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Reducing intersecting stigmas in HIV service organizations: An implementation science model

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Abstract:	Background. HIV-related and intersectional stigmas are key barriers for service delivery, but best practices are nascent for addressing them in high resource and high burden contexts like New York City (NYC). The Stigma Reduction and Resilience (STAR) implementation science (IS) Mapping Project in 2020 identified untested stigma-reduction efforts in HIV organizations, highlighting the need for an IS framework to guide future efforts. Setting. Organizations providing HIV prevention and/or care services in NYC. Methods. An inter-agency team determined that IS provides a structured approach for addressing identified gaps in stigma-reduction efforts, but that providing guidance for existing IS concepts was necessary to facilitate its use among HIV organizations. The Implementation Research Logic Model was adapted to empower HIV organizations to use IS to implement stigma reduction activities. Results. Questions, definitions, tips, and tools were developed to guide, strengthen, and improve how organizations address HIV and intersecting stigmas. The resulting Stigma Reduction Logic Model incorporates tools for implementers that synthesizes

	each component of the logic model. These include a menu of options for selecting stigma reduction interventions and implementation determinants, an adapted tool to assess organizational readiness for stigma reduction, and an IS terminology guide applied for stigma reduction. Conclusion. Future stigma reduction initiatives and research can utilize this model to enable implementers, researchers, and HIV organization stakeholders to use the methodology of IS to build consensus for, systematically plan, implement, and evaluate stigma reduction activities relevant to the HIV epidemic. The next step is testing the model's utility.
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Dear Brian Mustanski, Nanette Benbow, JD Smith, and Dennis Li,

We wish to submit an original research article entitled “Reducing intersecting stigmas in HIV service organizations: An implementation science model” for consideration in the JAIDS Special Supplement focused on implementation science. This work has not been published elsewhere, nor is it currently under consideration for publication elsewhere.

In this paper, we provide an adaption of the Implementation Research Logic Model that focuses on implementing programming for the reduction of HIV-related and intersecting stigmas, as well as other tools to aid HIV service organizations in carrying out stigma reduction using an implementation science framework. While implementation science has proven to be a meaningful path forward for speeding up the dissemination of new research on the HIV epidemic, few published resources exist that specifically provide a wide variety of resources in one place that focus on stigma reduction and provide a plain-language guide that will not just benefit IS researchers, but community workers and organizations who have limited resources to carry out work essential to stigma reduction. We also believe this is significant because relatively little of existing HIV/AIDS research focuses on stigma specifically, and especially in implementing interventions to reduce stigma, which impacts all 4 pillars for ending the epidemic (EHE).

This manuscript is nontraditional in format; we believe that it is innovative and provides a necessary resource for organizations and researchers alike, to further our understanding of how stigma-reduction can become a focus in HIV/AIDS research. In addressing HIV stigma, as well as other stigmas that intersect with it, organizations can reduce the barriers to treating and preventing HIV and truly end the epidemic. We hope you will find that this manuscript is appropriate for publication by JAIDS.

We have no conflicts of interest to disclose.
Please address all correspondence concerning this manuscript to me at
crodriguezhart@health.nyc.gov
Thank you for your consideration!

Sincerely, Cristina Rodriguez-Hart, PhD, MPH

Abstract

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Setting Organizations providing HIV prevention and/or care services in NYC.

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Results Questions, definitions, tips, and tools were developed to guide, strengthen, and improve how organizations address HIV and intersecting stigmas. The resulting Stigma Reduction Logic Model incorporates tools for implementers that synthesizes each component of the logic model. These include a menu of options for selecting stigma reduction interventions and implementation determinants, an adapted tool to assess organizational readiness for stigma reduction, and an IS terminology guide applied for stigma reduction.

Conclusion Future stigma reduction initiatives and research can utilize this model to enable implementers, researchers, and HIV organization stakeholders to use the

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Key words: implementation science; stigma interventions; HIV stigma; intersectional stigma

Reducing intersecting stigmas in HIV service organizations: An implementation science model

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Suggested Running Head: HIV Stigma and Implementation Science Logic Model

Abstract

Background HIV-related and intersectional stigmas are key barriers for service delivery, but best practices are nascent for addressing them in high resource and high burden contexts like New York City (NYC). The Stigma Reduction and Resilience (STAR) implementation science (IS) Mapping Project in 2020 identified untested stigma reduction efforts in HIV organizations, highlighting the need for an IS framework to guide future efforts.

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Introduction

HIV stigma and its intersections with other stigmas that can interact with and increase the impact of HIV stigma have been identified as key barriers to achieving the HIV National Strategic Plan 2021-2025, which calls for a 50% reduction in stigma affecting people with HIV (PWH) by 2025.[1] Stigma can manifest at the structural level through organization-wide policies or practices and the setup of the physical space, at the interpersonal level through staff behavior towards clients (enacted stigma), and at the individual level through the way clients view themselves and the expectations they have for how they will be treated (internalized and anticipated stigma).[2] Stigma reduction and promotion of resilience have been found to be important drivers for all aspects of HIV from HIV testing to access to and engagement in care, and viral load suppression.[3] Stigma reduction is also a key component of the New York State (NYS) and New York City (NYC) Ending the Epidemic (EHE) plans and dashboards.[4]

HIV stigma research has identified some commonly effective approaches within healthcare settings to address stigma: interpersonal contact, psychosocial support and empowerment, education and skills building, and policy and infrastructure changes; as well as forming stigma task forces, involving staff at multiple levels, collecting stigma data, and empowering groups most affected by stigma into decision-making roles.[3,5] The use of surveys has been effective in identifying HIV healthcare staff attitudes and behaviors associated with stigma and driving "total facility" stigma reduction initiatives.[6–8] These lessons learned from global health efforts provide best practices for implementation and scale up. And yet, theoretically grounded, methodologically rigorous implementation of stigma reduction programs in high resource and high HIV burden contexts like NYC remain scarce.[9]

Implementation science (IS) offers a proven, structured approach to address this gap by improving the implementation and dissemination of effective interventions into wide scale practice.[10] IS frameworks emphasize the characteristics of the intervention and implementers, the internal and external settings in which the innovation is adopted, as well as explicating implementation outcomes that are important to achieving service delivery and client-level outcomes.[11] Current stigma reduction efforts are siloed and disparate in NYC, which historically has been an innovator in HIV programming. In recognition of these silos and the potential of IS to improve stigma reduction, we began the Stigma Reduction and Resilience (STAR) Project (P30-MH43520 31S; PI Remien), a one-year IS planning initiative in fall of 2019 that included HIV providers, PWH, NYC Department of Health and Mental Hygiene, NYS Department of Health (NYSDOH) AIDS Institute, and Columbia University's HIV Center and Northeast/Caribbean AIDS Education and Training Center. One of its activities was the mixed methods Mapping Project, which aimed to obtain a preliminary understanding of important determinants of stigma reduction efforts in HIV service settings utilizing an exploratory determinants framework.[12]

The Mapping Project gathered information on HIV-related stigma reduction practices in 27 NYC organizations providing HIV services (C. Rodriguez-Hart, unpublished data, April 2021). Facilitators of current interventions included staff who were aware of the importance of stigma to health and the use of multi-level stigma reduction activities. Barriers included a lack of assessment of the effectiveness of stigma reduction activities, a lack of sustained practices, unfamiliarity with approaching stigma through a lens of intersectionality, and barriers impeding implementation at the structural or organizational level such as high client volumes and staff turnover. Not only did these gaps point to important next steps for the initiative, the project

also served to coalesce an inter-agency workgroup that, having become familiar with IS, understood that its use by HIV organizations would require translation.

The Implementation Research Logic Model (IRLM)

One important translational tool is the IRLM.[13] The logic model's causal pathway is valuable to structure implementation research projects in the phases of planning, organizing, guiding, and knowledge building. However, the language used within IS is rooted in academia. While sometimes necessary to make meanings more clear and develop specific terminology in a field, this can hinder the usage of IS within public health practice and community settings where implementation more commonly occurs. Similarly, although IS offers numerous sound frameworks, this creates more complexity and therefore less consensus on what should be used for implementation. The IRLM attempted to address these barriers by consolidating several well established IS frameworks as a part of the logic model and created tools to explain its components. Nonetheless, using the IRLM to plan out stigma reduction may still be less accessible to staff members, community organizers, and other implementers trying to combat stigma at their organizations. Stigma reduction is relatively new to the IS field and the lack of consensus on implementation strategies most relevant for stigma reduction or mechanisms of action for stigma reduction within the research literature makes building and utilizing a causal model such as the IRLM difficult. The simplicity of the IRLM format is both very helpful and less suited to issues that require multi-level and multi-pronged solutions as stigma does.

We will present an adaptation of the IRLM that focuses on stigma and integrates IS concepts and lessons learned from the STAR Mapping Project. Through this integration, we

demonstrate how IS can help HIV service organizations at each step of the implementation of HIV-related stigma reduction interventions. The guiding questions, tips, and tools within our model will make IS more accessible for non-academic audiences. In this way implementers are not excluded but rather are empowered through guidance and can swiftly move through the implementation phases, contributing to a holistic view of stigma planning that is seldom done in practice.

Methods

STAR Mapping Workgroup

As a follow-up to the first project of the STAR Mapping Project (C. Rodriguez-Hart, unpublished data, April 2021), our inter-agency team continued to meet on a bi-weekly basis between November of 2020 and June of 2021 to explore IS in greater depth and discuss its utility for stigma reduction efforts. The team was experienced in development of quality improvement (QI) tools, intervention and education packaging, and training of health care teams in HIV organizations throughout NYC's four EHE boroughs (Bronx, Manhattan, Queens, Brooklyn).

We reviewed IS frameworks including the recently published Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program's IS framework, which expressly sought "to support other public health agencies and community-based organizations that may be similarly trying to strengthen program implementation and evaluation projects."[14] HRSA identified IS as an essential field across the entire HIV care continuum. Their approach focuses on rapid implementation of strategies with demonstrated effectiveness, acknowledging that

some are not evidence-based or -informed but rather emerging strategies with demonstrated real world validity and effectiveness but insufficient published evidence.

Adaptation of IRLM

We engaged in an iterative consensus-building process to re-examine findings from the HIV organizations that participated in the Mapping Project and retool them for implementation planning and to prioritize domains commonly found to be effective for stigma reduction in research. We selected the IRLM as our foundational model as it integrates IS frameworks, but also structures its domains along a causal process that facilitates thinking through planning, implementation, and evaluation that is appropriate for implementation projects at various phases of rollout. We split up the components of the IRLM to study and discuss the frameworks underlying each. Where a synthesis of Mapping Project findings was felt to be insufficient for a component of the IRLM, we included established IS tools.

IS Terminology Guide

Many public health agencies and implementers have experienced challenges in operationalizing IS models and concepts for applied use.[14] Researchers, too, are sensitive to the need for terminology that is not only standardized but jargon-free. To that end, we developed a guide to common IS terminology to inform HIV organizations as they implement stigma reduction interventions (Appendix 1) (original sources are included to provide greater details). Definitions and applications of terms are based on relevant literature and adapted, when necessary, for stigma reduction. As one example, we use the term stigma reduction

"intervention" as distinct from "implementation strategy," despite the fact that research literature has at times conflated interventions with implementation strategies, and then distinguish that implementation strategies are the actions taken to increase implementation of selected stigma reduction interventions. We acknowledge that many activities may be either interventions or strategies depending on the goals of implementation, making it important to be clear where activities are positioned within the model.

Stigma Reduction Organizational Readiness Tool

This tool (Appendix 2) is an adapted version of the NYSDOH AIDS Institute Organizational Quality Management Assessment (OA). The OA is used by NYSDOH with HIV programs in NY as a checklist to assess the degree to which QI activities are implemented and fully integrated within the program's organizational structure. The tool focuses on six areas that were retained from the OA. Best practice identifies that the four areas of leadership support, stigma task forces, planning, and stigma data collection are important so they were retained as four areas within the tool.[5] Training of staff and engagement of community members were also retained for the tool, as they aligned with stigma-reduction principles and the stigma mapping survey findings[5] (and C. Rodriguez-Hart, unpublished data, April 2021). Areas that score less than a three are in practice often the areas organizations are encouraged to focus on improving.

We modified the language of the OA to make it a self-assessment, reflect a focus on stigma reduction and IS, and included language from the sub-constructs of organizational

readiness for implementation (leadership engagement, available resources, and access to knowledge and information) when missing.[16] For example, for "resources" we added agency equipment and space, funding, and IS coaching/technical assistance. IS was further integrated into the tool by: referencing it more frequently, requiring an implementation logic model, and adding language about training and technical assistance for IS.

Stigma Reduction Logic Model

As there is no one evidence-informed intervention to address stigma and instead it is recommended that multipronged and multilevel efforts be undertaken, we provide a model that allows flexibility in choosing stigma reduction interventions. To simplify the concepts and language we created guiding questions for each section, brief definitions, tips, and tools to facilitate its completion (Figure 1). A discussion among staff and clients about what stigma looks like at the organization and what programming serves the needs of the community may be helpful for completing the model. We suggest completing the model in the order of the following sections as this may be more intuitive. It is important to note that completing the model is an iterative process rather than a linear one. Parts of the model may need to be revisited as new ones are filled out and new aspects of the implementation process are discovered.

STIGMA REDUCTION INTERVENTION

What gaps in stigma reduction work are being addressed with a new intervention? Are interventions being thought of as addressing stigma intersectionally and have they been

selected with the input of community members with lived experience? Intervention selection should be informed by answers from the Stigma Reduction Organizational Readiness Tool (Appendix 2). If an organization scores lower than a three on any area when completing the tool, we recommend focusing on this area before selecting other stigma reduction interventions.

Additional options for intervention selection include our menu of intervention options, which was developed by re-examining our findings from the Mapping Project with the goal of creating a list from which organizations can select to save them time (Table 1), or they may choose from published stigma reduction interventions by searching the research literature.[17]

Throughout our description of each of the models' sections, we will provide the example of implementing a certified peer worker (CPW) role as a flexible, integrated staff member within healthcare teams to illustrate the model (Figure 3). The goal of providing this example model is to link abstract concepts to a real-world example and help implementers of stigma reduction interventions in understanding IS concepts and what implementation looks like in an organizational setting. This specific example was chosen because many of the HIV organizational staff we interviewed during the Mapping Project felt that having staff who are reflective of the populations served was a highly effective intervention to reduce stigma and there is research evidence that this may reduce stigma.[18]

OUTCOMES

What organizational changes are desired when a stigma reduction intervention is put into place? Implementation outcomes are the result of deliberate actions taken to *implement* a

new intervention; they differ from client-level outcomes, because they are indicators of how the implementation process went (e.g. how many staff at an organization use a new intervention, is it sustained), not how the intervention affects clients (e.g. viral suppression). To know whether or not implementation succeeded, outcomes need to be concrete and measurable. Both quantitative and qualitative data could be used for assessment of these outcomes. Tools for the selection of outcomes include the HIV Implementation Outcomes Crosswalk and the Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) Planning Tool (Appendix 1). In our CPW example, implementation outcomes may include having more CPWs hired and retained over time (a sustainability outcome) (Figure 3).

Although service and client-level outcomes, retained from the IRLM, are not a primary focus of our model, measuring changes in stigma before and after implementation is important. Examples of surveys to measure stigma are provided in Appendix 1. We recommend that HIV organizations simultaneously assess implementation success and client-level effectiveness[19] and that stigma data are aligned with client HIV data to set organizational priorities.

DETERMINANTS

What can influence the ability to implement the intervention? In the context of IS, determinants are factors that can make implementation easier or harder.[16] When developing a Stigma Reduction Logic Model, determinants are important to understand and identify because they allow for the choice of specific and tailored stigma reduction implementation strategies.

Examples of determinants identified through the Stigma Mapping Project were consolidated within Table 2 to serve as another menu of options to assist organizations in

quickly identifying relevant determinants for their settings. The determinants align with the domains of a well established IS framework, the Consolidated Framework for Implementation Research (CFIR) that organizes them according to five domains: characteristics of the intervention, inner and outer setting, implementers, and process.[16] The tool also includes applicable domains of the Stigma Reduction Organizational Readiness Tool, as lower or higher scores on these can help guide the choice of relevant determinants (e.g. low score on having a stigma reduction plan indicates a barrier). From the CPW example in Figure 3, a determinant could include negative associations with the term "peer" in the CPW position title (barrier) (Figure 3).

IMPLEMENTATION STRATEGIES

What specific actions will be taken in order to implement the stigma intervention, taking into consideration identified determinants? Strategies can be stand-alone or multi-faceted, but a variety of strategies at different levels should be used in order to optimally achieve your outcomes.

These categories can be used to think through different kinds of strategies:[20]

- Plan: gather data, build buy-in, initiate champions, develop relationships
- Educate: inform a range of stakeholders about the intervention
- Finance: incentivize the use of an intervention through payment
- Restructure: alter staffing structures, professional roles, equipment, or systems
- Quality management: create systems to evaluate quality of interventions

- Policy context: encourage use of interventions through executive boards, legal systems

For each selected strategy, specify the following:[21]

- Actor: Who carries out the strategy?
- Action: What is done?
- Temporality: How long will it take?
- Dose: How much of it will be given and at what frequency?
- Outcome: What is the end goal?
- Target: Who will be on the receiving end?
- Justification: Why will it work?

A strategy from the CPW example is linking CPWs to benefits counseling programs so that they understand how a higher salary when moving from part-time to full-time can impact their ability to access benefits such as housing vouchers and Social Security Disability benefits for PWH (Figure 3).

MECHANISMS

W*hy* and *how* will chosen implementation strategies work to achieve implementation outcomes? Mechanisms are the specific pathways along which an implementation strategy works to affect outcomes.[22] They can explain why a strategy does or does not achieve its intended effect. Understanding the mechanisms involved can help determine if the chosen

implementation strategies are the best to address determinants since mechanisms should reduce barriers and/or leverage facilitators.

Figure 2 depicts several possible ways mechanisms may fit within causal pathways from stigma reduction interventions to implementation outcomes. For the CPW example, mechanisms could include an increased positive regard for their new title and duties among non-peer staff (Figure 3).

Discussion

This Stigma Reduction Logic Model, adapted from the IRLM, can empower organizations to build consensus and confidence in stigma reduction initiatives. It provides a cohesive framework for multiple stakeholders, including health departments, researchers, community members, and community and clinical HIV organizations, to work collaboratively to reduce stigma. The visual representation of the causal pathway shows stakeholders how each IRLM component is interdependent and the effort that is needed to strategically plan, execute, and progress towards stigma reduction outcomes. It is a foundational tool that includes IS concepts and language, stigma intervention change ideas, and recommended measurement tools to ensure standardized interpretation and application of the model.

The model addresses several critical gaps in stigma reduction activities found through the Mapping Project: a lack of evaluation, lack of intersectional approaches, and barriers at the organizational level that included a lack of leadership support, staff turnover and burnout, and siloed bureaucracies (C. Rodriguez-Hart, unpublished data, April 2021). From the onset of planning, it promotes consideration of measurable and multi-level outcomes and collection of

downstream stigma data that are aligned with client-level HIV outcomes that organizations are currently assessing. This should lead to more of the untested stigma reduction interventions identified by the Mapping Project having evidence of effectiveness. A narrow approach to intersectional stigma, as found in the Mapping Project, is broadened through our menus of common and innovative interventions. Our Readiness Tool encourages organizations to conceptualize stigma intersectionally when assessing its infrastructure to reduce stigma. Similarly, the tools in our model also encourage multi-level approaches, including having leadership support, dedicated staff, and the resources to tackle stigma systematically in ways that may overcome some of the organizational challenges found.

To maximize the potential of our model, stakeholders must be included at every stage of implementation, outcomes must be disseminated rapidly for real-world relevance, and evaluation should be ongoing with iterative feedback loops to make adjustments along the way. Multiple types of stakeholders may find this model useful for promoting stigma reduction initiatives. Federal public health agencies and local health departments that are key in shaping public health practice can partner with HIV programs, researchers, and community members to design and/or fund stigma reduction implementation models. In addition to their ability to leverage partnerships, they have analytic and technical assistance capabilities, the ability to shape policy, and funding to build on existing public health infrastructure and disseminate public health research.[23]

Having found a limited capacity for some HIV organizations to carry out research, such as to explore IS determinants, our model leverages their resources by having them select an "emerging" stigma reduction intervention and implementing it using the model described in

this paper. A potentially beneficial use of the model would be for stakeholders to work with provider learning collaboratives/networks to plan stigma reduction quality improvement efforts using the model. The model creates an opportunity for peer-learning as conversations to share barriers, facilitators, and outcomes may help learning collaborative members tailor the model to their individual contexts while also creating generalizable knowledge through the sharing of similar best practices. Implementation researchers can also use the model to study the comparative effectiveness of implementation strategies for stigma reduction, an understudied issue, and partner with HIV practitioners on implementation projects. As stigma is a dynamic socially-constructed phenomenon requiring many socially complex solutions, unlike PrEP for HIV prevention, adaptations of the IRLM such as this are especially critical to improving the research to practice pipeline.[24]

Change agents, whether they are individuals, organizations or affected community members, can use this comprehensive model that provides context exploration, intervention readiness assessment, stigma reduction intervention planning, and implementation and evaluation guidance to further close the gaps between research and practice. Our next step is to use existing collaborative settings to partner with key stakeholders and test out the model with NYC HIV providers. With this model, we have the potential to deepen our understanding of the impact of a given strategy or intervention for reducing stigma on health outcomes for people with or affected by HIV along the entire HIV care continuum.

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Table 1 – Stigma reduction interventions by interview domain described by staff as occurring at 27 organizations providing HIV services in New York City.

DOMAIN	COMMON INTERVENTIONS FOR STIGMA REDUCTION	
STRUCTUAL LEVEL	Hire staff representative of communities served Provide and enforce policies and services that are informed by the specific needs and wants of client populations Create a physical space that is clean, welcoming, and shows inclusivity	Integrate HIV services into primary care and other services Require staff to attend cultural competency trainings and trainings that explicitly include stigma content Utilize language translation services
INTERPERSONAL LEVEL	Train staff on topics relevant to stigma including racism, gender identity, non-verbal communication, cultural competency, and de-escalation Have a culture that promotes the correct usage of client pronouns	Create a culture centering respect, as manifested by being welcoming, maintaining privacy and confidentiality, behaving in a way that is nonjudgmental and attentive, considering the whole person and meeting them where they are at, and using non-stigmatizing language Immediately address staff when enacted stigma occurs
INDIVIDUAL LEVEL	Maintain mental and behavioral health services onsite or through referral	Get input from clients through direct means like advisory boards Initiate client support groups based on expressed needs of clients and which are led or co-led by clients
STIGMA ASSESSMENT	Use validated surveys at least once to measure HIV or other types of stigma to prioritize stigma-reduction activities	Create stigma reduction plans in response to stigma measurement within the organization that operate at multiple levels of stigma Implement trainings and educational campaigns to address areas of continued stigma
FACILITATORS OF STIGMA REDUCTION	Education for clients and in the broader community that foster reflective and critical dialogue Increase frequency of staff trainings that are diverse and relevant to stigma	More explicitly address stigma- use the word, define what it is, then create programming for it Strengthen evaluation and feedback mechanisms to assess if what organizations do impacts stigma
SHARED DECISION MAKING BETWEEN STAFF AND CLIENTS	Establish a strong community advisory board (CAB) that meets at least quarterly Have CABs review organizational policies,	Empower CAB members to advocate on behalf of themselves and other clients in order to improve service delivery

	programming, and materials Utilize CABS for social or community-based events	
INTERSECTIONALITY	Case management to assure that clients are linked to services they need Integration of services for mental health care and substance use with HIV services to address multiple needs	Trainings on different kinds of stigma or "identity" groups Team-based care that deliberately integrates client's needs so that the care team has a holistic picture of a client
DOMAIN	**INNOVATIVE INTERVENTIONS FOR STIGMA REDUCTION**	
STRUCTURAL LEVEL	**Empowering Staff** Add content related to stigma to staff orientation trainings Host peer-to-peer trainings and workshops where staff teach each other new skills Start employee affinity groups that implement organizational policies Add racism as a core disparity to residency program curriculum **Creating a Welcoming Space** Make providers more approachable: they do not wear white coats, and clients address them by first name Remove no loitering signs and make signage bilingual Include signs about clients' right to be accompanied into exam rooms Display a collaboratively made "patient's bills of rights" throughout the facility Display quality improvement efforts in public areas where clients can see Remove arms on chairs in waiting room to accommodate all clients Add charging stations in waiting areas for client use	**Enhance Client Experience** Provide lab services at clients' homes Add client experience coordinators to staff Offer all clients assistance in completing forms Match providers to clients based on client preferences Have teams rotate around clients and communicate in advance of visits Screen for and discuss social determinants of health Analyze quality indicator data by intersections of demographics to identify unique outcomes **LGBTQ Client Support** Have LGBTQ+ liaisons in clinics Add gender identity and sexual orientation questions to paperwork Ask clients' pronouns and preferred names Providers wear pronouns and rainbow flags on ID badges Weekly clinic specifically for LGBTQ clients
INTERPERSONAL LEVEL	**Structural & Staff Changes** Create a care service model that aims for a family-like environment Conduct national or regional staff meetings for staff to share client case stories and receive emotional	**Increased Support for Client Experience** Have clinicians accompany outreach staff to clients' homes to understand the totality of their lives Have providers sit in on support groups

	support from each other Staff members work in teams and have daily/weekly "team huddles" Include evaluation of client interactions in staff performance reviews Have all new staff shadow existing staff for 2 weeks to understand their approach to care and how they treat clients Make and distribute stigma language guide Employ designated staff to de-escalate tense situations	to allow clients to have more face time with them and become more comfortable Operate from a perspective that staff never give up on clients Implement "patient experience" departments or units
INDIVIDUAL LEVEL	Have volunteers available to accompany transgender patients to ER and medical appointments Provide care packages for youth leaving detention and clothing for their job interviews Involve clients in grant writing for programming desired by clients Rename Peer Educators to "Community Wellness Advocates" and increase their compensation and job duties Homework given to clients to be kind to themselves and to increase self-esteem Offer wellness classes (yoga, cooking, dance, journaling on trauma) to improve client self-esteem and wellbeing Skills-building and vocational classes	Clients create "Safety Plans" to identify resources they have outside of the agency Give diplomas to clients who achieve progress with health goals and host celebrations of their milestones Refer to clients as "members" to make them feel they are a part of the institution Incorporate the topic of stigma into support and educational groups for clients Support groups implement pre- and post- affirmations where clients affirm their worthiness to themselves, or include meditation Clients dance to energetic music before support groups to "shake off what they walked in with"
STIGMA ASSESSMENT	Develop a workplan to address the issues raised by stigma assessment Create and support an anti-stigma task-force or campaign in response to measured stigma and keep stigma reduction activities at the forefront of improvement activities Document and share stigma reduction activities within the organization and external to the organization	Implement a top-down, agency-wide approach to addressing stigma Institute full-day, annual trainings for staff on a stigma-related topics Implement stigma assessment among clients in support groups, cooking classes, and other client services (including a pre and post assessment)
FACILITATORS OF	**Culture Changes**	**Client/Community Interventions**

STIGMA REDUCTION	Create a culture where staff feel comfortable holding each other accountable and giving routine feedback to each other Regularly bring stigma up in staff meetings to remind staff what the organization stands for Have strong peer programs that enable peers to be part of decision making Give peer workers paid opportunities where they can build their skills	Run social media campaigns or educational series that promote education about LGBTQ and people with HIV (PWH) to the broader community Organizations have informational material visible to dispel myths surrounding HIV (e.g. U=U posters)
SHARED DECISION MAKING BETWEEN STAFF AND CLIENTS	**Client Leadership** Clients are part of quality assurance committees, diversity and inclusivity committees, or sit on boards Create client/peer-run unions Encourage clients to serve on citywide HIV planning and/or advocacy coalitions Involve clients in stigma survey development and de-stigmatization campaigns Elicit client experiences of stigma at least annually through surveys or focus groups that reach clients	**General Client Input** Pop up events for client feedback and storytelling Map client experience of visits Hang client feedback on the walls of the organization to be read by all and added to Solicit client feedback directly during events (like cooking classes) Peer workers review and tailor client feedback forms Client input sought at the design stage or inception of every program
INTERSECTIONALITY	Analyze quality indicator data by intersections of demographics (e.g. race, gender, age, etc) within the client population to identify uniquely vulnerable populations	

Table 2 – Tool to select determinants of stigma reduction implementation including examples of barriers and facilitators reported by 27 organizations providing HIV services in New York City.

DETERMINANTS BY DOMAINS OF CONSOLIDATED FRAMEWORK FOR ADVANCING IMPLEMENTATION SCIENCE (CFIR)	GUDING TIPS FOR EXPLORING DETERMINANTS	EXAMPLES* OF STIGMA REDUCTION IMPLEMENTATION BARRIERS (+) AND FACILITATORS (-) AT HIV ORGANIZATIONS

STIGMA REDUCTION INTERVENTION CHARACTERISTICS	Applicable determinant(s) from Stigma Reduction Organizational Readiness Tool: Not applicable. These determinants relate to the specific intervention you have chosen to implement. Ask: What features of the specific stigma-reduction intervention you have chosen will make it easier or harder to implement?	Stigma reduction interventions are often complex and multi-level - Education and contact strategies commonly found to be effective but other evidence-based practices are lacking - Many tested stigma interventions are not specifically tailored to the US context - Tested interventions often occurred once with little follow-up data - Best practices for measurement and reduction of intersectional stigma unknown - Few validated metrics for assessing stigma in health services contexts - Stigma reduction interventions may be borrowed from other disciplines + Lack of explicit connections between stigma interventions and changes in HIV outcomes -
INNER SETTING	Applicable determinant(s) from Stigma Reduction Organizational Readiness Tool: A1 leadership engagement Ask: What is happening inside your organization or context that can affect implementation of your chosen stigma intervention?	Intersectional approaches largely limited to the integration of HIV services with mental health and substance use services - Staff are trained on how to make organization spaces welcoming to all clients + Hiring staff from the community and/or with lived experiences is prioritized + Inequitable power dynamics between staff and clients - Addressing stigma as a top priority + Organizational structure/capacity (large client volume, underfunded programs, bureaucracy, corporatization) - Physical spaces at organizations are made to be inclusive, welcoming, informative, and avoid

		siloing different types of care through integrating HIV services into other services + Stigma reduction as routine part of work/job + Cohesive support structure/hierarchy + Client-centered policies and practices + Disconnect between on-the-ground staff and higher-up decision makers - Stigma is not a commonly understood word - Lack of a formal stigma initiative and/or agenda - Leadership is divorced from client-level experiences and may not be convinced that stigma reduction is an important goal - Trainings are one-off, not sustained - Lack of representation and visibility of transgender and immigrant populations -
OUTER SETTING	Applicable determinant(s) from Stigma Reduction Organizational Readiness Tool: Not applicable. This domain has to do with factors outside of your organization. Ask: What is happening outside your organization that can affect implementation of your chosen intervention?	Lack of outside funding for organizations to conduct stigma reduction activities and programming - The organization has a strong presence in the community + Stigma still prevalent in the community and knowledge is low - Lack of control over stigma perpetuated in other spaces or parts of the same healthcare system - Stigma-targeted efforts by funders not sustained - Lack of community outreach as well as collaborative stigma reduction initiatives between communities and clinics - State level initiative and tool to

		measure stigma within healthcare organizations occurred and spurred motivation to address stigma +
CHARACTERISTICS OF STAFF	Applicable determinant(s) from Stigma Reduction Organizational Readiness Tool: B1 workforce engagement Ask: Who will carry out the implementation, and what are their beliefs, attitudes, knowledge, or other traits that can affect implementation?	Lack of understanding of what intersectionality means and how to implement an intersectional framework for stigma reduction services - Staff may hold stigmatizing beliefs - Staff burnout and turnover - Staff awareness of stigma is low - Staff self-efficacy on how to reduce stigma is low - Staff self-efficacy on how to reduce stigma is low - Staff representative of communities served + Staff attitudes value respect and client-centered care +
PROCESS	Applicable determinant(s) from Stigma Reduction Organizational Readiness Tool: A2 stigma reduction committee, A3 stigma reduction plan, A4 stigma data collection, and B2 community member engagement Ask: What processes exist in your organization that could facilitate change?	Organizations are involved with and reach out to the community (tabling events, etc) + Organizations have a lack of formal mechanisms and tools for evaluating data and conducting research - Stigma-reduction efforts are not consistently sustained - Space for client input through structured groups including support groups and community advisory boards (CABs) + Stigma is not explicitly addressed at CAB meetings - Clients are not asked about stigma explicitly in feedback surveys - Clients are able to communicate openly with the organization and understand goals of the organization and give feedback on goals and programs + Clients have a number of ways to be involved at the organization and programs +

For additional information on CFR determinants, see https://cfirguide.org/constructs/

*The characteristics described were derived from the experience of 27 HIV organizations in New York City, except in the case of “Stigma Reduction Intervention Characteristics” where the broader literature on stigma reduction research was consulted.

Figure 1

Determinants - 3

ASK: What can influence effective implementation of your stigma reduction intervention?

TIPS: Determinants are *factors* that make implementation easier or harder. Even if the strategies you pick will not address all of them, you want a comprehensive list of determinants. Consider factors both inside and outside your setting, as well as characteristics of the people involved in implementation, what your chosen intervention looks like, and what processes are already in place that can help implementation.

TOOLS:
Review **Table 2** for potential determinants, links to the Organizational Readiness Tool, and further considerations.

Implementation Strategies - 4

ASK: How will you get systems, programs, and/or staff to use the intervention? Are the strategies you chose specific to your determinants?

TIPS: Strategies are *actions* you will take to achieve your implementation outcomes, the "how" of implementation. They address your determinants, leveraging facilitators and addressing barriers. Ideally, they will address multiple levels and approaches (e.g., planning, education, finance, restructuring, quality management, and policy). Being specific about your rationale will improve staff and client engagement and adherence.

TOOLS:
1) Select the determinants to target: Prioritize addressing determinants in the Organizational Readiness Tool that scored below 3.
2) Choose implementation strategies: Different methods can be used, including a determinants-strategies matching tool, reviewing literature on strategies, or consulting evidence syntheses.
3) Strategy specification: Determine the Actor, Action, Temporality, Dose, Outcome, Target, and Justification for each strategy selected.

Mechanisms - 5

ASK: Why do the strategies you picked work to affect your implementation outcomes?

TIPS: A mechanism is the *process* through which your strategies work to achieve your outcomes. They reflect something that will change, often related to determinants, before your outcomes can be achieved. You should consider why your strategies will work before you use them.

TOOLS:
Review examples of how mechanisms fit within three potential stigma implementation scenarios in **Figure 2.** These mechanisms included increasing awareness, motivation, self-efficacy, and buy-in.

Outcomes - 2

ASK: What changes will happen in your setting that will tell you if implementation of a new stigma reduction intervention occurred?

TIPS: Outcomes are the *result* of your strategies. These outcomes are changes that will tell you whether your intervention is being used or is more likely to be used in the future. Identify data sources that can measure outcomes (e.g. EMR, interviews, enrollment and program data, focus groups, client satisfaction and staff surveys, etc.)

TOOLS:
1) Use the HIV Implementation Outcomes Crosswalk to select and operationalize outcomes according to implementation phase. When preparing for implementation, use 3 measures to assess likelihood of adoption of the stigma reduction intervention that can be collected at the level of site leadership, implementing staff, and/or clients (see "AIM,IAM,FIM" tab). During implementation/scale up, assess a broader set of outcomes (e.g. reach).
2) Alternatively, outcomes can be discussed and decided on using questions found in the RE-AIM Planning Tool.

Implementation Outcomes

ASK: Are services delivered respectfully?
TIPS: Assess for changes in enacted stigma, if the site is welcoming, and equity in policies and procedures.
TOOLS: Use stigma surveys and qualitative input.

Service Outcomes

ASK: Are clients reporting less stigma?
TIPS: Stigma and HIV data used together to set goals.
TOOLS: Use stigma surveys and qualitative input.

Client Outcomes

Stigma Reduction Interventions - 1

ASK: What is the intervention you will implement or scale up to reduce stigma? How did you decide to use it?

TIPS: It may be helpful to describe why you think the intervention will work to reduce stigma and what the key components are. Interventions should be decided on with clients, and stigmas that intersect with HIV stigma (e.g. racism, heterosexism) should be considered.

TOOLS: 1) Complete the **Stigma Reduction Organizational Readiness Tool** in Appendix 2 to assess your preparedness to implement stigma reduction. If you rate low on any areas, implement these first as these are key facilitators. 2) Review **Table 1** for a list of stigma-reduction interventions you can select from.

Underlined words refer to external resources in Appendix 1 that may be helpful in developing one's logic model. If a **word is both underlined and bolded** it refers to tools that emerged directly from the STAR Mapping Project in New York City. Red numbers indicate suggested order of completing the model.

Figure 2

Figure 2. Three potential pathways for how a chosen stigma reduction intervention is implemented, with a focus on demonstrating the importance of mechanisms for translating implementation strategies into implementation outcomes.

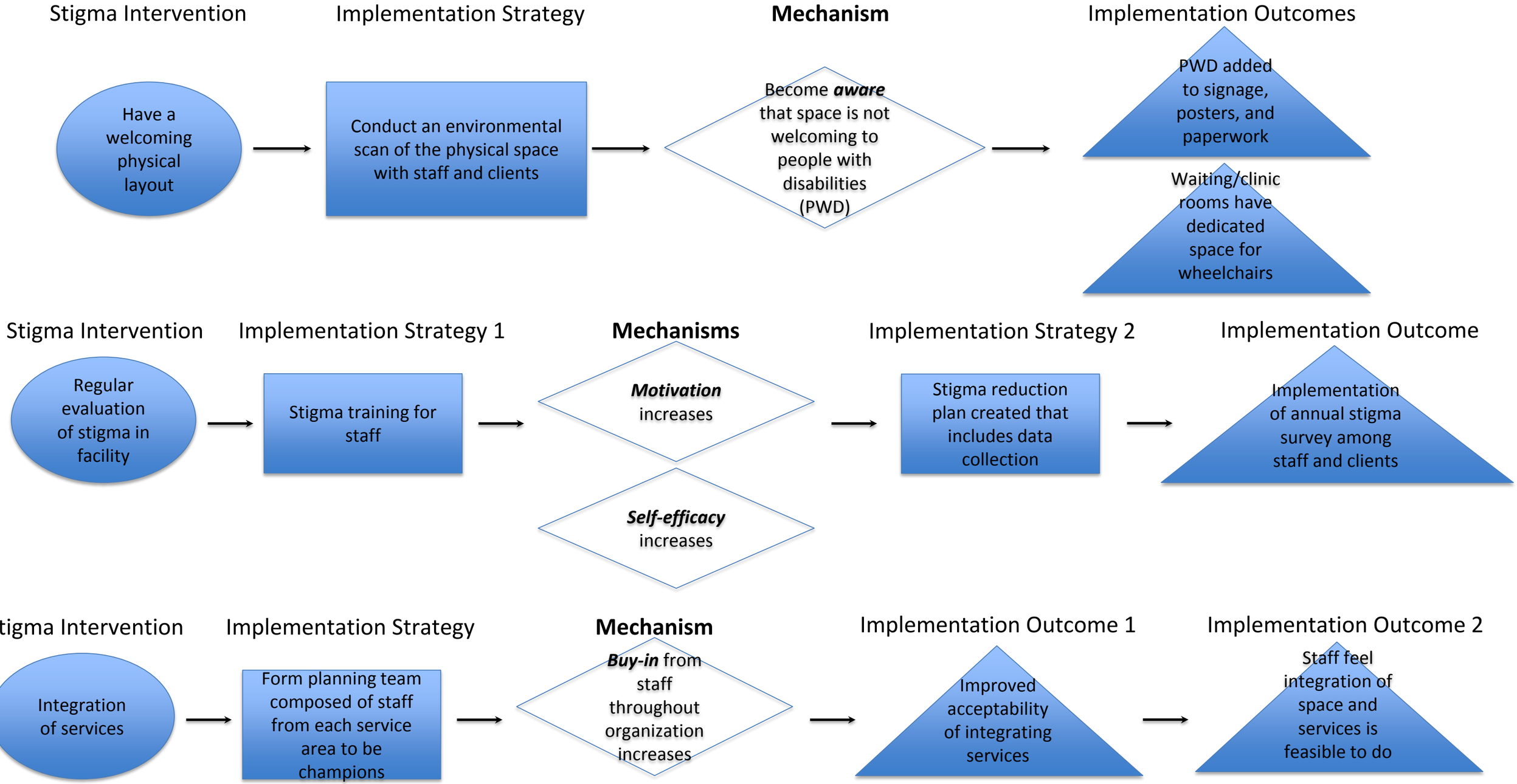
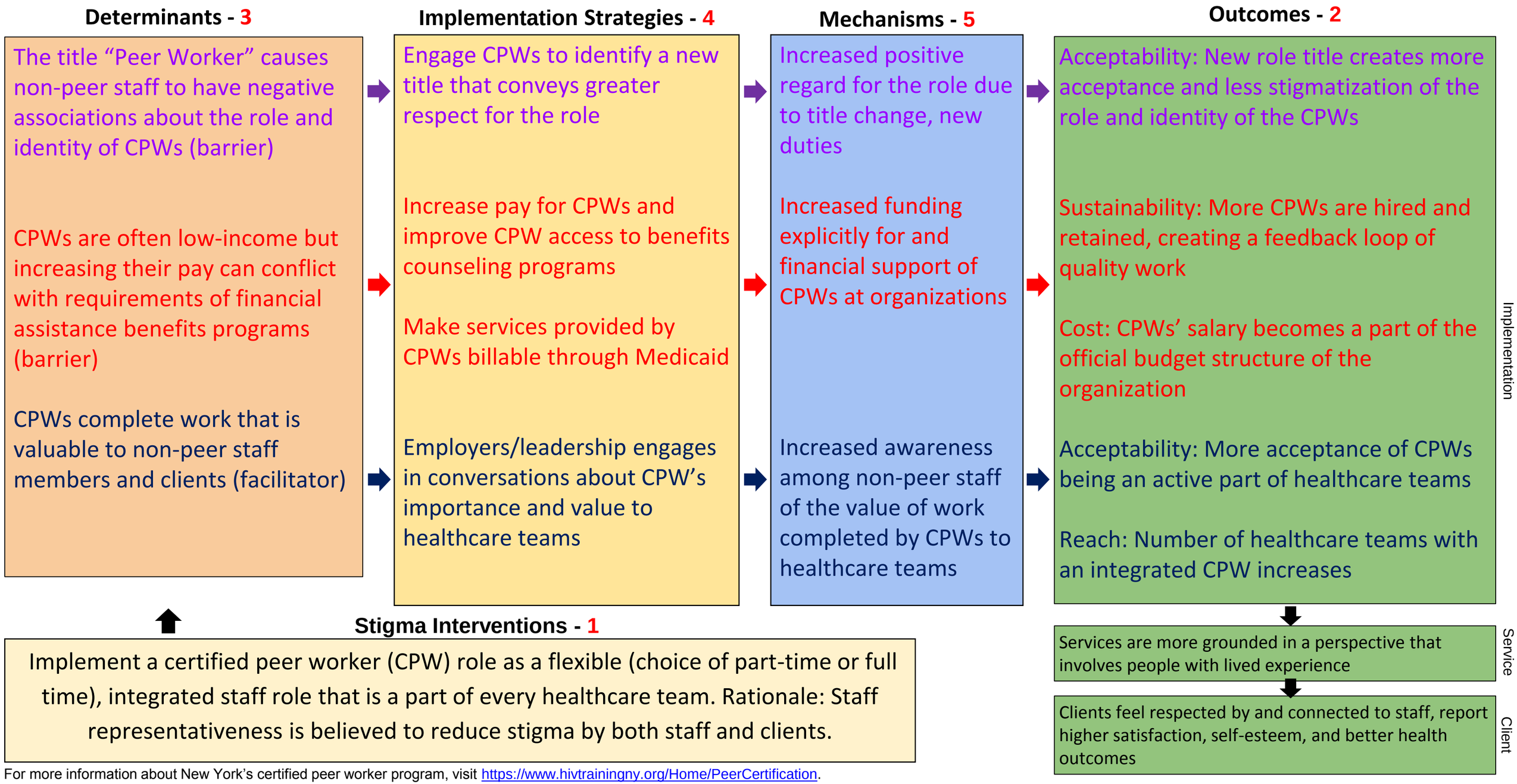
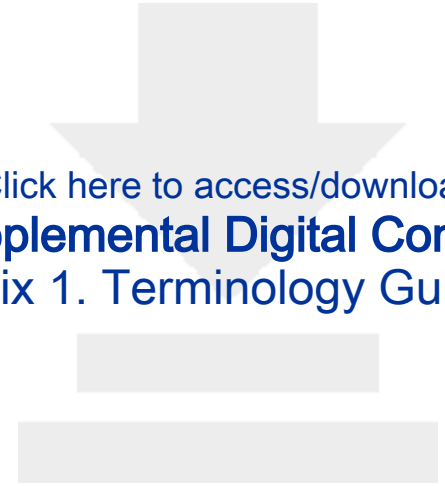


Figure 3. An example of stigma reduction implementation: The Certified Peer Worker (CPW) role



For more information about New York's certified peer worker program, visit https://www.hivtrainingny.org/Home/PeerCertification.

Appendix 1



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Supplemental Digital Content

Appendix 1. Terminology Guide.docx

Appendix 2

Click here to access/download

Supplemental Digital Content

Appendix 2. Stigma organizational readiness tool.docx