Program/Organization Information

HIV Program or Organization Name:

Contact Person Name:

Contact Email/Phone:

Main Program Address: City   State   Zip

Please include the name and address of the program's sites/clinic for which this Readiness Tool applies:

Site Name   Number of Clients   City   State   Zip

Type of Program/Organization (select one): Non-clinical Organization, FQHC, Community-based Clinic (non-FQHC), University Hospital, Other Hospital, Other

Funding Sources: Medicaid; Ryan White Part A, Part B, Part C, Part D; AETC; DOHMH Prevention Program Contract; Other

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Stigma Reduction Organizational Readiness Tool:

Purpose

Greater adoption, implementation, sustainment, and scaling up of stigma reduction interventions requires that organizations are ready and committed (Damschroder)[1]. Indicators of organizational readiness for stigma reduction implementation align with the components known to support strong quality management programming. This tool is an adaptation of the New York State Department of Health AIDS Institute Organizational Quality Management Assessment used to assess organizational capacity for sustained quality improvement. It incorporates best practices for stigma reduction in healthcare settings globally[2], along with findings from the NYC Stigma and Resilience Mapping Project[3] on the most important ingredients for successful stigma reduction.

Definitions and Theoretical Framework

We define stigma as a dynamic social process that involves the labeling, stereotyping, separation, status loss, and resulting discrimination that occurs within a context of a power imbalance[4] at the structural, interpersonal, and individuals levels. For example, 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 norms and expectations among staff

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[1] Damschroder, L.J., Aron, D.C., Keith, R.E. *et al.* Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Sci* **4,** 50 (2009). https://doi.org/10.1186/1748-5908-4-50

[2] Nyblade, L., Mingkwan, P., Stockton, M.A. Stigma reduction: an essential ingredient to ending AIDS by 2030. *The Lancet HIV* **8**, 2 (2021). https://doi.org/10.1016/S2352-3018(20)30309-X

[3] Rodriguez-Hart, C., Mackson, G., Belanger, D., West, N., Brock, V., Phanor, J., Weigl, S., Ahmed, C., Soler, J., Rule, A., Cournos, F., McKinnon, K., and Sandfort, T. HIV and Intersectional Stigma Reduction Among Organizations Providing HIV Services in New York City: A Mixed Methods Study. AIDS and Behavior. 2021. [Submitted].

[4] Link, B., & Phelan, J. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27*, 363-385. Retrieved May 19, 2021, from http://www.jstor.org/stable/2678626

for how community members are treated (enacted stigma), and at the individual level through how clients view themselves and the expectations they have for how they will be treated within the facility (internalized and anticipated stigma). Neither HIV nor stigma are one-dimensional issues; It is no longer sufficient to focus one stigma at a time in the context of ending an HIV epidemic that is driven by HIV stigma, sexism, racism, transphobia, homophobia, classicism, ableism, and stigma towards mental health and substance use. The communities most inequitably impacted by HIV and among whom evidence-based interventions often don't reach are facing multiple, interlocking structures that oppress them in ways that are common across and unique within groups at these intersections[5]. They manifest in disparities that must be recognized and addressed, as well as strength and resiliency. This tool promotes an intersectional lens to acknowledge and address the combined effects of experiencing more than one stigma. For example, when analyzing programmatic data or designing an intervention, an HIV program might be intentional about addressing how HIV stigma and racism together impact their community members. When we refer to "stigma" within this document we are referring to all stigmas relevant to the HIV epidemic and their intersectional impacts. When we refer to "community members" we are referring to people with lived experience of stigmas relevant to the HIV epidemic, whether living with HIV or not, and whether officially enrolled in services at the organization or not. This tool can be used by HIV programs or entire organizations.

Scoring

This tool focuses on six critical determinants of stigma reduction: senior leadership, stigma reduction committees, stigma reduction plans, data collection on stigma, engaged and trained staff, and input from communities with lived experience.

Scores from 0 to 5 (lowest to highest) are defined to identify gaps in readiness for stigma reduction and to set program priorities for selecting interventions and strategies for implementation. When assigning a score of 0-5, select the whole number that most accurately reflects organizational achievement in that area. If there is any uncertainty in assessing whether performance is closer to the statement in the next higher or lower range, choose the lower score. Scoring is designed so that all items in a score must be satisfied to reach any one score for a determinant. Scores below 3 on any determinant are considered low and point to an important contextual factor that could be addressed through implementation strategies. Applied annually, this tool will help a program evaluate its progress.

This tool can be administered as a self-evaluation. The results are ideally used to develop a stigma reduction implementation logic model and plans with specific strategies, timelines, and measurable implementation outcomes to guide the implementation process. Program leadership and staff should be involved in the assessment process to ensure that all stakeholders have an opportunity to provide important information related to the scoring.

Results of the assessment tool should be communicated to internal stakeholders, leadership and staff. Engagement of program leadership and staff is critical to ensure buy-in across the program, and essential for translating results into implementation practice.

A. Quality Management for Stigma Reduction

GOAL: To assess the HIV program infrastructure for readiness to support a systematic process to reduce stigma with identified leadership, accountability and dedicated resources.

Four components form the backbone of strong and sustainable stigma-reduction implementation: leadership, stigma reduction committee, a stigma reduction plan, and stigma data collection.

Leadership

Executive leadership staff are defined by each organization since titles and roles vary among organizations. Clinical HIV programs should include a clinical leader (medical director, senior nurse) and an administrative leader (program coordinator, clinic manager, administrative director). Programs may include additional leadership positions.

[5] Bowleg, L. The Problem With the Phrase Women and Minorties: Intersectionality- an Important Theoretical Framework for Public Health. *American Journal of Public Health* **102**, 1267_1273 (2012). https://doi.org/10.2105/AJPH.2012.300750

Leaders establish a unity of purpose and direction to engage all staff, community members with lived experience and external stakeholders in meeting organizational goals and objectives, this includes promoting a culture of shared responsibility and accountability, focusing on both teamwork and individual performance. HIV program leaders should prioritize stigma reduction implementation goals and projects for the year, and establish accountability for performance at all organizational levels. The benefits of strong leadership include clear communication of goals and objectives, where evaluation, alignment, and implementation of activities are fully integrated. Evidence of leadership support and engagement includes establishment of clear goals and objectives, communication of program/organizational vision, creating and sustaining shared values, and providing resources for implementation.

Stigma Reduction Committee

A stigma reduction committee drives implementation of the stigma reduction plan and provides high-level comprehensive oversight of the implementation process. This involves reviewing performance measures, developing logic models, chartering project teams, and supporting implementation progress. Teams should be multidisciplinary, have staff at multiple levels of the organization, and include community members. Representation of people with lived experience on the committee should be part of a formal engagement process where their feedback is solicited and integrated into the decision-making process from the start. The committee should have regular meetings, meeting notes to be distributed throughout the program, and a committee chair.

Stigma Reduction Plan

Stigma reduction planning occurs with initial program implementation and annually thereafter. A plan documents programmatic structure, annual goals, implementation activities, and timelines. The stigma reduction plan serves as a roadmap to guide implementation efforts, and includes a corresponding logic model to monitor progress and signify achievement of outcomes.

Determinant A.1. To what extent does executive leadership create an environment that supports HIV stigma reduction using an intersectional lens and shared decision-making with community members with lived experience?

<div align="center" style="color:red">Each score requires completion of all items in that level and all lower levels (except any items in level 0)</div>

Implementation Phase	Score	Determinant Criteria
Getting Started	0	☐ Senior leaders are not visibly engaged in stigma reduction activities.
Planning and initiation	1	Leaders are: ☐ Minimally involved in stigma reduction efforts, meetings about stigma reduction, supporting provision of resources (e.g. staff time, agency equipment and space, funding) for stigma reduction activities. ☐ Primarily focused on external requirements and supporting compliance with regulations. ☐ Inconsistent in use of data to identify opportunities for stigma reduction.
Beginning Implementation	2	Leaders are: ☐ Engaged in stigma reduction with focus on use of data to identify opportunities for reducing stigma from an intersectional perspective. ☐ Somewhat involved in stigma reduction efforts. ☐ Somewhat involved in meetings about stigma reduction. ☐ Supporting some resources for stigma reduction activities, including coaching on implementation science.
Implementation	3	Leaders are: ☐ Providing routine leadership to support the stigma reduction program. ☐ Providing routine and consistent allocation of staff or staff time for stigma reduction activities.

		☐ Actively engaged in stigma reduction activity planning and evaluation. ☐ Actively managing/leading meetings about stigma reduction. ☐ Clearly communicating stigma reduction goals and objectives to all staff. ☐ Recognizing and supporting staff and community members with lived experience involved in stigma reduction from an intersectional perspective. ☐ Routinely reviewing performance measures and patient outcomes to inform program priorities and data use for stigma reduction. ☐ Attentive to national stigma reduction trends/priorities that pertain to the program.
Progress toward systematic approach to stigma reduction	4	Leaders are: ☐ Supporting development of a respectful and welcoming culture of stigma reduction across the program, including provision of resources for staff participation in stigma reduction learning opportunities, conferences, stigma reduction materials, technical assistance on implementation science, etc. ☐ Supporting prioritization of stigma reduction goals based on data, and that critical areas of care are addressed from an intersectional lens, and in coordination with broader strategic goals for HIV care. ☐ Promoting patient-centered care and shared decision-making with community members with lived experience through the stigma reduction program. ☐ Routinely engaged in stigma reduction activity planning and evaluation. ☐ Routinely providing input and feedback to intersectional stigma reduction implementation teams.
Full systematic approach to stigma reduction in place	5	Leaders are: ☐ Actively engaged in the implementation and shaping of a respectful and welcoming culture of stigma reduction across the program, including provision of resources for staff participation in stigma reduction learning opportunities, conferences, stigma reduction materials, technical assistance on implementation science, etc. ☐ Encouraging open communication about how stigma shows up, its relationship to health, and how to reduce stigma through routine team meetings and dedicated time for staff and community members with lived experience feedback. ☐ Routinely and consistently engaged in stigma reduction activity planning and evaluation. ☐ Routinely and consistently providing input and feedback to stigma reduction implementation teams. ☐ Encouraging staff innovation through stigma reduction incentives, e.g. recognition and awards. ☐ Directly linking stigma reduction activities back to institutional strategic plans and initiatives.
Determinant A.2. To what extent does the HIV program have an effective stigma reduction committee to oversee, guide, assess, and plan stigma reduction activities to be implemented with an intersectional lens and informed by shared decision making with community members with lived experience?		
Each score requires completion of all items in that level and all lower levels (except any items in level 0)		

Getting Started	0	☐ A stigma reduction committee has not yet been developed or formalized or is not currently meeting regularly to provide effective oversight for stigma reduction activities.
Planning and initiation	1	The stigma reduction committee: ☐ May review stigma data triggered by an event or problem or generated by donor or regulatory urging. ☐ Has minimally integrated stigma reduction activities into other existing meetings.
Beginning Implementation	2	The stigma reduction committee: ☐ Has plans to hold regular meetings, but meetings may not occur regularly and/or do not focus on stigma reduction performance data. ☐ Has been formalized, representing most areas of the organization. ☐ Has identified roles and responsibilities for participating individuals.
Implementation	3	The stigma reduction committee: ☐ Is formally established and led by a program director, medical director, or clinician leader, as well as having community members within the committee. ☐ Has implemented a structured process to review stigma reduction data for improvement. ☐ Has defined roles and responsibilities as codified in the stigma reduction plan. ☐ Reviews stigma reduction performance data regularly, including staff and community member satisfaction. ☐ Discusses stigma reduction progress and redirects teams as appropriate.
Progress toward systematic approach to stigma reduction	4	The stigma reduction committee: ☐ Is formally established and led by a program director, medical director or senior clinician and is specifically tasked with active oversight of the stigma reduction program with established annual meeting dates. ☐ Represents all areas of the organization. ☐ Has established a process to routinely evaluate stigma reduction implementation measures and respond to data on enacted, anticipated, and internalized stigma. ☐ Communicates stigma reduction activities with non-members through distribution of minutes and discussion in staff and community member advisory meetings, revising activities based on input from staff and community members. ☐ Actively utilizes a stigma reduction plan to closely monitor progress of stigma reduction activities and team projects. ☐ Provides progress reports to individuals or teams within the organization responsible for reviewing the quality of delivered services.
Full systematic approach to stigma reduction in place	5	The stigma reduction committee: ☐ Is a formal entity led by a senior clinician or administrator and, where appropriate, is linked to organizational quality improvement initiatives through common members. ☐ Has established a formal policy to routinely evaluate stigma reduction implementation measures and respond to data on enacted, anticipated, and internalized stigma.

		☐ Is responsive to changes in treatment guidelines and external/national stigma reduction priorities, which are considered in development of indicators and choosing implementation initiatives. ☐ Has fully engaged senior leadership and at least one member of senior leadership participates in stigma reduction committee meetings. ☐ Effectively communicates stigma reduction activities, annual goals, performance results and progress on stigma reduction activities to all stakeholders, including staff, community members, and board members, revising activities based on their input.

Determinant A.3. To what degree does the HIV program have a comprehensive stigma reduction plan that is actively utilized to oversee stigma reduction interventions developed with shared decision making via the input of community members with lived experience and implemented with an intersectional lens?

<p align="center" style="color:red">Each score requires completion of all items in that level and all lower levels (except any items in level 0)</p>

Getting Started	0	☐ A stigma reduction plan, including elements necessary to guide the administration of a stigma reduction program with an intersectional lens, has not been developed.
Planning and initiation	1	The stigma reduction plan: ☐ Is written with some of the essential components necessary to direct the effective measurement and reduction of stigma within the program (see level 3). ☐ Is written for the parent organization but plans specific to the HIV program have not yet been developed (may not apply for organizations that do not have specific HIV Programs).
Beginning Implementation	2	The stigma reduction plan: ☐ Is written, containing some of the essential components (see level 3), with input from individuals knowledgeable in implementation science ☐ Is under review for approval (if required) by leadership and includes steps for implementation.
Implementation	3	The stigma reduction plan: ☐ Reflects essential components to effectively measure and reduce stigma within the program with an intersectional lens: - annual goals and objectives, - roles, responsibilities, - logistics, - routine measurement and evaluation of stigma, - an implementation logic model with implementation strategies and outcomes, - community member involvement for shared decision making ☐ Is routinely communicated to program staff and community members. ☐ Includes an annual workplan and timeline including essential components above.
Progress toward systematic approach to stigma reduction	4	The stigma reduction plan: ☐ Has been implemented and is used regularly by the stigma reduction committee to direct the stigma reduction program.

		☐ Includes annual goals identified based on internal performance measures and external requirements through engagement of the stigma reduction committee, staff, and community members. ☐ Workplan is modified as needed to achieve annual goals. ☐ Is routinely communicated to stakeholders, including staff, community members, board members and the parent organizations, if appropriate. ☐ Is evaluated annually by the stigma reduction committee to ensure that the needs of all stakeholders are met and that changes in the healthcare and regulatory environment are assessed to ensure that the program meets the changing needs of community members.
Full systematic approach to stigma reduction in place	5	The stigma reduction plan: ☐ Is written, implemented, and regularly utilized by the stigma reduction committee to direct the stigma reduction program and includes all necessary components (see level 3). ☐ Includes regularly updated annual goals that were identified by the stigma reduction committee using data on internal performance measures and external requirements through engagement of the stigma reduction committee, staff, and community members. ☐ Includes a workplan/timeline outlining key activities in place and is routinely and consistently used to track progress on stigma reduction performance measures and modified as needed to achieve annual goals. ☐ Is aligned with the parent organization and/or all network sites, as appropriate.

Determinant A.4. To what extent does the HIV program routinely measure performance and use data to monitor and improve intersectional and HIV stigma reduction activities?		
Each score requires completion of all items in that level and all lower levels (except any items in level 0)		
Getting Started	0	☐ <u>Stigma reduction measures</u> have not been identified.
Planning and initiation	1	Stigma reduction measures: ☐ Have been identified to evaluate some components of the program, but do not cover all significant aspects of service delivery. ☐ Are defined and understood by personnel at some but not all units or sites. <u>Stigma reduction data</u>: ☐ Collection is planned pending initiation.
Beginning Implementation	2	<u>Stigma reduction measures</u>: ☐ Are understood by personnel at all applicable sites. <u>Stigma reduction data</u>: ☐ Validation, analysis, and interpretation of results on measures are in early stages of development ☐ Results are occasionally shared with staff and community members.
Implementation	3	<u>Stigma reduction measures</u>: ☐ Meet the needs of stakeholders, including community members. ☐ Include training resources to ensure staff collecting data have knowledge of HIV and intersectional stigmas ☐ Are defined and consistently used by staff at all applicable sites. <u>Stigma reduction data</u>:

		☐ Are valid, analyzed, and reviewed regularly by the leadership. ☐ Are used to identify areas of ongoing stigma (perceived, enacted, or anticipated) and to prioritize stigma reduction improvement goals and plans. ☐ Are collected by staff with working knowledge of intersectional and HIV stigma reduction measures and their application. ☐ Results and associated measures are routinely shared with staff and community members and their input is elicited to make improvements.
Progress toward systematic approach to stigma reduction	4	Stigma reduction measures: ☐ Are aligned with annual organizational and HIV healthcare goals, as well as with the needs of community members and other stakeholders. ☐ Reflect priorities of clinic staff and community members, in consideration of local issues. Stigma reduction data: ☐ Are analyzed against stratified HIV continuum data to better understand disparities/inequities in care and health outcomes for sub-populations. ☐ Results and associated measures are frequently shared with staff and community members to elicit their input and engage them in improvement processes aligned with organizational goals.
Full systematic approach to stigma reduction in place	5	Stigma reduction measures: ☐ Are selected using organizational annual stigma reduction goals. ☐ Align with current evidence in the reducing of stigma as well as diagnosis and treatment of HIV. ☐ Reflect priorities of clinic staff and community members, in consideration of local issues. ☐ Are defined for each program component and actively used to drive stigma reduction activities. ☐ Are evaluated regularly to ensure that the program can respond effectively to internal and external changes quickly. Stigma reduction data: ☐ Are visible or easily accessible to ensure data reporting transparency throughout the HIV program. ☐ Are aligned with stratified HIV continuum data to set measurable goals to reduce disparities/inequities in care and health outcomes for sub-populations and to address intersectional stigma. ☐ Are arrayed in formats that enable accurate interpretation, such as run charts and/or control charts. ☐ Results and associated measures are systematically shared with all stakeholders, including staff, community members, and boards to elicit their input and engage them in stigma reducing processes aligned with organizational goals.
Comments:		

Determinant B. <u>**Workforce and Community Engagement in Stigma Reduction**</u>

GOAL: To increase motivation and self-efficacy of staff to implement stigma reduction interventions and regularly evaluate stigma occurring in the facility.

Staff (including peer workers) engagement in quality stigma-reduction activities at all organizational levels is central to successful implementation. This includes development and promotion of staff knowledge around organizational systems and processes to build sustainable stigma reduction interventions, such as full integration of HIV with other services, hiring and supporting staff who are reflective of the communities served, and sustained educational opportunities relevant to stigma.

Ongoing training and retraining in how stigma manifests, is associated with health, and practical skills to reduce stigma reinforces knowledge and the building of workforce expertise. Training should be designed to build capacity and capability of the workforce based on regular assessment and reassessment of staff knowledge and skills. It can be conducted at different times and in different ways including during new staff orientations; integrated into regular staff meetings; can occur onsite or offsite; and can be sponsored by the organization or an external credible organization. The regular collection, analysis, and dissemination of data on stigma occurring at multiple levels within the organization empowers staff to focus on key areas of care and build consensus around stigma interventions to improve patient outcomes. Data on stigma assists in the creation of stigma reduction plans and it builds in accountability for whether stigma interventions that are implemented have a measurable impact on reducing stigma.

As stigma reduction becomes part of the institutional culture and teamwork progresses, staff embrace their respective roles and responsibilities, acquiring a sense of ownership and deeper involvement in improvement work.

GOAL: To assess the extent to which community members with lived experience are formally integrated into stigma reduction planning and implementation.

Centering groups with lived experience is considered a core principle of stigma reduction. Community Member Involvement encompasses the diversity of individuals using HIV programmatic services and can be achieved in multiple ways including solicitation of community member perspectives through focus groups, key informant interviews and satisfaction surveys; a formal consumer advisory board that is actively engaged in improvement work; community members as members of program committees and boards; and conducting community member needs assessments and including community members in specific stigma reduction initiatives. Ideally, community members have a venue to identify stigma concerns and are integrated into the process to find solutions and develop implementation strategies. Overall, community members are considered valued members of the program, where community member perspectives are solicited, information is used for performance improvement and feedback is provided to community members.

Determinant B.1. To what extent are providers and other staff routinely engaged in HIV and intersectional stigma reduction interventions and provided training to enhance knowledge, skills, and methodology needed to fully implement stigma reduction interventions on an ongoing basis?

Each score requires completion of all items in that level and all lower levels (except any items in level 0)		
Getting Started	0	☐ All staff (clinical and non-clinical) are not routinely engaged in stigma reduction activities and are not provided training to enhance skills, knowledge, theory or methodology or encouragement to identify opportunities for improvement and develop effective solutions.
Planning and initiation	1	Engagement of staff in stigma reduction (clinical and non-clinical): ☐ Is under development and includes training in stigma reduction methods with an intersectional lens and opportunities to attend meetings where stigma reduction projects are discussed.

Beginning Implementation	2	Engagement of staff in stigma reduction (clinical and non-clinical): ☐ Is underway and some staff have been trained in stigma reduction methods that include a focus on structural, interpersonal, and individual-level stigma from an intersectional lens, as well as coached on implementation science. ☐ Includes stigma reduction meetings attended by some designated staff.
Implementation	3	Engagement of staff in stigma reduction (clinical and non-clinical) includes: ☐ Attendance in at least one training annually in stigma reduction. Staff members are generally aware of Program stigma reduction activities (action plan/priorities). ☐ Involvement in stigma reduction projects, project selection and participation in a stigma reduction committee. ☐ Stigma reduction project development, where stigma reduction projects are discussed and reviewed during staff meetings. ☐ Defined roles and responsibilities related to stigma reduction. Physicians and staff are aware of the stigma reduction plan and priorities for improvement. ☐ A formal process for regularly recognizing staff performance in stigma reduction via performance appraisals, public recognition during staff meetings, etc.
Progress toward systematic approach to stigma reduction	4	Engagement of staff in stigma reduction (clinical and non-clinical) includes: ☐ Demonstrated evidence that staff members are engaged and encouraged to use those skills to identify stigma reduction opportunities and develop solutions through shared decision making with community members. ☐ A shared language regarding stigma, which is evidenced in routine discussion. ☐ Description in the stigma reduction plan, and includes staff training and roles and responsibilities regarding staff involvement in stigma reduction activities and use in staff performance evaluation ☐ A formal process for recognizing staff performance internally and stigma reduction teams are provided opportunities to present successful projects to all staff and leadership.
Full systematic approach to stigma reduction in place	5	Engagement of staff in stigma reduction (clinical and non-clinical) includes: ☐ Staff awareness of the importance of stigma reduction developed through a process of shared decision making with community members, and their participation in identifying stigma-related issues, developing strategies for improvement, and implementing strategies. ☐ Continuous stigma reduction training and inclusion of training in staff performance reviews. ☐ Leadership who encourages all staff to make needed changes and improve systems for sustainable stigma reduction including the necessary data to support decisions. ☐ Formal and informal discussions where teamwork, and collaboration with community members is openly encouraged and leadership shapes teamwork behavior.

		☐ Routine communication about new developments in stigma reduction, including promotion of stigma reduction projects both internally (e.g., brown bags) and externally (e.g., conferences). ☐ Opportunities for abstract development and submission to relevant professional conferences and authorship of related publications about development and implementation of institutional stigma reduction programs.

Determinant B.2 To what extent are community members with lived experience effectively engaged and involved in HIV and intersectional stigma reduction implementation at the organization?

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Getting Started	0	☐ There is currently no process to involve community members in stigma reduction activities.
Planning and initiation	1	Community member involvement: ☐ A minimally formal process is in place for ongoing and systematic participation in stigma reduction activities. ☐ Is occasionally addressed by soliciting community member feedback.
Beginning Implementation	2	Community member involvement: ☐ Is addressed by soliciting community member feedback, with a formal process for ongoing and systematic participation in stigma reduction activities in development.
Implementation	3	Community member involvement: ☐ Includes engagement with community members to solicit perspectives and experiences related to stigma and ideas for reducing stigma. ☐ Is formally part of stigma reduction activities through a formal community member advisory committee, satisfaction surveys, interviews, focus groups and/or community member training/skills building. However, the extent to which community members participate in stigma reduction activities is not documented or assessed.
Progress toward systematic approach to stigma reduction	4	Community member involvement: ☐ Is part of a formal process for community members to participate in stigma reduction activities, including a formal community member advisory committee, surveys, interviews, focus groups and/or community member training/skills building. ☐ In stigma reduction activities includes three or more of the following: – sharing stigma data and discussing stigma reduction during community member advisory board meetings – membership on the internal stigma reduction committee – training on stigma reduction principles and methods – engagement to make recommendations based on performance data results – increasing documentation of recommendations by community members to implement stigma reduction activities. ☐ Information gathered through the above noted activities is documented and used to reduce stigma.
Full systematic approach to stigma reduction in place	5	Community member involvement:

		☐ Contribution and its impact on stigma are reviewed with community members. ☐ Is part of a formal, well-documented process for community members to participate in stigma reduction activities, including a community member advisory committee with regular meetings, community member surveys, interviews, focus groups and community member training/skills building. ☐ In stigma reduction activities includes four or more of the items bulleted in B2 #4. ☐ Information gathered through the above noted activities is documented, assessed, and used to drive stigma reduction activities and establish priorities for improvement. ☐ Includes work with program staff to review changes made based on recommendations received with opportunities to offer refinements for improvements. Information is gathered in this process and used for stigma reduction implementation. ☐ Involves at minimum, an annual review by stigma reduction committee of successes and challenges of community member involvement in stigma reduction activities to foster and enhance collaboration between community members and providers engaged in stigma reduction.
Comments:		