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HIV and Intersectional Stigma Reduction Among Organizations Providing HIV Services in New York City: A Mixed-Methods Implementation Science Project

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Abstract

Stigma remains a pervasive barrier to Ending the HIV Epidemic (EHE) in New York City (NYC). As part of an EHE implementation science planning process, we mapped multi-level HIV-related stigma-reduction activities, assessed their evidence base, and characterized barriers and facilitators. We interviewed and surveyed a convenience sample of 27 HIV prevention and/or treatment services organizations in NYC, March-August, 2020, using an embedded mixed-methods design. The greatest facilitators of stigma reduction included integration of health services, hiring staff who represent the community, and trainings. Intersecting stigmas were primarily addressed through the integration of HIV with mental health and substance use services. Barriers were multilevel, with organizational structure and capacity most challenging. A strong base of stigma-reduction activities was utilized by organizations, but intersectional frameworks and formal evaluation of activities' impact on stigma were lacking. Effectiveness-implementation hybrid research designs are needed to evaluate and increase the uptake of effective stigma-reduction approaches in NYC.

Keywords Stigma · HIV · Intersectional stigma · Mixed methods · Implementation science

Introduction

Much has been done to end the HIV epidemic in New York City (NYC). In 2018, new diagnoses fell under 2000 for the first time since reporting began. The city has led the nation in tracking and reducing new infections, which decreased 41% from 2014 to 2018. However, it continues to be one of the epicenters of the epidemic, containing 13% of all people with HIV (PWH) in the US and 5% of new diagnoses nationwide [1]. Inequities in new diagnoses persist by race, sexuality, and gender, with stigma considered a major driver of these inequities [2, 3]. Stigma is a dynamic social process that is driven by groups in society with greater access to social, economic, and political power and reinforces existing power structures within society, in which certain differences between groups are labeled and negatively stereotyped [4]. These labels are used to separate people into "us" vs. "them," making it easier to hold pejorative views of and discriminate against "them." PWH have been the subject of many such stigmatizing stereotypes, such as assumed injection drug use, sex work, or promiscuity [5]. Power imbalances, stereotypes, and resulting discrimination interfere with diagnosis, access to and retention in care, and viral load suppression [6].

Stigma is a multi-level problem that manifests at the individual, interpersonal, and structural levels [7]. There is a particular lack of evaluated multi-level strategies that

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consider how institutional practices or structural-level factors influence stigma, both in the US and globally [8, 9]. Stigma is also intersectional; multiple and interdependent systems of oppression can fundamentally change an individual's experiences with discrimination [10]. These interlocking social processes complicate the divergent ways in which HIV stigma is experienced by individuals [11]. Interventions that focus on intersectional stigma address this convergence, including those related to health conditions, behaviors, and demographic characteristics. Most stigma reduction interventions, however, do not focus on how intersecting oppressions can affect HIV stigma or outcomes among PWH [6].

HIV stigma and its intersections with other stigma are barriers to successfully supporting the four pillars of the Ending the HIV Epidemic (EHE) Plan: early diagnosis of HIV, rapid treatment, prevention of transmissions, and quick response to new outbreaks [12]. As such, reducing HIV stigma is a key component of the New York State (NYS) strategy to end the HIV epidemic [13]. Both NYS and NYC track HIV stigma, showing that almost 40% of PWH experienced some aspect of it in 2017 [14]. Despite initiatives to track and reduce stigma, it has not shown a decline. A stigma survey conducted in NY between 2016 and 2018 amongst PWH clients and staff of HIV healthcare organizations found that stigmatizing beliefs about PWH occurred among staff, and included the assumption that PWH had many sexual partners [15]. Clients reported stigmatizing behavior from front-desk and other staff, such as double gloving. A survey of PWH in NYC from 2014 to 2015 found that internalized HIV stigma was higher among Latinos, transgender persons, and those diagnosed with HIV in the past five years; the experience of stigma was associated with depression and binge drinking [16]. Another analysis of PWH in NYC found that HIV stigma was associated with lower perceived quality of HIV primary care; enacted stigma was associated with increased odds of inpatient hospitalizations, while internalized stigma was associated with decreased odds of adherence to HIV medications [17].

In response to the perceived need for a formal effort to reduce HIV and intersectional stigma and to build resiliency, the NYC Department of Health and Mental Hygiene (DOHMH), the NYS Department of Health (NYSDOH), and Columbia University undertook a one-year exploratory implementation science (IS) planning effort, the Stigma and Resilience (STAR) Project, in September 2019. The project includes a broad collective of approximately 50 community members and HIV service providers. Taken together, members are referred to as the STAR Coalition. The goal was to identify where and how stigma reduction interventions might be optimally implemented. The analysis in this paper, undertaken by the STAR Mapping Team, aimed to map existing stigma-reduction and resiliency-promoting activities in NYC and describe their underlying evidence base in clinical and community-based organizations (CBOs) providing HIV services. It focused on characterizing barriers, facilitators, and gaps to stigma reduction with a specific focus on intersectional stigma relevant to the HIV epidemic, in preparation for future IS initiatives.
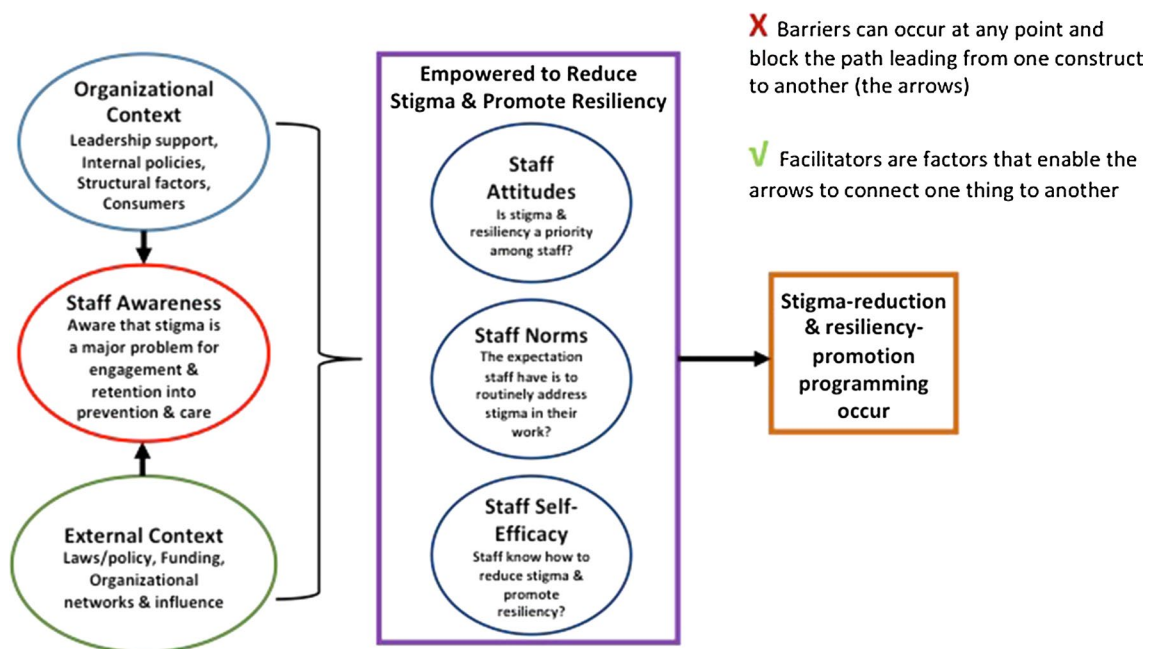
Conceptual Model

IS is a structured approach to test and improve the dissemination and uptake of evidence-based interventions into wide-scale practice [18]. IS frameworks commonly emphasize the characteristics of the intervention and implementers, but also the internal and external context in which the innovation is adopted. To guide the development of data collection instruments, a conceptual model (Fig. 1) was adapted from one which integrates IS frameworks with common theoretical components of behavioral change in psychology [19]. The original model aimed to explain how organizations adopt evidence-based interventions by merging together individual-level constructs from the theory of planned behavior (e.g. attitudes, norms, efficacy) [20] with characteristics of the organizational environment that enable or impede staffs' ability to adopt innovations (e.g. organizational culture) [21]. Potential causal mechanisms were incorporated to identify variables that could be targeted in future stigma-focused IS efforts. Factors both internal and external to the organization were considered that could affect staff awareness, attitudes, and self-efficacy around stigma. External factors included policies and laws, organizational networks, and funding. Internal factors included leadership support, organizational policies and structure, clients served and client input at an organization. This article will share and discuss stigma-reduction strategies implemented in NYC to encourage broader innovation as part of the federal EHE initiative.

Methods

Data Collection

An embedded mixed-methods approach was used [22]. The data collection was primarily qualitative, with the quantitative survey designed to complement the interviews but playing a secondary role. The conceptual model, survey, and interview guide developed by the Mapping Team were workshopped for feedback from the STAR Coalition and expert stigma investigators. As a result, language was changed to be less academic and additional questions regarding client involvement in organizational programming were added. Five pilot interviews were completed and used to refine the interview guide for question wording, informational overlap,

Fig. 1 Conceptual model of drivers of stigma reduction and resiliency promotion programming adoption within HIV organizations

and gaps. The finalized interview guide is supplemental file S1.

Survey

We developed the survey questionnaire (S2) to gather organizations' background characteristics, identify a range of potential stigma and resilience activities, and explore barriers and facilitators. Participants were provided a broad list of activities that may reduce stigma and build resiliency and that fall within four broad types of approaches found in the peer-reviewed literature. Previous reviews of stigma reduction have found that structural interventions, including provision of HIV medications and financial empowerment, were effective at reducing HIV stigma; therefore we asked about a broad range of structural-level activities [23], regardless of whether staff themselves believed these to be stigma-reducing. The survey asked whether their organizations participated in any of them within the last three years. In addition, they were asked to rate their organization on a series of internal and external contextual factors associated with stigma-reduction programming. The survey took approximately 20 min to complete and was distributed through SurveyMonkey.

Interviews

Interviews were used to gather rich data on participants' perspectives on stigma-reduction activities. Rather than providing a list of activities as was done in the survey, the

interviews asked respondents to name what activities were being implemented to reduce stigma at the structural (organizational policies and space), interpersonal (staff-client interactions) and individual (internalized client stigma) levels. Whereas the survey was broad and comprehensive, these questions aimed to get in-depth information from staff, enabling us to triangulate from the two data sources what organizations were doing that may reduce stigma. Respondents were asked to identify which activities were most effective and which could strengthen their existing efforts to reduce stigma (facilitators), barriers preventing stigma reduction, how decision making around organizational programming is carried out with clients, and which clients they felt were least comfortable accessing services.

The Mapping Team was composed of public health practitioners and researchers with a range of experience in qualitative methods who all participated in data collection. Each interviewer was provided with guided feedback after being observed by another member of the Team during their first interview. All interviews had at least two members of the Mapping Team participate to assist with probing and note-taking. All interviews were conducted using Zoom video conferencing technology and audio-recorded.

Recruitment

We recruited a convenience sample of staff at organizations providing HIV prevention and/or care services in NYC from NY Links, a NYSDOH HIV learning collaborative, and two HIV planning coalitions: the NYC HIV Planning Group and

the HIV Health & Human Services Planning Council of New York. Recruitment was negatively affected by the COVID-19 pandemic, which caused NYC to lock down as the process of contacting organizations began. However, members of the Mapping Team with established working relationships with staff at many of these organizations carried out targeted outreach by email. In total, 44 organizations were contacted with a 61% (N = 27) response rate. Data were collected from March to August 2020.

Our goal was to interview and survey at least one staff member from at least 25 organizations, with a second interview to be conducted with a staff member in a different role. At the end of the first interview with an organization, each respondent was asked to refer another staff member who might be willing to participate. Due to the ongoing strain caused by COVID-19, recruitment for second interviews was particularly challenging. We conducted interviews with 27 unique organizations, as well as ten follow-up interviews, bringing our total number of interviews to 37. Organizations were also allowed to have more than one staff member participate in an interview, resulting in 51 total staff being interviewed altogether. Although each participant completed an interview, and multiple individuals per organization were allowed to participate in any given interview, we asked that only one person complete a survey on behalf of the organization.

Analysis

Descriptive statistics from surveys were exported from SurveyMonkey into Microsoft Excel. One set of survey responses from each organization was included for summary statistics. Sometimes multiple participants from an organization completed surveys; however, the first survey submitted by an organization was used in our analysis. If it had a missing answer and a second survey for the organization had a complete response, we filled in the response from the second survey.

Instead of traditional qualitative coding for the interviews, rapid analysis methods were used, which have been shown to have good overlap with traditional methods [24, 25]. Recordings were used to summarize interviews into a Microsoft Word template developed by the Mapping Team. The template can be found in supplemental file S3. Interview questions were pre-assigned to domains, or thematic topics. Responses were summarized by a Team member who participated in the interviews under assigned domains and key quotes were pulled. The first author reviewed all summaries for quality and sent summaries back when further clarification was needed and then re-reviewed summaries. Summarized responses were entered into a matrix in Microsoft Excel which was arranged with each respondent as a row, and each domain as a column. Matrix analysis was used to identify common themes under each column [26].

Results

We separately present results from the survey and interviews, except in several notable instances where the two strands of data diverge or agree. As an exploratory planning project, we primarily focus on the findings from the qualitative portion of data collection according to interview domain.

Organizational Characteristics (Survey Findings)

Table 1 shows surveyed characteristics of organizations. Of the 27 surveyed organizations, 10 (37%) were healthcare organizations, and 17 (63%) were community-based organizations (CBOs). The organizations represented all five NYC boroughs, were generally large (44% served at least 1000 PWH in the previous 12 months), and served a range of populations that are disproportionately impacted by stigma (from a low of 85% having served immigrants to a high of 100% having served Black or Latina cisgender women). Many staff rated their organizations either 4 or 5 stars out of a possible score of 5 on internal organizational factors related to stigma reduction. The factors that received the lowest ratings were "leadership support for stigma reduction programming" (20% received a score of 5), "shared decision-making with clients to determine stigma programming" (24% received a score of 5), and only 21% agreed that "staff have expertise on how to reduce stigma." These three areas may be appropriate to focus on in future stigma reduction initiatives.

Encouragingly, a broad array of stigma-reducing programming was implemented in the 3 years prior and was multi-level (Table 2). There was great variability in the prevalence of activities, from a low of 19% having provided assistance with school tuition to 100% having done the following: educating clients on stigma or human rights, training staff on key populations, participating in organizational networks that focus on addressing stigma, providing or actively linking clients to housing, hiring people from affected/stigmatized communities, and providing or actively linking clients to food and nutrition services. Overall, activities focused on economic strengthening for clients were the least frequently reported. Although education/information activities were commonly reported as occurring in the past 3 years, this category saw the greatest decrease in whether they were still occurring. Many others were not ongoing, suggesting an issue with sustainability.

Table 1 Organizational characteristics, internal organizational context, and external context for 27 surveyed organizations providing HIV services in New York City, NY

Background characteristics	N	%
Organizational characteristics	27	100.0
Type		
Healthcare organization	10	37.0
Community-based organization that provides healthcare	9	33.3
Community-based organization that does not directly provide healthcare[a]	8	29.6
Boroughs served by organization		
Manhattan	20	76.9
Bronx	20	76.9
Brooklyn	17	65.4
Queens	15	57.7
Staten Island	8	30.8
Employees		
< 100	10	37.0
101–500	10	37.0
501 +	7	25.9
Organization proactively hires PWH[b]		
Yes	20	90.9
No	2	9.1
Total PWH clients in Past 12 months[c]		
< 1000	14	56.0
1000 +	11	44.0
Populations served by organization		
Black or Latina cisgender women	27	100.0
Transgender and gender non-binary individuals	26	96.3
Older people ages 50 +	26	92.6
Persons who use substances	25	92.6
Black or Latino gay, bisexual and other men who have sex with men	25	92.6
Persons who engage in transactional sex	25	92.6
Youth and young adults ages 12–29	25	92.6
Persons who are unstably housed	24	88.9
Persons diagnosed with mental illness	24	88.9
Persons involved with the justice system	24	88.9
Immigrants	23	85.2
Respondent's role in organization		
Director/Administrative leadership	9	33.3
Program staff[d]	10	37.0
Healthcare providers[e]	5	18.5
Peer worker	2	7.4
Attorney	1	3.7
Internal organizational context (conceptual framework domain)		
Leadership support for stigma reduction programming (organizational context)[c]		
1–3 stars	8	32.0
4 stars	12	48.0
5 stars	5	20.0
Shared decision-making with clients to determine stigma programming (organizational context)[c]		
1–3 stars	13	52.0
4 stars	6	24.0
5 stars	6	24.0
Addressing stigma is a top priority of the organization (staff attitudes)[c]		

Table 1 (continued)

Background characteristics	N	%
1–3 stars	9	36.0
4 stars	7	28.0
5 stars	9	36.0
Staff aware stigma a major barrier for hiv prevention and treatment (staff awareness)[c]		
1–3 stars	7	28.0
4 stars	7	28.0
5 stars	11	44.0
Stigma reduction an expected part of staff's routine work (staff norms)[f]		
1–3 stars	8	33.3
4 stars	4	16.7
5 stars	12	50.0
Staff have expertise on how to reduce stigma (staff self-efficacy)[f]		
Somewhat, but need more training	12	50.0
No	7	29.2
Yes	5	20.8
External context		
Funders fund their organization to do stigma reduction activities[c]		
No	9	36.0
Yes	8	32.0
Unsure	8	32.0
External laws/policies exist that make stigma reduction programming difficult[c]		
No	10	40.0
Yes	2	8.0
Unsure	13	52.0

PWH people with HIV

[a]All organizations that did not provide healthcare had a linkage agreement with an organization that does

[b]Due to adding this question midway, the N = 22

[c]Due to missing answers, the N = 25

[d]Program staff roles include administrative assistant, case manager, grants manager, QI coordinator and social worker

[e]Healhcare provider roles include physician assistant, physician, pharmacy specialist and nurses

[f]Due to missing answers, the N = 24

Organizational Strategies (Interview Findings)

The themes that emerged from interviews were organized according to the domains from the interview guide, which were: organizations' practices to reduce structural, interpersonal, and individual stigma; respondents' perceptions of the most effective facilitators to stigma reduction; and what barriers and gaps exist to stigma-reduction programming (Table 3).

Structural-Level

Interviewed organizations often implemented policies and practices that created a welcoming and informative space to put clients at ease, employed staff that reflected the clients to show their connection to the community, and provided a range of client-centered one-on-one and group services.

Physical spaces were welcoming, clean, and inviting and included educational resources that were demographically and linguistically diverse and for all levels of literacy. Most integrated HIV care with other services, clientele, and space to reduce stigma around services. One respondent emphasized, "we let people know that 'we are you'" (Manager of Retention and Adherence Program). Staff trainings were viewed as a powerful strategy against stigma, and organizations felt confident in staff members' ability to be informed and apply knowledge gained. Respondents frequently highlighted that services were adapted or created to fit specific populations they served, labeling them as 'client-centered.' One-on-one services included linkage to care, case management, and care adherence. Group-based initiatives varied between organizations as a reflection of the varying clientele. They mainly consisted of support groups, educational programming, and community-based initiatives and

Table 2 Services and activities that may reduce stigma and promote resiliency, by effective stigma reduction approach and frequency, carried out by 27 surveyed organizations providing HIV services in New York City, NY, 2017–2019

Stigma reduction programming by stigma reduction approach	Occurred at least once		Still occurring	
	N	%	N	%
Contact and community empowerment				
Clients lead or co-lead training for staff[a]	10	47.6	6	28.6
De-escalation or mental health first aid training for clients[b]	12	52.2	8	34.8
Education to clients on applying to grants or other funding[c]	13	59.1	7	31.8
Social marketing campaigns to reduce stigma specifically for clients[d]	18	75.0	17	70.8
Training for clients on how to carry out advocacy work[d]	20	83.3	15	62.5
Opportunities for staff and clients to socialize[e]	21	84.0	15	60.0
Developing self-efficacy skills for safe disclosure of stigmatized characteristic[d]	21	87.5	19	79.2
Community Advisory Board (CAB) that meets at least quarterly[d]	21	87.5	21	87.5
Bringing stigmatized individuals to speak on panels at the organization[c]	20	90.9	15	68.2
Client input into quality improvement planning and implementation[d]	22	91.7	21	87.5
Providing information on U=U to clients[d]	22	91.7	22	91.7
Promoting family and loved ones to be part of clients' support network[d]	22	91.7	22	91.7
Health literacy training[c]	21	95.5	18	81.8
Know-your-rights training or materials[b]	22	95.7	18	78.3
Routine and formal organization- wide input of patients/clients into operations and programming of our organization[b]	22	95.7	20	87.0
Providing clients with education on stigma or human rights[d]	24	100.0	20	83.3
Psychosocial support for clients				
Support groups centered around spirituality[c]	10	45.5	7	31.8
Support groups in languages other than English[b]	15	65.2	12	52.2
Support groups for people with mental health diagnosis[c]	15	68.2	13	59.1
Support groups for youth and young adults[d]	18	75.0	13	54.2
Support groups for people who use substances[d]	19	79.2	14	58.3
Support groups for people who are older[d]	19	79.2	14	58.3
Providing peer navigation for clients[d]	19	79.2	17	70.8
Support groups that are peer-led[f]	16	80.0	12	60.0
Community or safe spaces for clients to interact with one another[e]	20	80.0	18	72.0
Screening mental health with questionnaire (e.g. PHQ, CESD)[e]	20	80.0	20	80.0
Support groups for women[c]	18	81.8	15	68.2
Support groups for transgender and gender non-binary populations[b]	19	82.6	13	56.5
Support groups for lesbian, gay, or bisexual (LGB) populations[b]	19	82.6	15	65.2
De-escalation or mental health first aid training for staff[d]	20	83.3	16	66.7
Screening for coping skills[d]	21	87.5	20	83.3
Screening for trauma[e]	22	88.0	21	84.0
Support groups[d]	22	91.7	20	83.3
Development of coping skills among clients[d]	22	91.7	21	87.5
Providing active linkage to mental health services[e]	24	96.0	23	92.0
Education/information				
Creation of report or fact sheet on stigma[b]	14	60.9	8	34.8
Social marketing campaigns to reduce stigma in the community[b]	17	73.9	14	60.9
Activity for staff to examine one's own privilege or stigmatizing beliefs[b]	18	78.3	11	47.8
Training on unconscious biases for staff/providers[d]	21	87.5	14	58.3
Training on mental health for staff/providers[d]	21	87.5	16	66.7
Training on substance use for staff/providers[d]	22	91.7	14	58.3
Training on U=U for staff/providers[d]	22	91.7	16	66.7
Trainings on stigma (e.g. stigma generally, racism, homophobia) for staff/providers[d]	23	95.8	15	62.5
Training on key populations (e.g. transgender health) for staff/providers[e]	25	100.0	18	72.0

Table 2 (continued)

Stigma reduction programming by stigma reduction approach	Occurred at least once		Still occurring	
	N	%	N	%
Structual/institutional change				
Tuition reimbursement for clients[a]	4	19.0	3	14.3
Providing day care[d]	7	29.2	6	25.0
Mystery or secret shopper assessment to assess presence of stigma[c]	7	31.8	6	27.3
ESL classes for clients[c]	8	36.4	6	27.3
Assistance with credit scores for clients[f]	8	40.0	8	40.0
Assistance with apartment deposits for clients[a]	9	42.9	8	38.1
Emergency financial help for clients[a]	10	47.6	8	38.1
Forming stigma workgroup or taskforce[b]	11	47.8	8	34.8
Income generation/job training for clients[b]	13	56.5	11	47.8
Creating organizational stigma reduction plans[c]	13	59.1	9	40.9
Collection of data on stigma from staff[f]	12	60.0	8	40.0
Lactation rooms exist in your facility[f]	12	60.0	12	60.0
Mobile health unit[c]	14	63.6	12	54.5
Providing or active linkage to hometesting for HIV or STIs[b]	15	65.2	13	56.5
Creating reminders in the electronic medical records (EMR) system to offer HIV testing[a]	14	66.7	13	61.9
Collection of data on stigma from clients[a]	14	67.0	8	38.1
Providing emergency contraception[c]	15	68.2	13	59.1
Savings promotion/financial literacy traning for clients[b]	16	69.6	12	52.2
Visibility of a policy that explains consequences of stigma and discrimination towards clients in public waiting areas[a]	15	71.4	13	61.9
Assessing that referral organizations are not stigmatizing clients you send them[a]	16	76.2	16	76.2
Audio or web-based materials to make clients feel more welcome[c]	17	77.3	17	77.3
Routine opt-out HIV testing[d]	19	79.2	18	75.0
Changing signs or organizational name to not highlight HIV[a]	17	81.0	16	76.2
Raising awareness among staff around anti-stigma policies[c]	18	81.8	15	68.2
Providing or linkage to hormone replacement therapy or gender-affirming surgery[c]	18	81.8	18	81.8
Providing reproductive supplies (e.g. tampons)[g]	16	84.2	15	78.9
Written policy in place that explains consequences of stigma and discrimination towards clients[f]	17	85.0	16	80.0
Organizational advocacy to politicians[c]	19	86.4	15	68.2
Integrating trauma-informed care principles and training into organizational functions[c]	19	86.4	17	77.3
Changing the EMR system to be inclusive of a broader array of genders,names and pronouns[c]	19	86.4	19	86.4
Co-location (one-stop-shop) of more than 1 service that meets a high need for an affected/stigmtized population[b]	20	87.0	19	82.6
Providing or active linkage to same-day ART provision (iART)[d]	21	87.5	19	79.2
Providing or active linkage to telehealth services[d]	21	87.5	20	83.3
Moving organizational messaging away from fear-based or risk-based language[f]	18	90.0	17	85.0
Promoting people from affected/stigmatized communities into leadership positions within the organization[c]	20	90.9	19	86.4
Environmental scans to make public areas of the organization more welcoming[b]	21	91.3	19	82.6
Non-EMR methods to include a broader array of genders, names, and pronouns[b]	21	91.3	20	87.0
Providing or active linkage to unused syringes/syringe exchange[d]	22	91.7	19	79.2
Brochures, posters or other written materials to make clients from affected/stigmatized communities feel welcome[d]	22	91.7	19	79.2
Providing or linkage to substance use treatment[d]	22	91.7	21	87.5
Providing universal precaution supplies for staff[d]	22	91.7	22	91.7
Created a formal affiliation or parternship with another organization to meet a high need for a stigmatized population[f]	19	95.0	16	80.0
Creating partnerships with organizations that specialize in the care of key populations (e.g. providers that prescribe hormone therapy or carry out gender affirming care)[a]	20	95.2	18	85.7
Assistance with legal documentation (e.g. drivers license, voter registration, social security, birth certificates) for clients[c]	21	95.5	17	77.3
Improvements to or strengthening of client confidentiality[c]	21	95.5	20	90.9

Table 2 (continued)

Stigma reduction programming by stigma reduction approach	Occurred at least once		Still occurring	
	N	%	N	%
Providing or active linkage to testing for HIV, STIs and/or Hepatitis[b]	22	95.7	21	91.3
Providing or active linkage to PrEP[b]	22	95.7	21	91.3
Providing or active linkage to PEP[b]	22	95.7	21	91.3
Providing or active linkage to legal services that can address cases involving discrimination at low or no cost[d]	23	95.8	21	87.5
Providing or active linkage to medical case management/care coordination[d]	23	95.8	21	87.5
Screening for intimate partner violence and active linkage to resources for IPV[d]	23	95.8	22	91.7
Participating in organizational networks that focus on addressing stigma[d]	24	100.0	20	83.3
Providing or active linkage to housing that is safe and affirming of clients[d]	24	100.0	20	83.3
Hiring people from affected/stigmatized communities[d]	24	100.0	22	91.7
Providing or active linkage to food and nutrition services[b]	23	100.0	22	95.7

[a]Due to missing answers; the N = 21

[b]Due to missing answers; the N = 23

[c]Due to missing answers; the N = 22

[d]Due to missing answers; the N = 24

[e]Due to missing answers; the N = 25

[f]Due to missing answers; the N = 20

campaigns. Client-centered policies prioritized integrated care, inclusivity, and client feedback.

Interpersonal-Level

Staff training also came up frequently when respondents discussed common understandings among staff about how they treat clients. Organizations utilized training to minimize enacted stigma and maintain a culture of respect and client-centered care. The most common topics relevant to stigma included sexual and gender identity, motivational interviewing for behavior change, understanding non-verbal or subtle communication that can exhibit stigma, cultural competency, and de-escalation techniques to resolve conflict. Utilizing this training, respondents noted a very specific 'client-first' culture among staff. One respondent stated "I think the training that they gave them, that the client is the most important person. And I really see that being executed in this organization. When the client walks through that door…They ask him how he's doing. They say good morning to him. They ask him if he needs anything to eat" (Peer Educator).

Staff often used the word respect to refer to how they treated clients. Respect was manifested as being welcoming of everyone, maintaining privacy and confidentiality, holding to standards of behavior that are nonjudgmental and attentive, considering the client as a whole person and meeting them where they are, and avoiding stigmatizing language. One respondent noted, "the number one thing is trying to incorporate a client-centered feeling throughout the clinic" and stated the client is the "expert on their own life, we don't give up on (clients) no matter what" (HIV Program Manager).

When asked to describe a real or hypothetical situation where a staff member could have behaved better or responded better to a client, respondents described handling these on a case-by-case basis as they arose. These were largely one-on-one interactions, and included other staff directly intervening to de-escalate the situation, pulling someone aside to point out their stigmatizing actions, and supervisors having discussions with staff afterwards to discuss the appropriate course of action. Formal disciplinary actions (e.g. placing a memo in the staff member's file) or structural steps (e.g. changing the medical record to include preferred pronouns) were rarely described as a response. Some organizations had grievance procedures or client satisfaction surveys for clients to lodge complaints about staff behavior. Because we do not have client perspectives, it is unclear whether remediation mechanisms remain largely informal because they are effective or whether this is a gap that needs to be addressed.

Individual-Level

Organizations dealt with clients' internalized stigma as a part of broader set of services. This was done directly and indirectly at the individual level (e.g. counseling), within identity-specific support groups, and through the provision of behavioral health services (mental health and substance use). Behavioral health services were accessed by clients either on-site as a part of organizations' integrative care or

Table 3 Summary of thematic findings related to HIV and intersectional stigma reduction programming within 27 interviewed organizations providing HIV services in New York City, NY

Interview question	Summary of findings
Mapping stigma-reduction activities by stigma level	
Structural-level	
"Tell me about formal organization-wide policies or practices in place to help clients feel welcomed?" "Tell me about ways that the physical set-up of the space might give clients the message that they are welcomed and respected?"	Organizations employ informal and formal practices centered around creating a welcoming and informative space, employing staff members that are a reflection of the communities served, and providing a mixture of individual services, like linkage to care and case management, and group services, including support groups and educational programing
Interpersonal-level	
"What kinds of common understandings do staff have among themselves about how to treat clients?" "Can you describe a situation between a staff person and a client where the staff person could have behaved better or responded better to the client? [After they answer, then ask:] Why do you think this might have happened?"	Organizations commonly utilized a variety of staff trainings to minimize stigma, maintained a culture of respect or client-centered care, and relied on informal mechanisms to remediate enacted stigma without formal or structural processes as part of the solution
Individual-level	
"What are some ways the organization directly helps clients deal with negative attitudes or feelings they may have about themselves?"	Organizations offer various mental health and behavioral health services, provide space for individual input through structured groups including support groups and community advisory boards (CABs), as well as tackle internalized stigma one-on-one with clients through informal conversations that demonstrate respect and understanding
Shared-decision making with clients	
"How are clients or other individuals from affected communities that you serve involved in decision making or program planning at the organization?"	CABs and patient satisfaction surveys were the most common way of soliciting client input. A diversity of creative practices to engage client perspectives were believed to improve services, address organizational blindspots, and empower clients to advocate for themselves and each other. Some of these included client-led groups, staff affinity groups, clients on boards or quality assurance committees, staff attendance at CAB meetings, and client/peer input to design programs or materials
Assessing the evidence base underlying activities	
Assessing stigma within agency	
"A few years ago the AIDS Institute (AI) asked HIV organizations they fund to survey their staff and clients in regards to stigma. Did your organization participate in that, and if so, what did that entail? Was anything implemented as a result of the survey results?"	Most healthcare organizations participated in the NYSDOH – AI stigma reduction initiative to measure and respond to HIV stigma and stigma affecting key populations, implementing interventions at the structural, individual, and interpersonal level in response to the survey, with the primary interventions focused on anti-stigma campaigns and trainings. The initiative was not implemented with community-based organizations
Most effective strategies	
"You've described a number of different things to reduce stigma and promote resiliency in your organization. You mentioned [LIST STRATEGIES MENTIONED ABOVE]. Which do you think are one or two of the most effective for reducing stigma and why?"	The most common effective strategies for combating stigma across organizations include: having policies/programs in place that integrate HIV care with other services, staff that are well-trained/educated, outreach and education for clients, and staff that are representative of the communities served
Characterizing barriers and facilitators and identifying gaps	
Facilitators	
"What could strengthen what the organization is already doing to reduce stigma?"	Some of the things they could do to strengthen their efforts to further circumvent stigma included: reinforce training/education of staff on diverse topics, directly addressing stigma (in surveys, programs and workshops), and having methods for evaluating data and feedback
Barriers and gaps	

Table 3 (continued)

Interview question	Summary of findings
"We understand that your organization utilizes [LIST STRATEGIES MENTIONED ABOVE] to reduce stigma, however, could you describe for me any barriers or challenges your organization faces to making clients feel welcome or respected? Is there anything else you think the organization could do to reduce stigma for clients that it is currently not doing?"	The biggest barriers and gaps were associated with the inner context of organizational structure and capacity: large patient volumes, over-worked staff with resulting high turnover, bureaucratic and corporate systems, leadership disconnected from client-level experiences, and a lack of evaluation activity to measure stigma reduction were the most pressing concerns. The primary external context barrier was insufficient funding. Barriers at the level of staff and clients were infrequently reported
Missing clients	
"Who are the clients who might be uncomfortable seeking services from your organization and why? What do you think could be done to make them more comfortable?"	Among the most frequently mentioned clients they felt were missing from their organization were transgender individuals, individuals who worried about being seen receiving services at an HIV organization, and immigrants who were undocumented or did not speak English
Intersectional stigma	
"People can face challenges or stigma due to multiple issues in their life, and these disadvantages can build on each other. For example, maybe someone faces discrimination because they are living with HIV and with a mental illness or they're gay and a person of color. They face unique challenges as a result of the combination of the two. If at all, in what ways has your organization thought about or directly addressed the challenges clients have with experiencing multiple types of discrimination?"	Approaches to address intersectional stigmas were largely single-axis. The most common strategy was integration of services, primarily in reference to mental health care and substance use service integration with HIV care. Case management to assure access to all needed services and trainings on different kinds of stigma or "identity" groups were also reported

[] = instructions that were given to the interviewer and not to be said aloud to interviewee

NYSDOH – AI New York State Department of Health AIDS Institute

through referral processes that utilized the "warm hand-off." These services differed at organizations by how many sessions clients were entitled to, how frequently they were part of routine care, and what specific services and programs were included. Some organizations included sessions centered around a specific curriculum (e.g. Healthy Relationships) that included components related to stigma. Group sessions were the only time organizations explicitly mentioned evidence-based interventions.

Several respondents commented on individual-level strategies such as meeting with clients one-to-one to simply hear how they were doing in general, initiating dialogues around respect and understanding, and creating care plans with clients. One respondent advocated for "Re-brand(ing) HIV as a chronic illness…, a manageable treatable infection. When you talk to them about it in that way, they actually feel, ok, it's not a stain…you want to commend them for all the positives and let them know it's like any other chronic illness. This is not something to be ashamed of" (HIV Prevention Coordinator). Support groups were highlighted as a way to help minimize negative feelings, foster resiliency, and build community, while being described as confidential and safe places for clients. Groups were usually for a specific topic or subpopulation and included a range of stigma-related content such as substance use, gender identity, ageism, healthy relationships, empowerment, toxic masculinity,

anger management, and coping with trauma. Support groups could involve peers and/or be peer-led initiatives.

Consumer Advisory Boards (CABs) were utilized for clients to express feelings and experiences, with the intention of impacting policies and procedures at the organization. On this topic, one respondent concluded: "creating an environment where clients feel respected and worthy of being there is important" (Director of Health Services). CABs were often seen as a way to do this, giving power to clients by elevating them to leadership positions in a formally recognized, client-led entity within an organization. Almost all organizations had a CAB.

Effective Strategies and Facilitators

Respondents generally agreed on the most effective strategies to decrease stigma and how they could be used to facilitate further stigma reduction programming. Training, education, and outreach related to stigma for staff, clients, and the broader community (information-based practices that have been established as effective for stigma reduction in peer-reviewed literature) were commonly discussed by staff as highly effective. These educational practices helped provide clients a safe space through training staff on how to appropriately address clients, hosting campaign events to educate the community on stigma, and normalizing conversations around HIV and gender identity and sexual orientation. They

were viewed as part of the larger culture of the organization rather than limited to discrete events, and seen as a way to raise awareness and remind staff about stigma and resiliency. One respondent stated, "Training is useful because it reminds people of what they've previously heard and reinforces the organization's mission. Our staff meetings are not just about programming, but serve as reminders of who we are and how we should deliver our services" (Director of Health Services). Nonetheless, more information-based services were desired by respondents. This converged with survey findings where more than two thirds (71%) of respondents felt they could use more expertise in reducing stigma (Table 1). Survey findings also showed that while trainings often occurred at least once, there were sharp drops in the frequency of trainings occurring over time (Table 2).

Two other effective practices were commonly identified by respondents that are not often discussed in the stigma intervention literature. These were policies and practices that integrated HIV care with other services, and the hiring of staff representative of communities served. These are expanded upon below.

Service Integration

Integrated care and/or a team-based approach within organizations aimed to serve clients holistically and oftentimes within the same physical space in order to avoid clients feeling stigmatized for seeking services related to a specific aspect of their identity. Many respondents noted the importance of behavioral health services being offered to all clients by default. Within this framework, clients have access to services including care coordination, partnerships with other organizations, a monitored referral process, and interdisciplinary team-based care. Respondents also highlighted the importance of integrating all identities a client holds when working with them. Some organizations integrate HIV care into all primary care appointments, making HIV something that is not just for "some people" or "some clinics" but rather a component of everyday care. One respondent emphasized that "We don't treat HIV testing like it's apart from anything else in someone's healthcare. We try to deal with patients holistically. We treat HIV as one of the problems" (Social Work Supervisor). This holistic approach was seen to make stigma reduction easier because it both normalized HIV for clients and made sure that staff were aware of problems that clients might have as they arose.

Integration also referred to embedding the organization within the communities they are serving through activities like implementing outreach programs or collaborating with outside entities to host educational opportunities and surveys. One respondent stated "It's very effective because when we are at our organization, we are one. When we go out into the community, we are the same. We go out

together as a set of people of whichever aspect we are going out to outreach or support or teach, whichever it is, we represent the people that are being criminalized or stigmatized" (Coordinator of Health Education).

Representative Staff

Hiring staff members who come from the communities an organization serves was seen as a highly effective strategy because representative staff improved disclosure efficacy among clients by being open about their own HIV status, served as role models to clients, and were believed to improve communication and trust. Organizations frequently hired such staff, including peer workers, clients, and bilingual individuals, as an organization-wide practice. One respondent stated: "We have the population that's in our community that work here; either they have been trained, they came in as peers, or they have been staff members. We have a vast support system within our organization that identifies with the populations we work with in our community" (Coordinator of Health Education). They took time to develop relationships and clients saw themselves reflected in these staff: "The way that we have used peers in this agency is probably one of the best tools that we have. It really shows clients that are coming in that we are from the community for the community" (Director of Behavioral Health). Some organizations highly valued peer workers for understanding clients' perspectives and for improving programming through shared decision-making.

Barriers, Gaps, and Who is Missing

Staff perceived that contextual factors internal to organizations were the primary barriers to stigma reduction within HIV organizations. This recognizes that impediments to stigma reduction have less to do with staff attitudes or "hard-to-reach" clients, but with having favorable contexts in which to do this important work. The clients viewed as being underserved and the least comfortable receiving services at organizations were transgender clients, immigrants who were undocumented or who did not speak English, and clients who wished to avoid being associated with an organization known to provide HIV services. This latter group included both PWH who feared disclosure and those not living with HIV who feared others' assumptions that they may have HIV. This in part aligns with survey findings, where immigrants were reported as being the least frequently served (Table 1).

Internal Context

Most respondents reported internal organizational barriers and gaps related to organizational structure and capacity. Large client volumes contributed to long wait times, staff burnout and turnover, and limited time with clients, and could lead to busy staff that had difficulty connecting to and empathizing with clients. Organizational leadership was sometimes viewed as disconnected from the realities of staff on the ground and unaware or disinterested in how top-down policies contributed to stigma. Among survey respondents, leadership support received the lowest proportion of five stars (20%) and 36% rated their organization five stars on whether addressing stigma is a top priority (Table 1). Particularly in larger healthcare systems, the bureaucratic and corporate identities of their workplaces were perceived by staff to impede communication, disempower staff to make decisions about workspaces, and produce bottlenecks to hiring and disseminating non-stigmatizing messaging. One respondent lamented the influence of capitalism on organizational policies that incentivized providers to view clients who struggled to obtain positive health outcomes as a burden, saying "We are patient-first, quality care everything is our motto, but our system makes providers see clients as either giving or taking away from them. So vulnerable populations will fall through the cracks" (Manager of Retention and Adherence Program). Another respondent felt that the corporate identity of his hospital system contributed to physical spaces that made clients uncomfortable and created difficulty showcasing inclusive and respectful messaging, saying "The system really needs to break out of its corporate identity and become an identity of the community. I would love to see a total transformation in five years of how *the Organization* looks, how it feels, and how it serves people. We can be advocates in our little program, but there's so many corporate ladders to go up for all of those things. It will be *the Organization*'s biggest challenge, definitely. First step is recognizing it" (Health Educator and Outreach Worker).

Despite the prominence of staff-level domains in our conceptual framework, barriers related to staff knowledge, norms, and attitudes were infrequently described. This is consistent with survey findings, where "staff are aware that stigma is a major barrier" and "there is a general expectation within the organization that reducing stigma and promoting resiliency should be a routine part of the work of all staff" were rated the most favorably of all inner context factors (Table 1). Some interviewed respondents viewed a lack of evaluation and data collection related to stigma as a barrier, either because competing priorities left them with insufficient time or because awareness of evaluation methods that fit the context of their work was lacking. One respondent said "I feel like we're doing something different every week, so we're probably not the best at looking at that and analyzing it to see if everything that we do is effective or not, so we definitely could improve on that and make a formal QI process to identify the best way to reach a population or approach something" (Health Educator and Outreach Worker).

External Context

The biggest external barriers and gaps were insufficient funding, a lack of control over provider sites or other spaces clients accessed, and a lack of stigma awareness within the broader community. Only 32% of surveyed respondents reported that their organization was funded specifically to do stigma reduction (Table 1), and one interviewed respondent stated "When we're writing grants related to training, I'm invited to a lot of those meetings. I've never heard of a funding stream that just is dedicated to stigma" (Director for Peer Training). Our conceptual framework did not explicitly account for the influence of stigma in the community or in other spaces clients frequent, both of which staff felt they had less power to influence. One respondent stated, "We focus too much on the people who come in. It's not being addressed properly in our communities…in the minority communities" (HIV Prevention Coordinator). Laws and policies external to the organization were infrequently spoken of, mirroring the survey finding where 52% of respondents were unsure of the existence of laws or policies that made stigma reduction programming difficult. The COVID-19 pandemic presented new and unexpected challenges for organizations, such as a lack of access to appropriate technology, that exacerbated the already strained health systems.

Intersectionality

Most respondents acknowledged an awareness of the impact of multiple stigmas and their intersections upon PWH. However, understanding and work to address the impact of intersectional stigmas is emergent. Approaches to address stigmas were largely single axis in focus. Few assessed their programmatic and outcome data in an intersectional manner or implemented intersectionally-focused programming. Intersectionality as a concept was mainly thought of by staff through the lens of service integration, focusing on mental health care and substance use service integration with HIV medical services. Case management to assure access to all needed services and training on different kinds of stigma or "identity" groups were also reported to occur. Notably, there were few practices to address the convergence of racism and HIV stigma. Some shared that their organizations try to be

"colorblind," treating clients the same regardless of their race/ethnicity.

Discussion

This exploratory IS project identified field-based, multi-level, and diverse practices for reducing stigma in HIV-related organizations that form a first look at common "best practices" for NYC. Rapid qualitative analysis was used to identify actionable intervention components. Rapid assessments complement IS frameworks, which share an aim to reduce the time it takes to translate evidence into practice. This project minimizes the following gaps in existing stigma intervention literature: multi-level interventions, especially including the structural and organizational level; holistic approaches that go beyond education and contact strategies; investigating intersectional stigma; and a scarcity of reported US-based practices. Despite this, evaluation of the impact on stigma, intersectional measurement and interventions, and sustainment of existing practices were lacking.

Evaluate and Increase the Uptake of Emergent Best Practices

Emergent and existing stigma-reduction practices need to be evaluated for effectiveness and assessed for barriers and facilitators to adaptations. Robust evaluation components were lacking for most of the identified practices. However, incorporating a QI approach within an IS framework can leverage limited practice knowledge into the development of evidence-informed interventions. Successful uses of a QI approach to adapt stigma-reduction activities among HIV organizations have been demonstrated in Southeast Asia [27]. Hybrid implementation-effectiveness studies may be appropriate in the context of stigma-reduction initiatives in NYC since they evaluate whether an intervention is effective while simultaneously assessing how to improve uptake of such interventions, and thus accelerate the translation of research into practice [28].

Engage Leadership as a Driver for Change

Structural interventions have synergistic effects on stigmas that target individual and interpersonal levels, but they need leadership buy-in [8]. Leadership needs to champion anti-stigma work and implement policies and programs that shape their organization's culture and service delivery. Leadership should be informed on how their influence can be used to reduce stigma. Bureaucracy can hinder implementation of innovative activities due to the complexity of

decision-making and difficulty communicating across siloed realms of influence. The type and size of organizations, including those that are large in size and multi-component health systems, also contributed to this problem. In some cases, staff in CBOs had more autonomy in decision making than those in large hospitals. Given the substantial proportion of HIV care delivered in NYC through large health systems, these entities may need to make additional efforts to ensure leadership drives stigma reduction. A successful pretest–posttest control group study to improve organizational cultural competency at several hospitals in the US included hospital leadership as both drivers and targets of change [29].

Engage Key Stakeholders

Improving feedback loops between leadership, direct service staff, and those who directly experience stigma is critical to addressing inner context barriers. Strategies include engaging clients in decision making processes, training clients for leadership roles, and hiring peer workers. Some organizations had more progressive policies, engaging clients and peers in more equitable and influential roles. Structural barriers to these policies include: hiring practices that prevent PWH from applying; lack of board bylaws that require PWH participation; disempowered CABs with no impact on decision making processes; programming *for* PWH instead of *by* PWH; and utilizing PWH that do not reflect those most impacted by the epidemic [30]. Best practices for CABs are outlined by the NY HIV Health and Human Services Planning Council's Consumers Committee [31]. Leadership needs to seek out regular input from direct service providers and clients, and enact structural solutions to the reported staff burnout and turnover.

Reflect Communities Served

Many organizations have structural-level practices and policies that enable them to be reflective of the community. These included: staff who are representative of the clients' race, sexual identity, and culture; open door policies to fit with the cultural norms of their clients (describing that they did not want clients to feel that they are asking for a service but rather that they are in a family); annual staff evaluations that included whether staff communication conveyed sensitivity, respect, and compassion; interview questions in the hiring process to better identify applicants likely to be compassionate; multiple clinic locations that reflected the local culture of clients; and bilingual staff, although there remained some gaps in having all services and materials in needed languages.

Peer-delivered HIV care is beneficial in providing necessary psychosocial support and improving HIV outcomes

along the HIV care continuum [32]. In a review of Lay Health Worker (LHW) programs for postpartum mothers living with HIV in sub-Saharan Africa, retention in care and other health outcomes were generally higher in groups linked to LHW [33]. The success of these and other peer support models [34] could be more broadly adapted and funded in the U.S., such as by making peer services reimbursable by Medicare and Medicaid. Hiring peer workers and strengthening peer programs, such as NYSDOH's peer certification program, is another important stigma reduction intervention to evaluate and implement [35].

Integrate HIV Services

Integrating HIV care as part of an individual's primary healthcare emerged as a common best practice. Restructuring of HIV services has been associated with significant increases in patient satisfaction, destigmatizing care by shifting focus to a holistic view of clients [36–38]. Approaching HIV as one facet of healthcare can transform how it's viewed in the healthcare setting and community. For instance, current CDC guidelines are to offer HIV tests to all clients with the choice to opt out [39]. However, having signage with HIV in the title caused some clients to not seek care. Although many programs have evolved to treat patients holistically, their name and legacy may be seen as a risk of HIV status disclosure. Having signage and systems that are inclusive of everyone helps clients to integrate without feeling different or singled out—for example, changing electronic medical records to include gender identity and preferred pronouns to help staff avoid misgendering clients. In tandem with integration, the unique and intersectional needs of client populations also need to be considered in service design and this can create tension with broader integration efforts. The need for specialized providers, hours, and spaces can be assessed in conjunction with clients, and where such services are not possible to provide in-house, strong linkage agreements can be sought out with specialty providers (e.g., hospitals offering gender-affirming surgery).

Develop a Learning Culture

Education and trainings were some of the most common practices used to address stigma at all levels, but efforts were often not sustained currently. Furthermore, not many organizations performed evaluation of their trainings, possibly due to lack of knowledge or resources regarding evaluation. Learning is a dynamic process and should not be reduced to a one-time knowledge transfer event. Common occurrences such as rapid staff turnover, varied training needs, and the gap between knowledge and practice show the limits of a traditionally static training model. The whole organization should be continuously engaged in learning and adapting

[40]. This macro approach is needed because stigmatizing beliefs, attitudes, and behaviors can be ingrained within both the individual and the organization. Although many studies have found information-based stigma-reduction practices to be effective, organizations should take into account that educational practices alone are insufficient for stigma reduction; practices that are multi-level, multi-faceted, and implemented over longer periods of time are required [41].

Intersectionality

While there is a growing understanding that intersectional stigma is a problem, staff still showed a lack of understanding of intersectionality as a framework that seeks to understand how interlocking systems of oppression can fundamentally change the way stigma is enacted and perceived. This aligns with other findings: a recent meta-analysis of sexual or gender minority stigma interventions showed that less than half considered multiple stigmas, and only one explicitly used an intersectional framework [42]. Of particular note from the mapping interviews was a lack of understanding of how racism intersects with HIV stigma to affect health services. Providers' desires to "treat all patients the same," and to be "colorblind," aligned with traditional notions of equality rather than equity. This lens ignores the fact that an equitable and intersectional practice cannot treat every individual the same, because it must take power imbalances into account as well as the diverse synergistic downstream impacts [10, 11]. Intersectionality's relevance and its emphasis on moving away from single-axis approaches is critical for ending the HIV epidemic, where the groups most inequitably impacted by HIV are generally facing intersectional systems of oppression and best practices remain largely unknown.

This project had several limitations. Respondents were mainly recruited within the Team's network which may have resulted in a more homogenous mix of organizations, which may in turn reduce the generalizability of findings. Staff members that volunteered may be more likely to already be engaged in or aware of stigma reduction, resulting in a lack of data on challenges for organizations newly starting this work. Respondents could only provide a partial account of their organization's stigma activities based on their role, department, and time working in the organization. The interviews began during the COVID-19 pandemic, which prevented some organizations and people from being able to participate due to competing priorities and limited availability. Most of the participants were people within leadership and middle-management, so much was learned about overall service delivery, less about the first-hand experience of delivering services and client perspectives. More survey and interview questions focused on the internal context than the external context, which

may be a reason that external context barriers were less frequently described. Our project's conceptual framework did not explicitly include how HIV organizations engaged with the community to reduce stigma. However, respondents reported that it was imperative to reduce stigma in the broader community for their clients. This project did not capture the perspectives of clients directly during data collection, except where participating staff members were PWH. Client perspectives are critical when identifying and reducing stigma because it is a personal matter and directly impacts their care, so future efforts should incorporate clients into data collection to understand what they perceive to be stigma-reducing. As most stigma data collection has occurred among recipients of stigma, we felt it was important as a first planning effort that we focus on potential perpetrators of stigma, while soliciting client input through the membership of the STAR Coalition on project design and data collection.

Conclusion

This exploratory project revealed a variety of practices that target multiple levels of stigma, a number of which are not found in the global stigma intervention research literature. There were limited practices that addressed intersectional stigma, especially the intersection of HIV and racism. Common practices such as education and training tend to target the interpersonal level, while barriers and gaps were largely found at the structural level. Structural-level practices show promise to combat stigma and provide a better theoretical match between identified barriers and potential solutions. Examples found in this initiative are learning models that transform whole organizations, engaging people with lived experience, reflecting the community's needs to shape an organization's programming, and incorporating policies and structures that integrate HIV into primary care. These emerging best practices need to be evaluated for their impact on stigma. An IS framework to test, adapt, and scale practices that are salient and fit each organization's unique context is a promising next step.

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