

A STIGMA REDUCTION TOOLKIT FOR THE VICTORIAN HEALTHCARE WORKFORCE

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CONTENTS

04 BACKGROUND

- O4 What is the guide for?
- O4 Stigma or discrimination?
- 04 What will you find in this guide?
- O5 How is this guide to be used?

06 EXPLORATION

10 INITIAL IMPLEMENTATION

- **14 IMPLEMENTATION**
- 18 REVIEW, REFINE AND REFRESH

22 IMPLEMENTATION EXAMPLES

- 22 Implementation example A: Revising plans and goals in response to challenges
- 32 Implementation example B:
 An ongoing project to address stigma
 and discrimination and ensure best
 practice

40 IMPLEMENTATION RESOURCES

- 41 Reflection tables for tracking progress
 - 42 Working group reflection table
 - 43 Project staff reflection table
 - 44 Implementation planning table
 - 46 Review table
 - 48 Milestone progress tracking table
 - 50 Timeline table

50 THE PROJECT USED TO DEVELOP THIS GUIDE

BACKGROUND

In 2021, the Victorian Department of Health funded a research team at the Australian Research Centre in Sex, Health and Society, La Trobe University, to develop a broad-based stigma and discrimination reduction toolkit that is responsive to the needs of healthcare services who provide care to people affected by blood-borne viruses (BBVs) and sexually transmissible infections (STIs).

Conducting a series of focus groups with healthcare professionals and consultations with relevant community organisations, the research produced a <u>practice-ready toolkit</u> for Victorian health services to use in efforts to reduce stigma and discrimination related to BBVs and STIs.

This implementation guide was developed to support healthcare professionals and services to implement stigma and discrimination reduction strategies available in the toolkit.

With funding from the Victorian Department of Health, the team conducted a research project that piloted the toolkit in two programs at Your Community Health, a registered Victorian community health service. The lessons that emerged from this pilot, including implementation challenges and enablers, have been used to inform this guide. This implementation guide can be used alone or alongside insights from a recorded workshop available online. The workshop includes presentations from the team that produced the toolkit and conducted the research that informs this implementation guide alongside a panel discussion in which key representatives from community organisations discussed how healthcare services can demonstrate allyship with people affected by BBVs and STIs. Whether alone or in conjunction with the online workshop, this implementation guide provides step-by-step advice on how to make use of the toolkit in your healthcare service.

What is the guide for?

This implementation guide is designed to support healthcare services to develop and implement activities within their organisations which can address stigma and discrimination related to BBVs and STIs. By drawing on the lessons learnt by other healthcare professionals who used the toolkit in their service, this guide provides practical advice on how to address stigma and discrimination, as well as how to address any challenges that may arise when implementing strategies, activities and resources available in the toolkit.

The guide may also be useful for any Victorian organisations that provide services for people affected by BBVs and STIs.

Stigma or discrimination?

While stigma and discrimination are terms that are often used interchangeably, the toolkit and this guide approaches them as related but different issues. Discrimination is one possible manifestation of stigma: it is made and enabled through stigma. From this perspective, experiences of discrimination are effects of stigma. Reflecting this understanding of stigma and discrimination, the toolkit offers strategies and resources to address stigmatisation at the individual, institutional and community level. This implementation guide outlines processes for implementing toolkit strategies at the institutional or service level.

What will you find in this guide?

This implementation guide outlines a process for planning and then implementing initiatives drawn from the strategies and resources available in the toolkit. The process is organised into four implementation phases. These four phases are illustrated through examples drawn from the implementation project that informed the development of this guide.

This guide also contains helpful tips on implementation drawn from the experiences of

those in the two programs that piloted the toolkit. The information in this guide is also informed by consultations with community organisations in the BBV and STI sectors, workforce development organisations and an expert project advisory panel that guided aspects of the implementation project.

The implementation process set out in the guide follows four phases:

- Exploration: The exploration phase focusses on identifying policies, practices or workforce development areas to address. This phase will include setting goals, identifying resources that will be needed, potential barriers that might emerge and deciding which strategies or information from the toolkit will be most useful.
- Initial implementation: The initial implementation phase focusses on testing the plan developed in the exploration phase, identifying any parts of the plan that need to be adjusted and refining the goals and scope of the implementation.
- Implementation: The implementation phase carries out the plans developed in the previous two phases.
- Review, refine and refresh: The final review, refine and refresh implementation phase focusses on reviewing the outcomes of the implementation, refining implementation strategies and processes, and refreshing the approach for the next implementation.

This guide also contains several resources designed to support implementation. At the end of this guide can be found reflection tables that are designed to allow working group members and staff to record activities, interactions, challenges, and lessons on a weekly or fortnightly basis, depending on team preferences. These tables and other resources were designed by the research team in collaboration with the pilot site. The guide also contains implementation planning tables, milestone tables, a timeline template and other resources to support planning and recording progress:

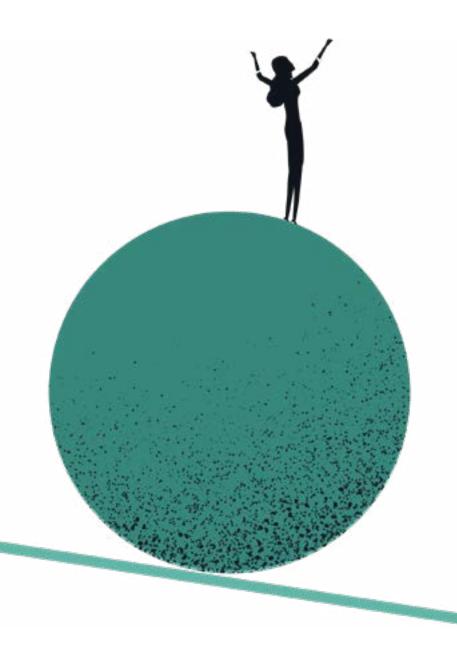
- Working group reflection table (designed to help the working group organise their activities and track progress).
- Project staff reflection table (designed to help project staff organise their activities and track progress).
- 3. Implementation planning tables for each phase (designed to help develop concrete goals for

- each stigma-related issue addressed in your implementation plan and identify the steps involved and the people and resources that will be needed to achieve them).
- Review table (designed to record barriers, enablers, achievements and lessons that emerged during implementation).
- Milestone progress tracking table (designed to help track the progress of key milestones including recording enablers and barriers).
- **6. Timeline template** (designed to keep the overall implementation on track).

Alongside the stigma and discrimination reduction toolkit, we hope this suite of tools will become a key workforce development and training resource for the Victorian healthcare sector.

How is this guide to be used?

Following input from healthcare professionals, the toolkit is designed to be used in a flexible way - it is not a universal resource or manual for addressing stigma and discrimination. For example, healthcare services may implement select strategies, focus on different elements or make use of specific resources according to the particular needs of their staff and clients. While flexibility and adaptability are key, toolkit implementation at the service level should still be carefully planned and coordinated. During the project that informed the development of this guide, the two programs we worked with found that promoting the toolkit to staff and encouraging change in individual practice was relatively straightforward. However, implementing service-level strategies (see page 25 of the toolkit) such as building connections with affected community or changing a policy or practice requires careful planning and coordination. Implementing different strategies and potentially embedding a suite of tools as a workforce development and training resource will likely involve several implementation plans or an implementation plan that can have new elements or activities added to it as the process progresses.



Starting to address stigma and discrimination

EXPLORATION

The exploration phase is about establishing your goals, documenting available resources and considering the toolkit strategies and their relevance to your service.

The stigma and discrimination toolkit includes a checklist on page 5 that will be helpful during the exploration phase, particularly for identifying which strategies will most effectively address the stigma-related issues your implementation will focus on. An abridged version of the checklist is included in this guide, but we recommend referring to the toolkit for the complete resource.

| IN | DIVIDUAL-LEVEL STRATEGIES | Build resilience |
|-----|--|--|
| lmp | Develop an understanding of what stigma is and its impacts on healthcare access and health | Educate clients about the transmission and diagnosis of BBVs and STIs Educate clients about healthcare rights and Victorian anti-discrimination legislation |
| | outcomes Incorporate education and training about BBV- related and STI-related stigma, cultural safety and diversity in compulsory training, professional development and workplace induction | Ensure complaints processes are available and accessible Promote the benefits of social support to client and of connections with peer-led organisations |
| Imp | Adopt 'stigma-sensitive practice' related to BBVs and STIs Enact processes to effectively address client diversity in relation to gender and sexuality Provide interpreter and translation services Use plain language English in all service encounters and on all documents Create a welcoming and culturally safe environment | Improve systems, standards and guidelines Include stigma reduction as a priority in your strategic plan Ensure your service has a charter of rights, and robust privacy and confidentiality policies and procedures Develop organisational capabilities in relation to inclusivity and stigma-free healthcare Establish systems to measure stigma-related progress and success |
| Em | bed reflective professional practice | COMMUNITY-LEVEL STRATEGIES |
| | Incorporate reflective practice into professional development and training Institute reflective practices as a routine part of professional practice | Promote advocacy and law reform Develop an advocacy plan for your healthcare service Advocate for change that will reduce stigma, |
| SE | RVICE-LEVEL STRATEGIES | and promote inclusivity and cultural safetyElevate the voices of people living with and |
| Der | Develop partnerships with communities living with and affected by BBVs and STIs Make your service visible to the communities it serves Employ people from communities affected by BBVs and STIs | affected by BBVs and STIs |

EXPLORATION

This phase should include:

- Establishing a team or working group to lead the planning and implementation of toolkit strategies
- Identifying stigma-related issues to address
- Identifying existing resources, programs or practices that can be built upon
- Establishing goals
- Establishing milestones
- · Creating a systematic plan of how to proceed
- · Preparing an implementation timeline

Exploration planning guiding questions

- · What are our overall goals?
- · What do we want to learn during this phase?
- · What milestones should we track?
- How can we accommodate the schedules of planning and implementation team members?
- Which stigma-related issue(s) do we want to address?
- Which toolkit strategies are likely to be most useful?

This planning table can be used to develop concrete goals for each stigma-related issue addressed in your implementation plan and identify the steps involved and the people and resources that will be needed to achieve them. You can find examples of completed planning tables for each phase in the implementation examples from page 22 of this guide.

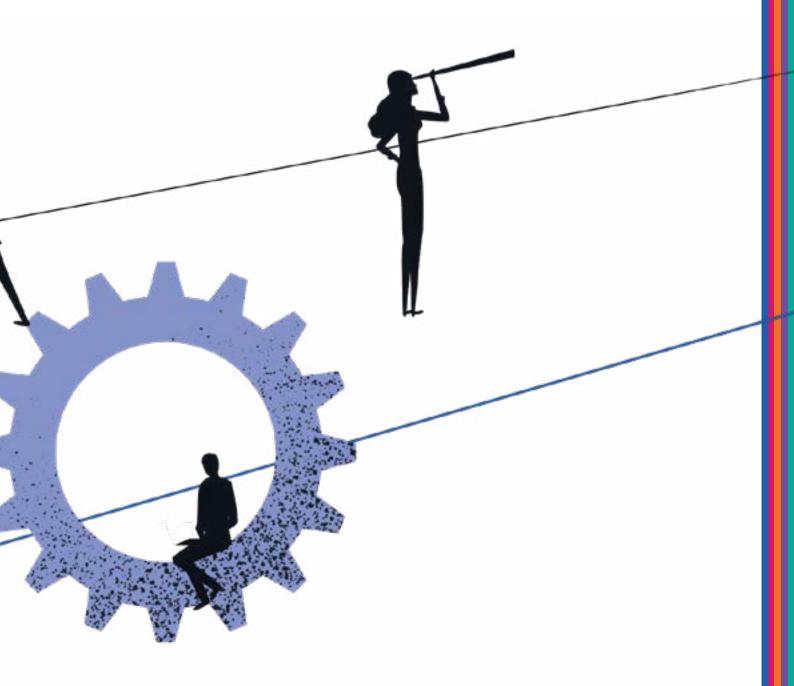
| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline |
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| Person/s responsible | Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
|-------------------------|---|--|-------------------------|-------------------------------|
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IMPLEMENTATION

The initial implementation phase is about testing the plans developed in the exploration phase, considering any potential challenges and establishing a clear way forward. This phase is also an opportunity to adapt the chosen toolkit strategies to ensure that they are tailored to your healthcare service.



This phase should include:

- Holding regular meetings for the planning and implementation team
- Developing a regular feedback process ensuring effective communication between all staff involved in the implementation
- Using feedback and team meetings to address any emerging challenges
- Using feedback to tailor the chosen toolkit strategies for the healthcare service
- Redefining or reconfirming goals
- Tracking progress on key milestones
- Confirming a systematic plan of how to proceed with the implementation process

Initial implementation planning guiding questions

- What are our overall goals?
- · What do we want to learn during this phase?

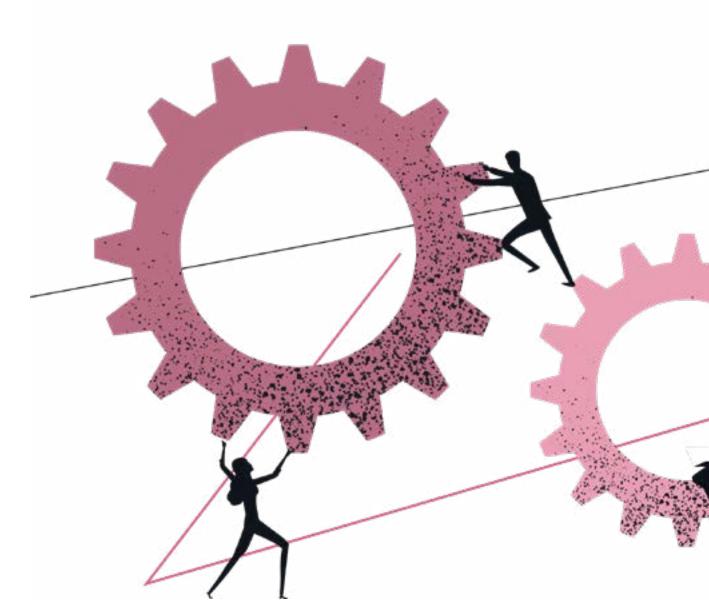
- · Are we progressing towards our milestones?
- Do our overall goals need to be refined or changed?
- How regularly should the planning and implementation team meet?
- How will staff provide feedback on the implementation process and progress?
- How can the toolkit strategy be tailored to meet our needs and goals?
- What is the most effective way to communicate plans, activities and outcomes across the service?

This planning table can be used to develop concrete goals for each stigma-related issue addressed in your implementation plan and identify the steps involved and the people and resources that will be needed to achieve them. You can find examples of completed planning tables for each phase in the implementation examples from page 22 of this guide.

INITIAL IMPLEMENTATION

| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline | Person/s responsible |
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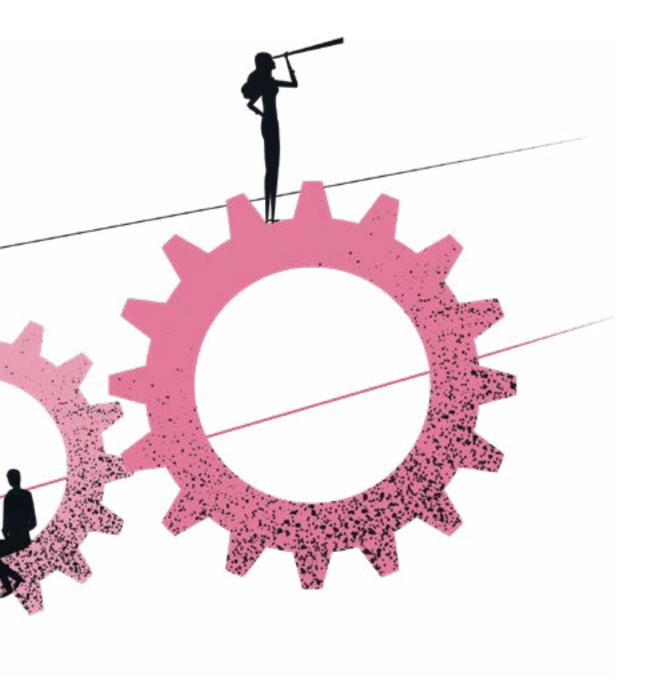
| Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
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Using the toolkit to address stigma and discrimination

IMPLEMENTATION

The implementation phase is about using the lessons of the previous phases to implement the toolkit strategy as part of your stigma and discrimination reduction project. During this phase, it is time to carry out the plans developed in the previous two phases and begin implementation. This phase will require careful monitoring of progress, including the documentation of any challenges that emerge.



This phase should include:

- Regular meetings for the planning and implementation team
- Regular feedback from staff about the implementation process
- Documenting challenges
- · Documenting strengths and enablers
- Communicating with staff about implementation progress, including challenges and successes

Implementation guiding questions

- What are our overall goals?
- Is the planning and implementation team meeting regularly?
- How are we progressing on the implementation timeline?

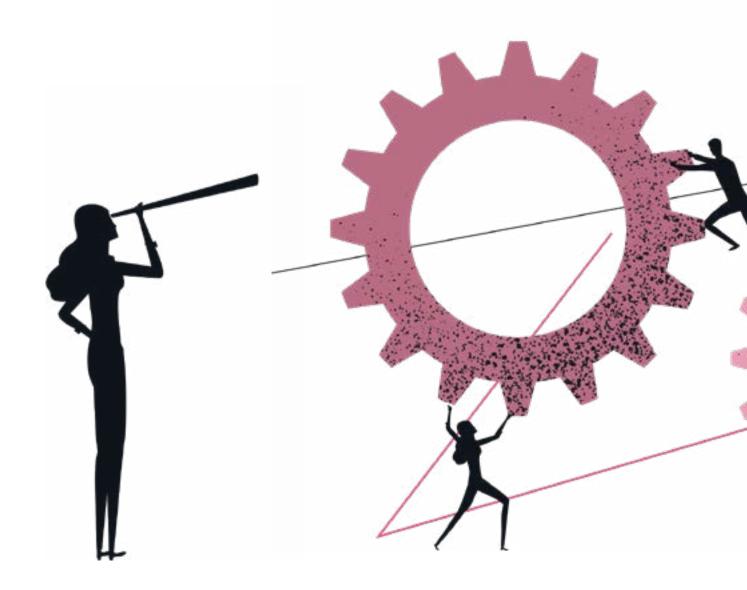
- · Are we meeting the milestones?
- What challenges have we encountered?
- What adaptations have we made to overcome challenges?
- · What strengths have we discovered?
- Are staff invested in the implementation?
- Are we communicating with staff effectively?

The planning table below can be used to develop concrete goals for each stigma-related issue addressed in your implementation plan and identify the steps involved and the people and resources that will be needed to achieve them. You can find examples of completed planning tables for each phase in the implementation examples from page 24 of this guide

IMPLEMENTATION

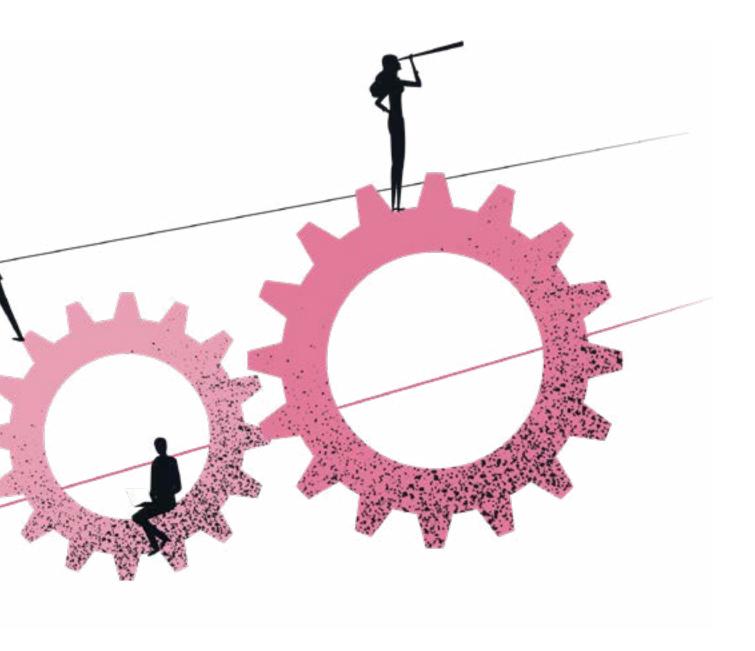
| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline | Person/s responsible |
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| Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
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REVIEW, REFINE AND REFRESH

Addressing stigma and discrimination in healthcare services is an ambitious project that requires long-term commitment. Given this challenge, the final implementation phase focusses on reviewing the outcomes of the implementation, refining implementation strategies and processes, and refreshing the approach for the next implementation.



This phase should include:

- Reviewing the barriers, enablers and lessons documented during the implementation process
- Planning how to make the most of the resources and enablers identified during implementation
- Planning how to address any barriers or challenges identified during implementation
- Refining implementation processes for future stigma and discrimination reduction efforts
- · Communicating outcomes to staff
- Refreshing the implementation process in order to inform the next implementation period

Review, refine and refresh planning questions

- What did we achieve?
- What barriers impacted our achievements?
- What resources and enablers shaped our outcomes?
- Did we achieve our milestones?

- · Was our timeline achievable and realistic?
- How can we use the lessons from this process to inform our next efforts to address stigma and discrimination?
- How should we adapt the toolkit strategy in our next efforts to address stigma and discrimination?

The review table below can be used to track the achievements of your implementation. The table can be used to reflect on the enablers and barriers identified during implementation and record lessons for future stigma reduction efforts. You can find an example of completed review tables in the implementation examples from page 24 of this guide.

IMPLEMENTATION

Review table

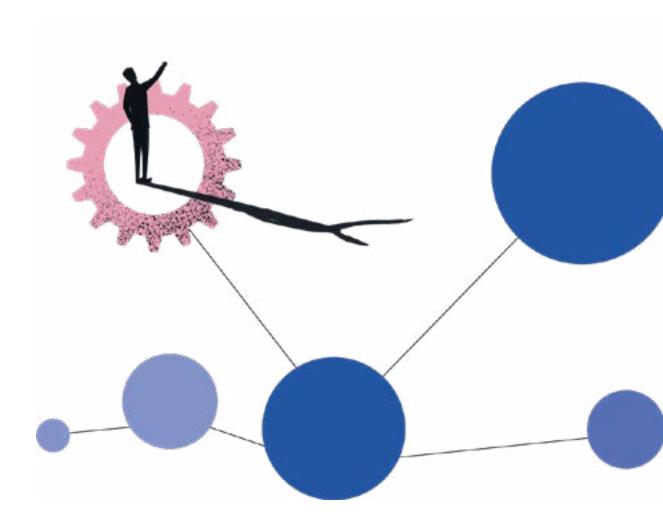
| Review | | |
|---------------------------|-------------------------------------|------------------------------------|
| Goal What did we achieve? | Strategies How did we achieve this? | Barriers What impeded progress? |
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Refine

Toolkit strategy

Was the strategy appropriate for our service? Do we need to refine the strategy? Do we need a different strategy?

| Enablers What supported progress? | Staff feedback What insights can staff offer on the process? |
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| Refresh | |
| Lessons for future efforts What would we do differently? | |
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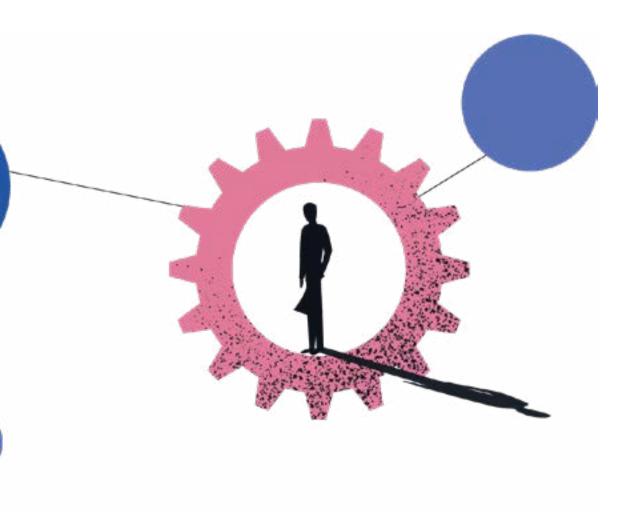


IMPLEMENTATION EXAMPLES

Implementation example A: Revising plans and goals in response to challenges

In this section, we describe two examples of implementing toolkit strategies at *Your Community Health Your Community Health* is a large community healthcare service with a focus on serving people who are marginalised or socioeconomically disadvantaged. It has a wide remit encompassing general medical services, dental services, allied

health and specialist services such as alcohol and other drug programs. *Your Community Health* also runs several health and wellbeing programs focussed on social connectedness, mental health, nutrition and physical therapy. Presented as narratives, these examples have been written to demonstrate how different activities can be



organised into the four implementation phases. The narratives explore different approaches to identify and overcome barriers to implementation, including by adjusting the plans and goals; as would be necessary when using the toolkit across various healthcare and other settings.

Note: This implementation process example is drawn from the research project that informed the development of this guide. While this example is inspired by discussions with the participants in the research, the details of the narrative such as the barriers that were overcome are not an exact reflection of the processes and outcomes of the pilot site. Further, several key details have been changed in order to protect the anonymity of the participants that piloted the toolkit. Overall, these examples aim to highlight different implementation possibilities and how implementation can be managed.

Exploration phase

Your Community Health is a community health organisation that provides government-funded dental care services to eligible Victorian adults and children. Stigma is often described as a barrier for some groups accessing dental care, including people who inject drugs. As such, Your Community Health determined that reducing stigma and discrimination should be a key part of their plans to improve dental healthcare access for this client cohort. Given BBV and injecting drug-related stigma are often intertwined, Your Community Health decided that the stigma and discrimination reduction toolkit was a useful resource to help them achieve their goal.

As their first step, Your Community Health established a joint working group with members from two of their programs: the Oral Health Service and Community Programs, focused on leading the implementation of relevant strategies from the toolkit. It was decided that working group membership would be an opt-in process to enhance buy-in from the outset. Expressions of interest for staff members to join a working group were distributed and eight members appointed.

IMPLEMENTATION EXAMPLE A

These included staff from the Oral Health Service and Community Programs and other programs within the service. Seniority of the individuals varied with managers, clinicians and outreach staff all joining the working group.

The working group began by defining project deliverables, outcomes and determining the appropriate meeting structure. In initially recognising the various interdependencies and challenges in maintaining a high-level of meeting attendance, the working group responded through coordination of more regular, weekly meetings of shorter duration. However, progress was stymied by inconsistent attendance of working group members. In response, the working group agreed to shorter weekly meetings. Importantly, this included *Oral Health Service* leadership staff supporting the release of resources from client-facing clinical duties, to be absorbed by this new initiative.

With the working group meeting weekly, the next step was to promote the availability of the dental healthcare service through specific alcohol and other drug-related programs. This process included building on an established alcohol and other drug oral health project that sought to promote the dental services to clients accessing outreach Needle and Syringe Program (NSP) services. In building on the existing initiative of providing dental information and care packs and information about dental health to NSP clients, this process allowed the working group to learn more about the potential barriers to accessing dental care. Staff feedback provided during this process suggested that upskilling staff communication strategies might be an important step in addressing the potential impact of stigma and discrimination on access to dental care for people who inject drugs.

Exploration phase planning table

| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline |
|--|---|--------------------------|
| Increase access to dental services for people who inject drugs. | Implement relevant 'service-level' strategies from the toolkit. | September – December. |
| Increase staff awareness of and capacity to address stigma and discrimination. | Provide the toolkit to staff in the dental program. | September. |
| Promote toolkit to staff. | All staff emails and intranet notification. | September – October. |
| Promote dental health service to NSP clients. | NSP staff discuss the dental service with clients. NSP staff distribute dental information and care packs. | September – November. |

| Milestone description | Planned completion date |
|---|-------------------------|
| Expressions of interest to join the working group circulated. | 3 September. |
| Working group established. | 17 September. |
| Promote toolkit to staff. | 24 SeptemberGood |

| Person/s responsible | Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
|--|---|--|--|---|
| Working group members. | Working group expertise.Stigma reduction toolkit. | Review resource to identify strategies. | Other responsibilities of working group members. | Working group membership established. |
| Working group members. | Good relationships between working group members and staff. Emails and staff service newsletter. | Ask staff to review 'service-level' strategies. | Length of the toolkit may be off- putting. | Email check-ins with staff and team leaders. |
| Working group members. | Email and staff newsletter. | Promote whole toolkit. | Length of the toolkit may be off-putting. | Email check-ins with staff and team leaders. |
| NSP staff.Dental staff. | NSP staff have good relationships with clients. Dental information and care packs. | Provide dental care packs to NSP clients as a way of demonstrating allyship and making clients feel welcome. | Busy staff.Busy clients. | Check in with staff to remind them about promotion. Check in with staff about client interest. |

| Enablers | Barriers | Status (not started, on track, behind, postponed, completed) |
|---|---|--|
| Good internal staff communications. Managers and staff that are committed to providing inclusive healthcare. | Staff unsure about stigma or concerned they do not have the expertise to work with people living with BBVs and STIs. | Completed. |
| Strong support for the project at the executive level including participation in the working group. | Staff availability and particularly those working directly with clients. Staff work across multiple sites. | On track (but still looking for a couple more members). |
| Good internal staff communications, including an internal digital newsletter and regular team meetings. | The size of the toolkit. | On track. |

Initial implementation phase

While promotion of the toolkit within the dental health service was underway, the working group reflected on the pre-existing use of some of the language and communication strategies found in the toolkit (page 19). Given the important role the reception area of a service plays in establishing a welcoming environment for clients, the reception was identified as an important setting to continue building-upon 'stigma-sensitive' communication strategies (page 19).

As an initial approach, facilitation of group reflection of stigma reduction opportunities and strategies occurred within weekly huddles or meetings attended by oral health staff in effort to ensure staff felt able to share their reflections. It was intended that these reflective opportunities would build staff confidence and capacity to embed toolkit strategies in their client-facing interactions. These huddles also offered an opportunity to explore how to overcome barriers associated with introducing toolkit strategies in reception work areas alongside current workloads.

Over the course of the initial implementation phase, the working group decided that their efforts would be enhanced by a focus on establishing stigma and discrimination as relevant issues for their service and promoting awareness of the toolkit as a useful resource. The goals and milestones were further defined to focus on building awareness and promoting organisational investment in addressing stigma and discrimination.

Returning to the toolkit, the working group considered the potential of allyship strategies to achieve their new goals (page 24). The discussion led to a plan to hold an event that would acknowledge that the healthcare system can be a site of stigma and discrimination for people affected by BBVs (and STIs) and offer an opportunity to raise awareness of the toolkit.

Initial implementation phase table example

| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline | Person/s responsible |
|---|--|--------------------------------------|---|
| Establish stigma and discrimination as relevant to our service. | Hold an online event for all staff. | December. | Working group. Program team leaders. |
| Get better understanding of barriers and enablers in the dental team. | Staff provide fortnightly reflection table. | Ongoing until end of December. | Dental team staff and team leader. |

| Milestone description | Planned completion date |
|--|-------------------------|
| Reflection table distributed. | 9 November. |
| Online event held to coincide with World AIDS Day. | 1 December. |
| Online questionnaires completed by staff who attend the event. | Early January. |

| Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
|---|---|--|---|
| Online infrastructure. The toolkit. | Adjust allyship strategies by translating client-focussed advice to address staff instead. | Need to avoid a negative tone. Ensure event is about building capacity rather than criticism. | Record attendance numbers. Take notes about participation and discussion. Online questionnaire results. |
| • Reflection table. | Stigma-sensitive practice resources (page 19). | Staff time, rostering, follow up. | Record when reflection tables are provided. Are they provided on time? Record key lessons from the tables (challenges/enablers). |

| Enablers | Barriers | Status (not started, on track, behind, postponed, completed) |
|--|--|--|
| Completion of the reflection table was voluntary. | Managing competing time demands. | Completed . |
| Online infrastructure for hosting events across the different sites. | Need to limit any disruption to client services. | Completed. |
| Managers and staff comfortable with providing feedback. | Making time to complete the questionnaire. | Completed. |

Implementation phase

Given the new focus, it was decided to leverage a related event, 'World AIDS Day', as a way to increase awareness of stigma and discrimination and the toolkit. The team decided that *Your Community Health* would host an online World AIDS Day event for staff across several programs within the service. Importantly, the *Oral Health Service* was one of the programs that would attend the event.

This event served as an opportunity to provide staff with information on the impact of BBV-related stigma on healthcare access, including for people who inject drugs. In order to emphasise that reducing stigma and discrimination was a priority for the service as a whole, some *Your Community Health* program directors contributed to the event, as did the CEO. In the lead-up, the toolkit was distributed to all staff with future plans to embed the toolkit as an induction and training resource for new staff.

The event included information about the impact of stigma and discrimination in healthcare settings for people living with BBVs, introduced attendees to the stigma reduction toolkit and highlighted several relevant strategies such as the importance of 'stigma-sensitive practice' (page 19), reflective practices and the need to create welcoming physical environments.

The event was a success. It was well attended and provided a forum for staff to express their interest in addressing the impact of stigma and discrimination on their practice and the healthcare service more generally. It became evident that *Oral Health Service* staff were highly motivated to address potential stigma and discrimination and were reminded that this was a commitment of the organisation too.

Implementation phase table example

| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline | Person/s responsible |
|---|--|--|---|
| Understand whether staff think BBV and STI-related stigma and discrimination is relevant to their work. | Use online questionnaire to gather staff perspectives. | December – January. | Working group members. Team leaders. |
| Increase staff awareness of 'stigma- sensitive practice'. | Discussion of 'stigma-sensitive practice' at the event. Also distribute the relevant section of the toolkit (separate from the rest of it). | Distribute toolkit section in late November. | Working group members. Internal presenters at the event. |

| Milestone description | Planned completion date |
|---|-------------------------|
| Online event held and well attended by a range of staff and managers. | 1 December. |
| Online questionnaires collected, analysed and shared with staff. | 30 January. |
| Fortnightly reflection tables collected and analysed and used to guide planning of future activities. | 30 January. |

| Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
|---|---|--|--|
| Mailchimp. Business support team can run the process. | • Not applicable. | Staff not submitting the questionnaires in a timely fashion. | Online questionnaire results. |
| • The toolkit. | 'Stigma-sensitive practice' only addresses hepatitis C. We'll need to adapt the principles for STIs and other BBVs. | Translation from hepatitis C to other BBVs and STIs might be challenging. Staff might also feel we are suggesting that they're not already sensitive. | Just ensure these are distributed at this stage. We'll need to follow up about how this informs practice down the track. |

| Enablers | Barriers | Status (not started, on track, behind, postponed, completed) |
|--|---|--|
| Participation strongly supported at the executive level. | Ensuring client services were not disrupted. | Completed . |
| Managers and staff comfortable providing feedback. | Making time to complete the questionnaire. | Completed. |
| Completing the reflection tables was voluntary. | Program leads finding the time and resources to generate new activities that incorporate information gathered in the reflection tables. | On track. |

Review, refine and refresh

The working group met following the 'World AIDS Day' event, deciding based on feedback that a more targeted, phased approach to embedding the use of the toolkit would be essential to addressing BBV-related stigma and discrimination in their service more generally.

Several immediate challenges were identified during this stage such as busy staff schedules and implementing effective communication processes. A broader challenge that emerged was the need to balance the desired outcomes of progressing organisation-wide stigma and discrimination reduction strategies with the specific needs and scope of different programs in ways that ensured implementation was sustainable. Importantly, several enablers were also identified, such as a workforce committed to addressing stigma and discrimination when provided with an opportunity to reflect on why these issues might matter, and how they related to current practice.

Given the continued importance of stigma reduction for Your Community Health, the working group decided to use the lessons from this implementation for future efforts to address stigma and discrimination. The group plans to establish regular events that focus on the importance of addressing different forms of stigma and discrimination in their service. Expanding these beyond 'World AIDS Day', the team plan to collaborate with peer-led organisations to develop alliances across the sector and invite clients to participate in future events. While their original implementation faced several hurdles, the lessons learnt led to more ambitious plans to embed addressing stigma and discrimination as a routine focus of Your Community Health

| Review | |
|--|--|
| Goal What did we achieve? | Strategies How did we achieve this? |
| Established reducing BBV and STI-related stigma and discrimination as service priorities. Integrated the toolkit into training. | Communication with staff and a large even Implemented the toolkit as an induction resource. |

Refine

Toolkit strategy

Was the strategy appropriate for our service? Do we need to refine the strategy? Do we need a different strategy?

- Allyship strategies have potential for the service.
- Potential to implement more ambitious allyship strategies down the track.
- Language and communication strategies have potential.
- Several strategies in the toolkit are relevant.
- Toolkit is too long so specific sections will need to be removed and used separately.

| Milestone description | Planned completion date |
|--|--|
| Reducing stigma and discrimination related to BBVs and STIs established as priorities. | Ongoing but should be completed within the next 12 months (January 2025). |
| Toolkit integrated into workforce training and development across the organisation. | Ongoing for the next 3 years (January 2027). |

Barriers

What impeded progress?

- Unsystematic feedback process during initial implementation.
- Limited awareness of the toolkit initially.

Enablers

What supported progress?

- Staff committed to stigma reduction.
- Regular working group discussion.
- Revised scope of implementation.
- · Committed staff.
- High profile events.
- Senior staff demonstrating use of the toolkit.

Staff feedback

What insights can staff offer on the process?

- Best ways to communicate and get feedback.
- Daily challenges to improving service.
- Most useful aspects of the toolkit for induction.

Refresh

Lessons for future efforts

What would we do differently?

- Establish working group parameters including meeting schedule and individual responsibilities at the onset.
- Communicate with staff about possible strategies during the exploration phase.
- Discussed with appropriate staff about which aspects of the toolkit to introduce into induction.

| Enablers | Barriers | Status (not started, on track, behind, postponed, completed) |
|---|---|--|
| Committed staff across several program areas. | The size of our service and the number of different health areas we cover. | On track. |
| Commitment of the CEO, program directors and team leaders. Commitment to identifying innovative ways to incorporate the toolkit into new projects. | Competing training and workforce development needs and limited resources. Stigma and discrimination reduction activities are not currently embedded in key performance indicators. | On track. |

Implementation example B: An ongoing project to address stigma and discrimination and ensure best practice

Note: This implementation process example is drawn from the research project that informed the development of this guide. While this example is inspired by discussions with the participants in the research, the details of the narrative such as the barriers that were overcome are not an exact reflection of the processes and outcomes of the pilot site. Further, several key details have been changed in order to protect the anonymity of the participants that piloted the toolkit. Overall, these examples aim to highlight different implementation possibilities and how implementation can be managed.

Exploration phase

Your Community Health is a healthcare facility that provides services for marginalised and socioeconomically disadvantaged people. Given healthcare is a setting known to be potentially stigmatising in Australia, Your Community Health have decided that they would like to embed the stigma and discrimination toolkit as a training and capacity building tool across all programs within the organisation. However, recognising that this a long-term, resource intensive and ambitious goal, they have decided to mobilise toolkit strategies for several smaller scale initiatives as they build towards their overall goal.

Your Community Health's initial goal is to ensure that the Oral Health Service is delivering services that are aligned with current clinical best practices and that they are providing inclusive and stigmasensitive care.

To begin, a working group was established. It was decided that given that the *Oral Health Service* was the target program, the working group would consist of dental staff including the director, manager and senior dentists, with membership supported by an open expression of interest disseminated to the team.

Once established, the working group began with a presentation from the members of the dental program explaining their hopes for the project, goals and the specific practices they sought to address. As was explained in these initial meetings, reviewing these practices is a large undertaking requiring long-term commitment and would potentially involve developing new staff training modules and other resources and strategies beyond those available in the toolkit.

Exploration phase table example

| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline |
|--|--|----------------------|
| Ensure management of herpes simplex in dental program is best practice and non-stigmatising. | Review current policies. | February – March. |
| Find out how we currently manage herpes simplex in the dental program. | Ask relevant dental staff to submit their current practices. | March – April. |

Exploration phase milestone tracking example

| Milestone description | Planned completion date |
|---|-------------------------|
| Policy found. | 9 February. |
| Working group discuss and review current policy. | 23 February. |
| Distribute table for staff to inform us of their current practices. | 12 April |

During these initial exploration meetings, the working group settled on ensuring the approach to providing dental care to clients with herpes simplex or cold sores was not experienced as stigmatising.

Established dental practice was to reschedule appointments for clients who attend appointments with a cold sore so they can attend their appointment after their sore has been healed, commonly delaying care for a period of two weeks. However, *Oral Health Service* staff were aware that

| Person/s responsible | Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
|--|---|--|--|---|
| Working group members. | Working group expertise.Organisation policy documents. | Review resource to identify strategies. | Policy may be out of date or not reflect current practice. | Provide current policy to working group members for discussion. |
| Working group members. Dental team. | Email. Create a simple table for staff to complete and submit. | Not applicable at this stage. | Dental team is extremely busy. Review might not seem relevant or important. | Ensure all staff submitted the table. Track any delays. |

| Enablers | Barriers | Status (not started, on track, behind, postponed, completed) |
|---|---|--|
| Extensive policy library. | None. | Completed. |
| Regular working group meeting schedule. | Not all members may attend. | Completed. |
| Good internal communication processes. | Staff are busy.Staff timetabling can be complex. | Behind. |

clients might encounter different approaches from different clinicians, may not always understand why they were being asked to reschedule their appointment and may experience this as discriminatory or stigmatising.

These discussions led to the decision to inform all *Oral Health Service* staff of an upcoming review of how they manage clients with herpes simplex.

Initial implementation phase

The exploration phase identified variation in the practices for managing herpes simplex within the *Oral Health Service*. Some staff, for example, were rescheduling appointments as soon as they noticed a cold sore while others were protecting the sore with Vaseline or having discussions with the clients about their options. Additionally, variation was also observed with respect to patient factors of comfort, pain and the type of dental care they were presenting for on the day.

Given that it would take time to understand how the different practices related to best clinical practice, stigma and accessible healthcare generally, the working group decided to distribute the toolkit language and communication strategies (pages 19 - 20) to the dental staff in the meantime. The idea was to ensure that stigma and discrimination remained at the front of staff minds while the working group ascertained whether the current practices reflected best practice. Given the importance of sensitive communication with clients, especially those with visible health conditions such as cold sores, the working group thought that the language and communication strategies were important to review regardless of the outcome.

Following more discussion, the working group identified weekly case meetings as another opportunity to discuss the project and ensure that their efforts to address stigma and discrimination were not forgotten. After consultation with staff, a small portion of case meetings were dedicated to discussing efforts to provide inclusive care, including review of potentially relevant parts of the toolkit.

Initial implementation phase table example

| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline |
|--|--|---------------------|
| Find out how we currently manage herpes simplex in the dental program. | Ask relevant dental staff to submit their current practices. | March – April. |
| Keep stigma project on the agenda. | Provide relevant toolkit strategies to staff. | March – ongoing. |

Initial implementation phase milestone tracking example

| Milestone description | Planned completion date |
|---|-------------------------|
| Provide language and communication strategies to dental team. | 10 April. |
| Collect current practices table from all staff. | 12 April. |
| Stigma and discrimination established as a part of case meetings. | 26 April. |

| Person/s responsible | Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
|--|--|--|---|--|
| Working group members. Dental team. | Current practice tables submitted by staff. We will need to set aside time to collate and discuss the responses on the table. | Not applicable at this stage. | Current practice tables are taking longer than expected. | Follow up with staff about delays in submitting the practice tables. Do staff need assistance to submit the tables? |
| Working group members. | Weekly case meetings could be an opportunity. | • Pull out language and communication strategies from the toolkit (pages 19 – 20). | Case meetings are occupied by other concerns. Staff do not appreciate adding a new issue to case meetings. | Check in with senior staff about how discussions are going. |

| Enablers | Barriers | Status (not started, on track, behind, postponed, completed) |
|--|---|--|
| Good staff relationships. | Providing the documents seems invasive. | Completed. |
| We have good internal communication processes. | Staff are busy.Staff timetabling can be complex. | Completed |
| Good staff relationships. | Case meetings already cover lots of territory. | On track. |

Implementation phase

The initial implementation phase did not result in a significant change in the scope, process or goals for the project.

Given the review of the current practices for managing herpes simplex within the *Oral Health Service* identified significant variation between staff, the working group collated the answers into a table to be provided to external advisors. It was decided that the first course of action was to connect with university dental schools to find out how local practices compared to what is currently taught as best practice. Following this review, the working group planned to establish a service-wide protocol for managing herpes simplex in the dental service.

Returning to the toolkit, the working group reflected on the notion of allyship (page 25). While the toolkit primarily focusses on demonstrating allyship through connection with organisations representing people affected by BBVs and STIs, the working group discussed the potential of broadening their approach to draw on the expertise of organisations and professionals potentially sympathetic to their aims of reducing stigma and discrimination. For example, they discussed the potential of establishing a coalition of like-minded organisations and individuals who could also ally with community and peer organisations in efforts to address stigma and discrimination in healthcare.

While their goals remained focussed on the service-level concern of managing herpes simplex appropriately, the potential for engaging with community-level advocacy and reform (page 41 – 43) was exciting. However, much like the intention to embed the toolkit as a training and capacity-building tool across all programs, the working group acknowledged that this was a long-term goal and should not distract from their current focus.

Implementation phase table example

| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline |
|--|---|---------------|
| Establish whether current practices for managing herpes simplex reflect best practice. | Attain external review from university dental schools. | April – June. |
| Create service- wide protocol for managing herpes simplex. | Use the assessment of our practices to review our current approach. | September. |

Implementation phase milestone tracking example

| Milestone description | Planned completion date |
|---|-------------------------|
| Develop document overviewing our current practices. | 5 June. |
| Attain external review of our current practices. | 5 July. |
| First draft of service-wide protocol. | 2 August. |
| Staff feedback on service-wide protocol. | 23 August. |
| Attain external review of service-wide protocol. | 30 September. |

| Person/s responsible | Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
|---|--|--|--|---|
| Working group members. External collaborators. | Overview document of our practices. Relationships with university dental professionals. | Not applicable for this stage. | We struggle to find university partners/ collaborators. | Create working relationships with university dental professionals. |
| Working group. | May need to include service staff from outside the working group. | Use language and communication advice to inform protocol. The advice about 'stigma-sensitive practice' and serving culturally linguistically diverse communities (page 19) could be especially useful. | This is a significant policy that will take time to develop. Need to ensure staff are included in policy development. Need to ensure we have staff 'buy-in.' | Track drafts of policy. Review staff feedback on policy. Seek external review. Staff feedback on protocol draft. |

| Enablers | Barriers | Status (not started, on track, behind, postponed, completed) |
|---|---|--|
| Staff have provided lots of great insights already. | • None. | On track. |
| Relationships with appropriate externals. | No budget to offer payment. | Not started. |
| Helpful feedback from external review. | Working group workload is becoming challenging. | Not started. |
| Staff are committed to stigma and discrimination reduction. | Again, workload may become challenging. | Not started. |
| Good relationships developed with external during this process. | No budget to offer payment. Asking for two rounds of review without payment. | Not started. |

Review, refine and refresh

While this ambitious project is still underway, the working group are preparing for the final review phase of implementation.

The service-wide protocol has not been developed but the lessons of the internal practice review suggested that moving to a case-by-case approach in which clients are given different options for receiving dental care with herpes simplex or cold sores will be likely to improve client experiences.

The implementation process has also emphasised the importance of breaking down ambitious plans to reduce stigma and discrimination into smaller, achievable projects such as reviewing specific practices within one service or program.

Even with this project underway, the lessons for future efforts are emerging from the implementation process. Plans are underway, for example, to establish a process to review the service-wide protocol after three to six months.

Further, the working group are planning a future project that mobilises the toolkit language and communication resources to review *Your Community Health* approaches to taking client medical histories.

Finally, the working group are also excited to turn their attention to the community-level strategies described in the toolkit (page 41 – 43) to consider whether they can work to establish a coalition of healthcare and other relevant organisations committed to ensuring inclusive healthcare is available within and beyond *Your Community Health*

Review

Goal

What did we achieve?

Strategies

How did we achieve this?

 Established the current ways dental staff manage herpes simplex. Coordinated communication with staff.

Refine

Toolkit strategy

Was the strategy appropriate for our service? Do we need to refine the strategy? Do we need a different strategy?

 Language and communication strategies have direct relevance to the management of herpes simplex in dental service.

Barriers

What impeded progress?

Logistical issues stemming from workloads, timetabling and staff working for several services.

Enablers

What supported progress?

- Staff committed to stigma reduction.
- Providing staff with simple table to fill out.

Staff feedback

What insights can staff offer on the process?

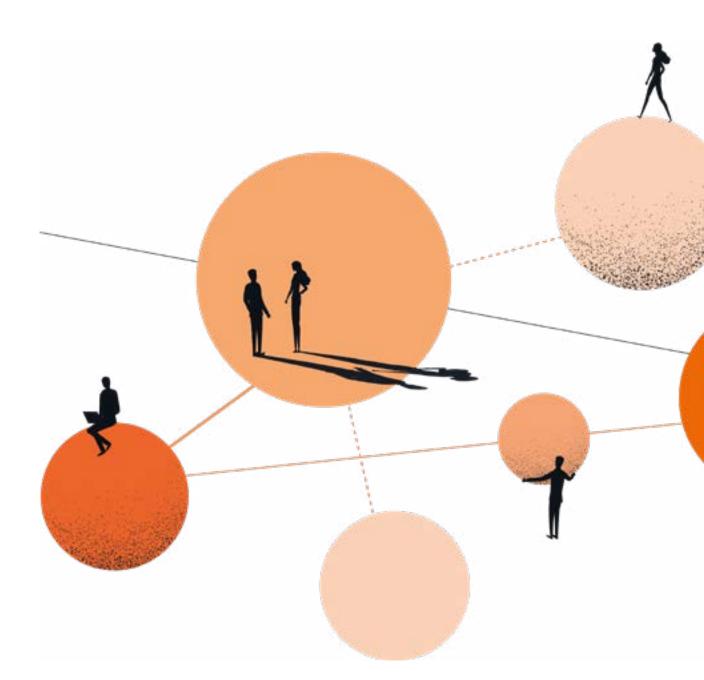
- Best ways to communicate and get feedback.
- Insights about relevance and suitability of toolkit strategies.

Refresh

Lessons for future efforts

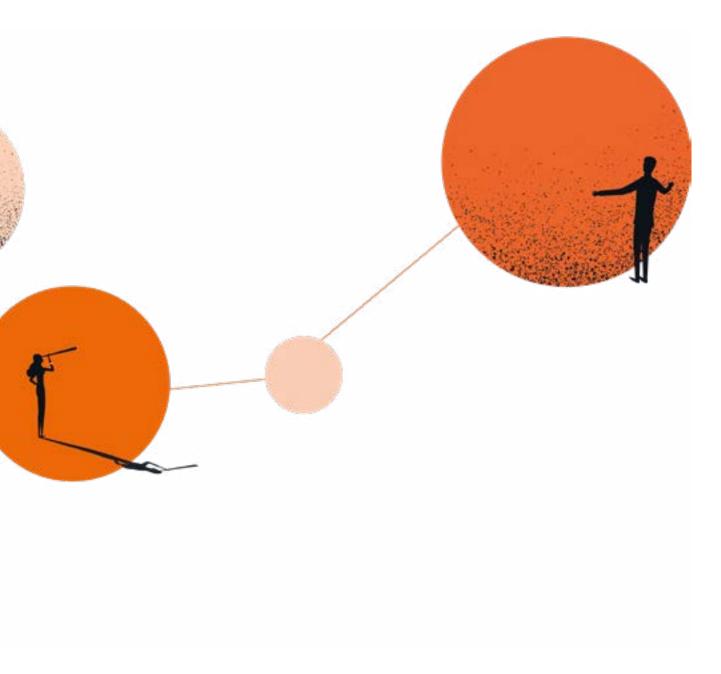
What would we do differently?

 Possibly seek a grant or other external funding to support policy and practice review and protocol implementation.



IMPLEMENTATION RESOURCES

Given your implementation plan is likely to be lengthy and made up of several milestones, this guide includes resources to help you track your progress over the course of your project.



Reflection tables for tracking progress

Keeping a weekly or fortnightly track of activities and experiences while implementing efforts to address stigma and discrimination will allow the team to reflect on the processes, successes and challenges that occur along the way and track the time involved in undertaking the project. The reflection table can be used to document formal and informal activities related to the project, email exchanges about the project, for example, or informal conversations between staff members about the stigma and discrimination toolkit that can often include informative insights as the project progress. Overall, keeping a team reflection table will support continuous improvement and adaptation.

Working group reflection table

| Working Group Name | |
|------------------------------------|--|
| Project Commencement: | |
| Project End Date: | |
| Document Revisions | Date Summary of Changes |
| Working group members | |
| Role on the working group | |
| Activities related to reducing BBV | Summary of working group meetings: |
| and STI-related stigma and | Meeting Date Summary of working group discussion/actions |
| discrimination | |
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| | |
| | What activities related to stigma and discrimination have been undertaken? |
| | Date Summary of working group discussion/actions |
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Project staff reflection table

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|------------------------------------|---|--|--|--|
| Activities related to reducing BBV | What activities related to stigma and discrimination have been undertaken? | | | |
| and STI-related stigma and | Date Summary of relevant activities | | | |
| discrimination | | | | |
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| | Please describe how the toolkit has been used: | | | |
| | How has the toolkit been used? What parts did you use? | | | |
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| | How has the toolkit met your needs? | | | |
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| | | | | |
| | Has the toolkit <u>not</u> met your needs? Why? | | | |
| | | | | |
| | | | | |
| Challenges | Outline any challenges experienced in relation to addressing stigma and discrimination and the toolkit (e.g. time constraints, limitations in the toolkit, negative responses to the project from colleagues or clients). | | | |
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| | Outline any enablers that supported your efforts to address stigma and discrimination and use of the toolkit. | | | |
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Implementation planning table

| Goal What do we want to achieve? | Strategies How will we accomplish our goal? | Timeline | Person/s responsible |
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| Resources and assets What resources and assets do we have? What resources will we need? | Toolkit strategy Which toolkit strategy should we try? | Potential challenges | Tracking progress/ success |
|---|--|----------------------|-------------------------------|
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Review table

| Review | | | |
|---------------------------|-------------------------------------|---------------------------------|--|
| Goal What did we achieve? | Strategies How did we achieve this? | Barriers What impeded progress? | |
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Refine

Toolkit strategy
Was the strategy appropriate for our service? Do we need to refine the strategy? Do we need a different strategy?

| Enablers What supported progress? | Staff feedback What insights can staff offer on the process? |
|--|---|
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| Refresh | |
| Lessons for future efforts What would we do differently? | |
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IMPLEMENTATION RESOURCES

Milestone progress tracking table

| Milestone description | Planned completion date | Enablers |
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| Barriers | Status (not started, on track, behind, postponed, completed) |
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Timeline template

| Task/Activity | Jan | Feb | Mar | Apr |
|----------------------|-----|-----|-----|-----|
| Project start (date) | | | | |
| Activity 1 | | | | |
| Activity 2 | | | | |
| Milestone 1 (date) | | | | |
| Activity 3 | | | | |
| Activity 4 | | | | |
| Activity 5 | | | | |
| Project end (date) | | | | |

THE PROJECT USED TO DEVELOP THIS GUIDE

This implementation guide was developed through a research partnership between the Australian Research Centre in Sex, Health and Society, La Trobe University and *Your Community Health*, a large community healthcare service in metropolitan Melbourne.

Your Community Health piloted the toolkit in two different programs of their organisation. The two programs involved in the pilot were: the Community Partnerships program, which included Needle and Syringe services, counselling services and health promotion; and the Oral Health Service. The two programs used strategies from the toolkit to plan a series of stigma reduction activities. The programs worked on some plans together and on others separately. While the research team worked closely with the two programs, all key decisions such as which activities to pursue and which elements of the toolkit to use were driven by the participating healthcare service staff members. The pilot period lasted six months unfolding across late 2023 and early 2024. The relatively short timeframe meant that both programs were only able to plan and implement small scale stigma reduction activities. The programs have indicated that they intend to keep implementing strategies from the toolkit after the pilot ended and that they aim to eventually embed the toolkit as a key resource across the organisation.

Through partnering with Your Community Health, the project aimed to assess the usability of the toolkit in real world health settings, and to identify the enablers and barriers to using the toolkit to address stigma in healthcare settings. The findings from the research were used to support the development of resources to promote the use of the toolkit in healthcare settings. These resources include the implementation guide and an online implementation workshop.

The project informing this implementation guide combined qualitative methods with research evaluation. The research used a 'realist' evaluation approach which allowed the research to focus on the processes and contexts through which the toolkit strategies were implemented.

| Jun | Jul | Aug | Sep |
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Realist approaches make it possible to identify the relationship between different factors that enable or constrain the success of an intervention. This approach allowed the research team and the healthcare service partner to identify the conditions that assist or limit the success of using the toolkit in each unique program.

The research team documented the implementation process through one-on-one interviews with staff and managers involved in piloting the toolkit and with staff who had not been directly involved but worked in one of the programs. Additionally, a member of the research team attended meetings and events with staff and managers during the project and recorded their observations in a series of fieldnotes.

While the pilot was primarily focussed on professional healthcare practices, the insights from relevant affected communities such as people living with hepatitis C or HIV were included through a consultation process. Through a focus group with key representatives from the BBV and STI community sector, the research team gathered important insights into how healthcare stigma and

discrimination shaped the experiences of relevant populations. Specifically, the focus group included representatives from HIV, hepatitis C, hepatitis B and sexually transmissible infections community organisations in Victoria, Australia. The focus group explored community perspectives on areas of health where stigma and discrimination were more likely to occur, priority issues that needed to be addressed, and which toolkit strategies they saw as most useful for addressing priority issues.

While the research component of the project forms the basis of this implementation guide, it is also informed by the literature related to planning and implementation approaches in health and community development.

Importantly, while all the material in this implementation guide was developed through the piloting process, no material directly represents the practices, approaches and outcomes of our research partner. Research partner experiences provided examples to draw on and processes to consider and, most generally, served as inspiration for the material in this guide.

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