

**National Institutes of Health Office of AIDS Research  
National Institute of Mental Health Division of AIDS Research**



**HIV-Related Intersectional Stigma  
Research Advances and Opportunities Workshop  
July - September 2020**

**Workshop Summary**

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## **Workgroup 4: Integrate and tailor intersectional interventions to advance EHE and improve HIV prevention and treatment outcomes**

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### **Members**

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## Executive Summary

HIV-related stigma and discrimination intersect with multiple important dimensions of life, social identity, and status; pose a critical barrier to the prevention, care, and treatment of HIV; and negatively affect quality of life in those living with HIV. To address these issues, the National Institutes of Health (NIH) Office of AIDS Research (OAR) and the National Institute of Mental Health (NIMH) collaborated to coordinate the HIV-Related Intersectional Stigma Research Advances and Opportunities Workshop (i.e., Workshop), a three-phase initiative to advance measurements of intersectional stigma among people living with HIV and to develop interventions to reduce this stigma.

The goals of the Workshop were to promote HIV prevention and treatment science and to inform the Department of Health and Human Services (HHS) Ending the HIV Epidemic: A Plan for America (EHE) initiative and other worldwide efforts in HIV by furthering intersectional stigma and discrimination research advances and opportunities. The Workshop brought together key researchers, government officials, and community partners to:

- Develop a common understanding of the concept of intersectional stigma and discrimination within the context of HIV prevention, treatment, and care;
- Harmonize methods and measurements of intersectional stigma and discrimination;
- Identify opportunities within, across, and beyond EHE jurisdictions to monitor intersectional stigma and discrimination;
- Highlight the evidence base of current interventions designed to reduce intersectional stigma and discrimination;
- Integrate and tailor intersectional interventions to advance EHE goals and improve HIV prevention and treatment outcomes; and
- Outline next steps to address research opportunities and to advance implementation plans.

In Phase I of the Workshop, experts, researchers, and community members shared their perspectives and reviewed their ongoing state-of-the-science work related to HIV-related intersectional stigma across four topics: Conceptual Frameworks, Community Perspectives, Interventions, and Measurement.

In Phase II, four interactive workgroups met to discuss in-depth the challenges and opportunities to:

- Harmonize methods and measurements of intersectional stigma and discrimination;
- Identify opportunities within, across, and beyond EHE to monitor intersectional stigma and discrimination;
- Highlight the evidence base of intersectional stigma reduction interventions; and
- Integrate and tailor interventions to advance EHE and improve HIV prevention and treatment outcomes.

In Phase III, the Workshop opened the discussion to the public and other stakeholders. Workshop members provided an overview of the presentations and deliberations from Phases I and II and answered questions from members of the public.

Going forward, NIH OAR and NIMH will collate the Workshop deliberations into a report for publication and will consider the recommendations developed by Workshop participants as potential next steps in supporting and sustaining momentum for addressing this important and timely topic.



## Introduction

Since the HIV/AIDS epidemic began in the early 1980s, the National Institutes of Health (NIH) has been at the forefront of health research initiatives to understand, prevent, and treat this disease. Yet despite recent availability of programs to treat and prevent HIV—notably, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)—evidence suggests that access to these critical HIV services remains uneven within and across communities, regions, and demographic groups. To reduce health disparities in HIV and to ensure that every person living with HIV has equitable access to a high standard of HIV health care, NIH aims to understand and address challenges to accessing these urgently important services.

Among these challenges are stigma and discrimination, which pose significant, complex barriers to health services access. From the individual to the health care provider and the policymaker, entrenched stigma about HIV remains a primary driver of health disparities among people living with the disease. However, HIV-related stigma alone cannot account for the highly personal, dimensional experiences of stigma among people living with HIV, who comprise diverse racial and ethnic groups, gender and sexual identities, socioeconomic classes, health comorbidities, and other identities that, taken together, inform access to HIV-related health services. Consequently, NIH recognizes that an intersectional approach to stigma—one which recognizes that the convergence of multiple, concurrently existing identities shapes an individual's unique experience of stigma—is necessary to capture a full, inclusive spectrum of health experiences among people who belong to one or more marginalized groups.

The many turbulent, traumatic events of 2020 underscore the urgency of this mission. For one, the COVID-19 pandemic has exacerbated and highlighted existing health disparities that, much like HIV-related health disparities, disproportionately impact people of racial and ethnic minorities; people from disadvantaged, underrepresented, and rural communities; sexual gender minorities; and people with lower socioeconomic status. Critically, equitable HIV research with accessible, effective outcomes must include diverse perspectives and approaches to addressing these disparities.

Further, the murders of Breonna Taylor, George Floyd, and other Black people at the hands of law enforcement officers have brought into sharp relief the dire consequences of systemic racism, discrimination, and stigma. NIH recognizes that these long-standing racial inequities must be addressed beyond the change-making capacity of individuals and communities to affect systems-wide shifts at structural and institutional levels.

To further our understanding of the complexities of HIV-related intersectional stigma, its consequences, and potential ways to better address it, the NIH Office of AIDS Research (OAR) and the National Institutes of Mental Health (NIMH) have collaborated to coordinate the HIV-Related Intersectional Stigma Research Advances and Opportunities Workshop (i.e., Workshop), a three-phase initiative to advance measurements of intersectional stigma among people living with HIV and to develop interventions to reduce this stigma. The ultimate goal of this workshop is to improve HIV testing, prevention, and care services among key populations disproportionately impacted by HIV.

## Background

Research efforts to address stigma and discrimination remain a high priority across NIH. These research areas are included the NIH HIV Research Program, which is managed and overseen by the NIH OAR, and operationalized NIH-wide. For example, NIMH specifically seeks to advance research on mental health

disparities and mental health outcomes associated with stigma and discrimination, and particularly those that exist at the intersections of other health conditions, such as HIV.

Within NIMH, the Division of AIDS Research (DAR) aims to support basic and clinical research to reduce the incidence of HIV/AIDS worldwide and to alleviate the physical and psychological burdens of living with HIV. This mission necessitates research to understand and address the impact of stigma and other social determinants of health as they relate to HIV prevention and treatment. Based on expert recommendations at a 2015 meeting to update the 2010 National HIV/AIDS Strategy, DAR partnered with OAR, the White House Office of National AIDS Policy, and other stakeholders to participate in the 2016 White House Meeting on HIV Stigma, which aimed to review best practices in monitoring and measuring stigma, evaluate current interventions to reduce stigma, and identify gaps in understanding.

Based on the priority areas that emerged from the 2016 meeting, NIMH co-hosted a 2017 workshop entitled “The Science of Stigma Reduction: New Directions for Research to Improve Health,” which convened multidisciplinary experts to refine the agenda for stigma research and global health. Discussion from this workshop motivated the funding of eight research awards within the Promoting Reductions in Intersectional StigMa (PRISM) initiative to advance measurements of intersectional stigma, examine the mechanisms and pathways by which stigma impedes prevention outcomes, and develop and test interventions to improve HIV prevention outcomes among key populations in the U.S. and worldwide.

OAR, DAR, and the entire NIH remain committed to advancing theory-driven research to support these objectives. OAR and DAR organized the HIV-Related Intersectional Stigma Research Advances and Opportunities Workshop, which was co-chaired by Dr. Maureen M. Goodenow, Director of OAR and Dr. Dianne Rausch, Director of DAR. Other NIH-affiliated lead representatives of the Workshop included NIMH Director Dr. Joshua Gordon, Dr. Paul Gaist and Ms. Amber Wilson of OAR, and Dr. Greg Greenwood of NIMH. The Workshop also partnered with the Department of Health and Human Services (HHS), represented by Mr. Harold Phillips of the HHS Office of Infectious Disease and HIV/AIDS Policy (OIDP) as the Senior HIV Advisor and Chief Operating Officer of the Ending the HIV Epidemic: A Plan for America (EHE) initiative.

## Purpose

The goals of the HIV-Related Intersectional Stigma Research Advances and Opportunities Workshop were to promote HIV prevention and treatment science, and to inform the EHE initiative and other worldwide HIV efforts. The Workshop brought together key researchers, government officials, and community partners to:

- Develop a common understanding of the concept of intersectional stigma and discrimination within the context of HIV prevention and care;
- Harmonize methods and measurements of intersectional stigma and discrimination;
- Identify opportunities within, across, and beyond EHE jurisdictions to monitor intersectional stigma and discrimination;
- Highlight the evidence base of current interventions designed to reduce intersectional stigma and discrimination;
- Integrate and tailor intersectional interventions to advance EHE goals and improve HIV prevention and treatment outcomes; and

- Outline next steps to address research opportunities and to advance implementation plans.

## Process

Phase I of the Workshop opened in July 2020 with a series of presentations, in which a panel of experts, researchers, and community members shared their perspectives and reviewed their ongoing state-of-the-science work related to intersectional stigma in HIV services. [Add links to NIMH DAR Webinar webpage (and NIH OAR's webpage when available).]

Phase II consisted of four separate workgroups that focused on different charges to further the understanding of intersectional stigma. Phase II workgroups met during multiple virtual meetings between July and September 2020 to deliberate their charge and develop key takeaways and recommendations.

Phase III was a report-out session open to the public in which representatives from Phases I and II presented and discussed conclusions from their workgroups. Each report-out was followed by a question and answer session with members of the public. [Add links to NIMH DAR Webinar webpage (and NIH OAR's webpage when available).]

The fourth and final phase focuses on post-Workshop activities, which include sharing recordings from the Workshop, development of this full Workshop report, dissemination of Workshop outcomes to the EHE initiative and other community stakeholders, and identification of future activities to implement over the next five years. A scientific journal supplement on HIV-related intersectional stigma is planned and will include the deliberations and outcomes of the Workshop.

## Phase I Presentations

Phase I of the Workshop convened experts to anchor the understanding of intersectional stigma with context and an overview of the state-of-science across four topics: Conceptual Frameworks, Community Perspectives, Interventions, and Measurement.

### Conceptual Frameworks

#### Overview

Dr. Lisa Bowleg of George Washington University and Dr. Ann Stangl of Hera Solutions reviewed **Conceptual Frameworks** and approaches towards defining stigma and discrimination across multiple dimensions. Underscored was the importance of understanding stigma within a broad structural context and encouraging stakeholders at all levels—including community members, researchers, clinicians, and policymakers—to recognize their complex roles in enacting stigma and discrimination and to engage collaboratively in the changemaking process.

#### Presentation Summaries

*Intersectionality and Intersectional Stigma and Discrimination in HIV Prevention and Treatment*

Lisa Bowleg, George Washington University

The concept of intersectional stigma as a theoretical framework represents an individual's lived experiences at the microlevel and how these experiences reflect the intersection of different types of discrimination (e.g., racism, sexism, classism, ageism). One of the original concepts of stigma arose from

sociology, and was characterized by Erving Goffman in *Stigma: Notes on the Management of Spoiled Identity* as a situation in which the individual is disqualified from social acceptance—reduced from a whole and usual person to a tainted and discounted one.

Researchers Dr. Bruce Link and Dr. Jo Phelan compared the term *stigma*, which focuses on the individual who is stigmatized and not those who are stigmatizing, to the term *discrimination*, which focuses on the producer of the discrimination and not the recipient. Focusing on the individual with the stigmatized identity is only one problem with defining intersectional stigma. Another is that the definition of intersectional stigma is often vague and describes multiple stigmatized identities rather than their intersection. Ignoring the broad role of power and structure in stigma is also a challenge that is not adequately addressed, but is critical in conceptualizing intersectional stigma as a social process.

Shifting the definition of intersectional stigma towards a conceptual framework looks at the source of the problems through social, political, economic, or other structural environments. This framework also provides an opportunity to develop interventional approaches that focus on those structural problems. Most of the barriers to prevention, whether for HIV or the novel infection COVID-19, are structural problems. For instance, income is a major predictor of COVID-19 infections and race is a predictor of both COVID-19 and HIV infections. From a structural perspective, racism imposes social barriers that constrain individuals from the opportunities to protect themselves in their community.

Another benefit of defining intersectional stigma as a structural problem is that it provides the framework for focusing on root causes. For instance, if racial inequities are broken into metrics such as household income, unemployment, or homeownership, one can trace the intersection of structural racism and structural poverty back to its root causes. Additionally, a focus on an individual's skin color, sexual minority status, or gender identity is a focus on factors that are not modifiable. Shifting the focus of stigma to underlying social processes allows for interventions on factors that can be modified and avoids blaming the victims of stigma and discrimination.

#### *A Health Stigma and Discrimination Framework*

Anne Stangl, Hera Solutions

The Health Stigma and Discrimination Framework evolved from the idea that a focus on stigma within specific health conditions narrows the topic into theoretical siloes, even though the stigmatization process is fairly similar across those health conditions. Previous health stigma frameworks tended to concentrate on psychological pathways among individuals rather than the social and structural pathways, which limited the ability to develop meaningful interventions and innovations.

The Health Stigma and Discrimination Framework was therefore built from existing conceptualizations of health-related stigma and from the collective practice experience of researchers from different fields of health stigma. The domains of the framework articulate the stigmatization process as a series of components that impact health and society. The first domain refers to factors that drive or facilitate health stigma. Drivers are negative and range, for example, from fear of infection and social ramifications to concerns about productivity due to poor health. Facilitators can be negative or positive, such as the presence or absence of occupational safety standards and protective supplies that can minimize or exacerbate stigmatizing avoidance behaviors by healthcare workers. The drivers and facilitators determine whether stigma marking occurs and if the stigma is applied to a population with perceived differences such as race, class, gender, sexual orientation, or occupation.

Once a stigma is applied to a group, it can manifest into a range of experiences and practices, which is the next domain. One type of experienced stigma refers to the stigmatizing actions that are external, such as the omission of a ramp for people with disabilities. Other types of experienced stigma include the internal feelings of social devaluation associated with the stigmatized status, the perceptions of how stigmatized groups are treated, the anticipation of experiencing bias, and the associative stigma that is experienced by families or friends. Stigma practices include the stereotypes and prejudice, behaviors, and attitudes that are reinforced by the stigmatization process. The final domain of the framework describes the different outcomes related both to the affected populations, such as access to justice or healthcare services, and also the outcomes related to the organizations and institutions, such as the laws and policies that influence the quality of healthcare or law enforcement practices.

The Health Stigma and Discrimination Framework is different than other frameworks because it does not distinguish the stigmatized individual from the stigmatizer (by removing the “us versus them” dichotomy); it separates the manifestations of stigma into experiences and practices; it highlights all change agents including community leaders, advocates, and policymakers; and it differentiates outcomes between affected populations and the related organizations and institutions. These differentiators clarify the path from stigma marking to outcome. The framework can be used to facilitate discussion among researchers, clinicians, and policymakers and to guide the areas of focus and intervention development. It also promotes the use of standardized outcome measures and enables the development of interventions that crosscut multiple inequities.

The Health Stigma and Discrimination Framework can be used to develop or adapt interventions that address intersectional stigma at multiple socioecological levels, to identify the commonalities and differences in stigma across health conditions, and to amplify the collective response to the drivers of poor health and social outcomes.

## Community Perspectives

### Overview

The moderator of the **Community Perspectives** presentations was Dr. George Ayala of MPact Global Action for Gay Men’s Health and Rights. Panelists were Mr. Justin Smith of the Campaign to End AIDS, Dr. Rafaelé Narváez of Latinos Salud, Omar Syarif of the Global Network of People Living with HIV, and Dr. Laurel Sprague of UNAIDS. Collectively, they brought many years of professional and lived experiences working within communities on health disparities and intersectional stigma. The themes in this session touched on how social prejudice (e.g., racism, sexism, homophobia, xenophobia) and social characteristics (e.g., class, economic status) converge to create health disparities. Critically, presenters emphasized that the community must always be the end beneficiary of research efforts, and that all steps of the research and intervention development process should be informed by perspectives and experiences of community members. Collaborative, equitable partnerships between researchers and communities remain a cornerstone of ethical, effective research.

### Presentation Summaries

#### *A Community-Based Perspective on Intersectional Stigma Research*

Rafaelé Narváez, Latinos Salud; Justin Smith, Campaign to End AIDS

The Black lesbian poet Audre Lorde said that “there is no such thing as a single-issue struggle because we do not lead single-issue lives.” Intersectional stigma research should enable HIV research and care to mirror the lived experiences of the communities to which researchers are accountable. As such,

researchers should focus on developing frameworks that can provide empirical data to support development of structural interventions to reduce stigma. For these interventions to be effective, the work must be visible and accessible to communities outside of traditional paywalled academic journals and translated quickly into both programmatic and policy solutions. Community organizations can play an important role both as partners and as leaders.

While interventions across all levels are necessary, public policy interventions have the broadest potential for high impact. Arts and cultural interventions also may have high impact at interpersonal and community levels. For instance, there is a Centers for Disease Control and Prevention (CDC) funded initiative to develop an interactive theater workshop to discuss HIV-related stigma among Black and Latinx adults. There is also a play titled *As Much As I Can*, which was developed through policy interviews with young Black gay men living with HIV. Researchers can build credibility and community trust by maintaining involvement in the end product.

It is important to combine quantitative methods with narrative and storytelling to comprehensively capture the lived experiences of community members. Researchers should also form partnerships with people outside of the public health field to ensure that the work targets broad systemic change.

#### *Intersectional Stigma and Discrimination*

Omar Syarif, Global Network of People Living with HIV

Current efforts related to intersectional stigma may be too narrowly focused on health behaviors and should include other social and economic factors. In a community-based perspective on measurement and intervention, researchers have a responsibility to involve communities in the research process and to translate their results into concrete actions and interventions to improve policies and practices. For instance, a popular index developed more than a decade ago has been implemented in more than 100 countries, yet few have used the data from this effort to inform advocacy or to develop policies and programs.

As a result, there is a need to balance measurements with interventions—specifically those designed to support communities rather than those limited to improving the capacity of health care workers. The HIV community must be the end beneficiary of HIV research, and the community needs space and a platform to specify their priorities throughout the process.

#### *A Community Perspective*

Laurel Sprague, UNAIDS

It is important to balance power dynamics between researchers and communities to ensure that stigmatized people are not devalued or diminished. Researchers should responsibly consider their positions and think carefully about how that position of power may impact their research. For example, most research hierarchically reinforces the imagined superiority of characteristics like whiteness, heterosexuality, maleness, and economic security. As a result, researchers must reflect on how their own identities may influence their research process and the end effects on the communities involved.

Researchers should measure and utilize opportunities related to how self-empowerment and supportive resilience present among networks of people living with HIV, networks of gay men, and networks of other LGBTQ+ communities. Because traditional research methods may struggle to comprehensively capture the complexities of these networks, it is important to develop novel methodologies.

## Measurement

### Overview

The moderator of the **Measurement** presentations was Dr. Stef Baral of Johns Hopkins University, and the panelists were Dr. Lisa Bowleg of George Washington University, Dr. Seth Kalichman of the University of Connecticut, Dr. Jonathon Rendina of Hunter College, Dr. Mark Hatzenbuehler of Harvard University, and Dr. James Hargreaves of the HPTN 071 (PopART) Study Team. They shared their work to develop, validate, and implement tools to measure HIV discrimination and stigma. Like most measurement tools, approaches vary by population, items, and outcomes of interest. Presenters generally agreed that the field of stigma research currently lacks adequate measures for certain dimensions of stigma, particularly at the structural and policy level, but with careful consideration for form and content, specially designed instruments can comprehensively capture multiple dimensions of stigma.

### Presentation Summaries

#### *Multi-level Intersectional Stigma in HIV Prevention*

Lisa Bowleg, George Washington University

HIV is particularly prevalent in the South, and Black gay, bisexual, and other men who have sex with men (GBMSM) living in the South are disproportionately affected by HIV. To address this, there is a current study to develop measures of multi-level intersectional stigma for Black GBMSM in Washington, DC and Jackson, MS.

Using Dr. Carmen Logie's framework to address intersectional stigma and barriers to health care at multiple socioecological levels, the research team interpreted literature, policy reviews, and interviews with Black GBMSM. They then developed quantitative measures and spatial visualization of multi-level intersectional stigma; assessed psychometrics of the measures at baseline and at six months; and synthesized these qualitative, spatial, and quantitative results towards a mixed method research approach.

To target intersectional stigma at the interpersonal level, the team interviewed participants and asked them to talk about stigmatizing experiences with other people, as well as their own experience of internalized, self-directed classism and racism. To target stigma at the community level, they asked the participants to discuss other community members' attitudes about Black GBMSM, with a particular focus on stigma perpetuated on social media platforms.

Recognizing that self-report interviews cannot accurately capture structural manifestations of stigma (such as policy), the team used the General Social Survey to collect and spatially represent data about relevant attitudes and policies, including anti-LGBTQ+ legislation, HIV exposure criminalization laws, and barriers to PrEP access (e.g., Medicaid coverage).

According to the Human Rights Campaign's State Inequality Index, Washington, DC provides many more legislative protections for vulnerable populations (particularly for the LGBTQ+ community) than does Mississippi. As a result, the team expects that their study participants in Washington, DC will report different structural-level experiences of stigma as those in Jackson, Mississippi. Taken together, these multi-level factors will inform a comprehensive understanding of interpersonal, community, and structural factors that influence barriers and facilitators to HIV prevention.

### *Individual-level Intersectional Stigma in HIV Prevention*

Seth Kalichman, University of Connecticut

The purpose of this project was to use the HIV Stigma Framework to disentangle HIV stigma from other highly correlated stigmatized identities (specifically race and sexual orientation), enabling the development of a reliable, valid new approach to assessing dimensions of intersectional stigma.

The team analyzed existing scales that assess stigmatized conditions and selected those that capture discrimination, microaggressions, interpersonal rejection, and anticipated enacted stigma. After pilot testing these items with 100 participants, they reconfigured the items into a categorical response format or a continuous, sliding bar scale response format. In the categorical format, participants were asked to select if they have experienced each of 36 potentially stigmatizing social situations (from “never” to “often”). In the continuous format, participants were asked to rate how stressful or upsetting each experience was on a scale from 0 to 100. Then, to target an intersectional understanding of stigma, they asked participants if they attributed the experience to their race, their sexual orientation, a combination of their race and sexual orientation, or some other reason. Each of these items yielded an individual score from 0 to 10.

The research team used these results to gain a deconstructed, dimensional understanding of complex intersectional stigma. For example, they were able to determine that GBMSM of color tend to attribute their stigmatizing experiences more to their race than to their sexual orientation. The team also used these unidimensional measurements of identity to create an innovative numerical metric of intersectionality. Using geometry, they developed a composite intersectional stigma score based on individual scores for race-attributed stigma and sexual orientation-attributed stigma. By plotting each of these individual scores along an x or y axis, they can conceptualize the geometric intersection of responses along both the race and sexual orientation response scales.

This novel approach can be applied to multiple stigmatized conditions across stigmas and identities (e.g., the intersections of diabetes and socioeconomic class). Because the preliminary results of this study show significant promise, they are already planning a validation study.

### *Event-level Intersectional Stigma in HIV Prevention*

Jonathon Rendina, Hunter College

Event-level measurement typically uses frequent, intensive sampling (i.e., daily diary entries or ecological momentary assessments) to repeatedly capture an experience over time. Because event-level measurement captures responses immediately after the event has occurred, this method is less affected by recall bias, a common problem for other methods such as retrospective measurement. Event-level measurement also enables the researcher to capture within-person variation in “state-like” measures as it varies over time and across context, allowing investigation of micro-longitudinal effects.

This type of measurement is best suited for outcomes of interest that vary within people and change across events (e.g., behaviors, state-level cognitive and affective variables, and fluctuating physiological markers such as heart rate). The method is especially useful when researchers anticipate reciprocal or spillover effects (i.e., emotions one day affect emotions the next day). Event-level measurement is particularly valuable for studying stigma because it captures processes and outcomes that change within one person over time and across contexts. However, the method is poorly suited when outcomes of interest are high-level measurements (e.g., a mental health diagnosis), if the researcher intends to



aggregate event-level data to create counts or averages over time, or if the researcher intends to capture rare occurrences.

Two studies exemplify the benefits and challenges of capturing stigma at the event level. First, Eldahan et al. (2016) collected 30 once-daily diary entries from a sample of 371 GBMSM in New York City, 44 percent of whom were living with HIV. When the research team examined measures of daily affect and stress, they were able to determine that stigma is associated with positive, negative, and anxious affect both between people and within each person over time and across events. Similarly, Rendina et al. (2018) collected twice-daily ecological momentary assessment data from 50 GBMSM living with HIV in New York City. This time, they found that internalization of stigma significantly affected within-person, but not between-people, experiences of anxiety, anger, and depression. Given these results, they concluded that much of the variability impacting daily affect over time is caused by changes *within* individuals over time.

An upcoming PRISM study will incorporate systematic literature reviews and qualitative reviews, cognitive interviews, and a daily diary validation study to generate and test a set of culturally sensitive, valid, reliable items to understand intersectional stigma among young adult Black, Latino, and White GBMSM in the U.S. To date, they have conducted 19 remote interviews with community-based and research/academic experts about intersectional stigma and best practices for measurement.

#### *Structural Stigma and Health Inequalities: Implications for Research on Intersectionality*

Mark Hatzenbuehler, Harvard University

The field of stigma research currently lacks adequate measures for structural stigma, generally understood to be state policies and institutional practices that perpetuate stigmatizing experiences and unequal outcomes. To address this dearth of measures of structural stigma, three approaches have gained recent popularity among stigma researchers.

The first measurement approach targets policies that promulgate stigma—either single policies or composite measures of several policies. The approach is advantageous because it relies on objective data sources and published language to code policies, providing tangible evidence of structural stigma. However, the approach is limited in that policies may not always capture the unwritten customs and procedures that undergird more informal practices. A recently published paper that exemplified this approach modeled 11 state policies related to sexual orientation over a 15-year period, finding that about 21 percent of late diagnosis and 10 percent of age-related death among adults with HIV in each state were attributable to the state’s policy climate.

The second approach considers aggregated social norms, which are an important indicator of structural stigma because social attitudes cyclically reflect and shape higher-level components at the structural level, such as policy regimes. This approach falls under two broad categories of measurement: explicit (self-report) and implicit (non-self-report). An advantage of explicit measures is that they minimize same-source bias because exposure and outcome are measured from two different data sources. However, explicit measures are subject to social desirability bias, subsequently underestimating true structural stigma. Given these limitations, researchers have developed implicit measures, such as Implicit Association Tests (IATs) and behavioral data (such as Google searches). Although these measures overcome social desirability biases, some researchers have expressed concern about their construct validity and other psychometric properties.

The final approach is a composite measure of structural stigma, which combines multiple measures to recognize that different dimensions of structural stigma (e.g., laws, attitudes) are highly correlated. This approach also tends to have robust psychometric properties, including high construct validity and shared variance, reducing measurement error. Despite these advantages, this approach is poorly suited for research questions that seek to target associations between individual components and health outcomes.

Researchers have yet to adequately integrate these theories within well-validated structural frameworks, nor have they tested these frameworks for their ability to measure social oppression. To overcome these challenges, researchers must obtain data from multiple components over time and across geographic spaces that correlate with existing health data sets, with a special focus on gathering data structures with geographic identifiers.

#### *HPTN 071 (PopART) Stigma Ancillary Study*

James Hargreaves, London School of Hygiene and Tropical Medicine

The HIV Prevention Trials Network (HPTN) 071 (*PopART*) Stigma Ancillary Study is one of the largest HIV prevention trials ever undertaken, involving nearly one million participants across 21 communities in Zambia and South Africa. The primary outcome of the study was HIV incidence among people without HIV, and the key secondary outcome was viral suppression among people living with HIV.

The team was primarily interested in fear and judgment, perceptions and levels of stigma, and anticipated stigma among community members, people living with HIV, and health care providers. They also aimed to capture data about stigma across settings, including intrapersonal or internalized stigma, interpersonal or community-level stigma, and stigma in the health care setting.

In developing measures for the *PopART* study, it was important to use parallel wording to ensure evenness of responses across diverse groups of participants (i.e., the team used near-identical phrasing in their questions specific to community members and in their questions specific to health care workers). They used a mixed methods approach, and, where possible, they based their work on existing survey items.

Their work is predicated on three hypotheses: that the *PopART* intervention may change levels of HIV stigma, that it may change forms of HIV stigma, and that HIV stigma may undermine the effectiveness of the *PopART* intervention. These clear guiding hypotheses have facilitated efforts to collaborate across organizations and to integrate this ancillary study with other work related to social determinants of health.

## Intervention

### Overview

The moderator for the **Intervention** presentations was Dr. Janet Turan of the University of Alabama at Birmingham. Panelists were Dr. Kumi Smith of University of Minnesota, Dr. Victoria Frye of City University of New York, Dr. LaRon Nelson of Yale University, and Dr. Laura Nyblade of the Research Triangle Institute. They outlined recent work to develop, implement, and evaluate interventions to address HIV-related intersectional stigma and discrimination in health care and community settings. Those who have begun delivery of their interventions have reported promising findings thus far.

Presenters shared barriers to implementation of interventions, which included cultural and community context, as well as major research disruptions caused by the COVID-19 pandemic.

## **Presentation Summaries**

### *Standardized Patient Intervention in a Health Services Setting*

Kumi Smith, University of Minnesota; Sean Sylvia, University of North Carolina, Chapel Hill

Many patients with marginalized identities report that clinical encounters may be highly stigmatizing, and many who experience stigma from health care providers are discouraged from seeking further health services. Researchers face challenges to examining enacted interpersonal stigma within health care settings because both parties are prone to inaccurate reporting—doctors may not be incentivized to be truthful about their own stigmatizing behavior, and patients may not be equipped to pinpoint exact reasons for their poor treatment.

In such cases, many researchers introduce a neutral third party to observe, witness, and report on enacted stigma in health care settings. However, clinicians are known to alter their behavior when they know another party is observing the encounter, therefore researchers prefer to use a technique called the “unannounced standardized patient visit.” This method uses actors who are specially trained to roleplay as patients and to objectively report on features of the clinical encounter. Although clinicians who have consented to participate in this technique know that an actor/patient could enter the clinic at any time, they do not know which of their patients may be a covert third party who will report back to researchers.

Using this approach, the research team randomly varied HIV status (positive or negative) and sexual orientation (GBMSM or non-GBMSM) of unannounced standardized patients, providing four dimensions of identity that would inform the average quality of care for a patient with each profile. Their standard reference case was “straight man without HIV.” The team’s ultimate goal is to use these standardized patients’ observations about the patient/provider encounter to inform the content of a targeted training intervention, which will be implemented in the clinics under observation. The team also intends to share their results with doctors, the LGBTQ+ community, and the community of people living with HIV.

### *Community-level Intersectional Stigma Intervention*

Victoria Frye, City University of New York

The *Challenge HIV Stigma and Homophobia and Gain Empowerment (CHHANGE)* community-based intervention is designed to shift community-level attitudinal norms and homophobia in New York City urban neighborhoods with high HIV prevalence to increase access to HIV treatment and prevention. This multi-component intervention was comprised of workshops and trainings for community businesses, residents, and community-based organizations; space-based, pop-up, arts-oriented educational and consciousness-raising events; and a bus shelter media campaign. These primary change components were adopted from curricula and campaigns developed by two organizations, the Community-Academic Partnership Gay Men of African Descent (GMAD) and CAMBA. The intervention targeted an intersectional approach to stigma by educating community members on the links and differences between homophobia and HIV stigma.

Using pre-intervention and post-intervention surveys, the research team did not find that the *CHHANGE* intervention affected community-level attitudes, but they did see a 350 percent increase in HIV testing

at the designated community site. Challenges included implementing the intervention and campaigns across a large spatial boundary, contamination between communities and neighborhoods, social desirability biases, and use of archival data.

Another project, the *Challenge HIV Stigma, Homophobia, and Racism and Gain Empowerment (CHHARGE)* community-based intervention, was specifically designed for and by communities of color. This intervention was concerned with emerging stigmas related to HIV testing and to PrEP/PEP use. To date, they have conducted community pilot trials to assess the feasibility and impact of CHHARGE on community-level stigmas (specifically HIV and PrEP/PEP stigma), homophobia, and racism. The team also is building complex causal models of stigma that enable them to simulate and estimate the impact of changing specific intervention parameters. Their ultimate goal is to increase access to and uptake of consistent HIV testing and preventative care, specifically within the context of White supremacy.

*Multi-level Intersectional Stigma Intervention in a Health Services Setting*  
LaRon Nelson, Yale University; Laura Nyblade, Research Triangle Institute

To understand intersectional stigma in health services settings, this intervention was guided by the socioecological model, which incorporates multiple overlapping factors that operate at different levels (organizational, interpersonal, and intrapersonal) to influence HIV testing. To ensure that their project comprehensively addressed the complex nature of intersectional multi-level stigmas, the team used a convergence framework that combined multiple interventions.

Their first goal was to evaluate the feasibility and acceptability of a novel multi-component, multi-level intervention to address intersectional stigma in health care settings. In the project's formative phase, the team conducted interviews with GBMSM and health care providers to examine drivers and manifestations of stigmas related to HIV status, gender identity, and sexuality, both in health facilities and in community peer groups. The team plans to use these data to refine the interventions and to generate an intervention manual, enabling them to move forward into the trial phase. They seek not only to reduce stigma but also to build skills, agency, social assets, and community partnerships among GBMSM.

They are now conducting the second phase of the study in eight health care facilities in two urban areas in Ghana, which are matched by city and size of staff. Each matched pair of health care facilities will be randomized either to implement the intervention or to continue the current standard of practice. Because the study design uses waitlisting, all 216 GBMSM participants will eventually receive the intervention.

To target stigma at the organizational level, the team will adapt the *HP+ Total Facility Approach*, an intervention to address same-sex stigma among adolescents seeking sexual and reproductive health care. Built on more than two decades of research and programmatic work, the intervention has already been tested successfully in Ghana, Tanzania, and Thailand.

To target interpersonal stigma, the team will use the *Many Men Many Voices (3MV)* intervention, a group-based CDC-designed best evidence intervention to increase HIV testing, decrease episodes of unprotected anal intercourse, and address behavioral and social determinants of HIV risk. This intervention has been previously implemented in Ghana, where it is called *Nyansapo*.

Finally, to target stigma at the intrapersonal level, the team will use the HIV Empowerment, Education, and Empathy (Hive3) model, a peer-based intervention delivered by mobile web app. The intervention educates participants about informational, emotional, and affirmational support. It also trains local peer mentors to nurture socioemotional resilience among participants to mitigate their internalization of intersectional stigma.

#### *Group-Level Intersectional Stigma Intervention in a Community Setting*

Laura Bogart, RAND Corporation

These community-based cognitive behavioral therapy (CBT) interventions aim to increase effective coping responses to intersectional stigma, to address medical mistrust in marginalized communities, and to improve health outcomes among Black and Latino GBMSM.

The team currently is conducting two ongoing randomized control trials. The first is *Still Climbin'*, an intervention to increase preventative care and health engagement among Black GBMSM regardless of their HIV status. The second is *Siempre Seguiré*, an intervention to increase HIV testing and PrEP use among Latino GBMSM whose HIV status is negative or unknown.

The interventions consist of eight community-based group sessions using CBT strategies, participant-based behavioral analysis, activities to enhance awareness of stigma and adaptive coping methods, take-home activities, and ongoing encouragement. Session topics include psychoeducation, identifying and overcoming barriers to effective coping, medical mistrust, social supports, and taking action to address structural discrimination.

Preliminary data from pilot interventions show promising effects. The pilot of the *Still Climbin'* intervention successfully increased effective coping strategies (problem solving, humor, and self-protective strategies), while the pilot of the *Siempre Seguiré* intervention increased adherence to HIV preventive medications, decreased negative religious coping beliefs, reduced internalized HIV stigma, and decreased medical mistrust. All participants reported positive feedback, and many would recommend the interventions to their peers, regardless of their sexual orientation or HIV status.

The intervention is well-suited for community settings because it can be sustained by trained peer counselors in a support group structure. However, individual-level interventions are insufficient for addressing structural discrimination, and higher-level complementary interventions are necessary to effect long-term, systemic change.

#### *Multi-level Intersectional Stigma Intervention in a Community Setting*

Jae Sevelius, University of California, San Francisco; Sheri Lippman, University of California, San Francisco

The *Manas* (meaning *sisters*) project is an intervention to reduce intersectional stigma among high-risk women in Brazil. In Southern Brazil, HIV prevalence is 25 to 30 percent among transgender women, 55 times higher than among the general population. Few transgender women use PrEP despite its availability in Brazil, but low uptake is not related to lack of interest or eligibility. Rather, low use of preventative care for HIV among Southern Brazilian transgender women is caused at least in part by a confluence of stigmas related to social identities, including sex work, substance misuse, HIV status, and race.

To this end, the objectives of this project were to address and reduce negative health impacts of intersectional stigma to improve HIV prevention strategies among women who are transgender. Specifically, the team aimed to increase testing, increase HIV prevention care, and address underlying mechanisms (i.e., reducing internalized stigma and increasing resilience). To develop the intervention, they used the Gender Affirmation Framework, which addresses critical ways in which need for and access to gender affirmation impacts experiences of stigma among women who are transgender, and the Intersectionality Framework. They used these frameworks to develop a conceptual model that focuses on intervening at the level of the stigma experience, from internalized stigma to anticipated stigma and enacted stigma. These interventions will occur with a peer-led navigator in a group-based setting.

Over five peer-led group sessions led by trained peer navigators, women who are transgender will learn about and discuss topics related to gender pride, group support, cohesion, coping strategies, empowerment, and resilience. After group sessions, each participant will receive individual peer navigation. Peer navigators will provide six months of one-on-one support for HIV testing, PrEP use, harm reduction, or HIV care (in the event that a participant tests positive during the intervention). This highly personalized support will enable peer navigators and participants to navigate stigma with attention and sensitivity to each individual's specific barriers to care. They will monitor and follow up with participants every six months and will use the Intersectional Discrimination Index and the Resilience to Stigma Scale to analyze data.

## Phase II Workgroups

Phase II of the Workshop provided an opportunity for interactive workgroups to meet and discuss four specific charges. These charges were:

**Workgroup 1:** Harmonization of methods and measurements of intersectional stigma and discrimination

**Workgroup 2:** Identify opportunities within, across, and beyond EHE to monitor intersectional stigma and discrimination

**Workgroup 3:** Highlight the evidence base of intersectional stigma reduction interventions

**Workgroup 4:** Integrate and tailor interventions to advance EHE and improve HIV prevention and treatment outcomes

## Workgroup 1: Harmonize Methods and Measurements of Intersectional Stigma and Discrimination

### Workgroup Charge

Workgroup 1 was charged with identifying best practices for harmonizing methods and measurements of intersectional stigma and discrimination in the context of HIV prevention and treatment, focusing on the multiple, interlocking dimensions and processes of intersectional stigma over a siloed approach.

### Scientific Context

The concept of intersectional stigma leverages and integrates several theoretical traditions, including intersectionality, stigma, minority stress, critical race theory, and feminism. Stigma is a social process that emerges at the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination within a power context. This process is recognized to be *multilevel* (i.e., manifested at structural, interpersonal, and individual levels) and *multidirectional* (i.e., stigma manifested at one level impacts

stigma manifested and experienced at other levels). To date, much stigma research has taken a “one stigma, one outcome” approach by focusing on how one category of stigma is associated with one type of health outcome (e.g., how HIV stigma is associated with ART adherence). Yet stigma research conducted through an intersectional lens recognizes that stigma is *multidimensional*; there are multiple, interlocking stigma processes that give rise to HIV inequities (e.g., racism, sexism, heterosexism). Recognition of the importance of adopting an intersectional stigma lens is growing within the field of HIV and other areas of health research, as reflected by increasing scholarship in this area. Emerging quantitative and mixed methods are increasingly used alongside qualitative methods that have traditionally been the centerpiece of intersectional stigma research.

### **Key Takeaways**

The Workgroup identified some distinct theories and concepts that integrate to form a concept of intersectional stigma. These include *intersectionality* as an interlocking system of power and oppression, *critical race theory* as a methodology to understand and combat root causes of racism, *stigma* as a theory focused on discredited attributes or identities that classify people, and *minority stress* as a public health model describing how multiple levels of chronic stress linked to marginalization explain health disparities. After discussing these theories, the Workgroup developed a definition of intersectional stigma research as that which “investigates interlocking systems of power and oppression to understand and combat the causes and consequences of stigma at multiple levels by integrating theories and methods from social science and public health with critical lenses from feminist, critical race, and queer theories.” The Workgroup realized that not all stigma research is intersectional, and that intersectionality is a construct that should be measured rather than implied. They also recognized that lived realities of intersecting identities does not equal intersectional methodology, and that an attempt to harmonize methods and measures may have drawbacks.

The Workgroup framed consensus of their definition around three broad benchmarks. The first benchmark was the need to center considerations of power, privilege, and oppression, and move beyond the independent effects and individual-level analyses. The focus of intersectional stigma across the research process should be the interlocking sources of power, privilege, and oppression to create social change and equity. Past research efforts tend to focus on stigmatized individuals, but should rather focus on the stigmatizing systems and structures. Intersectional stigma research should incorporate multidimensional, multilevel, and multidirectional constructs, and therefore use multiple methods. The second benchmark was the context in which stigma occurs, as opposed to people who experience it. They discussed contexts of policy, law, and history; organization and institutions; spaces; social networks; cultures; and time. A key concept they also considered was the critical race theory and the role of language to amplify the experiences of socially marginalized groups and shift the focus to power and oppression. The third benchmark was the empowerment of communities and individuals, focusing on the multiple levels of resources such as resilience and resistance to promote stigma reduction. This benchmark also encompassed the need to partner with communities, thought leaders, and social movements to forge new opportunities for change.

The Workgroup identified key challenges and opportunities. One challenge was the need for access to and development of data sources, and the related issues of privacy, resources needed, and sufficient representation of subgroups. Another challenge was training and networking capacity to cultivate next-generation researchers with the skills and tools they need to advance this research. The Workgroup also focused on the need for meaningful policy change rather than individual change, and mechanisms such as working groups or funding opportunities that would incorporate policy expertise. Finally, they recognized that engaging communities is critical to all stages of the research process, but can be

challenging especially in the early stages of research. There is a need to sustain the community work beyond the period of funding and to identify community leaders to support research.

### **Way Forward**

Practical implications of the Workgroup discussion include considering the significant mechanisms of policy and social change as opposed to individual-level change, the need for funding and resources for community partners to create relevant measures and methods, and the structural competence and mechanisms needed to address intersectional stigma in the context of care. In terms of HIV research, the Workgroup recommended developing a compendium (rather than harmonization) of measures, efforts to engage early stage researchers to ensure representation of intersectional identities, continued funding opportunities beyond PRISM, and a dedicated infrastructure for intersectional approaches to health equity. For EHE, they suggest fostering leadership roles for community and health leaders within NIH and supporting synergy through collaborations within other agencies across HHS.

The Workgroup also recommended using the term *intersectional* only when it is meaningful, increasing diversity of the biomedical workforce to include researchers with lived experience, developing a research guide of training and funding opportunities and existing datasets, creating mentorship networks dedicated for intersectional stigma, continuing funding opportunities beyond one-time Requests for Applications (RFAs), and considering the implications of structural and policy change implications towards public health impact.

Not all stigma research is, or needs to be, intersectional in nature. Although it is important to recognize the inherent intersectional nature of stigma, stigma research guided by other frameworks, models, and theories continues to have value in the context of HIV prevention and treatment. Similarly, not all intersectional research is, or needs to be, focused on stigma. Intersectionality research that interrogates processes other than stigma also continues to have value in the context of HIV prevention and treatment. As the field of intersectional stigma research advances, the benchmarks for intersectional stigma research will also evolve. It is important to expect and allow for changing consensus regarding best practices for intersectional stigma research.

## **Workgroup 2: Identify Opportunities Within, Across and Beyond EHE to Monitor Intersectional Stigma and Discrimination**

### **Workgroup Charge**

Workgroup 2 was charged with identifying opportunities within, across, and beyond EHE to monitor HIV-related intersectional stigma and discrimination. A primary focus area was the use and implementation of intersectional stigma measures to contribute to EHE monitoring, research, practice, or surveillance. Priority areas included characterizing common challenges, successful strategies, and valuable opportunities.

### **Scientific Context**

Researchers face a myriad of barriers and challenges to monitoring intersectional stigma and discrimination, but previous research efforts may guide their efforts to build objective standards for monitoring and for promoting buy-in with collaborators. There are also opportunities to collect intersectional stigma data from large, existing datasets. Mixed-methods research approaches to integrate both qualitative and quantitative data will provide a more in-depth understanding of the experience of intersectional stigma.



## **Key Takeaways**

One of the Workgroup's key considerations involved the *salience* (attributions that a person associates with their stigma), *variability* (magnitude of that attribute), and *temporality* (ability to recall experience) of intersectionality. Another key consideration was research practice, which involved contextual appropriateness (i.e., care versus clinical trial), data collection modality (i.e., paper, electronic), and data collection type (i.e., quantitative versus qualitative). The Workgroup considered community- and participant-focused approaches in terms of the length of data collection tools, how measures were reviewed by community members for relevance, who is administering the data collection, and what resources are needed to respond if a participant reports an experience. They also considered how to ensure that measures are adaptable to the context of the population, if the questions asked represented macro events or microaggressions, and if public health data was available to provide context for new data collections.

The Workgroup also talked about barriers and challenges of the implementation of intersectionality measures that the Workgroup defined. These included creating objective standards for monitoring multiple sites, fielding objections to monitoring due to a program's lack of time and resources, taking the time to explain and define intersectionality, and overcoming academic jargon. There is also the risk that a researcher, who conducts this work within a certain power dynamic, may be unaware of their own limitations or blind spots. The Workgroup identified lessons learned from prior efforts to measure and monitor intersectionality, including the need to promote buy-in and build trust, engage communities by using language that honors their experiences in terms of oppression rather than their identity, avoid the conflation of gender identity with sexual identity, shift the focus from the receiver to the perpetrator and systems, and recognize that monitoring projects may be more accepted and endorsed as community members gain trust in the research and measurement process.

## **Way Forward**

The Workgroup would like to create a toolkit for implementing measures of intersectionality, which has the types of measures, quantitative and qualitative approaches, and guidelines to adapt measures to meet the needs of communities. Community partnerships could be valued by investing time and attention to building trust, expanding reach, and explaining key benefits of monitoring stigma, as well as listening to the communities to understand their priorities and experiences while being open to the terms they use rather than academic jargon. The Workgroup also suggested ensuring ethical approaches that affirm interactions, personnel, and space; clarifying why certain questions are asked while maintaining awareness of the questions that may elicit emotional responses; minimizing participant fatigue through the use of a trauma-informed lens; developing protocols for responding to and providing resources for individuals who report intersectional stigma; and recognizing the limits of perceived "wokeness" by using a checklist to identify potential power imbalances and excluded or marginalized individuals.

The Workgroup suggested integrating intersectional stigma and discrimination items into all NIH HIV human research studies, as a fifth pillar within EHE, on the standard HIV testing form, as a routine item asked by medical providers, and into health department EHE plans. Beyond monitoring at the individual level, the Workgroup recommended monitoring acts by perpetrators, within institutions (e.g., across all employee and executive levels), and at the structural level. As key opportunities, they prioritized measuring intersectional stigma during implementation of evidence-based HIV interventions, leveraging existing data models that aggregate data across different sites, and ensuring that data collection models can reach marginalized communities. They also recommended extending monitoring to rural areas;

delivering Congressional briefings on needed policy changes; and disseminating findings via mass campaigns, conferences and forums, and other informational platforms. Generally, they would like to see the use of lay language or alternative terms when needed to overcome barriers, and panel discussions and social media interactions to further discuss these opportunities.

### **Workgroup 3: Highlight the Evidence Base**

#### **Workgroup Charge**

Workgroup 3 was charged with reporting on the evidence to date on HIV-related intersectional stigma reduction interventions. Acknowledging that there is a dearth of evidence that explicitly addresses HIV-related intersectional stigma, they focused on compiling, reviewing, and categorizing a broader range of relevant interventions across a range of socioecological levels.

#### **Scientific Context**

There is ample literature on HIV stigma reduction and extant theory around intersectionality, however, there are few programs that explicitly address intersectional stigma in the context of HIV. In fact, a brief search on PubMed with the search terms: "intersectional stigma," "intervention," and "HIV" resulted in 19 results. Eighteen were reports on cross-sectional associations or thought pieces, with only one that described an intervention with a qualitative evaluation. Most programming that does address intersectional stigma is not fully conceptualized as such.

#### **Key Takeaways**

The Workgroup's definition of intersectional stigma emphasized the role of multiple stigmatizing forces and highlighted that "studies of intersectional stigma seek to center and elucidate the experiences of people facing multiple discriminating forces (i.e., racism, sexism, transphobia, heterosexism, and classism) and social inequality due to interlocking systems of privilege and oppression." During the development of this definition, the Workgroup also recognized the need to consider measures and outcomes of the interventions.

The Workgroup's definition of *intersectional stigma-reduction interventions* required that the intervention "seek to address the systems of privilege and oppression that fuel intersectional stigma by intervening upon either these systems and/or one or more of the manifestations of intersectional stigma." These manifestations included stigma experiences among affected populations and stigma practices. According to the Workgroup, four components make an intervention intersectional. The intervention must 1) acknowledge conceptually that systems of power, privilege, and oppression impact individual experiences; 2) seek to change or mitigate the impact of those systems; 3) include community leadership and meaningful engagement; and 4) address the axes of interlocking forces of stigma and discrimination.

The Workgroup developed a complex, comprehensive approach to gathering and compiling evidence. Because there were few randomized controlled trials of intersectional stigma-reducing interventions, they sought to examine a broader base of examples that met their definition of an intersectional stigma intervention, regardless if they had been conceived of as such. Workgroup members were asked to provide examples of interventions and programmatic efforts with a range of outcomes. They categorized the interventions using levels of the socioecological model (i.e., individual, interpersonal, organizational, community, and policy/structural); many of the interventions included activities crossing at least two or more levels. They found few structural or policy interventions specific to HIV prevention

in the literature, but more policy or advocacy interventions intended to mitigate health inequities that would be important to HIV-related stigma.

The Workgroup reviewed some examples of interventions at each of the socioecological levels. Interventions at the individual level focused on promoting resiliency and skills. For example, a group-based CBT intervention, *ESTEEM-Connect*, showed improvements in mental health, sex health, and minority stress. Interpersonal-level interventions were also focused on resiliency and coping skills, but within a peer-based dyadic or group. The *Trans Amigas* program, for one, provided peer navigation to address barriers to HIV care by and for transgender women.

They also focused on interventions at the organizational level, such as the multi-level intervention Addressing Intersectional Stigma to Improve HIV Testing, which had been funded by PRISM and included an organizational-level component targeted to healthcare facilities. Such organizational-level interventions typically focused on provider training at institutions such as health facilities, law enforcement, or schools.

At the community level, interventions focused on mobilization, community empowerment, group identity, and cohesion building. For example, the *Sheroes* intervention was designed with an eye towards cultural context and sought to reduce the risk of HIV acquisition or transmission in women who are transgender. Structural- and policy- level interventions focused on advocacy activities, law and policy modification, human rights, and community equity and accountability. For example, the Mississippi Center for Justice (MSCJ) multi-level stigma reduction intervention to educate policy makers and the community towards understanding and acting on equal rights with a move towards structural changes.

### **Way Forward**

The Workgroup emphasized the importance of challenging current thinking and broadening the research paradigm box. Shifts in paradigm and language should focus not on the negatives of stigma, but more on the positives, such as resilience and community strength. Paradigm and language shifts should also move away from centering stigma on stigmatized identities and towards the impact of social forces such as racism, classism, and transphobia. The Workgroup also highlighted that language is important and needs to be inclusive and geared toward positive outcomes such as improved health. For instance, the term *intersectional* is not language that communities use, and can be a challenging concept to describe. Broadening the scope also refers to broadening research tools and measurement, which should include measures of health, well-being, or community engagement. Qualitative data is an especially important tool to understand the impact of interventions. Research measures should also include economic factors, such as poverty or homelessness.

These efforts should include more data about individual experiences, community engagement, program sustainability, and impact on peer facilitators and educators. This would broaden the evidence base for intersectional stigma. Funding agencies, such as NIH, can capture these shifts by seeking to avoid identity-based language, focus on social processes, and incorporate strength-based perspectives and structural changes. It would be helpful for funding agencies to provide follow-up time to track changes, and the ability to partner with intersectional stigma experts or networks. The Workgroup concluded by thanking the Black feminist scholars who pioneered this work.

## Workgroup 4: Integrate and Tailor Intersectional Interventions to Advance EHE and Improve HIV Prevention and Treatment Outcomes

### Workgroup Charge

Workgroup 4 was charged with determining how to integrate and tailor intersectional interventions to advance EHE and improve HIV prevention and treatment outcomes, specifically considering the environment of interventions, and the perspectives and influences of researchers, service providers, program sponsors, funders, and policymakers.

### Scientific Context

Explanatory research on the effects of intersectional stigma on uptake of HIV prevention and treatment approaches has increased in recent years, but is still developing. Currently, very few intersectional stigma interventions have been efficacious in controlled settings, and there remain significant challenges to demonstrating efficacy of interventions at levels higher than the individual. The scope and nature of programmatic work, including the development of hybrid or multilevel interventions, presently is unknown.

### Key Takeaways

The Workgroup defined intersectional stigma as occurring “at the juncture of multiple stigmatized identifies that call within or across several categories” (i.e., co-existing health conditions, sociodemographic characteristics, and behaviors or experiences). Through this lens, they defined intersectional stigma research as “that which seeks to center and elucidate the experiences of people facing multiple discriminating forces and social inequality due to interlocking systems of privilege and oppression.” During their discussion, the Workgroup aimed to clarify how interventions influence HIV outcomes by identifying what makes an intervention intersectional; how intersectional stigma impacts the uptake, delivery, and performance of HIV interventions; how to better support individual strengths during implementation; and how to increase the impact of interventions.

The Workgroup reviewed challenges to measuring the impact of intersectional stigma on HIV interventions. One challenge is that existing structures or systems can actively communicate belonging or alienation, and therefore representation must be included within the environment to adequately communicate belonging. Unfortunately, these environments sometimes focus on a siloed approach to HIV interventions, and ignore the complexity of the individual’s experience. Similarly, intersectional stigma could be primed through memories or an understanding of the organization’s history, and it is important to recognize this aspect of the environment. The Workgroup members reiterated that environment and language are key challenges. For instance, a person may feel compelled to downplay a part of their identity when facing a siloed or problematic environment, thus detracting from their quality of care. There is a risk that the implementation of HIV interventions may result in *othering* and not acknowledging intersectionality can reinforce that stigma. Certain acronyms and phrases that are not common outside of research or service environments can further stigmatize the individual; *people-first* language should instead be used.

They also discussed the need to support individual strengths, and they cautioned against dichotomizing individual- and structural-level interventions where an intervention can impact elements of both. For instance, individual changes can foster empowerment and community solidarity that lead to structural and social changes. However, addressing higher-level stigma is challenging because HIV research prioritizes behavioral and biomedical outcomes over structural stigma-related outcomes. The

Workgroup agreed that the policy and context within which interventions are embedded (e.g., sex education programs or HIV criminalization laws) can become a stigmatizing system.

Service delivery is another challenge to supporting individual strengths when the social contract to support a person is broken (e.g., food or housing insecurity as a barrier rather than part of intersectionality). To overcome these challenges, it is important to expand intervention measures to include structural outcomes in addition to individual outcomes. HIV prevention that is based on human rights and a whole person approach rather than a patient or an identity approach may also promote strength-based outcomes. It is critical to include the viewpoint of non-researcher experts. This shift towards approaches that celebrate the strengths of the whole person, community, culture is important toward improving the impact of HIV interventions.

### **Way Forward**

Enhancing intersectional stigma interventions is a difficult endeavor, given the lack of knowledge about which interventions are funded, the populations they target, and inclusion of intersectional approaches. Homegrown approaches to these efforts may exist, but researchers are not yet aware of them. As a result, the work may benefit from a forum (such as a database of programs) in which to share these promising programs or approaches, therefore expanding the knowledge base and providing collaboration opportunities.

The identification of core components of interventions would support the adaptation of an intervention from one environment to another. Siloes in both service provision and research funding can limit collaboration and intervention research, and a realignment of funding priorities towards stigma reduction and community relevance is important.

The Workgroup reiterated that community engagement to share skills and expertise is highly valuable to effective implementation of stigma reduction interventions. To work holistically with communities, they suggested that researchers aim to tailor interventions to the community, ensure that they are dynamic and flexible towards the communities' priorities, and that community voices are amplified through all stages of the research process.

Going forward, the Workgroup encouraged the research community to make bold efforts rather than skirt the edges of the complexities of intersectional stigma. They also recommended adopting a whole-human, rights-based approach; expanding measures to include social, community, and structural outcomes; building a database or catalogue of all intervention approaches (i.e., community-based, hybrid or multilevel interventions); promoting strength-based approaches and outcomes; and considering stigma as a standalone, high-priority outcome.

### **Future Direction**

Each Workgroup developed a set of actions (**Table 1**) to advance the measurement of intersectional stigma among people affected by HIV and to develop interventions to reduce this stigma. Going forward, they suggest that NIH and others focused on this area take these actions to inform and determine the direction of future activities and work.

**Table 1.** Future Direction for HIV-Related Intersectional Stigma and Discrimination Research

Workgroup	Charge	Future Direction
1	Harmonize methods and measurements	<ol style="list-style-type: none"> <li>1. Address barriers to, and strengthen investment in, the creation of and access to resources for HIV-related intersectional stigma research.</li> <li>2. Develop capacity to engage in intersectional stigma research and intervention.</li> <li>3. Identify and create meaningful pathways for intersectional stigma research to inform structural-level change.</li> </ol>
2	Identify opportunities for EHE and beyond	<ol style="list-style-type: none"> <li>1. Develop an intersectional stigma and discrimination toolkit.</li> <li>2. Value community and partnerships.</li> <li>3. Prioritize affirmation and ethics.</li> <li>4. Align NIH, Departments of Public Health, and EHE.</li> <li>5. Monitor stigma beyond individuals.</li> <li>6. Integrate intersectional stigma and discrimination measures.</li> <li>7. Conduct outreach, policy, and dissemination activities.</li> </ol>
3	Highlight the evidence base	<ol style="list-style-type: none"> <li>1. Ensure that the research process is community-led and grounded in the lived experiences of the communities who will benefit.</li> <li>2. Examine a wider range of proximal (e.g., mobilization and solidarity) and distal (e.g., changes in laws/policies) outcomes.</li> <li>3. Consider a broader range of evidence when assessing best practices for addressing HIV-related intersectional stigma.</li> </ol>
4	Integrate and tailor intersectional interventions	<ol style="list-style-type: none"> <li>1. Adopt a human rights-based approach to HIV prevention and treatment.</li> <li>2. Recognize, study, and catalogue ongoing substantial community and service provider efforts to address intersectional stigma.</li> <li>3. Change the funding system and other structures that marginalize communities.</li> <li>4. Partner communities, organizations, and researchers.</li> <li>5. Evaluate the benefit of multi-level “hybrid” interventions.</li> <li>6. Identify and accelerate determinants of rapid intersectional stigma decline.</li> <li>7. Examine the evolution of stigma over time to inform delivery of new HIV prevention and treatment interventions and strategies.</li> </ol>

### Phase III Public Report Out Session

Phase III of the Workshop provided an opportunity for members of the Workshop to review highlights from the Phase I presentations and for representatives of each workgroup to report on their deliberations and recommended actions developed in Phase II. These presentations were open to the public and provided an opportunity for question and answers. More than 750 people attended this

virtual presentation. Dr. Paul Gaist opened Phase III of the Workshop by reviewing the structure of the three phases and the charge given to the Workshop participants. Dr. Maureen M. Goodenow, Dr. Dianne Rausch, and Mr. Harold Phillips provided a brief review of the history of events that led to the Workshop and the timeliness of this effort to address HIV-related Intersectional stigma and discrimination.

Dr. Carmen Logie of the University of Toronto and Dr. Chelsea Gulden of RAIN Carolina discussed the history of intersectionality as a concept and the development of the current conceptual framework that describes the multiple levels across which stigma and discrimination impact health outcomes. The Workshop members who provided highlights from Phase I were Ms. Marcia Ellis of the DC Center for AIDS Research, who presented on the **Community Perspectives** session; Dr. Tamara Taggart of George Washington University, who presented on the **Measurement** session; and Dr. Viraj Patel, who presented on the **Intervention** session.

Dr. Jonathon Rendina of Hunter College reported on the deliberations of **Workgroup 1: Harmonize methods and measurements of intersectional stigma and discrimination**. Attendees asked Dr. Rendina about community partnerships, research funding, and specific challenges in measures. Dr. Rendina acknowledged the ongoing need for standardized measures and discussed the concept of time and its relationship to intersectionality.

Dr. Sannisha Dale of University of Miami reported on the deliberations of **Workgroup 2: Identify opportunities, within, across, and beyond EHE to monitor intersectional stigma and discrimination**. Attendees asked Dr. Dale about measurement and recruitment challenges. Dr. Dale clarified that the Workgroup sought to measure both enacted and anticipated stigma, and recommended the development of a toolkit with measures that were both brief and adequately captured relevant information. Dr. Dale also addressed recruitment in her own research, suggesting that recruitment is less challenging if there is community engagement from the beginning of the research process.

Dr. Maria Amelia Veras of Faculdade de Ciências Médicas da Santa Casa de São Paulo and Dr. Sheri Lippman of University of California, San Francisco reported on the deliberations of **Workgroup 3: Highlight the evidence-base of intersectional stigma-reduction interventions**. Attendees asked about the implementation of interventions within communities or social networks, in religious communities and similar complex institutions, and across clinical settings. Dr. Lippman said that the Workgroup did not conduct a comprehensive review of all interventions, and they hope to capture more information about those populations in the future. Dr. Veras added that intervention research should include not only community members and their specific experiences, but also members of institutions, such as healthcare providers. Dr. Vera talked about her research in Brazil, which looked at a political and social environment that was similar in complexity and impact as other large institutions.

Dr. Victoria Frye and Dr. David Matthews of City University of New York reported on the deliberations of **Workgroup 4: Integrate and tailor intersectional interventions to advance EHE and improve HIV prevention and treatment outcomes**. Attendees asked about recruitment and retention in clinical trials. Dr. Frye responded that authentic engagement with communities and their movements would establish the consistency and trust needed to overcome recruitment challenges. Attendees also asked about embedding a focus on structural levels and community engagement across NIH. Dr. Frye suggested that the Workshop report will aid in this action, with the hope that future RFAs will call for a co-leadership with both scientific and community leaders.

## Conclusion

Although the concept of HIV-related intersectional stigma is complex, Workshop participants generally were in consensus about future directions for reducing stigma and improving HIV prevention and care. They established that intersectional stigma is best represented by a multilevel model that includes systemic measurements. They also agreed that inclusion of community partners is key to a successful research and implementation process, and that interventions should expand their reach towards positive attributes such as resilience and empowerment. To have the greatest impact, interventions and measures should consider intrapersonal, interpersonal, community, and structural level factors. There are also opportunities for creative approaches in integrating lived experiences and embedding interventions within art and culture. The way forward should include increased training, capacity building, and leadership to ensure that the important work achieved through this Workshop continues its momentum.