"Why Not Just go on PrEP?": A Study to Inform Implementation of an HIV Prevention Intervention Among Hispanic/Latino Men Who Have Sex With Men in the Northeastern United States

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Background: Preexposure prophylaxis (PrEP) is an effective biological option for HIV prevention yet persistent disparities in PrEP uptake and retention exist among Hispanic/Latino men who have sex with men (MSM). We evaluated barriers and facilitators to PrEP care among Hispanic/Latino MSM at risk for and living with HIV.

Setting: A small urban setting in the Northeastern United States.

Methods: This was a mixed-methods, exploratory, sequential, qualitative and quantitative pilot study among Latino MSM at-risk and/or living with HIV across (1) semistructured qualitative interviews (N = 15) and (2) cross-sectional survey (N = 98).

Results: Participants reported a diverse range of sexual identities, HIV statuses, and PrEP statuses. Qualitative participants described feelings of isolation in both Hispanic/Latino and queer communities that made it challenging to learn about HIV prevention or PrEP from peers. Participants in the survey indicated that they would be more inclined to uptake PrEP if PrEP were offered in primary care settings (n = 61; 62.2%); there were specific LGBTQ+ affirming medical settings (n = 36; 36.7%); and/or they could meet other people who are currently on PrEP and sharing experiences online (n = 46; 46.9%) or in person (n = 38; 38.8%). Findings were organized to reflect determinants and implementation strategies that could be used to improve PrEP uptake among this population.

Conclusions: This mixed-methods study identified several challenges and opportunities for increasing the reach of PrEP to Hispanic/Latino MSM. These findings should be used to inform tailored implementation strategies to promote PrEP uptake among this at-risk yet currently underserved population.

Key Words: preexposure prophylaxis, HIV, Hispanic/Latino, mixed methods

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A portion of qualitative data presented here were presented at an internal academic research day in the Department of Medicine at Warren Alpert Medical School of Brown University and the Brown School of Public Health. In addition, some of these data were presented at the Sexual and Gender Minority Special Interest Group poster session at the 56th Annual Convention of the Association for Behavioral and Cognitive Therapies in New York, New York. The full data set has never been presented in abstract or presentation form. None of these data have been submitted to a prior journal.

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INTRODUCTION

Preexposure prophylaxis (PrEP) for HIV is extremely efficacious when taken as directed. PrEP is now approved in several forms, which include a daily oral medication,[1,2] an "as-needed" oral medication to be taken immediately before and after a potential exposure (referred to as 2-1-1 or "event-driven" PrEP[3]), and most recently, as an intramuscular injection. These options significantly expand the choices available to prevent HIV acquisition. Before FDA approval of PrEP in 2012, HIV prevention relied heavily on sexual risk reduction counseling and behavioral strategies like condom use, reducing the number of concurrent sexual partners, and serosorting or seropositioning to avoid HIV transmission.[4–6] PrEP offers an additional effective approach for HIV prevention.[7] This has influenced dating, partnerships, and sexual confidence particularly among gay, bisexual, and other men who have sex with men (MSM).[8] Despite the numerous forms of PrEP and its proven efficacy for preventing sexually

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transmitted HIV, PrEP continues to suboptimally reach those who could most benefit from it. Importantly, White MSM are significantly more likely than non-White MSM to access, uptake, and persist in PrEP care.[9,10]

Hispanic/Latino MSM face structural and cultural barriers to PrEP use, potentially driving this health care disparity. Issues of accessing health care (often because of immigration status or issues with legal documentation) may present challenges or negatively affect an individual's willingness to seek any form of preventive health care including PrEP.[11,12] Even with legal documentation, Hispanic/Latino MSM may be less likely to hold jobs that provide insurance and thus may have reduced access to health insurance to cover the costs of care.[13] These factors are modifiable at a structural level, such that structural changes (eg, universal health care) could eliminate these structural barriers. However, even when these structural issues are mitigated, there are cultural factors or existing belief systems, traditions, and ways of relating to others that impact willingness to seek PrEP care. For example, cultural taboos around sexual health may make conversations about HIV prevention challenging, and internalized stigma related to sexual behavior may present a barrier to seeking out sexual health care for Hispanic/Latino MSM.[14,15] In addition, Hispanic/Latino MSM report that disclosing their PrEP use to their families can heighten tensions, particularly for those with already strained relationships with their family because of their sexual orientation.[16]

A recent systematic review conducted by Li et al[17] examining determinants of PrEP decision making concluded that overall, PrEP use determinants are well documented; yet, there is more to learn for specific understudied subpopulations, including Hispanic/Latino MSM for whom determinants related to PrEP uptake, adherence, and persistence are not well documented. This is an important gap within the literature given that the rates of HIV seroconversion are significantly higher among Hispanic/Latino MSM (1:4) than White MSM (1:11).[18] Many prior research studies have pointed to issues with immigration and documentation, reduced access to health insurance and health care, and limited providers with expertise to prescribe PrEP.[19,20] However, this disparity in access to PrEP and higher rates of HIV among Hispanic/Latino MSM persists even in jurisdictions with almost universal health care, access to health care through large academic medical centers, and multiple providers who prescribe PrEP, including the Northeastern US Within the Northeast, 31.3% of individuals living with HIV identify as Hispanic/Latino,[21] which is an overrepresentation of this demographic relative to the general population, which is only 16% Hispanic/Latino.[22]

As such, the goal of this study was to characterize the determinants of PrEP uptake among Hispanic/Latino MSM within the Northeastern United States to inform tailored implementation strategies to enhance uptake of PrEP among Hispanic/Latino MSM in this geographic context. Specifically, we sought to examine factors associated with low PrEP uptake among Hispanic/Latino MSM in the context of barriers and facilitators to accessing health care in real-world settings. These factors were used to select implementation strategies from the Expert Recommendations for Implementing Change (ERIC) taxonomy.[23] The ERIC taxonomy provides a list of 73 possible implementation strategies that have been used across research studies, including PrEP-related studies.[24,25] With intention, this study was conducted in a small, urban setting in the Northeast, where 96% of state residents have health insurance and there are numerous affordable, public health insurance options.[26] Given this context, our sample was naturally restricted to include only those with access to both health care and PrEP, which allowed us to explore some of the more sociocultural factors related to Hispanic/Latino MSM engagement in PrEP. Our primary research questions were (1) *What are the barriers and facilitators to PrEP care among Hispanic/Latino MSM?* and (2) *How could we leverage clinical and social resources to engage Hispanic/Latino MSM in PrEP care?* Both research questions were asked with the purpose of informing future PrEP implementation including the selection of tailored implementation strategies to increase PrEP use among this community.

METHODS

Study Design

This study was an exploratory, sequential, qualitative and then quantitative mixed-methods study that used community-engaged research principles. Throughout the design and data collection phases, the lead author and study PI were in communication with the CFAR Community Engaged Research Council (C-CERC) for ongoing feedback. The C-CERC is composed of individuals affected by HIV who also work in the field and are available for ongoing consultation related to research design and implementation.

We designed the qualitative interview guide to center the lived experiences of Latino MSM to understand barriers and facilitators for PrEP use. Initially, we were planning to focus on those not engaged in care, but then we were advised through the C-CERC to look at experiences across the HIV continuum of care—those not engaged in PrEP care, those engaged in PrEP care, and those living with HIV—to understand PrEP engagement more holistically. We analyzed data from qualitative interviews using Rapid Qualitative Analysis (RQA) and used to design questions and answer choices within the quantitative survey.

Part 1: Qualitative Procedures and Participants

Study recruitment took place from October 2020 to September 2022. Recruitment approaches for the qualitative component of the study included study flyers shared on email listservs for local LGBTQ+ community spaces and events, social media pages for the study, word-of-mouth, and through recruitment in the context of routine clinical care at an academic medical center STI/HIV clinic.

All consent forms, advertisements, questionnaires, and interview guides were translated into Spanish. Qualitative interviews were completed on Zoom through a university-

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based subscription which offers a "Health Services" or HIPAA-compliant version that has end-to-end encryption and disables recording of the interview or storage on the Cloud. At the interview visit, participants were provided a link to a REDCap-based survey to provide their consent to participate and complete background questions about their demographic information and current behaviors. Once completed, they started the qualitative interview. All interviews were audio recorded using a handheld recording device and transcribed before analysis.

As compensation, participants received a $30 gift card to a large, coffee and baked goods chain with multiple locations in the area. Gift card numbers were delivered verbally to participants at the end of the interview who entered information into the application within their smart phones; receipt of the funds was confirmed before ending the interview.

Part 2: Quantitative Procedures and Participants

Based on responses from the qualitative portion of the study, we developed a quantitative survey. Survey questions were informed by qualitative findings, and we included questions about knowledge and attitudes toward PrEP, behavioral risk factors for HIV, and ideas for improving HIV prevention approaches among Hispanic/Latino MSM. Qualitative findings informed response choices options in the survey. For example, in the qualitative interviews, individuals recommended using social media influencers to promote PrEP, so this was an answer choice option of a "check all that apply" response within the quantitative survey question that asked about increasing PrEP awareness among Latino MSM.

To reach a larger portion of Latino MSM than our qualitative study, the C-CERC suggested the use of online recruitment for the follow-up survey aim. However, because we wanted the experience to reflect the population from which the sample was drawn geographically, we limited the radius of advertisements to include only the hospital-based clinic catchment area, which includes all of Rhode Island, parts of eastern Connecticut, and parts of southeastern Massachusetts. Accordingly, for this portion of the study, participants were recruited online using Google search terms and on social networking and dating applications that specifically reach MSM. Regional targeting of messaging focused on Southern New England (parts of Connecticut, parts of Massachusetts, and the state of Rhode Island). Advertisements included images, language, and themes focused on recruiting Hispanic/Latino MSM and were designed by a research team that included Latino-identified and LGBTQ+-identified individuals. These advertisements included images of Latino men alone or talking with others. Some were smiling and others were texting (as if on dating apps). Images included people, bright colors, and text to with messages focused on participating to help the Latino MSM community.

All study procedures were approved by The Miriam Hospital Institutional Review Board and participants were digitally consented at the time they took the survey. Participants also provided their email address at the end of survey completion so that they could be sent compensation for participation. Participants who both completed the survey and provided their email address were sent $20 electronic gift cards to a large, consumer products website.

Measures

Qualitative Interview Guides

A qualitative interview guide was used to guide the semistructured interviews. The qualitative interview guide focused on background and history, HIV and PrEP knowledge and experience, individual-level behaviors related to HIV acquisition and transmission risk, preferences related to PrEP, and suggestions for future strategies to increase PrEP use among Hispanic/Latino MSM.

Quantitative Survey Items

All participants confirmed that they were aged 18 years or older and identified as Hispanic/Latino before they could complete the survey. Questions included demographics, HIV and PrEP status or history, mental health symptoms, and sexual behavior. Participants were then asked to select reasons they thought some people might not want to take PrEP and to select which ideas they felt would be most helpful in encouraging Hispanic/Latino MSM to consider PrEP. The options for this question were drawn from the results of the qualitative interviews. Finally, participants were asked about disclosure of their sexual orientation or HIV status and experiences of discrimination related to various aspects of their identities. All questions had a "Prefer not to respond" answer choice so that individuals were able to select out of answering questions.

Research Team

Our team consisted of affirming researchers at various levels of professional training and experience with training in public health and medicine. All team members worked in ongoing research related to HIV prevention primarily among MSM and all identified as allies of the Hispanic/Latino and LGBTQ+ communities. Some had shared identities with study participants, which was helpful in gaining both emic and etic perspectives in analyzing the data. All team members involved in conducting interviews and coding data received an initial training in qualitative research and a second training in rapid qualitative analytic methods and ongoing weekly meetings to allow for questions, supervision, and completing the RQA.

Qualitative Analysis

Rapid qualitative analyses (RQA[27,28]) is an established qualitative approach particularly useful for health services–related research because of its efficiency in conducting rigorous analyses and translating them into actionable steps for implementation. Instead of relying on a process of coding and then analyzing, RQA uses the following steps to ensure rigorous and data-driven analysis. All staff were trained in the

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RQA process and supervised by the first author for the ongoing analyses.[29]

In following the rigorous and structured steps of RQA,[30] the first author developed an interview summary template that contained questions from the interview and sections for documenting illustrative quotes and pertinent information related to the interview. Next, the first author trained the team to use the template to complete interview summaries for each completed interview. Team members reviewed the transcripts and completed the summary for their assigned interviews. The first author audited every summary for quality control. When transcripts and summaries needed more context, the first author listened to audio files to verify the summaries. The team convened to review these summary forms together. During this meeting, data were transferred into a matrix summary that displayed all participant responses within a specific domain to allow team members to analyze. This complete process was repeated twice throughout the study—the first time was after the first 6 interviews and the second at 15 interviews. We reached saturation at 12 participants, meaning that new themes were only identified with participants 1–12.[31] All authors agreed on the accuracy of the findings, reported below.

Quantitative Analysis

Data were characterized using measures of central tendency and deviation as well as frequencies and percentages. The focus of the quantitative analyses was on capturing information about specific content areas that had been raised within the qualitative portion of the study. For example, questions about the best way to increase uptake were asked with answer choices drawn directly from qualitative responses, and participants were presented with options in a checklist and asked to "check all that apply."

To be inclusive of multiple ways individuals identify and the multiple sexual behaviors that individuals can have, we did not specify an exclusion criterion that screened individuals out based on sexual or gender identity or behavior. We did include a consent form that indicated that we were aiming to recruit Hispanic/Latino MSM. We recruited N = 200 individuals within 1 month, and all participants identified as adults of 18+ years and Latino; however, only about half of the sample (N = 98) reported being individuals assigned male at birth who identified as MSM and Hispanic/Latino. Most of the remaining participants identified as Latina cisgender women and a portion identified as transwomen, transmen, nonbinary, or gender diverse. For the purposes of this article, and so that our quantitative findings can be matched with our qualitative findings, we have focused on our Latino MSM survey respondents.

Mixed-Methods Approach

Within the results section, we present qualitative themes and quantitative survey data together. This was an intentional approach to "mix the methods" and works well given that our first study of qualitative interview findings was used to directly inform the questions and answer choices included on the quantitative survey. We also applied an implementation science framework and organized findings around determinants (informed by the Consolidated Framework for Implementation Research or CFIR) and implementation strategies (informed by the ERIC or ERIC).

RESULTS

Study Findings

Qualitative study findings are explored below, in detail, organized by theme and with illustrative quotes to exemplify the theme. Of note, the following themes were identified: (1) social context and stigma (determinant #1), (2) experiences with PrEP and HIV (determinant #2), and (3) implementation strategies to improve PrEP uptake among Latino MSM. Our quantitative findings asked close-ended questions aligned with these topic areas and quantitative results from the survey are presented below the qualitative findings for each theme.[23]

Sample Characteristics

The qualitative sample included N = 15 participants, all of whom identified as Hispanic/Latino MSM. Within self-identifying as MSM, individuals had various sexual identities, including gay (n = 9), bisexual (n = 4), pansexual (n = 1), and queer (n = 1). About half were HIV negative and not taking PrEP, the remaining half were either taking PrEP (n = 5) or living with HIV (n = 3). The sample was extremely diverse with regard to country of origin, including individuals with backgrounds and heritage from South America, Central America, and the Caribbean with varied immigration histories. There was an approximately even split between those born within (n = 8) and outside (n = 7) the United States. For optimal participant information safety and privacy to promote engagement, we opted to collect demographic data and report in aggregate format only. Thus, no identifying information was linked to specific quotes presented herein. For more information about participant characteristics, see Table 1.

The quantitative sample (survey respondents) who identified as Hispanic/Latino MSM were retained for this analysis (N = 98) and consisted of individuals who identified White (n = 78; 79.6%), Black (n = 6, 6.1%), Asian (n = 7; 7.1%), and a variety of other racial identities. Most identified as gay (n = 88; 89.8%) and a small portion identified as bisexual (n = 10; 10.2%). Many spoke English (n = 96; 98.0%) and Spanish at home (n = 66; 67.3%) and a few spoke Portuguese (n = 2; 2.0%) at home. Most had at least some college (n = 13; 13.3%), university (n = 25; 25.5%), and/or graduate schooling (n = 48; 49%). More than half the sample had an annual salary of more than $50,000/year. Most had health insurance (n = 78; 79.6%) and nearly two-thirds had taken PrEP (n = 66; 67.3%), and slightly more than half reported their status to be HIV negative (n = 59; 60.2%), whereas about one-quarter reported that they were HIV positive (n = 23; 23.5%), and a significant portion chose not to answer (n = 18; 18.4%). For additional sample characteristics, see Table 2.

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TABLE 1. Qualitative Interview Sample Characteristics (N = 15)

	N	%
Ethnicity		
Hispanic/Latino	15	100.0
Race		
White	9	60.0
Black/African American	3	20.0
Another racial identity	6	40.0
Sexual orientation		
Gay	9	60.0
Bisexual	4	26.7
Pansexual	1	6.7
Another sexual orientation identity	1	6.7
Language spoken at home (check all that apply)		
English	11	73.3
Spanish	9	60.0
Level of education		
Some high school	1	6.7
High school or GED	6	40.0
Technical school	1	6.7
Associate	1	6.7
Undergraduate	4	26.7
Graduate	2	13.3
Health insurance status		
Yes	12	80.0
No	3	20.0
HIV status		
Positive	3	20.0
Negative	12	80.0
Currently taking PrEP		
Yes	5	33.3
No	10	66.7
Annual income		
Less than $10,000	7	46.7
$30,001-$40,000	5	33.3
$60,001-$70,000	1	6.7
$110,001-$120,000	1	6.7
$150,000 or more	1	6.7

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Qualitative Themes

Determinants

Social Context and Stigma

Participants were asked about cultural background, home environment, and current social situation to understand the context of their lives and barriers to PrEP. Individuals felt that their social context was often not safe or affirming to fully disclose their sexuality and that they experienced multiple forms of oppression because of sexuality, ethnicity, gender expression, and a variety of other aspects of identity. During interviews, individuals spoke of feeling isolated or that they did not belong within their Hispanic/Latino communities and families of origin because of their sexual orientation:

> But, I think among many other things to mention there is that … I don't perceive them [my family] as being accepting of gay people. They are in the 'love the Sinner, hate the sin,' which for me is not something I'm comfortable being open to them about… And that's mostly 'cause my mother's very Catholic. I'm just … not going to be out. In fact, I'm generally not out to too many of my friends.

Participants described their families as influenced by cultural beliefs about same-sex attraction and behavior, which

TABLE 2. Sample Characteristics of Online Survey Sample (N = 98)

	N	%
Ethnicity		
Hispanic/Latino	98	100.0
Race		
White	78	79.6
Black or African American	6	6.1
Asian	7	7.1
American Indian or Alaska Native	1	1.0
Native Hawaiian or other Pacific Islander	1	1.0
Another racial identity	5	5.1
Sexual orientation		
Homosexual, gay, or same gender loving	88	89.8
Bisexual	10	10.2
Language spoken at home		
English	96	98.0
Spanish	66	67.3
Portuguese	2	2.0
Level of education		
Elementary or middle school	1	1.0
Some high school	7	7.1
High school or GED	4	4.1
Some college or Technical school	13	13.3
Undergraduate	25	25.5
Graduate	48	49.0
Health insurance status		
Yes	78	79.6
No/unsure	20	20.4
HIV status		
Negative	59	60.2
Positive	23	23.5
Ever taken PrEP		
Yes	66	67.3
No/unsure	31	31.6
Annual income		
$15,001–$20,000	1	1.0
$20,001–$25,000	8	8.2
$25,001–$35,000	7	7.1
$35,001–$50,000	11	11.2
$50,001–$75,000	13	13.3
$75,001–$100,000	30	30.6
$100,001 or more	27	27.6

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have historically been negative. Participants described feeling "othered" within their own families and unable to disclose their sexual orientation or be fully themselves when at home and/or with family:

> It's weird like yeah, we, like my mom and dad even though like they were born here and everything they still have a Latino square-mindedness, kinda like weird, to the point where like to this point, they don't fully know that I'm gay.

Participants spoke about how having a lack of "community belonging" and there not being a present or visible LGBTQ+ Latino community in their geographic area directly related to them feeling less knowledgeable about HIV prevention and PrEP than if they imagined they would be if they were integrated in a community of peers. Being in a location with fewer Hispanic/Latinos (the Northeast) than other areas of the United States and losing contact with their Hispanic/Latino roots resulted in participants feeling as if they did not belong within the community:

> Being Latino has impacted me in a way that isn't the way you would think is. I'm uncultured and a lot of other Latino men look at me like, 'you don't speak Spanish? You don't eat Spanish food? You don't do this thing that…' kinda makes me feel bad about myself…And I just feel left out of my own culture. It sucks.

Many described feelings that their identities as Hispanic/Latino and queer were at odds with each other. As one individual identified, even the Spanish language media was organized in a way that made him feel as if his identity as a gay man was not recognized:

> It barely comes up on Spanish television anyways, or anything gay, I don't think there is anything at all that comes up, I mean gay-wise in Hispanic news. So, it is just a very nonspoken subject all together.

We further explored issues related to identity-based discrimination within the quantitative survey. When asked specifically about racial and ethnic discrimination, 45.92% reported experiences of discrimination and when asked specifically about sexual orientation discrimination, 44.90% reported experiences of discrimination. In a question about all sources of identity-based discrimination and response choices that were check all that apply, participants answered that they had experienced discrimination because of their gender (18.37%), gender expression (44.90%), sexual orientation (59.18%), race or color of skin (17.35%), ethnicity or cultural background (20.41%), citizenship status (9.18%), language skills (7.14%), and weight or body size (4.08%).

When asked about sexual attraction and behaviors and openness/outness, responses included not being out to anyone about their attractions or behaviors (10.20%), out to all of their friends (16.33%), out to some of their friends (27.55%), out to all of their classmates/colleagues 8.16%), out to some of their classmates/work colleagues (11.22%), out to all of their sexual partners (50%), out to some of their sexual partners (11.22%), out to all of their immediate family (14.29%), out to only some of their immediate family (16.33%), and out to all of their extended family (6.12%). We asked about disclosure and "outness" because in the qualitative study, individuals indicated that this was a major barrier to engaging in PrEP. Within the quantitative survey, we asked about these perceptions as well. Participants indicated that fear of family finding out and facing judgment [about PrEP use] (17.34%) and stigma associated with PrEP as a "gay" drug (29.59%) were barriers to engaging in PrEP care. Finally, we asked participants about their openness/outness of their HIV status; this varied by HIV status such that individuals living with HIV were more likely to be "out" about their status. Approximately 35.71% of the sample was out to all or almost all of the people they know. For those who are HIV negative, only 22.03% of the sample endorsed being out to all of their social network, whereas 78.26% of those who were HIV positive were out to almost everyone they knew.

Experiences with PrEP and HIV

All the participants who were interviewed were aware of their HIV status and had been recently tested for HIV and STIs, as most were recruited from an STI/PrEP/HIV clinic often during clinic visits and actively engaged in care. Participants were generally supportive of PrEP use for themselves and their sexual partners; however, they indicated that stigma was a barrier to accessing it and raised concerns about finding providers who would be willing to prescribe and manage PrEP. As one individual shared, searching for a local PrEP provider can be a challenge:

> I remember that … I went into Truvada's website, and there was a link that would ask you about receive it for free or apply for a free whatever, but it wasn't like it wasn't available in Rhode Island, because it was asking for your zip code. I thought it was weird, and then when I was in for my checkups and everything … the doctor or someone told me that … we could get PrEP in the clinics, I'm like 'oh I didn't know that.'

There were several individuals who had a history of PrEP use. Some of them had since seroconverted, often because of a gap or lapse in their access to PrEP:

> So when I was 24 I tried to get on PrEP when I left my ex. That was all when COVID started, so it was March, around March, the end of March. I called, I think I called CVS. Or I called someone, and I asked. Oh yeah, I called my old doctor in [city in MA] and I asked if I could get on PrEP. And they said they shipped it on over to, a prescription over to CVS. I called CVS and they told me they had no more stock. Yeah, and shortly

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after that I contracted- ironically, shortly after that, I got HIV.

Men living with HIV (most who had been diagnosed within the past 1 to 2 years) were surprised by how supportive the larger MSM and LGBTQ+ community was of their diagnosis:

> Shockingly, when I posted my status [on a dating app], my message box was flooded with support. I was shocked. I was shocked when I was open about it and like people were like, "you're brave for this." Like, they gave me the facts. They gave me recommendations for doctors. Like they gave me, like, you know, closure that I needed … I thought no one was ever going to want me again, but like, it was crazy. People were like, 'as long as you take care of yourself,' you know, I was shocked.

Participants in the quantitative study were asked about comfort in seeking STI and HIV prevention services, condom use, sexual health behaviors, and HIV risk perceptions Table 3. Participants' PrEP engagement status knowledge about PrEP, HIV testing status, concern for HIV infection, and knowledge of someone diagnosed with HIV was reported in the survey. Participants were fairly knowledgeable about PrEP, identified reasons for taking PrEP, and challenges with ongoing PrEP care Table 4. Of the 98 who were included in the analysis, 67.3% (n = 66) had taken PrEP before and 80.6% (n = 79) ranked their knowledge of PrEP as "good" or "very good." The majority of the sample reported that they had been recently tested for HIV. When asked about testing, 80.6% (n = 79) reported that they had been tested for HIV within the past year and an additional 10.2% (n = 11) had been tested 1–2 years ago. Only 4% (n = 4) had never been tested, and 3% (n = 3) had been tested more than 2 years ago.

Reasons for discontinuing and not using PrEP use could be due to medical, social, or financial reasons. In the survey, of those who reported taking PrEP in the past (N = 66), the most common reason for stopping was concern about side effects (n = 16; 24.2%), and the second most common reason was concern about the cost (n = 15; 22.7%). Others reported that they did not want to take a medication every day (n = 11; 16.7%), they decided that they did not need PrEP (n = 7; 10.6%), or they were concerned about what others might think (n = 7; 10.6%). Participants were also asked what they perceived to be reasons that people do not take PrEP. The most common reasons given were primary care physicians never mentioning PrEP (n = 50; 75.7%), not knowing where to get PrEP (n = 49; 74.2%), not wanting to take preventative medication (n = 19; 28.8%), inability to pay for medication or medical visits (n = 14; 21.2%), or not having the time for added doctor's visits and testing (n = 13; 19.7%). These answers varied by HIV status, with the most common answer among HIV-positive individuals being that they do not know where or how to get PrEP (n = 22, 95.7%), whereas the most common answer for HIV-negative individuals was that their primary care doctor never recommending PrEP (n = 27, 45.8%).

Implementation Strategies to Improve PrEP Uptake Among Latino MSM

This study took a community-engaged approach and empowered participants to share their own perspectives on how to engage other Latino MSM in PrEP care given their experiences. Participants expressed a desire for medical providers to communicate that antiretroviral medication is taken either preventively in the case of PrEP or as treatment, underscoring the relevance of status neutral messaging:

> I think either way, in the gay community, you're gonna get on either Biktarvy or PrEP, so it's like, why not just go on PrEP? 'cause it's like, you're gonna get on Biktarvy otherwise 'cause like you can't trust everyone in the gay community. Well, that's kind of a blanket statement, that's kind of unfair for me to say.

Another described the importance of status-neutral messaging including "U=U" (Undetectable equals Untransmittable) to promote positive relationships within the MSM community and health promotion regardless of HIV status:

> I think they [medical providers] can explain, I think they need to explain what undetectable means to everybody, and explain the medications that people who have HIV take, and the medications, and like to basically state, like, like if you're like, they just need to explain that if you're, if you're a HIV positive, and you take your medication, you're basically—they just need to explain that, cause I think there's a misunderstanding. That like if you're not on PrEP and you have sex with someone who's undetectable you can't pass HIV to that person. It's basically like I'm on PrEP now.

In addition to status-neutral messaging to promote PrEP uptake, many expressed a preference for obtaining PrEP from providers they felt comfortable with because they were familiar (eg, primary care provider) and/or LGBTQ+ affirming and/or personable/warm:

> You know I just like I found so like inviting about the clinic here is like everyone is just so nice, like somebody called, this casual like I mean the person on the phone is super like diffusive and really funny umm, and then the receptionist that I have had interface with several times, that is just like the most sweetest, wonderful human. So I think, I do think you know there's something to be said about how you foster a kind of like ecology of like warmth and kindness in the middle you know what I mean? Yeah and and it can look a lot of different ways … personable staffing and I think like you know like culturally affirming or like you know or or competent staffing I think it's also important.

Other participants suggested an increased community presence from PrEP clinics in their area. Individuals also

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TABLE 3. Sexual Health Behaviors of Online Sample of Latino MSM (N = 98)

	Total N	Total %	HIV− (n = 59)	HIV− %	HIV+ (n = 23)	HIV+ %
Do you have one person you think of as your personal doctor or primary health care provider?						
Yes	81	82.65	50	84.75	22	95.65
No	15	15.31	9	15.25	1	4.35
Don't know/not sure	2	2.04	0	0.00	0	0.00
Do you feel comfortable having a conversation with a medical provider about your sexual health?						
Yes	74	75.51	46	77.97	22	95.65
No	21	21.43	12	20.34	1	4.35
Don't know	2	2.04	1	1.96	0	0.00
When was your last HIV test?						
Less than 3 mo ago	32	32.65	8	13.56	21	91.30
3–6 mo ago	37	37.76	32	54.24	1	4.35
7–11 mo ago	10	10.20	8	13.56	0	0.00
1–2 yrs ago	10	10.20	7	11.86	0	0.00
More than 2 yrs ago	3	3.06	1	1.96	0	0.00
Never been tested	4	4.08	2	3.39	1	4.35
Don't know/not sure	1	1.02	1	1.96	0	0.00
How likely would you say that you are to become infected with HIV?						
Extremely unlikely	19	19.39	19	32.20	N/A	N/A
Very unlikely	7	7.14	7	11.86	N/A	N/A
Somewhat likely	17	17.35	17	28.81	N/A	N/A
Very likely	6	6.12	6	10.17	N/A	N/A
Extremely likely	9	9.18	9	15.25	N/A	N/A
How concerned are you about getting HIV?						
Not concerned	3	3.06	3	5.08	N/A	N/A
A little concerned	7	7.14	7	11.86	N/A	N/A
Moderately concerned	10	10.20	10	16.95	N/A	N/A
Concerned	12	12.24	12	20.23	N/A	N/A
Extremely concerned	27	27.55	27	45.76	N/A	N/A
Do you know anyone who is living with HIV?						
Yes	26	26.53	24	40.68	1	4.35
No	69	70.41	35	59.32	22	95.65
Don't know	2	2.04	0	0.00	0	0.00
When was your last STD test?						
Less than 3 mo ago	34	34.69	9	15.25	21	91.30
3–6 mo ago	30	30.61	24	40.68	0	0.00
7–11 mo ago	17	17.35	13	22.03	2	8.70
1–2 yrs ago	11	11.22	9	15.25	0	0.00
More than 2 yrs ago	2	2.04	2	3.39	0	0.00
Never been tested	1	1.02	1	1.69	0	0.00
Don't know/not sure	2	2.04	1	1.69	0	0.00
Have you tested positive for an STD in the past 12 mo?						
Yes	43	43.88	21	35.59	17	73.91
No	53	54.08	38	64.41	6	26.09
Don't know/not sure	1	1.02	0	0.00	0	0.00
Any anal sex partners in the past 3 mo						
Yes	97	98.98	57	96.91	23	100
No	1	1.02	1	1.96	0	0.00
When you have anal sex, how often do you ask your partner's PrEP status?						
Never	6	6.12	2	3.39	3	13.04
Rarely	14	14.29	11	18.64	0	0.00
Some of the time	24	24.49	18	30.51	1	4.35
Most of the time	23	23.47	18	30.51	1	4.35
All of the time	26	26.53	6	10.17	18	78.26
Don't know	2	2.04	0	0.00	0	0.00

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TABLE 3. (*Continued*) Sexual Health Behaviors of Online Sample of Latino MSM (N = 98)

	Total N	Total %	HIV− (n = 59)	HIV− %	HIV+ (n = 23)	HIV+ %
When you have anal sex, how often do you use condoms?						
Never	24	24.49	3	5.08	17	73.91
Rarely	12	12.24	10	16.95	0	0.00
Some of the time	26	26.53	18	30.51	3	13.04
Most of the time	22	22.45	18	30.51	0	0.00
All of the time	9	9.18	6	10.17	2	8.70
Any vaginal partners in the last 3 mo						
Yes	32	32.65	26	44.07	4	17.39
No	66	67.35	33	55.93	19	82.61
When you have vaginal sex, how often do you use condoms?						
Never	3	3.06	0	0.00	2	8.70
Rarely	8	8.16	7	11.86	1	4.35
Some of the time	7	7.14	7	11.86	0	0.00
Most of the time	3	3.06	2	3.39	1	4.35
All of the time	8	8.16	7	11.86	0	0.00
When you have vaginal sex, how often do you ask your partner's HIV status?						
Never	3	3.06	1	1.96	1	4.35
Rarely	6	6.12	5	8.47	1	4.35
Some of the time	9	9.18	8	13.56	1	4.35
Most of the time	5	5.10	4	6.78	0	0.00
All of the time	6	6.12	5	8.47	1	4.35
When you have vaginal sex, how often do you ask your partner's PrEP status?						
Never	2	2.04	1	1.96	0	0.00
Rarely	2	2.04	2	3.39	0	0.00
Some of the time	11	11.22	10	16.95	1	4.35
Most of the time	5	5.10	5	8.47	0	0.00
All of the time	7	7.14	6	10.17	1	4.35
Don't know	3	3.06	0	0.00	0	0.00
In the past (3) months, have you participated in sex work?						
Yes	30	30.61	19	32.20	5	21.74
No	62	63.27	38	64.41	15	65.22
Don't know/not sure	6	6.12	0	0.00	3	13.04
In the past (3) months, have you had sex with someone who has participated in sex work?						
Yes	50	51.02	19	32.20	23	100
No	44	44.90	36	61.02	0	0.00
Don't know/not sure	4	4.08	0	0.00	0	0.00

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mentioned having clinics engage with the LGBTQ+ community around STI/HIV testing and prevention including PrEP, which some had seen done in other parts of the United States,

> this clinic would show up and like table at a lot of the events, like a lot of the drag shows, a lot of the balls, a lot of the leather and kink parties, or like the leather markets. It would just show up and table and they would have like you know like little lube whatever things and like they would like they would like cohost events sometimes … in the community like you know we're like where people are at ….

Participants felt that the presence and information about PrEP wherever someone may meet a sexual partner—in person or online—was important. As one participant explained,

> at clubs too. Little pamphlets, like I think anywhere anyone is gonna go hook up with someone, essentially, there needs to be like something there that like brings awareness to what this is. I think any places that has chances where you're gonna like meet a partner and have sex, I think that needs to like, like [on dating apps], I think all the apps need them. Be posting them. Definitely doctors' offices. And like even like maybe like peer support groups.

Some participants expressed a desire for educational materials that are not merely translated but also culturally competent and clearly made for individuals who are Hispanic/Latino and not just translated from English:

> Yeah, and who's speaking in a way that it's not just like 'oh like I understand it' or 'I'm fluent in

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TABLE 4. PrEP Knowledge, Attitudes, and Behaviors of Online Sample of Latino MSM (N = 98)

	Total N	Total %	HIV− (n = 59)	HIV− %	HIV+ (n = 23)	HIV+ %
How would you rate your knowledge about PrEP?						
Very good	50	51.02	25	42.37	21	91.30
Good	29	29.59	21	35.59	0	0.00
Acceptable	13	13.27	10	16.95	1	4.35
Poor	4	4.08	2	3.39	0	0.00
Very poor	2	2.04	1	1.96	1	4.35
Do you know anyone who has been on PrEP?						
Yes	58	59.18	41	69.49	9	39.13
No	34	34.69	16	27.12	13	56.52
Don't know/not sure	5	5.10	0	0.00	0	0.00
Have you ever taken PrEP before even if just 1 pill?						
Yes	66	67.35	41	69.49	20	87.00
No	29	29.59	17	28.81	3	13.04
Don't know/not sure	2	2.04	0	0.00	0	0.00
You mentioned you had taken PrEP before but stopped. What were the reason(s) you stopped taking PrEP?						
I was concerned about potential side effects	16	16.33	15	25.42	0	0.00
I was concerned about the cost	15	15.31	14	23.73	0	0.00
I decided I didn't need PrEP	7	7.14	7	11.86	0	0.00
I didn't want to take a medication every day	11	11.22	10	16.95	1	4.35
I was concerned about what people would think if they knew I was taking PrEP	7	7.14	7	11.86	0	0.00
What are some of the reasons you might be interested in taking injectable PrEP?						
Others would not have to know (no medicine bottle as "evidence")	40	40.82	20	33.90	18	78.26
Do not have to remember to take medicine every day	40	40.82	21	35.59	12	52.17
It is efficient	41	41.84	30	50.85	6	26.09
Fewer side effects	26	26.53	22	37.29	0	0.00
Don't know	3	3.06	1	1.96	0	0.00
What are some of the reasons that you would dislike taking injectable PrEP?						
Having to attend medical appointments more often	47	47.96	23	38.98	20	87.00
Potential discomfort at the injection site	37	37.76	30	50.85	2	8.70
Not liking vaccines/injections	32	32.65	25	42.37	2	8.70
Worried about side effects	30	30.61	21	35.59	4	17.39
Don't know	2	2.04	1	1.96	0	0.00
Although PrEP is now available in multiple forms—pills and injectable—many people still do not want to take PrEP. What are some reasons you think people do NOT take PrEP?						
They do not know where or how to get PrEP	49	50.00	24	40.68	22	95.65
Their primary care doctor/general practitioner never recommended they take PrEP	50	51.02	27	45.76	17	73.91
They do not feel at risk for HIV	18	18.37	9	15.25	4	17.39
Stigma associated with PrEP as a "gay" drug	29	29.59	24	40.68	0	0.00
Not wanting to be on medication for prevention of a condition that you do not have	19	19.39	16	27.12	1	4.35
Fear of family finding out and facing judgment	17	17.35	14	23.73	0	0.00
They do not have the ability to pay for the medication or medical visits	14	14.29	13	22.03	1	4.35
They do not have time for the added doctors' visits and testing	13	13.27	10	16.95	1	4.35
Don't know	0	0.00	0	0.00	0	0.00
Which of these ideas do you think would be most helpful for encouraging other Hispanic/Latino men who have sex with men to consider PrEP to prevent HIV as part of their ongoing health care?						
Make PrEP more available in medical settings (primary care)	61	62.24	33	55.93	21	91.30
Have advertising that extends to all individuals not just LGBTQ+ folks	34	34.69	27	45.76	1	4.35
Offer "rapid initiation" of PrEP on mobile vans parked in public places where people gather (eg, bars, community events, parks, beaches, etc.)	35	35.71	31	52.54	1	4.35
Create medical settings that are more explicitly affirming of LGBTQ+ individuals and/or are specific to the community so people feel comfortable asking for PrEP	36	36.73	33	55.93	0	0.00
Meet other people IN-PERSON who are currently taking PrEP and can talk about their experience	38	38.78	14	23.73	20	87.00
Meet other people ONLINE who are currently taking PrEP and can talk about their experience	46	46.94	21	35.59	21	91.30

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Spanish,' but also where it has a resonant sound, like 'oh this is somebody I can talk to who understands where I am coming from.'

In addition, participants felt that all PrEP options including 2-1-1 or on-demand PrEP as well as injectable PrEP should be mentioned in educational materials:

> I'd say in the advertising, the promotion or whatever, just let people know or the options that they are. Because I didn't know there were so many options, like you could only take it like on demand, or like every day, or an injection that they're working on, yeah, I guess just more promotion on the options.

Finally, many talked about the advertising they saw on television by pharmaceutical companies, which seemed to be extremely targeted toward LGBTQ+-identified audiences based on what shows these advertisements were displayed during and the actors they had included. For some, this felt further marginalizing rather than helpful:

> "It, like, I know that being queer, being gay, being trans, whatever, makes me, like, puts me more at risk statistically for HIV, but I think, like, the stigma around HIV still remains, like, I mean, it used to be called "gay cancer," so that kind of think that, like, only gay people can get it, and like especially trans people, especially trans femmes, and especially people of color, it's like, only their problem, even though we know that's not true. So I think that kind of very, very targeted advertising only, like, kind of exacerbates that cultural and historical pain for certain communities. Because like, it is true, like, the queer and trans communities of color were the most hit by the HIV/AIDS epidemic, and, like, still are, but, like, we don't need to be reminded of that.

Another individual pointed out that PrEP ads were always displayed during YouTube videos that featured drag queens, and it was noticeable that this was a way of reaching the community at risk for HIV:

> whenever I like I go on like YouTube and I watch like a video of these two funny drag queens, Trixie and Katya, that's when I start getting all the PrEP ads and all the HIV testing ads and all that, like whatever wants something stereotypically gay that's when I got those ads, but whenever I'm not watching anything like that I don't see anything about it.

To combat the stigma that larger advertising campaigns might unintentionally create, individuals suggested partnering with influencers on social media like through TikTok or YouTube as a helpful way to promote use while lessening the stigma of identifying as someone at-risk for HIV:

> Think more like digital ads, social media ads, more, like, influencer marketing, kind of because I feel like, at least in my perspective, like, now as an adult I see it different but when I was like first coming out as, you know, a gay whatever Latino

TABLE 5. Determinants and Proposed Implementation Strategies From Qualitative Interviews

	Determinants		Implementation Strategies	
	Patient Needs and Resources			
	Barriers (−)	Facilitators (+)	Implementation Strategies from Participants	ERIC Strategy
Social context and stigma	→Not belonging within families of origin →Lack of "community belonging" with peers related to feeling less knowledgeable about HIV prevention and PrEP →Hispanic/Latino and queer identities at odds with 1 another	→Support from LGBTQ+ community around HIV status	→Partner with social media influencers to help promote PrEP use and decrease HIV stigma; "community" as including online influencers →Clinics offering PrEP should more actively engage with communities affected by HIV	→Build a coalition of LMSM to support PrEP scale up and dissemination within peer networks →Facilitation →Model and simulate change →Increase demand
Experiences with PrEP and HIV status	→Stigma (and identity-based stigma) is a barrier to accessing PrEP →Difficulty finding LGBTQ+ affirmative providers to prescribe and manage PrEP →English-only information and/or not well tailored information →Media messaging that feels stigmatizing →Lack of knowledge of various forms of PrEP or how to access it →Difficulty learning about PrEP from peers	→Regular STI/HIV testing →Supportive of PrEP use for themselves and sexual partners →Knowing someone who takes PrEP →Antiretroviral medication taken preventively as PrEP	→Education on U=U →LGBTQ+ affirmative health care providers who know information about PrEP for HIV →Linguistically and culturally tailored educational pamphlets →Have information about PrEP wherever someone may meet a sexual partner (in person or online) →Have opportunities for those with PrEP experience to connect with others online or in-person (peer education and navigation)	→Conduct educational outreach visits to clinics →Conduct ongoing training →Develop educational materials →Distribute educational materials

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> person, and I first learned about PrEP. I didn't want to take it 'cause I felt like, like, I don't know, I had kind of like a stigma towards it? … I felt like by doing this I'm like exposing myself to HIV I guess, is what I felt like.

The majority of those surveyed indicated that primary care providers offering PrEP would be a good way to encourage Hispanic/Latino MSM to use PrEP (n = 61; 62.2%). Many also indicated that creating affirming medical settings (n = 36; 36.7%) and meeting other people who are currently on PrEP and care share their experiences either online (n = 46; 46.9%) or in person (n = 38; 38.8%) would be helpful ways to encourage PrEP uptake. Others supported rapid initiation of PrEP in mobile vans (n = 35; 35.7%), advertising that extends to all individuals rather than just LGBTQ folks (n = 34; 34.7%) and including PrEP as part of sex education curricula in schools (n = 19; 19.4%). For additional details on how determinants were associated with implementation strategies suggested by participants see Table 5.

DISCUSSION

This study evaluated barriers and facilitators for Hispanic/Latino MSM in learning about and accessing PrEP care. Their observations, experiences, and suggestions offer important areas of target for future implementation strategies. HIV acquisition and incidence in the United States disproportionately affects gay, bisexual, and other MSM who represent approximately 70% of new HIV diagnoses.[32] Importantly, there are significant racial/ethnic disparities underlying these numbers. Hispanic/Latino MSM are diagnosed with HIV at significantly higher rates than their white counterparts. White MSM have a 1 in 11 lifetime risk of HIV compared with 1 in 4 for Hispanic/Latino MSM.[33] The reasons for this are multifactorial and complex. However, increasing to the reach of PrEP to Hispanic/Latino communities could offer a biobehavioral prevention tool that is currently underused.

Our study included a very diverse Hispanic/Latino MSM sample with regards to familial country of origin (in total, participants identified 20 countries as their ethnic heritage), self-defined sexual orientation, self-defined gender identity, and occupation. Our sample was also intentionally diverse with regards to HIV status, experience with PrEP, and current PrEP/ART status. Prior research has focused on engaging HIV-negative samples in asking them about willingness to take PrEP. We intentionally chose to include individuals across the HIV care continuum to characterize the experiences of those not on PrEP, taking PrEP, and living with HIV to gain diverse perspectives.

Some of the key findings included needing more access to PrEP in various settings and a strong preference for providers who are LGBTQ+ affirming and/or are familiar and comfortable with Hispanic/Latino MSM, so they can share openly about their sexual behavior and readiness to take PrEP. Regarding the type of providers offering PrEP care, prior studies have concluded that same-race/ethnicity-matched and/or same gender/sexual orientation–matched providers are beneficial[34–36] and that patients prefer matching; this was not our finding. Participants expressed that more important than "matching" based on demographic characteristics was a desire for providers with an affirming approach and temperament and an openness, comfort, and willingness to discuss sexual behavior as part of medical care in a way that destigmatizes and promotes sexual health and well-being inclusive of PrEP. This is consistent with prior research that has shown patients who feel their providers are seeing them first "as a person" tend to do better in care.[37] Broadly speaking, Hispanic/Latino cultures are considered "high-context" cultures meaning that relationships and the environment are considered central to all interactions including those involving medical care.[38] This has also been supported by prior studies of MSM who have shared that LGBTQ+ affirming and sex-positive providers are important for promoting their sexual health and engaging them in care over time.[39–42] Given the importance of relationships in "high-context" cultures and the concerns about potential stigmatizing interactions, prioritizing affirming PrEP care for Hispanic/Latino MSM may be even more important than for other subgroups at-risk for HIV.

In addition, survey participants overwhelmingly reported (75%) that a medical provider had never mentioned PrEP to them. This suggests that there might be a bias in provider practices with regards to discussing and prescribing PrEP to Hispanic/Latino MSM. Prior research has demonstrated that there are significant biases in PrEP prescribing,[43] including biases based on anticipated risk compensation,[44] race, and partner gender.[45] This identified gap also suggests that there are opportunities for directly intervening on provider behavior to offer PrEP to Hispanic/Latino MSM. These interventions could significantly increase uptake and adherence in this population, which experiences significant HIV disparities yet is underreached by PrEP services.

Taken together, these findings suggest that increasing uptake of PrEP among Hispanic/Latino MSM starts by having providers who are affirming, culturally competent, and trained in screening and referral for PrEP. Individuals shared with us in both interviews and survey responses that anticipated stigma prevented them from asking about PrEP and that providers infrequently offered it to them. Potential policy changes at the clinical level could include screening all adults regardless of perceived sexual orientation or identity for PrEP eligibility as part of a routine wellness visit. Recent CDC guidelines have expanded to include all genders and sexual orientations as appropriate for PrEP and recommend referrals based on behaviors associated with HIV transmission, including limited condom use, multiple sexual partners, and/or drug use.[46] To facilitate inclusion of questions related to eligibility for PrEP at wellness visits, clinics could program questions into note templates and/or routine screening prompts within the electronic health record (EHR) so that providers are encouraged to ask questions of all patients. Automation within the EHR could score and evaluate risk, so that if a provider entered certain responses, an alert would activate noting that this was a patient appropriate for PrEP

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and suggest discussing it with them.[47] This type of system-level intervention and real-time feedback could help minimize provider bias and improve equity in who is screened for and offered PrEP. To encourage this type of change to become widespread, payers could offer billing codes for screening, counseling, and/or referral to PrEP. Reimbursement for these services would be a form of "external incentive" to motivate clinics to build these questions into chart notes and individual providers to ask questions of all patients.

Our study analysis was strengthened by all contributing authors identifying as holding affirming views of both Hispanic/Latino and the LGBTQ+ community. Many of our authors also shared some of these identities and/or were partnered in relationships or in families where these identities were represented. This likely impacted how team members understood experiences shared by our participants and increased the depth and nuance during analysis.

The strengths of this study must be interpreted considering its limitations. Although efforts were made to create a comfortable environment, this research was being conducted during COVID-19 and various phases of shutdowns and institutional restrictions on meeting with participants in person. Thus, at an early stage of the project, it was decided that all interviews would take place over video platform for participant and interviewer safety and health.

Hispanic/Latino culture is considered a "high-context" culture in which relationships and expressions are highly valued.[38,48] We had a difficult time recruiting for and engaging individuals to participate, which we suspect might have been because of the online/remote interviewing. To try to address this barrier, we had research assistants recruiting in-person in the clinic and a community recruiter in public spaces like bars and clubs to try to add a "personal" component to the recruitment process. This was somewhat effective; however, it limited our ability to conduct the study expeditiously and may have biased who was willing to participate (those who were comfortable with video). Still, efforts were made to select a diverse sample, which we were able to achieve.

CONCLUSIONS

The scale-up and scale-out of PrEP among MSM at risk for HIV has been largely successful among MSM at risk for HIV within the United States. However, in certain groups experiencing HIV disparities including Hispanic/Latino MSM, the reach of PrEP has not kept up with PrEP need, which has perpetuated existing HIV disparities. Our study focused on identifying specific cultural and/or social factors that could explain the slow rate of adoption among Hispanic/Latino MSM even in the context of access to health insurance, medical care, and a large and thriving academic medical center–based PrEP clinic. Participants reported a need for reduced stigma within clinical visits and more awareness within the broader community to increase PrEP use among Hispanic/Latino MSM. Based on our findings, we suggest specific policy recommendations for consideration, including use of EHR tools to prompt screening and evaluation for PrEP in all settings and payer reimbursement for PrEP screening, counseling, and referral services for all patients. Increased screening at a population health level could help improve equity in PrEP access for Hispanic/Latino MSM and other individuals who may paradoxically be at high need for PrEP yet be least likely to be referred.

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