For Organizations and Policy Makers

# Stigma Reduction Initiative Planning Guide

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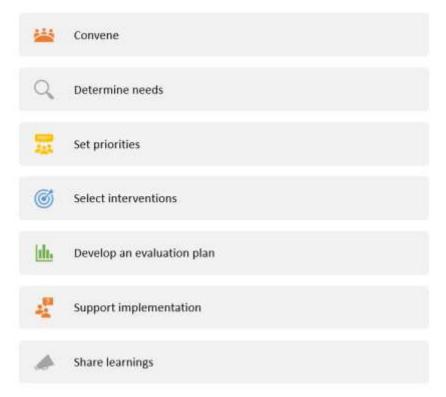
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## So you want to address health-related stigma?

Congratulations, you recognize the importance of addressing stigma to improve the health and well-being of patients, clients, residents, and the people you serve. This guide has been developed to help you plan, implement, and evaluate health-related stigma reduction initiatives. It pulls together best practices, useful resources, and tools in evidence-based practice, planning, implementation science, stigma reduction initiatives, and evaluation.

This guide is organized around the generic program planning steps. It uses a participatory approach to planning, implementation and evaluation in order to ensure that the right strategy, for the right populations, at the appropriate times, with the appropriate scale and efficiency is selected (Aral, 2012 & 2013). Each section of the Guide provides guidance, resources, and in some cases, tools to support the main tasks in that step. The steps are:



"Stigma is a major social determinant of health that drives morbidity, mortality, and health disparities and has been described by the World Health Organization as a hidden burden of disease."

Kame et al. (2019, p. 17)

"Stigma is understood as a socially constructed phenomenon that occurs when members of a group experience status loss or discrimination on the basis of some shared characteristic that is deemed undesirable by a dominant group." (Millum, et al, 2019, p. 2)

"Stigma is a dynamic process enacted through structures and individuals, mediated by relationships of power and control that are constantly being produced and reproduced." (van Brakel et al, 2019, p. 14).

Whether or not you choose to follow each of the steps, there are four key features that should ground your work in stigma reduction:

- 1. Engage people with lived experience.
- 2. Form a working group or coalition.
- 3. Use a variety of evidence and information to select and plan the initiative, and
- 4. Evaluate.



# Step 1: Convene – Engage people with lived experience, and form a working group, committee or coalition

#### "Nothing About Us, Without Us"!

- Engaging people with lived experience is key to planning any program, service or policy. People with lived experience bring critical knowledge, skills, and experience that benefit the planning process and the resulting program, service or policy.
- Need help in getting started? Check out the many resources on engagement curated by the BC SPOR Support Unit: <a href="https://bcsupportunit.ca/resources">https://bcsupportunit.ca/resources</a>

#### Why do this in partnership?

- To create a comprehensive response. Multiple types of initiatives are needed to address stigma and one organization is unlikely to have the mandate, resources, or expertise to tackle the range of initiatives needed (see Step 4, selecting initiatives) or to address stigma experienced by different populations.
- To avoid re-creating the wheel or duplicating efforts of others already engaged in this work.
- To enhance the buy-in for initiatives especially when champions within organizations may be needed to support uptake and embed stigma reduction efforts into organizational policies and practices.
- To ensure the initiatives will be planned to match the contextual needs of the organizations and populations.
- To leverage synergy. Many organizations already have a commitment to equity, safety or patient-centered practices and stigma reduction initiatives fit right into and further these types of initiatives.

#### Levels of Involvement

When convening people with lived experience, it is important to spell out why they are being involved and their level of involvement. The International Association for Public Participation offers a useful diagram showing the different levels of involvement and publishes a series of manuals with many ideas for engagement activities.



Figure 1: Levels of Engagement

Source: https://sustainingcommunity.wordpress.com/2017/02/14/spectrum-of-public-participation/

Before beginning any engagement, it is important to think through the purpose of the engagement and the overall objective for engaging with different groups or representatives. Keep in mind that you don't need to engage all groups in the same ways.

#### How?

There are lots of options for how you structure the engagement; spreading the involvement across multiple working groups or committees may serve you and your partners well. You may want to form an overall advisory committee to guide the work and task-specific or time-limited working groups to tackle specific pieces of work. You can also engage people through one-off events, like a Deliberative Dialogue sessions (see Step 3) to help plan the initiative or the evaluation. To avoid overburdening any particular person or organization, it will be useful to form different committees or working groups for different tasks or hold time-limited one-off meetings or events.

#### Who?

Who you invite to work with you will depend on your context, where you are in your planning journey, and if known, the type of stigma you want to address and the type of initiative you want to implement.

Consider the representation from the following groups:

- People with living and lived experience(s)
- Care providers or program staff
- Organizational leadership
- Community-based organizations
- Advocacy groups

- Researchers studying stigma
- Funders
- Evaluators
- Volunteers
- Community leaders
- Policy groups

It may be useful to conduct a simple stakeholder analysis to help you think through the range of people who would be interested in stigma reduction and/or are affected by stigma. You can create a simple table like the one below to record your ideas and document how you want to engage the different groups.

Table 1: Stakeholder Analysis Worksheet

| Stakeholder Group<br>(Name of person or  | What is their interest in stigma reduction? | What role can they play in initiative planning?  |
|--|---|--|
| stakeholder group, e.g.,<br>service provider, program<br>manager, patient, client,<br>family, staff, funder,<br>executive decision maker,<br>etc.) | Be as specific as possible.                 | <ul> <li>☐ Member of the advisory committee</li> <li>☐ Invited to provide input</li> <li>☐ Informed of initiative</li> <li>☐ Member of a topic specific working group</li> <li>☐ Etc.</li> </ul> |
|  |   |  |
|  |   |  |
|  |   |  |
|  |   |  |

#### A note:

When you begin inviting people to engage with you in stigma reduction work, you may need to explain why it is important to address stigma.

Here are some key points you can communicate:

- Research has clearly demonstrated that health-related stigma undermines diagnosis, treatment, and successful health outcomes (Kane, et al, 2019) and has many other negative effects on many aspects of people's lives (Rao, et al. 2019).
- Healthcare and social service providers in particular, need to understand and address stigma in order to deliver quality care and services and achieve optimal outcomes (Nyblade, et al, 2019).
- Stigma prevents people from seeking treatment or accessing services, adhering to treatment or attending services and creates a barrier to prevention.

# Q

## Step 2: Determine needs

Even though you have already decided to address health-related stigma, you have a lot more decisions to make and will need lots of different types of information to help you made these decisions.

Which health-related stigma do you want to address? Stigma towards people who use drugs; stigma towards people living with HIV; stigma associated with other sexually transmitted and blood borne infections (STBBIs); stigma related to aspects of identity like gender, race, or ethnicity; or stigma related to life circumstances (e.g., immigrant status, poverty, etc.) Unfortunately, stigma is a feature

of many health conditions, identities, and circumstances.

- Which populations do you want to work with?
  - People experiencing stigma
  - Health care or social service providers
  - Family members or supporters or
  - Community members.
- Which aspect of stigma are you going to address? (exposure to stigma and discrimination, internalized stigma, enacted stigma, resistance to stigma, see Step 4)
- What type of initiative are you going to implement?

Some of these decisions will be made for you because of the mandate of your organization or the populations you serve. Others who want to address stigma will need to think through the focus for their stigma reduction initiatives.

In order to answer these questions, you need information on needswhich populations are most affected by stigma in your community, as well as the specific stigma-related challenges people are facing. The stigma literature identifies different "types" of stigma:

Experienced stigma – the stigma and discrimination experienced by people.

Self-stigma – negative feelings or self-image that results from stigma.

Enacted stigma – stigmatizing attitudes or practices, and

Secondary stigma – stigma experienced by family members or friends of the stigmatized person.

You can determine needs in a variety of ways. Figure 2: The Range of Evidence Needed for Evidence-Based Practice Evidence-based public health tells us to collect information that speaks to:

- 1. Community needs
- 2. Community preferences
- 3. Effective practices, and
- 4. Available resources.

Collecting information on community needs and community preferences can be done in a variety of ways:

- Convene a meeting where people talk about their experiences.
- Collect information via surveys, interviews, or focus groups. There are many validated stigma tools that you can use to collect information about stigma. For example, if



Adapted from National Collaborating Centre for Methods and Tools: A Model for Evidence Informed Practice. Accessed at: <a href="https://www.nccmt.ca/uploads/media/0001/01/d9f5cec8637db62f8edda6a6a2551b293a053ede.pdf">https://www.nccmt.ca/uploads/media/media/0001/01/d9f5cec8637db62f8edda6a6a2551b293a053ede.pdf</a>

- working with people who are living with HIV, you can use the HIV Stigma Index to uncover their stigma experiences, see Step 5).
- Conduct a stigma audit or assessment to determine how stigma is experienced by people using the program and services of your organization (see Step 6).
- Engage the members of your steering committee to surface needs.
- Conduct a literature search or document review.



# Step 3: Set priorities

The information you gathered in the previous step should provide you with a good understanding of the stigma-related problems in your community and for your populations. You now have to decide which needs you are going to address. It is unlikely you can tackle everything you have uncovered.

There are many ways to set priorities. All are routed in engagement:

| Different   | Description  | Where to go for more information  |
|---|--|---|
| ways to   |  |   |
| determine   |  |   |
| priorities<br>Hold a<br>Deliberative<br>Dialogue<br>session | A Deliberative Dialogue is a process through which community members are able to talk productively about an issue of mutual concern. The goal is to bring more people into the discussion and identify shared areas of interest for action.  | www.ncdd.org  |
| Use a<br>ranking or<br>rating<br>question on<br>a survey    | Here you create a survey, list all the needs identified and get people to decide which ones should be addressed by placing them in their desired order or by assigning a value   | https://peoplepulse.com/survey-<br>question-design-ranking-vs-rating-<br>questions/ |
| Prioritize<br>with<br>dotmocracy                            | Here people vote on their chosen option using a limited number of stickers or pen  | https://dotmocracy.org/what_is/   |
| Use paired comparisons                                      | With this tool, people compare a limited number of options against each other and the most favoured option emerges.  | https://www.toolshero.com/decision-making/paired-comparison-method/                 |
| Conduct a<br>quadrant<br>analysis<br>/decision<br>box.      | This technique allows each option to be rated along two or more dimensions of importance. The group can decide on the dimensions of importance and can include things like size of problem, ability to address it, cost, or potential impact. Each option or idea is placed in the | https://www.nccmt.ca/knowledge-repositories/search/136                              |

quadrant or grid that reflects its standing with respect to the dimension.

This technique enables http://www.liberatingstructures.com/12-participants to rate a range of options multiple times and allows

Use 25/10

sourcing

crowd

You can consult the links provided to get more information on any of these or Google the techniques yourself to learn more about them. Many of these can be done in-person or online (synchronous- where everyone is together at the same time, or asynchronous, where people participate at different times, when it is convenient for them). In-person sessions require a skilled facilitator to promote inclusion, stay on track, and maximize the achievement of the meeting objectives. A great source for learning about different ways to engage people to achieve different objectives is Liberating Structures (www.liberatingstructures.com).

the top scoring ideas to emerge.

### Step 4: Select initiatives



Lots of different things have been tried to reduce stigma and lessen its impact. The stigma

literature contains hundreds of stigma reduction initiatives. This section summarizes what is known about stigma reduction initiatives. It is based on a synthesis of the articles included in the 2019 issue of *BMC Medicine* and a 2013 review of stigma reduction initiatives conducted by Stangl et al.

- Several good reviews of stigma reduction initiatives exist. Together they provide information on over 150 initiatives. The sidebar shows the landscape of these stigma reduction initiatives.
- 2. Most stigma initiatives are successful at reducing stigma among health care providers, and people who experience, internalize or anticipate stigma. But we don't know their long-term impacts.
- 3. Most initiatives show decreases in stigma. For example, in the review conducted by Nyblade et al. (2019) 32 out of the 42 initiatives (76%) showed reductions in stigma. In the review conducted by Rao et al. (2019) 17 out of the 24 studies reported reductions in stigma. In the review conducted by Stangl et al. (2013) 79% of the 48 initiatives reported statistically significant reductions in all stigma measures.
- 4. Many stigma reduction initiatives exist and have been evaluated (close to 150). Despite the prevalence of initiatives, stigma reduction is not routine in health care or part of pre-service or in-service training for most health care workers (Nyblade et al 2019).
- 5. The state of knowledge about stigmareduction initiatives is not yet at the place where we know what works for whom, in what contexts, and how. However, "available

# The landscape of stigma reduction initiatives:

#### **Health conditions:**

HIV/AIDS, tuberculosis, mental illness, substance use, diabetes, leprosy, cancer, STI, epilepsy.

# Number of initiatives or articles reviewed:

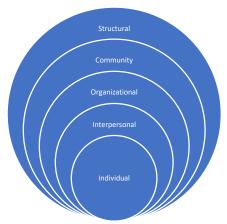
Nyblade et al. (2019) – 42 initiatives. Kemp et al. (2019) – 29 initiatives. Rao et al. (2019) – 24 studies. Stangl et al. (2013) – 48 articles.

#### **Countries:**

Angola, Australia, Bangladesh,
Botswana, Canada, Cameroon, Chad,
Czech Republic, Chile, China, Cote
D'Ivoire, Egypt, El Salvador, England,
Equatorial Guinea, Ethiopia, Ghana,
Greece, Haiti, Hong Kong, India,
Indonesia, Ireland, Israel, Kenya,
Lesotho, Malawi, Malaysia,
Mozambique, New Zealand, Nigeria,
Peru, Puerto Rico, Russia, sub-Saharan
Africa, Saudi Arabia, Senegal, South
Africa, Swaziland, Tanzania, Thailand,
Uganda, UK, USA, Vietnam, Yemen,
Zambia, Zimbabwe.

evidence suggests that stigma should be tackled at multiple levels, by using multiple strategies and the initiatives must be context specific and continued or repeated to achieve a lasting impact." (van Brakel et al., 2019, p. 18).

The table below has a few examples of the types of initiatives that can be implemented at each level.



| Individual level           | <ul> <li>Initiatives focus on people living with stigmatized<br/>conditions or identities. Initiatives involve self-help, skill<br/>development, counselling, empowerment, and treatment.</li> </ul> |  |
|----------------------------|--|--|
| Interpersonal level        | The focus of interpersonal initiatives is on increasing social<br>support in the stigmatized persons' local environment of<br>family, friends, and networks. Peer to peer programs are<br>common.    |  |
| Community level            | <ul> <li>Community level initiative work on reducing stigmatizing<br/>attitudes and behaviours in non-stigmatized groups. The<br/>focus is on cultural values, norms and attitudes.</li> </ul>       |  |
| Organizational level       | <ul> <li>Organizational initiatives focus on reducing stigma within organizations or institutions.</li> </ul>  |  |
| Structural or policy level | <ul> <li>Structural initiatives focus on establishing and enforcing<br/>legal, policy and right-based solutions.</li> </ul>  |  |

#### **Stigma Reduction Strategies**

There are many ways to reduce stigma or lessen its effects. The few studies that compared differences in how programs were offered (e.g., in person vs video based, etc.) did not find significant differences in stigma reduction suggesting that any number of delivery methods can be effective (Nyblade et al. 2019). Within the literature reviewed, several stigma reduction strategies were mentioned and are described below. These strategies can be used with any population.

Education/Provision of information – Stigma reduction can involve providing information about stigma and its manifestations and impacts on health. Information-based strategies are used to reduce negative attitudes among community members (sometimes called public stigma). Negative attitudes are assumed to be based on lack of knowledge, incorrect knowledge, myths, beliefs or stereotypes about a given condition or group of people. Information can be provided in a variety of ways including print, media campaigns, posters, radio or television, and internet.

#### **Social Media**

Sickboy podcast
(www.sickboypodcast.com) is a
weekly podcast about the stigma
associated with illness and disease.
It has been turned into a live show
and the podcasters also offer
speaking engagements.

Social marketing – social marketing initiatives are a subset of information provision initiatives as they target community norms, values, and attitudes toward stigmatized populations. These initiatives are delivered through social media channels.

Skills building – Skills building initiatives target professional who work with people experience

stigma (e.g., health service providers) and people who experience stigma. When working with professionals, the focus of these initiatives is on recognizing stigmatizing practices and developing non-stigmatizing ways of providing service. When the initiatives focus on people who experience stigma, the focus is on developing coping strategies and enhancing resilience. Initiatives that include counselling for people living with stigmatized conditions can be considered within this group of initiatives.

Empowerment – Empowerment initiatives are a subset of skills building initiatives with an explicit focus on resilience.

Peer counselling or counselling/support—In these initiatives, people with the same conditions are trained as counsellors and support others through listening, problem solving, and provision of information, including information on human rights. The counsellor can also serve as a role model. Other terms used for this type of initiative include peer educator or community-linkage facilitator. These initiatives have been used in the fields of mental health and HIV.

Contact with stigmatized group – These initiatives involve members of the stigmatized group in the delivery of the initiative to develop empathy, humanize the stigmatized individual, and break down stereotypes. Many examples of this exist. Contact can take different forms including direct or live contact or contact via media (videos). According to van Brakel et al. (2019), opportunities for discussion are an important element.

#### **Skills Building**

An anti-stigma HIV initiative in Nigeria involved providing life skills education. (Kemp, et al. 2019).

An anti-stigma HIV initiative in Tanzania and other African countries involved community mobilization, community HIV voluntary counselling and testing and post-test support services.

#### **Education & Empowerment**

The Karnataka Health Promotion Trust organization (India) educated female sex workers on their legal rights and implemented sensitization and awareness training with government officials, policy, and journalists (Kemp, et al. 2019).

#### Contact

An initiative reported by Nyblade et al. (2019) involves primary health providers and clients with mental illness or substance abuse working together to produce art that is presented to others.

#### Change agents/Popular opinion leaders (POLs) –

POLs display positive attitudes and spread a nonstigmatizing message. They can even fight enacted stigma in a social group. POLs initiatives have been implemented with different populations in many countries.

Structural or policy change – includes policies, providing clinical materials, complaint and reporting systems, and facility restructuring. Examples include anti-discrimination policies, infection control supplies, standardized precaution infection control practices, client complaint and compliment mechanisms, and changes to physical spaces.

#### **Popular Opinion Leaders**

An HIV-related initiative offered in China involved participatory training of champions from several hospitals and the provision of universal precaution materials (Nyblade, et al. 2019).

Another HIV initiative also offered in China involved training market vendors and community popular opinion leaders. (Kemp et al. 2019).

Biomedical – biomedical initiatives for HIV, for example, include testing and antiretroviral therapies. While these initiatives do not directly target stigma, they are part of the multicomponent, multi-level programming needed to combat stigma. An example of a biomedical initiative for people who use opioids is opioid antagonist treatment (OAT). Interestingly, a recent study found that OAT had its own stigma associated with it (McCradden, et al, 2019).

Combinations – initiatives involving more than one approach or targeting more than one level:

- Stangl et al. (2013) reported on an initiative in hospitals in China that combined information and skills building for healthcare workers with structural changes; in this case the provision of universal precautions.
- Stangl et al. (2013) also reported on an initiative that combined community-wide availability of home-based HIV counselling and testing with counselling and support for people living with HIV.

#### **Multi-Component Initiatives**

An initiative to reduce stigma for people using heroin involved education sessions and training on motivational interviewing for health care workers in China.

An HIV initiative in Ghana involved mass media, promotional materials, and training for local religious leaders.

These combination initiatives reflect the realization that individual or interpersonal level initiatives need to be bolstered by supporting or enabling environments or structures.

#### Delivery methods

A range of delivery methods have been used in stigma reduction initiatives. These include inperson, video, films, streaming, mobile technology, phone apps, material, champions, and opinion leaders.

#### Beyond Single or Multi-Level Initiatives

Because of the ubiquitous nature of stigma and the need for multi-level, multi-component initiatives (Nyblade, et al. 2019), stigma reduction could also be supported through initiatives that have been used in other fields, like as collective impact and/or implementation support systems, in addition to the single or multi-level stigma reduction initiatives described above.

"There is growing recognition that, to deliver a sustainably and scaled response to health facility stigma, it is important to address stigma at multiple ecological levels within a health facility." (Nyblade et al. 2019, p. 9)

Collective impact initiatives bring together stakeholders with common interests and support them in addressing and evaluating initiatives (see Kania & Kramer, 2011). There are many existing collective impact initiatives and online forums for people engaged in these initiatives. In Canada, for example, the Ontario HIV Treatment Network (OHTN) runs a collective impact initiative in HIV/AIDS (www.ohtn.on.ca).

Systems for implementation support typically include tools, training, technical assistance, and quality assurance/quality improvement (Wandersman, Chien & Katz, 2012). The Canadian Public Health Association is currently implementing a 5-year project (2017-2022) to provide a suite of professional development and knowledge translation resources focused on the reduction of stigma associated with sexuality, substance use and STBBIs. The website for this project offers several supports that are typically included in implementation support systems (see <a href="https://www.cpha.ca/sexually-transmitted-and-blood-borne-infections-and-related-stigma">https://www.cpha.ca/sexually-transmitted-and-blood-borne-infections-and-related-stigma</a>).

#### Summary

As this section has shown, there are a wide range of stigma reduction initiatives and strategies that can be implemented. The strategy selected should be the one that best fits the needs of your community, the preference of your target population and the resources you have available.





The best time to plan the evaluation of the stigma reduction initiative is when the initiative is being planned. The first step in developing most evaluation plans is to determine what you want to evaluate. The easiest way to do this is to identify the questions you want the evaluation to answer. For stigma reduction initiatives, there are three key questions that can be answered in any evaluation:







#### Impact on Stigma

In stigma reduction initiatives one of the key questions that should be answered is determining the impact of the initiative on stigma.

A few things to note about stigma measurement:

- There are many validated tools that assess stigma.
- Tools that were developed for a specific stigmatized disease or condition have been adapted for other stigmatized conditions. This means that if a tool does not exist for the specific condition or population you want to work with, you can always adapt a tool used with other populations. For example, the Berger HIV Scale, which was originally developed to assess HIV has been adapted for other health related stigmas including mental health, substance use, and tuberculosis.

"A large number of instruments [to measure stigma] have been developed, often within specific fields such as mental health or HIV. In addition, tools have been developed for many of the different domains of stigma such as perceived or anticipated stigma, internalized stigma, public stigma, stigma by association, and healthcare provider-based stigma." (van Brakel et al, 2019, p. 15).

The choice of which stigma assessment tool to use should be based on the population you are working with, the type of stigma you are addressing, the fit with the population you are working with, and the resources you have for collecting data.

#### Impact on Drivers and Protective Factors

In evaluating stigma reductions initiatives, it will be important to also measure the effect of the initiative on the drivers of stigma and the factors that protect people from experiencing negative effects.

#### **Drivers**

Common drivers for stigma include (Nyblade, et al. 2019; Stangl et al, 2013):

- Negative attitudes
- Fear (e.g., fear of infection, fear of the behaviour of stigmatized groups, or fear of mortality associated with a condition)
- Beliefs
- Lack of awareness or knowledge about the condition or stigma
- Inability to clinically manage conditions (for health care providers), and
- Institutional procedures or practices (e.g., providing care at a separate clinic or "flagging" charts).

#### **Protective Factors**

Not everyone exposed to stigma will be adversely affected. There are things that can prevent or lesson negative reactions or prevent stigma from happening in the first place. Examples include:

- Social support
- Norms supportive of diversity and inclusion
- Knowledge or awareness of rights
- Complaint or grievance redressal systems, policies or processes, and
- Protective or punitive laws.

Many tools exist for assessing drivers and protective factors.

#### A note about intersectionality

Because of the myriad combinations of intersecting stigmas and the need for initiatives to address intersectionality, one way to approach the incorporation of intersectionality into the evaluation is to use the three types of analyses commonly used in intersectional research (Turan et al., 2019):

"Intersectionality is a lens through which researchers seek to understand the complex nature of identify, health, social relationships and power that plays out within human interaction and experiences."

Turan et al. (2019, p. 5)

- Anticategorical involves enabling respondents to choose multiple categories in any forcedchoice survey item.
- Intracategorical involves in-depth exploration of a particular constellation of identities and conditions.
- Intercategorical allows comparisons between groups or individuals with different identities or experiences (e.g., Black men who have sex with men versus two spirit men who have sex with men). The data is then usually analyzed using a variety of analytic strategies as long as the dependent variable is quantitative.

Intersectionality is a recognition that identity and its many layers co-exist and shape experience in unique ways. The stigma experienced, for example, by a racialized non-binary person living with HIV may differ significantly from the stigma experienced by a cisgender woman who uses drugs. It is also a recognition that people experience multiple stigmatized identities or conditions (e.g., as a racialized person who uses drugs, and is living with HIV.

#### Implementation

In anticipation of sharing your stigma reduction work with others, it will be important that your evaluation collects the type of information others would need to know in order to decide whether to adopt or adapt the initiative you have implemented. Proctor et al. (2010) suggest you should also collect information on:

- 1. The acceptability of the initiative on the target population.
- 2. The number of organizations or providers offer the service or engaging in the practice. This is known as **adoption**.
- 3. The appropriateness of the initiative. The "perceived fit, relevance or compatibility of the practice for a given practice setting, provider, or consumer" (Proctor et al, 2010. P.5). This concept is similar to acceptability but brings in the notion that an initiative can be acceptable but not appropriate for a particular setting.
- 4. The **feasibility** of the initiative. This looks at the extent to which the initiative can be implemented or carried out with a given organization or setting.
- 5. The **fidelity** of the initiative. Here the focus is on the degree to which the initiative is implemented as it was intended by the original program developers.
- 6. **Implementation cost.** This is the total cost of running the initiative.
- 7. **Penetration**. This is the level of uptake within an organization or within a population (e.g., the number of eligible consumers who use the service divided by the total number of persons eligible for the service or the number of providers who deliver a service divided by the total number of providers trained or expected to deliver the service), and
- 8. **Sustainability**. This speaks to the extent to which a newly implemented initiative is maintained.

In your evaluation you may not be able to collect information on all these elements of the initiative but thinking through the type of information that others implementing your initiative may want or need to know will be helpful.

#### Step 6: Support Implementation



Once you have decided on the initiative you will implement, you are not quite done with

planning. Implementation planning and support is a key part of program planning. Here the basic task is to think through what will be needed to support effective implementation by the people who will deliver the program or service or implement the practice. Implementation support essentially deals with the behaviour change needed by service providers.

To learn about what will support service providers to implement your initiative, you will need to engage your stakeholders again. These may be the same stakeholders you are engaging through your advisory committee or it may be new stakeholders. You want to be able to work with the actual people who will implement the program or practice change and the people who manage the organization in which the program will be run (or the service will be offered), and of course, the program clients or participants.

"Results from over 500 studies show that...implementation affects the outcomes obtained" (Durlak & DuPre, 2008, p. 327)

"The magnitude of mean effect sizes are at least two to three times higher when programs are carefully implemented and free from serious implementation problems then when these circumstances are not present" (Durlak & DuPre, 2008, p. 340).

The key task here is to surface barriers and facilitators for service providers and their organizations and roll out the initiative to minimize barriers and support facilitators. What we are really talking about here is practice or behaviour change; providers will either need to incorporate something new into their practices or change the way they are already doing something. Luckily, implementation science researchers have spent a great deal of time studying implementation and have learned about what helps service providers incorporate new practices and what created barriers.

There are many things that can affect implementation. In an early paper, Durlak & DuPre

(2008) identified 23 factors that affect implementation and grouped them into 5 domains that resemble the socio-ecological levels (Community Level, Provider Characteristics, Characteristics of the Initiative, Delivery System/ Organizational Capacity, and the Implementation Support System). Other researchers have made it even easier to think through the barriers and facilitators and offer the COM-B model (Michie, van Stralen & West, 2011) which breaks down the drivers of behaviour change into three groups: capability, motivation and opportunity.

Capability

Motivation

Opportunity

Behaviour

Figure 3: COM-B

Capability is defined as the individual's psychological and physical capacity to engage in the practice change or activity concerned. It includes having the necessary knowledge and skills. For example, do health care providers know how to reduce stigma in their behaviour and services? Having the knowledge and skills to do something is necessary but not sufficient to bring about the behaviour change.

Motivation is also needed. Here the issue would be: do health care providers see the value in reducing stigma and providing a safe and welcoming setting?

The last factor is opportunity. Opportunity is defined as all the factors that lie outside the individual that make the behaviour possible or prompt it. Here the focus is on organizational supports for practice change.

Thinking about capability, motivation, and opportunity and using this model makes it clear that you need to engage providers in asking them about whether they have the knowledge, skills, interest, and organizational support to implement stigma reduction initiatives and what is needed to provide this. If the initiative is some sort of training for point of care service providers, then the focus becomes what needs to be set up so service providers will want to take the training, be able to access the training, acquire and practice the skills being taught in the training, and ultimately incorporate the skills into their everyday practices.

This is the realm of implementation strategies and encompasses a myriad of things that will support uptake of the training, for example. It is not the training course itself, but the persuasive elements that make the training irresistible and the acquisition of new skills easier. Things like:

- Including the training in new staff orientation packages.
- Paid time off to take the training.
- Including professional development credits or hours.
- Linking the new practices to performance reviews.
- Using organizational champions to talk about the importance of the practices.
- Using teach back methods.
- Audit and feedback, or
- Coaching.

The list of implementation strategies or supports is almost endless and not all are equally effective, but you need to work with your stakeholders to determine which will work best in your context. The behaviour change wheel, a tool for selecting implementation strategies includes the following categories of different strategies you can use (Michie, van Stralen & West, 2011):

- Education
- Persuasion
- Incentivization
- Coercion

- Training
- Restriction
- Environmental restructuring
- Modelling

## Step 7: Share Learnings



Once you have implemented and evaluated the policy, program, or practice to reduce stigma or its effects, you should share what you learned. In program planning language, this is known as dissemination. You will want to disseminate in order to:

- Secure ongoing funding or embed the initiative into the operations of your organization.
- Spread the initiative to other units or departments in your organization.
- Support uptake (adoption or adaptation) by other organizations or other communities.

There are many ways to share information on your initiative. Listed below are common ways of disseminating information on initiatives:

- You can share information about your program in-person meetings with organizations that serve the same populations you work with.
- You can present your findings to Communities of Practice, if they exist in your area of practice.
- You can post information about the program on your website.
- You can create some user-friendly products like infographics or slidedocs and post them on your website or disease specific websites.
- You can host a webinar or record a short video to talk about your program.
- You can write a blog.
- You can host or present at a community meeting or event.
- You can present at conferences.
- You can post the initiative on the Canadian Best Practices Portal (<a href="https://cbpp-pcpe.phac-aspc.gc.ca/">https://cbpp-pcpe.phac-aspc.gc.ca/</a>) or other initiative portals within your domain of interest.
- You can write up a publication to appear in an academic journal.

When your intention is to help adopt or adopt the initiative, make sure to include information on implementation mentioned in Step 5.

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