screening among 317 TG clients showed that 27% had minimal symptoms, 20% had mild symptoms, 3% had moderate symptoms, 1.6% had moderately severe symptoms and 0.3% had severe symptoms. Of note, 26 individuals reported suicidal ideation in the past two weeks.
- Clients with significant symptoms were linked to mental health care with a choice of three options of where to receive care, which included a referral to Chulalongkorn Hospital, a referral to the designated hospital according to their registered healthcare scheme, or making an appointment with a psychiatrist at the Tangerine Clinic.
- All of the clients offered linkage to mental health care chose to make an appointment with a psychiatrist at the Tangerine Clinic. Those diagnosed with a mental health disorder by a psychiatrist were prescribed medications during the visit. Clients who requested to meet with a psychiatrist upfront were referred immediately.
- Key to the success of this implementation was the KP-led implementation strategy, that involved expanding the roles of peer counsellors and nurses to conduct PHQ-2 and PHQ-9 screening and psychosocial support counselling which was integrated efficiently into the flow of the clinic.
- The Tangerine Clinic has adapted a standard mental health service package as a result of this implementation study. Additional qualitative study and testing on a larger scale will be needed to further refine the implementation strategies for integrating mental health services.

Topic Presentations (cont'd)

Community-Led Monitoring in the Philippines

Presenter:
Rocky Rinabor
Project Manager
TLF Sexuality, Health and Rights Educators Collective (TLF Share)

- The aim of CLM in the Philippines is to assess how the HIV-related health and social systems are responding to community needs. "Community" is defined as PLHIV, KP, and other marginalized groups. Community needs are systematically documented to create rights-based improvements in the HIV response. An externally funded activity, CLM is being piloted in metro Manila in three sites. There are plans for expansion in 2024-2025. CLM is used for TB as well and has been adapted for COVID.
- The three objectives of CLM are to document evidence, experiences, trends related to the four pillars of CLM; improve community capacities to generate and use data for advocacy; trigger co-creation of solutions by the different rights holders and duty bearers of the multisectoral HIV response.
- Despite previously gathering community feedback, a baseline study revealed that most civil society organizations (CSOs) did not have the capacity to implement valid CLM. For CSOs to co-manage CLM, TLF Share led capacity development in implementing a systematic process with standardized tools.
- The CLM system is designed to monitor four pillars: service quality, S+D, policy implementation, and financing of the HIV response (see Table 1). After being gathered at the community and facility levels, CLM data are analyzed to identify solutions with action points that can be packaged for advocacy and dissemination. Data that are flagged for action are responded to immediately and presented to the relevant decision-makers who work to resolve barriers to implementation. Changes will ideally be incorporated in clinical practice guidelines and shared through omnibus health guidelines to city health boards. CLM is then used to verify the implementation of the change and measure the impact.

Topic Presentations (cont'd)

Community-Led Monitoring in the Philippines (cont'd)

Table 1, Four Pillars of PH CLM

Pillars	Monitoring components
Service Quality	▪ Level of Service, Quality of HIV Services ▪ Level of Satisfaction with Services Received ▪ Service Availability ▪ Service Accessibility ▪ Service Affordability ▪ Commodity Stock Out ▪ Breach of Confidentiality ▪ Service Continuity
Stigma and Discrimination	▪ Cases Of Stigma & Discrimination ▪ Prevalence Of Stigma & Discrimination ▪ S+D Experienced by PLHIV in Community Settings ▪ S+D Experienced by PLHIV in Healthcare Settings ▪ Discriminatory Attitudes Towards PLHIV ▪ Internalized Stigma Reported by PLHIV ▪ S+D Experienced by KPs ▪ Avoidance of Healthcare Among KPs Because of S+D
Policy	▪ Implementation of Republic Act No. 11166 ▪ Implementation of the HIV Community Agenda ▪ Local Laws and Policies Related to HIV, Anti-Discrimination, SRH
Investment	▪ Amount of investment needs for the HIV response ▪ Amount of Budget Appropriated for the HIV response ▪ HIV Budget Utilization ▪ PhilHealth Outpatient HIV/AIDS Treatment (OHAT) ▪ HIV-related Out-of-Pocket Expenditures Among KPs and PLHIV

- A public website, com.musta?, is a reporting and analysis platform for CLM data. Any service delivery organization interested in improving their community response can access their data directly. The platform will also allow community members to provide online feedback through the Exit Feedback Tool, Stigma and Discrimination Tool, and Service Quality Tool.

Toward zero Discrimination for PLHIVs and Key Population in Cambodia

Presenter:
Seum Sophal
Representative of the **Forum of Network of PLHIV and KPs** (FoNPAM)

- CLM in Cambodia is externally funded and conducted by FoNPAM in seven provinces.

Topic Presentations (cont'd)

Toward Zero Discrimination for PLHIVs and Key Population in Cambodia (cont'd)

It is structured to complement the ongoing PSF surveys with a focus on communities instead of at ART clinic experience. The process begins with online surveys for PLHIV and KP.

- The areas being monitored include service delivery, social protection, gender-based violence, prevention, PrEP, care treatment and S+D. Results feed into a dashboard that generates a community score card that is reviewed quarterly by FoNPAM (See Figure 2). Areas for improvement are identified and documented with action points, relevant stakeholders, and status updates.

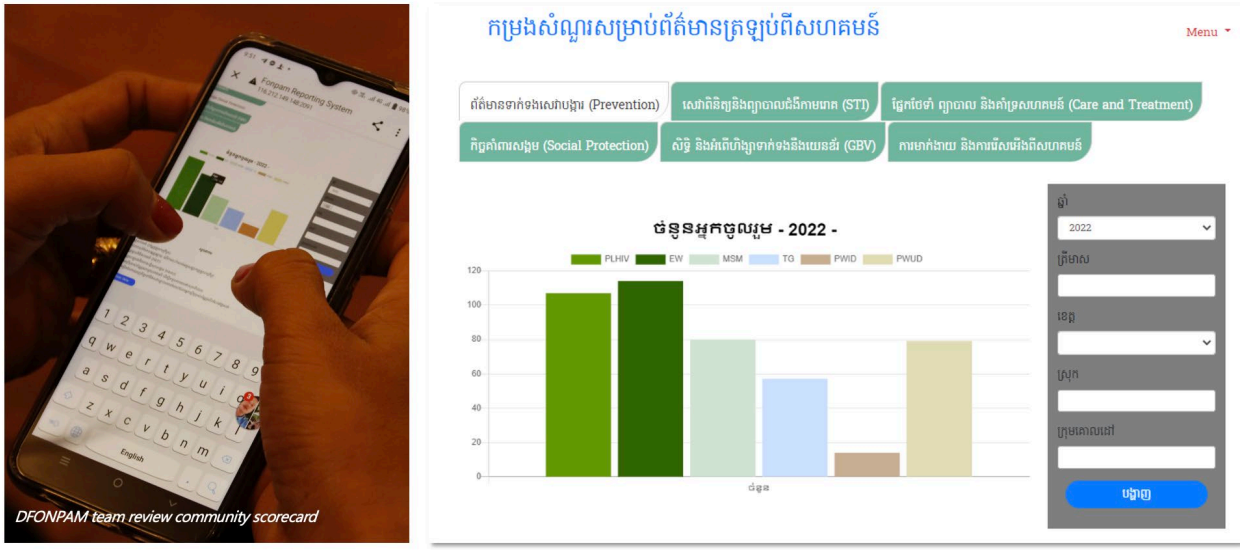


Figure 2, CLM Dashboard with Community Scorecard

- The CLM process has revealed three key areas for improvement with corresponding action points:
  - Many eligible PLHIV are not fully informed on the process of obtaining an IDPoor equity card, which allows access to universal health coverage and other free social services. In response, the team is working to speed up the administrative process and promote eligibility information.
  - Additional resources are needed to prevent and support victims of human rights violations and gender-based violence. The team is working with NAA (National AIDS Authority) and other stakeholders to better coordinate responses to sexual abuse, including timely provision of PEP, PrEP and emergency contraception.
  - In 2022, 43% of CLM respondents reported experiencing S+D from the community and 17% reported experiencing a provider avoiding physical contact while providing care. The team aims to decrease S+D from family, community, and healthcare providers through promoting S+D reduction mechanisms and online awareness campaigns.
- CLM is used for QI at facility and regional levels. In one example, Battambang province responded to issues raised in CLM data by improving wait times for PLHIV.

Topic Presentations (cont'd)

Toward Zero Discrimination for PLHIVs and Key Population in Cambodia (cont'd)

- Challenges in implementing CLM include: online nature of the survey has limited the respondents to those with access to smart phones; limited capacity in administering organizations; lack of KP/PLHIV leadership in CLM; lack of broad CLM data utilization for QI; and limited funding/support for increased geographical coverage.
- FoNPAM aims to scale CLM to additional provinces through additional support from development partners. Without funding, the community will advocate with NAA and NCHADS to integrate CLM into a new social contract and national program. Additional priorities include strengthening national and subnational partnerships to better respond to improvement areas identified through CLM, engaging KP/PLHIV in CLM leadership and ownership, revising the CLM questionnaire and dashboard to be more accessible to the community, and developing a CLM roadmap with operational guidelines.

Community-Led Monitoring (Breakout Session)

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

1. ***How is community-led monitoring implemented in your country? Who conducts it? How is it paid for?***
2. ***What are the major domains considered through your CLM activities? Does CLM include any focus on S+D? Patient experience during clinic visits? Does CLM address issues of services for key populations?***
3. ***In which clinics or areas is CLM conducted? Why was this area selected? If this is not a national activity, are there plans for expansion?***
4. ***How are CLM data reported? Specifically, how are CLM data fed back to the facility? To the district or province? To the national program? How are CLM data disseminated beyond those who are involved in the CLM activities?***
5. ***Are there expectations for use of CLM data as part of quality improvement activities at the facility? Are there any examples you can describe and share?***
6. ***How are CLM data considered as part of national program planning and quality management programming? How are CLM implementers involved in program planning, policy discussions and quality management TWGs?***
7. ***How will CLM activities be sustained in the absence of donor funding? If no plan is yet in place, how would you consider adopting CLM as a routine activity?***
8. ***Are there CLM activities in any other areas besides HIV? How might CLM be extended to address other chronic conditions to include this kind of civil society participation?***

- In partnership with community, the **Malaysia** MOH has several mechanisms to obtain input about quality of care. CLM is funded domestically as a national activity across all sectors and all clinics, principally centered around the online survey questionnaire MySES (Malaysia Stigma Evaluation Survey) which is an incident reporting system.

Topic Presentations (cont'd)

Community-Led Monitoring (cont'd)

Complaints generated from this system are addressed and also inform QI activities at the facility level. Monthly progressive reports submitted to the Malaysia AIDS Council by CBOs evaluate stigma at the facility level. The government creates webinars to show results of S+D activities and what actions have been taken. Incidents are also reported by CBOs. In an example of how incidents are addressed, following reporting of delay in dental appointment scheduling due to HIV status, the system was modified to ensure HIV patients have a neutral intake experience. In another incident, after discovery that HIV patients were placed on "no-fly" lists for air travel due to their status, the issue was resolved.

- In the **Philippines**, the CLM system is being piloted in metro Manila in three sites and is in the start-up phase. CLM considers S+D, patient experience during visits, and service experience for KP. Data will be fed into a monthly reporting dashboard after being processed, with quarterly reports available publicly. CLM data are formally submitted to DOH. The QI component for CLM is just beginning, but survey fatigue for patients is a concern. See presentation on Philippines CLM.
- In **Lao PDR**, CLM is still in the planning phase and will be implemented by CSOs
- In **Cambodia,** CLM is being conducted by FoNPAM and is currently being administered in seven provinces. CLM covers six areas, including S+D. Social support for KP is a major focus. CLM data are reported quarterly by NCHADS. The CLM results are shared during meetings with relevant stakeholders at the national level and with a subnational forums. CLM is a part of the national strategy program. The data are used to advocate for PLHIV to receive Health Equity Fund Cards in the universal health coverage scheme, and at the facility and community levels to inform QI activities. Issues are raised during the quarterly meetings of provincial TWGs. See presentation on Cambodia CLM.
- In **Vietnam**, CLM is part of a broader community monitoring strategy currently being supported by PEPFAR. CLM coordinates and integrates its activities with other existing initiatives including the Community Advisory Board, KP Friendly model, and C2P models (a community-public partnership model). CLM is implemented by VNP+ and the Ho Chi Minh AIDS Association currently in 37 public and KP-led HIV service sites in 11 PEPFAR provinces representing 50% of the HIV burden in the country. There is no national strategy or system for CLM.
    - Quantitative questionnaires include 12 indicators to measure quality of services and client satisfaction. In-depth interviews collect information from clients who have dropped out of treatment or are not accessing HIV services. CLM monitors S&D (attitudes of heath staff) and collects detailed information from in-depth interviews. CLM data highlight potential site and health systems issues. Data are used for QI activities.
    - Quarterly reports are provided to PEPFAR stakeholders, who then advocate for interventions based on the data. Clinics are selected by the CLM body semi-annually and rotate. The CLM body advocates with other stakeholders to disseminate the information to facilities with quarterly coordination meetings that include PEPFAR implementing partners. The reports are not yet officially shared with the national HIV program.

Topic Presentations (cont'd)

Community-Led Monitoring (cont'd)

    - Community representatives have utilized CLM data in establishing CABs, implementing stigma monitoring, and designing person-centered service provision. CLM is still in pilot phase, however, there is a plan to include CLM indicators in national M&E frameworks. Expansion will require government buy-in and additional donor support to be integrated into national reporting platforms.
- In **Thailand**, CLM is funded through PEPFAR and the Global Fund. CLM has been piloted in 72 sites since 2019. Data are reported through REDCap and are used to inform changes to national guidelines. The Department for Disease Control is testing CLM during healthcare visits for prisoners.

Tangerine Clinic, Stigma and Transgender Health (Presentation)

Presenter:
Jemma Samitpol
Tangerine Clinic Supervisor
Institute of HIV Research and Innovation (IHRI)

- Globally, transgender women (TGW) have 49-fold higher risk of HIV than the general population, which is higher than any other KP. In Thailand, there is a 17.3% prevalence of HIV among TGW with a yearly incidence rate of 2.12%.
- Key to S+D for TGW in Thailand is the lack of legal gender recognition, which has cascading effects on all aspects of life, including access to healthcare. Transgender status is not recognized in public health information systems, nor are data on transgender health available. There are no national guidelines for transgender health, nor standards for interacting with transgender patients. IHRI is currently advocating with the National Health Security Office to include transgender health coverage in the national program.
- A national survey conducted in 2015 by The Foundation of Transgender Alliance for Human Rights (Thai TGA) and Transgender Europe (TGEU) of the transgender population revealed that 48% have reported negative experiences from HCW. A related survey also revealed that among HCW, 15% thought HIV-positive TGW should be ashamed. For TGW who declined PrEP, 1.2% cited stigma as the cause. With a scarcity of gender-affirming care providers and the deterrence generated by S+D, many TGW are self-administering hormone therapy without having routine health monitoring or hormone level monitoring, raising major concerns about their health and the quality of care.
- In 2020, a survey of transgender clients at the Tangerine Clinic reported that 47% felt rejected because of their gender identity, 24% had been bullied by classmates, 16% had experienced public shame,11% were physically abused, and 8% were coerced into sex.
- The Tangerine Clinic, a transgender-specific health clinic, was designed to provide a destigmatized and discrimination-free experience for transgender clients seeking care. The team engaged in discussions with the transgender community before launching the clinic in 2015 to fully address existing issues for clients. The clinic offers sexual health and wellness services, including mental health, in addition to hormone therapy.

Topic Presentations (cont'd)

Tangerine Clinic, Stigma and Transgender Health (cont'd)

- The clinic developed a training for staff on providing a secure and destigmatized environment for transgender clients. The training covers best practices for interacting with clients and the differences between gender identity, expression, biological sex, and sexual orientation. Under "The Tangerine Academy" program, the clinic offers technical assistance through onsite training and apprenticeship in transgender health for external HCW; published The Thai Handbook of Transgender Healthcare Services as a universal resource; and, provides technical guidance to other countries establishing transgender health clinics. K. Jemma provided an overview of key points from these trainings.
- The National Health Security Office has begun a process to endorse a service package for transgender clients.
- While most clients visit the clinic for gender-affirming care, HIV testing is offered as a standard procedure with 95% of TGW receiving testing and 94% of those who tested positive linked to same-day ART initiation. Among HIV-negative clients, 26% have been initiated on PrEP. Self-testing is being piloted in the clinic and may prove to be another effective tool in overcoming S+D barriers.
- The experience in Thailand has reaffirmed that transgender community-led and community-owned response is critical to increase access to transgender healthcare, including HIV prevention, care and treatment, and that gender-sensitivity, transgender-competent and holistic healthcare settings are key to mitigate stigma and discrimination and to promote health access among transgender people.

Stigma and Transgender Health (Breakout Session)

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

1. ***Based on your experience and knowledge, how does stigma manifest for transgender people? What are some of the intersecting issues that make them vulnerable to stigma?***

   Participants noted the ways external and internal stigma can manifest and influence one another. Societal and religious views towards transgender identity can lead to self-stigma (internalized) for transgender people and leads to poorer outcomes for physical health, mental health, employment, and socioeconomic status. This context limits one's ability to discuss their gender with friends and family, compromising the benefit of their social network and leading to seeking supportive services.

2. ***What are the key issues affecting the quality of care for trans persons i.e., access to and quality of health services?***

   Poor understanding of trans people and the absence of trans health policies compromise healthcare quality. Stigmatizing attitudes towards transgender clients among HCWs can lead to poorer quality of care (ex: medication approval) and disincentivize some from seeking care.

Topic Presentations (cont'd)

Stigma and Transgender Health (cont'd)

Transgender services are often relegated to private clinics with no guarantee that trans-specific services will be available and limiting care options for those with lower socioeconomic status who cannot afford these options.

3. ***What are some of the existing challenges that make it difficult to a) design b) implement programs / interventions for transgender persons in your country. Note: include structural, systemic, legal and individual challenges***

   Currently none of the countries in the QIS+D network have national guidelines on transgender care. HCWs who aim to serve transgender clients lack guidance on how trans care and services should be delivered.

4. ***What are your recommendations, based on your country situation and perspective on how to address some of the challenges above.***

   Changes at the facility, community, and national level can make a difference in health outcomes for transgender clients. Some intervention strategies include:
   - *National guidelines for trans care and inclusion in basic standards of care*
   - *Peer navigation*
   - *Collaboration with communities*
   - *Friendly clinic services*
   - *Privacy and confidentiality during clinic visits*
   - *Safe spaces for clients to walk through*
   - *Training for transgender clients to navigate care*
   - *Online communities*
   - *Counseling for transgender individuals on how to process gender identity*

Introduction to PrEP Stigma Concepts (Presentation)

Presenter:
Bruce Agins
Director
UCSF HEALTHQUAL

- With rates of PrEP use below global targets, addressing S+D barriers to PrEP initiation is a crucial component of the response. PrEP stigma, like HIV-related stigma, differentiates PrEP users and assigns negative value judgements to them that lead to worse health outcomes for individuals and the community.
- Those who benefit from PrEP are HIV-negative and usually KP, which generates unique intersections of stigma that providers must consider. Internalized and anticipated PrEP stigma can arise from fear of disclosing KP status, attitudes about sexual behaviors (i.e., perceived promiscuity before and after PrEP initiation), and fear of being perceived as having HIV infection because of antiretroviral use.

Topic Presentations (cont'd)

Introduction to PrEP Stigma Concepts (cont'd)

- Healthcare providers can often be the genesis of PrEP stigma. HCW might express judgement related to sexual behaviors or risk compensation, defined as increases in sexual activity due to protection offered by PrEP. The potential for risk compensation should not be a factor in decisions to prescribe PrEP since it is neither a guaranteed outcome nor does it negate HIV prevention benefits.
- Addressing PrEP stigma for trans populations requires additional considerations, including the need for client and community education about the safety of simultaneous hormone therapy and PrEP.
- Strategies that help overcome trans stigma include trans-inclusive messaging in PrEP outreach programs and national guidelines for gender-affirming care. Even KP-friendly clinics that can administer PrEP may not have the capabilities or capacity to address trans-specific issues, underscoring the benefit of trans-led clinics such as the Tangerine Clinic in Bangkok.
- The construct of risk assessment and language used to describe risk may be a cause of stigma. PrEP eligibility is usually determined through a risk assessment based on sexual behavior or demographic attributes (KP, serodiscordant partner). This risk framing, however, can counterintuitively generate stigma towards a person labeled as "risky" or require disclosure of stigmatizing characteristics. Approaching PrEP enrollment with positive framing that emphasizes benefits over risk can more effectively encourage PrEP use. A status neutral approach further destigmatizes this process through embedding PrEP in routine sexual health discussions, primary care, or the points of service where potential PrEP users most often receive care, e.g., school health centers. Whether clients would benefit more from dedicated versus integrated PrEP services depends on the demographics of the target population and individualized preferences, although dedicated services in peer-led clinics offer both safe spaces and specialized knowledgeable care for the population.
- Measuring PrEP stigma can mirror current efforts in measuring HIV S+D through HCW surveys. Survey questions can address HCW attitudes, provider knowledge, and facility capacity (see Table 2). PrEP stigma reduction can also be integrated into facility QI activities. Existing PrEP stigma surveys designed for research are complex and require adaptation into practical indicators for use in quality improvement.
- Key interventions to address PrEP stigma include routinization of PrEP discussions in primary care, universal PrEP education, positive framing, KP staff, PrEP navigators, in-facility outreach, separated PrEP/HIV services, strengths-based counseling, and addressing intersectional stigma. KP-led clinics have arisen as a powerful approach to create a destigmatizing environment for removing barriers to PrEP initiation.

Topic Presentations (cont'd)

Introduction to PrEP Stigma Concepts (cont'd)

Table 2 HIV stigma questions adapted for PrEP

Attitudes	Provider Preparation	Facility
I prefer not to provide services to [group]	I am comfortable discussing the benefits of PrEP with patients.	My clinic offers and provides counseling on PrEP and PEP to ____
People acquire HIV because they engage in irresponsible behaviors	I have had sufficient training to provide services to [MSM/TG/IDU]	How well is the facility staffed to provide PrEP services?
If PrEP were available would you offer it to potential users	How confident are you discussing sexual history and sexual practices [unique healthcare needs] with ____	My clinic creates a welcoming environment by having (e.g., MSM) cues in the clinic (posters, pictures, educational materials, resources)

Appendix

Meeting attendees

Cambodia

CPN+
Sophal Seum

NCHADS - MOH
Bora Ngauv
Bottra Ngeth
Siem Reap Provincial Dept.
Sarath Kros
Samnang Tep

FHI360/EpiC Cambodia
Steve Wignall

Lao PDR

APL+
Kolakanh Mr

Center for HIV/AIDS and STI - MOH
Dr. Bouathong Simanovong
Vixay Bounyavong

CHIAS Laos
Vongphachanh Temmelath

Mittaphap Hospital
Dr. Phengphanh Chomlasy

Malaysia

Bandar Penawar Health Clinic, Johor
Dr. Dewi Juliana Binti Mohd. Namsah

Johor State Health Department
Dr. Emmy Marina Binti Aripinmaizira
Nurmawati Binti Ahmad

Malaysian Aids Council
Kavindharan A/L Venugopal

Ministry of Health Malaysia
Dr. Anita Suleiman
Dr. Mazliza Binti Ramly
Nur Ezdiani Binti Mohamed

Pandamaran Health Clinic, Selangor
Noor Harzana Binti Harrun

Persatuan Insaf Murni
Abdul Muizz Bin Che Zani

Philippines

LoveYourself, Inc.
John Danvic Rosadiño

SHIP
Ildebrando Jr. Rodel Ruaya
Dr. Kate Tolentino Leyritana
Michaela Dominguez Bravo

TLF Share
Amal-Ryan “Rocky” Bansuan Rinabor

Philippines Department of Health
Zashka Alexis M. Gomez

Thailand

CDC
Bongkoch Jetsawang

IHRI
Rena Janamnuaysook
Jemma Samitpol

Ministry of Public Health
Cheewenan Lertpiriyasuwat

Division of AIDS and STIs, Dept. of Disease Control
Dr. Darinda Rosa
Liewwanichtrakul Ayre

Appendix (cont'd)

Meeting attendees (cont'd)

Vietnam

HAIVN
Dang Tra My

Lighthouse
Trinh Dinh Minh Viet

Nam Tu Liem District Health Center
Nguyen Thi Thu Trang

VAAC
Nguyen Quynh Mai

Vietnam Association of HIV/AIDS Prevention and Control
Dang Thi Thu Nga

VNP+
Nguyen Anh Phong

CDC
Asia Nguyen

Other

Gilead
Boon-Leong Neo
Do Tran

ICAP
Dr Tharaphi Lin

AFAO/SKPA
Cookie Monsude Chansiri

Centre for Social Research in Health; Social Policy Research Centre
Carla Treloar, PhD, FASSA, GAICD

QIS+D Network Core Team

UCSF HEALTHQUAL
Dr. Bruce Agins
Richard E. Birchard
Jackson Lee

UNAIDS
Quinten Lataire
Belice Odamna

APN+
Harry Prabowo