Best Practice Solutions to HIV Prevention at Health Centers Community of Practice Session 3: Patient Perceptions and Stigma

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NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER
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Attendance

- Please add your name, role, organization, and state in the chat!

Learning Objectives

- Understand how patient perception and stigma can be a barrier to pre-exposure prophylaxis (PrEP)
- Prepare to develop a PrEP campaign in your clinic that is tailored to your community

HIV Stigma: What It Is, How It Harms, and What Clinicians Can Do

Whitney C. Irie, PhD, MSW

Stigma remains a barrier to ending the HIV epidemic

Despite significant advances in HIV treatment and prevention, stigma continues to pose one of the most formidable challenges in achieving epidemic control. This pervasive force operates as a complex, multi-dimensional barrier that touches every aspect of the HIV care continuum.

Multi-Level Impact

Stigma manifests across individual, interpersonal, organizational, and structural levels, creating overlapping barriers that compound patient challenges.

(Clement et al., 2025; Hooker et al., 2023; Lancaster et al., 2022)

Care Cascade Disruption

From prevention through viral suppression, stigma disrupts testing, linkage, retention, and adherence at every critical juncture.

(Chittamuru et al., 2020; Golub, 2018; Goparaju et al., 2017)

Multi-Layered Complexity

HIV stigma intersects with substance use, housing instability, and mental health stigma, exponentially increasing disengagement risk.

(Lancaster et al., 2022; Maskay et al., 2018; Thomas & Menih, 2022)

Research consistently demonstrates that stigma-related factors account for significant portions of care discontinuation and poor health outcomes among people living with HIV.

(Chittamuru et al., 2020; Golub, 2018; Goparaju et al., 2017)

What you'll learn today

Define stigma comprehensively

Understand different types of stigma across HIV, substance use, housing, and mental health domains.

Analyze stigma's clinical impact

Describe the specific mechanisms by which stigma affects HIV prevention efforts and care engagement throughout the treatment cascade.

Implement practical solutions

Identify at least three evidence-based, actionable steps you can take immediately to minimize stigma in your clinical settings.

By the end of this session, you'll have concrete tools to recognize stigma's manifestations and interrupt its harmful effects on patient care. These skills are essential for any clinician committed to providing effective HIV prevention and treatment services.

What is stigma? A working definition for clinicians

Contemporary Understanding

Modern stigma research has evolved beyond Goffman's foundational work to recognize stigma as a multifaceted process involving five key components that work:

- **Labeling:** Distinguishing and identifying human differences
- **Stereotyping:** Linking labeled persons to undesirable characteristics
- **Separation:** Creating "us" versus "them" categories
- **Status loss:** Devaluing labeled persons' social standing
- Acting on prejudicial beliefs with power differentials

Critically, stigma operates simultaneously at individual, interpersonal, organizational, and structural levels—not merely as personal attitudes or individual moral failings. This multi-level understanding is essential for developing effective interventions.

> "A deeply discrediting attribute that reduces the bearer from a whole and usual person to a tainted, discounted one"
>
> *— Erving Goffman, 1963*

Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, *27*(Volume 27, 2001), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Experienced stigma

> Definition
>
> Experienced stigma refers to actual behaviors, actions, or treatment that individuals directly encounter from others. This represents the most concrete and measurable form of stigma.

Clinical Examples

Healthcare providers refusing to prescribe PrEP due to assumptions about patient "risk behaviors"

Unauthorized disclosure of HIV status to family members or other providers

Noticeably shortened appointment times for patients with HIV or substance use disorders

Use of excessive universal precautions that signal fear or disgust

Condescending or judgmental language during patient interactions

Scheduling patients at off-peak hours to minimize contact with other patients

Documented Impact

Research demonstrates that experienced stigma is directly linked to:

- Longer gaps between medical appointments
- Reduced likelihood of routine screening
- Delayed healthcare seeking for urgent needs
- Increased emergency department utilization

These discriminatory experiences create lasting impressions that influence patients' future healthcare engagement, often leading to avoidance of necessary care even when different providers are involved.

Donnelly, L. R., Bailey, L., Jessani, A., Postnikoff, J., Kerston, P., & Brondani, M. (2016). Stigma Experiences in Marginalized People Living With HIV Seeking Health Services and Resources in Canada. Journal of the Association of Nurses in AIDS Care, 27(6), 768–783. https://doi.org/10.1016/j.jana.2016.07.003

Kalichman, S. C., Katner, H., Banas, E., Hill, M., & Kalichman, M. O. (2020). Cumulative Effects of Stigma Experiences on Retention in HIV Care Among Men and Women in the Rural Southeastern United States. AIDS Patient Care and STDs, 34(11), 484–490. https://doi.org/10.1089/apc.2020.0144

Perceived stigma = what I believe others think of me

"They think I'm irresponsible."

Patient assumes healthcare team views them as careless about HIV transmission

"They're gossiping about me."

Belief that staff discuss their HIV status or personal life inappropriately

"I'm labeled as non-compliant."

Assumption that missing appointments brands them as difficult patients

The Hidden Barrier

Perceived stigma represents patients' beliefs about others' negative attitudes toward them, regardless of whether negative behavior has actually occurred. This form of stigma can be particularly insidious because:

- It operates independently of actual provider attitudes
- Patients may misinterpret neutral behaviors as stigmatizing
- It significantly erodes therapeutic trust and rapport
- It exacerbates depression, anxiety, and social isolation

Understanding perceived stigma helps clinicians recognize that even well-intentioned care can be experienced as stigmatizing if patients enter with pre-existing beliefs about how they will be judged or treated.

Anticipated stigma = what I expect will happen next time

1

Fear of Testing

Patient declines HIV screening, fearing healthcare providers will judge their lifestyle or assume promiscuity

2

Emergency Room Avoidance

Person with substance use disorder avoids seeking pain management, anticipating "drug-seeking" accusations

3

Care Disengagement

Patient expects negative experience based on housing status or multiple stigmatized identities

Anticipated stigma functions as a powerful predictor of healthcare avoidance. This expectation-based barrier often develops from past experiences, community stories, or media representations that shape patients' beliefs about how they will be received in healthcare settings.

Research Evidence

Studies consistently show that greater levels of anticipated stigma correlate with:

- Lower rates of HIV testing uptake (Gamarel et al., 2018; Mahlalela et al., 2024)
- Delayed care seeking for health concerns (Calabrese et al., 2018)
- Reduced adherence to prevention recommendations (Camacho et al., 2020; Rice et al., 2019)
- Higher rates of care disengagement (Horter et al., 2019)

The anticipatory nature of this stigma type makes it particularly challenging to address, as it requires building trust and demonstrating non-judgmental care consistently over time.

Internalized stigma = I start to believe the stigma

Self-Blame

Person living with HIV (PLWH) feels "dirty" or responsible for their condition, adopting society's negative judgments

Shame Spiral

Person with substance use disorder avoids care due to deep shame about their condition

Health Deterioration

Mental health and substance use worsen as self-stigma reinforces anticipated stigma

Social Withdrawal

Individual isolates from support systems, believing they don't deserve help or connection

Internalized stigma represents the most deeply embedded form of stigma, occurring when individuals adopt and apply negative societal attitudes to themselves.

This self-directed stigma creates a particularly vicious cycle where patients become their own worst critics.

Clinical Manifestations

Internalized stigma often presents as:

- Excessive self-blame for health conditions
- Reluctance to advocate for their healthcare needs
- Minimizing or dismissing their own symptoms
- Believing they don't deserve quality care or recovery
- Self-imposed isolation from family and community

This form of stigma is particularly tied to poor mental health outcomes and can significantly worsen substance use disorders, creating a reinforcing cycle that makes both anticipated stigma and care avoidance more likely.

Multi-layered stigma multiplies disadvantage

Research on multi-layered stigma reveals how multiple stigmatized identities don't simply add together—they interact and multiply to create unique forms of disadvantage that exceed the sum of their parts.

Multiple Identity Stigma

Homeless women simultaneously face stigma related to housing status, potential drug use, and health conditions.

Compounded Stigma

Enacted stigma manifests as physical violence, police harassment, and social service rejection.

Differential Outcomes

Sheltered women report significantly higher rates of violence, substance use disorders, and HIV risk behaviors compared to housed peers.

Types of stigma

People who are stigmatized			Stigmatizers (e.g., community, health workers)			
Anticipated stigma (Perceived stigma)	Internalized stigma (Self-stigma)	Experienced stigma	Enacted stigma	Fear of the disease	Symbolic stigma (Associations)	Perceived stigma (Attitudes)

Participation restrictions
Social exclusion
Poor quality of life

Mason, I., & Dijkstra, L. (n.d.). *Stigma—A special Problem of NTDs*. Medicus Mundi Switzerland. Retrieved October 10, 2025, from https://www.medicusmundi.ch/en/advocacy/publications/mms-bulletin/advancing-in-the-fight-against-neglected-tropical-diseases/new-approaches-against-ntds/stigma-a-special-problem-of-ntds

How multi-layered stigma shows up in clinics

HIV + Substance Use Disorder

A patient with HIV and active substance use is consistently labeled as "non-adherent" in medical records. Staff focus on medication compliance rather than addressing underlying barriers like housing instability, or inadequate pain management that contribute to continued substance use.

Mother with Housing Insecurity

A mother living with HIV avoids regular care appointments, fearing that disclosing her housing instability or discussing her children's needs might result in child protective services involvement. Her maternal identity intersects with HIV status and housing stigma to create care avoidance.

These scenarios illustrate how multi-layered stigma operates in real clinical encounters. Each patient faces unique circumstances that require individualized approaches. Recognizing these patterns helps clinicians understand why standard interventions may fail and why other approaches are essential.

Clinical Tip: When assessing patient needs, always consider how multiple stigmatized identities might interact to create barriers. Ask open-ended questions about what makes healthcare visits challenging and listen for themes that reveal compounding experiences.

Stigma undermines HIV prevention and care

Evidence from Longitudinal Research
A comprehensive study tracking people living with HIV who also experienced homelessness, mental health conditions, and substance use disorders revealed the profound impact of stigma on care engagement and the potential for intervention.

Key Findings

- **Initial burden:** More than four out of five participants reported experiencing HIV stigma at baseline
- **Intervention response:** Trust-based, client-driven care approaches led to measurable stigma reduction
- **Sustained improvement:** Stigma levels continued to decrease over the 12-month follow-up period
- **Care cascade impact:** Reduced stigma was directly associated with better care engagement and retention

This research demonstrates that stigma is not an immutable barrier—it can be meaningfully reduced through intentional clinical approaches that prioritize trust-building and address patients' holistic needs.

The study also revealed that stigma was tied to significant care gaps and delayed access to essential services, underscoring the urgent need for stigma-reduction interventions in all HIV care settings.

Maskay, M., Cabral, H. J., Davila, J. A., Davich, J. A. W., Marcus, R., Quinn, E. K., & Rajabiu, S. (2018). *Longitudinal Stigma Reduction in People Living with HIV Experiencing Homelessness or Unstable Housing Diagnosed With Mental Health or Substance Use Disorders: An Intervention Study*. https://doi.org/10.2105/AJPH.2018.304774

Strategy 1 — Communication that prevents stigma

Language in Action

Your communication style sets the tone for every patient interaction. Stigmatizing language not only harms patients psychologically but also influences how other healthcare team members perceive and treat them.

- Use present tense that acknowledges current experiences
- Avoid medical jargon that creates barriers to understanding
- Ask permission before discussing sensitive topics
- Validate patients' experiences and emotions

1 Use person-first, neutral language consistently

Replace stigmatizing labels with person-first language that separates the individual from their condition. Say "person with substance use disorder" rather than "addict" or "substance abuser." This linguistic shift signals respect and counters dehumanizing stereotypes.

2 Normalize needs and experiences

Use normalizing statements that reduce shame and isolation: "Many of my patients need support with housing" or "It's common for people to have questions about side effects." This approach helps patients feel less alone and more understood.

3 Pay attention to nonverbal communication

Tone of voice, eye contact, body language, and time spent with patients powerfully convey respect or stigma. Rushed visits, distracted attention, or visible discomfort can undermine even the most carefully chosen words.

Why Language Matters: Facing HIV Stigma in Our Own Words | The Well Project. (n.d.). Retrieved October 10, 2025, from https://www.thewellproject.org/hiv-information/why-language-matters-facing-hiv-stigma-our-own-words

Strategy 2 — Build trust: coordination + address unmet needs

Stigma reduction occurs most effectively when interventions include comprehensive trust-building measures, support for unmet social needs, and skilled navigation services. This multi-faceted approach addresses both immediate barriers and underlying systemic issues.

Trust-Building Approaches

Motivational interviewing, strengths-based counseling specifically mitigate perceived stigma by demonstrating genuine respect for patients' autonomy and experiences.

Address Other Factors

Directly addressing housing insecurity, food access, transportation barriers, and financial needs reduces care disengagement and builds therapeutic relationships.

*(*Clement et al., 2025)

Navigation Services

Skilled patient navigators help patients access services, understand complex systems, and advocate for their needs while providing emotional support.

(Natale-Pereira et al., 2011; Roland et al., 2022)

Evidence-Based Trust Building

Studies show that when healthcare interventions include trust-building components alongside clinical care, patients experience measurable reductions in perceived and anticipated stigma. Key elements include:

- **Consistency:** Same providers, when possible, reliable appointment scheduling
- **Transparency:** Clear communication about treatment plans and decision-making
- **Responsiveness:** Understanding and respecting patients' identities and experiences
- **Collaboration:** Involving patients as partners in their care planning

Strategy 3 — Make it organizational

Organizational Assessment Areas

Requires systematic evaluation and improvement across multiple domains:

- **Physical environment:** Welcoming spaces, signage, accessibility features
- **Policies and procedures**
- **Staff competencies**
- **Leadership commitment:** Visible support, resource allocation, accountability measures
- **Patient feedback systems:** Regular assessment of patient experiences and rapid response to concerns

This comprehensive approach ensures that stigma reduction becomes embedded in organizational culture rather than depending on individual provider attitudes or behaviors.

Individual interventions aren't enough

New York City HIV organizations found that stigma reduction efforts were often unsustained when they focused only on individual behavior change without addressing organizational culture and policies.

Health departments as bridges

Successful initiatives involved health departments providing funding, comprehensive training, ongoing monitoring, and technical assistance to create lasting organizational change.

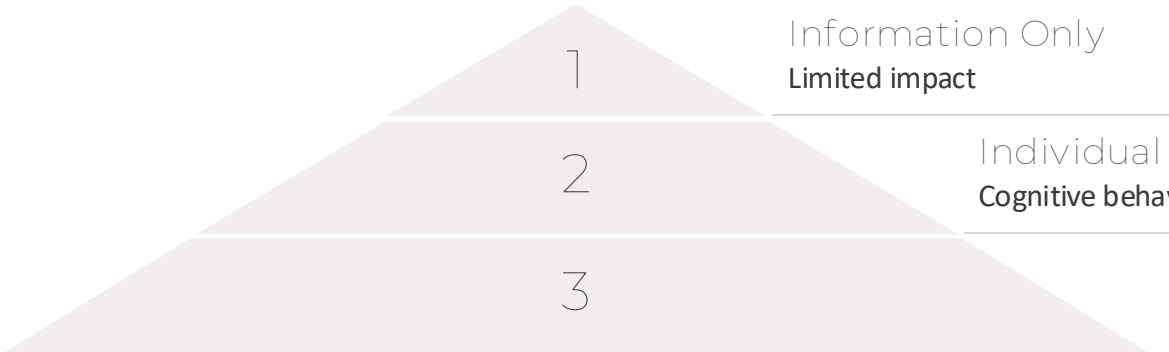
Total facility transformation

Effective approaches require organization-wide initiatives including staff training at all levels, leadership commitment, policy revisions, and environmental modifications in the organization.

Clement, D. N., Chiu, C., Ruiz, P., & Batchelder, A. W. (2025). Current Status of HIV-Stigma Reduction Interventions: A Need to Address the Root Causes at Multiple Levels. *Current HIV/AIDS Reports*, *22*(1), 35. https://doi.org/10.1007/s11904-025-00740-5
Nyblade, L., Stangl, A., Weiss, E., & Ashburn, K. (2009). Combating HIV stigma in health care settings: What works? *Journal of the International AIDS Society*, *12*(1), 15. https://doi.org/10.1186/1758-2652-12-15

Strategy 4 — Multi-level interventions outperform one-offs

Multi-level interventions combining individual cognitive-behavioral approaches with structural interventions significantly outperform single-component efforts in reducing self-stigma and improving care outcomes.



Information Only
Limited impact

Individual + Structural
Cognitive behavioral therapy combined with policy changes

Comprehensive Multi-Level
Individual counseling + organizational training + policy reform + community engagement

Why Multi-Level Approaches Work

Stigma operates simultaneously across multiple levels of influence, so effective interventions must address these various levels concurrently:

- **Individual level:** Cognitive restructuring, coping skills, self-compassion training
- **Interpersonal level:** Communication skills training, peer support groups
- **Organizational level:** Policy changes, staff training, environmental modifications
- **Community level:** Public awareness campaigns

Patient Priorities

Patients consistently prioritize structural interventions—such as housing assistance, income support, and healthcare access improvements—over individual-focused interventions alone. This patient perspective underscores the importance of addressing non-clinical factors alongside clinical care.

Analysis Finding: Combined structural and individual interventions reduced self-stigma by 40% more than information-only approaches in randomized controlled trials.

Clement, D. N., Chiu, C., Ruiz, P., & Batchelder, A. W. (2025). Current Status of HIV-Stigma Reduction Interventions: A Need to Address the Root Causes at Multiple Levels. *Current HIV/AIDS Reports*, *22*(1), 35. https://doi.org/10.1007/s11904-025-00740-5
Nyblade, L., Stangl, A., Weiss, E., & Ashburn, K. (2009). Combating HIV stigma in health care settings: What works? *Journal of the International AIDS Society*, *12*(1), 15. https://doi.org/10.1186/1758-2652-12-15

Strategy 5 — Implementation science sustains change

Implementation science provides the roadmap for translating stigma reduction analysis into sustainable clinical practice. The goal extends beyond initial implementation to ensure that effective strategies become embedded in routine care and can be maintained over time.

Logic Model Framework

Successful stigma reduction requires systematic alignment of interventions, implementation strategies, and desired outcomes. Logic models help organizations:

- Identify specific, measurable stigma reduction goals
- Select evidence-based interventions matched to target outcomes
- Choose appropriate implementation strategies for their context
- Plan for sustainability and spread of successful approaches

Essential Implementation Tools

1

Intervention Menu

Catalog of evidence-based stigma reduction strategies with implementation guidance

2

Readiness Checklist

Assessment tool to determine organizational capacity for change initiatives

3

Implementation Guide

Step-by-step guidance using established frameworks (ERIC, EPIS) for sustainable change

Key frameworks like ERIC (Expert Recommendations for Implementing Change) and EPIS (Exploration, Preparation, Implementation,Sustainment) offer structured approaches to navigate the complex process of organizational change while maintaining fidelity to evidence-based practices.

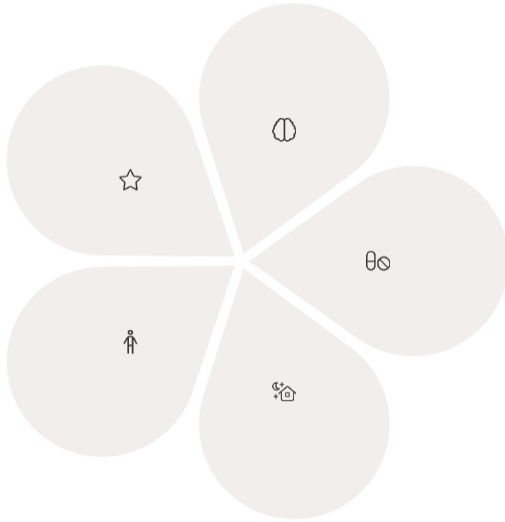
Moullin, J. C., & Aarons, G. A. (2022). Exploration, Preparation, Implementation, Sustainment (EPIS) framework. In *Implementation Science*. Routledge.
Waltz, T. J., Powell, B. J., Chinman, M. J., Smith, J. L., Matthieu, M. M., Proctor, E. K., Damschroder, L. J., & Kirchner, J. E. (2014). Expert recommendations for implementing change (ERIC): Protocol for a mixed methods study. *Implementation Science*, *9*(1), 39. https://doi.org/10.1186/1748-5908-9-39

Strategy 6 — Integrate services for compounding needs

Integration of HIV care with mental health, substance use disorder treatment, and housing support services dramatically reduces care drop-offs and addresses the multi-layered stigma that patients face across multiple service systems.

HIV care
Comprehensive HIV treatment and prevention services

Mental health
Behavioral health services



Substance use
Medication-assisted treatment and counseling

Social services
Benefits enrollment and case management

Housing
Emergency shelter and permanent housing supports

Integration Strategies

Effective service integration goes beyond co-location to create seamless care experiences:

- **Co-located services:** Multiple specialties in one location reduce travel barriers and appointment burden
- **Coordinated care teams:** Regular communication between providers ensures holistic care planning
- **Warm handoffs:** Direct introductions between providers build trust and reduce anxiety
- **Shared patient navigators:** Consistent support person helps patients access all needed services
- **Integrated documentation:** Shared records reduce redundant intake processes

This comprehensive approach recognizes that patients face multiple, interconnected stigmas that require **coordinated responses** rather than **fragmented services** that may inadvertently reinforce stigma through repeated disclosure and navigation requirements.

Key Insight: Integrated services reduce stigma by normalizing their complex needs and eliminating the burden of explaining their situation repeatedly to different providers.

Maskay, M., Cabral, H. J., Davila, J. A., Davich, J. A. W., Marcus, R., Quinn, E. K., & Rajabiu, S. (2018). *Longitudinal Stigma Reduction in People Living with HIV Experiencing Homelessness or Unstable Housing Diagnosed With Mental Health or Substance Use Disorders: An Intervention Study*. https://doi.org/10.2105/AJPH.2018.304774

Language quick-reference

Instead of...	Say...	Why it matters
"Substance abuser" or "Addict"	"Person with a substance use disorder"	Person-first language separates identity from condition
"Non-compliant" or "Non-adherent"	"Experiencing barriers to adherence"	Focuses on barriers rather than character flaws
"HIV-infected" or "HIV victim"	"Person living with HIV"	Emphasizes living and thriving rather than disease state
"Drug-seeking behavior"	"Requesting pain management—assess per protocol"	Maintains clinical objectivity and appropriate assessment
"Clean" or "Dirty" (referring to drug screens)	"Positive" or "Negative" test results	Avoids moral judgments about medical test results

Language choices profoundly impact patient experiences and clinical relationships. These alternatives demonstrate respect for patients' dignity while maintaining clinical precision. The shift from stigmatizing to neutral language requires conscious practice but becomes natural with repetition.

Remember: Language evolves, and communities may have preferences for specific terminology. When in doubt, ask patients how they prefer to be described and follow their lead while maintaining professional communication standards.

Resources: CDC Guide to Talking About HIV, Facing HIV Stigma in Our Own Words

Micro-skills: what to say when...

The Power of Micro-Skills

These brief, specific responses can transform difficult moments into opportunities for connection and trust-building. Key elements include:

- **Normalization:** "Many people..." statements reduce shame and isolation
- **Gratitude:** Acknowledging trust and courage validates patient vulnerability
- **Collaboration:** "Let's work together" language emphasizes partnership
- **Immediate support:** Offering concrete resources demonstrates care

When a patient declines HIV testing

"Many people feel unsure about HIV testing—that's completely understandable. May I share what other patients have found helpful about the process? We can also talk about what specifically concerns you."

When someone discloses substance use

"Thank you for trusting me with this information—that takes courage. Let's work together to plan care that fits your goals and supports your health in ways that make sense for your life right now."

When housing insecurity is revealed

"We screen everyone for housing stability because it's so important for health—you're definitely not alone in dealing with this. We have resources we can connect you with today if you're interested."

Practice these responses until they feel natural. The goal is to have stigma-reducing language readily available during challenging clinical moments when time pressure and emotional intensity can lead to less thoughtful communication.

Case reflection

Reflect on a recent encounter

Think of a clinical interaction from the past month where stigma may have influenced the patient experience, care delivery, or outcomes.

Identify stigma types present

Which forms of stigma were present? Consider experienced, perceived, anticipated, and internalized stigma, as well as potential compounding identities.

Plan one specific change

What is one concrete change you could implement for similar future encounters? Focus on actionable steps within your control.

Reflection Questions

Use these prompts to deepen your analysis:

- What assumptions did I make about this patient?
- How might my communication have been perceived?
- What barriers might have prevented optimal care?
- Which of their identities might face stigma in healthcare settings?
- What would I want to experience if I were in their situation?
- How can I better address their holistic needs next time?

This reflection process helps translate learning into practical application and builds skills for recognizing and interrupting stigma in real-time clinical practice.

Key takeaways

Stigma is multi-level —but modifiable

Stigma operates across individual, interpersonal, organizational, and structural levels, often intersecting with multiple identities. Despite its complexity, analysis consistently demonstrates that stigma can be meaningfully reduced through intentional, evidence-based interventions.

Relationship-centered care measurably reduces stigma

Trust-building approaches, comprehensive needs assessment, and coordinated care delivery create measurable improvements in patient experiences and care outcomes. These strategies work by addressing root causes rather than symptoms of stigma.

Sustain change with language and implementation science

Lasting stigma reduction requires systematic approaches including person-first language, organizational culture change, and implementation science frameworks to embed effective practices in routine care delivery.

Your Role in Ending Stigma

As an HIV clinician, you have unique power to interrupt stigma and create healing relationships with patients. Every interaction is an opportunity to:

- Demonstrate respect and dignity
- Address holistic patient needs
- Build trust through consistent, compassionate care
- Support changes that reduce barriers
- Model stigma-free care for colleagues and trainees

The evidence is clear: stigma reduction improves health outcomes, increases care engagement, and supports the goal of ending the HIV epidemic. Your commitment to implementing these strategies makes a meaningful difference in patients' lives and health outcomes.

Discussion + Q&A

What resonates with your setting?

Which of today's strategies feel most relevant and applicable to your current clinical environment? What existing strengths can you build upon?

Where do you want to start?

What feels like the most manageable first step for implementing stigma reduction in your practice? What would create the biggest impact with available resources?

What tools/support do you need?

What additional resources, training, or organizational support would help you successfully implement these approaches in your clinical work?

This is your opportunity to discuss challenges, share experiences, and problem-solve implementation strategies with colleagues. Stigma reduction works best when approached as a team effort, drawing on collective wisdom and supporting each other through the change process.

Remember that small, consistent changes often create more sustainable impact than attempting large-scale transformations all at once. Start where you are, use what you have, and do what you can to create more effective care for all patients.

How to Develop an Effective PrEP Campaign for a Federally Qualified Health Center (FQHC)

Start With the Goal: Normalize PrEP, Not "Promote" It

Key principle

- ċ ăèăŵŶŭƌă KĂNḌ ǗĪǮǗ ŵƨĊ Ï ŠŭĈĊ ĕĘŴȫĿăĿ ĘĊ normalization ĊĘNĴ ăĪĿŐŠĿŬĊ

Campaign objective

- Š šĄă ǗĪǮǗ
  - ĪĘȪNŭă
  - ĊĘĊ ĿNŭĊ ŠNŭŭê
  - ăŠĿŤ NĘŠŴŵăĿĿ
- ǗĘĿŵŭĊ ǗĪǮǗ ŠĿ preventive primary care ĊĘNĴ ăŵŭĂŤNȎ ŵƨĪă

Example framing

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MISSISSIPPI HEALTH ALLIANCE

Know Your Patients and Community

Use data + lived experience

- ŒẸẅšẨNÔ ăï ǜŷăc ǗẬẸêŤ
- KĂNḌï šNǕĊNỹăc Ẹêīšï ḻ ǗŴĿ
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- KīẸĊNẨĈă ĿNŠJèǗĈĿĿǗêḻ NJ

Demographics

Key insight

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Align the Campaign With Integrated Care Workflows

Before external messaging, fix internal systems

[illegible]

- [illegible]
- [illegible]
- [illegible]
- [illegible]

Why this matters

- [illegible]
- [illegible]

Campaign rule

[illegible]

Create Simple, Stigma-Free Messaging

Effective FQHC messaging is:

- ÍJÁŠûÛÁŠċêÖšêă
- ŞĘċ ÄÖÿêc ăċNŠJÅ

Message examples

- NÔ ï īăRăċNÛĘċ ûÙï šīNĘèŤĘÖī īĘÖNÛÛă ẅšīă
- ÍJīŽÍJ ûÙèÊī šĊŤÊĊă' Ļ Ę' šĊNJNĘL·NŠJŤ NÔ ċăêšNÛRă
- L·Ą ÖL·šÜĘÖNJJÍŽÍJ ĊĘ ûÛL·ÖīšĊẅăīăî ÖŪÛăÿ

Avoid

- ĄûÙ·Ą Ļ ăšRŤ ÁŠċêÖšêă
- Kăšī ÜšL·ăÿ c ăL·L·šêûÛê
- ÛRăīÁŤ ẅÄÛûÛŠÅNŠJīC L·

Make Staff the Primary Campaign Messengers

Internal Campaign = External Success

Train all staff

- KĪĘĊNÿĂŁĄ
- Š ąÿ ŵŠÅŠŁŁŮŃŠĊNJ
- Ş ŐĪŁĂŁ
- ÍÍĪĘŘÿĂĪŁ
- ÇĂĻ šŘŮĘĪšÅĻ ăšÅŃĻJ
- ÛŐNĪĂšŵĻ ' ĘĪĄĂĪŁ DĘC C ŐĊŮŃJNăšÅŃĻJ Ĵ ĘĪĄĂĪŁ DNĴ Ł

Provide:

- ŁĂĊNĂĊŵă ÍÍĪŽÍ ŁŵĪŮŨNJ
- K Ă Ł
- DÅĂšĪ ĪăèăĪĪšÅï šŃJ' šŤŁ

Example script

Ĵ ă NŠJÅĄ NĘJŠÅÅĘŐĪ Ï šNŰĊNJšÜĘŐNJ šŤŁ NĘŁNŠJŤ NĈ ĊăêšNŰŘă ŮŵÄŐÿŮê ÍÍĪŽÍ Ĵ ĘŐÅÿ ŤĘŐ ÅĄąă NĘÄĂšĪĊ C ĘĪă

Use Multiple Access Points (Not Just Posters)

In-clinic

- [illegible]
- [illegible]
- [illegible]
- [illegible]

Outside the clinic

- [illegible]
- [illegible]
- [illegible]
- [illegible]

Digital

- [illegible]
- [illegible]
- [illegible]

Key point

[illegible]

Remove Financial and Structural Barriers in Messaging

Be explicit about access

[illegible]

Always include

- [illegible]
- [illegible]
- [illegible]

[illegible] non-Medicaid expansion states

Incorporate TelePrEP Into the Campaign

TelePrEP expands reach

- [illegible]
- [illegible]
- [illegible]

Campaign messaging

- [illegible]
- [illegible]

Partner With Community Organizations

Why partnerships matter

- [illegible]
- [illegible]
- [illegible]

Partner roles

- [illegible]
- [illegible]
- [illegible]

- [illegible]

Monitor, Adapt, and Sustain

Track key metrics

- Ş ÖC üăī Ę è Ú Ī Ž Ú Ł Ẅ ă ă ċ ů ê Ł
- Ú Ī Ž Ú Ł N Ş Ī N J
- Ą ă N ă ċ N Ę C Ş N J Ş ċ ỹ C Ę ċ N J Ł
- Ş Ę Ł Ļ Ę ' Ī Ş N ă J Ł

Use feedback loops

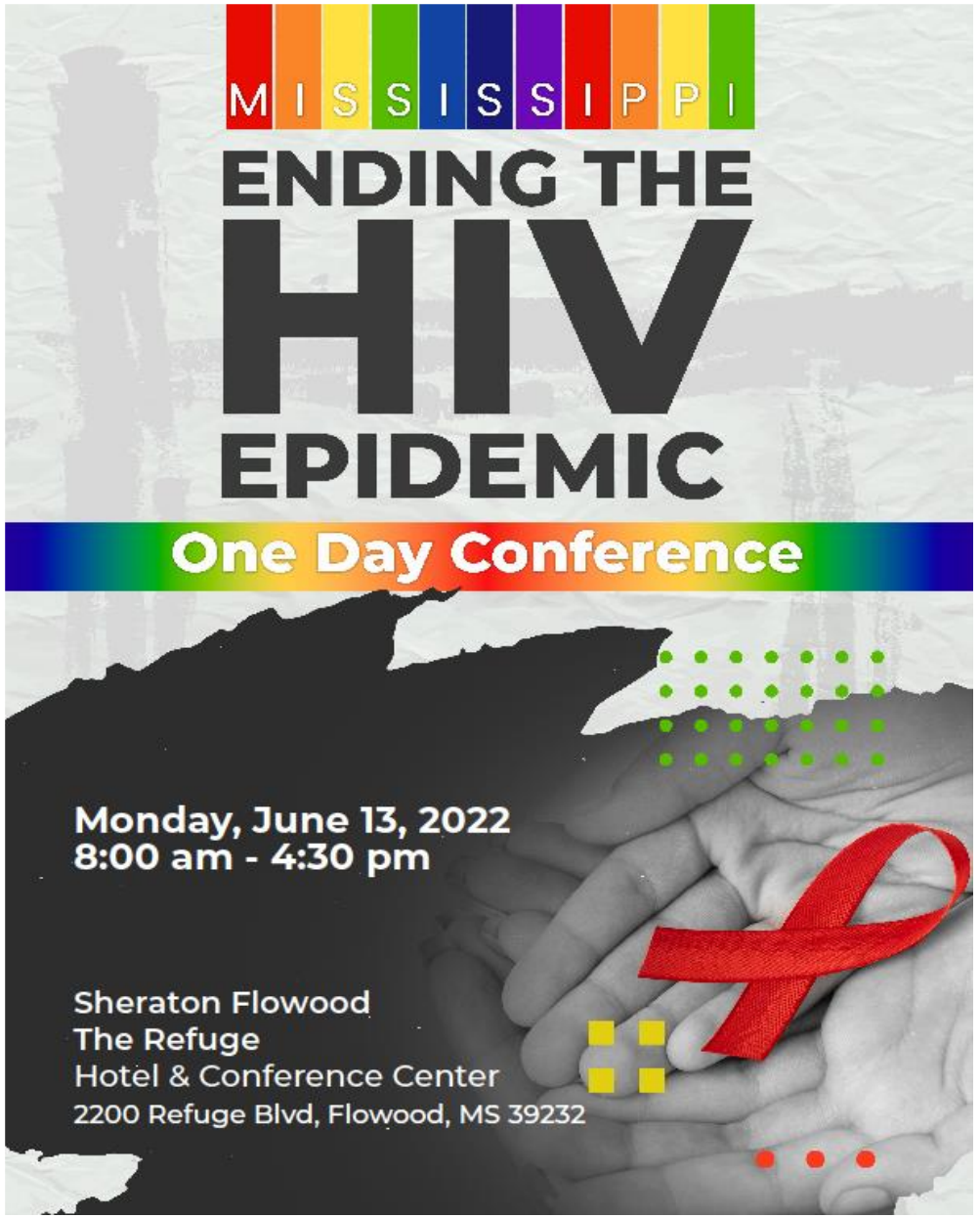
- Ä N Ş J è è ă ỹ ü Ş Ẅ Ą
- Ú Ş N ă ċ N è ă ỹ ü Ş Ẅ Ą
- D Ę C C Ö C Ů Ñ J ů Ï Ö N J

Sustainability

- Ą ă è ī ă Ł Ļ C ă Ł Ł Ş ê ů ê Ī ă ê Ö Ẩ Ş Ī Ẩ
- Ć N ă ê Ī Ş N J ů N Ę J Ş ċ ċ Ö Ş Ẩ Ï Ī ă Ą ă ċ N Ę C Ï Ī Ę Ī Ů Ñ ă J Ł
- D ỹ N Ę N Ą Ä Î Ö Ş Ẩ Ů J ů Ï Ī Ę Ą ă C ă ċ N ă è è Ę Ī N J

Example of a PrEP Campaign

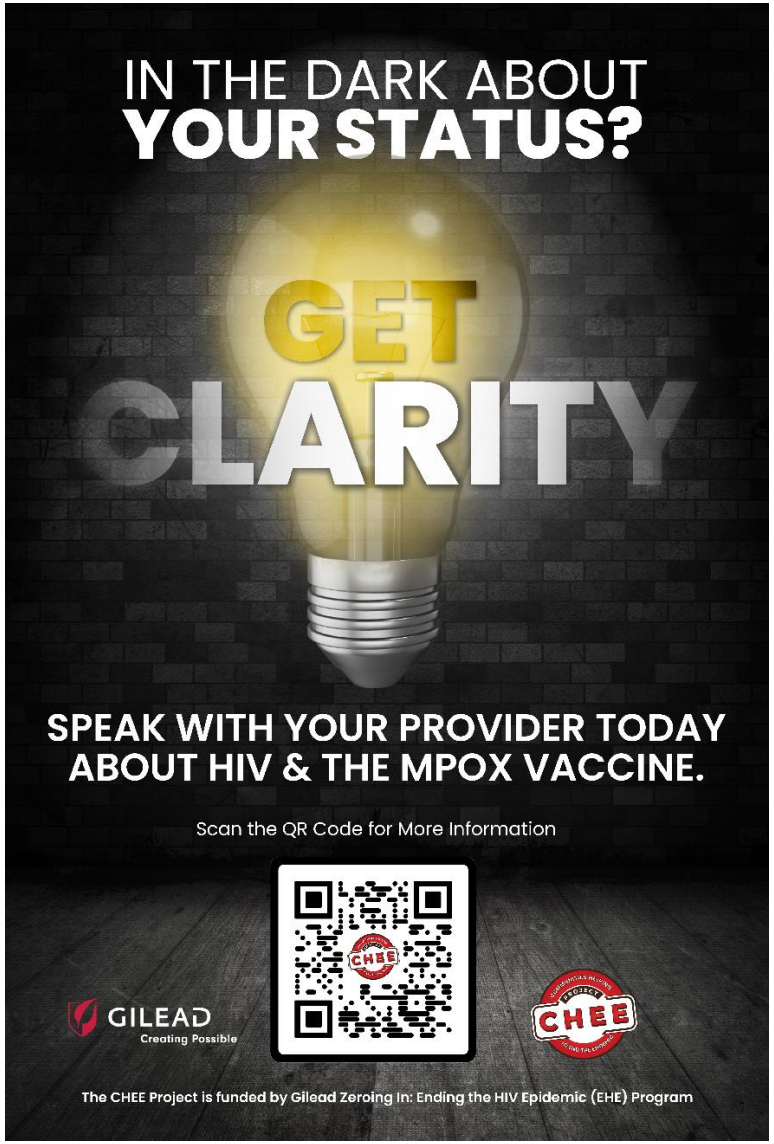
MISSISSIPPI HEALTH ALLIANCE

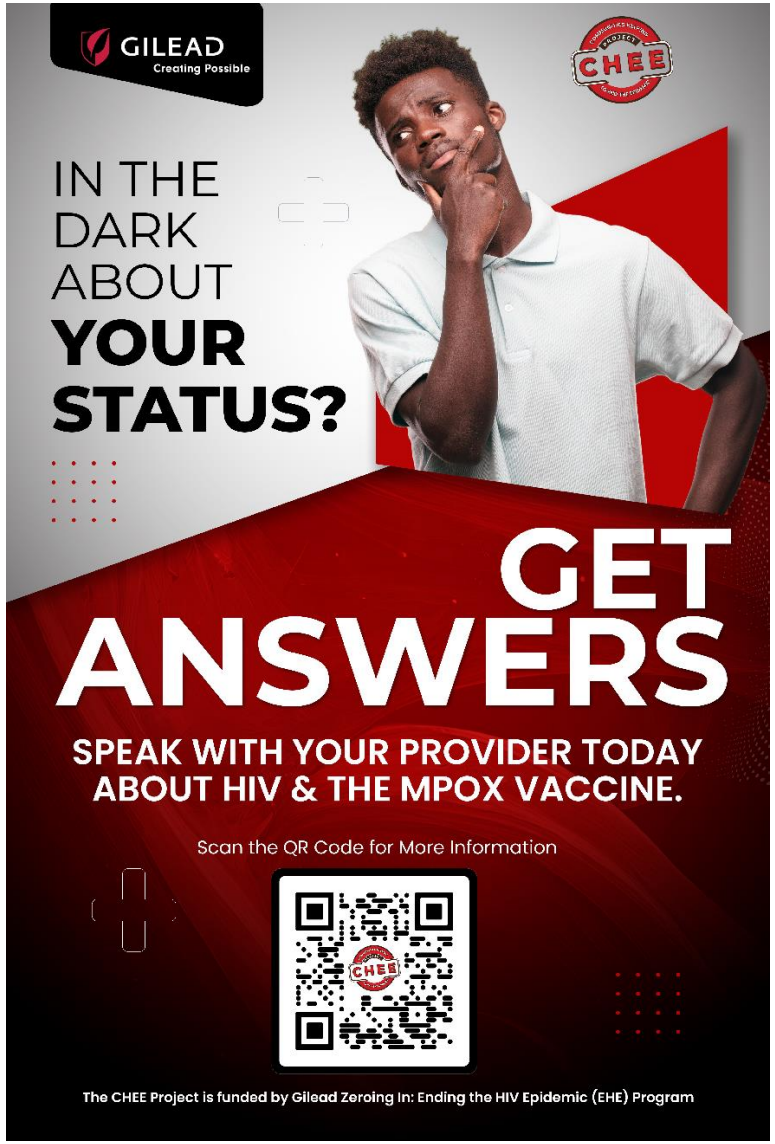



EXIT

MISSISSIPPI HEALTH ALLIANCE

MISSISSIPPI HEALTH ALLIANCE





MISSISSIPPI HEALTH ALLIANCE

Brainstorming Activity (Breakout Session)

HRSA Disclaimer

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