HHS Public Access

Author manuscript

Arch Sex Behav. Author manuscript; available in PMC 2023 July 05.

Published in final edited form as:

Arch Sex Behav. 2022 July ; 51(5): 2583–2601. doi:10.1007/s10508-021-02213-3.

"Let's Be a Person to Person and Have a Genuine Conversation": Comparing Perspectives on PrEP and Sexual Health Communication Between Black MSM and Healthcare Providers in the US

Sarah K Calabrese[1,2,*], **Sharanya Rao**[1,*], **Adam I Eldahan**[3], **Mehrit Tekeste**[1], **Djordje Modrakovic**[1], **D Dangaran**[4], **Cheriko A Boone**[1], **Kristen Underhill**[5,6], **Douglas S Krakower**[7,8,9], **Kenneth H Mayer**[7,8,10], **Nathan B Hansen**[11], **Trace S Kershaw**[12], **Manya Magnus**[13], **Joseph R Betancourt**[14], **John F Dovidio**[12,15]

[1]Department of Psychological and Brain Sciences, George Washington University, Washington, DC, USA

[2]Department of Prevention and Community Health, George Washington University Washington, DC, USA

[3]Columbia School of Nursing, Columbia University, New York, NY, USA

[4]Harvard Law School, Harvard University, Boston, MA, USA

[5]Columbia Law School, Columbia University, New York, NY, USA

[6]Heilbrunn Department of Population and Family Health, Columbia University, New York, NY, USA

[7]Beth Israel Deaconess Medical Center, Harvard University, Boston, MA, USA

[8]The Fenway Institute, Fenway Health, Boston, MA, USA

[9]Department of Population Medicine, Harvard University, Boston, MA, USA

[10]Department of Global Health and Population, Harvard University, Boston, MA, USA

[11]Department of Health Promotion and Behavior, University of Georgia, Athens, GA, USA

[12]Social and Behavioral Sciences Department, Yale University, New Haven, CT, USA

Correspondence concerning this article should be addressed to Sarah K Calabrese, George Washington University, 2125 G Street NW, Washington, DC 20052, USA. skcalabrese@gwu.edu.

*Co-first authors

Authors' Contributions

Study conceptualization was led by Sarah K Calabrese and Sharanya Rao with support from all co-authors. Data were collected by Sarah K Calabrese, Adam I Eldahan, and D Dangaran. Formal analyses were led by Sharanya Rao with support from Sarah K Calabrese, Djordje Modrakovic, and Mehrit Tekeste. The first draft of the manuscript was written by Sarah K. Calabrese and Sharanya Rao. All authors provided feedback on the drafted manuscript and approved the final version of the manuscript.

DECLARATIONS

Compliance with Ethical Standards

All study procedures were approved by the Yale University Human Subjects Committee (#HSC-1308012487) prior to implementation. Verbal informed consent was obtained from all study participants.

Code Availability

N/A.

[13]Department of Epidemiology and Biostatistics, George Washington University, Washington, DC, USA

[14]Disparities Solution Center, Harvard University, Boston, MA, USA

[15]Department of Psychology, Yale University, New Haven, CT, USA

Abstract

Patient-provider communication is a key factor affecting HIV pre-exposure prophylaxis (PrEP) awareness and access among Black sexual minority men (SMM). Optimizing patient-provider communication requires a deeper understanding of communication dynamics. In this study, we investigated the perspectives of both HIV-negative/status-unknown Black SMM and practicing community healthcare providers regarding patient-provider communication about PrEP and sexual health. We conducted eleven semi-structured qualitative focus groups (six with Black SMM; five with providers) in the Northeastern US and thematically analyzed transcripts. A total of 36 Black SMM and 27 providers participated in the focus groups. Our analysis revealed points of alignment and divergence in the two groups' perspectives related to patient-provider communication. Points of alignment included: (a) the importance ascribed to maximizing patients' comfort and (b) belief in patients' right to non-discriminatory healthcare. Points of divergence included: (a) Black SMM's preference for sexual privacy versus providers' preference that patients share sexual information, (b) Black SMM's perception that providers have an ethical responsibility to initiate conversations about PrEP with patients versus providers' perception of such conversations as being optional, and (c) Black SMM's preference for personalized sexual health conversations versus providers' preference for standardized conversations. Findings underscore a need for providers to offer more patient-centered sexual healthcare to Black SMM, which should entail routinely presenting all prevention options available—including PrEP—and inviting open dialogue about sex, while also respecting patients' preferences for privacy about their sexuality. This approach could increase PrEP access and improve equity in the US healthcare system.

Keywords

PrEP; Black sexual minority men; Healthcare providers; Sexual health

INTRODUCTION

Despite being one of the most effective methods of HIV prevention available, pre-exposure prophylaxis (PrEP) continues to be underutilized in the US (Centers for Disease Control and Prevention [CDC], 2021b; Harris et al., 2019). Uptake has been disproportionately low among Black sexual minority men (SMM)[2] relative to White SMM, particularly when considered in the context of existing HIV disparities (CDC, 2021a; Kanny et al., 2019). Black SMM account for 25% of new HIV diagnoses in the US and are over four times as likely as White SMM to acquire HIV in their lifetime (CDC, 2021a; Hess et al., 2017).

[2]We use the term sexual minority men (SMM) throughout this work to refer to "men whose sexual identities, orientations, or behaviors differ from the heterosexual majority" (Timmins & Duncan, 2020, p. 1667), including when referring to study samples or surveillance categories originally labeled as men who have sex with men (MSM).

However, Black SMM at risk for sexually acquiring HIV are significantly less likely than their White counterparts to have discussed PrEP with a provider or to have initiated PrEP after discussing it with a provider (Kanny et al., 2019). A more nuanced understanding of communication dynamics between Black SMM and healthcare providers could enhance the quality of conversations related to sexual health and facilitate future PrEP access for Black SMM.

There are a number of socio-structural barriers to Black SMM accessing health services and having the opportunity to discuss PrEP with healthcare providers. For example, longstanding mistreatment of Black people in the US healthcare system has engendered medical mistrust, and systematic exclusion of Black men from the workforce has resulted in limited insurance coverage and financial resources to support preventive care and care continuity (Boone & Bowleg, 2020; Cahill et al., 2017; Eaton et al., 2017; Elopre et al., 2020; Philbin et al., 2018). For Black SMM, multiple marginalized identities (e.g., race, sexual orientation) confer enhanced vulnerability to discrimination within the healthcare system, which may further discourage healthcare engagement (Brooks et al., 2019; Quinn, Bowleg, et al., 2019; Sullivan & Eaton, 2020).

For Black SMM who are engaged in health services, effective patient-provider communication about PrEP requires that both parties are able and willing to openly discuss PrEP and sexual health (Maloney et al., 2017). Limited awareness and knowledge about PrEP among both providers and patients can hinder such ability (Sewell et al., 2021). A meta-analysis encompassing over 18,000 US providers indicated that 32% of providers were unaware of PrEP (Zhang et al., 2019). Providers who are unaware of PrEP cannot initiate conversations about PrEP with their patients. Providers who are aware of PrEP but possess only limited knowledge (e.g., lack familiarity with PrEP clinical guidelines) may also be unlikely to engage patients in conversation about PrEP to the extent that their knowledge limitations translate to discomfort discussing and providing PrEP (Pleuhs et al., 2020). Providers' lack of ability or comfort is of particular concern because recent estimates suggest that 14–37% of US Black SMM are themselves unaware of PrEP (Kanny et al., 2019; Russ et al., 2021; Sullivan et al., 2020) and thus reliant on providers to initiate PrEP conversations if communication about PrEP is to take place during a health visit. Furthermore, Black SMM who are aware of PrEP have expressed hesitancy to broach the topic with providers, particularly those whose knowledge about PrEP is limited (Brooks et al., 2015; Quinn, Bowleg, et al., 2019).

Deficiencies in patient-provider communication about PrEP are only partially attributable to awareness and knowledge deficits. There are multiple reasons why providers who are informed about PrEP do not initiate conversations about PrEP with their patients, including the belief that PrEP is beyond the scope of their medical purview. The "purview paradox" refers to this belief being held concurrently by primary care providers and HIV specialists – each believing PrEP is in one another's professional domain and not their own, resulting in neither group taking ownership over PrEP-related care (Krakower et al., 2014; Pleuhs et al., 2020). Additionally, some informed providers, including those who have prescribed PrEP, do not routinely engage patients in conversations about PrEP because they do not regard PrEP as a standard prevention option that they are obligated to discuss with all patients (Krakower

et al., 2017). Instead, these providers may initiate conversations about PrEP selectively or only in response to patient requests, the latter of which could systematically disadvantage Black SMM and other groups with lower PrEP awareness than White SMM (Calabrese et al., 2019; Kanny et al., 2019; Krakower et al., 2017). Providers also cite specific reservations about PrEP, including concerns related to patient behavior (e.g., suboptimal adherence, "risk compensation") and logistical challenges (e.g., medication cost) as barriers to offering PrEP to patients (Pleuhs, 2020).

Conversations about PrEP and sexual health are also constrained by provider discomfort discussing sex and sexual health with patients. Sexual health encompasses not only HIV prevention, but also sexual relationships, pleasure, reproductive goals, and prevention of other sexually transmitted infections (STIs; Ford et al., 2019; WHO, 2017). In a review of perspectives on sexual health communication held by providers and patients (unrestricted by race or sexual orientation) across a range of health domains, Zhang et al. (2020) found that providers generally reported lower comfort and confidence discussing patients' sexual health than patients themselves. In one national survey of US providers, substantial percentages of primary care providers reported that they did not feel comfortable discussing sexual behavior (25%) or sexual orientation (11%; Petroll et al., 2017). Such discomfort could lead to avoidance or deprioritization of sexual health conversations during health visits. Providers have expressed discomfort initiating and engaging in conversations about patients' sexual behavior in the context of HIV risk and PrEP in particular (Wilson et al., 2020). Some providers may be especially uncomfortable discussing sexual health with SMM and other sexual minority patients to the extent that they have not received adequate training about providing care that is culturally responsive to lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients (Gott et al., 2004; Nowaskie & Sowinski, 2018; Sekoni et al., 2017; Shindel et al., 2010). Anticipated or actual challenges discussing sexual health can limit patients' opportunity for PrEP uptake and subsequent engagement in ongoing sexual healthcare.

When communication about PrEP and sexual health does occur between providers and patients, the quality of that communication is likely to vary according to patients' sexual orientation as well as other social and behavioral characteristics. Interpersonal stigma or bias, which refers to the negative evaluation or discriminatory treatment of individuals based on one or more distinguishing characteristics (Major et al., 2018), is a recognized barrier to PrEP uptake and can impact associated patient-provider communication (Brooks et al., 2019; Cahill et al., 2017; Pleuhs et al., 2020; Thomann et al., 2018). Such stigma may be overt, such as providers directly chastising patients for engaging in same-sex sexual behavior or downgrading the quality of care provided upon learning of their same-sex orientation (Quinn, Dickson-Gomez, et al., 2019; Thomann et al., 2018). Stigma may also operate in more subtle ways, such as providers assuming patients are at risk for HIV merely because they are SMM, or providers recommending condoms or monogamy instead of PrEP due to their discomfort with same-sex sexual expression (Brooks et al., 2019; Golub, 2018; Patel et al., 2016; Quinn, Dickson-Gomez, et al., 2019). For many Black SMM, past negative experiences following sexual disclosure have eroded trust and cultivated expectations that future disclosure with other healthcare providers will elicit similar judgment and mistreatment (Quinn, Dickson-Gomez, et al., 2019). Accordingly,

a substantial number of Black SMM are reluctant to disclose their sexual orientation or behavior to providers and regard discussion of their sex life with a provider as a barrier to PrEP uptake (Lelutiu-Weinberger & Golub, 2016; Quinn, Bowleg, et al., 2019). Black SMM's lack of comfort and/or trust in their provider during a health visit can deter open communication about sexual health (Rucker et al., 2018).

Because effective patient-provider communication is instrumental to PrEP uptake and regimen maintenance as well as sexual healthcare more generally, there is a critical need for improved understanding of existing dynamics from both patient and provider perspectives, which can inform future intervention efforts. The disproportionate HIV incidence and unique stigma faced by Black SMM with respect to their gender, race, and sexual orientation necessitate a nuanced exploration of the perspectives of this group in particular. The objective of this qualitative focus group study was to explore HIV-negative/status unknown Black SMM and practicing community healthcare providers' views on patient-provider communication about PrEP and sexual health. Such dual insights could help to illuminate prospective points of intervention, leading to improved patient-provider communication about sexual health and greater PrEP awareness and access among Black SMM.

METHOD

Participants

The study sample included two sets of participants—Black SMM and healthcare providers—who were recruited independently. We use the term "Black SMM" when referring to the first set of participants because Black SMM were recruited based on their race and sexuality and were not specifically recruited as patients or healthcare consumers. We use the term "providers" when referring to the second set of participants because providers were recruited based on their medical credentials irrespective of their race or sexuality. We do not know whether or how many Black SMM participants were healthcare providers because we did not systematically collect information about their professions. None of the provider participants identified as Black SMM.

Both the Black SMM and healthcare provider participants were recruited to partake in a study about attitudes and experiences related to PrEP and patient-provider communication. For Black SMM, eligibility criteria included identifying as a man and as Black/African American, as well as reporting: male biological sex, 18+ years of age, HIV-negative or unknown HIV status, anal sex with a male partner in the last 12 months, and English language fluency. Black SMM were recruited both online (e.g., via advertisements on social networking sites and dating apps) and in person (e.g., via flyers and palm cards distributed in LGBTQ-friendly public spaces) in Connecticut and New York City. They were also recruited through participant referral, whereby participants received a $10 gift card for every enrolled participant that they recruited into the study, with a maximum of 10 referrals per participant.

For community healthcare providers, eligibility criteria included reporting: 18+ years of age, English language fluency, and licensure to prescribe medication. Healthcare providers were recruited to participate in the study through in-person, email, and phone outreach to community healthcare centers in the Northeastern US.

The final analytic sample consisted of 63 individuals: 36 Black SMM (six groups of 4–8 participants) and 27 providers (five groups of 4–7 participants)[3].

Procedure

All study procedures were approved by the Yale University

Human Subjects Committee prior to inception. The principal investigator (SKC), who was trained in qualitative research methods, and a research assistant (AIE), whom she supervised, facilitated the eleven semi-structured focus group discussions between March 2015 and October 2015, each lasting approximately 60–90 minutes. One Black SMM focus group was held on campus at Yale University (New Haven, CT), and the other five were held at an LGBTQ community center in New York City. Healthcare provider focus groups were each held at a different community health center in Connecticut or Rhode Island.

We opted to use focus groups because this research method allowed for naturalistic discussion amongst participants about the chosen topic, and group dynamics such as agreements, disagreements, or debates about specific issues offered important social context (Wilkinson, 2015). Each focus group had 4–8 participants, which is the size recommended to encourage group discussion without intimidating or overwhelming participants while discussing sensitive topics such as healthcare experiences (Kreuger, 2002; Wong, 2008).

All participants provided verbal consent in lieu of signed consent at the outset of the focus group to help protect their confidentiality. Verbal consent procedures involved the principal investigator presenting an overview of the study, reviewing the approved verbal consent form with the participants, and inviting the participants to look over a copy of the form and ask questions before vocalizing consent. When establishing ground rules, the primary facilitator highlighted the goal of maintaining confidentiality, asking that participants refrain from discussing the session with people outside of the group in a way that could identify other participants in the group. Before beginning the discussion, the principal investigator informed participants of her and her co-facilitator's academic positions, that they were not medical providers, and that they and the study had no ties to the pharmaceutical company that made tenofovir disoproxil fumarate with emtricitabine (TDF/FTC; Truvada®), which was the only medication approved by the US Food and Drug Administration for PrEP at the time the study took place.

In both Black SMM and provider focus groups, discussions followed an organized guide that included specific questions and follow-up prompts about participants' knowledge, attitudes, and experiences related to patient-provider communication about sex and PrEP. In addition, Black SMM were specifically asked about their knowledge of and experiences with stigma in healthcare and perspectives on equity related to PrEP prescription. In both Black SMM and provider groups, after the initial questions related to PrEP knowledge were asked, a scripted overview paragraph was read to ensure all participants had a basic understanding of

[3]Two other research team members conducted a sixth group with community healthcare providers in Massachusetts, but this group was excluded from the analytic sample because it was considerably shorter (began late and terminated prematurely due to health center schedule constraints), was repeatedly interrupted, was held substantially later than the first five (summer of 2016 versus 2015), and was considerably larger in size ($n = 18$).

PrEP before being asked to share their attitudes and intentions related to PrEP. The scripted paragraph included information about the dosing regimen for PrEP, its side effect profile, and its approval by the US Food and Drug Administration.

In addition to the focus group discussion, all participants completed a brief questionnaire that assessed sociodemographic characteristics, prior PrEP awareness, and other relevant information. For Black SMM, the questionnaire also gathered information on participants' HIV status and experience using PrEP. For healthcare providers, the questionnaire also assessed participants' clinical background (degree, work setting, specialization); comfort prescribing PrEP; and prior clinical experience discussing and prescribing PrEP.

Black SMM each received $40 in cash and entry into a lottery for an all-expenses-paid trip valued at approximately $1,440 (i.e., $40 per participant x 36 participants) as compensation. Healthcare providers each received an $80 gift card as compensation. Although standard compensation for focus groups was $40 with community members and $80 with healthcare providers at that particular time and geographic location, our research team felt strongly that the value allocated for each participant in the Black SMM focus groups and provider focus groups should be equivalent. We agreed upon the $40 cash + lottery entry for the Black SMM participants to establish this equivalency while also respecting institutional review board concerns regarding undue influence if $80 cash was offered to a community population.

Analysis

All participant focus group discussions were audio-recorded and transcribed. Field notes and transcripts were imported into NVivo 11 for analysis. The Framework Method was used to guide textual analysis of the data through systematic organization, summarization, and identification of notable themes (Gale et al., 2013). This method, recommended for use in multidisciplinary health research, consists of transcription, data familiarization, coding, development of a working analytical framework, framework application, data charting, and interpretation (Gale et al., 2013). The Framework Method was especially well suited as an analytic strategy for this study because the structuring of data facilitated comparisons within and between focus groups conducted with the two different types of participants.

In consultation with the principal investigator, two research assistants who were not involved in facilitating the focus groups (DM and MT) drafted the initial analytic coding framework, which was then refined through an iterative process, whereby the two research assistants repeatedly coded transcripts independently and then came together to discuss and revise existing codes and add new code as needed. Coding decisions and conventions were documented. Once the analytic framework was finalized, the two research assistants used the finalized framework to independently code two transcripts from the focus groups conducted with healthcare providers and two from focus groups conducted with Black SMM and then compared coding to establish interrater reliability (Burla et al., 2008; MacPhail, Khoza, Abler, & Ranganathan, 2015). Upon establishing acceptable reliability based on these four transcripts, all of the other transcripts were independently coded by a single research assistant. Another team member (SR) read all transcripts and charted the coded textual data. In consultation with the principal investigator, SR used the chart to guide data interpretation

and select illustrative quotes, each of which is presented below along with the corresponding focus group number, participant number, and select sociodemographic information of the participant in brackets.

Reflexivity

Reflexivity refers to researchers' reflection upon how their personal backgrounds and experiences may have shaped the study, including the themes identified and interpretations drawn from the data (Creswell & Creswell, 2018). In the current study, the research team and focus groups were led by a White, cisgender, heterosexual woman. Groups were co-facilitated by a mixed-race, cisgender, gay man. Data analysis was led by a South Asian, cisgender, queer woman. The larger team was racially and sexually diverse and included academic researchers from multiple disciplines with experience conducting HIV prevention research with Black SMM. The team entered into the research with background knowledge about PrEP and a shared belief that patients should be informed about PrEP. The focus groups were conducted as part of a needs assessment to inform the development of a one-hour, provider-targeted training session intended to support PrEP discussion and prescription in healthcare settings.

RESULTS

Sample Characteristics

Tables 1 and 2 present sample characteristics for the 36 Black SMM and 27 providers included in the analytic sample. Black SMM participants' age ranged from 19–58 years (M = 30.17, SD = 10.10). Most identified as non-Latino/x (89%), were born in the US (81%), and identified as gay (69%). The vast majority (92%) were aware of PrEP prior to the study. Four (11%) reported current or prior PrEP use. Provider participants' age ranged from 25–66 years (M = 40.07, SD = 11.78). Most identified as White (78%) and non-Latino/x/a (93%) and were born in the US (70%). The majority identified as female (85%) and heterosexual (81%). Professionally, 74% had nursing degrees (26% medical doctorates), all worked in community healthcare centers, and 11% worked in one or more other settings as well. Most providers (85%) were primary care providers, 11% specialized in women's healthcare,[4] and 7% were HIV specialists. (Categories were not mutually exclusive.) Most (89%) were aware of PrEP prior to study participation, but only 30% reported being comfortable prescribing PrEP, 22% had previously discussed PrEP with an HIV-negative patient, and 15% had previously prescribed PrEP.

Themes

Both points of alignment and points of divergence emerged in Black SMM and providers' perspectives about patient-provider communication regarding PrEP and sexual health more broadly, particularly with respect to the values and expectations that they expressed. Black SMM and providers aligned in the importance they ascribed to maximizing patients' comfort

[4]Further inspection of questionnaire and transcript data from the three providers who reported specializing in women's healthcare indicated that two of three had experience caring for SMM patients. The third, who did not have experience caring for SMM patients, is not quoted in the results.

and in their belief in patients' right to non-discriminatory healthcare. They diverged in their preference for sexual privacy versus information-sharing, perception of providers' initiation of PrEP conversations being an ethical responsibility versus optional, and preference for personalized versus standardized conversations about sex.

Aligned Perspectives

Importance of Maximizing Patients' Comfort.: Both Black SMM and providers underscored the importance of prioritizing patient comfort when communicating about PrEP and sexual health.

Environmental and Interpersonal Cues.: Black SMM desired healthcare that was safe, confidential, and nonjudgmental. Part of the safety that they sought was related to the physical environment: Black SMM found visual cues like a rainbow flag or sign designating the office as a safe space for LGBTQ individuals to be comforting. They also identified several interpersonal cues that put them at ease and could be readily enacted by providers, including: using sensitive language ("I have a physician who sort of normalizes queer bodies, so like the idea of asking me my son's sex at birth versus like my [son's] gender" [Black SMM FG3/P17, 27 years old]); asking—rather than assuming—permission to inquire about their sexual histories ("Giving space for that – like, distance, um, in terms of like, 'Do you feel comfortable talking about your sex?'" [Black SMM FG3/P17, 27 years old]); and expressing queer- and sex-positive attitudes.

> [My provider] knows I'm bisexual, and I went to see him. I had my checkup, and he says, "How are you? I haven't seen you in six months … so what's going on? What's new?" I said, "Well, you know, I just came from Maryland." He says, "Did you have sex?" I was like, "Yes." He says, "Well, great" … And I was like, "Wow." You know, it's awesome to get feedback from a physician that actually cares about what you do and who you do it with, but he wasn't negative. He was positive about it … it felt great that I could see somebody that could identify and really respect me for me and not judge me for what I do. [Black SMM FG3/P16, 30 years old]

Providers reported employing similar strategies to those recommended by Black SMM participants to foster patient comfort. For example, several reported being attentive to the language that they used when discussing sexuality in an effort to facilitate patient comfort and cultivate mutual understanding:

> I use the CDC's tried and true line. Do you have sex with women, men, or both? It's just nonjudgmental, frank … The word gay is just – it's not gonna cut it. It means different things to different people. [Provider FG4/P20, 50-year-old White man]

Of note, the choice of language was not necessarily informed or affirmed by patients themselves; therefore, its acceptability to patients and impact on patient comfort was sometimes assumed. In this example, the provider's language was based on recommendations by US health authorities, but the inherent gender binary or presumption of sexual activity may have detracted from its intended sensitivity.

Providers often assured their patients of the confidentiality of their visits: “I remind people that whatever they say in the office is confidential … it doesn’t go anywhere else …” [Provider FG5/P23, 43-year-old White woman]. Many providers also said that they tried to normalize the experience of asking patients about their sexual history: “I just try to maintain this kind of even emotionality on my end, so it’s just routine. It’s just another question. There is not a whole lot of pressure built up behind it” [Provider FG2/P10, 33-year-old White man].

An additional strategy for enhancing patient comfort that was mentioned by a couple of providers was using humor to lighten the atmosphere and humanize the exchange.

Building Rapport Over Time.: Black SMM and providers both recognized that patient comfort coincided with patient-provider rapport, which was built over time. Several Black SMM reported finding it easier to talk to their providers—and to disclose private details of their sexual lives—if they had an established relationship with them. In the context of a conversation about negative healthcare experiences and finding affirming providers, one participant said:

> I’ve been getting comfortable with talking to – like I said, I went to the clinic, you know, when I got my test last week. It took me a couple years to sit here and, you know, when they ask that question, “Do you have sex with guys, girls?” and you know, oral … I was, like – at first, I was, like, I really feel uncomfortable answering this question. But now it’s – now – now with them, it’s like, yeah, this, that, boom, bang. [Black SMM FG1/P7, 26 years old]

Likewise, providers perceived patient comfort and patient-provider rapport to be a function of time invested in the relationship. Referring to Black and Hispanic male patients, one provider stated:

> “It takes a while … if you present – present the information [about sexual health], then they sometimes will come back later on because they’ve remembered that you’ve said, “Oh you can talk to me at any time.” “Well, I remember, you know, I remember that and now here I am, you know.” [Provider FG4/P19, 66-year-old White woman]

Several providers noted a tension between their desire to develop rapport with their patients and their capacity to actually devote time to doing so given the limited time allocated in their schedules for each patient visit.

Patient-Provider Sociodemographic Concordance.: Notably, several providers speculated that Black SMM would feel more comfortable with providers of their own gender, race, or sexual orientation. One provider stated, “I’m very, very comfortable with all, you know, of our patient population. But I think from their perspective, especially from a teen’s, you know, I think they see me a lot, and they’re like, ‘Oh, boring old White guy’” [Provider FG2/P10, 33-year-old White man]. Many Black SMM, however, asserted that they were more concerned about providers’ personal qualities (e.g., professionalism, sex-positivity, respectfulness) than providers’ sociodemographic characteristics. Furthermore, Black SMM

who did express sociodemographic preferences varied considerably in their preferences, with some preferring similarity and others preferring difference:

> When I was younger … I needed a gay [provider] … if he had been Black that would've been something beneficial, too, because we'd have that in common. But it was more so definitely sexual orientation and, you know, sexual practice and experience, that I just needed somebody to relate to, and also somebody that wasn't gonna judge me. [Black SMM FG3/P20, 39 years old]

> I'd be highly reluctant to go to a Jamaican doctor, just because I'm Jamaican and just because in Jamaica, even people who are trained doctors, nurses, teachers, therapists, psychologists, psychiatrists, they are very, very homophobic … So even [in the US], I would not go to a Jamaican. [Black SMM FG4/P26, 33 years old]

Patients' Right to Non-Discriminatory Healthcare.: Black SMM and providers both valued culturally competent sexual healthcare, mutually endorsing the attitude that marginalized patients were entitled to fair and equitable treatment. Stigma and cultural insensitivity were nonetheless discernable in some of the healthcare experiences reported by Black SMM and the perspectives articulated by providers.

Cultural Competence Aspirations.: Some Black SMM said they sought out health centers specifically geared towards the LGBTQ community to try to mitigate the risk of being judged or mistreated. When speaking about ways to decrease discrimination in healthcare, Black SMM recommended that healthcare providers and staff participate in ongoing cultural competence training to uphold expectations of non-discriminatory healthcare:

> It has to be a consistent or frequent, uh, training that happens … That's something has to be happening every six months, um, from the time – the time of their, uh, residency … Not – not somethin' that just happens once. [Black SMM FG4/P21, 34 years old].

Providers agreed that their patients had a right to non-discriminatory healthcare, and several mentioned receiving cultural sensitivity training as part of their broader medical training. They reflected upon how providers' clinical judgment and decision-making could be impacted by stigma. For example, one provider described how risk-related patient stereotypes could lead to medical missteps: "I think that you shouldn't think about those different risk categories. I mean you have to know the sexual history, but if you approach a patient from a kind of a preconceived notion of what they may be doing, either sexually or with drugs, then you're often gonna miss something" [Provider FG1/P6, 56-year-old White woman].

Expressions of Stigma.: Black SMM highlighted the unique stigma that they experienced because of intersecting racism and heterosexism: "I do think there's a stigma around gay sex with Black people that may not affect White people as much" [Black SMM FG3/P20, 39 years old]. Black SMM commonly recounted previous medical visits during which they had felt judged or stigmatized. Some participants described detecting subtle expressions of stigma, for example, "when you go to a clinic and you say you're gay or you have sex

with such and such, you might see an eyebrow rise" [Black SMM FG2/P15, 40 years old]. Perceived manifestations of stigma could also be more overt:

> I had been traumatized earlier on in my youth going to a physician who I shared with that I was having anal sex and who explicitly told me that that was unhealthy, and I needed to stop doing that. [Black SMM FG3/P20, 39 years old]

Although providers expressed a shared commitment to non-discriminatory care, several providers' choice of language and shared anecdotes suggested that they may not be fully attuned to their own biases. Although all providers are vulnerable to implicit social biases (Hall et al., 2015), participants displayed limited awareness about their own vulnerability or that of other healthcare workers. In one of the more blatant examples, a provider asserted, "In the real world, as a provider, I don't think anybody has a prejudice or a bias against a specific color or race" [Provider FG5/P24, 48-year-old South Asian woman].

A few providers perceived patient discrimination operating at the institutional level. When discussing equitable access to healthcare, one provider highlighted how race and socioeconomic status (inferred by health insurance status) could intersect to adversely affect care:

> There's a, a culture within much larger, larger organizations, hospitals specifically, that they don't get reimbursed as well. They're discouraged a lot from the Medicaid and uninsured patients. And unfortunately, in this country, those tend to be more often patients of, you know, [racial] minority patients. [Provider FG2/P10, 33-year-old man]

Divergent Perspectives

Preference for Sexual Privacy Versus Sexual Information-Sharing.: Black SMM and providers expressed inconsistent views surrounding patients' sharing of information about their sexuality. Participants in both groups acknowledged that reporting same-sex behavior or sexual minority identity could be challenging for patients. Many Black SMM, however, questioned the necessity of such reporting, including within the context of PrEP provision, whereas providers generally regarded patients' self-reporting of sexual behavior as germane to their ability to provide optimal healthcare.

Black SMM's Preference for Sexual Privacy.: Several participants described social pressure, including from within the Black community or ethnic subgroups thereof, that led them to conceal their same-sex behavior. One participant, however, pointed instead to the broader racial context: "The issue is Black folks, um – we're not more homophobic. We're more conservative in our sexuality in general … because our survival was predicated on respectability politics" [FG3/P17, 27 years old]. Irrespective of ascribed origin, there was agreement that Black SMM experienced heightened vulnerability around sharing information about their sexuality, which led them to question its necessity when seeking health services.

> I shouldn't have to [report sexual information], and that's another thing. I try not to because I already look at how society looks down upon the gay community, and

> because, you know, they look down upon us, like, “Oh, it’s not right.” You got people preachin’ against it, you know, hate crimes and everything. [Black SMM FG1/P7, 26 years old]

With respect to PrEP-related care in particular, several Black SMM deemed reporting of sexual behavior or orientation to be an unnecessary prerequisite for PrEP access, emphasizing that PrEP should be offered as an option to patients regardless of their sexual orientation: “You see a patient, you bring it up, period” [Black SMM FG4/P26, 33 years old]. This related to their perceived right to privacy:

> If it’s not a gay drug, for gay people, you shouldn’t have to be, like, “Oh, I’m having sex with men,” in order to have this drug … I don’t feel like you had to necessarily go into your sexuality in order to reference that you need the drug … As if HIV is a gay – gay disease … you shouldn’t have to tell your doctor if you’re sleeping with men. If you are having sex, you are at risk for HIV. [Black SMM FG1/P6, 21 years old]

The desire for privacy was tied to concerns about provider judgment as well. Black SMM expressed hesitation around reporting their sexuality to their providers for fear of experiencing further stigmatization beyond that already experienced in their daily lives. Participants also anticipated that reporting same-sex behavior or orientation could adversely impact the quality of care that they subsequently received. As one participant suggested, sharing such information could prompt assumptions about risk and consequent need for HIV/STI testing:

> “I think when you say that you have sex with a woman, it’s not an issue. There’s no risk … They go, “Okay, have a good day” … But as soon as it comes to a man with a man, “Oh, [let’s] schedule all these tests.” [Black SMM FG2/P9, 23 years old]

Another participant communicated concerns that informing his provider that he was gay could confer vulnerability to mistreatment: “How do I know that you’re gonna give me the right treatment for it? How you gonna give me the right medicine for this? How do I know that – again, trust issues…” [Black SMM FG1/P7, 26 years old]

Black SMM indicated that, beyond causing anxiety and discomfort for some patients, provider expectations around patient sexual information-sharing during a healthcare visit did not always elicit the desired response. One participant described how a preference for privacy around his same-sex behavior led him to misrepresent his sexual history to his provider when seeking a PrEP prescription. He stated, “So, I told my doctor and I – I kinda made it up a little bit, but enough for him to know what he needed to know.” He further explained, “I’m a very private person … he got what he needed to know so I could get what I needed to get” [Black SMM FG1/P5, 49].

Black SMM also pointed out that anticipating provider expectations for patients to report their sexual behavior or orientation could deter care-seeking. As one participant explained, some men who were not open about their same-sex sexual behavior would prefer not to visit their providers, despite needing services, because of the threat that they perceived such a visit would pose to their sexual privacy:

> So, back a couple of years ago, my area that I lived in was a high-risk rate. There was a hospital right there, but again people are on the DL. People are on the low. They don't want to be exposed. They out there … you can be exposed to anything – gonorrhea, it's a lot of things out there that can impact your life. But the stigma of "I'm a young Black man or MSM or anybody going for an HIV test," it's a kind of – they don't want to be caught out there because the world's – [city name]'s very small. [Black SMM FG3/P16, 30 years old]

A few Black SMM offered counterpoints to the majority opinion, asserting that it was important for individuals to share information about their sexuality to reduce the stigma as well as to give their providers a full and contextualized understanding of their health. For example, one participant stated it would be "dangerous" not to report sexual orientation and a complete sexual history to their providers because he viewed it as necessary information for the providers to assess their patients' risk [Black SMM FG6/P31, 26 years old].

Providers' Preference for Sexual Information-Sharing.: Providers commonly viewed asking their patients about their sexual orientation or sexual behavior as a routine component of sexual healthcare. Some regarded it as fundamental to their ability to help their patients, echoing the perspective of the few Black SMM who disagreed with the majority's preference for privacy: "If you disclose all the information to me, that's the only way that I can really help you" [Provider FG5/P26, 32-year-old White woman]. Many providers stated that they relied on this information to tailor discussions about safe sex and preventive testing to patients' needs and circumstances. Consistent with the experiences of Black SMM participants, reporting male same-sex behavior or sexual minority orientation often prompted more rigorous questioning, counseling, or testing than other patients received: "Any male who admits or discloses that they're having sex with another male, that to me, you know, warrants that discussion [about PrEP and sexual health]" [Provider FG2/P10, 33-year-old White man]. Some providers justified more intensive discussion or assessment of patients' sexual health based on epidemiology (e.g., additional questions or testing for a patient who does sex work, whose partner has HIV, or whose partner is bisexual [Provider FG4/P19, 66-year-old White woman]).

While generally preferring that sexual information be shared, providers perceived some sexual minority patients, particularly SMM of color, as being reticent to openly discuss their sexual orientation or sexual histories: "Black males, you know, some Hispanic patients don't wanna say anything about their sexual orientation. It takes a while" [Provider FG4/P19, 66-year-old White woman]. Despite recognizing patients' preference for privacy around their sexuality, providers generally expressed the perspective that patients should nonetheless report such information in healthcare settings. Some providers indicated that if their patients expressed discomfort with reporting their sexual identity, they would try to respect the patients' boundaries: "I feel like most men are probably uncomfortable talking with me … or they don't, you know, they don't really elaborate, so then I don't push it, you know?" [Provider FG5/P23, 43-year-old White woman]. Others noted that they would wait for rapport to be built with the patient over multiple appointments. A few providers acknowledged that, in some circumstances, patients' omission or misrepresentation of the details of their sexual history—for example, patients stating that they had one partner whom

they thought posed a risk STIs rather than acknowledging that they had multiple partners whom they thought posed a risk—may not impact the type of care that providers would offer (e.g., STI testing). The overarching sentiment, however, was that sharing accurate sexually history information was important and enabled optimization of care, which contrasted with many Black SMM's perspective that sharing such information was unnecessary or could compromise the quality of care.

Providers' Initiation of PrEP Conversations: Ethical Versus Optional.: Compared with providers, Black SMM more commonly vocalized the belief that providers should routinely discuss PrEP with patients. Providers perceived initiating such conversations as discretionary rather than necessary; the majority had never discussed PrEP with a patient.

Black SMM's Perception that Providers Have an Ethical Responsibility to Initiate PrEP Conversations.: Black SMM participants were nearly unanimous in the opinion that the onus to initiate conversations about PrEP should be on the provider rather than the patient, with many seeing it as the "responsibility" of the provider "no matter who's sittin' in front of 'em" [Black SMM FG2/P12, 52 years old]. One participant stated, "Most people don't know about most things. So [providers] should bring it up" [Black SMM FG6/P31, 26 years old], alluding to the importance of providers initiating conversations about PrEP given widespread unawareness among patients. He also highlighted the potential for routine communication about PrEP to have a destigmatizing effect:

> [Providers] should talk to everybody … your healthcare provider is, is someone, like when you hear it, they can take away stigma from most medical things. If every health provider – like when you get a cold. There's no stigma about getting a cold or taking medication if you get a cold because everyone talks about it. [Black SMM FG6/P31, 26 years old]

Black SMM participants' preference for PrEP conversations to be routinely initiated by providers contrasted with the actual experiences of most, who—if they had discussed PrEP with a provider at all—reported that they had been the ones to broach the topic of PrEP, not their providers. Furthermore, some participants expressed frustration that they had to self-advocate and "push" for PrEP prescriptions in the face of provider ignorance or resistance. The few Black SMM who reported that a provider had initiated a conversation about PrEP with them typically had accessed care at HIV clinics or health centers specifically geared toward the LGBTQ community.

Because participants believed that providers were ethically obligated to initiate PrEP-related discussions, many also ascribed blame to providers for neglecting to inform patients about PrEP. One participant attributed a friend's seroconversion to healthcare providers' failure to inform the friend about PrEP. The friend tested HIV-positive over two years after PrEP was first federally approved, and the friend had been unaware that PrEP existed prior to his HIV diagnosis despite multiple visits with healthcare providers during those two years, visits during which he had reported his same-sex sexual orientation. The participant assumed that the providers had known about PrEP and withheld information:

> If you were being honest, they're supposed to tell you what risk you have … That's their job, the doctor … That's the part that got me … They knew [about PrEP], but they did not tell him … [Black SMM FG1/P5, 49 years old]

Another participant expressed similar frustration that his provider had not informed him about PrEP yet:

> After [the provider] asked me if I'm sexually active and I say "yes" and then continue to give him a little detail, I feel like he should have been, like, "We have [PrEP]" … I would have liked to known [about PrEP] … two years ago. [Black SMM FG1/P6, 19 years old]

Based on Black SMM's reported experiences, simply informing patients about PrEP would be a step in the right direction. However, in addition to being informed about PrEP, Black SMM desired an opportunity for two-way communication:

> And like [the provider] just kinda mentioned [PrEP] and threw it out there. I didn't really get to go in depth … they didn't really carry me through … Bam. The conversation's closed. It's like, okay, great idea. But you're not really communicating with me. We're not having a conversation … you just kinda of mentioned it and just said, "Okay, I did it." Almost like they were doing a little checklist. [Black SMM FG5/P29, 24 years old]

Providers' Perception that Initiating PrEP Conversations is Optional.: Black SMM participants' perception that providers had a duty to inform patients about PrEP was not echoed among most providers or reflected in their reported experiences. Over three quarters of providers had never previously discussed PrEP with patients, and among those who had, several reported that their patients typically initiated the conversation. In fact, some providers first heard about PrEP from their patients, who had generally accessed information about PrEP from friends, sexual partners, or other informal sources. Several providers expressed comfort with patients initiating conversations about PrEP:

> It was very easy to prescribe to the first patient because he was so educated about it and really wanted it … So, I had no problem with it at all … I've never had the conversation with someone to just suggest it … So, I, I'm sure that would be a – maybe a little bit more difficult. [Provider FG5/P26, 32-year-old White woman]

Some providers reported reservations about initiating conversations about PrEP because they lacked familiarity with PrEP or were unconvinced of its safety and efficacy based on their understanding of the scientific evidence that had accumulated at that time. Even those who were open to offering PrEP sometimes lacked the time or incentive needed to routinely initiate conversations about PrEP during health visits:

> You can force a provider to do certain things if it's tied to how they're being paid … If you leave it on the provider to say, "Hey, you can do it or you can't do it," it's like, "I don't have the time; I'm not going to do it" … I don't have the time to ask, "Have you thought about PrEP?" Yeah, so if it's tied to how you get money from the insurance or anything like that, then the medical community and a provider will get on it. [Provider FG4/P22, 32-year-old South Asian woman]

The novelty of PrEP as an added health topic to be addressed along with the many other topics regularly covered during a health visit also served as a barrier to providers initiating conversations about PrEP:

> I think it's just gonna take some time, at least for me, to get used to remembering to say, "Oh yes, and by the way, there's something available, you know. Your partner has HIV, you know, maybe you would wanna take [PrEP]." [Provider FG4/P19, 66-year-old White woman]

The potential need for cueing or reminding was corroborated by another provider, who stated that although routinely asking her patients about their sexual behavior prompted her to consider testing the patients for STIs, it did not similarly prompt her to discuss PrEP with her patients:

> I ask usually, like, "Do you have sex with men, women, or both?" … I usually think about it is in terms of assessing what risks, like what sexually transmitted infections I would want to screen this person for. I don't use it to think about PrEP. [Provider FG3/P14, 32-year-old White woman]

Personalized Versus Standardized Conversations about Sex.: Black SMM and providers differed in their preferred style of patient-provider conversation about sexual behavior: Whereas the former typically favored an unscripted dialogue, the latter valued checklists and other standardized tools to help guide the conversation.

Black SMM's Preference for Personalized Conversations about Sex.: Many Black SMM emphasized the importance of a personalized, two-way conversation about sex that fostered the sense that the provider cared about and was invested in the patient's wellbeing. They suggested that an unscripted dialogue was preferable to providers' reliance on standardized tools such as a checklist or scripted set of questions to guide the conversation because it would communicate an authentic interest in their lives and health, thereby encouraging them to be more open:

> You always have to be genuine 'cause people can see when you're doin' your job and you're just, like, "You have sex with men? Okay." You know what I'm sayin'? You're goin' down the checklist … I don't know how to tell someone to be genuine, but I'm sayin' if you can actually, like, look someone in the face, like, and just talk to them and try to have a conversation with them instead of, like, doctor and patient. Let's be a person to person and have a genuine conversation and see if I can get you to open up a little bit more and then, you know what I'm sayin', we'll be like, "Okay, well, I met this guy, I'm doin' this guy. I'm doin' this guy, I need some condoms and I need PrEP too." [Black SMM FG1/P3, 21 years old]

Corroborating this perspective, another participant stated:

> I think it just comes down to care, and you have to really want to. It's not a checklist. It's like you have to really care. It's something inside of you. You have to care about the [HIV] epidemic. You have to really care about the person that you're speaking with. [Black SMM FG5/P29, 24 years old]

Black SMM also expressed that having a natural, free-flowing dialogue about sex and PrEP would help them feel more confident about their providers' comfort with sexual minority patients:

> I think it's in tone and gestures. Um, the lightness in the way they speak, uh, like it shouldn't be, like I said, stiff or heavy, like, you know, reading the paper, they're not making any eye contact while I'm trying to talk to you about, you know, what kinda stuff you have and, like, makes it seem like you talk about this every day. [Black SMM FG4/P21, 34 years old]

Some men felt as though a provider's reliance on standardized tools to guide the conversation felt dismissive, not only of their experiences but also of their own knowledge on the topic. Referring to a provider's failure to assess his knowledge as a patient and tailor the conversation accordingly, one participant pointed out, "You're not educating me. You didn't even know how educated I am because I could be more educated than you are" [Black SMM FG5/P29, 24 years old].

Although Black SMM largely expressed a preference for an unscripted, personalized approach to conversations about sexual health and PrEP, a few participants acknowledged that standardized tools may normalize the conversation by making it seem routine or give participants a greater sense of confidentiality. One participant suggested that asking a standard set of questions in written form could ease discomfort around talking about sexual health: "I think [the conversation about sex] would be more discreet if you used a questionnaire to ask those questions" [Black SMM FG6/P34, 28 years old].

Providers' Preference for Standardized Conversations about Sex.: Providers' opinions on using standardized tools were mixed, but most providers favored their use for asking patients about sexual health and behavior, reporting that such tools offered several benefits. One benefit was that the tools provided necessary structure given the limited amount of time that providers had with each patient. As stated by one provider, "The fifteen-minute template is a curse" [Provider FG4/P20, 50-year-old White man]. Many providers acknowledged that they would prefer to have longer discussions with their patients about sexual health and behavior, and some had the flexibility to accommodate such discussions. Lengthier conversations, however, were simply not feasible in other settings. Giving patients a form to fill out about their sexual history or using a checklist opened the door to conversations about sex and helped to focus those conversations in time-limited settings.

Irrespective of time constraints, providers found checklists and other standardized tools useful for ensuring that they covered key content. One provider described how the use of a checklist for HIV counseling enabled her to feel confident that she had "done a good job of educating [her] patient":

> When we first started doing HIV testing, I remember that far enough back, um, they actually had a little ha-, a little card … like a little cheat sheet that you had that said, okay, you need to do this, this, and this, and then you can feel like you've covered the bases. [Provider FG1/P5, 53-year-old biracial woman]

Providers further suggested that specific guidelines could help them to ask the "right" questions and use appropriate language when broaching sensitive topics with their patients: "Especially the ones that are bisexual or homosexual … How do you talk to them, how do you explain to them, and how do you get them to talk to you … how to ask those right questions to get some information" [Provider FG2/P11, 38-year-old White woman].

As was raised in the Black SMM focus groups, a standard form or set of questions could function as a basis for reassuring patients. Referring to ways to make patients feel more comfortable during visits, one provider explained, "… because they start looking at me like, 'Why are you asking me these questions?' 'It's in the form. I just have to do it, so just tell me'" [Provider FG4/P18, 37-year-old South Asian woman].

Despite the multiple benefits that providers ascribed to standardized tools, using such tools was not universally preferred over open-ended conversation. One provider reported using a form or checklist to be overly restrictive and did not use such forms to guide sexual health conversations even when that was standard practice at her medical facility:

> I'm not form-driven anyway. I do it because I – if I'm doing it, I'm doing it because I want to do my job well. And so, if I see a patient that [PrEP] is appropriate for, I'm gonna offer it. And I don't think I'll ever be the type of person I'm gonna offer it because it's on a form … I feel so oppressed by all these forms. [Provider FG4/P21, 51-year-old White woman]

Sometimes providers deviated from standardized tools but still invoked their own standard in terms of the question(s) asked, guidance given, or patients engaged, which could adversely affect patient care. In one extreme example, a provider described her approach as follows:

> "Okay, so are you having sex with any other – are you straight or gay?" That's my first question. Half of them laugh and say, "No, we're straight." And the one who says "gay," they will just start looking a bit uncomfortable, and then those are the patients that I push into, like, "Okay, you know that you are supposed to use condoms." I'm not totally comfortable in discussing about sexual life with every single patient that come through the door … It's more like there's some patients who come in and say that they're coming in because they want to be tested for HIV or STD. Then I'm, like, "Why?" Then we go further into that. But, like, if a 19-year-old comes and says that she's coming in for a physical, I just say, "Are you sexually active?" "No." Okay … you know, two-minute spiel and I'm done with it. I don't spend an extra ten minutes trying to take their sexual history. [Provider FG4/P18, 37-year-old South Asian woman]

Given that Black SMM generally preferred a personalized, free-flowing sexual health conversation in which a provider did not rely on standardized tools, this example—in which the provider disregarded the discomfort that they perceived on the part of patients and assumed a paternalistic tone when delivering sexual health guidance—suggests that training or oversight may be advantageous to ensure that unscripted conversations are sensitive and respectful and occur routinely.

DISCUSSION

This integrated analysis of Black SMM and provider perspectives provides compelling insights regarding patient-provider sexual health communication, a fundamental precursor to PrEP initiation and an ongoing component of regimen maintenance. The perspectives voiced by Black SMM aligned with those expressed by providers in multiple ways: Both groups perceived maximizing patients' comfort to be important, and both believed that patients had a right to non-discriminatory healthcare. Divergent views also emerged, including Black SMM's preference for sexual privacy versus providers' preference that patients share sexual information, Black SMM's perception of providers' initiation of conversations about PrEP as being an ethical responsibility versus providers' perception that initiation of such conversations was optional, and Black SMM's preference for personalized conversations versus providers' preference for standardized conversations about sex.

Black SMM and providers jointly acknowledged the value of patient-provider rapport in fostering open communication about sex and enhancing patient comfort. Patients' trust in their providers can play a key role in sexual health decision-making. For example, Braksmajer et al. (2018) found that Black and Latino/x/a patients who had greater trust in their primary care provider had over three times the odds of being willing to try PrEP as those with lesser trust.

Despite Black SMM and providers' mutual desire to develop rapport, several structural barriers constrain their opportunity to do. A salient barrier in the current study was the lack of time allotted for patient visits, which is generally dictated at the organizational level and financially motivated. Though relevant to all patients, time limitations could be a particular hindrance to patient-provider rapport-building for Black SMM and other populations with histories of medical mistreatment to the extent that more time is required to establish trust. Compounding this disadvantage, systematic exclusion from the workforce and interruptions in healthcare coverage disrupt care continuity for Black SMM (Philbin et al., 2018). As one participant in our study raised, insurance reimbursement is higher for employer-sponsored health insurance compared with Medicaid, which disincentivizes provision of care to patients who are unemployed or uninsured, who are disproportionately people of color. Thus, pervasive inequities at the structural level can hinder the development of ongoing, trusting relationships between Black SMM and their providers and Black SMM's consequent comfort during health visits.

Both Black SMM and providers reported valuing patients' right to non-discriminatory healthcare. However, this value conflicted with the actual experience of multiple participants. Black SMM highlighted the unique stigma that they faced due to their gender, race, and sexual orientation and recounted several instances of stigmatizing treatment by past providers, including subtle nonverbal cues and microaggressions that may operate at an implicit level for providers. Some providers in our study sample and others have displayed limited insight into their own biases and vulnerability to bias (Calabrese et al., 2019). For example, one provider reported asking patients, "Are you straight or gay?," which not only ignores a range of sexual orientations (e.g., bisexuality, pansexuality) but may also seem intimidating, insensitive, or abrupt to patients, particularly those who value their privacy

or for whom sharing their sexual orientation enhances vulnerability. Language such as "admits … having sex with men," a statement made by a provider in reference to a male patient, conveys underlying heterosexism and could undermine rapport with Black SMM and other patients. This turn of phrase and other stigmatizing rhetoric have previously been identified within providers' notes in patients' medical records as well as in the attitudes that some providers have explicitly verbalized (Doblecki-Lewis & Jones et al., 2016; Skolnik et al., 2019). Even providers who made a conscious effort to convey acceptance of sexual diversity in their choice of words (e.g., "Do you have sex with women, men, or both?") may inadvertently communicate a lack of sensitivity to gender and sexual diversity by framing gender as binary and assuming the patient is engaging in sexual activity with others.

Providers would benefit from ongoing training to improve cultural competence, including LGBTQ sensitivity. Several Black SMM in our study reported specifically seeking care in LGBTQ specialty settings to avoid being stigmatized. Not all Black SMM, however, have access to LGBTQ specialty settings, and, more importantly, Black SMM should not need to seek out specialty settings to receive appropriate care. Cultural competence training can inform providers about optimal ways to engage and provide care for LGBTQ populations. The lack of awareness about personal biases displayed by some providers in our study suggests that discussion of cultural humility should be an integral component of training. Cultural humility is an active process involving self-questioning, learning from patients, and partnership-building with patients (Chang et al., 2012). Cultural competence training programs and resources have become increasingly available, including online (e.g., https://www.lgbtqiahealtheducation.org/).

Training could help to mitigate provider bias, but may not fully eradicate it. A recent literature review documented an absence of evidence to date for any training having lasting impact on implicit bias, casting doubt on whether implicit bias can be durably modified (Greenwald et al., 2021). If reporting same-sex sexual behavior or sexual minority orientation is going to prompt expressions of implicit bias from some providers that are beyond their control and resistant to long-term change, at least with respect to currently available training options, this begs the question of whether such reporting is in fact in patients' best interest and necessary for care, particularly with respect to accessing PrEP.

Against a backdrop of entrenched racism and heterosexism in the US healthcare system and the consequent medical mistrust fostered among Black people and sexual minorities, it is perhaps unsurprising that most Black SMM in the study voiced reservations about disclosing their sexuality to providers. For some, firsthand experience of mistreatment in healthcare settings had contributed to medical mistrust and hesitancy about reporting sexual behavior or orientation. A few perceived sexual information-sharing to be necessary so that providers had a comprehensive understanding of their health and could tailor their care accordingly —a view that is consistent with other reports of sexual minorities perceiving inquiries about their sexual orientation and relationships in a healthcare setting to be important and validating (Cahill et al., 2014; Schwartz & Grimm, 2020). Previous research has found that Black SMM are less likely than White SMM to report their sexual orientation to their healthcare providers (Millett et al., 2012), which may be because Black SMM are less likely to identify with Eurocentric sexual orientation labels commonly used to communicate

about sexual orientation (e.g., “gay”); may experience their identities in more complex, intersectional ways; face social pressures that may interfere with integration of their sexuality into their self-concept or lead to compartmentalization of their sexual identity; and encounter unique challenges and vulnerabilities to reporting their sexual orientation within and beyond healthcare settings (Bowleg, 2013; Fields et al., 2016; Malebranche, 2020; Millett et al., 2012; Quinn, Dickinson-Gomez, et al., 2019). For example, on top of the threat of racial discrimination, Black SMM fear being humiliated or fetishized by providers and having other healthcare needs overlooked as a result of disclosing their sexuality (Quinn, Dickinson-Gomez, et al., 2019). Thus, there may be a greater cost of sexual information-sharing for Black SMM relative to other groups.

Considering both the limited controllability of implicit bias and variability in patients’ circumstances, it may be valuable to revisit the expectation that patients disclose their sexual orientation or behavior in healthcare settings. Patients’ reporting of their sexual behavior and the gender of their sexual partners may be more appropriately framed as an option rather than an expectation. Research suggests that reporting sexual orientation to a provider may facilitate access to PrEP: SMM who have not reported their same-sex orientation to providers are less likely to have discussed PrEP with their provider and are more likely to have been denied PrEP by a provider than those who have (Furukawa et al., 2020). This association between sexual orientation self-reporting and PrEP access could systematically hinder access for Black SMM to the extent that they are more inclined to maintain privacy around their sexuality than other patients. As participants pointed out, HIV risk transcends sexual orientation categories, and PrEP is not solely indicated for SMM. Patient care may be enhanced by providers routinely discussing PrEP with all patients instead of treating sexual information-sharing as a determinant of PrEP eligibility or prerequisite for PrEP discussions.

When questions about sexuality are to be advanced, such questions can be prefaced by a gentle inquiry about patients’ openness to answering such questions, asking rather than assuming patients’ permission. Specific questions pertaining to patients’ sexual history or the gender of their sex partners can be asked in an open-ended manner that signals acceptance of non-heteronormative sexual relationships, and they can be accompanied by an explanation for why the information is important to their care. For example, at present, tenofovir alafenamide with emtricitabine (TAF/FTC; DESCOVY®) is not indicated for vaginal sex (DESCOVY for PrEP®, 2020), so understanding whether a patient’s HIV risk involves anal sex, vaginal sex, or both is pertinent to PrEP medication selection for Black SMM and others.

Black SMM in our study voiced both a desire and an expectation for providers to consistently initiate conversations about PrEP with them and other patients. None of the providers, however, reported routinely discussing PrEP with patients as a standard component of care. This is consistent with a recent review of sexual health communication among a variety of providers and patients indicating that while patients typically believed providers should initiate discussions of sexual health, many providers preferred to discuss sexual health only if broached by the patient and deprioritized it relative to other aspects of health (Zhang et al., 2020). Some providers in our sample relied on patient requests to prompt PrEP discussion; this passive approach to PrEP service delivery has been

documented among other providers as well (Krakower et al., 2017). A benefit of this approach to which providers in our sample alluded is that patients requesting PrEP generally have at least a basic level of knowledge about PrEP, which reduces the amount of patient education that providers need to provide. Consequently, these patient-initiated conversations likely demand less time and preexisting knowledge about PrEP from providers. But a passive approach does not comport with the expectations expressed by Black SMM, who placed the onus squarely on providers to be knowledgeable about PrEP and routinely initiate conversations about PrEP with patients.

Proactively initiating conversations about sexual health and PrEP instead of relying on patients to initiate these conversations may put patients at ease and could potentially avert systematic disparities in PrEP access resulting from certain patient groups (e.g., White SMM) being more likely to initiate PrEP conversations (Calabrese, 2019; Rucker et al., 2018). Provider training on PrEP and sexual health should be prioritized to prepare providers to consistently initiate conversations about PrEP with patients and to engage in conversations about PrEP competently and confidently. Additionally, clinical guidelines and health center protocols that explicitly establish PrEP as a standard component of routine sexual health counseling could reinforce providers' consistent initiation of such conversations. Memory cues and increased time allocated for providers to spend with each individual patient could further facilitate sexual health conversations.

The preference that Black SMM reported for providers to engage in a more personalized, free-flowing style of conversation that communicates genuine care and respect coincides with other research in which SMM have suggested that increased provider warmth and compassion would enhance their comfort in seeking PrEP services (Rogers et al., 2019) and that a checklist or scripted approach to sexual health conversations constrains communication and the personalization of care (Devarajan et al., 2020). Having a free-flowing conversation about PrEP and sexual health requires more in-depth knowledge of these topics than some providers appear to possess (Rogers et al., 2019), and this lack of knowledge, inexperience, and consequent discomfort are among the reasons why providers may not initiate conversations about PrEP (St. Vil, 2019).

Black SMM's preference for unstructured conversation is potentially inconsistent with the desire for standardized tools that many providers expressed in our study and others (O'Connell & Criniti, 2020; St. Vil et al., 2019). Benefits of standardized tools that providers highlighted in the current study were focusing conversations in time-limited settings, ensuring that key content is covered, and justifying the questions asked of patients. A standardized tool can also provide scripted language and counseling guidance that would promote more sensitive, patient-centered conversations, particularly when conversing with sexual minorities. Although many providers in our study embraced a standardized approach, others preferred a freestyle approach that was less "form-driven." The mixed views and potential tradeoffs of standardized tools illuminated by Black SMM and providers in our study dovetail with previous research in which providers have described standardized tools as both a "crutch" when patients are reluctant to discuss their sexual histories as well as a barrier to "real" conversation (St. Vil., 2019). Collectively, these findings suggest that it may be beneficial to use standardized tools only if they can be used sensitively

and discreetly. Specifically, they should be used to prompt open dialogue rather than constraining conversations to a scripted, unidirectional delivery of instructions or close-ended patient interview.

Study Limitations

The themes identified in our study offer important insights about provider training needs that align with prior research and likely resonate with other Black SMM and providers. Findings from this exploratory qualitative study, however, are not intended to be broadly generalizable. The relevance of the themes may vary, for example, across geographic and healthcare settings. Black SMM participants were recruited in New York City and Connecticut, and provider participants were recruited in Connecticut and Rhode Island community healthcare settings; unique characteristics of these environments may have shaped participant perspectives in nuanced ways.

Notably, the two samples were recruited through different venues and were not matched. Although it is possible that Black SMM who participated in our study were patients of the providers who participated, it is unlikely. Thus, the experiences and attitudes reported by the two samples were not in direct reference to one another and should not be interpreted as such. Additionally, whereas providers were specifically recruited because of their role as providers, the Black SMM participants were not specifically recruited because of their role as healthcare consumers. Furthermore, questions asked of providers and provider responses were not specific to Black SMM patients (though sometimes did refer to them). Future research using matched patient-provider samples recruited from the same healthcare venues could offer nuanced insight by collecting dual perspectives on the same clinical interactions, particularly those involving Black SMM.

There are also limitations to our method of data collection: Focus groups can be susceptible to reflecting a few dominant voices in the group or polarizing opinions on the topic (Morgan, 1996). Our focus group facilitators made efforts to elicit participation from all members of the group and encourage participants to vocalize their opinions even if they differed from the opinions of others. Accordingly, some participants in both Black SMM and healthcare provider groups expressed opinions differing from others in their group, suggesting that the research method did not stifle opposing perspectives.

Additionally, we note that the focus groups were conducted in 2015, and attitudes and experiences related to patient-provider communication about PrEP and sexual health may have evolved in the years since. Nonetheless, these findings continue to be pertinent to the extent that communication barriers persist, including limited provider knowledge about PrEP and discomfort discussing PrEP with patients (St. Vil et al., 2019).

Conclusion

In conclusion, this integrated analysis deepens our understanding of patient-provider communication as a barrier to PrEP access for Black SMM. Findings illuminate the perspectives of Black SMM as consumers of healthcare and the ways in which their perspectives align with and diverge from those of providers. When considered

concomitantly, the perspectives of Black SMM and providers underscore the need for more patient-centered sexual healthcare for Black SMM that includes respect for patients' privacy; routine, proactive counseling about PrEP; and personalized conversations. Prioritizing the needs and preferences of Black SMM is essential to improving their access to PrEP and advancing treatment equity in the context of pervasive racism and heterosexism in the US healthcare system.

ACKNOWLEDGMENTS

The authors thank the focus group participants who generously dedicated their time and effort to study participation. We are also grateful to those who assisted with study recruitment, including community health center leaders who helped to disseminate study recruitment materials and coordinate focus group logistics.

Funding

This study was funded by the National Institutes of Health (NIH; K01-MH103080; PI: Sarah K Calabrese). Resources were contributed by the Yale University Center for Interdisciplinary Research on AIDS, which is funded by the NIH (P30-MH062294). Support was also received from the District of Columbia Center for AIDS Research, which is also funded by the NIH (P30AI117970). The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

Conflicts of Interest/Competing Interests

Sarah K Calabrese received partial support from Gilead Sciences to attend a research conference. Douglas S Krakower has been a consultant to Fenway Health for research studies funded by Gilead Sciences, has a pending grant with unrestricted project support from Merck, and has received personal fees to develop medical education content for Medscape, MED-IQ, DKBMed, and UpToDate, Inc. Kenneth H Mayer has conducted research with unrestricted project support from Gilead Sciences and Merck and is a member of the faculty and advisory board of the National LGBTQIA+ Health Education Center, which the paper references in the discussion as a source of health education resources.

Availability of Data and Material

Full interview transcripts and individual-level questionnaire data have not been made publicly available to protect the privacy of participants. All excerpts of the transcripts that are relevant to the paper (including those not quoted within the paper) are available from the corresponding author upon request.

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Table 1.

Black SMM Sample Characteristics[a]

		N = 36	
		n	**%**
Gender[b]			
	Male	35	97.22
	Gender Queer	1	2.78
Race[b]			
	Black/African American	35	97.22
	Multiracial	1	2.78
Ethnicity			
	Latino/x	5	13.89
	Non-Latino/x	31	86.11
Country of Birth			
	United States	29	80.56
	Other	7	19.44
Sexual Orientation			
	Gay	25	69.44
	Bisexual	9	25.00
	Queer	1	2.78
	Pansexual	1	2.78
HIV Status			
	Negative	35	97.22
	Unknown	1	2.78
Prior PrEP Awareness			
	Yes	33	91.67
	No	3	8.33
Current or Prior PrEP Use[c]			
	Yes	4	11.11
	No	32	88.89

[a]Response categories that were not endorsed by any participants are not shown.

[b]During original eligibility screening, consistent with eligibility criteria, all participants reported identifying as men and Black or African American. Characteristics reported here are based on questionnaires completed at the time of focus group participation.

[c]Only participants who endorsed prior PrEP awareness responded to this item. The three participants who reported no prior awareness were directed to skip this item and were assumed not to have used PrEP.

Table 2.

Provider Sample Characteristics[a]

		N = 27	
		n	**%**
Gender			
	Male	4	14.81
	Female	23	85.19
Race			
	Black/African American	1	3.70
	White	21	77.78
	Asian	4	14.81
	Multiracial	1	3.70
Ethnicity			
	Latino/x/a	2	7.41
	Non-Latino/x/a	25	92.59
Country of Birth			
	United States	19	70.37
	Other	8	29.63
Sexual Orientation			
	Heterosexual	22	81.48
	Lesbian or Gay	2	7.41
	Prefer Not to Say	3	11.11
Professional Degree			
	Medical Doctorate (MD, DO)	7	25.93
	Nursing Degree (DNP, APRN, NP)	20	74.07
Work Setting			
	Community Health Center Only	24	88.89
	Multiple Settings	3	11.11
Provider Type[b]			
	Primary Care Provider	23	85.19
	Women's Health/OBGYN	3	11.11
	HIV Specialist	2	7.41
	Other	1	3.70
Prior PrEP Awareness			
	Yes	24	88.89
	No	3	11.11
Comfort Prescribing PrEP[c]			
	Very Comfortable	1	3.70
	Comfortable	7	25.93
	Neither Comfortable nor Uncomfortable	8	29.63

		N = 27	
		n	**%**
	Uncomfortable	4	14.81
	Very Uncomfortable	4	14.81
Previously Discussed PrEP with HIV-Negative Patient[c]			
	Yes	6	22.22
	No	21	77.78
Previously Prescribed PrEP to HIV-Negative Patient[c]			
	Yes	4	14.81
	No	23	85.19

[a] Response categories that were not endorsed by any participants are not shown.

[b] Participants could endorse multiple responses.

[c] Only participants who endorsed prior PrEP awareness responded to this item. The three participants who reported no prior awareness were directed to skip this item and were assumed not to have previously discussed or prescribed PrEP.