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Decreasing HIV Stigmatization for Care of Young Men of Color Who Have Sex with Men

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Alethea A. Miller

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Walden University
2020

Abstract

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by

Alethea A. Miller

MSN, Walden University 2012

ADN, Delaware Technical & Community College, 2007

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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February 2020

Abstract

HIV-related stigma from healthcare provider attitudes, beliefs, perceptions, or misconceptions has been a barrier to healthcare delivery. This project was conducted to examine whether an HIV-related stigma education provided to healthcare clinic staff with a focus on advance practice registered nurses can improve knowledge and empathy toward young men of color who have sex with men (MSM), which can lead to improved overall quality of healthcare through increased health behaviors and retention in care. An educational intervention was conducted utilizing a blended-learning environment focused on social cognitive theory to influence social behavior change among healthcare professionals, increasing their exposure, knowledge, and awareness of HIV-related stigma. A self-administered pretest and posttest, online videos, and PowerPoint presentations were utilized to measure drivers of HIV-related stigma and assess knowledge growth post-intervention of clinic staff. A total of 7 of 15 clinic staff voluntarily participated in the full educational intervention. The greatest growth was in dressing wounds and drawing blood, with pre-intervention results indicating that 14.2% were worried, 28.5% were a little worried, and 42.8% were not worried and post-intervention results showing that 0% were worried, 14.2 were a little worried, and 71.4% were not worried. Addressing healthcare provider HIV-related stigma provides social change by increasing access and care for at-risk young MSM of color supporting national HIV prevention strategies and goals.

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Dedication

I would like to dedicate this project to my wonderfully amazing and supportive children, Harlan (B.J.), Marcus, and Renicia, my grandchildren, Raven, Rayne, Christian, Chloe, Ryan, and Bree for reminding me of my strength and greatness even when I did not see it. Additionally, I dedicate this project in loving memory of my grandson Rhavon, my brother Leroi Mack III, and best friends Kenneth Burton and Alisa Johnson, whose presence continually lifted me during those moments I considered giving up and whispering words of encouragement that kept me always moving forward.

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Section 1: Nature of the Problem

Introduction

HIV attacks and destroys the body's immune system, leaving it unable to fight off diseases and infections and potentially leading to AIDS (Centers for Disease Control and Prevention [CDC], 2019a). HIV has the three identified stages: acute HIV infection, clinical latency, and AIDS (CDC, 2019a). More than 1 million people have been estimated to be infected with HIV, with the largest number living in urban areas of the United States (Krebs et al., 2019). In 2017, men who have sex with men (MSM) accounted for nearly 70% of all HIV diagnoses in the United States, and young MSM accounted for more than 80% of all new infections (CDC, 2019a).

Although there has been much research, currently there is no cure for HIV or AIDS (CDC, 2019a). Treatment for HIV focuses on antiretroviral therapy (ART), a medication used to lower the viral load thereby reducing the amount of the virus circulating within the blood to reach undetectable levels (CDC, 2019a). If properly managed, people living with HIV who sustain undetectable viral loads can live a long healthy life comparable to those without the disease (CDC, 2019a; Freeman et al., 2017). Thus, it is important to identify individuals who already are infected or who are potentially at-risk of becoming HIV infected (Yi et al., 2015). For instance, HIV testing increases awareness of HIV status and reduces the risk of transmission (Bond et al., 2015), and getting diagnosed can lead to early treatment to slow down or avert progression of the disease (CDC, 2019a). Prevention strategies that include scalable multi-level interventions such as pre-exposure prophylaxis (PrEP), condom distribution,

HIV and sexually transmitted infection testing and treatment, and linkage-to-care combined with stigma reducing education and activities targeting young MSM of color offer the most comprehensive approach to addressing the HIV epidemic (National Alliance of State & Territorial AIDS Directors [NASTAD], 2018).

As part of addressing HIV, there are cultural and social factors related to stigmatization that place MSM of color at increased risk for HIV infection, who are disproportionately impacted by HIV (Bogart et al., 2017). Social stigma precipitates a decrease in self-disclosure and a willingness to engage in HIV prevention services (Lindinger-Sternart, 2015; Stockton, Giger, & Nyblade, 2018). Stigmatization may be layered, where devalued vulnerabilities are combined with social characteristics that include religion, culture, gender roles, social taboos, lack of awareness or knowledge, and societal perceptions (Rogers et al., 2014). Layered stigma is an overlapping of multiple socially devalued characteristics found to be common among individuals or groups (Stahlman et al., 2017). For example, characteristics or attitudes of healthcare providers that may overlap include HIV infection, irrational fears of transmission by uninfected individuals, attributing blame to those infected due to behaviors that placed them at-risk, and stereotypes related to race or gender, illicit or injection drug use, or sexual orientation (Nyblade et al., 2018). Layered stigmatization negatively impacts disease prevention, detection, treatment, and linkage to healthcare services for young MSM who are of color and at-risk of acquiring the HIV infection (Stahlman et al., 2017).

The burden of stigma can exceed the burden of the disease, impacting overall quality of life (Rao et al., 2019). Patients encountering HIV-related stigma from

healthcare providers has resulted in a reduction of preventive services such as condom use, PrEP uptake, HIV testing, linkage-to-care, medication adherence, and retention in care (Geter, Herron, & Sutton, 2018). Worldwide, HIV-related stigma and discrimination has been linked to low numbers of testing and poor treatment adherence when healthcare facilities are the source of the stigma or discrimination (Gwadz et al., 2018; Srithanaviboonchai et al., 2017). Therefore, it is necessary for healthcare providers to support interventions that address HIV-related stigma and discrimination (Feyissa, Lockwood, Woldie, & Munn, 2019).

Addressing stigma within healthcare is significant because stigma can prevent timely diagnoses and treatment for already disproportionately affected and marginalized populations (Nyblade et al., 2018; Nyblade et al., 2019). This can be done by engaging healthcare staff within community settings and providing HIV-related stigma education to ensure services and interventions are stigma reducing and provider-centered (Geter et al., 2018). Additionally, because healthcare facilities help identify other diseases that exposes patients to multi-layered health condition stigma such as STI-related stigma, a multi-level approach that focuses on both the healthcare staff (individual level) and the healthcare facility policies and environment (structural level) can address stigmatization in healthcare settings (Nyblade et al., 2019).

This Doctor of Nursing Practice (DNP) project provides a staff education intervention within a designated healthcare facility providing HIV stigma-free education and promoting awareness among public health clinic staff to include advanced practice registered nurses (APRNs). Therefore, it is essential to address HIV-related stigma

awareness, unfounded fear of transmission, and attitudes of healthcare providers through training based on social cognitive theory (SCT) principles (Nyblade et al., 2018). Training can include all staff APRNs, disease investigation specialists (DIS), administrative staff, support staff, and clinic managers due to their proximity to patients entering the healthcare facility (Jain, Carr, & Nyblade, 2015), which in this project involved APRNs taking the lead as mentors within the healthcare facility promoting stigma and discrimination reduction beyond the staff education project. Initiatives to reduce the stigma and discrimination need to be continuous to successfully work toward the goal of elimination (Ikeda, Nyblade, Srithanaviboonchai, & Agins, 2019). Because individual level and structural levels of stigma are rooted in behavior, it is important that interventions have multiple facets, are aware of change, and target both the individual and the healthcare facility (Ikeda et al., 2019). This DNP project aligns with Walden University's mission of social change within a marginalized population that are disproportionately at-risk of HIV infection and HIV-related comorbidities (CDC, 2019a).

Problem Statement

HIV is chronic and poses the greatest risk for MSM (de Fatima Cordeiro Dutra, Cordova, & Avant, 2018). Young HIV infection rates among Black/African American men are higher than any other racial group (Scott et al., 2014), with Black/African-American MSM comprising over three-fourths of all new HIV diagnoses in the United States (Cooke et al., 2017). With an estimate of nearly 1.1 million individuals in the United States infected with HIV, data for 2014 indicated that nearly three-fourths of all new HIV infections annually were attributed to MSM (CDC, 2018). Young,

Black/African American MSM between the ages of 13-24 years have been disproportionately impacted by new diagnoses compared to other race/ethnicities, sex, or age whose numbers have been decreasing (CDC, 2018). By the end of 2016 more than 225,000 African-American MSM were estimated to be infected with HIV, and 2,500 died as a result (CDC, 2019a). Of the almost 40,000 new HIV diagnoses in 2017, 37% were African-American MSM (CDC, 2019a). Thus, the CDC awarded a significant amount of funding in 2017 to various community-based organizations across the country with a focus of providing HIV testing to young MSM of color (CDC, 2019a). However, HIV-related stigma and discrimination still places all MSM at risk for comorbidities and impacts health seeking behavior (CDC, 2019a). Levels of PrEP treatment for Hispanic/Latino and Black/African American MSM is low among both groups despite it being highly effective in preventing their acquiring or transmitting HIV infection (CDC, 2019a).

Disease-associated stigma affects health care equality, especially among already disempowered individuals (Elafros et al., 2018). The CDC (2018) noted that homophobia, stigma, and discrimination potentially place MSM at greater risk for comorbidities such as physical and mental health issues that further hinder access to quality health care services. Stigmatization is marked by shame, disgrace or disapproval, causing individuals to be shun or rejected by others (Gagare, Inuwa, Babatunji, & Njodi, 2017). Stigmatization can be based on an individual's race or ethnicity, age, gender, sexual orientation, socioeconomic status, culture, religion, literacy, use of drugs, sexual behaviors, a medical disease, or mental health condition (Martin, 2015). HIV-stigma has

increasingly been a barrier to healthcare delivery and utilization, largely due to community and healthcare provider attitudes, beliefs, perceptions, or misconceptions that negatively impact health behaviors of young MSM of color (Batey et al., 2016). This behavior impacts the prevention, treatment, and management of HIV (Batey et al., 2016). Stigmatizing behaviors from healthcare providers include using stigmatizing language, denial of medical services, and even unnecessary precautionary measures (Geter et al., 2018).

The role of APRNs in HIV care is significant for preventive and management efforts (Rouleau et al., 2019). Advance practice nursing frameworks serve a significant function in applying evidence-based interventions to real-world issues due to their varied level of practice and policy-level knowledge (Nelson et al., 2018). The APRN's role is remarkable in reducing gaps in access to HIV-related care among marginalized populations at-risk for HIV infection (Nelson et al., 2018).

Purpose Statement

Community and healthcare provider attitudes, beliefs, perceptions, or misconceptions have increasingly impacted health behaviors of young MSM of color (Batey et al., 2016). There have been low numbers of testing for HIV, PrEP uptake, medication adherence, linkage-to-care, HIV care continuum, and the use of condoms associated with HIV stigma (Geter et al., 2018). Because healthcare providers with limited HIV stigma training are more likely to exhibit stigmatizing behaviors toward patients (Geter et al., 2018), the purpose of this DNP project was to determine whether an HIV education initiative provided to healthcare facility staff and APRNs could increase

knowledge related to the negative impact stigmatization has on the prevention and treatment of HIV, especially among young MSM of color being cared for by public health clinic staff. I conducted this initiative in a public health clinic in the northeast United States.

Education drives understanding and awareness of stigmatization that bridges the gap between knowledge and behavior of clinicians to influence public health practice (Jain et al., 2015; Nyblade et al., 2018). Activities to address stigma around disease, fear of transmission, and negative attitudes toward young MSM of color focuses on development of stigma-free education and training that supports the promotion of learning, creation of empathy, and building of self-efficacy skills to affect a change in behavior of healthcare facility staff towards young MSM of color (Nyblade et al., 2018). Nurses with HIV-related stigma self-awareness can be leaders and role models to nurses and clinic staff in reducing stigma (Lewis, 2011). Increasing knowledge and self-awareness empowers APRNs to function as leaders, mentors, and change agents in supporting the elimination of HIV-related stigma and discrimination that impacts health outcomes for marginalized groups within multifaceted communities of color (Lewis, 2011; Nelson et al., 2018; Walden University, 2017).

Nature of the Doctoral Project

This evidence-based staff education project was a blended-learning intervention piloted within a public health clinic in the northeast United States. A thorough review of the literature utilizing various search engines and databases, such as the Cumulative Index of Nursing and Allied Health Literature (CINAHL), ProQuest, Medline, Cochrane,

PubMed, and Google Scholar, was conducted to ensure current practice standards were used for this project. Clinical practice guidelines from professional organizations and data from government agencies were also explored. SCT provided the theoretical framework. Planning, implementation, and evaluation of the project was guided by the Walden University, DNP project Manual for Staff Education.

The main goal of this project was to increase clinic staff and APRN knowledge and awareness of HIV-related stigma and its impact on HIV prevention and treatment. The evidence-based, blended-learning curriculum included HIV 101 education that addressed transmission of HIV, PrEP education related to stigma, case studies and videos on stigma, national and local HIV statistical data for young MSM of color, and HIV-related posters and resources for HIV screening provided by the government health department's HIV prevention and surveillance program staff. Content experts reviewed the curriculum prior to implementation of the pilot program. Participants signed the consent for anonymous pre- and post-participation questionnaires used to assess the impact of the initiative on participant knowledge and awareness. Additionally, the administrator of the public health clinic where the project was implemented signed the site agreement, and Walden University Institutional Review Board (IRB) approval was obtained prior to project implementation.

Significance

This DNP project provides staff education that supports APRNs in leading and sustaining interventions post-implementation for clinic staff to build support for HIV-related stigma-free care to young MSM of color to increase HIV testing, strengthening of

health seeking behaviors through education, self-awareness, and knowledge. HIV-related stigma affects access, uptake, and adherence to HIV prevention and management efforts, but interventions can create a space for behavior change among healthcare providers (Nyblade et al., 2018). Creating a space that is free of stigma and discrimination requires education focused on all staff within the facility who come in contact with those seeking services from administrative to APRNs (Jain et al., 2015; Nyblade et al., 2018). This project may improve prevention, identification, treatment, and management of those most at-risk for or acquiring HIV infection through a blended-learning approach that includes the increase of education, upscaling of preventive measures, policy change, and developing an environment free of HIV-related stigma and discrimination (Jain et al., 2105; Nyblade et al., 2018).

Although healthcare providers are expected to provide support for those who receive their care, research has shown many present stigma (Feyissa, Lockwood, Woldie, & Munn, 2019). This stigma can include negligence, breaches of confidentiality, differential treatment, and baseless referrals that further comprise critical care and support (Feyissa et al., 2019). For this reason, educating staff is important to address stigma and discrimination within a healthcare facility (Nyblade et al, 2018). Further, individuals visiting public health clinics are diverse and interact with a diverse workforce, making it important to have a multidisciplinary approach targeting all staff with HIV-related stigma and discrimination education (Jain et al., 2015; Nyblade et al., 2018).

The education was focused on the importance of addressing HIV-related stigma attitudes, perceptions, and misconceptions held by healthcare providers and how it impacts disclosure, prevention, linkage-to-care, medication adherence, treatment of young MSM of color (Nelson et al., 2018; Nyblade et al., 2018). Research has shown the three key drivers of HIV-related stigma for healthcare providers consist of fears and misconceptions around HIV transmission, negative attitudes toward marginalized groups at-risk of acquiring HIV or those HIV-positive, and a lack of knowledge and awareness of stigma and its effects (Nyblade et al., 2018). As such, the curriculum for this educational intervention included universal precaution and infection control, knowledge of stigma and methods to reduce stigma, the importance of behavior change, HIV preventive care services and delivery, and experiences related to HIV-stigma of those at-risk for or living with HIV (Jain et al., 2015; Nyblade et al., 2018).

Summary

HIV-related stigma is a barrier to testing and treatment of HIV, particularly for young MSM (CDC, 2019), which can further impact health seeking behaviors of young MSM of color (Geter et al., 2018). Stigma from providers within healthcare settings is the most detrimental (Nyblade et al., 2018). Therefore, it is important to address HIV-related stigma and discrimination within healthcare to support HIV testing, prevention, and treatment for this at-risk population (CDC, 2019a; Nyblade et al., 2018). This project addressed this issue with a staff education project.

Section 2: Background and Context

Introduction

HIV is a chronic disease impacting nearly 40 million people worldwide with more than 1 million living the United States within urban areas (Krebs et al., 2019; Oskouie, Kashefi, Rafii, & Gouya, 2017). By attacking the immune system of infected individuals, the infection can result in significant rates of HIV-related comorbidities such as pulmonary tuberculosis, Kaposi's sarcoma, progressive multifocal leukoencephalopathy, Cryptococcal meningitis, and potentially AIDS (CDC, 2019a). Because of advancements in HIV research and treatment, individuals living with HIV maintaining an undetectable viral load can live long healthy and productive lives (CDC, 2019a). However, it is important to identify those most at-risk for HIV to prevent new infections, transmission of HIV to noninfected individuals, and support of medication adherence for those already in treatment (Scott et al., 2014).

Stigma and discrimination play a significant role in efforts to address health outcomes for a population disproportionately impacted by HIV, young MSM of color (Jain et al., 2015). For 2010-1016, HIV diagnoses among Black/African American MSM between the ages of 25-34 rose by nearly 40% (CDC, 2019a). Cultural and social factors related to stigmatization place MSM of color at increased risk for HIV infection (Nelson et al., 2018). HIV stigma can then be a barrier to the care of these individuals such as nurses double-gloving, unnecessarily using masks, and refusing or avoiding collection of blood specimens for fear of becoming infected with HIV (Reyes-Estrada et al., 2018).

The practice-focused question for this DNP project was whether an HIV-related stigma education program utilizing a blended-learning curriculum for all healthcare staff—with APRNs leading sustainment of the intervention long term as "Stigma Champions"—piloted in one of the six public health clinics in northeastern United States, improves healthcare staff and APRN knowledge, attitudes, and perceptions to provide HIV-related anti-stigma and anti-discrimination healthcare to young MSM of color who are at-risk of contracting HIV infections. This education was aimed to help increase prevention strategies such as HIV testing and PrEP treatment as well as increase HIV treatment adherence. This can be done by developing stigma and discrimination free environments to increase and sustain prevention interventions and promote harm-reduction strategies.

Concepts, Models, and Theories

SCT was the conceptual framework for this DNP project. Supporting both disease prevention and health promotion, SCT is a learning theory integrated with psychology and developed by Albert Bandura in 1986 (Bandura, 1998). The theory explains how an individual's experiences, behavior of others, and environmental factors shape individual health behaviors (Bandura, 1998; Nyblade et al., 2018). The focus of Bandura's theory is on observational learning and modeling and self-efficacy's influence on the development of behavior (Bandura, 1998). SCT is grounded in strategies that are focused on behavior change interventions (Nyblade et al., 2018). Bandura (2004) suggested that it is knowledge of an individual's habits around lifestyle and personal beliefs of self-efficacy that leads to change, thereby affecting an individual's health.

This education project was provided to APRNs and clinic staff as a method to increase exposure, knowledge, and awareness of HIV-related stigma and discrimination. Education encourages multi-level stigma change, prompting self-efficacy and resulting in a reduction of misconceptions, perceptions, and prejudices affecting young MSM of color at-risk for or already infected with HIV within a health care setting (Jain et al., 2015; Nyblade et al., 2018). SCT addressed multi-layered stigma and its influence on HIV testing and health behaviors among young MSM of color when health care providers are the source of the stigma or discrimination perceived (Jain et al., 2015; Nyblade et al., 2018). The use of SCT also supports efforts to implement interventions that focuses on individual cognitive behaviors, environment, policy changes, and education related to reduce HIV-related stigma (Nyblade et al., 2018). Behavior change among healthcare providers might influence changes in behavior of individuals seeking care by promoting inclusion, building self-efficacy, and reducing perceptions and misconceptions that impact health seeking behaviors to include HIV testing and initiation of PrEP treatment as harm reduction strategies (Nelson et al., 2018; Nyblade et al., 2018).

Relevance to Nursing Practice

Health seeking attitudes become predictors of health behaviors (Nyblade et al., 2018). Layered stigmatization influences disease prevention, detection, treatment, and use of healthcare services for young MSM of color at-risk of acquiring or transmitting HIV infection (Bogart et al., 2017; Rogers et al., 2014; Stahlman et al., 2017). The prevalence and incidence rates for young MSM of color is disproportionately higher than any other group of MSM in the United States. (CDC, 2019a; Scott et al., 2014). HIV-

related stigma is a barrier to testing, medication adherence, and health service utilization that impacts morbidity and mortality prevalence and incidence (Oskouie et al., 2017; Nyblade et al., 2018). However, expanding access to evidence-based HIV prevention programs can improve racial and sexual disparities by providing services geared toward MSM (CDC, 2018). The CDC has placed a focus on increasing PrEP treatment among Black/African-American and Hispanic/Latino due to the high prevalence of HIV infection in both groups (Finlayson et al., 2019).

APRNs have a significant role in the increase of HIV testing and health promotion behaviors among young MSM to decrease associated rates of HIV morbidity and mortality, improve outcomes for an already marginalized population, and provide awareness and education to healthcare providers through sustained behavioral changes (Nelson et al., 2018). For example, APRNs in the public health clinic are the primary healthcare clinicians who provide direct care to patients seeking services, thereby making it feasible for them to integrate the clinical management of HIV PrEP into their role (Nelson et al., 2018). PrEP is a form of an approved preventive medication that prevents the transmission of HIV with a more than 95% rate of efficacy; however, there is a low number of African-American MSM who use it even though they are diagnosed with HIV infection 8 times the rate of White MSM (Nelson et al., 2018). Thus, increasing PrEP use can help end the HIV epidemic by reducing new HIV infections, which places APRNs in a position to contribute to meeting the U.S. Department of Health and Human Services strategic initiative to end the HIV Epidemic in the United States by reducing new HIV infections by 90% between 2020-2030 (Finlayson et al., 2019; Nelson et al., 2018).

APRNs positively influence best practice and evidence therefore making APRNs uniquely positioned to influence directly the practice of healthcare staff to provide counseling, support, prevention services, and linkage-to-care that threatens to disrupt health care delivery (Nelson et al., 2018; Reyes-Estrada, 2018). As such, utilizing APRNs who already provide an array of services to this population serve as an effective resource in providing empathetic, nonjudgmental, nondiscriminatory, and stigma-free care to a population at-risk for transmission of HIV infection (Nyblade et al., 2018). Scott et al. (2018) suggested literature has shown although reduction of new HIV infections is a priority for public health most notably for MSM of color, there needs to be adoption of PrEP to meet goal objectives. APRNs have the knowledge to function at clinical levels of expertise that support positive patient outcomes (White & Zaccagnini, 2014).

Those best suited to close this gap in access would be APRNs because of the population they serve, those most vulnerable to HIV infection (Nelson et al., 2018; Scott et al., 2018). The additional role held by APRNs are as primary health educators for their patients that aides in behavioural change interventions for their patients providing a solid basis of knowledge to support decision-making amongst their vulnerable populations at-risk for acquiring or transmitting HIV infection (Nelson et al., 2018). Addressing and decreasing healthcare provider HIV-related stigma has the potential of increasing access and care for those at-risk for HIV infection approaching national HIV prevention goals to reduce stigma (Geter et al., 2018).

Local Background and Context

Delaware is a small Mid-Atlantic Coast State bordered by Pennsylvania, New Jersey, and Maryland. The State of Delaware reported a population of 961,939 in 2017 with a racial breakout of more than two-thirds white, one-quarter African American/black, and slightly over a one-tenth combination of Latino/Hispanic and Asian (United States Department of Commerce, 2017). With its combination of urban, suburban, and rural areas throughout its three counties the state offers culture rich in diversity. Public health clinics positioned throughout the state provide services to a swathe of diverse individuals, communities, cultures, and practices that focus on prevention efforts as it relates to services that include HIV testing and linkage-to-care for treatment.

The practice setting for this staff education project takes place within a public health clinic that provides such services as sexual reproductive health to include HIV, STI, and viral hepatitis screening, testing, and linkage-to-care for treatment. Six public health clinics span the state with clinic program managers providing facility-leveled supervision of staff and services provided. The chosen practice setting for this staff education pilot maintains one or more APRNs, registered nurses, DIS, administration specialists, and support staff similar to the other five clinics within the state. Providers with limited recent HIV stigma training were more likely to exhibit stigmatizing behaviors toward patients causing a decrease in HIV testing and prevention (Geter et al., 2018). To date there has not been any formal trainings for APRNs, registered nurses, DIS, administrative specialists, or support staff related to stigma and most in particular

HIV-related and layered stigma. Nursing education is limited to that provided through the division that includes annual trainings but few focused-on HIV specific education for nurses and DIS staff while administrative specialists receive no HIV-related education. Presently, preventive services for HIV are limited to testing but PrEP treatment is not provided with APRNs rarely linking patients to care to due not having PrEP specific education. Geter et al. (2018) proposed the implementation of education, HIV policies, and effective procedures support HIV treatment adherence that improve outcomes for HIV infected individuals.

Role of the DNP Student

The DNP prepares and positions the student for a role in leadership and clinical practice as an advance practice nurse capable of designing, implementing, and evaluating programs, influencing health care policies, and effecting evidence-based practice change by conducting and utilizing established research based upon grounded theory and health promotion models (Edwards, Coddington, Erler, & Kirkpatrick, 2018). Advance nursing practice is synonymous with evidence-based practice and serves as the framework that allows nurses to translate evidence-based research into practice to evaluate and analyze practice data (White & Zaccagnini, 2014). Because of the role held as a content expert and consultant for viral hepatitis, an infectious disease that sometimes results in co-infection, HIV was a likely choice for this DNP project. This DNP student will function in a role of leadership and facilitator of this staff education project.

Role of the Project Team

The project team identified as content experts include the HIV prevention and surveillance program staff who have agreed to review the education pilot program content, pre and post questionnaires as well as, aid in the planning and implementation of this staff education project. Clinic staff include the APRNs as the primary participant and the clinic manager, DIS, administrative specialists, and support staff who will serve as secondary participants.

Summary

There have been great advances in HIV prevention interventions and treatment for a chronic disease associated with increased risks of multiple comorbidities but with treatment can be effectively managed (CDC, 2019a). With nearly 40,000 HIV infections estimated annually it is important to have adequate initiatives in place to encourage increased testing and treatment adherence to sustain undetectable viral loads to reduce the risk of transmission (CDC, 2019a). Nyblade et al. (2018) suggested stigma is the most common barrier to HIV testing among MSM of color who are fearful of being diagnosed as HIV-positive. The fear of an HIV-positive results impedes preventive services and has been shown to be a major link to delayed and poor testing numbers (Scott et al., 2014). The presence of social stigma related to HIV precipitates a decrease in self-disclosure and willingness to engage in HIV prevention services made far more serious and consequential when the source of the stigma and discrimination is clinicians within a health care setting (Lindinger-Sternart, 2015). In an effort to address the knowledge gap of clinic staff and APRNs education will be provided utilizing a blended-learning

curriculum that will be further detailed in the next section where supporting evidence will

be provided.

Section 3: Collection and Analysis of Evidence

Introduction

HIV-related stigma is a barrier to HIV testing and treatment among young MSM of color (CDC, 2019a), affecting HIV prevention, identification, and treatment adherence (Batey et al., 2016). Despite the success of ART, the mortality rate for HIV-positive Black/African-American and Hispanic/Latino MSM are greater than that of all other nationalities (CDC, 2019a). In 2016, there were just under 1 million individuals in the United States infected with HIV, with an estimated 15% not realizing they were infected (CDC, 2019; Chou, Dana, Grusing, & Bougatsos, 2019). However, inadequate HIV-related stigma and discrimination education and self-awareness about HIV infection control and transmission, preconceived ideas and stereotypes, and negative attitudes toward vulnerable populations impedes HIV testing, diagnosis, linkage-to-care, and treatment affecting young MSM of color (Geter et al., 2018). Thus, it is important to address healthcare provider fears of transmission and stigma to reduce HIV stigma, help increase PrEP treatment, and develop and reinforce policies around HIV and stigma (Nyblade et al., 2018). Having HIV policies has led to low incidences of providers exhibiting stigma and discrimination related to HIV (Geter et al., 2018).

Practice Focused Question

The purpose of this DNP project was to provide a staff education project that provides strategies to increase interventions to promote HIV prevention, identification, detection, and management for individuals at-risk for or already infected with HIV by changing the behavior of healthcare staff through knowledge attainment (Geter et al.,

2018; Nyblade et al., 2018). If healthcare staff and APRNs are more aware of and understand the stigma felt by their patient, they are more likely to buy into methods to address the stigma and the role they play in its manifestation (Nyblade et al., 2018). As such, the practice-focused question for this DNP project was aimed at determining whether an HIV-related stigma education program at a clinic in a northeast state utilizing a blended-learning curriculum for all healthcare staff could improve healthcare staff and APRN knowledge, attitudes, and perceptions to provide HIV related anti-stigma and anti-discrimination healthcare to young MSM of color who are at-risk of contracting HIV infections.

The goal was to have APRNs lead the sustainment of reducing stigmatization, increasing the use of prevention strategies such as HIV testing, PrEP treatment in addition to HIV treatment adherence by developing stigma and discrimination free environment. An outcome for this project includes greater self-efficacy and understanding that prompts behavior change among healthcare care providers, leading to addressing HIV-related stigma and discrimination toward an already marginalized group of individuals (Nyblade et al., 2018).

Sources of Evidence

A literature review was conducted with sources of evidence including online databases such as CINAHL, ProQuest, Medline, PubMed, Cochrane clinical trials and systematic reviews, and Google Scholar. Clinical practice guidelines from professional organizations and data from government agencies were also explored, and HIV stigma toolkits created by the National Alliance of State & Territorial AIDS Directors and the

Health Policy Project were reviewed. Additionally, aggregate data were reviewed from an HIV program 2019 surveillance report and survey that included de-identified basic demographic characteristics of participants, medical staff, age, race, education, and perceptions as factors associated with stigma affecting young MSM of color. Keywords in the database search included *African American/Black, health care provider stigma, HIV/AIDS, HIV and men of color, HIV-related discrimination, HIV-related stigma, Latino/Hispanic, layered stigma, men who have sex with men, self-disclosure, social discrimination*, and *stigma*.

The literature review yielded more than 100 primary sources of relevant literature focused on publication years 2014-2019 with the exception of approximately three articles that were necessary to provide additional foundational information. The literature reviewed supported the implementation of HIV-related anti-stigma education for healthcare staff as a method to reduce stigma and discrimination towards young MSM of color (Frye et al., 2017). It is important that healthcare providers are educated on the significance of providing anti-stigma care to a population disproportionately associated with negative outcomes to better address the issue of HIV-related stigma and discrimination in healthcare settings (Jain et al., 2015; Nyblade et al., 2018). The articles chosen for this DNP project were focused on those identifying and supporting the implementation of programs driven toward education for healthcare providers to better understand and support strategies to address the misconceptions, stereotypes, and prejudices affecting this MSM of color who are at-risk for acquiring or transmission of HIV infection (Jain et al., 2015; Herbst et al., 2014).

Relevant Literature

The literature indicated that stigma was a significant barrier to HIV testing and care. MSM are the most stigmatized group affected by HIV and AIDS (Rogers et al., 2014). For example, Wei et al. (2014) conducted focus group discussions with 49 MSM, who identified barriers such as HIV-related stigma, questions around death due to not having a cure for HIV, perceptions involving HIV risk and threats, testing sites, breaches in confidentiality by healthcare providers, fear of testing positive for HIV, MSM-related stigma, and costs for testing. The results indicated that there is a need for more educational and promotional interventions related to MSM (Wei et al., 2014). Healthcare staff lack education involving HIV-related care of MSM and HIV-infected individuals. Further, higher stigma can be attributed to nonclinical staff compared to clinical staff, emphasizing the need to prioritize training (Rogers et al., 2014). It is also important to establish an environment that is stigma free to increase the number of MSM within the facility (Rogers et al., 2014).

The reduction of HIV-related stigma requires development of providers who are knowledgeable of HIV and aware of stigma, leading to providing nonstigmatized care to their young MSM patients of color (Jain et al., 2015; Nyblade et al., 2018). The strengthening of prevention programs for individuals at-risk for new HIV infections, and advancement of HIV care continuum to sustain low viral loads supports a healthy quality of life (Jain et al., 2015; Nyblade et al., 2018). Addressing HIV-related stigma within healthcare settings requires a triple level approach to increasing stigma awareness among healthcare providers that includes the adoption of knowledge on HIV transmission, self-

reflection of healthcare providers, and an understanding that there is no link to HIV and behaviors that are viewed as immoral or abhorrent (Nyblade et al., 2018). Providers who increase their awareness and bridge the gaps in knowledge, attitudes, and misconceptions related to HIV stigma and MSM of color can provide care that increases awareness of risky behaviors, health-promotion behaviors, and self-efficacy for a population at-risk of acquiring HIV or not adhering to treatment for HIV (Herbst et al., 2014).

Stigma and discrimination have a profound effect on young Black/African-American MSM of color who are at-risk or already infected with HIV as they move along the HIV care continuum to include prevention, care, and treatment adherence (Hightow-Weidman et al., 2017). For instance, Black/African-American and Hispanic/Latino MSM experience low uptake of HIV ART due to poor levels of engagement that lead to poor health outcomes (Freeman et al., 2017). However, adherence to treatment plays a key role in HIV prevention, clinical practice, and research (NASTAD, 2018). For example, Hightow-Weidman et al. (2017) conducted a randomized control trial of online interventions with 465 young Black/African-American MSM between 18-30 years old, exploring predictors of engagement in care, missed visits, ART uptake, self-reported adherence, and viral suppression (Hightow-Weidman et al., 2017). The results showed that there were multiple barriers at multiple levels suggesting the need for methods to engage young Black/African-American MSM into care to be able to attain sustained virologic suppression (Hightow-Weidman et al., 2017).

Nurses with HIV-related stigma self-awareness are significant in addressing and reducing both stigma and discrimination by serving as leaders and role models to other

nurses and providing anti-stigma education to the community-at-large (Lewis, 2011). Batey et al (2016) conducted an intervention that included healthcare providers to determine if implementing a stigma-reduction intervention within a healthcare setting could be successful. Recognizing health provider behaviors can adversely affect health outcomes related to HIV stigma and discrimination leads to poor outcomes for those within marginalized populations (Batey et al., 2016). Results based upon a pretest and posttest utilizing qualitative content analysis indicated the intervention was successful as it provided a prediction that such an intervention was feasible and effective (Batey et al, 2016).

Frain (2017) conducted a study to determine the impact of incorporating into undergraduate nursing program curriculum HIV-related stigma to gauge knowledge and attitudes of nursing students towards HIV infected individuals before and after an intervention. Utilizing a quantitative descriptive pretest and posttest design the results showed scores were statistically significant based on the posttest ($p = .000$) following the HIV/AIDS intervention showing an improvement overall for the nursing students (Frain, 2017). The recommendation was to have HIV education permanently incorporated into the curriculum (Frain, 2017). It is important to note results showed there to be a link between a decrease in HIV/AIDS education in nursing programs as the perception of the epidemic began to wane (Frain, 2017).

Analysis and Synthesis

Geter et al. (2018) identified three factors that influence stigma in healthcare settings: negative attitudes, beliefs, and behaviors of healthcare providers, staff fears of

transmission limiting the quality of care provided to patients, and the level of education or training provided to healthcare clinicians on stigma and its impact. This staff education project will address these three factors by introducing strategies to reduce and improve HIV-related stigma towards young MSM of color within a designated public health clinic.

The hope of this DNP project will be to increase knowledge and self-awareness in hope of reducing or eliminate barriers to improve health outcomes and quality of life for disproportionately affected young MSM of color (Nyblade et al., 2018). To meet this objective, the initial step includes approval from the formed DNP committee followed by approval from the Institutional Review Board (IRB) per Walden guidelines and as written in the Staff Education Project Manual for Doctor of Nursing Practice Scholarly Project. The purpose of the IRB is to ensure during the collection of data no harm occurs to participants and that measures are utilized to ensure the project is conducted in an ethical manner (Carr, Kidd, Fitzgerald, & Nyblade, 2015).

The healthcare setting for this staff education project pilot will take place at a designated public health clinic that provides sexual reproductive health services to adults that include STD screening, testing, and treatment as well as HIV and viral hepatitis screening, testing, and linkage-to-care. Because individuals visiting public health clinics are in contact with a range of various staff from the moment they walk through the door this will intervention will take a multidisciplinary approach with all staff receiving education (Jain et al., 2015; Nyblade et al., 2018). Therefore, public health staff participating in this staff education pilot include the clinic manager, three APRNs, one

registered nurse, five DIS, one medical records technician, and two administrative support staff. APRNs designated as the "Stigma Champions", will be the primary targets of this DNP project with the clinic manager and healthcare staff serving as secondary targets of this educational training. Preliminary engagement and buy-in was gained previously from receptive staff and as such, participation is voluntary with no expectation of compensation. Following the Walden University Manual for Staff Education clinic administration will sign the site agreement to cover participation in the designated public health clinic. Written consent will be obtained prior to the start of the piloted staff education project from the staff for their participation in completing anonymous questionnaires.

The plan is to address stigma within the healthcare setting beginning with a review of DPH clinic policies and protocols that guide the expectation of behavior and conduct of staff as it relates to stigma and discrimination (Jain et al., 2015; Nyblade et al., 2018). Prior to beginning the piloted intervention, there will be an assessment of staff that measures the extent and nature of the stigma and discrimination among staff that provided a baseline of information through completion of a self-administered Health Work Questionnaire, a quantitative 22-question pretest (Carr et al., 2015). To ensure anonymity the pretest will be secured in a locked box in a designated room for staff to place once completed. An additional questionnaire will be provided to collect data for triangulation through the clinic manager to determine if written guidelines have been established and are in place that protects and ensures patients are not subjected to discriminative practices within the identified healthcare facility (Jain et al., 2015).

Because the healthcare setting in which this staff education project is to be piloted takes place in a busy public health clinic a blended-learning environment will be utilized.

Once the anonymous pretests are completed, staff will then place their pretests in an envelope to be sealed and then placed in the secured box for safekeeping. Staff will then have access to online vignettes provided through the CDC that address HIV-related stigma and discrimination to include fears, attitudes, and healthcare setting barriers from the perspective of HIV infected individuals. The next step will be the implementation of the training component. Following the online portion of the intervention, a half-day training will be conducted on topics that include HIV-related stigma and discrimination attitudes, fears, and healthcare setting barriers, an HIV101 education, PrEP education related to stigma, facts on infection control measures, a refresher on confidentiality, review of case studies, and national and local HIV statistical data for young MSM of color. When the training component is complete staff will be provided with a 22-question posttest to measure the educational intervention through comparing the pretest to the posttests.

The last component of this intervention looks at methods to monitor and sustain progress with this intervention. The clinic will be provided with HIV-related posters and resources from the CDC's new HIV prevention campaign "Let's Stop HIV Together" to be displayed in the lobby, exam rooms, and hallways of the clinic to establish an anti-stigma environment. A six-month follow-up will be conducted to assess retention of knowledge and progress in creating a non-stigma and discrimination environment. This intervention will then become the model to be implemented in other public health clinics

leading to community-based organizations and other healthcare settings that screen, test, and provide treatment to young MSM of color at-risk or already infected with HIV.

To analyze the pretests and posttests, the information will be entered into a computerized software system such as the Statistical Package for the Social Sciences (SPSS) or Statistical Analysis System to be tabulated. The analyzed data will be compared for statistically significant improvement in knowledge. Throughout the process all data collected will be maintained in a secure, password protected location to ensure confidentiality and reliability. The data within the chosen statistical software will remain in the system for 10 years and destroyed at that end of the 10-year period. For the purpose of this project, due to time limitations, a six-month follow-up will be provided in the form of a recommendation to determine if the educational intervention was sustainable.

Summary

The experience of young MSM of color when they experience stigma and discrimination, whether perceived or actual, has the potential to affect their entire existence (Bogart et al., 2017). HIV-related stigma for young MSM of color propels them further towards marginalization that for some may be lethal (Bogart et al., 2017). The negative effects of HIV-related stigma towards young MSM impedes prevention efforts and treatment adherence (CDC, 2019a; Nyblade et al., 2018). Maulsby et al. (2014) identified a study that reported more than 30% of Black/African-American MSM have faced discrimination related to race while nearly 40% faced discrimination related to sexual orientation. As an effort to reduce HIV-related stigma to support the uptake of HIV testing and maintaining an HIV continuum of care, the use of a grounded theory of

behavior change will be the underpinning to improve outcomes for young MSM of color

(Jain et al., 2015; Nyblade et al., 2018). Most often stigma and discrimination is a

manifestation of cognitive behaviors that results in a limited uptake of testing, access to

care, and treatment adherence that leads to health disparities and poor outcomes (Nyblade

et al., 2018). The focus of interventions to reduce HIV-related stigma will be to increase

healthcare provider knowledge and awareness that serves to decrease negative attitudes

that inflict blame and shame upon an already marginalized group (Nyblade et al., 2018;

Nyblade et al., 2019). Further, it addresses the fears of healthcare providers related to

transmission will serve as an additional driver to introduce quality care and promote

health outcomes for this marginalized group (Nyblade et al., 2018). The next section will

provide findings to include the strengths and limitations of this DNP project as well as

recommendations to guide further interventions and research.

Section 4: Findings and Recommendations

Introduction

Healthcare delivery and utilization becomes compromised when healthcare provide attitudes, beliefs, perceptions, or misconceptions result in HIV-related stigma regarding young MSM of color (Batey et al., 2016). This DNP project addressed HIV-related stigma and discrimination toward young MSM of color within a healthcare facility to improve health outcomes for a population already at-risk for acquiring or transmitting HIV infection (Dong et al., 2018; Nyblade et al., 2019). The staff education project was aimed at increasing knowledge and awareness of HIV-related stigma and its impact on HIV prevention and treatment for clinic healthcare staff with a focus on APRNs to drive behavior change in attitudes and misconceptions that disrupt health seeking behaviors of young MSM of color (Nyblade et al., 2018). This evidenced-based DNP project utilized a framework of SCT focused on behavior change interventions to address gaps in care for a vulnerable population due to HIV stigma. The education provided to APRNs and clinic staff was a method to increase exposure, knowledge, and awareness of HIV-related stigma and discrimination, which the practice-focused question addressed. Reducing stigma can increase prevention strategies such as HIV testing and PrEP treatment as well as HIV treatment adherence.

Findings and Implications

This DNP project used a blended-learning curriculum to support staff education that included the viewing of videos, a pretest and posttest 22-question Health Worker Questionnaire (Appendix A) to collect quantitative data, and PowerPoint presentations

provided by staff from the HIV Prevention and Surveillance programs and me. As the team lead for this project, I conducted a literature review, gathered materials, established timeframes, created objectives and outcome criteria, researched questionnaires, and sought approval from the various entities to conduct this evidence-based project. Preparation for this DNP project educational intervention began the summer of 2019 and included engaging public health clinic and administrative leadership. A request to implement was placed in writing with approval gained in September of 2019. More than a month prior to implementing the DNP project, I met with clinical staff to provide an idea of the project and the need to address this relevant topic and issue.

The pretest questionnaire intervention was conducted on November 18, 2019 prior to the six brief HIV-related stigma videos of young MSM of color describing the impact of the stigma they have personally faced. Posttest questionnaires followed the educational intervention PowerPoint presentation on the following day, November 19, 2019. Pretest and posttest questionnaires were used to determine whether knowledge and attitude as a result of learning and training transfer, yielded changes among healthcare staff as a result of HIV-stigma and discrimination towards young MSM of color. After viewing various questionnaires, I determined to use one that had already been developed, tested, and reviewed. The quantitative Health Worker Questionnaire was developed and tested by an international team of researchers as a tool and resource under a cooperative agreement known as the Health Policy Project funded by the U.S. Agency for International Development (Carr et al., 2015; Jain et al., 2015).

Inclusion criteria for this evidence-based project included all public health staff working within the clinic encountering patients seeking testing or treatment, at least 18 years old, voluntary agreement to participate in this educational intervention, and those who have worked for at least 1 year within the public health clinic this intervention was implemented. Exclusion criteria included building staff who provide security and direction to the designated floor in which the public health clinic is housed. A total of 15 staff were invited to participate, which was reduced to eight participants then seven after one person was unavailable to attend the educational portion of the intervention and take the posttest questionnaire. The seven participants who completed the full educational intervention for this project included three APRNs, one administrative assistant, one medical records technician, one supervisor, and one clinic manager.

Data were collected using quantitative methods in the form of a questionnaire with sections that include background data on demographics and roles within the facility; causes of stigma such as fears, policies, and attitudes towards those at-risk or infected with HIV; and various forms of discrimination in the form of infection control and layers of stigma utilizing a Likert scale (Jain et al., 2015). An administrative questionnaire (Appendix B) for triangulation was given to the clinic manager to assess for written guidelines already in place that protects and ensures patients visiting this public health clinic are not subjected to discriminative practices (see Jain et al., 2015).

The DNP project covered a 2-day timeframe both consisting of half-days with the first day having participants complete a standardized brief self-administered pretest questionnaire containing 22-questions after receiving a complete explanation of the

project that included informed consent. The questionnaire was then followed by

participants individually viewing on a designated laptop six previously prepared brief

videos created by the CDC for their "Let's Stop HIV Together" prevention campaign

(Appendix C). The second day, participants attended a staff education presentation that

included PowerPoint presentations on HIV 101 focusing on infection control measures,

national and local data that directly draws attention to young MSM of color that included

a synopsis of an HIV-related stigma survey and data describing the significance of PrEP,

and closed with a comprehensive view of HIV-related stigma in healthcare affecting

young MSM of color.

      After allowing time for discussion and questions, the presentation was followed

by the same self-administered 22-question posttest questionnaire provided in the pretest.

Following the educational intervention, the clinic manager was provided with posters,

handouts, and other resources from the CDCs prevention campaign to be placed within

the clinic to support anti-stigma and anti-discrimination awareness for staff and

individuals visiting this public health clinic.

      Participants were assured of confidentiality and then directed to place their names

on a blank sheet of paper already attached to the self-administered pretest and posttest

questionnaires that were then placed into two separate labeled boxes previously prepared

to prevent access to the contents to maintain confidentiality and integrity of the data. I

chose to execute this questionnaire as one that is self-administered to reinforce to

participants the goal of ensuring confidentiality in hopes of promoting truthful and honest

responses to the questions (see Jain et al., 2015). The contents of each box following the

pretest and posttest were then retrieved with each participant de-identified by being

assigned a select number for the pretest and corresponding posttest questionnaires with

that information then transferred onto a password protected flash drive for data reliability

and to ensure confidentiality of the participants in preparation of data analysis. The flash

drive was placed in a locked cabinet to further protect participant data with only myself

having access.

Quantitative data collected involved nominal and an interval levels of

measurement for basic data classification and included a type of Likert scale to rank the

stigma questions. Analysis of the quantitative data included a simple data tabulation to

describe the information with frequency and percentage distributions. Results were

tabulated using basic data classification methods to describe statistical relevance. These

statistical techniques served to show whether there was a relationship exists between

pretest and posttest responses that describe a change in healthcare staff knowledge,

attitudes, and the fears within this clinic as it relates to HIV-related stigma and

discrimination. Data collected were placed in the secure database, analyzed, and

presented in tables describing results. Results of the DNP project educational intervention

will be provided to public health administration, clinic healthcare staff, and Walden

University DNP Program.

Data collected from the completed questionnaires by participants ($N = 7$) began

with the first section Questions 1 through 7 that collected background demographic

information was analyzed and yielded results presented in Table 1. Most of the

participants were female at 71.4%, and above 50 years of age (71.4%). Nearly half of all

participants work in the position of APRN/nurses at 48.5%, close to three-fourths

(71.4%) of the clinic staff have worked within healthcare for more than 12 years, and

more than half (71.4%) of the staff have experience working in a setting that specializes

in HIV care and treatment. Although this public health clinic is positioned within a high

prevalence area, less than one-third (28.5%) of the staff were aware of how many patients

are seen in a 1-week period. As for trainings, more than half (57.1%) of staff have had

some form of stigma and discrimination training, whereas 42.8% has had more training

specific to HIV. Further, most staff have indicated that they have received some level of

training that was focused on informed consent, privacy, and confidentiality.

The next section, Questions 8 through 9 of the questionnaires, addressed fears of

contracting HIV through infection control measures. Participants answered questions to

determine their level of worry engaging in various healthcare services for patients at-risk

of infection or HIV positive and infection control measures for patients living with HIV

(Table 2). All participants acknowledged that they were not worried about touching the

clothing of individuals living with HIV pretest and posttest, with similar results (71.4%,

85.7%) when it came to taking a temperature, respectively. When it came to tasks that

were more invasive and presented a greater risk for exposure to blood and other fluids the

pretest indicated a combination of worried (14.2%), little worried, (28.5%) and not

worried (42.8%) at all. The posttest indicated that the intervention was successful, as the

responses showed a change with no worried responses and raised levels of not worried to

71.4% and above, with the exception of one individual determining that it is not a task

they would do and one a little worried. As for further measures involving infection

control, responses for pretest and posttests were fairly unchanged with the exception of no one feeling the need to double-glove (see Table 2).

Section 3 covered Questions 10 through 13 and included response involving practices within the healthcare clinic for the past 12 months (see Table 3). When asked about behavior observed by their colleagues the responses were consistent pretesting and post testing for the most part. At least one person witnessed a coworker speaking badly about people living with or thought to be living with HIV. The next set of questions addressed perceptions held by participants describing how they were treated by friends, family, colleagues, and people as a result of working with people living with HIV (see Table 3). Responses again were consistent with very little change between the pretests and posttests, although one had experienced someone speaking badly about them because of their caring for patients living with HIV. The final question of being hesitant to working next to a colleague with HIV showed a change with the one participant who had some hesitation moving to no hesitation post-intervention joining all the other participants. Although there was some improvement or change noted post-intervention, there were responses that could have indicated participants might have benefited from more time to complete their posttests.

Questions 14 through 17 related to how aware and knowledgeable of protocols, policies, and work environment participants were within the clinic supporting HIV anti-stigma and anti-discrimination. Responses indicated that staff had a basic understanding of protocols and are aware of tools that support their ability to safely provide services and care to individuals at-risk or infected with HIV (see Table 4). The response presented

either 100% pretest and posttest for most questions or a change post-intervention to move to 100%. The deficit in knowledge was if there were written policies to protect patients living with HIV from discrimination. Most were unsure if policies existed specific to HIV and discrimination supporting the responses within the questionnaire completed by the administrator of the clinic. There are no written guidelines to protect individuals within this group nor are there standard operating procedures describing how treatment and care should take place. It is unclear what written policies more than half (57.1%) the participants felt existed, but it is important to ensure all are adhering to the same policies and procedures.

Finally, Questions 18 through 22 referred to attitudes and prejudices in the form of opinions held by the participants about people living with HIV (see Table 5). For the most part responses were unchanged pre- and post-intervention, indicating that participants (85.7%) have addressed behavior that is stigmatizing or discriminatory with the exception of one outlier (14.2%) for the pretest and posttest. It was unclear as to whether they held strong negative opinions or were unsure about the questions asked. Additionally, many positive pretest responses changed to negative perceptions and opinions post-intervention, leading to additional questions to support choice of responses (see Table 6). The questions that prompted additional responses from one participant indicated that there was a preference to not provide services to people who inject illegal drugs, MSM, and sex workers but only for the posttest. Again, it is unclear if this participant understood the questions because the responses indicated that they disagreed with all of the choices provided to explain the reason for their strong negative opinions.

Table 1

Participant Background Information

Demographic information	Frequency (*N*= 7)	Percentage
1. Age		
40 - 49 years	2	28.5
50 + years	5	71.4
2. Gender		
Female	5	71.4
Male	2	28.5
3. Occupation		
Nurse	3	42.8
Other	2	28.5
Receptionist/Medical Records Personnel	2	28.5
4. Years worked in healthcare		
3–5	2	28.5
12+	5	71.4
5. Ever worked in healthcare setting specializing in HIV care/treatment		
Yes	2	28.5
No	5	71.4
6. Number of HIV+ patients per week		
0–10	2	28.5
11–20	0	0.0
Unknown	5	71.4
7. Previous training(s) in:		
HIV stigma and discrimination	3	42.8
Infection control/universal precautions (including PEP)	5	71.4
Patient informed consent, privacy, and confidentiality	6	85.7
Key population stigma and discrimination	4	57.1

Table 2

Infection Control Concerns in Targeted Health Facility

Worried about getting HIV by doing the following…	Touching the clothing of patient with HIV	Dressing wounds of patient with HIV	Drawing blood of patient with HIV	Taking temperature of patient with HIV
Pretest				
Worried	-	1(14.2)	1(14.2)	-
Not worried	7(100)	3(42.8)	3(42.8)	5(71.4)
A little worried	-	2(28.5)	2(28.5)	1(14.2)
Not applicable	-	1(14.2)	1(14.2)	1(14.2)
Posttest				
Worried	-	-	-	-
Not worried	7(100)	5(71.4)	5(71.4)	6(85.7)
A little worried	-	1(14.2)	-	-
Not applicable	-	1(14.2)	2(28.5)	1(14.2)

Typical measures used when providing care or services to patient living with HIV	Yes	No	Not Applicable	No Answer
Pretest				
Avoid physical contact	-	6(85.7)	1(14.2)	-
Wear double gloves	1(14.2)	5(71.4)	1(14.2)	-
Wear gloves during all aspects of the patient care	3(42.8)	3(42.8)	1(14.2)	-
Use special infection control measures with patients living with HIV not used with other patients	-	4(57.1)	2(28.5)	1(14.2)
Posttest				
Avoid physical contact	-	6(85.7)	1(14.2)	-
Wear double gloves	-	5(71.4)	2(28.5)	-
Wear gloves during all aspects of the patient care	2(28.5)	3(42.8)	2(28.5)	-
Use special infection control measures with patients living with HIV not used with other patients	1(14.2)	4(57.1)	2(28.5)	-

Table 3

Health Facility Environment and Practices Caring for HIV Patients

Health care facility practices	Pretest		Posttest	
	Frequency (*N*= 7)	%	Frequency (*N*= 7)	%
Observed healthcare provider unwillingness to care for HIV patients				
Never	6	85.7	6	85.7
No answer	1	14.2	1	14.2
Observed healthcare workers providing poorer quality of care to HIV patients or relatives				
Never	6	85.7	7	100
No answer	1	14.2	-	-
Observed healthcare workers talking badly about people living with or thought to be living with HIV				
Never	5	71.4	6	85.7
Once or twice	1	14.2	1	14.2
No answer	1	14.2	-	-
In the past 12 months how often have you				
Experienced people talking badly about you because you care for patients living with HIV?				
Never	5	71.4	4	57.1
Once or twice	1	14.2	1	14.2
No Answer	1	14.2	2	28.5
Been avoided by friends and family because you care for patients living with HIV?				
Never	6	85.7	5	71.4
Once or twice	-	-	-	-
No Answer	1	14.2	2	28.5
Been avoided by colleagues because of your work caring for patients living with HIV				
Never	6	85.7	5	71.4
Once or twice	-	-	-	-
No answer	1	14.2	2	28.5
How hesitant are healthcare workers in this facility to work alongside a coworker living with HIV, regardless of their duties				
Not hesitant	6	85.7	7	100
A little hesitant	1	14.2	-	-
No answer	-	-	-	-

Table 4

Health Facility Policies and Work Environment

	Pretest		Posttest	
	Frequency (*N*= 7)	%	Frequency (*N*= 7)	%
In my facility it is not acceptable to test a patient for HIV without their knowledge				
Strongly Agree/Agree	7	100	7	100
No Answer	-	-	-	-
I will get in trouble at work if I discriminate against patients living with HIV				
Yes	7	100	7	100
No Answer	-	-	-	-
There are adequate supplies in my health facility that reduce my risk of becoming infected with HIV				
Strongly Agree/Agree	6	85.7	7	100
No answer	1	14.2	-	-
There are standardized procedures/protocols in my health facility that reduce my risk of becoming infected with HIV				
Strongly Agree/Agree	6	85.7	7	100
No answer	1	14.2	-	-
My health facility has written guidelines to protect patients living with HIV from discrimination				
Yes	2	28.5	4	57.1
No	1	14.2	1	14.2
Don't Know	3	42.8	2	28.5
No Answer	1	14.2	-	-

Table 5

Opinions About People Living with HIV

Participants strongly agree/agree or strongly disagree/disagree with the following statement	Pretest Frequency (*N*= 7)	%	Posttest Frequency (*N*= 7)	%
Most people living with HIV do not care if they infect other people				
Strongly Agree/Agree	1	14.2	1	14.2
Strongly Disagree/Disagree	6	85.7	6	85.7
People living with HIV should feel ashamed of themselves				
Strongly Agree/Agree	1	-	-	-
Strongly Disagree/Disagree	6	85.7	7	100
Most people living with HIV have had many sexual partners				
Strongly Agree/Agree	1	14.2	-	-
Strongly Disagree/Disagree	6	85.7	7	100
People get infected with HIV because they engage in irresponsible behaviors				
Strongly Agree/Agree	1	14.2	1	14.2
Strongly Disagree/Disagree	6	85.7	6	85.7
HIV is punishment for bad behavior				
Strongly Agree/Agree	-	-	-	-
Strongly Disagree/Disagree	7	100	7	100
Women living with HIV should be allowed to have babies if they wish				
Strongly Agree/Agree	7	100	6	85.7
Strongly Disagree/Disagree	-	-	1	14.2
If I had a choice, I would prefer not to provide services to people who inject illegal drugs				
Strongly Agree/Agree	-	-	1	14.2
Strongly Disagree/Disagree	7	100	6	85.7
If I had a choice, I would prefer not to provide services to men who have sex with men				
Strongly Agree/Agree	-	-	1	14.2
Strongly Disagree/Disagree	7	100	6	85.7
If I had a choice, I would prefer not to provide services to sex workers				
Strongly Agree/Agree	-	-	1	14.2
Strongly Disagree/Disagree	7	100	6	85.7

Table 6

Opinions About Working with People At-Risk for HIV

**Posttest Reasons for participant who strongly agree/agree not to provide services to people who inject illegal drugs, men having sex with men, and sex workers	They put me at higher risk for disease	This group engage in immoral behavior	I have not received training to work with this group
Reasons I would prefer not to provide services to people who inject illegal drugs			
Strongly Agree/Agree	-	-	-
Strongly Disagree/Disagree	1(100)	1(100)	1(100)
Reasons I would prefer not to provide services to men who have sex with men			
Strongly Agree/Agree	-	-	-
Strongly Disagree/Disagree	1(100)	1(100)	1(100)
Reasons I would prefer not to provide services to sex workers			
Strongly Agree/Agree	-	-	-
Strongly Disagree/Disagree	1(100)	1(100)	1(100)

Recommendations

Despite a low number of participants this project was able to bring attention to the importance of reducing HIV-related stigma and discrimination towards young MSM of color by healthcare providers. With 47% of invited staff participating in this educational intervention it was quite glaring that an entire group the DIS team, apart from their supervisor, chose not to participate in the full intervention. This is regretful since this group serves as frontline staff conducting interviews of individuals who have tested positive for an STI and/or HIV with a key role to seek out those individuals within and outside the walls of this public health clinic. Engagement might improve if future efforts include mandatory participation of all staff within the clinic and ongoing trainings. Many

times, behavior is entrenched and difficult to change therefore, ongoing trainings should be a consideration.

Although the DIS team did not participate in completing the pretest or posttest questionnaires that included viewing of the targeted videos, they were present for the educational presentation on the second day and appeared interested in the content, but there is no way of knowing since I was unable to capture their views on the topic. Further, it would have been optimal to have a longer amount of time to provide the educational intervention. That might have increased participation from this challenging group and resolved the question of responses that were unclear. Further recommendations include additional research on the impact of HIV-related stigma when healthcare providers are the source of such stigma especially related to young MSM of color.

Finally, it is recommended that a six-month follow-up be conducted providing the same questionnaire to determine if scores increase and if change was sustainable as a result of knowledge retention. This intervention should then serve as a model to be implemented in other public health clinics throughout the state. It should serve as the *gold standard* to be implemented within other community-based organizations and healthcare settings that screen, test, and provide treatment to young MSM of color at-risk for or already infected with HIV to support a culture and environment free of stigma and discrimination.

Contribution of the Doctoral Project Team

The contribution of the doctoral project team has been significant in their ability to provide an education that fully encompassed the plight of young MSM of color not

only across the nation but more specifically within the state this project was implemented. The doctoral project team consisted of an HIV Prevention Health Program Coordinator who provided infection control measures describing how HIV is acquired and transmitted. This portion of the project with the HIV Surveillance Administrator and HIV Surveillance Health Program Coordinator provided national and state level data for young MSM of color that include analysis of an HIV-related stigma survey conducted in 2017. The last contributor providing knowledge of healthcare providers as a source of HIV-related stigma impacting young MSM of color was me, the DNP student and facilitator of this DNP project. Following the presentation, it was clear this team worked well together and saw the benefit of piloting this project in other areas within the state. Since the intervention the team has discussed how to improve the project and present to public health administration to gain support for implementation that would eventually be moved to community-based organizations and other providers within the state.

Strengths and Limitations of the Project

Strengths of this project include the level the of engagement and enthusiasm of those who participated. Although the population for this project was small, it was representative of varied roles within the clinic and included all APRNs working within the clinic chosen for this evidence-based project intervention. Budget costs to implement this project were negligible therefore replication of such a project to other locations is more than feasible. Another strength of this project was to provide a private space for individuals to complete the survey and view of videos and making participation voluntary to reduce the risk of response bias (Jain et al., 2015).

The limitations of this this project included the small sample size of participants (*N*=7) and issues with a breakdown in collaborative relationships between the DIS team and other clinic staff that has existed prior to implementation of this project. This lack of communication and partnering serves as a potential barrier to positive outcomes for the community they serve. An additional limitation or weakness of this project was attributed to limited timeframes to fully implement the intervention when working around clinic hours. The only open window for conducting the PowerPoint presentation included a limited schedule of a monthly staff meeting. The time allotted for that period was an hour with an additional half-hour. Any additional time would have required shutting the clinic down of patients earlier than the already approved timeframe. Delays took place when the APRNs were still seeing patients thereby cutting into the presentations and keeping staff later than they would have liked to be held on that day. Although administration provided approval to conduct this educational intervention, approval to close the clinic earlier for a half-day to allow for adequate time to provide learning was not given. Further follow-up is needed to include a six-month qualitative study to determine if what was learned was retained, translatable, and sustainable.

Section 5: Dissemination Plan

Having an adequate dissemination plan serves to fill the gap between research and practice when the goal is to improve health outcomes where inequality is prevalent (Brown et al., 2018). As such, dissemination of this project will include providing results of this DNP project educational intervention in the form of a summary to public health administration, clinic healthcare staff to include APRNs, policy makers, and the Walden University DNP Program. I have already been asked to present this project to the HIV Planning Council, which is a body of government and community-based agencies, providers, and stakeholders. Again, this intervention will hopefully serve as a model to be implemented in other public health clinics and then various community-based organizations as the *gold standard* for addressing healthcare provider HIV-related stigma and discrimination.

Analysis of Self

As a sister, a niece, a friend, and step-mother of a young MSM of color, the choice of topic and its implementation was a significant labor of love. It is important to eliminate challenges for this disproportionately affected and at-risk group of individuals to ensure they are comfortable to test and secure health care services to reduce their risk for HIV infection and transmission. As a DNP-graduate with a background in mental health, community nursing, and infectious diseases, this project was an opportunity to address the challenges around HIV-related stigma as well as change the trajectory of HIV infection and transmission within communities and families. Changing how healthcare professionals perceive individuals at-risk of or infected with HIV potentially saves lives.

In Delaware, Black/African Americans were nearly three-fourths of all new HIV infections in 2018, although they are only 21% of the overall population (Dowling, 2019). Additionally, for 2010-2018, young MSM of color in Delaware were diagnosed at a disproportionate rate of more than 60% within the county where this project was implemented compared to the other counties within the state, and in 2018, young MSM of color were 12% of all newly diagnosed cases in the state (Dowling, 2019). For 2015 and 2016, of the 340 HIV-infected individuals surveyed through the HIV Medical Monitoring Program, more than half of the males believed that most people with HIV would be rejected if someone found out about their positive status (Dowling, 2019). Further, more than one-third of all males surveyed indicated that they felt individuals infected with HIV are seen as disgusting by most noninfected individuals (Dowling, 2019).

Hence, measuring and addressing HIV-related stigma and discrimination to reduce barriers faced among this marginalized population was a significant goal in this study, as it affects testing, treatment, support services, and medication adherence for individuals at-risk of HIV infection or transmission (Jain et al., 2015). An individual seeking care within a public health clinic setting who encounters stigma and discrimination is least likely to seek testing that leads to delays in treatment despite the high burden of HIV within their community (Jain et al., 2015).

This project was challenging in coordinating interventions that engage multiple levels of staff within public health from leadership to those on the frontline. But the goal of this project outweighed some of the challenges, especially when a participant reached

out in tears post-intervention indicating an increase in knowledge and a change in

perceptions. This project helped healthcare staff to gain knowledge that supports a

reduction of fears that leads to their providing quality healthcare to all those who seek

and need their services. To gain buy-in and secure engagement, there was a multi-level

approach to increase participants' knowledge of stigma and discrimination through the

presentations; increase empathy as it relates to how moral judgements, values, and

attitudes by viewing the six videos of young MSM of color describing its impact when

the source is healthcare providers; and evoke emotional relativeness by providing a

personal connection to the importance of addressing this issue (i.e., stressing this could be

their brother, uncle, cousin, friend, or even their child). Addressing stigma and

discrimination within healthcare facilities at the individual and structural level can lead to

changes in facility policies and environment (Nyblade et al., 2019).

Summary

HIV-related stigma and discrimination continues to be a persistent national and

global challenge, serving as a barrier to healthcare delivery and utilization when

healthcare provider attitudes, beliefs, perceptions, or misconceptions adversely influence

health behaviors of young MSM of color (Batey et al., 2016). HIV-related stigma within

the healthcare setting deepens health disparities and further marginalizes a population

disproportionately impacted by HIV, young MSM of color (Dong et al., 2018; Nyblade et

al., 2019). According to 2017 data, MSM of color were more than 75% of all newly

infected individuals in the United States (de Fatima Cordeiro Dutra et al., 2018; CDC,

2019). HIV-related stigma can take the form of refusal to encounter or provide care to

individuals who are at risk for or infected with HIV, which impedes and undermines HIV testing, self-disclosure, and treatment for young MSM of color (CDC, 2019a). Because of the correlation between health outcomes for those at-risk or infected with HIV and HIV-related stigma, it is important to address discrimination at the individual and environmental level (Chambers et al., 2015).

The reduction of HIV-related stigma through provider-focused education and training can promote efforts toward national prevention goals to improve prevention and healthcare services to vulnerable individuals at risk for HIV infection or transmission (Geter et al., 2018). The outcome of this intervention was to determine whether HIV-related stigma education provided to healthcare clinic staff with a focus on APRNs, improves knowledge and empathy toward young MSM of color, translating into improved overall quality of healthcare further reducing risk for comorbidities and mortality due to increased health seeking behaviors and retention in care. Support from public health administration leadership, the clinic manager, APRNs, most of the clinic staff, HIV program, and STI program was well received and encouraging. It is my hope there will be implementation of this pilot within other public health clinics throughout the state leading to it being embraced and modeled within community-based organizations.

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Appendix A: Health Worker Questionnaire Pretest and Posttest

From the Health Policy Project (2013).

Measuring HIV Stigma and Discrimination Among Health Facility Staff:
Standardized Brief Questionnaire

SECTION 1: BACKGROUND INFORMATION

First we will ask about your background.

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

2. What is your sex?

   ☐ Female   ☐ Male

3. What is your current job?
   (Adjust as appropriate for country context by adding or deleting categories according to sample.)

   ☐ Accountant   ☐ Cashier   ☐ Cleaning Staff   ☐ Clinical Officer
   ☐ Dentist   ☐ Dental Technician/Hygienist   ☐ Doctor
   ☐ Educator   ☐ Laboratory Technician
   ☐ Lay Health Worker/Peer Educator   ☐ Medical Records Personnel
   ☐ Medical Technician   ☐ Nurse   ☐ Pharmacist   ☐ Receptionist
   ☐ Security Guard   ☐ Ward Attendant   ☐ Phlebotomist
   ☐ Other: [_____]

4. How many years have you worked in healthcare?   [_____] years

5. Have you ever worked in a clinic/hospital/department that specialized in HIV care and treatment?

   ☐ Yes   ☐ No

6. If low prevalence, use question 6a. If high prevalence, use question 6b.

   a. *In the past 12 months,* approximately how many HIV-positive patients did you provide with care or services?   ☐☐☐

   b. *In a typical week,* approximately how many HIV-positive patients do you provide with care or services?   ☐☐☐

7. Did you ever receive training in the following subjects? (Check all that apply.)

   a. HIV stigma and discrimination   ☐
   b. Infection control and universal precautions   ☐
      (including post-exposure prophylaxis)
   c. Patients' informed consent, privacy, and confidentiality   ☐
   d. Key population stigma and discrimination   ☐

Measuring HIV Stigma and Discrimination Among Health Facility Staff:
Standardized Brief Questionnaire

SECTION 2: INFECTION CONTROL

Now we will ask you about infection concerns in your health facility.

8. .How worried would you be about getting HIV if you did the following?
If any of the following is not one of your job responsibilities, please select "Not applicable."

    a. Touched the clothing of a patient living with HIV
       ☐ Not worried ☐ A little worried ☐ Worried ☐ Very worried ☐ Not applicable

    b. Dressed the wounds of a patient living with HIV
       ☐ Not worried ☐ A little worried ☐ Worried ☐ Very worried ☐ Not applicable

    c. Drew blood from a patient living with HIV
       ☐ Not worried ☐ A little worried ☐ Worried ☐ Very worried ☐ Not applicable

    d. Took the temperature of a patient living with HIV
       ☐ Not worried ☐ A little worried ☐ Worried ☐ Very worried ☐ Not applicable

9. Do you typically use any of the following measures when providing care or services for a patient living with HIV?

    a. Avoid physical contact
       ☐ Yes   ☐ No   ☐ Not applicable

    b. Wear double gloves
       ☐ Yes   ☐ No   ☐ Not applicable

    c. Wear gloves during all aspects of the patient's care
       ☐ Yes   ☐ No   ☐ Not applicable

    d. Use any special infection-control measures with patients living with HIV that you do not use with other patients
       ☐ Yes   ☐ No   ☐ Not applicable

SECTION 3: HEALTH FACILITY ENVIRONMENT

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

10. In the past 12 months have you seen a person living with HIV in your health facility?

    ☐ Yes ——————> go to question 11
    ☐ No ——————> skip to question 12
    ☐ Don't know ——————> skip to question 12

11. *In the past 12 months*, how often have you observed the following in your health facility?

    a. Healthcare workers unwilling to care for a patient living with or thought to be living with HIV
       ☐ Never   ☐ Once or twice   ☐ Several times   ☐ Most of the time

Measuring HIV Stigma and Discrimination Among Health Facility Staff:
Standardized Brief Questionnaire

    b. Healthcare workers providing poorer quality of care to a patient living with or thought to be living with HIV, relative to other patients
       ☐ Never   ☐ Once or twice   ☐ Several times   ☐ Most of the time

    c. Healthcare workers talking badly about people living with or thought to be living with HIV
       ☐ Never   ☐ Once or twice   ☐ Several times   ☐ Most of the time

12. If low prevalence, use question 12a. If high prevalence, use question 12b.

    a. How worried are you about

       i. People talking badly about you because you care for patients living with HIV?
         ☐ Not worried ☐ A little worried ☐ Worried ☐ Very worried

       ii. Friends and family avoiding you because you care for patients living with HIV?
         ☐ Not worried ☐ A little worried ☐ Worried ☐ Very worried

       iii. Colleagues avoiding you because of your work caring for patients living with HIV?
         ☐ Not worried ☐ A little worried ☐ Worried ☐ Very worried

    b. *In the past 12 months*, how often have you

       i. Experienced people talking badly about you because you care for patients living with HIV?
         ☐ Never   ☐ Once or twice   ☐ Several times   ☐ Most of the time

       ii. Been avoided by friends and family because you care for patients living with HIV?
         ☐ Never   ☐ Once or twice   ☐ Several times   ☐ Most of the time

       iii. Been avoided by colleagues because of your work caring for patients living with HIV?
         ☐ Never   ☐ Once or twice   ☐ Several times   ☐ Most of the time

13. How hesitant are healthcare workers in this facility to work alongside a coworker living with HIV, regardless of their duties?

      ☐ Not hesitant   ☐ A little hesitant   ☐ Somewhat hesitant   ☐ Very hesitant

SECTION 4: HEALTH FACILITY POLICIES

Now we are going to ask about the institutional policy and work environment in your facility.

14. In my facility it is not acceptable to test a patient for HIV without their knowledge.
      ☐ Strongly Agree   ☐ Agree   ☐ Disagree   ☐ Strongly Disagree

15. I will get in trouble at work if I discriminate against patients living with HIV.
      ☐ Yes   ☐ No   ☐ Don't Know

Measuring HIV Stigma and Discrimination Among Health Facility Staff:
Standardized Brief Questionnaire

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

    a.   There are adequate supplies in my health facility that reduce my risk of becoming infected with HIV.
        ☐ Strongly Agree   ☐ Agree   ☐ Disagree   ☐ Strongly Disagree

    b.   There are standardized procedures/protocols in my health facility that reduce my risk of becoming infected with HIV.
        ☐ Strongly Agree   ☐ Agree   ☐ Disagree   ☐ Strongly Disagree

17. My health facility has written guidelines to protect patients living with HIV from discrimination.
    ☐ Yes   ☐ No   ☐ Don't Know

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Measuring HIV Stigma and Discrimination Among Health Facility Staff:
Standardized Brief Questionnaire

SECTION 5: OPINIONS ABOUT PEOPLE LIVING WITH HIV

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

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

    a. Most people living with HIV do not care if they infect other people.
        ☐ Strongly Agree   ☐ Agree   ☐ Disagree   ☐ Strongly Disagree

    b. People living with HIV should feel ashamed of themselves.
        ☐ Strongly Agree   ☐ Agree   ☐ Disagree   ☐ Strongly Disagree

    c. Most people living with HIV have had many sexual partners.
        ☐ Strongly Agree   ☐ Agree   ☐ Disagree   ☐ Strongly Disagree

    d. People get infected with HIV because they engage in irresponsible behaviors.
        ☐ Strongly Agree   ☐ Agree   ☐ Disagree   ☐ Strongly Disagree

    e. HIV is punishment for bad behavior.
        ☐ Strongly Agree   ☐ Agree   ☐ Disagree   ☐ Strongly Disagree

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

20. Please tell us if you strongly agree, agree, disagree, or strongly disagree with the following statement:

    a. If I had a choice, I would prefer not to provide services to people who inject illegal drugs.
        ☐ Strongly Agree ————→ go to question 20b
        ☐ Agree ————————→ go to question 20b
        ☐ Disagree ——————→ skip to question 21
        ☐ Strongly Disagree ——→ skip to question 21

    b. I prefer not to provide services to people who inject illegal drugs because (check all reasons that apply)
       i. They put me at higher risk for disease.   ☐ Agree   ☐ Disagree
      ii. This group engages in immoral behavior.   ☐ Agree   ☐ Disagree
     iii. I have not received training to work with this group.   ☐ Agree   ☐ Disagree

21. Please tell us if you strongly agree, agree, disagree, or strongly disagree with the following statement:

    a. If I had a choice, I would prefer not to provide services to men who have sex with men.
        ☐ Strongly Agree ————→ go to question 21b
        ☐ Agree ————————→ go to question 21b
        ☐ Disagree ——————→ skip to question 22
        ☐ Strongly Disagree ——→ skip to question 22

Measuring HIV Stigma and Discrimination Among Health Facility Staff:
Standardized Brief Questionnaire

    b. I prefer not to provide services to men who have sex with men because (check all reasons that apply)

i. They put me at higher risk for disease.	☐ Agree	☐ Disagree
ii. This group engages in immoral behavior.	☐ Agree	☐ Disagree
iii. I have not received training to work with this group.	☐ Agree	☐ Disagree

22. Please tell us if you strongly agree, agree, disagree, or strongly disagree with the following statement:

    a. If I had a choice, I would prefer not to provide services to sex workers (*specify: male or female or both, depending on context*).

        ☐ Strongly Agree ─────→ go to question 22b

        ☐ Agree ─────────→ go to question 22b

        ☐ Disagree ───────→ skip to question 23

        ☐ Strongly Disagree ───→ skip to question 23

    b. I prefer not to provide services to sex workers because (check all reasons that apply)

i. They put me at higher risk for disease.	☐ Agree	☐ Disagree
ii. This group engages in immoral behavior.	☐ Agree	☐ Disagree
iii. I have not received training to work with this group.	☐ Agree	☐ Disagree

Appendix B: Facility Administrator Questionnaire

Appendix A: Facility Administrator Questionnaire

1. Are there standard precaution guidelines in place at this facility?

   ☐ Yes   ☐ No *(skip to Question 3)*

2. May I see them?

   ☐ Observed   ☐ Did not observe

3. Are there Standard Operating Procedures (SOPs) for care and treatment of people living with HIV in place at this facility?

   ☐ Yes   ☐ No *(skip to Question 5)*

4. May I see them?

   ☐ Observed   ☐ Did not observe

5. Are there written guidelines to protect people living with HIV from discrimination?

   ☐ Yes   ☐ No *(skip to Question 8)*

6. May I see them?

   ☐ Observed   ☐ Did not observe

7. How are the written guidelines to protect people living with HIV enforced/implemented?

8. What happens if a provider discriminates against a patient living with HIV at this facility?

9. Are informed consent protocols enforced when screening patients for HIV?

   ☐ Yes   ☐ No *(End the interview)*

10. Please describe the protocols used.

14

From Jain, Carr, and Nyblade (2015)

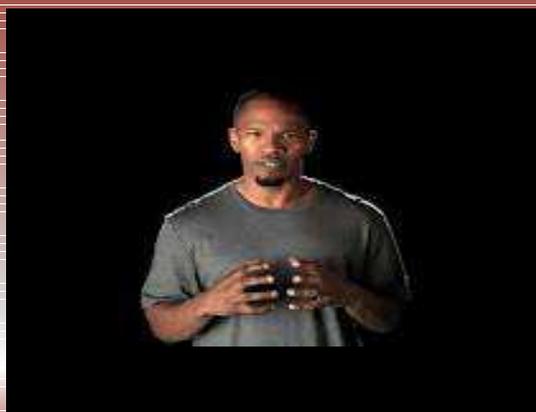Appendix C: Centers for Disease Control and Prevention "Let's Stop HIV Together"

Videos

HIV-Related Stigma Videos

Time to View All Videos = less than 15 minutes
All Videos were produced by the CDC for their
"Let's Stop HIV Together" Prevention Campaign

Thank You for Your Participation
Alethea A. Miller

YOUNG MSM OF COLOR AND HEALTHCARE STIGMA

Talk About HIV – Jamie Foxx

YOUNG MSM OF COLOR AND HEALTHCARE STIGMA
Jamar & His Mother

YOUNG MSM OF COLOR AND HEALTHCARE STIGMA
Antron's Story

CDC: Antron's Story, Let's Stop HIV TogetherCenters for Disease Control and Prevention (CDC) • 2.5K views2:41

• Right click on link and click on "Open Hyperlink" to go to Youtube video

YOUNG MSM OF COLOR AND HEALTHCARE STIGMA
Stephen & His Brother, Joe
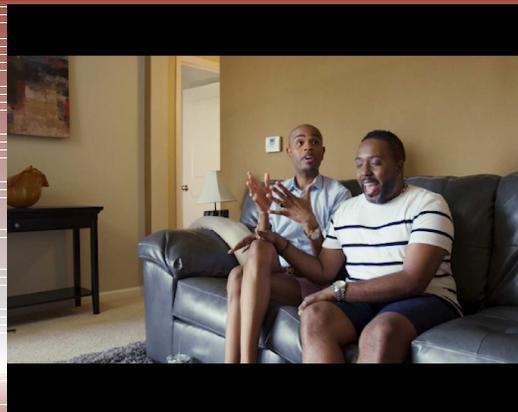
https://www.youtube.com/watch?v=ct3XJh6-WRQ&t=1s

- Right click on link and click on "Open Hyperlink" to go to Youtube video

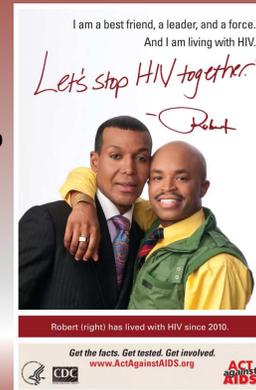# YOUNG MSM OF COLOR AND HEALTHCARE STIGMA

Stop HIV Stigma-
David & Johnny

YOUNG MSM OF COLOR AND HEALTHCARE STIGMA
Robert & His Friend, Dwight

https://youtu.be/N6zb8Mpkd6w

• Right click on link and click on "Open Hyperlink" to go to Youtube video

From CDC (2019b)