Methods in HIV-Related Intersectional Stigma Research: Core Elements and Opportunities

Valerie A. Earnshaw, PhD, H. Jonathon Rendina, PhD, MPH, Greta R. Bauer, PhD, MPH, Stephen Bonett, PhD, Lisa Bowleg, PhD, Joseph Carter, MA, Devin English, PhD, M. Reuel Friedman, PhD, MPH, Mark L. Hatzenbuehler, PhD, Mallory O. Johnson, PhD, Donna H. McCree, PhD, MPH, RPh, Torsten B. Neilands, PhD, Katherine G. Quinn, PhD, Gabriel Robles, PhD, MSW, Ayden I. Scheim, PhD, Justin C. Smith, MS, MPH, Laramie R. Smith, PhD, Laurel Sprague, PhD, Tamara Taggart, PhD, MPH, Alexander C. Tsai, MD, PhD, Bulent Turan, PhD, Lawrence H. Yang, PhD, José A. Bauermeister, PhD, MPH, and Deanna L. Kerrigan, PhD, MPH

Researchers are increasingly recognizing the importance of studying and addressing intersectional stigma within the field of HIV. Yet, researchers have, arguably, struggled to operationalize intersectional stigma.

To ensure that future research and methodological innovation is guided by frameworks from which this area of inquiry has arisen, we propose a series of core elements for future HIV-related intersectional stigma research. These core elements include multidimensional, multilevel, multidirectional, and action-oriented methods that sharpen focus on, and aim to transform, interlocking and reinforcing systems of oppression. We further identify opportunities for advancing HIV-related intersectional stigma research, including reducing barriers to and strengthening investments in resources, building capacity to engage in research and implementation of interventions, and creating meaningful pathways for HIV-related intersectional stigma research to produce structural change.

Ultimately, the expected payoff for incorporating these core elements is a body of HIV-related intersectional stigma research that is both better aligned with the transformative potential of intersectionality and better positioned to achieve the goals of Ending the HIV Epidemic in the United States and globally. (*Am J Public Health*. 2022;112(S4):S413–S419. https://doi.org/10.2105/AJPH.2021.306710)

AJPH Supplement 4, 2022, Vol 112, No. S4

Researchers have recognized, studied, and addressed the role of stigma in HIV prevention and treatment since the early years of the epidemic. Stigma is a social process supported by social power that distinguishes people based on social statuses and results in devaluation.[1] As the HIV epidemic has become concentrated in populations at the nexus of multiple forms of oppression, such as Black sexual minority men in the United States, researchers have increasingly sought to adopt an intersectional lens when studying stigma. Yet, researchers have, arguably, struggled to operationalize intersectional stigma.

Intersectional stigma recognizes that HIV stigma intersects with other stigmas, such as stigma associated with race and sexuality, to create unique and sometimes new oppressive conditions and experiences.[2] (For more on the definition and framework of intersectional stigma, see Bowleg's introductory editorial in this supplement, p. S224.) Operationalizing intersectional stigma presents challenges because theoretical frameworks do not prescribe to researchers a predetermined set of variables to be measured or associations to be tested.[3] They instead offer researchers essential tenets to guide their choices of research questions, study designs, measures, and analyses. To guide future innovation in HIV-related intersectional stigma research, we propose a series of theory-based core elements of, and identify several opportunities for, advancing HIV-related intersectional stigma research.

CORE RESEARCH ELEMENTS

Core elements of HIV-related intersectional stigma research include multidimensional, multilevel, multidirectional, and action-oriented methods that sharpen focus on, and aim to transform, interlocking and reinforcing systems of oppression. As described here and in Box 1, these methods can be integrated into research in many ways. We describe examples of studies that have applied these core elements to HIV-related stigma research, including research on stigma experienced by key populations and people living with HIV, in the sections that follow. Many of these examples incorporate only 1 or 2 core elements (e.g., multidimensional or multilevel elements); consequently, incorporating multiple core elements (e.g., multidimensional and multilevel elements) is a key next step for HIV-related intersectional stigma research.

Multidimensional

Much of the recent methodological innovation related to intersectional stigma research has focused on the multidimensional aspect of intersectionality or the ways in which multiple, interlocking dimensions of stigma (e.g., racism, heterosexism, transphobia, HIV stigma) shape HIV and other health outcomes.[4,5] Although work on multidimensional methods is certainly not complete, it has perhaps been the first frontier of HIV-related intersectional stigma research. Qualitative methods were the cornerstones of early work.[3] For example, qualitative findings suggest that Black gay and bisexual men generally experience their social identities as interlocking and mutually constitutive rather than independent and additive (although underscoring the complexity of intersectionality, some Black gay and bisexual men view themselves as Black first).[6] Qualitative methods continue to play key roles in intersectional stigma research given their capacity to yield insights into complex social phenomena that play roles in HIV prevention and treatment.[3,5]

Researchers have recently made innovations in quantitative approaches to capturing the multidimensional nature of intersectional stigma, many of which have been summarized in recent reviews.[4,5,7] Multidimensional measurement approaches include intercategorical measures that capture stigma across a range of intersections of social identities and positions: the Intersectional Discrimination Index does not include attributions for discrimination, instead asking participants to reflect on experiences they have had or expect to have because of "who they are."[8] Measures additionally seek to capture unique experiences of stigma within specific groups: the Black Men's Experiences Scale measures experiences at the intersection of race and gender among Black men in the United States.[9] Other approaches incorporate parallel

BOX 1— Concepts, Recommendations, and Examples of Methods for Core Elements of HIV-Related Intersectional Stigma Research

Concept	Recommendation	Examples of Methods
Multidimensional: HIV inequities are shaped by multiple forms of stigma (e.g., racism, sexism, heterosexism, HIV stigma).	Interrogate interlocking stigma processes that give rise to HIV inequities.	• *Qualitative methods*: in-depth interviews, focus groups, ethnography, photovoice, and observational studies • *Individual- and interpersonal-level measures*: intercategorical, group-specific, parallel • *Analyses*: moderation (i.e., regression with interaction terms), hierarchical regressions, latent variable approaches, and structural equation modeling
Multilevel: HIV-related intersectional stigma exists at multiple social–ecological levels, including the structural, interpersonal, and individual levels.	Center considerations of social–structural contexts of stigma.	• *Multilevel models*: span multiple social–ecological levels • *Policy and legal analysis*: national, organizational, and institutional policy indices • *Spatial methods*: photovoice, ecological momentary assessment, experimental field studies and randomized audit studies, in-depth interviews, participant observation, spatial meta-analyses • *Network methods*: social network methods (egocentric and sociometric), dyadic methods
Multidirectional: HIV-related intersectional stigma at one level shapes stigma at other levels.	Explore the social construction and deconstruction of stigma.	• *Multilevel models*: tests of cross-level effect modification, direct cross-level effects, and indirect cross-level effects • *Longitudinal designs and analyses*: span policy (de)implementation
Action-oriented: The transformation of power structures that give rise to HIV inequities is the end goal of HIV-related intersectionality research.	Promote social change.	• *Community leadership and engagement*: community-based participatory research, participatory action research • *Structural intervention*: rights-based policy change

measures of multiple dimensions of stigma: the Multiple Discrimination Scale measures stigma associated with sexual orientation, race/ethnicity, and HIV status with parallel items.[10] Multidimensional analytic approaches identified by Turan et al.[5] and Bauer[4] include moderation (e.g., regression models with product terms to assess for potential interaction), hierarchical regression, latent variable approaches, and structural equation modeling. For example, latent class and profile methods have been used to identify patterns of interpersonal stigma experiences within samples and to explore associations between these patterns and health outcomes.[5]

Multilevel

Intersectionality calls for the consideration of how systems of oppression operating at multiple social–ecological levels create inequities within society and ultimately affect HIV prevention and treatment outcomes. Stigma exists at multiple levels, including individual (e.g., internalized stigma), interpersonal (e.g., discrimination), and structural (e.g., laws).[1,11] Although HIV-related intersectional stigma research to date has primarily focused on capturing the multidimensional nature of stigma at the individual or interpersonal levels (as described in the previous section and in other reviews[5]), there have been notable recent advancements in measuring stigma at the structural level.[11] This work has provided new evidence that policy and legal structures create and reinforce intersectional stigma via sociopolitical systems that systematically reproduce oppression and ultimately generate inequities in health. For example, Black sexual minority men living in US states with high levels of both structural racism and anti–lesbian, gay, bisexual, transgender, and queer policies are at heightened risk of precursors to suicidality and HIV risk, and those living in US states with high levels of anti–lesbian, gay, bisexual, transgender, and queer policies report less frequent HIV testing.[12] Focusing on the structural level yields insight into how intersectional stigma is manifested within and between organizations and institutions of power and privilege. For example, HIV disclosure policies within employment settings prevent the hiring and promote the firing of people living with HIV.[13]

Attending to cultural contexts can inform understanding of how intersectional stigma is locally manifested by preventing stigmatized individuals from fully participating in local, culturally valued activities.[14] Culturally salient measures can be used to better attend to cultural contexts. The WMM (What Matters Most) Cultural Stigma Scale for Women Living With HIV in Botswana captures culturally relevant aspects of stigma at the intersection of gender and HIV (e.g., achieving capabilities core to "womanhood" or taking care of home and children).[14] Methods that attend to spatial contexts can help researchers explore how intersectional stigma is attached to various spaces, places, and locations. Photovoice, a participatory research method involving photographs and storytelling, has been used to explore how contextual factors within clinical settings shape stigma experienced by people who use drugs.[15] Network methods offer powerful tools to understand how intersectional stigma is shaped by social relationships and experienced from unique sources. A sociocentric network study of a rural region of Uganda found that individuals endorse greater HIV stigma if their peers also endorse greater HIV stigma.[16]

These studies have mostly focused on stigma processes that occur above the individual and interpersonal levels. Innovation in multilevel methods, or those that can be used to integrate multiple social–ecological levels of stigma simultaneously, is a key next direction for research. Emerging research provides some promising examples of the kind of multilevel work that is needed. As examples, researchers have begun to explore associations between stigma at the structural (e.g., same-sex marriage and civil union laws) and interpersonal (e.g., discrimination) levels.[17,18]

Multidirectional

Intersectional stigma is a dynamic, reciprocal, and reinforcing social phenomenon. Once researchers have established a foundation of multidimensional and multilevel methods, they may expand their focus to multidirectional methods that enable researchers to study how changes in HIV-related intersectional stigma at one level produce changes in HIV-related intersectional stigma at other levels, which may in turn produce reciprocal changes at the original level. Researchers may study the construction of HIV-related intersectional stigma by investigating how stigma at one level reinforces and strengthens stigma at other levels. Stigma can be constructed from the top down: the introduction of a same-sex marriage ban was associated with increasing rates of homophobic bullying among youths in California between 2008 and 2009.[17] Stigma can also be constructed from the bottom up: individuals with high levels of stigma toward people with opioid use disorders are more supportive of punitive

versus public health–oriented policies to address the opioid crisis.[19]

Researchers may study the deconstruction of HIV-related intersectional stigma by investigating how empowerment at one level destabilizes and weakens stigma at other levels. Stigma can be deconstructed from the top down: longitudinal research suggests the passing of civil union legislation was associated with decreased experiences of stigma and better mental and behavioral health outcomes among sexual minority women, with greater benefits for racial/ethnic minority women and those with less formal eduation.[18] Stigma can also be deconstructed from the bottom up: activism led by people living with HIV has contributed to the repeal of HIV criminalization policies worldwide.[20] Intersectionality recognizes that systems of oppression are interlocking[21]; thus, as stigma associated with one social status is deconstructed, stigma associated with other social statuses may also weaken.

Action-Oriented

As a critical social theory, intersectionality is a tool for social change that calls for action.[21] We echo and amplify other theorists[22] by proposing that action-oriented methods that promote social change in partnership with communities of people living with and affected by HIV are a core element of HIV-related intersectional stigma research. Such action-oriented methods are made more effective through the integration of multidimensional, multilevel, and multidirectional methods. Community-based participatory research and participatory action research approaches that emphasize the equal participation of community stakeholders and researchers are needed to promote social change through research. The liberation of communities most affected by HIV-related intersectional stigma cannot be achieved without leadership reflective of those communities.

Centering considerations of social–structural contexts encourages interventionists to set their sights on structural change to eliminate HIV inequities. For example, interventions that aim to establish and enforce rights-based policies are needed to dismantle HIV-related intersectional stigma. Moreover, community-led research that investigates how to prevent and eliminate intersectional stigma across contexts, sources, and levels is critical for stigma-reduction efforts. In particular, research that focuses on policymakers, health care providers, and hegemonic community norms can investigate strategies to rebalance interlocking systems of power and transition from an exclusion-focused "them/deficits" approach to an inclusion-focused "we/assets" approach to HIV prevention and treatment.

RESEARCH OPPORTUNITIES

Despite growing recognition of the importance of adopting an intersectional stigma lens within HIV research, there are several prominent barriers to engaging in this work. Following, and in Box 2, we identify key opportunities for addressing barriers to enhance the field's potential for engagement in HIV-related intersectional stigma research.

Reduce Barriers and Strengthen Investment

Identifying structural determinants of HIV prevention and treatment is foundational to HIV-related intersectional

BOX 2— Opportunities and Examples of Strategies for Advancing HIV-Related Intersectional Stigma Research

Opportunity	Examples of Strategies
Reduce barriers and strengthen investment.	• Facilitate access to and support the development of data sets needed for multilevel analyses, including geocoded, population-based, and policy data sets. • Remove barriers to the use of geographic indicators in existing population-based data sets. • Create a compendium of intersectional stigma methods, measurements, and approaches. • Continue to invest in funding opportunities to support development of innovative methods and measurements.
Build capacity.	• Invest in training of future researchers via training and mentorship opportunities. • Invest in professional development of current researchers via workshops, institutes, and short courses. • Develop a resource guide that outlines educational and training opportunities, sources of seed and pilot funding, and existing data sets. • Increase the diversity of the biomedical and scientific workforce, with a focus on communities that have been disproportionately affected by the HIV epidemic.
Create pathways to structural change.	• Identify and develop pathways for research to contribute to structural change. • Facilitate opportunities for researchers and policymakers to engage at the local, regional, and national levels through advocacy, networking, and other initiatives. • Engage communities in all stages of the research process.

stigma research. Opportunities exist to strengthen access to resources to enable researchers to better study these determinants. First, access to and the development of data sets needed for multidimensional and multilevel analyses can be facilitated. These include geocoded data sets to enable researchers to examine associations between structural and contextual factors with individual-level HIV risk and prevention outcomes; population-based data sets that include multidimensional stigma measures and that oversample underrepresented key populations to facilitate adequate statistical power for intersectional analyses; and data sets with indicators of structural stigma, which often require substantial time and resources to develop, yet are vital for multilevel analyses. Establishing a centralized mechanism for collecting longitudinal data on laws, policies, and other institutional factors could greatly accelerate the scalability of research by enabling researchers to more easily incorporate indicators of HIV-related intersectional stigma into a wide range of studies.[23]

Second, barriers must be removed to facilitate the use of geographic indicators in international, national, and local-level data sets. Numerous health data sets provide insufficient information on participants' geographic residence, which prevents the examination of structural factors. Other data sources release data at only 1 geographic level of analysis (e.g., state), which restricts researchers' ability to examine structural determinants across multiple geographic levels, or provide geographic indicators but restrict the ability of researchers to use it (e.g., variables that may identify a particular state), which limits the types of analyses that are possible.[11] Third, the creation of a compendium of intersectional stigma methods could accelerate their uptake and usage by researchers. Fourth, continued investment in funding opportunities would promote the development of innovative methods for HIV-related intersectional stigma research.

Build Capacity

Intersectional stigma is a complex phenomenon that requires advanced understanding of theory and specialized skill sets to research. Training early career investigators in theory and methods for HIV-related intersectional stigma research and strengthening mentorship networks will accelerate this area of research. All training should include a strong focus on theory to ensure that research remains rooted in considerations of power, social justice, and Black feminist thought.[21,22] Increasing the diversity of the biomedical and scientific workforce, with a focus on communities that have been disproportionately affected by the HIV epidemic, will ensure that HIV-related intersectional stigma research is informed and led by researchers with relevant lived experiences. Investments can additionally be made in professional development of established researchers via workshops, training institutes, and short courses to enable them to engage with HIV-related intersectional stigma research as investigators, mentors, and peer reviewers. In their roles as peer reviewers, established researchers act as gatekeepers to innovative methods—accelerating or blocking their advancement.

Create Pathways to Structural Change

To achieve the action-oriented elements of intersectionality research, we recommend the creation of pathways for research to contribute to structural change. Greater engagement between researchers with policymakers and health care leaders at the local, state, and national levels through advocacy, networking, and other initiatives can better enable research findings to inform policy and health care decisions. Researchers may bridge the research–policy and bench-to-bedside gaps by communicating with policymakers and health care providers in ways that meet the demands of policymakers' and providers' time and needs (e.g., synthesized, policy- and practice-relevant, easily digestible communications).[24] Similarly, policymakers and health care leaders may bridge these gaps by investing in systems, programs, and personnel that better tap the expertise of researchers.

For research to inform structural change, communities living with and affected by HIV should be engaged in all stages of the research process. Researchers can provide opportunities for community members to engage in the formulation of research to ensure that research projects reflect community priorities surrounding HIV-related intersectional stigma. Funders can ensure that community members receive funding to engage in grant projects, rather than relying on their involvement as volunteers, to promote equitable research partnerships. Funders can also support efforts for communities to sustain their work after the research project so that research can promote lasting changes in intersectional stigma.

CONCLUSIONS

Recognition of the importance of adopting an intersectionality lens within HIV-related stigma research is growing.

To date, most of the field's methodological innovation related to intersectional stigma has focused on developing multidimensional methods that explore how multiple, interlocking dimensions of stigma shape HIV outcomes at the individual or interpersonal levels. Although this work has been important, multilevel, multidirectional, and action-oriented methods are critical for understanding and transforming interlocking and reinforcing systems of oppression. These core elements may not be easily captured with a single study design, measure, or analysis. Instead, researchers should consider employing multiple methods in concert to triangulate evidence regarding HIV-related intersectional stigma. Ultimately, we believe that the payoff for incorporating these core elements and addressing barriers to their implementation will be a body of HIV-related intersectional stigma research that is both better aligned with the transformative potential of intersectionality and better positioned to achieve the goals of Ending the HIV Epidemic in the United States and globally. AJPH

ABOUT THE AUTHORS

Valerie A. Earnshaw is with the Department of Human Development and Family Sciences, College of Education and Human Development, University of Delaware, Newark. H. Jonathon Rendina is with the Department of Epidemiology, Milken Institute School of Public Health, George Washington University, Washington, DC. Greta R. Bauer is with the Department of Epidemiology and Biostatistics, Schulich School of Medicine and Dentistry, Western University, London, ON, Canada. Stephen Bonett is with the School of Nursing, University of Pennsylvania, Philadelphia. Lisa Bowleg is an *AJPH* Associate Editor and is with the Department of Psychological and Brain Sciences, George Washington University. Joseph Carter is with the Department of Psychology, Hunter College, New York, NY. Devin English is with the Department of Urban-Global Public Health, School of Public Health, Rutgers University, New Brunswick, NJ. M. Reuel Friedman is with the Department of Infectious Diseases and Microbiology, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, PA. Mark L. Hatzenbuehler is with the Department of Psychology, Harvard University, Cambridge, MA. Mallory O. Johnson and Torsten B. Neilands are with the Department of Medicine, University of California, San Francisco. Donna H. McCree is with the National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, Atlanta, GA. Katherine G. Quinn is with the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, Milwaukee. Gabriel Robles is with the School of Social Work, Rutgers University, New Brunswick. Ayden I. Scheim is with the Department of Epidemiology and Biostatistics, Dornsife School of Public Health, Drexel University, Philadelphia, PA. Justin C. Smith is with Positive Impact Health Centers, Atlanta. Laramie R. Smith is with the Division of Global Public Health and Infectious Diseases, School of Medicine, University of California, San Diego. Laurel Sprague is with the Department of Gender Equality, Human Rights, and Community Engagement, Joint United Nations Programme on HIV/AIDS, Geneva, Switzerland. Tamara Taggart and Deanna L. Kerrigan are with the Department of Prevention and Community Health, Milken Institute School of Public Health, George Washington University. Alexander C. Tsai is with the Center for Global Health and Mongan Institute, Massachusetts General Hospital, Boston. Bulent Turan is with the Department of Psychology, Koc University, Istanbul, Turkey. Lawrence H. Yang is with the Department of Social and Behavioral Sciences, School of Global Public Health, New York University, New York, NY. José A. Bauermeister is with the Department of Family and Community Health, School of Nursing, University of Pennsylvania, Philadelphia.

Note. The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

CORRESPONDENCE

Correspondence should be sent to Valerie A. Earnshaw, PhD, 111 Alison Hall West, Newark, DE 19716 (e-mail: earnshaw@udel.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

PUBLICATION INFORMATION

Full Citation: Earnshaw VA, Rendina HJ, Bauer GR, et al. Methods in HIV-related intersectional stigma research: core elements and opportunities. *Am J Public Health*. 2022;112(S4):S413–S419.

Acceptance Date: December 29, 2021.

DOI: https://doi.org/10.2105/AJPH.2021.306710

CONTRIBUTORS

All authors substantially contributed to the conceptualization of the article, revised it for content, and approved the final version to be published. Authorship order was mainly determined alphabetically by last name. V. A. Earnshaw drafted the article with help from H. J. Rendina. J. A. Bauermeister and D. L. Kerrigan led group discussions that informed the foundation of the article.

ACKNOWLEDGMENTS

We thank the US National Institutes of Health Office of AIDS Research and National Institute of Mental Health for convening our group, and the guest editors of the special issue on HIV-related intersectional stigma for their helpful feedback on our article. We also thank communities of people living with and affected by HIV for leading and partnering on HIV-related intersectional stigma research.

CONFLICTS OF INTEREST

A. C. Tsai reports receiving a financial stipend from Elsevier Inc. for his work as Co–Editor in Chief of the journal *SSM-Mental Health.*

HUMAN PARTICIPANT PROTECTION

This study did not require human participant research.

REFERENCES

1. Major B, Dovidio JF, Link BG, Calabrese SK. Stigma and its implications for health: introduction and overview. In: Major B, Link BG, Dovidio JF, eds. *The Oxford Handbook of Stigma, Discrimination, and Health.* New York, NY: Oxford University Press; 2018:3–28.
2. Berger MT. *Workable Sisterhood: The Political Journey of Stigmatized Women With HIV/AIDS.* Princeton, NJ: Princeton University Press; 2004.
3. Bowleg L. The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *Am J Public Health.* 2012;102(7):1267–1273. https://doi.org/10.2105/AJPH.2012.300750
4. Bauer GR. Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity. *Soc Sci Med.* 2014;110:10–17. https://doi.org/10.1016/j.socscimed.2014.03.022
5. Turan JM, Elafros MA, Logie CH, et al. Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Med.* 2019;17(1):7. https://doi.org/10.1186/s12916-018-1246-9
6. Bowleg L. "Once you've blended the cake, you can't take the parts back to the main ingredients": Black gay and bisexual men's descriptions and experiences of intersectionality. *Sex Roles.* 2012;68(11):754–767. https://doi.org/10.1007/s11199-012-0152-4
7. Bauer GR, Churchill SM, Mahendran M, Walwyn C, Lizotte D, Villa-Rueda AA. Intersectionality in quantitative research: a systematic review of its emergence and applications of theory and methods. *SSM Popul Health.* 2021;14:100798. https://doi.org/10.1016/j.ssmph.2021.100798
8. Scheim AI, Bauer GR. The Intersectional Discrimination Index: development and validation of measures of self-reported enacted and anticipated discrimination for intercategorical analysis. *Soc Sci Med.* 2019;226:225–235. https://doi.org/10.1016/j.socscimed.2018.12.016
9. Bowleg L, English D, del Rio-Gonzalez AM, Burkholder GJ, Teti M, Tschann JM. Measuring the pros and cons of what it means to be a Black

man: development and validation of the Black Men's Experiences Scale (BMES). *Psychol Men Masc.* 2016;17(2):177–188. https://doi.org/10.1037/men0000026

10. Bogart LM, Landrine H, Galvan FH, Wagner GJ, Klein DJ. Perceived discrimination and physical health among HIV-positive Black and Latino men who have sex with men. *AIDS Behav.* 2013;17(4):1431–1441. https://doi.org/10.1007/s10461-012-0397-5
11. Hatzenbuehler ML. Structural stigma and health. In: Major B, Link BG, Dovidio JF, eds. *The Oxford Handbook of Stigma, Discrimination, and Health.* New York, NY: Oxford University Press; 2018:105–121.
12. English D, Carter JA, Boone CA, et al. Intersecting structural oppression and Black sexual minority men's health. *Am J Prev Med.* 2021;60(6):781–791. https://doi.org/10.1016/j.amepre.2020.12.022
13. Sprague L, Simon S, Sprague C. Employment discrimination and HIV stigma: survey results from civil society organisations and people living with HIV in Africa. *Afr J AIDS Res.* 2011;10(suppl 1):311–324. https://doi.org/10.2989/16085906.2011.637730
14. Yang LH, Foster ARH, Becker TD, et al. Psychometric validation of a scale to assess culturally-salient aspects of HIV stigma among women living with HIV in Botswana: engaging "What Matters Most" to resist stigma. *AIDS Behav.* 2021;25(2):459–474. https://doi.org/10.1007/s10461-020-03012-y
15. Switzer S, Guta A, de Prinse K, Chan Carusone S, Strike C. Visualizing harm reduction: methodological and ethical considerations. *Soc Sci Med.* 2015;133:77–84. https://doi.org/10.1016/j.socscimed.2015.03.040
16. Takada S, Nyakato V, Nishi A, et al. The social network context of HIV stigma: population-based, sociocentric network study in rural Uganda. *Soc Sci Med.* 2019;233:229–236. https://doi.org/10.1016/j.socscimed.2019.05.012
17. Hatzenbuehler ML, Shen Y, Vandewater EA, Russell ST. Proposition 8 and homophobic bullying in California. *Pediatrics.* 2019;143(6):e20182116. https://doi.org/10.1542/peds.2018-2116
18. Everett BG, Hatzenbuehler ML, Hughes TL. The impact of civil union legislation on minority stress, depression, and hazardous drinking in a diverse sample of sexual-minority women: a quasi-natural experiment. *Soc Sci Med.* 2016;169:180–190. https://doi.org/10.1016/j.socscimed.2016.09.036
19. Kennedy-Hendricks A, Barry CL, Gollust SE, Ensminger ME, Chisolm MS, McGinty EE. Social stigma toward persons with prescription opioid use disorder: associations with public support for punitive and public health-oriented policies. *Psychiatr Serv.* 2017;68(5):462–469. https://doi.org/10.1176/appi.ps.201600056
20. Cameron S, Bernard EJ. Advancing HIV justice 3: growing the global movement against HIV criminalisation. 2019. Available at: http://www.hivjustice.net/wp-content/uploads/2019/05/AHJ3-Full-Report-English-Final.pdf. Accessed June 28, 2021.
21. Collins PH, Bilge S. *Intersectionality.* Cambridge, UK: Polity Press; 2016.
22. Bowleg L. Evolving intersectionality within public health: from analysis to action. *Am J Public Health.* 2021;111(1):88–90. https://doi.org/10.2105/AJPH.2020.306031
23. Blake VK, Hatzenbuehler ML. Legal remedies to address stigma-based health inequalities in the United States: challenges and opportunities. *Milbank Q.* 2019;97(2):480–504. https://doi.org/10.1111/1468-0009.12391
24. Gaieck W, Lawrence JP, Montchal M, Pandori W, Valdez-Ward E. Science policy for scientists: a simple task for great effect. *Proc Natl Acad Sci U S A.* 2020;117(35):20977–20981. https://doi.org/10.1073/pnas.2012824117

is your organization an **APHA** member?

Nonprofits, government agencies and educational institutions play an important role in public health. But did you know they can also be members of APHA?

As an APHA agency member, you get discounts on ads in APHA publications and job postings on Public Health CareerMart.

And your employees receive registration discounts for APHA's Annual Meeting and Expo and savings of up to $150 on individual APHA membership.

Become an APHA agency member today!

For details, call **202-777-3914**
or visit **www.apha.org/membership**.