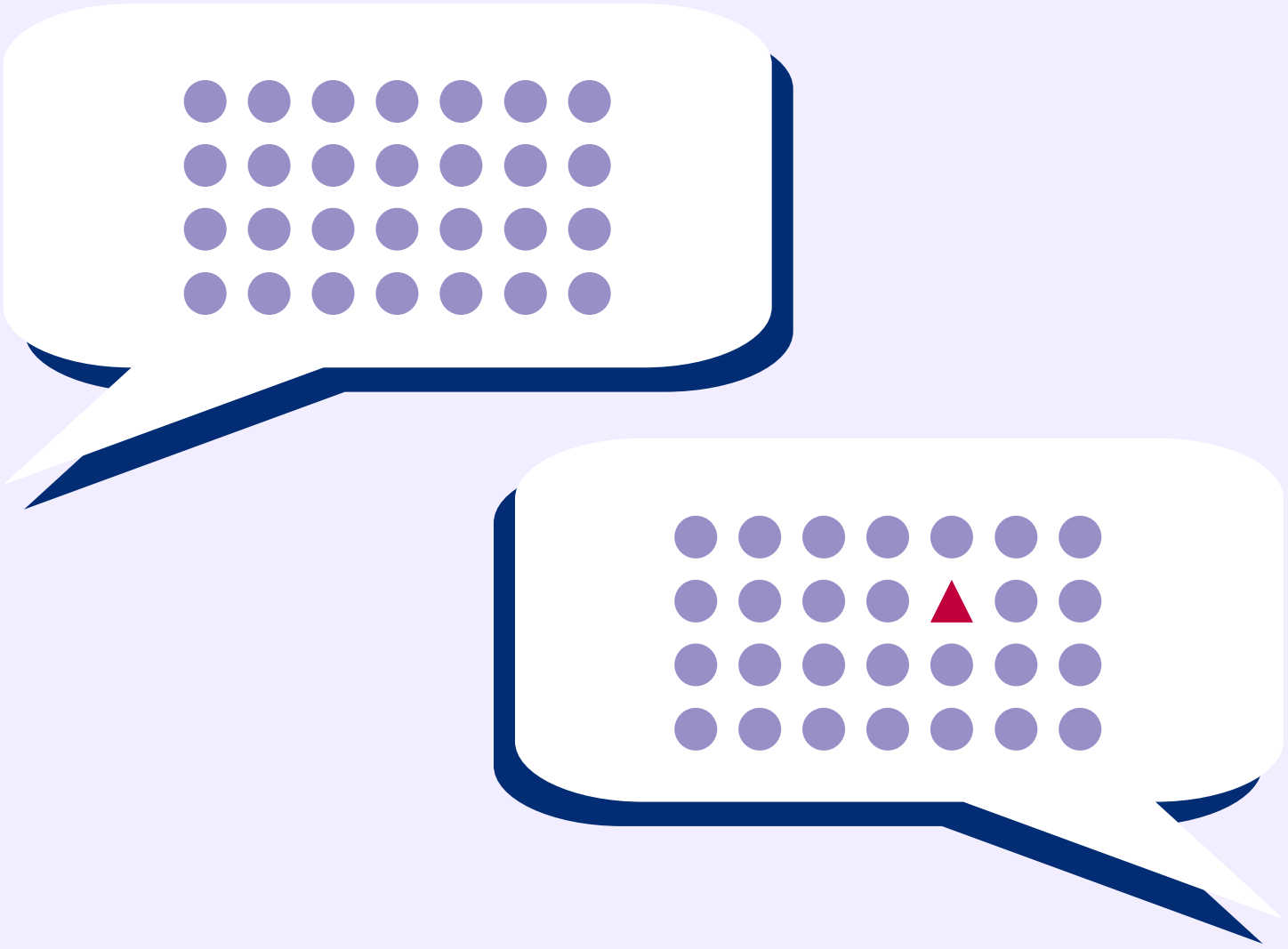
Quality of Care Program
HIV and Intersectional Stigma Reduction Toolkit



NEW YORK STATE | Department of Health

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Purpose of the Toolkit

HIV stigma and its intersections with other stigmas[1] have been identified as significant barriers to achieving the goals of the National HIV AIDS Strategy, and to quality-of-care outcomes for people with HIV (PWH)[2]. Notable barriers to positive health outcomes, such as HIV viral load suppression, include lower medication and visit adherence, higher instances of depression, and lower quality of life[3]. This stigma reduction toolkit is intended for organizations, programs, and providers to use to organize the implementation process and resources for program staff and others interested in addressing the various intersections of stigma. Importantly, stigma reduction work is driven by the community, so this tool organizes the resources recommended by and produced for the community and establishes community involvement as fundamental to the stigma reduction process.

How to Use the Toolkit

This toolkit provides guidance on how an HIV service provider might successfully design a stigma reduction intervention. Starting from a general background in HIV stigma as a foundation, the incorporation of the Stigma Reduction Readiness Tool and Logic Model guides the process of creating a stigma reduction intervention. Evidence-Informed Interventions for specific communities impacted by stigma are included in this toolkit, to further inform and inspire innovations.

[1] "Other stigmas" includes but is not limited to stigma driven by racism, sexism, transphobia, homophobia, classism, ableism, stigma around mental health, substance use, documentation status and incarceration status.

[2] Department of Health and Human Services. National Strategic Plan for the United States: A Roadmap to End the HIV Epidemic for the Unites States (2021-2025) [Internet]. 2020. Available at: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf. Accessed October 4, 2021.

[3] Turan B, Budhwani H, Fazeli PL, et al. How Does Stigma Affect People Living with HIV? The Mediating Roles of Internalized and Anticipated HIV Stigma in the Effects of Perceived Community Stigma on Health and Psychosocial Outcomes. *AIDS Behav*. 2017;21(1):283-291. doi:10.1007/s10461-016-1451-5

Background on HIV Stigma

History of HIV

HIV was first identified as a pneumonia in people who inject drugs[4], and amongst gay men and MSM in 1981.[5] Even though it was understood that HIV was an immunodeficiency disorder, it was thought to only affect drug users and the gay community and was at one point called GRIDS ("Gay-related immuno-deficiency syndrome"). This led to further stigmatization of these communities, which resulted in governmental and health organization neglect, restrictive immigration policy, and daily stigmatizing experiences highlighted by people like Ryan White, who called for national attention to the issue of HIV and need for education[6]. In 1982 the disease was renamed "Acquired Immune Deficiency Syndrome (AIDS)," and in 1986, the HIV virus which causes AIDS was identified.[7]

> *"When it comes to stigma, the first time I experienced it was when I was hospitalized in an AIDS designation isolation room in the 90s. They would throw the food trays in there because they wouldn't want to come in the room, and I couldn't get up to get it." – HIV Care Consumer*

Organized movements were generated in response to the stigma surrounding people at risk for and living with HIV, with the creation of documents like the Denver Principles in 1983, which outlined the rights of "People with AIDS,"[8] and promoted their self-empowerment. ACT UP (AIDS Coalition to Unleash Power), founded in 1987, fought for the rights of people living with AIDS and mobilized collective action to end the AIDS crisis. Their first action was protesting against the Wall Street pharmaceutical companies profiting off of AIDS drugs, like AZT. Later, their demonstrations would expand to accelerating the development of HIV treatments, spreading awareness of communities impact by AIDS, denouncing the neglect of government entities in addressing the AIDS crisis, and further advocating for the accessibility of HIV treatments, which resulted in significant improvements in HIV healthcare and services[9]. Despite the progress made,

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[4] Masur H, Michelis MA, Greene JB, et al. An outbreak of community-acquired Pneumocystis carinii pneumonia: initial manifestation of cellular immune dysfunction. *N Engl J Med*. 1981;305(24):1431-1438. doi:10.1056/NEJM198112103052402

[5] Centers for Disease Control (CDC). A cluster of Kaposi's sarcoma and Pneumocystis carinii pneumonia among homosexual male residents of Los Angeles and Orange Counties, California. *MMWR Morb Mortal Wkly Rep*. 1982;31(23):305-307.

[6] A timeline of HIV and AIDS. HIV.gov. https://www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline. Published September 7, 2021. Accessed October 26, 2021.

[7] History of HIV and AIDS overview. Avert. https://www.avert.org/professionals/history-hiv-aids/overview#footnote2_lhaf9n7. Published October 10, 2019. Accessed January 26, 2022.

[8] The Denver Principles. The ACT UP Historical Archive. https://actupny.org/documents/Denver.html. Accessed October 26, 2021.

[9] Act Up Accomplishments and Partial Chronology. ACT UP NY. https://actupny.com/actions/. Published May 13, 2021. Accessed October 26, 2021.

however, HIV stigma still plays a prevalent role in reducing health outcomes for PLWH. For more information on the historical background of HIV, consult the resources located in the “Improving Staff Education” section of the toolkit.

HIV Stigma

Stigma is a social process enacted through labeling, stereotyping, and separating people into categories of “us” versus “them”, resulting in status loss and discrimination occurring in a context of power[10]. Stigma is multi-level (Figure 1), manifesting at the structural level through organizational policies, cultural norms, care environment and infrastructure. Examples of structural stigma include the criminalization of identity or widespread negative public attitudes. At the interpersonal level, there are overt and hidden expressions of stigma known as enacted stigma, such as the interactions between program staff and PLWH, differential treatment, or verbal harassment. Lastly, anticipated and internalized stigma exist at the personal level, where the expectation of experiencing enacted stigma and the acceptance of stigma as an internal concept of self, leads to fear of disclosing HIV status and feelings of shame.

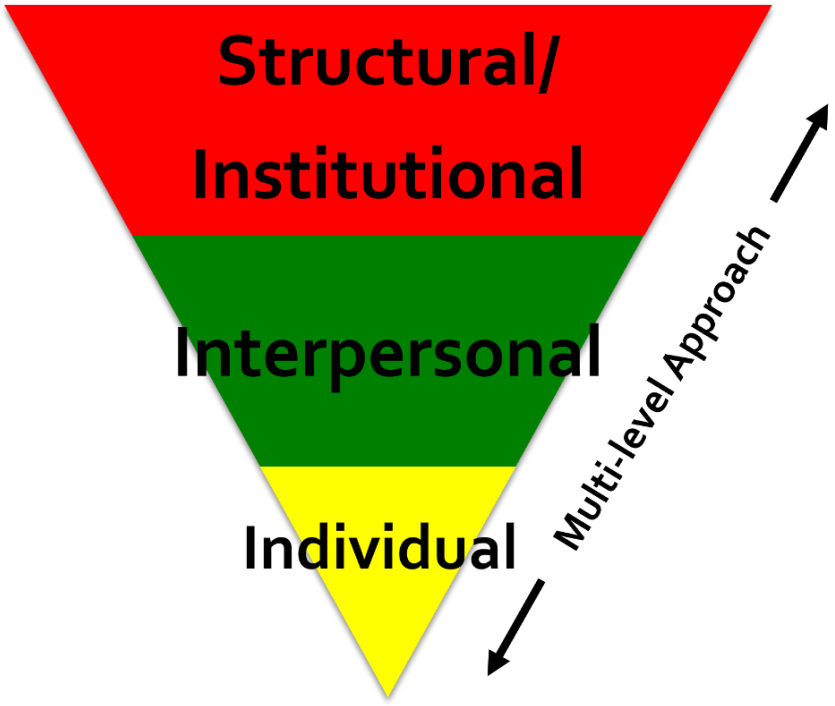

Figure 1. Levels of Stigma. Reprinted from Dr. Cristina Rodriguez-Hart’s presentation on “Stigma as a Driver of the HIV Epidemic”.

[10] Link, B., & Phelan, J. (2001). Conceptualizing Stigma. Annual Review of Sociology, 27, 363-385. Retrieved Oct 5, 2021, from http://www.jstor.org/stable/2678626

HIV stigma is characterized by the silence, exclusion, and isolation of people based on their HIV positive status, marking PLWH and intersecting marginalized communities[11] as socially undesirable and less valuable[12]. Furthermore, the anticipation and experience of HIV stigma hinders engagement in the HIV care continuum (Figure 2) (testing, prevention, linkage to care, treatment adherence, and viral suppression), where PLWH feel discouraged from seeking health care out of fear of being stigmatized. Because individuals are composed of multiple identities, they may simultaneously experience stigma related to other specific aspects of their identity. This creates intersectional stigma with nuanced experiences, strengths, and vulnerabilities within the context they live in[13].

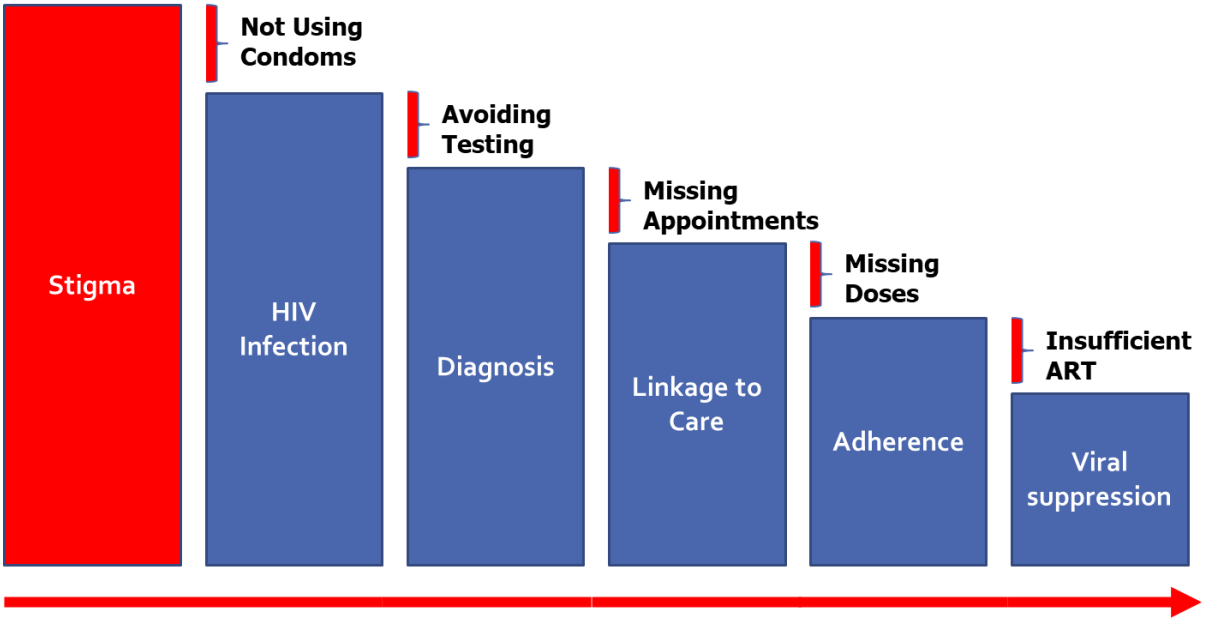

Figure 2 HIV Care Continuum. Reprinted from Dr. Cristina Rodriguez-Hart's presentation on "Stigma as a Driver of the HIV Epidemic."

[11] Nyblade L. (2021). Stigma reduction: an essential ingredient to ending AIDS by 2030. The Lancet HIV, 8, E106-E113. Retrieved Oct 5, 2021, from https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30309-X/fulltext

[12] Turan B, Budhwani H, Fazeli PL, et al

[13] Nyblade L.

AIDS Institute Response to HIV Stigma

As part of the 2016 HIV Quality of Care Program Review, all sites providing medical care to HIV positive patients in New York State were expected to complete activities focusing on stigma reduction. To begin this initiative, a survey for healthcare workers and solicitation of consumer feedback were developed to measure HIV and key population-related stigma in the healthcare setting. The final product from the collection of feedback was the creation of a stigma reduction action plan based on stigma measurements and consumer input. Upon the completion of this initiative, the important target areas in stigma reduction were found:

- Improving Staff Education
- Creating a Welcoming and Inclusive Environment
- Structural Changes of Focus

Measuring Stigma in Healthcare Settings

> *"One time I went to the emergency room for my foot and the doctor stood at the door and wouldn't come in the room to examine my foot and diagnosed me from the door. He refused to come into the room. This was an eye-opener that stigma still is going on, although I have people that uplift me, when I do feel it, it's a jolt of realizing the work still needs to be done. You would think people knew the simple things like how HIV is transmitted] but some refuse to hear the education." – HIV Care Consumer*

Stigma measurement was first discussed at the HIV Quality of Care Advisory Committee (QAC) meeting in June 2015 when Dr. Laura Nyblade presented her work in the field of stigma reduction in healthcare facilities. In response to this presentation and the goals of the ETE blueprint, a stigma subcommittee composed of representatives of both QAC and the HIV Quality of Care Consumer Advisory Committee (CAC) first convened in early 2016. Their purpose was to adapt the Health Policy Project's "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire," led by Nyblade, to the context of HIV care in NYS and for practice sites to administer to staff.

The survey they developed contains questions on organization-level and interpersonal-level HIV related stigma and can measure stigma reduction activity effectiveness when

implemented in timed intervals. In addition, there is a section on key population-related stigma consisting of people with transgender/gender non-conforming experience, women, men who have sex with men (MSM), people of color, and people living with a mental health diagnosis. While the survey doesn't address intersectional stigma, it can be adapted to do so. The survey can be viewed in **Appendix 1** of this toolkit.

Improving Staff Education

Improving staff education was identified as one of the target areas of stigma reduction through the Quality of Care Program's stigma survey initiative. Healthcare staff reported not receiving training about HIV-related stigma, discrimination, and policies on confidentiality. Similarly, staff reported having a lack of training on key populations and barriers to recovery, involved in women's health, transgender and gender non-conforming individuals (TGNC), people with mental health diagnosis, people who use drugs, and PrEP and PEP availability for all populations. While the action plans from HIV organizations developed improvements on these gaps in training following the feedback from the survey, a larger discussion on the expectations of "improving" is needed. Improvement can vary, it can mean changing staff education to be more comprehensive and continuous, or considering how staff training can be enforced, or how to help staff retain stigma reduction information, or how regular trainings and resources will be presented. Additionally, improving staff education can mean departing from the didactic to more non-traditional methods of educating staff.

> *"One of the things that I think is the importance of staff education is to create [cohesion] with clients…If a client feels stigmatized or isolated, they will not return and you will never really know…they don't usually share that information. Education of staff is not a race, it's a marathon. We have to have a strategic plan, like every three months, it's a cultural shift from the top to the bottom." – HIV Care Provider*

Creating a Welcoming and Inclusive Environment

Creating a welcoming and inclusive environment was another target area of stigma reduction identified through the Quality of Care Program's stigma survey initiative. When organizations solicited consumer feedback, consumers reported that they felt discomfort in the healthcare setting, encountered unwelcoming front desk/waiting areas, experienced stigma throughout the healthcare facility, extra protection procedures practiced by staff, observing staff talking badly about patients (PLWH, TGNC folks, and people with a mental health diagnosis specifically), and privacy and confidentiality concerns. Consumers

> *"Language is important when reducing stigma. I never use the word clean or infected when it comes to HIV. There are other words that can be used." – HIV Care Consumer*

reported experiencing more stigma in the community than in the healthcare setting, described as worrying about disclosing HIV status, anticipating discrimination, and facing an overall lack of knowledge in the community. Previously collected action plans showed a focus on stigma reduction initiatives such as developing and posting resources for all key populations and promoting Undetectable=Untransmittable messaging. Above all, creating a welcoming and inclusive environment falls into methods of reframing an environment that supports appropriate language, conducive discussion aimed at de-stigmatization, and actionable and physical changes that promote inclusivity.

Structural Changes of Focus

'Structural changes' was the third target area identified by organizations completing the stigma survey initiative. These take place at the macro-level of the healthcare and community setting, with some overlap within the aforementioned areas of improving staff education and creating a welcoming and inclusive environment. Action plans collected from organizations include updating policies and employee handbook guidelines related to HIV and key population-related stigma and discrimination, and communicating policies to staff members. In addition, adopting more inclusive and person-centered language regarding sexual orientation and gender identity, gender pronouns, and mixed identities are important to spotlight. Lastly, the creation of stigma reduction work groups for consumers and staff, and the creation of support groups for key populations are suggested.

> *"When someone experiences stigma, or goes to the ER, or speaks to the front desk, who do you report the stigma to? How do you report this without proof?"*
> *– HIV Care Consumer*

> *"When a person walks into your structural office building, you have to be welcoming. And we work really hard to make sure that the faces the patient will see fit the demographics of the community…so it feels like you're walking down a street in your community, it feels safe. So you have that first visual contact, like okay, they're like me, at least my skin color, who I am."*
> *– HIV Care Provider*

Overall, it is important to note that these responses are not an exhaustive list, and these target areas are more of a jumping off point for stigma reduction interventions to be created.

Implementing Stigma Reduction Activities

Stigma Reduction Organizational Readiness Tool

To effectively implement stigma reduction strategies, stigma reduction must first be a priority within the culture of the organization. The Stigma Reduction Organizational Readiness Tool, adapted from the NYS AIDS Institute Quality Management Assessment (Appendix 2), can be utilized to determine an organization's level of readiness and commitment to developing interventions, which must be both adaptable and sustainable in order to be effective and impactful. This tool, located in the appendix of this toolkit, uses successful practices in stigma reduction in conjunction with findings from the NYS Stigma and Resilience Mapping Project, to suggest effective stigma reduction tactics. These strategies identify and account for the determinants of stigma reduction, which include senior leadership, stigma reduction committees, stigma reduction plans, data collection on stigma, engaged and trained staff, and input from communities with lived experiences. These factors must be considered in order to develop and implement successful strategies for stigma reduction. The Stigma Reduction Readiness Tool is used to identify these determinants of stigma reduction, in order to determine any gaps in readiness for implementing stigma reduction interventions. Using this tool to identify strengths and needs of an organization will assist in specifying effective stigma reduction techniques to be utilized. This tool is ideally used as the first step in the process, as it is important to know where you are starting from to understand where you are going.

> *"Usually [front line staff] are reflective of a bigger dynamic. They are the ones that are seen, but it's much deeper than front line staff. It usually is the CEO or manager that they are reflecting, the behavior above them. In order for that environment to change, it really has to start from those who have the authority or privilege of setting those tones." – HIV Care Provider*

Stigma Reduction Logic Model

Developed by the STAR (Stigma Reduction and Resiliency) Coalition, the Stigma Reduction Logic Model was created to assist in the initial stages of implementing interventions using an Implementation Science approach, while also referencing tools to be used for stigma reduction (Appendix 3). The first step of the Stigma Reduction Logic Model includes the use of the Readiness Tool, as it is included within the model. This model is helpful to use when considering recommendations to reduce stigma, to better understand the path to implementation. The Stigma Reduction Logic Model provides insight into the effects of the intervention chosen to be implemented, by forecasting certain outcomes, determinants, strategies, and mechanisms resulting from enactment of the intervention. The model is helpful in providing examples for implementing interventions to address the determinants of stigma, as circumstances evolve. It can also

provide a foundation for organizations to expand and develop new stigma interventions. Finally, the Stigma Reduction Logic Model can be used to determine if an intervention is effective in unique environments differing between organizations.

Some guiding questions included in the Stigma Reduction Logic Model to assist with intervention development and execution are as follows:

1. **Stigma Intervention:** What is the intervention you will implement or scale up to reduce stigma? How did you decide to use it?
2. **Outcomes:** What changes will happen in your setting that will tell you if implementation of a new stigma reduction intervention occurred?
3. **Determinants:** What can influence effective implementation of your stigma reduction intervention?
4. **Implementation Strategies:** How will you get systems, programs, and/or staff to use the intervention? Are the strategies you chose specific to your determinants?
5. **Mechanisms:** Why do the strategies you picked work to affect your implementation outcomes?

Resources and Interventions

Stigma can have effects impacting populations at Institutional/Structural, Interpersonal, and Internalized levels. Institutional/Structural level stigma occurs due to policies enacted, a lack of resources within a community, and societal practices[14]. Structural stigma is propagated by policies and organizations with practices that affect communities, and negatively impact the wellbeing of key populations. Interventions are implemented to impact populations at a community level, while combatting organizational and policy-level stigma. At the Interpersonal level, stigma occurs due to interactions between a provider and consumer, or within a social network. This level of stigma is a result of social attitudes, affecting communication, social support, and interactions between PLWH and providers. Stigma can result in internalized effects as well, which are defined as negative attitudes about one's status or identity, and the anticipation of stigma. Negative messaging and stereotypes can result in internalized stigma, as one may begin to apply such attitudes to themselves. For key populations, these levels of stigma are not distinct; intersectional stigma exists for many as each level of stigma can overlap for many populations.

> *"The more that some of us come out and say that we are living with HIV and are thriving and help educate, the more faces people see, the more real it will be as long as there is diversity. For the longest time people only saw gay black and white men. You did not see a lot of heterosexual men out with their status and don't think it pertains to them." – HIV Care Consumer*

[14] Hatzenbuehler ML. Structural stigma: Research evidence and implications for psychological science. *Am Psychol*. 2016;71(8):742-751. doi:10.1037/amp0000068

Evidence-informed resources, recommendations, and trainings tailored for each key population can be found in the tables below, although these are not an exhaustive list of options available to providers. These resources apply to the multiple levels of stigma, as well as to several key populations, which in conjunction, can be used to address instances of intersectional stigma.

Evidence-Informed Interventions

The evidence-informed resources in the tables below represent studies and interventions proven to be successful in improving wellbeing in various settings. The resources in the tables below provide insight into the implementation of effective interventions, tailored to the needs of various key populations at each level of stigma. These resources can be utilized to suggest stigma reduction strategies and services that are useful and effective to providers and organizations. The recommendations are drawn from interventions proven to be effective for several key populations. Suggested recommendations can then be adapted and implemented for use within diverse settings. This non-exhaustive list of resources and interventions can serve as a model for multiple interventions that consider several levels of stigma to address intersectional stigma, as well.

Intersectional Stigma

> *"I think healthcare has a lot of intersectional stigma when it comes to HIV care. Seemingly, a vast range of medical providers bypass notes of varying gender identities, pronouns, and chosen names. The current structure to healthcare is only within the gender binary creating traumatic and potentially life threatening situations for our persons of trans experience. An added layer of stigma that occurs is the assumption being of trans experience automatically means an HIV diagnosis, and assumptions regarding transmission, as well as lack of education or sensitivity when giving HIV/AIDS Diagnoses." – HIV Care Consumer*

Intersectional stigma is the idea that multiple stigmatized identities can be experienced within a person or group, concurrently impacting their health[15]. Different life experiences can affect anticipated and enacted occurrences of stigma. Intersectional stigma occurs when multiple levels of stigma affect a certain population. It is defined as stigma that occurs when class, race, sexual orientation, age, disability, and gender are considered together rather than separately because of systems in power[16]. Various levels of stigma can overlap, and those that are members of multiple key populations may face stigma

[15] Turan, J.M., Elafros, M.A., Logie, C.H. *et al.* Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Med* 17, 7 (2019). https://doi.org/10.1186/s12916-018-1246-9

[16] Intersectionality and Stigma. NASTAD. Accessed October 15th, 2021. https://www.nastad.org/talking-points-resource-guide-facilitating-stigma-conversations/vignettes

affecting them in a multifaceted manner. The resources and interventions suggested below are stratified based on stigma level and the key population impacted but resulting stigma can be co-occurring for those experiencing intersectional stigma. A provider supporting a person experiencing multiple stigmatized identities may not find just one intervention to be impactful and may prefer to utilize several of the strategies outlined below. A multi-dimensional understanding of the stigma faced by populations can provide insight into effective interventions addressing the intersectional stigma faced by key populations.

Table 1. Improving Staff Education

Stigma related to…	**Institutional/Structural Stigma** (also thought of as community-level, organization and policy-level stigma)	**Interpersonal Stigma** (i.e. interactions between provider and consumer or within social network)	**Internalized Stigma** (negative feelings about one's status or identity; includes perceived or anticipated stigma)
HIV status	History of HIV: • A Timeline of HIV and AIDS (HIV.gov) • The Denver Principles (1983) (ActUpNY) • ACT UP Accomplishments – 1987-2012 (ActUpNY)		

	• HIV Stigma and Discrimination	• HIV/AIDS Confidentiality Law Overview (CEI)
		• Educate yourself and others about HIV (CDC)
		  • Stigma Scenarios: Support in Action (CDC)
		  • Stigma Language Guide (CDC)
		Stigma impedes HIV prevention by stifling patient–provider communication about U = U (JIAS):
		  • Incorporate U = U into clinical education for all HIV service providers
		• Escalate (NMAC)
			• How Does Stigma Affect People Living with HIV? (NIH):
			Helpful to consider when designing stigma reduction interventions
			• The Positive Life Workshop (The Alliance)

		• Interpersonal and intrapersonal factors as parallel independent mediators in the association between internalized HIV stigma and ART adherence (NIH) ○ Helpful to consider when designing stigma reduction interventions	

Sexual orientation	• HIV Stigma and LGBT Communities (AETC) • A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black and Latino Gay Men (NASTAD): • increase opportunities for learning and skill-building for both provider and consumer • How HIV Impacts LGBTQ+ People (HRC) • Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S. (KFF)	• Patient-Provider Communication Barriers and Facilitators to HIV and STI Preventive Services for Adolescent MSM (NIH) • Foundations of LGBTQIA+ Health – Modules 1 & 2 (National LGBTQIA+ Health Education Center)	• Hidden from Health (LWW) • Discrimination and homophobia fuel the HIV epidemic in gay and bisexual men (APA)
	• HIV and Homophobia (Avert)		

Race	• Health Equity Training (AIDS Institute) • Harm Reduction Strategies for Addressing Structural Racism (AIDS Institute) • Racial Disparities in the Criminal System (Harvard Law School) • HIV by Race/Ethnicity (CDC) • Stigma and Racial/Ethnic HIV Disparities: Moving Toward Resilience (NIH) • Intersectional minority stress disparities among sexual minority adults in the USA: the role of race/ethnicity and socioeconomic status (NIH)	• The Role of Stigma and Medical Mistrust in the Routine Health Care Engagement of Black Men Who Have Sex With Men (NIH) • Challenges and opportunities in examining and addressing intersectional stigma and health (BMC) • An Intersectional Perspective on Stigma as a Barrier to Effective HIV Self-management and Treatment for HIV-infected African American Women (Herald)	• Stigma and Racial/Ethnic HIV Disparities: Moving Toward Resilience (NIH) • The influence of internalized racism on the relationship between discrimination and anxiety (APA)
Transgender and Gender Non-conforming	• Transgender Sexual Health Clinic Training - (How to Provide Sensitive, Affirmative, and Informed Transgender Health Care) (Callen-Lorde) • Stigma and discrimination related to gender identity and vulnerability to HIV/AIDS among transgender women: a systematic review (NIH)		
	• Health Disparities, Stigma and Terminology (National	• HIV Prevention and Care for the Transgender Population (CDC)	• Internalized Transphobia, Resilience, and Mental Health: Applying the Psychological Mediation Framework

	LGBTQIA+ Health Education Center)	• Delivering HIV Prevention and Care to Transgender People (National LGBTQIA+ Health Education Center) • Foundations of LGBTQIA+ Health – Modules 1 & 2 (National LGBTQIA+ Health Education Center)	to Italian Transgender Individuals (NIH)
Women	• Women living with HIV/AIDS (WLHA), battling stigma, discrimination and denial and the role of support groups as a coping strategy: a review of literature (NIH)		
	• Perceptions of intersectional stigma among diverse women living with HIV in the United States (Social Sciences and Medicine) • "She Told Them, Oh That Bitch Got AIDS": Experiences of Multilevel HIV/AIDS-Related Stigma Among African American Women Living with HIV/AIDS in the South (AIDS Patient Care and STDs)		
	• HIV and Women: Prevention Challenges (CDC) • Why Race Matters: Women, Intersectionality, and HIV (The Well Project)	• Quality of care for Black and Latina women living with HIV in the U.S.: a qualitative study (International Journal for Equity and Health)	
Mental health status	• The Intersection of HIV and Mental Health: Addressing Stigma and Implicit Bias in the Healthcare Setting (AETC)	• Target-specific stigma change: a strategy for impacting mental illness stigma (NIH) • The Extra Stigma of Mental Illness for African-	• Mental health: Overcoming the stigma of mental illness (Mayo Clinic) • From Discrimination to Internalized Mental Illness Stigma: The Mediating Roles of Anticipated

	• Trauma-Informed Medical Education (TIME) (NIH) • Stigma Reduction: Promoting Greater Understanding of Mental Health (Wilder)	Americans (The New York Times) • Trauma, Mental Health, Distrust, and Stigma Among HIV-Positive Persons: Implications for Effective Care (Journal of Behavioral Medicine)	Discrimination and Anticipated Stigma (NIH) • The Real Causes of Depression (How To Academy Mindset)
Immigration status	• Mechanisms by Which Anti-Immigrant Stigma Exacerbates Racial/Ethnic Health Disparities (NIH)	• Documenting best practices for maintaining access to HIV prevention, care and treatment in an era of shifting immigration policy and discourse (Plos One) • Stress & Trauma Toolkit for Treating Undocumented Immigrants in a Changing Political and Social Environment (American Psychiatric Association) • Doctors for Immigrants - Educate and train on the practices of "Sanctuary Doctoring"	• The Effects of Perceived Discrimination on Immigrant and Refugee Physical and Mental Health (NIH)
Substance use	• Understanding Stigma of Mental and Substance Use Disorders (NIH) • Understanding Substance Use: A health promotion perspective (HereToHelp)		
	• The Intersection of Incarceration, HIV, & SUD (AETC)	• Stigma: how it affects the substance use disorder patient (BMC)	• Substance Use Stigma, Avoidance Coping, and Missed HIV Appointments Among MSM Who

	• Harm Reduction Strategies for Addressing Structural Racism (AIDS Institute) • Stigma and substance use disorders: an international phenomenon (NIH)	• Reducing Stigma Surrounding Substance Use Disorders: Videos (Opioid Library) • Reducing Stigma Education Tools (ReSET) • HARM REDUCTION EDUCATION ON-DEMAND (National Harm Reduction Coalition)	Use Substances (AIDS and Behavior)
PrEP use	• HIV Preexposure Prophylaxis and Treatment as Prevention - Beliefs and Access Barriers in Men Who Have Sex With Men (MSM) and Transgender Women: A Systematic Review (NIH)		
	• PrEP Stigma: Implicit and Explicit Drivers of Disparity (NIH) • Stigma and Shame Experiences by MSM Who Take PrEP for HIV Prevention: A Qualitative Study (SAGE Journals) • Understanding, Contextualizing, and Addressing PrEP Stigma to Enhance PrEP Implementation (Springer Link)	• PrEP Care for Patients Experiencing Homelessness (National LGBTQIA+ Health Education Center) • Differences in Medical Mistrust Between Black and White Women: Implications for Patient-Provider Communication About PrEP (NIH)	• The Pre-Exposure Prophylaxis-Stigma Paradox: Learning from Canada's First Wave of PrEP Users(Liebert Publishers)
Socioeconomic status	• The Role of Stigma in Access to Health Care for the Poor (NIH)		

	• Intersectional minority stress disparities among sexual minority adults in the USA: the role of race/ethnicity and socioeconomic status (NIH)		
	• "Who Do They Think We Are, Anyway?": Perceptions of and Responses to Poverty Stigma (SAGE Journals)	• Neighborhood Socioeconomic Disadvantage and Access to Health Care (SAGE Journals)	• Neighborhood Racial Diversity, Socioeconomic Status, and Perceptions of HIV-Related Discrimination and Internalized HIV Stigma Among Women Living with HIV in the United States (Liebert Publishers)
Sex work	• The Stigmatization Behind Sex Work (Samuel Center for Social Connectedness) • The role of sex work laws and stigmas in increasing HIV risks among sex workers (NIH) • The global response and unmet actions for HIV and sex workers (NIH)	• "Feeling Safe, Feeling Seen, Feeling Free": Combating stigma and creating culturally safe care for sex workers in Chicago (Plos One) • Stigma and Empathy: Sex Workers as Educators of Medical Students (Springer Link) • 'They won't change it back in their heads that we're trash' The Intersection of Sex Work Related Stigma and evolving Policing Strategies (NIH) • Social Capital Moderates the Relationship Between Stigma and Sexual Risk Among Male Sex Workers in the US Northeast (NIH)	• Sex work, stigma and whorephobia (Wellcome Collection) • Associations among experienced and internalized stigma, social support, and depression among male and female sex workers in Kenya (Springer Link) • Confirmatory Factor Analysis and Construct Validity of the Internalized Sex Work Stigma Scale among a Cohort of Cisgender Female Sex Workers in Baltimore, Maryland, United States (Taylor & Francis Online)

Age	• Healthcare for LGBTQIA+ Older Adults (National LGBTQIA+ Health Education Center) • Healthcare for LGBTQIA+ Youth (National LGBTQIA+ Health Education Center) • A Social Psychological Perspective on the Stigmatization of Older Adults (NIH) • Age Stereotypes and Age Stigma: Connections to Research on Subjective Aging (ResearchGate) • Stereotypes of Aging: Their Effects on the Health of Older Adults (Hindawi)	• Living with Stigma: Depressed Elderly Persons' Experiences of Physical Health Problems (Hindawi) • HIV and Aging: Double Stigma (NIH)	• Taking a closer look at ageism: self- and other-directed ageist attitudes and discrimination (NIH) • Global reach of ageism on older persons' health: A systematic review (Plos One) • What Does Aging with HIV Mean for Nursing Homes? (PMC)
Disability	• The Rise of Disability Stigma (JStor) • "The land of the sick and the land of the healthy": Disability, bureaucracy, and stigma among people	• Disability Attitudes of Health Care Providers (CQL) • Three Things Clinicians Should Know About Disability (AMA Journal of Ethics)	• "You Look Fine!": Ableist Experiences by People With Invisible Disabilities (SAGE Journals)

	living with poverty and chronic illness in the United States (NIH) • Born that way or became that way: Stigma toward congenital versus acquired disability (SAGE Journals)		
Incarceration	• "You're in a World of Chaos": Experiences Accessing HIV Care and Adhering to Medications After Incarceration (ScienceDirect)		
	• The Intersection of Incarceration, HIV, & SUD (AETC) • Criminal Justice Policy Program: Racial Disparities in the Criminal System (Harvard Law School) • Enduring Stigma: The Long-Term Effects of Incarceration on Health (SAGE Journals)	• A Qualitative Examination of Stigma Among Formerly Incarcerated Adults Living With HIV (SAGE Journals) • How to Talk with Patients about Incarceration and Health (AMA Journal of Ethics)	• Self-stigma among criminal offenders: Risk and protective factors (NIH)
Housing Status - Homelessness	• Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care (BMC)	• PrEP Care for Patients Experiencing Homelessness (National LGBTQIA+ Health Education Center)	

Table 2. Welcoming and Inclusive Environment

Stigma related to…	**Institutional/Structural Stigma** (also thought of as community-level, organization and policy-level stigma)	**Interpersonal Stigma** (i.e. interactions between provider and consumer or within social network)	**Internalized Stigma** (negative feelings about one's status or identity; includes perceived or anticipated stigma)
HIV status	• Measuring and Addressing Stigma in the Healthcare Settings (AIDS Institute): Develop an Ad campaign (Edgier, sex positive, celebrate PLWH)	• Measuring and Addressing Stigma in the Healthcare Settings (Callen-Lorde via AIDS Institute): Keep alive conversations of sex and drugs Establish messaging and language that is acceptive of all patients and emphasizes safety • Facilitate patient–provider conversations about U = U with concrete tools Broaden public awareness of U=U through public health messaging • Stigma impedes HIV prevention by stifling patient–provider communication about U = U (JIAS)	• The Positive Life Workshop (Alliance)
Sexual Orientation	• HIV and Homophobia (Avert)-Advocate and educate against homophobia through: public campaigns, school programs, and community-based organizations.	• Addressing Stigma (NASTAD) – Create an environment of acceptance – cultural competency training	• Addressing Stigma (NASTAD)– Develop anti-stigma campaigns around HIV and homophobia

Race	• Implementing Anti-Racism Interventions in Healthcare Settings (MDPI) – Reorganize power between healthcare sites and community you serve, strengthen community relationships and build partnerships, to engage community in all levels of health service delivery. Build support system for racialized staff. Develop consultation groups for community. Ensure language translation and culturally-specific services are available. Incorporate explicit and shared anti-racism language, deter from using broad terms.	• Implementing Anti-Racism Interventions in Healthcare Settings (MDPI) – Along other trainings on anti-racism, discuss appropriate humor in the healthcare setting. Also, promote the discussion and develop guidelines on how to address racist or prejudicial comments.	• Implementing Anti-Racism Interventions in Healthcare Settings (MDPI) – Anti-racism training and education targets to make the individual more self-reflective, in the concepts of racism, implicit bias, stereotype, and prejudice. Educate on cultural medicine as well
Transgender and Gender Non-conforming	• Measuring and Addressing Stigma in the Healthcare Settings (AIDS Institute): Create a welcoming environment with signs/posters • 10 Tips for Improving Services for Transgender People (Transgender Law Center)	• Creating a safe and welcoming clinic environment (UCSF Transgender Care): Creating an affirming clinical environment includes components of: cultural humility, staff training, waiting areas, bathrooms, fluency of terminology, and collection of gender identity data (“two-step” method)	• Tips for Allies of Transgender People (GLAAD): General tips on interacting with Transgender people, which can apply inside and outside of the healthcare setting.

Women	• Creating an enabling environment (WHO)- create positive and equitable social norms and support, including interventions aimed at broader community members and institutions. Includes: social inclusion and acceptance, community empowerment, and supportive laws and policies and access to justice. • Women, HIV & Stigma: A Toolkit for Creating Welcoming Spaces (WHAI)	• Creating an enabling environment (WHO)- Decrease stigma, discrimination, and interpersonal violence among partners, families, peers and health workers, to promote equality and inclusion. Includes: integration of SRHR and HIV services, protection from violence and creating safety, and social inclusion and acceptance.	• Creating an enabling environment (WHO)- Support WLWH achieve self-confidence and personal agency to enact decisions and promote health. Includes: psychosocial support, healthy sexuality across the life course, economic empowerment and resource access
Mental health status	• Interventions to Reduce Mental Health Stigma and Discrimination (RAND) – Media campaigns that destigmatize mental health, reducing negative attitudes and/or produces recognition of symptoms within oneself/others. • Approaches to Reducing Stigma (NAP) Mental Health literacy campaigns	• Approaches to Reducing Stigma (NAP) contact-based behavioral health interventions – facilitating contact between people with lived experience of mental illness and substance abuse disorders with the community; sharing their challenges and stories of success	• Approaches to Reducing Stigma (NAP) Peer services are an example of contact-based interventions.
Immigration status	• Welcoming and Protecting Immigrants (Doctors for Immigrants) –Designate public and private space that ensures protection and	• Barriers to health care for undocumented immigrants (DovePress) – Utilize linguistically appropriate information on how to navigate health care system.	• Welcoming and Protecting Immigrants (Doctors for Immigrants) – Educate patients on legal rights, collaborate with medical legal organizations,

	confidentiality of patient information	Also employ navigators to help undocumented immigrants maneuver through system.	promote affirming messages, incorporate deportation preparedness to patient emergency preparedness, empower and engage patient to seek immigrant community networks. Create alternative ways of providing healthcare services.
Substance use	• Early Intervention, Treatment, and Management of Substance Use Disorders (US Department of Health and Human Services) – Promote an environment of early intervention and Harm Reduction. Start the conversation with Brief Intervention methods and educational campaigns.	• Early Intervention, Treatment, and Management of Substance Use Disorders (US Department of Health and Human Services) – Harm reduction environments can be needle exchange programs, naloxone distribution centers, recovery supportive housing. Community reinforcement programs.	• Early Intervention, Treatment, and Management of Substance Use Disorders (US Department of Health and Human Services) – Personalize treatment plans that creates a therapeutic alliance between provider and patient. Social support, motivation, and adherence. Motivational Enhancement Therapy.
PrEP use	• #PrEP4Love: An Evaluation of a Sex-Positive HIV Prevention Campaign (JMIR) – Example of Educational campaign that promotes health equity and sex positivity in the discussion of PrEP	• What does PrEP mean for 'safe sex' norms? (PLOS One) – Engage discussion on what is now considered "safe sex" for people who take PrEP? PrEP use rises conversations of sex positivity and sexual behaviors, which illuminates HIV prevention methods that promote choice and personalized to each individual.	• Talk About PrEP - Getting To Zero (San Diego HHSA) Creating an environment that is conducive to the discussion of PrEP • How Do I Talk to My Provider about PrEP? (HRC)

Socioeconomic status		• Listening to Low-Income Patients (The CommonWealth Fund) – Consider discussions of affordability, high costs of care, schedule flexibility, and avoiding negative experiences with healthcare providers.	
Sex work	• Overview and Evidence-Based Recommendations to Address Health and Human Rights Inequities Faced by Sex Workers (Springer) – Recognize Sex Work as work. Understand that the decriminalization of sex work will open access to healthcare and meaningful development of healthcare services for sex workers.	• Overview and Evidence-Based Recommendations to Address Health and Human Rights Inequities Faced by Sex Workers (Springer) – Understand diverse needs of sex workers, which is more than individual treatment of disease. Health also includes wellbeing (justice and social protection). Support and collaborate with sex worker-led organizations	• "Feeling Safe, Feeling Seen, Feeling Free": Combating stigma and creating culturally safe care for sex workers in Chicago (PLOS One)– To create community empowered, culturally safe care, open communication between provider and patient is needed to share experiences that will help develop care that is relevant to the lived experiences of sex workers.
Age	• Toward Reducing Ageism: PEACE (Positive Education about Aging and Contact Experiences) Model (Gerontologist) – Display accurate representations of aging, and inform public on lived experiences of aging.	• Ageism (NCEA) – Disrupt ageist assumptions by reframing aging as a positive experience. One model suggested was: OPERA Create sustainable intergenerational exchanges and service-learning programs that make interpersonal relationships	• 5 Ways to Challenge Ageism in Your Life (AARP) – Discuss aging with friends, assess your own understanding of your age, be mindful of ageist language, be open to perspectives from all ages, and call out ageism.

	Promote intergenerational contact. • Global report on ageism (WHO)	between older people and students.	
Disability	• Disability Inclusion Strategies (CDC) – Uphold and promote universal design, reasonable accommodations, accessibility, and appropriate language when communicating with and about people with disabilities.	• Three Things Clinicians Should Know About Disability (AMA) – Disrupt power dynamic between provider and people with disabilities: develop disability humility in practice, improve communication, recognize the lived experience of people with disabilities and participation in their care.	
Incarceration	• Words matter: a call for humanizing and respectful language to describe people who experience incarceration (BMC) – Use appropriate language that humanizes people who experience incarceration.	• Incarceration and Health (AAFP) – Develop collaborations with social services and community health services that aid the transition back into their communities.	• Leading with Conviction (JLUSA and Center for Social Change)– Utilize the role of people who were formerly incarcerated, as leaders to promote social change.
Housing Status	• Homelessness, Health, and Human Needs (NAP) – Organize around the issues of affordable housing and maintaining income and benefits	• Homelessness, Health, and Human Needs (NAP) – Emphasize Discharge planning, Inadequate planning with community based organization, housing, and social supports increase the risk of being homeless Holistic understanding of lived experiences of homeless people. Using appropriate	

		language and creating an environment safe enough for person to disclose their housing status.	

Table 3. Structural Changes of Focus

Stigma related to…	**Institutional/Structural Stigma** (also thought of as community-level, organization and policy-level stigma)	**Interpersonal Stigma** (i.e. interactions between provider and consumer or within social network)	**Internalized Stigma** (negative feelings about one's status or identity; includes perceived or anticipated stigma)
HIV status	• AI Response (AIDS Institute): Promote U=U, update policies, establish organizational work groups, support groups for consumers Integrate HIV with primary care • Stigma reduction: an essential ingredient to ending AIDS by 2030 (ScienceDirect): Address stigma by focusing on immediate actionable drivers of HIV stigma, such as centering stigmatized groups and key populations, and then engaging opinion leaders and creating partnerships with affected groups	• Stigma reduction: an essential ingredient to ending AIDS by 2030 (ScienceDirect): Contact and partnership approach, including PLWH and other stigmatized groups in the delivery of interventions that create empathy and humanize the stigmatized individual • Stigma impedes HIV prevention by stifling patient–provider communication about U = U (JIAS): Establish universal U = U patient education in normative guidelines dictating clinical practice • Beyond tokenism in quality management policy and programming: moving from participation to meaningful involvement of people with HIV in New York State (Oxford Academic) – Consumer involvement model	• Stigma reduction: an essential ingredient to ending AIDS by 2030 (ScienceDirect): Counseling Approach, offering PLWH therapy that builds coping mechanisms against stigma

	• Building patient participation in quality of care through the healthcare stories project: A demonstration program in New York State HIV clinics (PXJ) – Case study that demonstrates the Healthcare Stories Project, which highlights patient-centered and patient-partnered quality of care, better understanding patient experiences and acting with patients to develop practical improvements and a more coproduced healthcare system.		
Sexual Orientation	• Intersectionality and Stigma (NASTAD) – Routinize HIV and other STD testing, Create new indicators that measure progress, offer sexual health vaccinations, improve access to mental health services to increase engagement	• Rights in Action: Access to HIV Services among Men Who Have Sex with Men (FHI 360) – Hire MSM workers to deliver services, create more safe spaces for MSM, Increase internet accessibility, support grassroots empowerment and mobilizations	• Sexual Identity and HIV Status Influence the Relationship Between Internalized Stigma and Psychological Distress in Black Gay and Bisexual Men (NIH) Tailor programming and messaging in interventions/psychological care towards MSM

Race	• Ryan White Minority AIDS Initiative (HRSA) Utilize outreach services to access HIV/AIDS medication and services	• Stigma and Racial/Ethnic HIV Disparities: Moving Toward Resilience (NIH) Reduce medical mistrust by means of enhancing cultural competency and working with diverse providers	• Stigma and Racial/Ethnic HIV Disparities: Moving Toward Resilience (NIH) Offer social support, adaptive coping, and counseling with diverse PLWH
Transgender and Gender Non-conforming	• AI Response (AIDS Institute): Update health records to be respectful of TGN identities, Adopt appropriate language around gender • Callen-Lorde: Include more representation of TGN people, especially trans men	• Health Policy Project (HPP) Work with TGN people to create competency programs for healthcare providers, hire TGN workers to implement such programs	• Interventions that Work! Engaging the Transgender Client (Target HIV) Integrate behavioral health, motivational interviewing, harm reduction, and trauma informed care with HIV primary care services
Gender	• Piecing It Together for Women and Girls (IPPF) Include representation of multiple genders in advocacy and care	• Stigma and HIV service access among transfeminine and gender diverse women in South Africa – a narrative analysis of longitudinal qualitative data from the HPTN 071 (PopART) trial (BMC) Offer community support groups to manage gender identity-based stigma	• Piecing It Together for Women and Girls (IPPF) Work with openly HIV-positive staff of multiple genders, talk about gender identity-based experiences during HIV care visits
Mental health status	• Mental health and HIV/AIDS the need for an integrated response (LWW) Increase PrEP use/availibility to decrease mental burden, prioritize and integrate	• The impact of mental health across the HIV care continuum (APA) Utilize interventions involving peers and other PLWH, and HIV specific interventions	• HIV AND YOUR MENTAL HEALTH (Avert) Offer community mental health support groups, promote professional help, normalize mental health check ins during HIV care

	mental health screening during all HIV testing/treatment settings • The impact of mental health across the HIV care continuum (APA) Integrate mental health interventions into primary care in community based health care settings		
Immigration status	• Documenting best practices for maintaining access to HIV prevention, care and treatment in an era of shifting immigration policy and discourse (PLOS One) Strengthen partnerships between legal and medical partnerships in the event of discrimination • Welcoming and Protecting Immigrants in Healthcare Settings: A Toolkit Developed from a Multi-State Study (Doctors for Immigrants) – Limit cooperation with immigrant officials and develop internal policy for how to interact with immigrant officials. Designate public and	• Documenting best practices for maintaining access to HIV prevention, care and treatment in an era of shifting immigration policy and discourse (PLOS One) Strengthen cultural competency practices in healthcare settings • Welcoming and Protecting Immigrants in Healthcare Settings: A Toolkit Developed from a Multi-State Study (Doctors for Immigrants) Provide supportive services for immigrant employees.	• Documenting best practices for maintaining access to HIV prevention, care and treatment in an era of shifting immigration policy and discourse (PLOS One) Work with health care professionals that are translators, promote continuous care, prevention and treatment • HIV/AIDS Resources for Interpreters (XCulture) Work with interpreters and translators to promote continuous care, prevention, and treatment.

	private space, ensure protection and confidentiality of patient information, limit acquiring and documenting immigration status, and designate a immigration point-person/taskforce.		
Substance use	• Substance Use and HIV Risk (HIV.gov) Implement comprehensive syringe services programs with education and treatment components	• HIV Stigma Among Substance Abusing People Living with HIV/AIDS (Levi-Minzi 2014) Increase social support with community based groups, promote routine testing/care, and syringe services programs	• HIV Stigma Among Substance Abusing People Living with HIV/AIDS (Levi-Minzi 2014) Promote routine testing and HIV care services
PrEP use	• Measuring and Addressing Stigma in the Healthcare Settings (AIDS Institute): Make PrEP and PEP available to everyone	• Prevent (CDC) Increase PrEP availability in community health centers	• Prevent (CDC) Consultations with service providers to educate about PrEP use to individuals and community members
Socioeconomic status	• HIV: Overview (Health Policy Project): Increase equitable access to ARV, PrEP, and PEP • HIV/AIDS & Socioeconomics (APA)	• Evidence for eliminating HIV-related stigma and discrimination (UNAIDS) Work with community organizations (faith based groups, recreation centers, youth groups, etc.) to facilitate services and social support	• Evidence for eliminating HIV-related stigma and discrimination (UNAIDS): Allow household/ community members to serve as social support to promote treatment and care
Sex work	• Sex Work, HIV and AIDS (Avert) Community-empowered based responses, working with sex worker-led groups to	• Implementing Comprehensive HIV/STI Programmes with Sex Workers (WHO) Foster sex-worker led outreach, cross-training providers	• Implementing Comprehensive HIV/STI Programmes with Sex Workers (WHO) Offer voluntary screening services, offer sex worker-led HTC, mental health services

	advocate for rights-based services • Implementing Comprehensive HIV/STI Programmes with Sex Workers (WHO) Establish safe spaces, community led quality management of services		
Age	• HIV Age Positively (Gilead) Inform policy to increase care for people aging with HIV • What Does Aging with HIV Mean for Nursing Homes? Interventions targeting stigma faced by those in nursing homes	• HIV Age Positively (Gilead) Continue to train/educate/inform providers and health professionals • Understanding the impact of stigma on older adults with HIV (APA) Create community groups consisting of PLWH as a form of social support	• HIV Age Positively (Gilead) Offer mental health hotlines, meal delivery services • Strategies to Improve the Health of Older Adults Living with HIV (NCIHC) Decrease isolation, screen for depression and substance use promote sexual health and treatment with aid of PLWH
Disability	• Disability and HIV (UNAIDS) Ensure that people with disabilities can participate in the planning and implementation of HIV programs, accommodating services during care (interpretation), access to justice, access to disability-sensitive education • Medical Interpreting (Sign Language NYC)	• Fighting Stigma Against Persons with Disabilities Living with HIV/AIDS (Disability Rights Fund) Implement advocacy, community dialogues, education, peer-to-peer groups • Disability and HIV (UNAIDS) Involve women/TGN people with disabilities in implementation of HIV programs	• People with Disabilities (Avert) Implement right-based approach to HTC, addressing gender-inequality and violence due to stigma

	Provide ASL translation resources and interpretive services during care visits		
Incarceration	• Incarceration (Avert) HIV testing and counseling, treatment, care and support, information, education and communication, harm reduction, condom programs	• HIV prevention, treatment, and care in prisons and other closed settings (UNODC) Implement informational/educational interventions led by those incarcerated	• HIV among persons incarcerated in the US (Westergaard 2013) Utilize Rapid HIV testing, ARV, counseling, treatment • Mental Health and Substance Abuse (NMAC) Interventions led by incarcerated PLWH regarding mental health and substance abuse
Housing Status	• NYC Services (Alliance)	• Harlem United Community based housing initiatives with access to health-related services	• Housing Opportunities for Persons With AIDS (HOPWA) Assists with finding housing and can utilize HUD housing counseling services

Appendix

1. Measuring Stigma in Healthcare Settings - Comprehensive Questionnaire

New York State Department of Health AIDS Institute
2016 HIV Quality of Care Program Review

Measuring Stigma and Discrimination Among Healthcare Practice Site Staff
(Adapted for New York State)

The Health Policy Project's tool "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" was developed and field tested in China, Dominica, Egypt, Kenya, Puerto Rico, St. Christopher & Nevis. This tool was created to be a brief, globally standardized questionnaire for measuring HIV-related stigma and discrimination in healthcare practice sites as well as a tool to be used in the creation and improvement of stigma reduction programming at the healthcare practice site-level.

The NYSDOH AIDS Institute Stigma Sub-Committee adapted the Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" for practice sites in NYS to administer to staff. The survey contains questions on healthcare practice site-level and personal-level HIV-related stigma with an additional section on key population-related stigma consisting of people of transgender/gender non-conforming experience, women, men who have sex with men (MSM)/men who identify as gay or bisexual, people of color, and people living with a mental health diagnosis.

This survey will take 15-20 minutes to complete. Your participation in this survey is voluntary and to ensure confidentiality, your name will not be on the survey. Please write or select the answer, as appropriate, that best represents what you think or feel. Your responses will have no adverse effect on your occupational standing.

Adapted for NYSDOH AIDS Institute from Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" (Nyblade et al., 2013)

SECTION 1: BACKGROUND INFORMATION

First we will ask about your background.

1. How old were you at your last birthday? _____ years

2. a. What sex were you assigned at birth?
   ☐ Male ☐ Female
   b. What is your current gender identity?
   ☐ Male ☐ Female ☐ Trans male/ Trans man ☐ Trans female/ Trans woman
   ☐ Genderqueer/Gender non-conforming ☐ Different identity (please specify) _____

3. What is your sexual orientation?
   ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Straight ☐ Different orientation (*please specify*) _____

4. What is your race/ethnicity (*check all that apply*)?
   ☐ Black /African American ☐ Hispanic/Latino(a) ☐ Caucasian/White
   ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
   ☐ Different race/ethnicity (*please specify*) _____

5. What is your current job?
   ☐ Cleaning Staff ☐ Clinic Manager ☐ Patient Educator
   ☐ Medical Technician ☐ Medical Records Personnel ☐ Nurse ☐ Nurse Practitioner
   ☐ Nutritionist ☐ Peer Educator ☐ Pharmacist ☐ Pharmacy Staff
   ☐ Phlebotomist ☐ Physician ☐ Physician Assistant
   ☐ Psychiatrist/psychologist ☐ Receptionist ☐ Security Guard
   ☐ Social Worker/Case Manager ☐ Substance Use Counselor
   ☐ Different job (*please specify*): _____

6. How many years have you been working at a healthcare practice site that provides HIV care and treatment?
   _____ years
   a. *In a typical week*, approximately how many HIV-positive patients do you provide with care or services?
   _____

7. Did you ever receive training in the following subjects? (Check all that apply).
   a. HIV stigma and discrimination ☐
   b. Key population stigma and discrimination ☐
      i. *Key populations = People of transgender/gender non-conforming experience, Women, Men who have sex with men (MSM)/Men who identify as gay or bisexual, People living with mental illness, People of color*
   c. Patient confidentiality and privacy ☐

Adapted for NYSDOH AIDS Institute from Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" (Nyblade et al., 2013)

SECTION 2: HEALTHCARE PRACTICE SITE ENVIRONMENT

Now we will ask about practices in your healthcare practice site and your experiences working in a site that provides care to people living with HIV.

8. *In the past 12 months*, how often have you observed the following in your healthcare practice site?
    a. Healthcare workers unwilling to care for a patient living with or thought to be living with HIV.
        ☐ Never ☐ Once or twice ☐ Several times ☐ Most of the time
    b. Healthcare workers providing poorer quality of care to a patient living with or thought to be living with HIV than to other patients.
        ☐ Never ☐ Once or twice ☐ Several times ☐ Most of the time
    c. Healthcare workers talking badly about people living with or thought to be living with HIV.
        ☐ Never ☐ Once or twice ☐ Several times ☐ Most of the time

SECTION 3: HEALTHCARE PRACTICE SITE POLICIES

Now we are going to ask about the healthcare practice site policy and work environment.

9. I will get in trouble at work if I discriminate against patients living with HIV.
    ☐ Yes ☐ No ☐ I don't know

10. My healthcare practice site has written guidelines to protect patients living with HIV from discrimination.
    ☐ Yes ☐ No ☐ I don't know

11. There are adequate supplies in my healthcare practice site that reduce my risk of becoming infected with HIV.
    ☐ Yes ☐ No ☐ I don't know

12. There are standardized procedures/protocols in my healthcare practice site that reduce my risk of becoming infected with HIV.
    ☐ Yes ☐ No ☐ I don't know

Comments:

_____

_____

_____

_____

_____

Adapted for NYSDOH AIDS Institute from Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" (Nyblade et al., 2013)

SECTION 4: OPINIONS ABOUT PEOPLE LIVING WITH HIV

Now we are going to ask about opinions related to people living with HIV.

13. Do you strongly agree, agree, disagree or strongly disagree with the following statements?
    a. Most people living with HIV have had many sexual partners.
       ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree
    b. People get infected with HIV because they engage in irresponsible behavior.
       ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree
    c. Most people living with HIV do not care if they infect other people.
       ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree
    d. People living with HIV should feel ashamed of themselves.
       ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree
    e. HIV is punishment for bad behavior.
       ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

14. Women living with HIV should be allowed to have babies if they wish.
    ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

15. Please tell us if you strongly agree, agree, disagree or strongly disagree with the following statement:
    a. If I had a choice, I would prefer not to provide services to people who inject illegal drugs.
       ☐ Strongly agree → go to question 15b
       ☐ Agree → go to question 15b
       ☐ Disagree → skip to next section
       ☐ Strongly disagree → skip to next section
    b. I prefer not to provide services to people who inject illegal drugs because (check all that apply):
       i. They put me at a higher risk for disease.
          ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐ I don't know
       ii. This group engages in immoral behavior.
          ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐ I don't know
       iii. I have not received training to work with this group.
          ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐ I don't know
       iv. People who inject illegal drugs are disruptive.
          ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐ I don't know
       v. People who inject illegal drugs do not deserve the same amount of treatment/care time as people who do not abuse drugs.
          ☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐ I don't know

Comments:

_____

_____

SECTION 5: QUESTIONS ON KEY POPULATIONS

Now we are going to ask you questions regarding attitudes and stigma in key populations at your healthcare practice site; please answer without consideration toward their HIV status (unless otherwise stated).

Men who have sex with men (MSM)/men who identify as gay or bisexual (*all questions in this section refer to MSM/men who identify as gay or bisexual who are not transgender or gender non-conforming*)

1. In the past 12 months, how many MSM/men who identify as gay or bisexual have been treated in your healthcare practice site?

☐ 0-10 ☐ 11-50 ☐ 51-200 ☐ 201 or greater ☐ Not applicable

2. *In the past 12 months*, how often have you observed the following in your healthcare practice site?

	Never	***Once or Twice***	***Several Times***	***Most of the time***
a. Other healthcare workers providing poorer quality of care to a MSM/men who identify as gay or bisexual than to other patients.				
b. Other healthcare workers talking badly about MSM/men who identify as gay or bisexual (ex. making negative comments, speaking harshly to or about, using derogatory language).				

3. Do you agree or disagree with the following statements?

	Agree	***Disagree***	***I Don't Know***
a. My healthcare practice site has a policy for addressing discriminatory comments and behavior by health facility staff towards MSM/men who identify as gay or bisexual.			
b. My health clinic has MSM/men who identify as gay or bisexual-focused medical and support services that we offer, either in clinic or by referral in the community.			
c. My health clinic offers and provides counseling on pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to MSM/men who identify as gay or bisexual and their sexual partners.			

Please see next page for more questions

4. Do you strongly agree, agree, disagree or strongly disagree with the following statements about your healthcare practice site?						
	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. My health clinic creates a welcoming environment by having MSM/men who identify as gay or bisexual-positive cues in the clinic (pictures, posters, education materials, resource materials, stickers, buttons, etc.)						
b. I have received training (in-service, cultural competence class, group discussion, etc.), *in the past 12 months*, on how to properly treat MSM/men who identify as gay or bisexual.						
c. I have received training (in-service, webinar, group discussion, etc.), *in the past 12 months*, on how to properly screen MSM/men who identify as gay or bisexual for sexually transmitted infections.						

5. Do you strongly agree, agree, disagree or strongly disagree with the following statements?						
	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. I am comfortable talking about sexual practices with MSM/men who identify as gay or bisexual.						

Comments:

_____

_____

_____

_____

_____

_____

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People of transgender and gender non-conforming experience (TGNC)

1. *In the past 12 months*, how many transgender/gender non-conforming (TGNC) patients have been treated in your healthcare practice site?

 0-1 2-10 11-20 21-40 41 or greater Not applicable

2. *In the past 12 months*, how often have you observed the following in your healthcare practice site?

	Never	***Once or Twice***	***Several Times***	***Most of the time***
a. Other healthcare workers providing poorer quality of care to TGNC patients than to other patients.				
b. Other healthcare workers talking badly about TGNC people (ex. making negative comments, speaking harshly to or about, using derogatory language).				

3. Do you agree or disagree with the following statements?

	Agree	***Disagree***	***I Don't Know***
a. My healthcare practice site has a policy for addressing discriminatory comments and behavior by healthcare workers towards TGNC people.			
b. My healthcare practice site has gender-neutral bathrooms available for TGNC patients, and makes patients aware of this.			
c. My healthcare practice site has TGNC-focused medical and support services that we offer, either in clinic or by referral in the community.			
d. My healthcare practice site offers and provides counseling on pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to TGNC and their sexual partners.			

Please see next page for more questions

4. Do you strongly agree, agree, disagree or strongly disagree with the following statements about your healthcare practice site?

	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. My healthcare practice site creates a welcoming environment by having TGNC-positive cues in the clinic (pictures, posters, education materials, resource materials, stickers, buttons, etc.)						
b. My healthcare practice site has provided guidance to make sure staff refers to TGNC patients by the name and pronoun that corresponds with their gender identity.						
c. I have received training (in-service, cultural competence class, group discussion, etc.), *in the past 12 months*, on how to properly treat TGNC patients.						
d. I have received training (in-service, webinar, group discussion, etc.), *in the past 12 months*, on how to properly screen TGNC patients for sexually transmitted infections.						

5. Do you strongly agree, agree, disagree or strongly disagree with the following statements?

	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. I am knowledgeable on the drug interactions between hormone therapy and HIV medication.						
b. I believe that genital status determines a person's gender.						
c. I am comfortable talking about sexual practices with TGNC patients.						

Comments:

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Adapted for NYSDOH AIDS Institute from Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" (Nyblade et al., 2013)

Women

1. *In the past 12 months*, how often have you observed the following in your healthcare practice site?

	Never	***Once or Twice***	***Several Times***	***Most of the time***
a. Other healthcare workers providing poorer quality of care to female patients than to other patients.				
b. Other healthcare workers talking badly about women (ex. making negative comments, speaking harshly to or about, using derogatory language).				

2. Do you agree or disagree with the following statements?

	Agree	***Disagree***	***I Don't Know***
a. My healthcare practice site has a policy for addressing discriminatory comments and behavior by healthcare workers towards women.			
b. My healthcare practice site has female-focused medical and support services that we offer, either in clinic or by referral in the community.			
c. My healthcare practice site offers and provides counseling on pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to female patients and their sexual partners.			

3. Do you strongly agree, agree, disagree or strongly disagree with the following statements about your healthcare practice site?

	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. My healthcare practice site has displays (pictures, posters, education materials, resource materials, etc.) promoting women's health.						
b. My healthcare practice site supports HIV-positive women who want to have children.						
c. My healthcare practice site has resources to help women who are juggling many responsibilities (such as single mothers, women who are head of household, etc.). Examples could be extended hours, babysitting, open access, etc.						
d. I have received training (in-service, cultural competence class, group discussion, etc.), *in the past 12 months*, on how to properly treat women living with HIV.						

Adapted for NYSDOH AIDS Institute from Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" (Nyblade et al., 2013)

4. Do you strongly agree, agree, disagree or strongly disagree with the following statements?

	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I don't know***	***Not Applicable***
a. I think most women living with HIV have been promiscuous in their sexual history.						

Comments:

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Adapted for NYSDOH AIDS Institute from Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" (Nyblade et al., 2013)

People with a mental health diagnosis

1. *In the past 12 months*, how often have you observed the following in your healthcare practice site?				
	Never	***Once or Twice***	***Several Times***	***Most of the time***
a. Other healthcare workers providing poorer quality of care to patients living with a mental health diagnosis than to other patients.				
b. Other healthcare workers talking badly about people with a mental health diagnosis (ex. making negative comments, speaking harshly to or about, using derogatory language).				

2. Do you agree or disagree with the following statements?			
	Agree	***Disagree***	***I Don't Know***
a. My healthcare practice site has a policy for addressing discriminatory comments and behavior by healthcare workers towards people with a mental health diagnosis.			
b. My healthcare practice site offers focused medical and mental health services for people with a mental health diagnoses, either on-site or by referral in the community.			

3. Do you strongly agree, agree, disagree or strongly disagree with the following statements about your healthcare practice site?						
	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. My healthcare practice site supports patients with a mental health diagnosis by providing on-site mental health services or easy access to off-site mental health services.						
b. In my healthcare practice site, it is obvious which people have a mental health diagnosis (for example: where they check-in, where they wait to be seen, how they check out, etc.).						
c. I have received training (in-service, cultural competence class, group discussion, etc.), *in the past 12 months*, on how to properly treat patients with a mental health diagnosis.						

Adapted for NYSDOH AIDS Institute from Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" (Nyblade et al., 2013)

4. Do you strongly agree, agree, disagree or strongly disagree with the following statements?						
	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. I am more comfortable helping a person who has a physical illness than I am helping a person with a mental health diagnosis.						
b. I think that most people with a mental health diagnosis are unpredictable.						
c. I think that most people with a mental health diagnosis are dangerous.						

Comments:

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People of color

1. *In the past 12 months*, how often have you observed the following in your healthcare practice site?				
	Never	***Once or Twice***	***Several Times***	***Most of the time***
a. Other healthcare workers providing poorer quality of care to patients of color than to other patients.				
b. Other healthcare workers talking badly about people of color (ex. making negative comments, speaking harshly to or about, using derogatory language).				

2. Do you agree or disagree with the following statements?			
	Agree	***Disagree***	***I Don't Know***
a. My healthcare practice site has a policy for addressing discriminatory comments and behavior by healthcare workers towards people of color.			

3. Do you strongly agree, agree, disagree or strongly disagree with the following statements about your healthcare practice site?						
	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. My healthcare practice site creates a welcoming environment in the clinic for people of varying ethnicities and races (such as through pictures, posters, education materials, resource materials, stickers, buttons, etc.)						
b. My healthcare practice site provides supportive services to help people of color to successfully remain in care.						
c. My healthcare practice site provides supportive services to people of color who have financial and housing needs/responsibilities.						
d. My healthcare practice site provides supportive services to help people of color to successfully get into treatment.						
e. Members of my healthcare practice site's staff are culturally diverse.						
f. I have received training, *in the past 12 months*, in cultural competence on how to provide equal quality of care to people of color.						
g. I have received training, *in the past 12 months*, on how to provide the best quality of care to people of varying cultures.						

Adapted for NYSDOH AIDS Institute from Health Policy Project "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Comprehensive Questionnaire" (Nyblade et al., 2013)

4. Do you strongly agree, agree, disagree or strongly disagree with the following statements?						
	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***	***I Don't Know***	***Not Applicable***
a. I believe that most people of color will be less adherent to treatment and therefore, I do not prescribe treatment as frequently.						
b. I believe that most people of color are not as ready for treatment and need to be prepared longer before being prescribed medications.						

Comments:

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2. Stigma Reduction Organizational Readiness Tool

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

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 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.

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?		
Each score requires completion of all items in that level and all lower levels (except any items in level 0)		
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	<u>Leaders are</u>: ☐ 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	<u>Leaders are</u>: ☐ 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	<u>The stigma reduction committee</u>: ☐ 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	<u>The stigma reduction committee</u>: ☐ 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	<u>The stigma reduction committee</u>: ☐ 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?		
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 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	☐ Stigma reduction measures 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. Stigma reduction data: ☐ Collection is planned pending initiation.
Beginning Implementation	2	Stigma reduction measures: ☐ Are understood by personnel at all applicable sites. Stigma reduction data: ☐ 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	Stigma reduction measures: ☐ 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. Stigma reduction data: ☐ 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. Workforce and Community Engagement in Stigma Reduction		

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	<u>Engagement of staff in stigma reduction (clinical and non-clinical) includes</u>: ☐ 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	<u>Engagement of staff in stigma reduction (clinical and non-clinical) includes</u>: ☐ 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	<u>Community member involvement</u>: ☐ 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:		

3. Stigma Reduction Logic Model

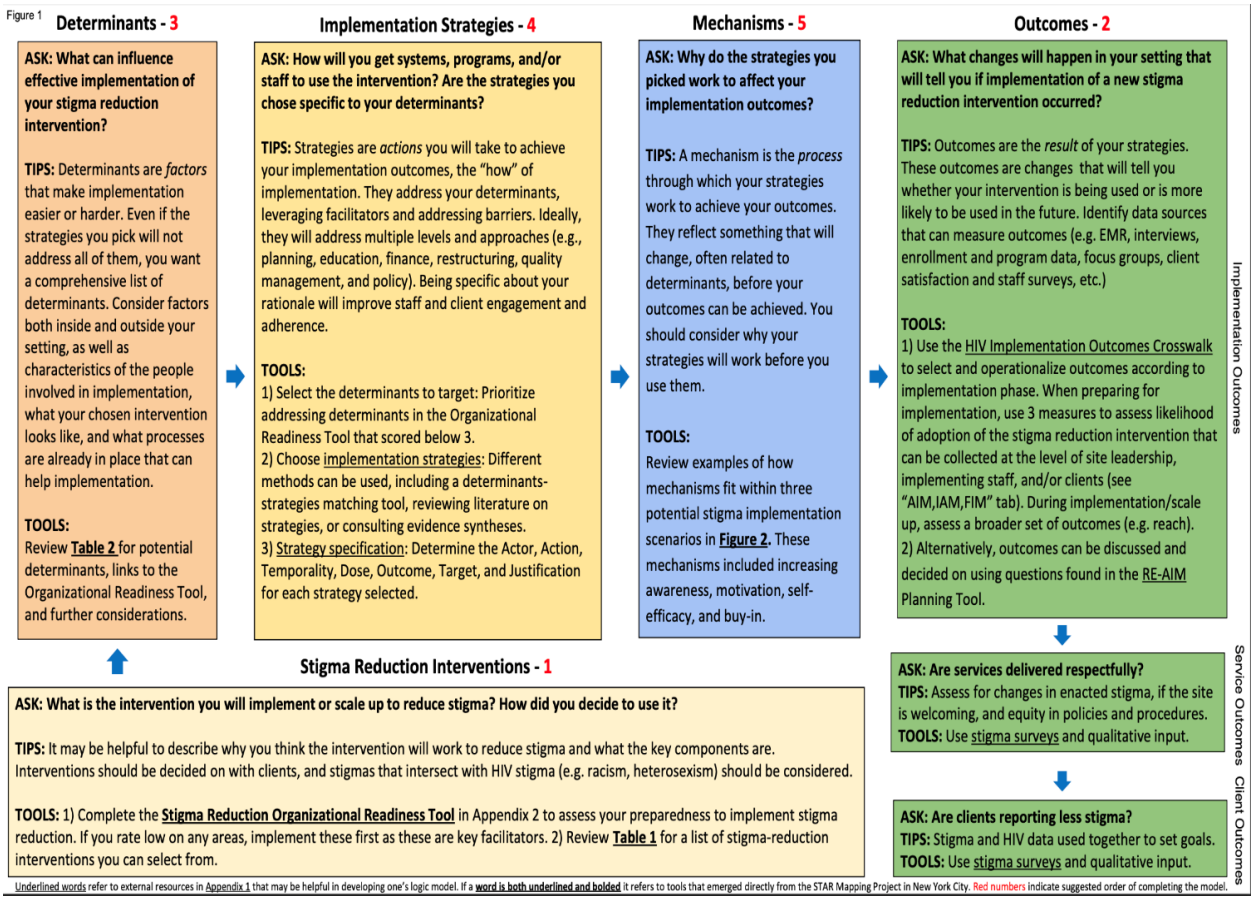


Figure 2

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.

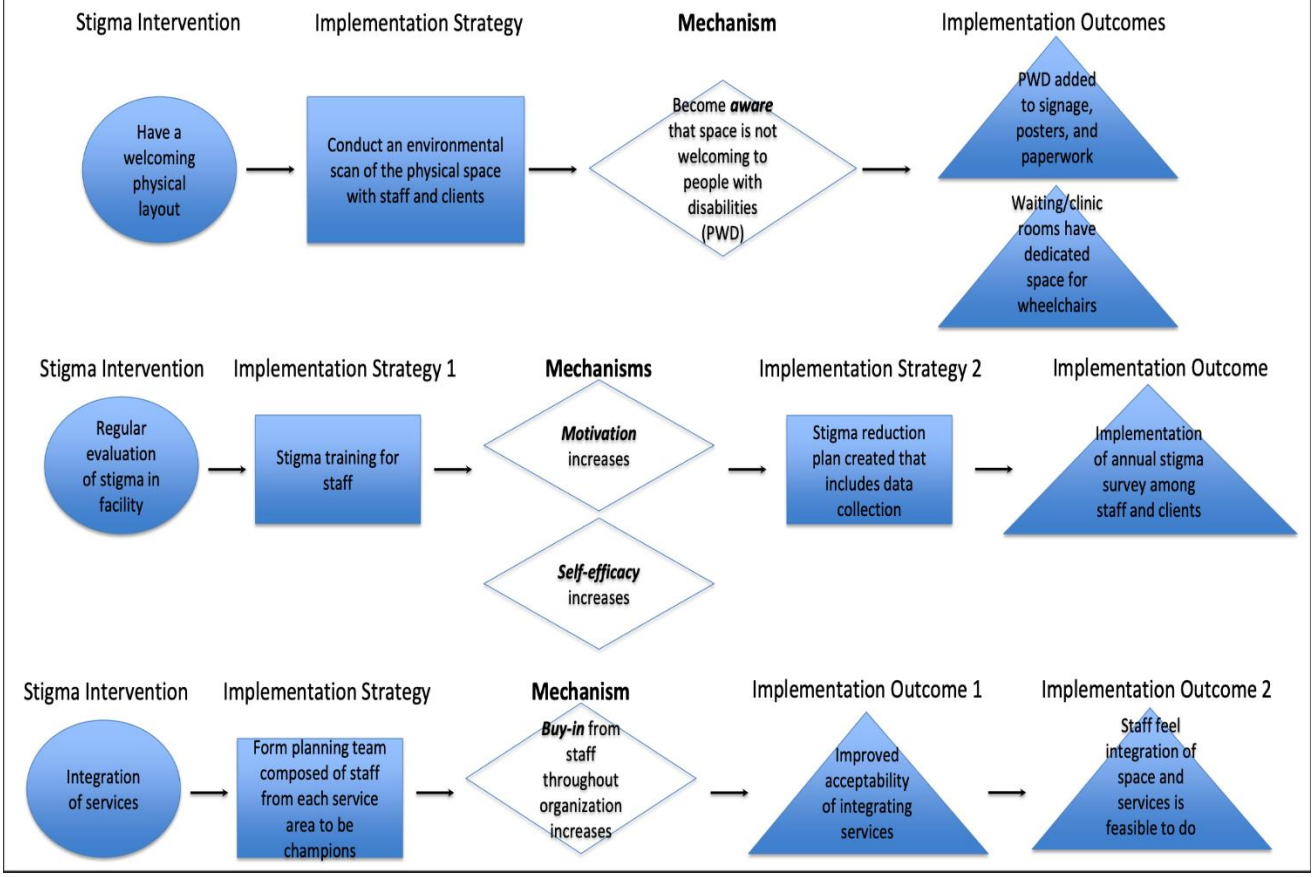
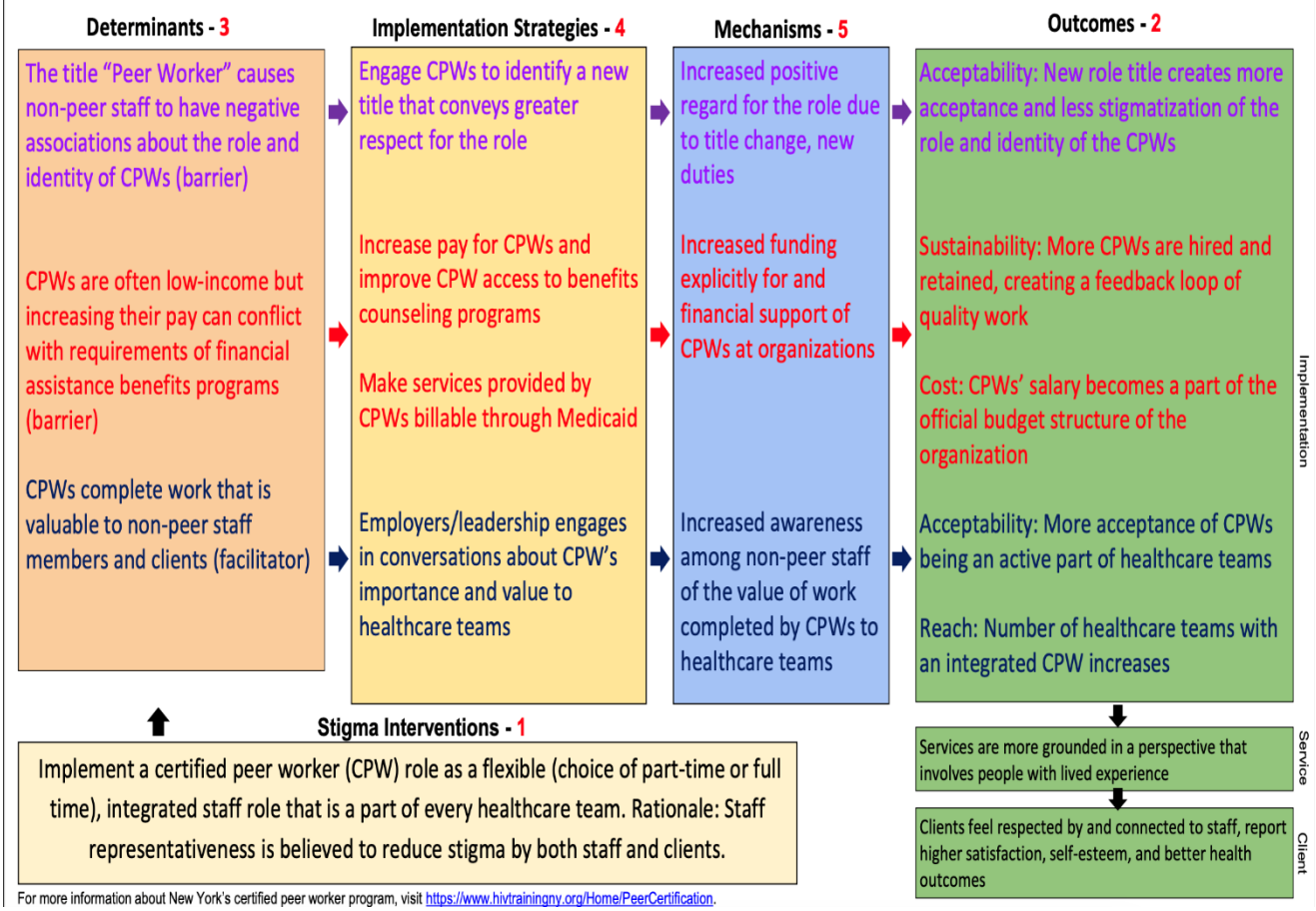


Figure 3

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.