A Quality Improvement Approach to Reduce HIV and Intersectional Stigma Among HIV Service Organizations

Daniel Belanger, MSW, AIDS Institute, New York State Department of Health

Rebekah Glushefski, LMSW
The Institute for Family Health

Aishwarya Govindarajan, AIDS Institute, New York State Department of Health

Disclosures

Presenters Daniel Belanger, Rebekah Glushefski and Aishwarya Govindarajan have no relevant financial interests to disclose.

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There was no commercial support for this activity.

Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Learning Objective 1: Understand a quality improvement approach to measure HIV related and intersectional stigma and implement and sustain stigma reduction activities across a statewide system of HIV care
2. Learning Objective 2: Understand best practices, emerging strategies and interventions to reduce HIV and intersectional stigma at the structural, interpersonal and individual levels in the HIV service settings
3. Learning Objective 3: Become familiar with a package of innovative tools for systematically addressing HIV related and intersectional stigmas and how these can be tailored for use within HIV service settings

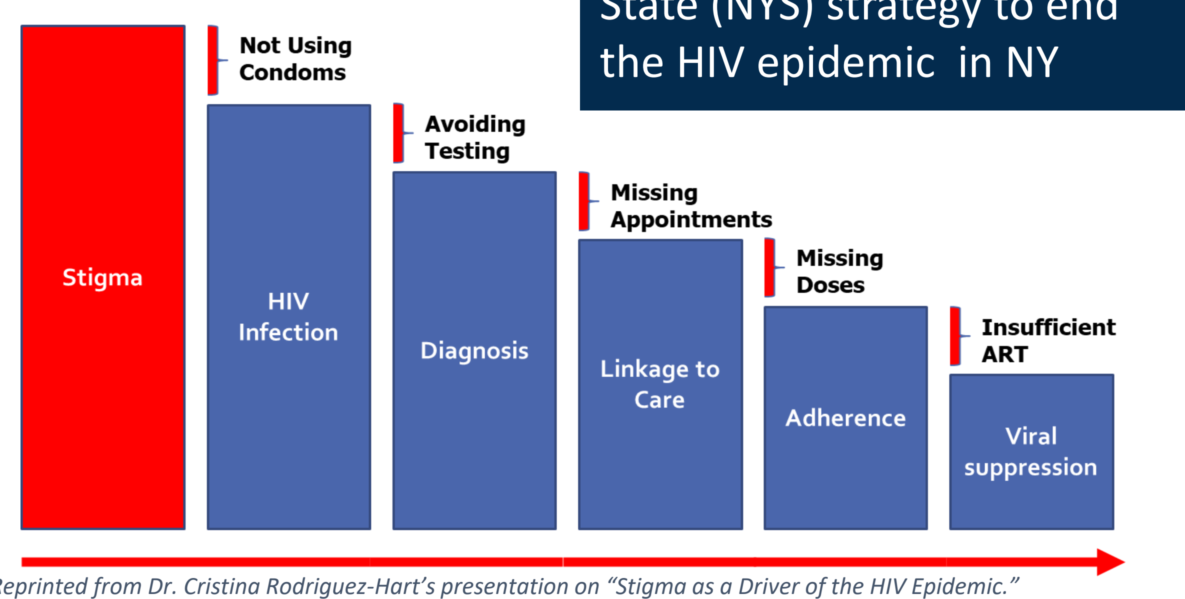
Defining Stigma

Stigma Reduction and EHE

HIV stigma and its intersections with other stigmas presents a significant barrier to successfully achieving goals set out in the four pillars of the U. S. Department of Health and Human Services Ending the HIV Epidemic (EHE) Plan

Reducing HIV stigma is a key component of the New York State (NYS) strategy to end the HIV epidemic in NY

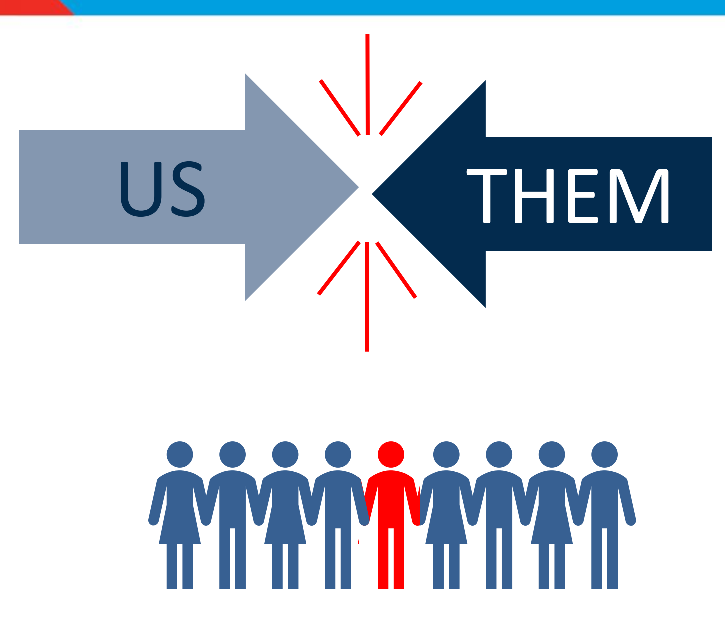
Four Pillars			
Early diagnosis of HIV	Treat PWH effectively and rapidly	Prevent new HIV transmissions	Respond quickly to HIV outbreaks and provide prevention and treatment services

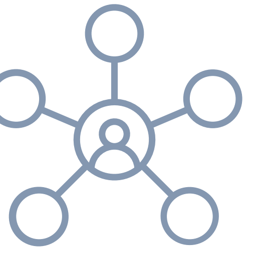


Reprinted from Dr. Cristina Rodriguez-Hart's presentation on "Stigma as a Driver of the HIV Epidemic."

Defining 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.[1]
- Stigma is also intersectional; multiple and interdependent systems of oppression can fundamentally change an individual's experiences with discrimination. [2]
- HIV stigma is characterized by the silence, exclusion, and isolation of people based on their HIV positive status, marking PLWH and intersecting marginalized communities as socially undesirable and less valuable.[3]





Three Levels of Stigma

- Stigma is multi-level and manifests at the structural level through organizational policies, cultural norms, care environment and infrastructure.
- At the interpersonal level, overt and hidden expressions of enacted stigma can occur, such as with interactions between program staff and PLWH, differential treatment, or verbal harassment.
- Internalized stigma exists at the individual 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

Structural/ Institutional

Interpersonal

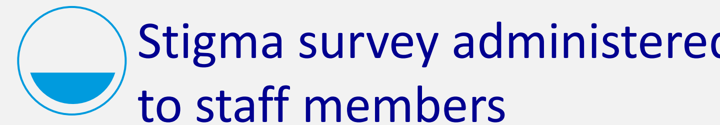
Individual

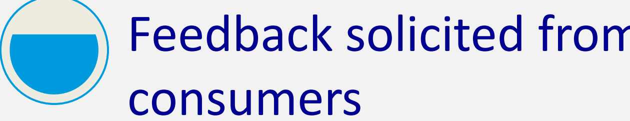
From Dr. Cristina Rodriguez-Hart's presentation on "Stigma as a Driver of the HIV Epidemic."

NYS Quality Improvement Approach to Stigma Reduction

NYS Quality Improvement Stigma Reduction Initiative

Three Components

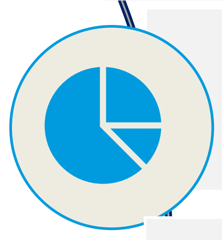




Stigma reduction action plan created based on results

Summer 2017 – Submit Plan

- Submit detailed plan of how stigma survey for healthcare workers will be administered and consumer feedback will be obtained



Fall 2017 – Submit Results and Action Plan

- Submit results of stigma survey and consumer feedback
- Submit stigma reduction action plan based on results

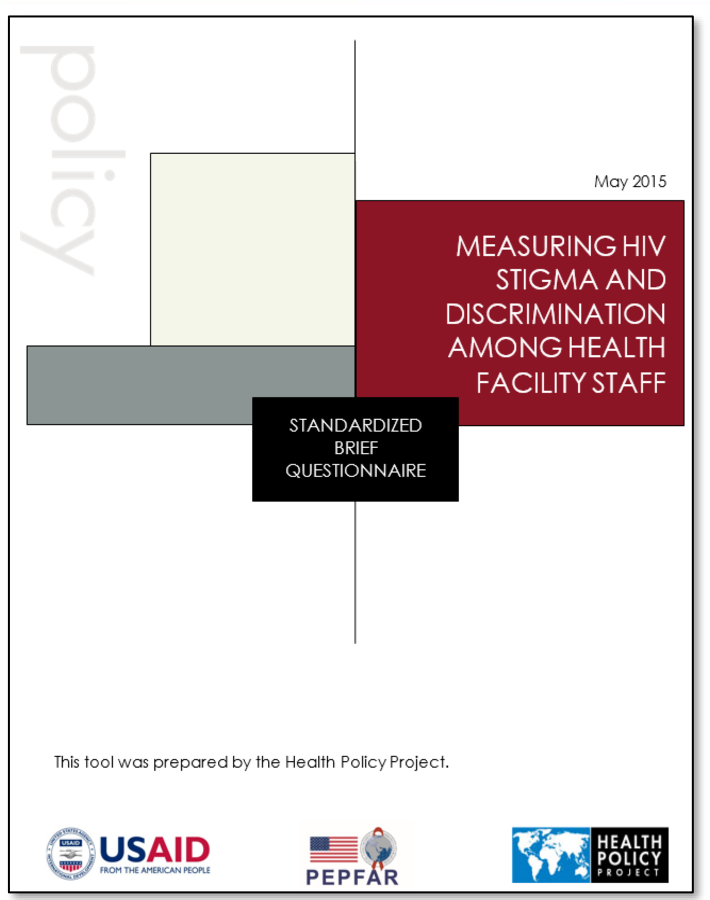
Spring 2018 –Report Progress on Action Plan

- Status update on stigma reduction programming
- How stigma reduction programming was received
- What changes will be made for future quality improvement

Fall-Winter 2018 –Statewide Report

- Present statewide survey results, organization action plans and consumer feedback

Stigma Survey for Healthcare Staff



Health Policy Project's "Measuring HIV Stigma and Discrimination Among Health Facility Staff" by Dr. Laura Nyblade

Section	Description
Staff demographics	Age, race, gender, sexuality, occupation
Health facility environment and health facility policies	Questions on training background and work experience
	Questions on facility policy and work environment
Opinions about people living with HIV	Attitudes and willingness to provide care
Questions on key populations	People Who Use Drugs, Men Who Identify as Gay or Bisexual, People of Transgender and Gender Non-Conforming Experience, Women, People with a Mental Health Diagnosis, People of Color

Consumer feedback

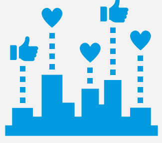
Sites were asked to create their own approach to obtaining consumer feedback; these included utilizing surveys and conducting interviews with willing participants.

Organizational Stigma Reduction Action Plans

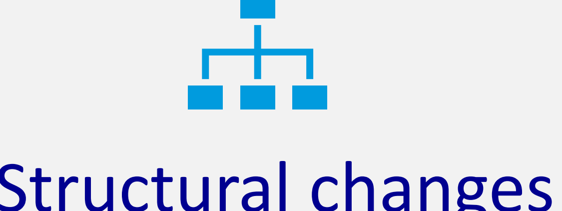
Following staff survey responses and consumer feedback, sites were asked to develop their own stigma reduction action plans to address the findings

Common elements include

Improving staff education



Creating a more welcoming and inclusive environment



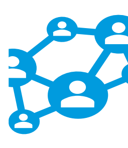
Structural changes

Stigma Reduction Action Plan Themes

IMPROVING STAFF EDUCATION

Training on HIV-related stigma and discrimination

Importance of confidentiality



Training on key populations and barriers to recovery

- Transgender and Gender Nonconforming People (TGNC), interactions between hormone treatment and HIV meds
- LGBTQ cultural competency, STI screenings
- Mental and behavioral health, substance use
- PrEP and PEP availability for all populations

Stigma Reduction Action Plan Themes Part 1

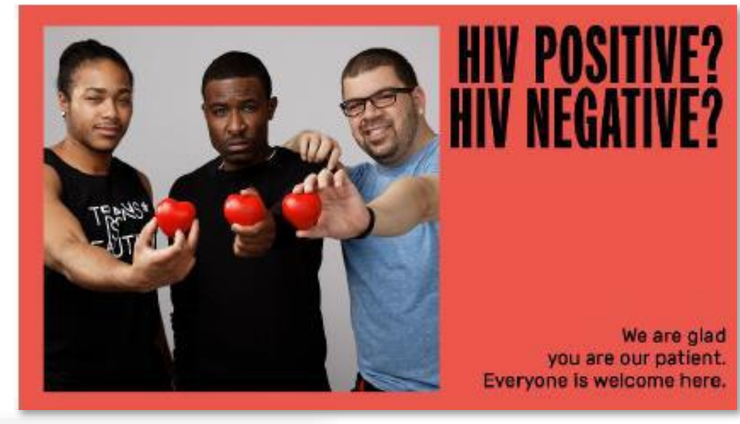
CREATING A MORE WELCOMING, INCLUSIVE ENVIRONMENT

Incorporating signage and posters for all populations

- Positive digital/visual cues
- Posters and resources for all populations (women, TGNC, PLWH)

Promoting U=U

- Undetectable = Untransmittable (Callen Lorde, Institute for Family Health)



Stigma Reduction Action Plan Themes Part 2

STRUCTURAL CHANGES

Updating policies and employee handbook guidelines

- HIV and key population-related stigma and discrimination
- Communicating policies to staff members

Adopting more inclusive, person-centered language

- Sexuality and gender identity (SOGI), gender pronouns, mixed identities

Creation of stigma reduction work groups (consumers and staff)

- Stigma survey results are being shared with consumer advisory boards for feedback

Creation of support groups for key populations

The Institute for Family Health

Highlights of interventions to address HIV and related stigma

Who We Are

- Federally qualified community health center (FQHC) with sites across NYC and the Mid-Hudson Valley of New York State
- Primary integrated health care services, including Articles 28 and 31 mental health, oral health, case/care management, and specialty services
- **As an FQHC, we don't turn anyone away, regardless of immigration status or ability to pay**

HIV Care and Prevention Services at IFH (aka: COMPASS)

Comprehensive

Outpatient

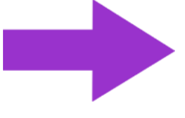
Medical

Practice

And

Support

Services

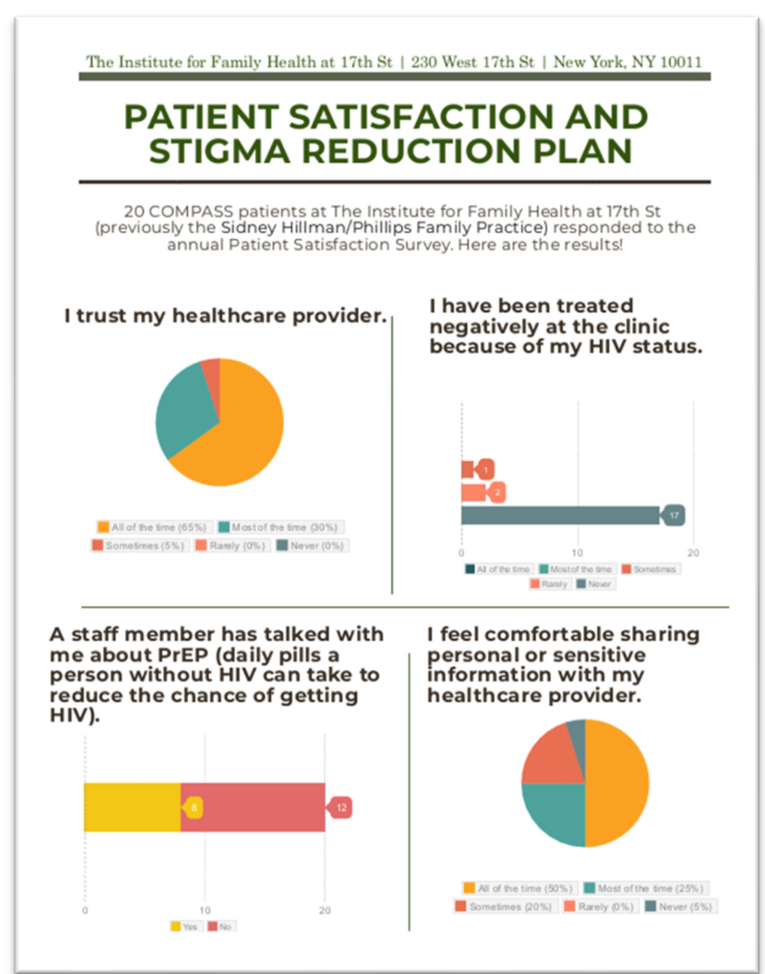


Individualized, patient-centered, comprehensive services. Rooted in harm reduction with an anti-stigma, anti-racism, social justice lens for people living with HIV or engaged in HIV prevention services

- HIV Primary Care
- Rapid iART (“Quick Start”)
- Care Coordination
- Case Management
- Lived-Experience Supports
- Treatment Adherence Services
- Mental Health and Substance Use / Harm Reduction Services
- Groups
- Field Outreach
- Anti-Stigma Task Force
- Directly Observed Therapy
- Residency/Mentorship Services
- HIV related trainings for non-COMPASS Clinic Staff
- PrEP and PEP Navigation

Identifying HIV Related and Intersectional Stigma

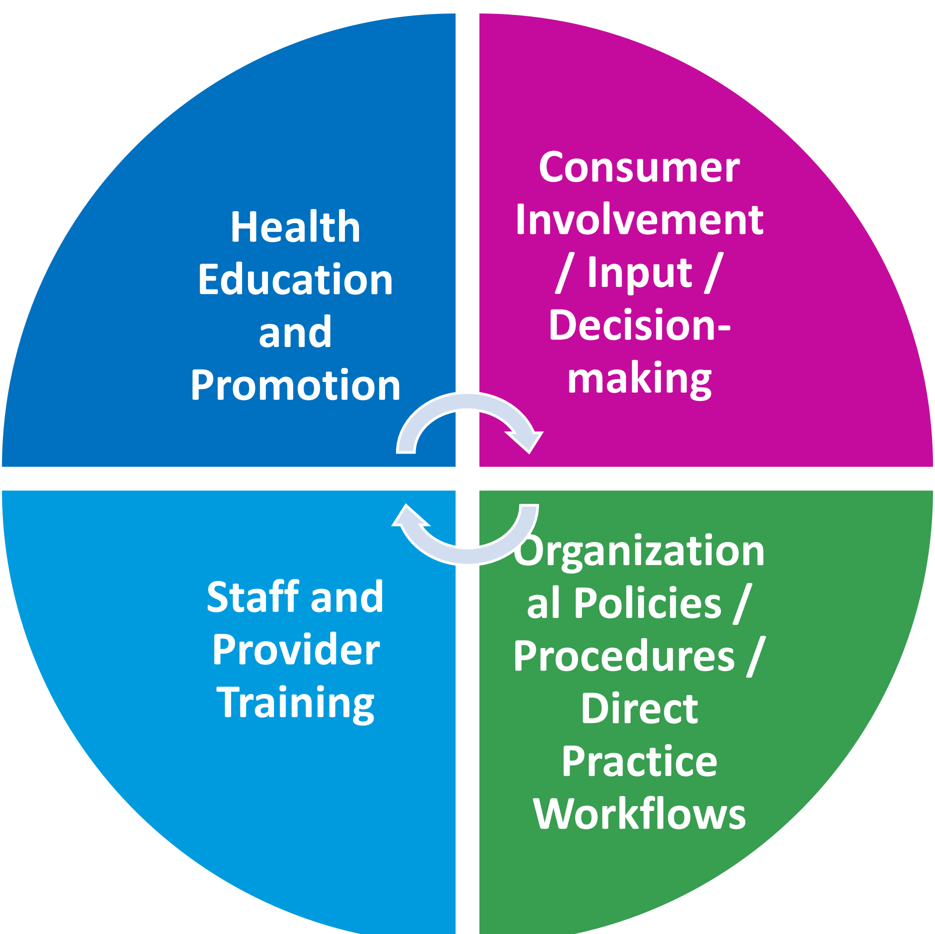
- Collected responses from consumers and staff to identify stigmatizing experiences and beliefs
  - New York State Department of Health AIDS Institute – ***Measuring and Addressing Stigma in Healthcare Settings NYS Survey*** (166 participants)
  - Annual ***COMPASS Patient Satisfaction Survey*** conducted via paper surveys at three (3) health centers providing integrated HIV specialty care (77 participants)
  - ***Consumer Feedback on Stigma in Healthcare Settings*** interviews conducted with consumers by Community Wellness Advocates (17 participants)
- Collaborated with staff trained in social science research to analyze responses
- Used online Piktochart tool to create reports with key findings for Community Advisory Boards and administrative leadership



Core Categories of Anti-Stigma Related Interventions

- **Custom U=U and other health promotion campaigns** to circulate through health centers
- Adapting CDC and DOH developed resources to customize with IFH logo, building on trust consumers have with health center

- "Gender Unicorn" training and utilization of pronoun buttons by workforce
- **Anti-Stigma Language Guide**
- **2-year HIV specialty elective in family medicine residency program**
- In-service training for staff and providers outside of HIV care programs (e.g. practice-wide meetings, departmental meetings)



- Community Advisory Boards
- **Anti-Stigma Task Force**
- **Continuous Quality Improvement (CQI) Committee** and projects
- Consumer Satisfaction Surveys

- HIV specialty services integrated into primary care setting
- Rapid treatment protocols across clinics
- Program intake/assessment forms address U=U, stigma, and disclosure topics
- **Role of Certified Peer Workers**
- Code Yellow Response Team with trauma-informed care training protocols (aiming to avoid utilization of 9-1-1)
- SOGI (Sexual Orientation and Gender Identify) form with pronouns integrated into EMR

Consumer Involvement / Input / Decision-making

Continuous Quality Improvement (CQI) Committee Membership

- Currently three active consumer members from different health centers in our network
- CQI Committee meets monthly
- Project teams meeting in between Committee meetings
- Consumer members have participated in projects such as rapid treatment workflows, crystal meth use consultation/treatment to address treatment cascade measures, and disparities in viral load suppression rates across the Bronx health centers as compared to Manhattan centers
- Addressing HIV related and intersectional stigma is woven into projects, workflows, or materials
  - *"Is any aspect of this perpetuating stigma?"*
  - *"Is this helping to address stigma someone might be experiencing related to their HIV diagnosis? Substance use? Mental health condition? Gender identify or sexual orientation?*

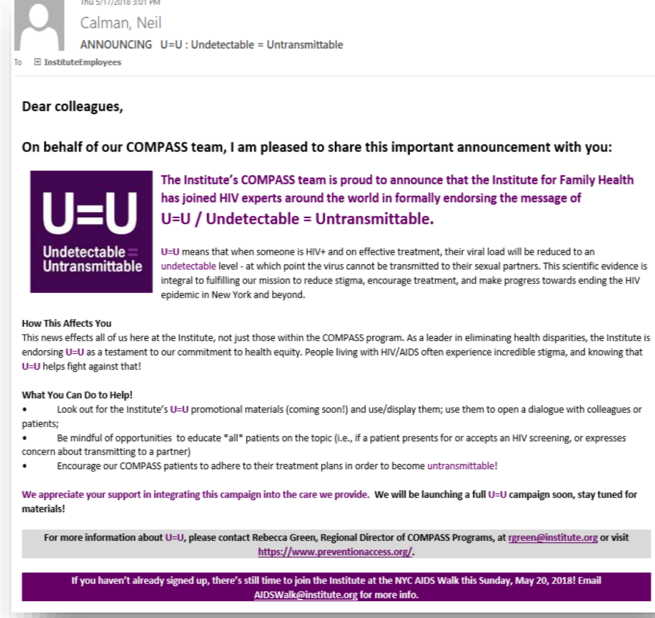
Anti-Stigma Task Force

- Organized group of staff and consumers that would work on planning and carrying out anti-stigma activities
- Recognized that HIV-related stigma is connected to discrimination based on race, ethnicity, class, LGBTQ+ identity, gender, dis/ability, and other intersecting aspects of identity
- Worked collaboratively to:
  - solicit **feedback** on wants/needs
  - develop and distribute **resources** to address those wants/needs
  - **educate** staff, providers, and the broader community to create an inclusive environment for all

Cameron Kinker from Prevention Access Campaign joined us for a Task Force meeting so that we could learn more about the U=U movement across the world

Health Education and Promotion

Custom U=U Campaign



Thu 5/17/2018 3:01 PM

Calman, Neil

ANNOUNCING U=U : Undetectable = Untransmittable

To InstituteEmployees

Dear colleagues,

On behalf of our COMPASS team, I am pleased to share this important announcement with you:

U=U
Undetectable = Untransmittable

The Institute's COMPASS team is proud to announce that the Institute for Family Health has joined HIV experts around the world in formally endorsing the message of U=U / Undetectable = Untransmittable.

U=U means that when someone is HIV+ and on effective treatment, their viral load will be reduced to an undetectable level - at which point the virus cannot be transmitted to their sexual partners. This scientific evidence is integral to fulfilling our mission to reduce stigma, encourage treatment, and make progress towards ending the HIV epidemic in New York and beyond.

How This Affects You

This news effects all of us here at the Institute, not just those within the COMPASS program. As a leader in eliminating health disparities, the Institute is endorsing U=U as a testament to our commitment to health equity. People living with HIV/AIDS often experience incredible stigma, and knowing that U=U helps fight against that!

What You Can Do to Help!

- Look out for the Institute's U=U promotional materials (coming soon!) and use/display them; use them to open a dialogue with colleagues or patients;
- Be mindful of opportunities to educate *all* patients on the topic (i.e., if a patient presents for or accepts an HIV screening, or expresses concern about transmitting to a partner)
- Encourage our COMPASS patients to adhere to their treatment plans in order to become untransmittable!

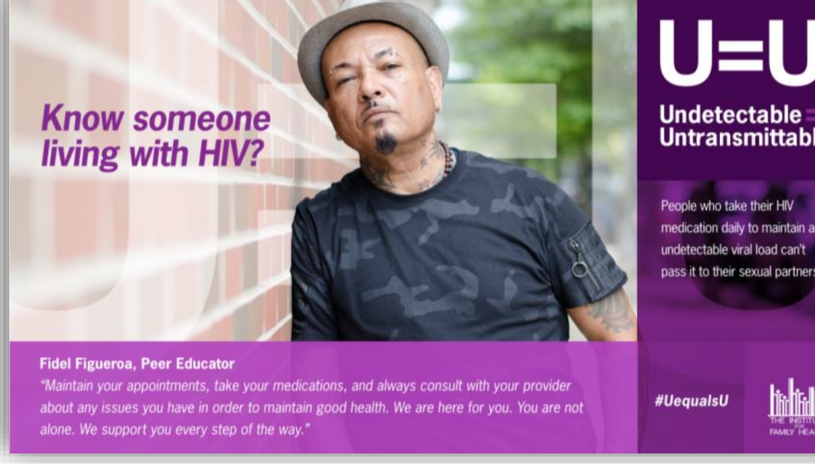
We appreciate your support in integrating this campaign into the care we provide. We will be launching a full U=U campaign soon, stay tuned for materials!

For more information about U=U, please contact Rebecca Green, Regional Director of COMPASS Programs, at rgreen@institute.org or visit https://www.preventionaccess.org/.

If you haven't already signed up, there's still time to join the Institute at the NYC AIDS Walk this Sunday, May 20, 2018! Email AIDSWalk@institute.org for more info.

- E-blast from CEO served as official launch of U=U campaign
- Email series from Regional Director of HIV Care and Prevention continued the agency-wide promotion
- Presentations and trainings conducted for staff across multiple center locations
- Agency U=U buttons and "swag" distributed
- Incorporated into patient care workflows (intake/reassessment forms)
- Digital posters in waiting rooms

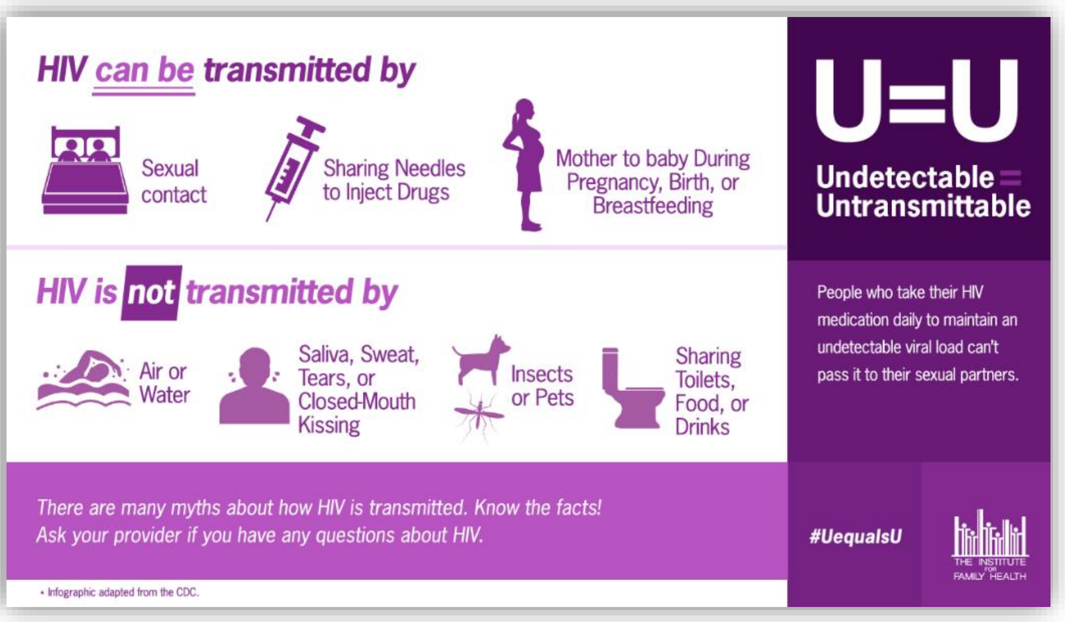
Custom Designed U=U Campaign Featuring Consumers and Staff



- People that others recognize or know from coming to the health center are pictured along with their personal messages, building trust factor with audience
- Slides rotate through waiting room monitors in our health centers, each in Spanish and English
- Spanish-speaking Task Force members advised that the Spanish-language U=U slides remain "U=U" for continuity and recognition instead of "I=I" (as is used in some campaigns)

Expanded Health Education Within U=U Campaign to Promote Science, Not Stigma

- Debunking myths about transmission and prevention to promote science, not stigma
- Waiting room slides show how HIV can and <u>cannot</u> be transmitted (below)
- Personalized adaptation of CDC infographic to build upon established trust consumers have with IFH health centers



Staff and Provider Training

Anti-stigma Language Guide

- Developed by the Anti-Stigma Task Force using a range of established resources on stigma-free language
- Includes language recommendations that are HIV, substance use, gender and sexuality, and mental health diagnoses/treatment related (intersectional stigma)
- Condenses these many resources to make this critical information more accessible
- Distributed to staff and providers during various orientation and training moments

Language Use and Anti-Stigma Recommendations

By the U=U/ Anti-Stigma Task Force

The Anti-Stigma Task Force is a group of IFH participants and employees working together to promote stigma-free healthcare practices at the Institute.*

Introduction

Stigma is the devaluation of a person(s) because of attributes that one perceives to be negative. It results in discrimination, shaming, violence, and health disparities, and is the greatest barrier to accessing care.** We at the Institute are well-positioned to ensure that people who come to our centers experience stigma-free care. One way to avoid stigmatizing people is to adjust our language based on current guidelines. Following are a few key recommendations made by people engaged in care at the Institute, some specific examples for how we can adjust our language to be stigma-free, and a collection of resources that contain detailed language guides and will support continued learning about stigma and its impact on individuals and communities.

General Recommendations/ Guidelines

- Use "person first" language. It is a neutral, nonjudgmental way to refer to someone without defining that person based on conditions. Person-first language suggests that a person *has* a condition that can be addressed, whereas not using person-first language can imply that the person *is* the problem. See the person, not just the condition.
- Be transparent in your interactions. If you are completing an assessment with someone, share about the purpose of the questions you are asking. It helps to inform people of certain standards of care so that individuals don't feel "singled out" because of their identities and conditions, for example when you are conducting a sexual health assessment, offering HIV and other STI tests, or completing a PHQ-9.
- There is no one-size-fits-all approach to communicating with people in a way that is affirming. Language evolves with culture, and people are individuals with distinct feelings and expectations for their care. Explore with people how you can be affirming of who they are in your care for them. An example of affirming communication includes asking what pronouns a person uses.
- "Try using "people," "person," or "participant" instead of "patient" and even "client" whenever possible. This can better balance the power dynamic between you and the person that is engaging in care with you.

Examples of changes we can make to prevent people from feeling stigmatized in our centers:

Avoid Saying or Doing This	Say and Do This
"She's bipolar" which defines the person by her condition	"She has bipolar disorder" which is person-first language
"Committed suicide" which dates back to when suicide was considered a crime	"Died by suicide" which is direct and avoids the suggestion of "wrong-doing"
"Patient is IDU (injection drug user)"	"Individual uses X substance(s) by way of injection" / "Person that injects X substance(s)"
"They are an addict"	"They have a substance use disorder"
"HIV-infected" (perceived by clients as "contaminated" or "dirty")	"Person living with HIV"
"Controlling their A1C level" which does not reflect an understanding of determinants of health outside of someone's control	"Managing their A1C level" which acknowledges that there could be contributing factors person cannot control
"What is your preferred pronoun?" which suggests that the use of one's pronouns is only a preference and not necessary	"What pronouns do you use?", and then document and use those pronouns; correct others that are not using identified pronouns
Assuming someone has a certain gender identity or sexual orientation based on physical appearance	Refer to the Sexual Orientation and Gender Identity (SOGI) form in Epic, complete it, follow it, and continue to refer to it with people on your panel to ensure it is up-to-date; someone's identified sexual orientation and gender identity can change over time
Avoid creating binary choices for people and their partners (there are more options than male/female or gay/straight)	

Family Medicine Residency's 2-Year HIV Specialty Track

Dr. Mara Phelan

Dr. Lauren Middleton

Dr. Yasmin Hashemi

Dr. Mark Bornstein

Dr. Bianca Hill

Dr. Mallika Govindan

Dr. Mark Lorthe

Dr. Seer

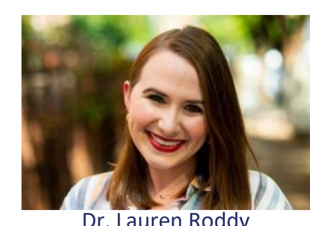
Dr. Alexa Goldstein

Dr. Andreas Lazaris

Dr. Jesse Cole

Dr. Jordan Coleman

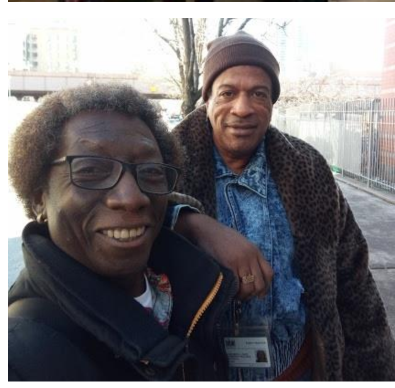
Dr. Brittany Jacob


Dr. Lauren Roddy

- Supporting growth of HIV primary care in family medicine practices vs. "infectious disease" clinics
- 2-year specialty track prepares new family medicine providers to become Certified HIV Specialists
- Generally two residents per cohort join track at the start of year 2
- Carry a panel of COMPASS patients and have dedicated COMPASS sessions with faculty HIV Specialists preceptors
- Routinely review caseload/consult with HIV Medical Director
- Participate in HIV related CMEs, case conferences, and other training opportunities
- Collaborate with COMPASS support service staff to deliver integrated HIV primary care

Organizational Policies / Procedures / Workflows

Integral Role of People with Lived Experience in Addressing Stigma



- All peer staff have completed New York State Certified Peer Worker Program and maintain continuing education certification
- Peer staff identified that their previous title "Peer Educator" itself felt stigmatized in two ways:
    1. It is a title often associated with a much more limited scope of work (e.g. providing accompaniments and other outreach, but not participating in case conferences or accessing the EMR)
    2. It can "out" someone's status with lived experience and take agency away from the worker to determine if, when, and how to use disclosure of lived experience to benefit the consumer
- Staff led a collaborative process of renaming "Peer Educator" title to "Community Wellness Advocate" (CWA)
- Unionized position in same salary scale as case managers and care navigators

Community Wellness Advocates as Core COMPASS Care Team Members

- An integral part of the multidisciplinary care teams, directly collaborating with primary care providers, care managers/coordinators, and clinicians
- Present and participate in case conferences (e.g. viral load suppression case conference)
- Have full access to patient charts and utilization of electronic medical record
- Inform the creation and revision of programmatic materials, including intake/assessment workflows and documentation templates
- Involved with interviewing and hiring new staff, and other key decision-making processes including the redesign of the annual evaluation form
- Peer models can be mutually beneficial to the worker and the client/consumer in addressing stigma experienced at all levels

Key Recommendations

Our Key Recommendations for Your Anti-Stigma Work

- Look for stigma! (survey, interview, observe)
- Identify stakeholders and folks that can lead and support the work
- Carve out time from patient care to allow staff engagement
- Leverage existing resources (e.g. Prevention Access Campaign, DOH materials)
- Incorporate stigma as a focus in existing initiatives and spaces (e.g. CQI projects, therapy or support groups, medical residency training material)
- Fold anti-stigma work into anti-racism work (take an intersectional approach)
- Support leadership of consumers and staff in non-management roles

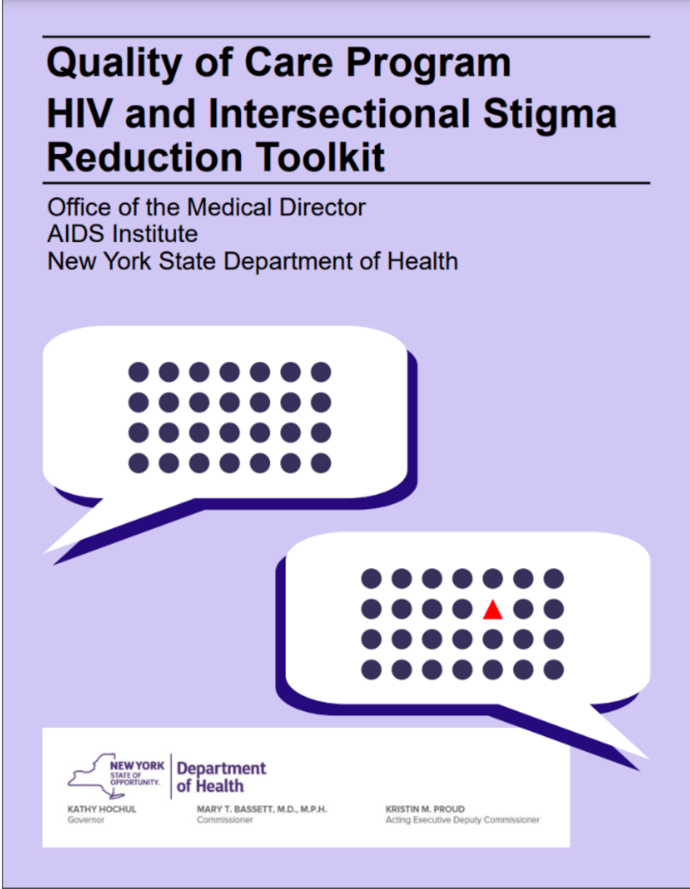
Acknowledgements

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you **made them feel.**

– Maya Angelou

- The consumer members of the Anti-Stigma Task Force, Continuous Quality Improvement Committee, Community Advisory Boards, and all of the groups held over the years.
- The team members who have poured their ideas and energy into eradicating HIV related and intersectional stigma experienced in and outside of our health centers.
- The community of HIV care and prevention staff and providers who are committed to ending stigma in healthcare.

HIV & Intersectional Stigma Quality Improvement (QI) Initiative



HIV & Intersectional Stigma Reduction Toolkit cover page

REVISED Measuring Stigma in Healthcare Settings Survey	The AIDS Institute is in the process of revising the survey to be aligned with current knowledge related to stigma. HIV care organizations will be asked to survey their staff and consumers again in 2022.
NEW HIV & Intersectional Stigma Reduction Toolkit	The AIDS Institute will disseminate the newly developed toolkit with the survey to give providers a resource to help them implement stigma reduction activities based on survey results.
UPDATED Stigma Reduction Action Plans	Using results of the survey and the toolkit as a resource, HIV organizations will develop stigma reduction quality improvement action plans to build on the work they have begun.

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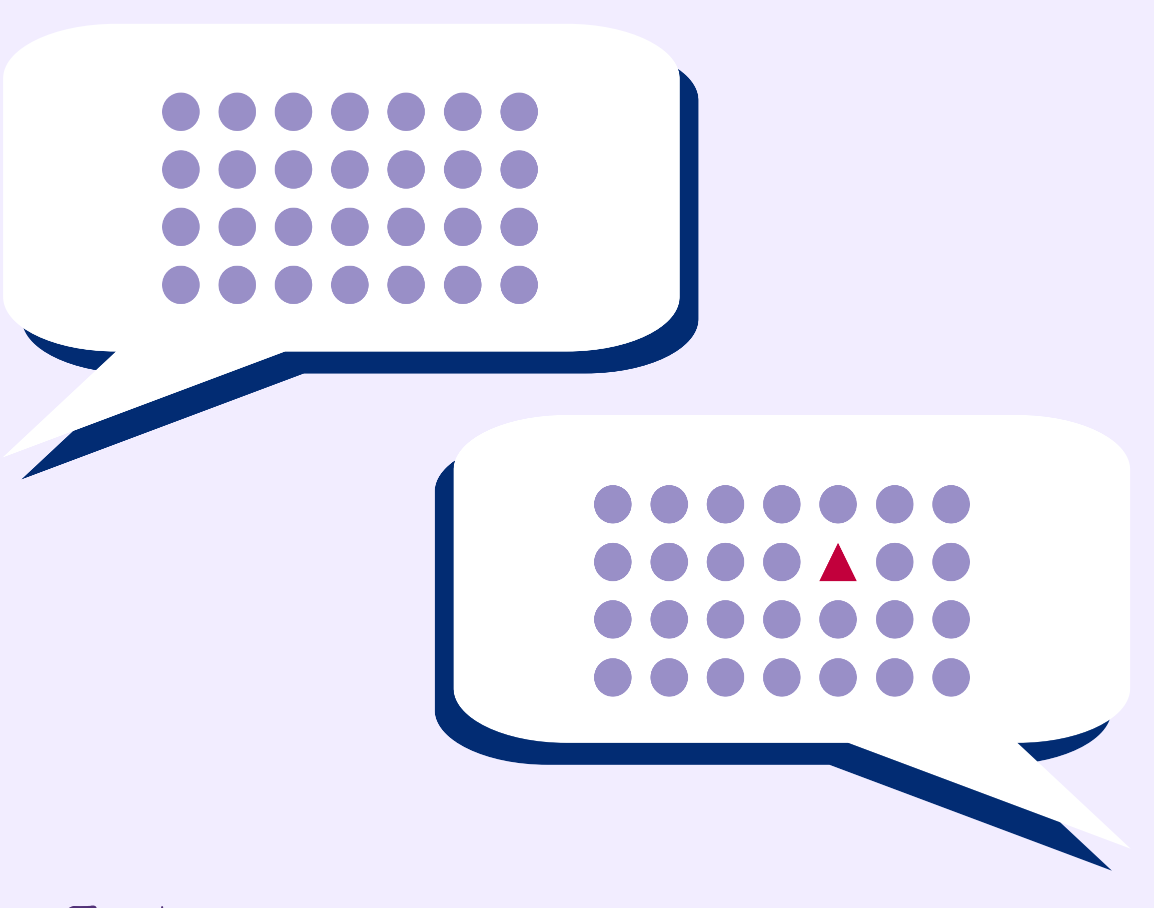
Quality of Care Program HIV and Intersectional Stigma Reduction Toolkit



NEW YORK STATE | Department of Health

Stigma Reduction Toolkit

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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.

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[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

"When it comes to stigma, the first time I experienced it was when I was hospitalized in AIDS designation isolation rooms 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

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 people who use drugs 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].

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 impacted by AIDS, denouncing the neglect of government entities in addressing the AIDS crisis, and further advocating for the accessibility of HIV treatments, which

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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.

resulted in significant improvements in HIV healthcare and services[9]. Despite the progress made, 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 or widespread negative public attitudes toward a particular identity. 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.

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

[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

Alternative text: A funnel diagram indicating a multi-level nature of stigma, where stigma exists at most wide-spread level of structural/institutional stigma, a smaller level at interpersonal stigma, and at the most personal level within individual stigma.

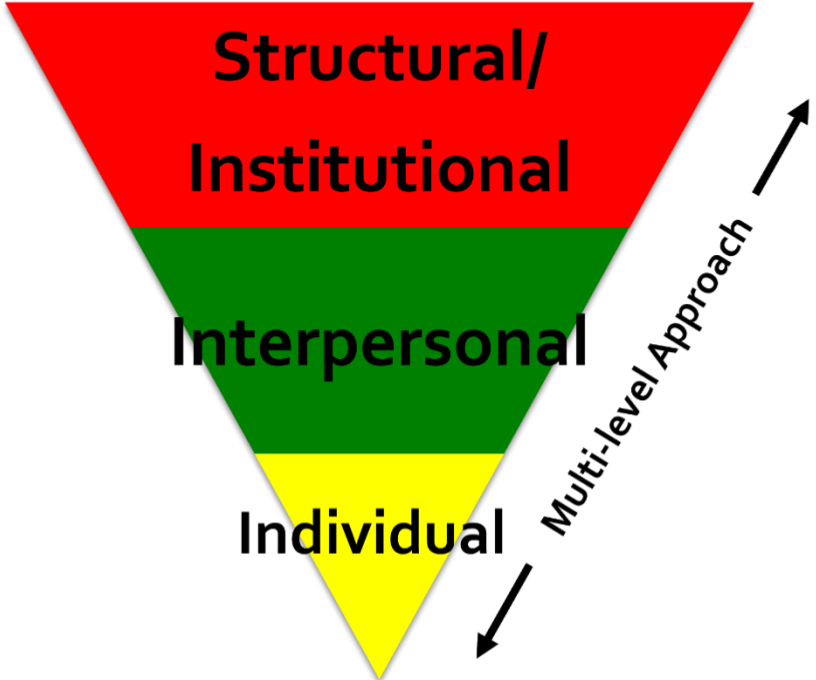

Figure 1. Levels of Stigma. Reprinted from Dr. Cristina Rodriguez-Hart's presentation on "Stigma as a Driver of the HIV Epidemic".

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 experi*ences, strengths, and vulnerabilities within the context they live in*[13].

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[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.

Alternative text: A diagram detailing how HIV stigma can exist in various levels of HIV care, at the stages of HIV infection, diagnosis, linkage to care, adherence to medication and viral suppression. HIV stigma can manifest in behaviors such as not using condoms, avoiding testing, missing appointments, missing doses, and insufficient ART.

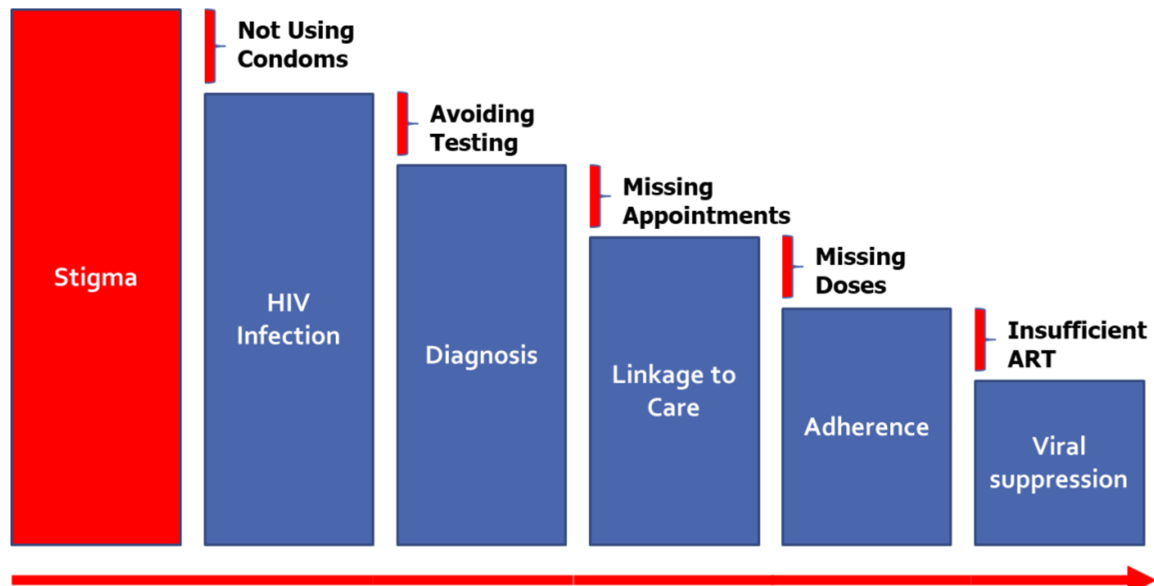

Figure 2 HIV Care Continuum. Reprinted from Dr. Cristina Rodriguez-Hart's presentation on "Stigma as a Driver of the HIV Epidemic."

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:

1. Improving Staff Education
2. Creating a Welcoming and Inclusive Environment
3. Structural Changes

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

"One of the things that I think shows the importance of staff education, is the creation of [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

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, including in areas such as 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.

Creating a Welcoming and Inclusive Environment

"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

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 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

"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

'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.
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

"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

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.

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

"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

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 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. 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. They 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 can serve as a model for multiple interventions that consider several levels of stigma to address intersectional stigma, as well.

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

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 [that] 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 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.

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[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

Table 1. Improving Staff Education

<table>
<tr><th>Stigma related to…</th><th>Institutional/Structural Stigma (also thought of as community-level, organization and policy-level stigma)</th><th>Interpersonal Stigma (i.e. interactions between provider and consumer or within social network)</th><th>Internalized Stigma (negative feelings about one’s status or identity; includes perceived or anticipated stigma)</th></tr>
<tr><td rowspan="3">HIV status</td><td colspan="3">History of HIV:
• A Timeline of HIV and AIDS (HIV.gov)
• The Denver Principles (1983) (ActUpNY)
• ACT UP Accomplishments – 1987-2012 (ActUpNY)</td></tr>
<tr><td rowspan="2">• HIV Stigma and Discrimination</td><td>• 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)</td><td>• How Does Stigma Affect People Living with HIV? (NIH) – Helpful to consider when designing stigma reduction interventions

• The Positive Life Workshop (The Alliance)</td></tr>
<tr><td colspan="2">• Interpersonal and intrapersonal factors as parallel independent mediators in the association between internalized HIV stigma and ART adherence (NIH) –</td></tr>
</table>

		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)	• 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)	• Stigma and Racial/Ethnic HIV Disparities: Moving Toward Resilience (NIH) • The influence of internalized racism on the relationship between discrimination and anxiety (APA)

<table>
<tr><td></td><td>• 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)</td><td>• An Intersectional Perspective on Stigma as a Barrier to Effective HIV Self-management and Treatment for HIV-infected African American Women (Herald)</td><td></td></tr>
<tr><td rowspan="2">Transgender and Gender Non-conforming</td><td colspan="3">• 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)</td></tr>
<tr><td>• Health Disparities, Stigma and Terminology (National LGBTQIA+ Health Education Center)</td><td>• HIV Prevention and Care for the Transgender Population (CDC)
• 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)</td><td>• Internalized Transphobia, Resilience, and Mental Health: Applying the Psychological Mediation Framework to Italian Transgender Individuals (NIH)</td></tr>
<tr><td rowspan="2">Women</td><td colspan="3">• 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)</td></tr>
<tr><td colspan="2">• Perceptions of intersectional stigma among diverse women living with HIV in the United States (Social Sciences and Medicine)</td><td></td></tr>
</table>

	• “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) • Trauma-Informed Medical Education (TIME) (NIH) • Stigma Reduction: Promoting Greater Understanding of Mental Health (Wilder)	• Target-specific stigma change: a strategy for impacting mental illness stigma (NIH) • The Extra Stigma of Mental Illness for African-Americans (The New York Times) • Trauma, Mental Health, Distrust, and Stigma Among HIV-Positive Persons: Implications for Effective Care (Journal of Behavioral Medicine)	• Mental health: Overcoming the stigma of mental illness (Mayo Clinic) • From Discrimination to Internalized Mental Illness Stigma: The Mediating Roles of Anticipated 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)	• The Effects of Perceived Discrimination on Immigrant and Refugee Physical and Mental Health (NIH)

		• 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"	
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) • Harm Reduction Strategies for Addressing Structural Racism (AIDS Institute) • Stigma and substance use disorders: an international phenomenon (NIH)	• Stigma: how it affects the substance use disorder patient (BMC) • Reducing Stigma Surrounding Substance Use Disorders: Videos (Opioid Library) • Reducing Stigma Education Tools (ReSET) • HARM REDUCTION EDUCATION ON-DEMAND (National Harm Reduction Coalition)	• Substance Use Stigma, Avoidance Coping, and Missed HIV Appointments Among MSM Who 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)	• PrEP Care for Patients Experiencing Homelessness	• The Pre-Exposure Prophylaxis-Stigma Paradox: Learning from

	• 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)	(National LGBTQIA+ Health Education Center) • Differences in Medical Mistrust Between Black and White Women: Implications for Patient-Provider Communication About PrEP (NIH)	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)	• 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)

		• '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)	• 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)	• Disability Attitudes of Health Care Providers (CQL)	• "You Look Fine!": Ableist Experiences by People With

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<tr><td></td><td>"The land of the sick and the land of the healthy": Disability, bureaucracy, and stigma among people 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)</td><td>Three Things Clinicians Should Know About Disability (AMA Journal of Ethics)</td><td>Invisible Disabilities (SAGE Journals)</td></tr>
<tr><td rowspan="3">Incarceration</td><td colspan="3">“You're in a World of Chaos”: Experiences Accessing HIV Care and Adhering to Medications After Incarceration (ScienceDirect)</td></tr>
<tr><td rowspan="2">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)</td><td colspan="2">A Qualitative Examination of Stigma Among Formerly Incarcerated Adults Living With HIV (SAGE Journals)</td></tr>
<tr><td>How to Talk with Patients about Incarceration and Health (AMA Journal of Ethics)</td><td>Self-stigma among criminal offenders: Risk and protective factors (NIH)</td></tr>
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