UCSF

2026

Addressing Stigma in HIV Prevention Services

TOOLKIT

table of CONTENTS

EXECUTIVE SUMMARY

Community-based organizations play a vital role in HIV prevention.[1] Every day, peer navigators, outreach workers, counselors, and program staff connect people with HIV and STI testing, prevention education, PrEP referrals, and other supportive services.

At the same time, stigma related to HIV, sexuality, substance use, and other factors can still shape how people experience prevention services.[2,3,4] Stigma may appear in outreach materials, intake processes, service settings, or everyday interactions between staff and clients.[3,4] When stigma is present, it can make it harder for people to seek services, share information, return for follow-up care, and stay engaged in prevention.[4]

This toolkit was developed for community-based organizations in the United States that provide HIV prevention services. It is intended for organizational leadership, program managers, peer navigators, counselors, outreach workers, and others involved in direct service delivery or program design. While we recognize that staff might face stigma within the workplace, this toolkit focuses on client experiences.

This toolkit focuses on three areas where stigma often appears:

1. Program promotion and health education materials
2. Organizational policies and service processes
3. Interactions between staff and clients

Organizations can use this toolkit as a discussion guide, a self-assessment resource, a planning tool, or a starting point for stigma-reduction efforts. Reducing stigma is not a one-time task. It is an ongoing process of reflection, learning, and improvement.

Purpose of This Toolkit

This toolkit is designed to help organizations:

- Identify where stigma may unintentionally occur
- Understand how stigma affects HIV prevention services
- Strengthen services so more people feel welcome and supported
- Apply practical strategies to reduce stigma

1. Marano-Lee M, Williams W, Xu S, Andia J, Shapatava E. Contributions of the Community-Based Organization Program Funded by the Centers for Disease Control and Prevention to Linkage to HIV Medical Care. Public Health Rep. 2024;139(6):662-668. doi:10.1177/00333549241252579
2. Luderer M, Stockreiter D, Binder A, et al. Stigma from healthcare professionals and care-limiting behaviors in individuals with substance use disorders: a mixed-methods study. Lancet Reg Health Eur. 2026;63:101587. Published 2026 Jan 12. doi:10.1016/j.lanepe.2025.101587
3. Nyblade L, Stockton MA, Giger K, et al. Stigma in health facilities: why it matters and how we can change it. BMC Med. 2019;17(1):25. Published 2019 Feb 15. doi:10.1186/s12916-019-1256-2
4. Price T, McGowan V, Cooper C, Scott S. Exploring the impact of stigma on the health of inclusion health groups: a qualitative scoping review and critical analysis. BMC Public Health. 2025;26(1):24. Published 2025 Nov 24. doi:10.1186/s12889-025-25603-x

THE TEAM BEHIND THE TOOLKIT

This toolkit was developed by the UCSF Technical Assistance Team to support community-based organizations working to strengthen HIV prevention services.

Our team partners with organizations to support program planning, implementation, and quality improvement in HIV prevention and related services. We bring experience in public health research, community-engaged practice, technical assistance, and implementation support.
This toolkit is one resource organizations can use to review current practices, identify opportunities for improvement, and strengthen stigma-reducing approaches in their programs.

The Authors at UCSF

Sophia Zamudio-Haas, DrPH, MSc.
Luz Venegas, MPH
Barbara Green-Ajufo, PhD
Jen Shockey, MPH
Kim Koester, PhD, MA
Ben Zovod
John Haminga
Hong-Ha Truong, PhD, MS, MPH
Janet Myers, PhD, MPH, MA
Greg Rebchook, PhD

HIV Services Organization Contributors

Aaron Armer, Health Services Outreach Manager, at Sacramento LGBT Center
Chey Mongeon, Education, Outreach and Prevention Coordinator, at Sunburst Projects
Cristobal Valdebenito, MPH, MA, Director of Community Health, at OUTMemphis
Tabasha A Davis, Director of Opioid & HIV Prevention Services, at Williams & Associates, Inc.

KEY TERMS
STIGMA

Stigma refers to negative attitudes, beliefs, or judgments about a person or group based on characteristics such as HIV status, sexual behavior, sexual orientation, gender identity, substance use, mental health, or demographic characteristics (e.g., age, religion, socioeconomic status).[1] Stigma can affect how people are treated, how comfortable they feel accessing services, and how they feel about themselves.[2]

Anticipated Stigma

When someone expects they may be judged, treated poorly, or discriminated against if they seek HIV-related services. This expectation may lead people to delay or avoid services.

Experienced Stigma

Experienced stigma happens when someone is directly judged, treated differently, or discriminated against in a service setting or another environment.

Internalized Stigma

Internalized stigma occurs when a person begins to believe negative stereotypes about themselves. This can affect self-esteem, decision-making, and willingness to seek care.

Economic Stigma

The judgment and devaluation of individuals experiencing low incomes or those who rely on public assistance. It often manifests as the false perception that poverty is solely a personal moral failing rather than a systemic issue.

People-Centered Programs

People-centered programs focus on the needs, priorities, and lived experiences of the people they serve. These programs listen to clients, respect their choices, and create welcoming environments.[3]

Whole-Person Approaches

Whole-person services support a person's overall health and wellbeing regardless of HIV status. People who test HIV-negative can be connected to prevention services such as PrEP, while people who test HIV-positive can be connected to HIV care and treatment. Whole-person approaches also address the broader factors that shape health, such as housing, mental health, and social support.

Integrated Services

Integrated services bring multiple forms of care and support together, such as HIV testing, PrEP referrals, mental health services, substance use support, primary care, and harm reduction services.

1. Goffman E. Stigma: Notes on the Management of Spoiled Identity. Prentice-Hall; 1963.
2. American Psychiatric Association. Stigma, prejudice and discrimination against people with mental illness. Reviewed March 2024. Accessed August 11, 2026. https://www.psychiatry.org/patients-families/stigma-and-discrimination
3. Coulter A, Oldham J. Person-centred care: what is it and how do we get there?. Future Hosp J. 2016;3(2):114-116. doi:10.7861/futurehosp.3-2-114

How does stigma show up in HIV prevention?

Stigma is not always obvious. It often appears through small signals, assumptions, or systems that unintentionally make people feel judged or excluded. Even organizations that are deeply committed to their communities may have practices that unintentionally reinforce stigma.
In HIV prevention services, stigma often appears in three areas:
(1) Program promotion and health education materials
(2) Organizational policies and processes
(3) Interpersonal interactions

1. Program Promotion and Health Education Materials

Outreach materials are often the first interaction people have with an organization. Flyers, websites, social media posts, and educational materials can send strong messages about who services are for and what clients can expect.
Stigma may appear when materials:

- Suggest only certain groups should use services
- Reinforce stereotypes through language or images
- Focus on “risk” in ways that feel blaming or judgmental

Example: A PrEP campaign focuses heavily on “high-risk behavior” and multiple partners. Some community members interpret the message as judgmental or assume the service is not meant for them.

2. Organizational Policies and Processes

The way services are organized also shapes the client experience. Referral pathways, intake forms, appointment systems, and service locations may unintentionally fuel stigma by separating clients based on HIV status and behaviors or through language used to determine eligibility.
Stigma may appear when:

- Intake forms make assumptions about identity or behavior
- Service hours or locations are limited to specific groups of people
- Privacy feels inadequate

Example: A clinic revises its intake process by renaming the "Risk Assessment" section to a "Life Assessment." This shift moves away from a deficit-based framing that centers on what could go wrong, and instead takes a social and structural determinants of health approach, inviting a more holistic conversation about the client's overall life, goals, and circumstances.

3. Interactions Between Staff and Clients

Everyday interactions between staff and clients can strongly shape whether services feel welcoming and respectful. Stigma often emerges when interactions focus narrowly on individual behavior, rather than understanding a person within the broader social and structural context of their life.

Stigma may appear when staff:

- Make assumptions about a client's identity or behavior, without considering the factors shaping their experiences.
- Ask questions in ways that feel intrusive or judgmental.
- Use language that blames, shames, or expresses surprise.

Example: A health practitioner reflects on how she maintains compassion in difficult interactions. Even when her clients don't treat her with a lot of kindness, she explains, "it does not diminish my own capacity if someone cannot afford me kindness."

WHY THIS MATTERS

When stigma shows up in services, even unintentionally, it can affect whether people:

1. Seek out HIV prevention services
2. Feel comfortable sharing information
3. Return for follow-up care
4. Recommend services to others

Creating stigma-aware services helps more people feel welcome, respected, and supported.

Identify Sources of Stigma In your Organization

Reducing stigma starts with identifying where it may appear in your programs and services. A simple review of program data, outreach materials, staff perspectives, and client feedback can help organizations spot barriers and identify opportunities for improvement.

1. Review Program Data

Look for patterns that may suggest barriers to access or engagement.
Questions to consider:

- Who is using our services most often?
- Are some groups underrepresented?
- Are clients returning for follow-up visits?
- Where do people tend to disengage?

2. Review Outreach & Educational Materials

Review flyers, websites, social media posts, and counseling materials.
Questions to consider:

- Do our materials reflect all the communities we serve?
- Are materials offered in multiple languages?
- Could any messaging unintentionally reinforce stereotypes?
- Are materials fear-based or use alarming statistics?
- Do materials clearly communicate that services are welcoming to all people?

Identify Sources of Stigma In your Organization

3. Talk With Staff (monthly or annually)

Staff often see where clients feel comfortable and where barriers appear.
Questions to consider:

- When do clients seem hesitant or uncomfortable?
- What questions come up about privacy, confidentiality, or judgment?
- What changes might make services more welcoming?

4. Talk With Community Members

Community member feedback is essential. Learn about how community members talk about services. Possible approaches include: informal conversations, satisfaction surveys, community advisory boards, listening sessions, or focus groups.
Questions to consider for community member or client feedback:

- Did you feel welcomed and respected?
- Was anything confusing or uncomfortable?
- What could we improve?

Team Reflection Questions

- Where might stigma unintentionally appear in our services?
- What are we already doing well?
- What small changes could improve the client experience?
- What more do we need to learn from staff or clients?

Reminder: The goal is not to assign blame. It is to create opportunities for reflection and improvement.

Strategies to reduce stigma

IN HIV PREVENTION SERVICES

Once organizations identify potential sources of stigma, the next step is to take action. This section highlights three practical, evidence-informed approaches.

STEPS	DETAILS	ACTIONS
1. Whole-Person Approaches	Status-neutral services support people regardless of HIV status and connect them to prevention or care as needed. This approach can reduce stigma by emphasizing health, wellness, and continuity of care.	• Provide guidance or education to staff on status-neutral language • Present prevention and treatment as part of the same continuum • Frame services around wellness and support • Update materials to emphasize self-care and empowerment
2. Integrate Services When Possible	Clients often have multifaceted needs; however, policies that separate programs by health area can unintentionally reinforce stigma, by contributing to assumptions or labels about clients' behaviors or sexuality from attending services.	• Offer co-located or coordinated services • Cross-train staff across programs • Share information about all services provided with every client
3. Develop Appealing and Relevant Health Promotion Materials	Health promotion materials can help people see services as relevant, respectful, and welcoming.	• Use plain, nonjudgmental language • Avoid blame-based or overly risk-focused messaging • Reflect a range of styles and cultures • Clearly communicate privacy, support, and access

FROM REFLECTION TO **ACTION**

Organizations do not need to change everything at once. Small, practical steps can make a meaningful difference. Updating forms, revising outreach materials, adjusting service flow, or strengthening staff communication can all improve the client experience.

How Do You Know If Efforts Are Working?

Reducing stigma is an ongoing process. As organizations update materials, adjust service processes, or train staff, it is important to track whether these changes are improving the client experience.
Monitoring does not need to be complicated. A small number of practical measures can help organizations understand whether their efforts are making a difference.

1. Gather Client Feedback

Useful approaches to gauge how clients feel about stigma reduction efforts include:

- Short surveys: ask about program promotion and health education materials (e.g., Are the materials relevant? Are they appealing?), what is working or could be improved around intake processes or interactions with staff, or how to make the physical space more welcoming
- Informal conversations: ask clients about their experiences or how they feel about specific changes your organization made to reduce stigma
- Advisory boards or listening sessions: facilitate group sessions to learn more about client and community perceptions on change efforts

Questions to consider

- Did you feel welcomed and respected from entry to exit?
- Was anything uncomfortable about the way you were treated or spoken to?
- Did staff explain all prevention options in language that made you feel they understood your priorities?
- What could we do better?

2. Check In With Staff

Including time to check-in around stigma reduction efforts routinely can help identify what is changing and what support is still needed to achieve shared goals. Consider introducing stigma reduction efforts in routine organization or team meetings and then following up in individual meetings around any change ideas for organizational policy and protocols, client interactions, or health promotion materials.

Topics may include

- What changes have staff noticed in client interactions since trying a new change idea?
- Whether conversations feel easier or more open after trying the new approach or strategy.
- Ongoing challenges in service delivery could be due to unintentional stigma.
- Additional training or resources needed to continue to address and reduce stigma.

3. Track the Impact of New Outreach and Communication Materials

Look for signs that revised materials are reaching and resonating with the community.

Possible indicators include

- More inquiries about services from new potential clients.
- Increased outreach engagement or referrals through social networks.
- Broader range in demographics or prevention needs among clients accessing services.

Keep it Simple

Organizations do not need to track everything. Start with a small number of measures that reflect your goals. For example:

- Client feedback about feeling respected
- Staff reflections on service delivery
- Engagement with outreach materials

Review these measures regularly, such as every 6 or 12 months, and use what you learn to keep improving services.

Note: Certain intake items (e.g., education, employment status) may carry stigmatizing connotations for some respondents. Such questions are often included on intake forms by default, rather than because a specific analysis needs them. For populations already facing structural marginalization, they can carry an implicit judgment (unemployment or lower education read as personal failure rather than as the product of documented discrimination in hiring, school retention, etc.). Asked without context, they can also read as gatekeeping, think: "prove you're stable enough to be worth serving." Inclusion of such items should be weighed against their necessity for the analysis' specific aims.

Next Steps

TOOLS AND RESOURCES

This toolkit is intended to help organizations begin or strengthen stigma-reduction work in HIV prevention services. The most effective approaches are those that fit your setting, reflect your community, and evolve over time.

QUICK REFLECTION TOOL

Use the questions below in a staff meeting or planning session:

1. What signals do clients receive when they enter our space?
2. Where might clients feel uncomfortable or judged?
3. Do our materials reflect the communities we serve?
4. What feedback have we heard from clients?
5. What small changes can we make now?

RESOURCES

Include links here to:

- CDC resources on HIV program monitoring and evaluation
- Stigma-reduction training materials: [Resource 1]; [Resource 2]
- UCSF technical assistance resources

MOVING FORWARD

Reducing stigma is an ongoing process of learning, reflection, and action. Community-based organizations play a vital role in creating HIV prevention services that are welcoming, respectful, and responsive. By taking practical steps to identify and address stigma, organizations can strengthen trust, improve access, and better support the health and well-being of the communities they serve.

Stigma Reduction
ACTION PLANNER

Reducing stigma is an ongoing process. This worksheet can help your team identify small, practical steps to make HIV prevention services more welcoming and accessible.
Use this tool during staff meetings, program planning sessions, or quality improvement activities.

STEP 1: IDENTIFY AREAS FOR IMPROVEMENT

Think about where stigma may unintentionally appear in your programs or services.
Examples may include:

- outreach materials and messaging
- intake forms or service processes
- referral systems
- staff communication with clients
- program environment or physical space

Discussion Questions

- Where might clients feel uncomfortable or judged?
- What feedback have we heard from clients about their experience?
- What parts of our services could be more welcoming or accessible?

Team Notes

Stigma Reduction
ACTION PLANNER

STEP 2: CHOOSE ONE OR TWO PRIORITIES

Focus on a small number of changes that your team can realistically implement in the next few months.

Examples may include:

- Revising outreach materials
- Simplifying referral pathways
- Updating intake forms
- Providing staff training on stigma reduction
- Strengthening client feedback system

Priority Areas

Stigma Reduction
ACTION PLANNER

STEP 3: PLAN YOUR ACTION STEPS

Priority Area	Action Steps	Who Is Responsible?	Timeline
Example: Improve outreach materials	Review language in current flyers and update messaging	Outreach team	3 months

Team Notes

Stigma Reduction
ACTION PLANNER

STEP 4: DECIDE HOW YOU WILL MONITOR PROGRESS

Choose simple indicators to help track whether your changes are improving services.

Examples may include:

- Revising outreach materials
- Simplifying referral pathways
- Updating intake forms
- Providing staff training on stigma reduction
- Strengthening client feedback system

Indicators We Will Monitor

Team Notes

Stigma Reduction
ACTION PLANNER

STEP 5: REVIEW AND ADJUST

Set a time to revisit this plan and discuss what you have learned.
Suggested timeline: every 6–12 months

Discussion questions:

- What improvements have we noticed?
- What challenges have we encountered?
- What changes should we make next?

Team Notes

Reminder: Reducing stigma is a continuous process.

Small, consistent improvements can help create services that feel welcoming, respectful, and supportive for all clients.

Are Our Services Welcoming to Everyone?

CHECKLIST

1. Program Environment: Physical space, mobile units, etc.

- We clearly communicate that services are welcoming to all communities.
- Privacy and confidentiality are protected.
- Service hours and locations are accessible.

2. Service Processes

- Intake forms use inclusive language.
- Referral processes are simple and easy to navigate.
- Clients are offered prevention options without assumptions.

3. Staff Interactions

- Staff use respectful, nonjudgmental language (e.g., people with HIV vs. HIV-positive people; people who inject drugs vs. drug users)
- Staff receive training on stigma reduction and client-centered communication.
- Clients feel comfortable asking questions.

4. Outreach and Education

- Materials reflect our communities.
- Messaging focuses on health, prevention, and empowerment.
- Materials avoid language that feels blaming or stigmatizing.

APPENDIX A

CASE STUDIES

Creating a Welcoming Environment

A community health center noticed that some clients who expressed interest in PrEP during HIV testing stopped coming in for follow-up visits. The HIV services team wondered what was happening and facilitated a conversation on the topic with a group of core clients. They learned that staff in reception were not calling clients by their lived names and were treating clients who used a different name than the one on their government photo ID coldly or dismissively.

The organization updated forms to include lived names. They changed protocols to ask all clients their names and pronouns, so that no client was singled out. They provided all staff with training on using neutral and respectful language. Over time, staff reported more open conversations with clients, and the HIV services team noticed improved follow-up.

Integrating Services to Reduce Barriers

A harm reduction program offering syringe services and referrals to other prevention services found that many clients were not following up with referrals to HIV tests. The program responded by strengthening partnerships and expanding access to testing, PrEP navigation, and mental health support within their program. They invited providers in their organization to offer services in the syringe exchange space, a setting where clients already felt comfortable.

Use of HIV prevention and mental health services increased. Clients shared they felt more at ease accessing multiple types of care in one setting, without having to follow up on referrals to services in other locations. Some noted that going for an HIV test outside of the syringe exchange made them concerned that people in their social network would see them and make assumptions about their sexual behaviors or sexuality.

APPENDIX A

CASE STUDIES

Streamlining Intake to Build Trust

An HIV testing program noticed that clients frequently commented on how long and personal the intake process felt before they could even be tested. Front-desk staff reported that some clients grew visibly uncomfortable or hesitant when asked about their education level and employment status, questions that were part of the standard intake form but not tied to any specific analysis the program was conducting. A few clients left before completing intake, and others disclosed afterward that the questions felt more like a judgment of their worth than a step toward getting care.

The program reviewed its intake form item by item, asking whether each question was actually necessary for service delivery or evaluation. Items like education and employment status, which had been included by default rather than for a defined purpose, were removed. Questions that remained were introduced with brief explanations of why the information was being collected and how it would be used.

Clients reported feeling less scrutinized and more willing to complete the full intake process. Staff noted that appointments moved more efficiently once the form was shortened, and follow-through to testing improved. Several clients specifically mentioned that removing questions about employment and education made the experience feel less like they had to "prove" they deserved services, and more like a straightforward path to care.

ACKNOWLEDGEMENTS

University of California San Francisco
Department of Prevention Medicine
550 16th St.
San Francisco, California,
94158, USA
https://prevention.ucsf.edu/

WE THANK YOU

FOR YOUR COMMITMENT TO REDUCING STIGMA

IN HIV PREVENTION SERVICES