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Scaling Up and Out HIV Prevention and Behavioral Health Services to Latino Sexual Minority Men in South Florida: Multi-Level Implementation Barriers, Facilitators, and Strategies

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Abstract

Latino sexual minority men (LSMM) are disproportionately affected by HIV in the United States. Concurrently, behavioral health disparities, including mental health and substance use concerns, worsen HIV disparities affecting LSMM. Yet, evidence-based HIV prevention and behavioral health services are insufficiently scaled up and out to this population, perpetuating health disparities, thwarting efforts to control the HIV epidemic, and highlighting the need for culturally relevant evidence-based implementation strategies that address these disparities. Participants included 28 LSMM with varying degrees of engagement in HIV prevention and behavioral health services, and 10 stakeholders with experience delivering HIV prevention and behavioral health services to LSMM in South Florida, an HIV epicenter in general and in particular for LSMM. Participants completed semistructured interviews (English/Spanish) regarding LSMM's barriers and facilitators to engaging in HIV prevention and behavioral health services. Interviews were audio recorded and analyzed using thematic analysis. The 16 themes that emerged from the qualitative analysis were consistent with the consolidated framework for implementation research, an implementation research framework that articulates barriers and facilitators to implementing clinical interventions. Findings suggested the need for implementation strategies that simplify and reduce costs of HIV prevention and behavioral health services, address syndemic challenges impacting service use among LSMM, reduce stigma about service utilization, leverage peer networks, increase provider and community knowledge about services, and build LSMM's readiness and motivation to engage in services. Such strategies may ultimately address HIV and behavioral health disparities among LSMM and facilitate achievement of *ending the HIV epidemic* goals in this disproportionally affected population.

Keywords: Latino sexual minority men, HIV prevention, behavioral health, health disparities, implementation strategies, implementation science

Introduction

Nearly 40 years into the HIV epidemic, the emergence of evidence-based HIV prevention interventions highlights the urgency of scaling up and out these interventions to the community settings where they are needed most.[1] While scaling up refers to efforts to reach the larger population on which an intervention has been tested, scaling out refers to efforts to implement interventions in new populations and contexts.[1] As such, the US *Ending the HIV epidemic* (EHE)

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plan sets forth the goal of coordinating with local health authorities to scale up and out evidence-based HIV prevention interventions, particularly within the geographic HIV hotspots and among disproportionately affected populations.[2]

High on the list of disproportionately affected populations identified by the EHE plan are Latino sexual minority men (LSMM), who account for 20% of new HIV cases in the United States (as of 2018).[2,3] Moreover, among the EHE geographic hotspots, Miami, Florida is one of the leading jurisdictions for overall HIV incidence, and within Miami, account for the majority of new cases.[2–4]

The disproportionate impact of HIV on LSMM and the insufficient reach of existing, evidence-based HIV prevention interventions to LSMM have been explained by barriers to engagement in health care. Compared with non-Latino White SMM, LSMM have lower awareness of preexposure prophylaxis (PrEP), likelihood of discussing PrEP with a health care provider, and PrEP use.[5,6] Moreover, LSMM have identified a multitude of barriers to accessing HIV prevention services (e.g., HIV testing and PrEP), including difficulty locating providers; concerns regarding insurance and finances; fear of testing positive; lower perceived risk of HIV; concerns regarding sexual identity and HIV stigma; discomfort discussing their sex lives with their doctor; and lower desire for agency in participating in medical decisions.[7,8]

Elevated HIV incidence among LSMM occurs against a backdrop of behavioral health disparities among SMM. SMM experience elevated rates of mental health problems (e.g., anxiety, depression, suicidality, body image disorders, general distress) and substance use, particularly when compared with heterosexual counterparts.[9–15] Behavioral health disparities experienced by SMM have been explained by minority stress theory, positing that heterosexist social contexts produce chronic stressors and stigma for sexual minorities, predisposing them to higher rates of psychological distress.[16,17] Syndemic research has in turn shown how disparities in behavioral health are synergistic and exacerbate HIV acquisition and transmission among SMM, and LSMM in particular.[18–22]

For LSMM, disparities in behavioral health and associated HIV disparities are further exacerbated by known barriers Latinx individuals face in accessing behavioral health interventions: Latinx individuals have been found to have lower rates of service utilization and lower perceived need for mental health and substance use treatment relative to non-Latinx White counterparts.[23–25] Potential barriers to behavioral health services identified among Latinx people include reduced perceptions of distress, stigma, lower mental health literacy, and greater reliance upon public insurance programs that limit provider choice.[23,25]

Thus, to achieve the EHE goals, multi-level, culturally relevant implementation strategies—''methods or techniques used to enhance the adoption, implementation, and sustainability of a clinical program or practice''[26]—are needed to scale up and out evidence-based HIV prevention and behavioral health interventions in geographic HIV hotspots and for populations disproportionately affected by HIV. Accordingly, the current study sought to identify specific barriers and facilitators to HIV prevention and behavioral health service utilization by a population disproportionately affected by HIV (LSMM) in a geographic HIV hotspot (Miami). This study's engagement with an equivalent proportion of US- and foreign-born LSMM and its involvement of stakeholders were designed to reveal barriers that need to be addressed, facilitators that can be leveraged, and culturally appropriate implementation strategies that may bridge gaps in service delivery to LSMM that are needed to end the HIV epidemic.

Methods

Participants and procedures

We recruited 28 LSMM and 10 providers of behavioral health/HIV prevention services to LSMM in South Florida (stakeholders). Recruitment ended when thematic saturation was reached.[27] LSMM were recruited among individuals screening in as eligible for one of two HIV prevention and behavioral health trials.[28,29] Recruitment was stratified based on whether individuals participated in the prior trials (''engagers,'' $n = 15$; ''nonengagers,'' $n = 13$) and on nativity (US- vs. foreign-born). To facilitate equitable representation of foreign-born participants, we began to screen out US-born participants midway through the recruitment process. Although recruitment was stratified by nativity, there was no inclusion criteria for foreign-born participants related to specific country of origin.

Study inclusion criteria specified that LSMM were (1) gay, bisexual, or other men who have sex with men (MSM) (current gender identity, regardless of sex assigned at birth), (2) Latino/x or Hispanic (self-report), (3) self-reported HIV-negative or of unknown HIV status, (4) South Florida residents, and (5) 18–60 years old. Trained, bilingual staff were available to conduct the study in English or Spanish; other languages were not available for participation.

We recruited stakeholders from partner organizations providing HIV prevention/behavioral health services to LSMM in South Florida as well as through social media and local listservs. Stakeholders were eligible if they worked with LSMM in South Florida and were 18 years or older.

Potential participants were screened by phone to confirm eligibility. Eligible individuals who completed an interview received a $50 incentive. All procedures were reviewed and approved by the Institutional Review Board at the University of Miami.

Data collection

Demographic surveys. Participants completed surveys collecting information on race, birth country, years in the United States, preferred/native language, sexual orientation, relationship status, education, and income. Stakeholders reported the number of years working with LSMM in South Florida.

Semistructured interviews. Semistructured interviews were developed to assess LSMM's barriers and facilitators to accessing HIV prevention services [PrEP, postexposure prophylaxis/(PEP), HIV testing] and behavioral health services (mental health/substance use treatment), and to elicit suggestions for improving service reach among LSMM (i.e., implementation strategies). Given that HIV disparities among LSMM are synergistically fueled by behavioral health concerns, we explored factors impacting engagement in both types of services. Accordingly, all LSMM were asked questions about multi-level factors facilitating or impeding their

access to each type of service. In addition, both LSMM and stakeholders were asked about barriers and facilitators for other LSMM in South Florida to access HIV prevention and behavioral health services. Study staff were trained to complete the interviews, which lasted 30–90 min and were conducted in English ($n = 36$), Spanish ($n = 1$), or both ($n = 1$).

Research team

Our research team of seven was diverse with respect to race/ethnicity, gender identity, sexual orientation, training level (e.g., undergraduates/graduate students, postbaccalaureate research staff, faculty), and discipline (psychology, public health). Team members held lesbian, gay, biracial, transgender, queer (LGBTQ)- and Latinx-affirming views. The first author provided team members with ongoing training in qualitative research, study objectives, and LSMM health disparities.

Qualitative analysis

Interviews were audio recorded, transcribed verbatim (in the original language and then translated), and analyzed in NVivo 12 using thematic analysis.[30] The first author's initial review of the data produced a preliminary codebook on which four coders were trained. Two coders independently coded each interview. The first author reviewed for consensus and either applied a final consensus code or facilitated discussion to consensus among coders. Coding meetings allowed coders to discuss codebook interpretations and propose modifications for emerging codes, ensured consistent coding, and/or clarified code meanings. Team members utilized a reflexive approach, drawing on academic, professional, and personal expertise to inform a ''fair'' representation of participants' perspectives.[31]

Upon coding completion, the lead author and a team member sorted codes ($n = 150$) into themes ($n = 16$). Sullivan and colleagues[32] illustrated the applicability of the Consolidated Framework for Implementation Research (CFIR)[33] for distilling a complex, multi-level set of barriers to PrEP uptake in the US South into a synthesized framework. The CFIR is an implementation determinant framework articulating a variety of constructs across five domains (intervention characteristics, outer setting, inner setting, characteristics of individuals, and process) that can impact the degree to which evidence-based interventions are implemented. Themes in the current study aligned with the CFIR, and as such, we present them in a similar manner to Sullivan and colleagues, embedded within the CFIR (Table 1).

Results

Demographics

LSMM ranged from age 18 to 40 years [mean = 28.64, standard deviation (SD) = 5.21]. They identified their race as White (67.9%), multi-racial (25.0%), or indigenous (7.1%). Most identified as gay (82.1%). Participants had high educational attainment, with 64.3% reporting that they had a college or university degree. Although the majority reported their native language was Spanish (57.1%), the majority reported their preferred language as English (89.3%). LSMM were born in the United States, Colombia, Cuba, Ecuador, Jamaica, Panama, Peru, Puerto Rico, and Venezuela.

Key informants reported working with the LSMM community in South Florida for an average of 8.70 years (SD = 8.05). All but one identified as Latinx/Hispanic, with their racial identities being White (60.0%) and multi-racial (40.0%). As with LSMM, key informants' native language was mostly Spanish (70.0%), but most reported their preferred language as English (80.0%). Key informants were born in the United States, Colombia, Cuba, and Venezuela.

Qualitative themes

The 16 themes are described below (identified in italics), which are also presented within the CFIR framework in Table 1 and with illustrative quotations reported in Table 2. Themes emerged in relation to all services.

Intervention characteristics

Complexity. The complexity involved in obtaining HIV prevention and behavioral health services affected LSMM's access. The *burdensomeness versus simplicity of engaging* in services impacted whether LSMM would engage based on factors such as time and paperwork required or clinic hours (Table 2, Q1). Organizations making it simple and convenient to engage (e.g., services on nights and weekends, reduced wait time, remote service delivery) (Q2) were more usable and improved access. Implementation strategies to improve access included enhancing convenience and routinizing HIV testing, PrEP referral, or behavioral health screening when accessing other services so that LSMM need not request them specifically (Q3).

Financial access and insurance complicated LSMM's ability to obtain HIV prevention and behavioral health services. Financial barriers, challenges navigating insurance programs, and difficulty enrolling in and managing cost-reduction programs for services impeded access for many (Q4, Q5). A suggested implementation strategy to address this problem was to reduce patient costs (Q6).

Relative advantage. Relative advantage refers to advantages conferred by engaging in the intervention versus not engaging. Participants explained that LSMM weighed *pros and cons of service use versus nonuse* to guide service utilization decisions. Cons included worrying that PrEP would change sexual behavior, medications would cause harmful side effects, or receiving behavioral health services would be limiting (e.g., job prospects) (Q7). Other participants cited the absence of pros, describing how services had not been or would not currently be helpful (Q8). Perceiving pros to service use—increased enjoyment of one's sex life, reduced anxiety, or trusting in the confidentiality of services—increased likelihood of engagement. Participants recommended implementation strategies such as emphasizing direct benefits of HIV prevention and behavioral health services to prospective LSMM clients through outreach efforts, as well as ensuring all services are safely and confidentially accessible (Q9).

Outer setting

External policy and incentives. Policies and incentives impact the degree to which evidence-based interventions reach intended consumers. Participants explained that the

Table 1. Barriers and Facilitators to HIV Prevention and Behavioral Health Services Among Latino Sexual Minority Men and Corresponding Implementation Strategies

CFIR domain and subdomain	*Barrier/facilitator*	*Implementation strategies*
1. Intervention characteristics		
1.A. Complexity	Burdensomeness vs. simplicity of engaging	Routinize services
	Too burdensome or time-consuming	Streamline administrative processes
	Easier to engage if convenient, simple	Reduce number of visits/time to access services
	Need problem solving skills to access	Offer evening/weekend services
		Offer patient navigation/problem solving
	Financial access and insurance	Reduce consumer costs
	Insurance status and income impact access	Make services free/affordable
	Free/affordable services easier to access	Reduce the complexity of insurance coverage or reduced cost programs
	Insurance and reduced cost programs are complex	
1.B. Relative advantage	Pros and cons of service use vs. nonuse	Emphasize direct benefits of receiving services
	Perceiving services as helpful or effective	Emphasize and ensure confidentiality and safety of services
	Concerns about negative consequences resulting from services (e.g., breach of confidentiality, negative health effects)	
2. Outer setting		
2.A. External policy and incentives	Degree of political will or policy support for services	Create policy and legal changes to enhance access
	Sociopolitical and policy issues affecting service access for LSMM	Increase funding for services
		Offer LSMM incentives for engaging
2.B. Patient needs and resources	Syndemic problems affecting service use	Address transportation issues
	Access to reliable transportation	Be clear about eligibility for services
	Education	Reduce complexity/burdensomeness of services
	Immigration status and competing demands	
	Mental health/substance use	
2.C. Peer pressure	Degree to which service use is stigmatized for LSMM	Normalize and destigmatize LSMM using services through fun, positive, and destigmatizing outreach and messaging
	HIV, PrEP, mental health, and sexual orientation stigma among peers and family	Increase destigmatizing public information and stories about LSMM using services
	Concealing service use and fears of being outed	Use destigmatizing outreach methods and normalize service use for LSMM
	Self-affirmation vs. self-stigma	
	Internalized stigma vs. affirmation about sexual orientation, gender, mental health	
	Services are normalized	Show examples of LSMM peers using services
	Peers are knowledgeable, have positive attitudes, and use services themselves	Hire staff who represent the LSMM community
	Having a peer assist in obtaining services	
	Connectedness to LSMM communities and spaces	Conduct outreach through LSMM community events and spaces
	Being connected to the broader LSMM community	Outreach and public health messaging should appeal to LSMM's community altruism
	Altruistic views toward LSMM community	
3. Inner setting		
3.A. Access to knowledge and information	Provider knowledge about services and interventions	Provide education and training to providers/organizations
	How to deliver services or where to refer	
	LSMM knowledge about HIV, behavioral health, and services	Provide clear, accurate outreach and public health messaging about services
	Where and how to get services	Ensure messaging is pervasive throughout community and public spaces
	Knowledge about service options	Outreach using social/sexual networking sites/apps
3.B. Culture	Identity-based affirmation and fit	Culturally relevant outreach and services (e.g., cultural references, language)
	Feeling affirmed and safe vs. stigmatized or judged by provider	Create an LGBTQ-affirming, nonjudgmental organization and make this stance clear via outreach and public information about the organization
	Cultural relevance of outreach and services	
	Trust, connection, and personalism	Train on personalism and ''customer service'' skills to engage LSMM
	Overly clinical, medical, risk-focused	
	Preference for warmth, trust, personalism	

(*continued*)

Table 1. (Continued)

CFIR domain and subdomain	*Barrier/facilitator*	*Implementation strategies*
3.C. Relative priority	Prioritization of patient needs Provider thoroughness (vs. dismissiveness) Providers initiate discussion about HIV and BH	Train providers on thorough clinical assessments and initiating conversation about HIV prevention and behavioral health services
3.D. Available resources	Organizational resources Degree to which services exist, are not overburdened, and are physically well maintained in a community	Increase funding in ''service deserts''
4. Characteristics of individuals		
4.A. Individual stage of change	Readiness for change LSMM vary along the readiness for change continuum, with those in the precontemplative stage least engaged	Outreach to LSMM who are engaged in other medical services Increase motivation to engage in services (e.g., motivational interviewing)

BH, behavioral health; CFIR, consolidated framework for implementation research; LGBTQ, lesbian, gay, bisexual, transgender, queer; LSMM, Latino sexual minority men; PrEP, preexposure prophylaxis.

degree of political will and policy support for services impacted how accessible they were (Q10). Citywide statements on scaling up HIV prevention and behavioral health services were influential on organizations' willingness to do so, thereby benefiting LSMM (Q11). Recommended implementation strategies included increasing funding for HIV prevention and behavioral health programs and organizations, policy changes to enhance access (e.g., removing parental consent requirements for minors seeking services, removing prescription requirements for PrEP/PEP, requiring insurance companies to cover services), and financially incentivizing engagement in health services (Q12).

Patient needs and resources. Participants described specific needs impacting LSMM's access to services. LSMM's *syndemic problems affected service use*, with mental health and substance use, job insecurity/inflexibility, lack of education, transportation issues, and immigration status converging to worsen their ability to access needed services (Q13). Participants suggested addressing transportation issues as one implementation strategy to enhance LSMM's access to services (Q14).

Peer pressure. Peer pressure includes themes related to peer influences on LSMM's service engagement. Participants explained that the *degree to which service use is stigmatized for LSMM* affected access and engagement. Participants described interpersonal stigma (related to HIV and PrEP, mental health, and sexual orientation), concerns about sexual orientation disclosure through service use, and the need to conceal service use to avoid stigmatization (Q15). Relatedly, LSMM's degree of *self-affirmation versus self-stigma* impacted their comfort with using services; those rejecting stigmatizing interpersonal messages and maintaining higher levels of self-acceptance were more engaged in services (Q16). Participants suggested that outreach efforts and public health messaging about HIV prevention and behavioral health services be fun, positive, and destigmatizing, and that publicizing destigmatizing stories about HIV prevention and behavioral health services would help LSMM overcome service utilization stigma.

Some thought *services were normalized* and modeled within the LSMM community, thus increasing service use (Q17). To leverage this facilitator, participants recommended highlighting examples of LSMM using services in outreach efforts and hiring staff from the LSMM community. LSMM's degree of *connectedness to LSMM communities and spaces* also impacted their engagement in services, with connected LSMM more likely to hear about services and know how to obtain them (Q17). Similarly, LSMM with altruistic views toward the LSMM community and/or sexual partners were more likely to use services. Strategies for improving service uptake based on this theme included conducting outreach through events and community spaces that cater to LSMM (Q19).

Inner setting

Access to knowledge and information. LSMM's access to services was constrained by *provider knowledge about services and interventions*. Several described providers lacking knowledge or information to provide appropriate care or referrals to services, most often in settings not specifically catering to LGBTQ or HIV-affected populations, such as emergency rooms, hospital settings, or private providers (Q20). In addition, *LSMM's knowledge about HIV, behavioral health, and services* was critical to engagement. Many participants only learned of PEP during their interviews, suggesting low overall PEP knowledge, with some LSMM coming from countries where PrEP and PEP were less available (Q21). To overcome knowledge-related barriers, participants suggested widespread advertising in public spaces to reach those less involved in the LSMM community, using social and sexual networking sites for outreach, and using outreach efforts to provide basic education about health and available services, making it clear how to navigate health systems (Q22).

Culture. Organizational culture where LSMM sought services was important in determining access. LSMM sought *identity-based affirmation and fit* with organizations and providers, preferring organizations and providers that were LGBTQ-affirming, nonjudgmental, nonstigmatizing, and

Table 2. Example Quotations Elucidating Themes Consistent with the Consolidated Framework for Implementation Research

CFIR domain and subdomain	*Barrier/facilitator theme*	*Illustrative quotes*
5. Intervention characteristics		
1.A. Complexity	Burdensomeness vs. simplicity of engaging	Q1: ''It was a process [to get PrEP]. There was a lot of documents to be filled out. I did have to go to the clinic about two or three times before so it took a second and there was some paperwork and things to do.'' (White Latinx gay man, early 30s, US born)
		Q2: ''I think just having the resources out in the community to talk to people about it and possibly, you know, write prescriptions [for PrEP] for them on site.'' (White Latinx bisexual man, late 20s, US born)
		Q3: ''We're trying to create a hotline. It's the next thing we're going to be doing. We're gonna have a 24-hour PrEP and PEP hotline and we're gonna have a Facetime with the doctor to write a prescription for someone who needs it right away.'' (Stakeholder, PrEP Navigator)
	Financial access and insurance	Q4: ''The other aspect is insurance too, I mean I do have insurance…but the insurance only covered like thirty percent of the [PrEP] prescription and I was going to have to pay three-hundred dollars out-of-pocket…so I ended up getting a coupon that's worth like two-thousand dollars from the manufacturer…Gilead, but that's one time and once your credit runs out off of that coupon then it's up to you for the rest of the time…so it still is very expensive.'' (White Latinx bisexual man, late 20s, US born)
		Q5: ''Well, in terms of mental health, there is almost no availability of psychological counseling at low cost or free. There are very few places and usually you have to qualify under certain requirements to join the program. Maybe they give you one free visit, but after that, the person isn't able to continue going. Maybe they have no job, or it's too expensive. Another factor that affects all of this is that Miami is expensive. Whether you're Latin-American or not, MSM or not, it's expensive. Even more for Latinos who arrive without documentation, they aren't able to work and they don't speak English, and on top of it—if they're in the community MSM, they're going to feel marginalized.'' (Stakeholder, PrEP Services Coordinator)
		Q6: ''I get that everyone needs to make money. Everyone needs to make a living, but I wish that—I don't know—that some organization or whatever is able to provide those services either for free or at a reduced cost where it's manageable for someone to actually go.'' (White Latinx gay man, mid 20s, US born)
1.B. Relative advantage	Pros and cons of service use vs. nonuse	Q7: With Latin guys specifically, I feel like there was maybe some—a lot of skepticism about it like, first of all, if it even works, right? ''Does it really work?'' I would hear that. Then concern about side effects. Then kind of just this general discomfort around medicine, sort of just the stigma of taking a pill. People feel weird about that. Yeah. With Latino guys, I would say there probably was a lot of skepticism about its effectiveness (Multiracial Latinx gay man, mid 30s, Caribbean born)
		Q8: ''I guess maybe I still wasn't comfortable with the idea of therapy and I was just going through a lot at that time and I didn't realize that therapy was a great way to help with your problems.'' (Indigenous Latinx gay man, mid 20s, South American born)
		Q9: ''I mean, more like, higher discretion is one thing cause they can get the help they need and be discreet about it and like so it's not-like not as to where everyone knows, even what they tell them. I think that helps (White Latinx gay man, mid 20s, US born)
6. Outer setting		
2.A. External policy and incentives	Degree of political will or policy support for services	Q10: ''Once they max out those benefits, we're kind of at a standstill. We're stuck. All of our resources have been exhausted…I mean, we try to provide—if this was an HIV-positive patient and their co-pay cards were maxed out on their HIV medications, we would provide

(*continued*)

TABLE 2. (CONTINUED)

CFIR domain and subdomain	*Barrier/facilitator theme*	*Illustrative quotes*
		them to them at no cost. We're in the process now of incorporating PrEP users into that role, but we haven't fully gotten there yet. We've reached out to upper management and things like that to say, 'Can we provide these services free even though the patient has maxed out on benefits?' We're in the works of getting that done, but that's just our company. What other pharmacy does that, just waives a $300.00 co-pay for Truvada? It's kind of impossible.'' (Stakeholder, PrEP Pharmacist)
		Q11: ''At first, we didn't really promote PrEP very much because the organization felt as though maybe that was encouraging the lack of a condom or lack of using condoms, so we didn't wanna really get into that too much, but we're opening up more for PrEP because we do feel as though the studies and things have shown that there is a correlation between reduced number of new infections with PrEP usage…Maybe the [health department] and their mission [to scale up PrEP] has influenced us to take more responsibility and helping people access that.'' (Stakeholder, Navigator)
		Q12: ''I think if we can work out the—again, for PEP, you have to have an HIV test. Doing all those things might be difficult to put together. It's not unsurmountable. There could be standing orders. You could go take your medication, start taking your medication that won't affect the results of a test. If you realize that the person is positive, having taken suboptimal treatment for a week isn't really gonna affect the treatment long term. I think there are ways of working it out…The fact of the matter is, is that we don't have a good PEP infrastructure. That's what we need to develop first. We can publicize PEP all we want. If people call and can't get access to it, it doesn't do any good.'' (Stakeholder, Sexual Health Education Program Consultant)
2.B. Patient needs and resources	Syndemic problems affecting service use	Q13: I've actually made appointments [for behavioral health services], and I've been there while I'm doing the blood test or whatever. I'll go over to behavioral, ''Hey, let me make an appointment, blah, blah.'' Then I just don't come through…I've done that three times. Two of those times, I consciously said, ''No, fuck it. I'm not going.'' One was just more like transportation and lack of planning rather. I've made an attempt and then, boom, I don't come through because of substance abuse and stuff. (White Latinx bisexual man, mid 30s, Caribbean born)
		Q14: Uber Health—that's something we're initiating here. I think we can do it for PrEP as well, but I know we do it for anybody who tests positive in the field. Basically, it's a service where we offer to the client, and which is no cost to the client—the agency is the one that pays for it—we order them an Uber. We order an Uber to a specific spot…they pick 'em up and drive them to the location…Obviously, let's say they don't have money for a bus or anything like that or don't know how to use the bus…we do all the work for them. All they have to do is be at the specific spot at the exact time, and then they just go into the car and take 'em over…Obviously the driver doesn't know what they're there for 'cause, again, it's Uber Health. It's all HIPAA compliant. (Stakeholder, HIV Testing Counselor)
2.C. Peer pressure	Degree to which service use is stigmatized for LSMM	Q15: Then, also, there's like ''Oh, you're on daily medication because of your sexuality.'' I'm in the closet. My pharmacist can see this. My doctor's gonna see this prescription. Who's gonna come into my house and see this on my bathroom sink?…I take daily medication for my bipolar, but when I have a new friend come over, I'm open about it, but they're gonna come into my room and see three pill bottles and be like, ''Whoa, what's going on?'' (White Latinx gay man, mid 20s, US born)

(*continued*)

TABLE 2. (CONTINUED)

CFIR domain and subdomain	*Barrier/facilitator theme*	*Illustrative quotes*
	Self-affirmation vs. self-stigma	Q16: It's a little different because in Colombia, I—the people that I hang out with, they are, very much, okay with who they are. It's a younger generation where they're like—it's very different. It's this balance of people who wanna, ''throw away the patriarchy,'' but at the same time, they live there. They're very comfortable. They do get discriminated a lot, but they are very comfortable with themselves. I think that helps them out a little bit. It opens up a lot of these talks [about sexual health to get PrEP]. (Multiracial Latinx gay man, mid 20s, South American born)
	Services are normalized	Q17: If you have friends—I think probably one of the best things is if you have a friend that has gone through it and is very open about it and talks about it like it's a normal thing. Especially if they're a person that you respect, that—I think that is actually very powerful because I think a lot of people would look at a person that they respect and then if they say like, ''Oh, yeah. No. I went to therapy, and it was great, and da-da-da, and it helped. I was going through this, but it really helped me.'' I think that might make people think, oh, wow. Maybe I could… I feel like we all kind of start off with that stigma, with that idea in our head. Unless we hear stories or things that make it seem like a thing that isn't all these negative things that we already think about it, then we're just gonna stay with those ideas, those negative ideas. (Multiracial Latinx gay man, mid 30s, Caribbean born)
	Connectedness to LSMM communities and spaces	Q18: Even if you're minorly active in the LGBT community, even if you have two gay friends and that's it, you probably already know about PrEP in my opinion, so it's really getting to those low income areas outside of the LGBT community. (Indigenous Latinx gay man, mid 20s, South American born)
		Q19: For example, today at [local bar], they have [weekly event], which is a very popular event for the Latino gay community. Having a sponsored night there. Have free condoms and educational pamphlets and people there to tell you about why it's important to get tested. Getting really involved in where the community is, I think would be a really powerful way of reaching the people you want to be reaching directly. (White Latinx gay man, mid 20s, US born)
7. Inner setting		
3.A. Access to knowledge and information	Provider knowledge about services and interventions	Q20: There are people who have dropped out of the treatment because private doctors don't follow the every-three-months protocol and they might see them only every six months, and they not only—they only get them tested for HIV, but they don't get them tested for all other diseases, plus kidney functioning—so, when the person already knows that's what they should do, they leave the private doctor until they find another place. Maybe they go straight to someone who knows—that would be a lucky case—usually they lose their health care because of the provider's lack of knowledge. (Stakeholder, PrEP Services Coordinator)
	LSMM knowledge about HIV, behavioral health, and services	Q21: Like I said, in Venezuela, there's no PrEP. That doesn't exist…They only have treatment for HIV-positive people, which in the end, Truvada is part of that treatment, but it's different for prevention. Coming here, I mean, it was through Grindr, but that was something new to me, completely new. I didn't know about PrEP, or what it was, or any of that. (White Latinx gay man, mid 30s, South American born)
		Q22: Um again I known about it [PEP] because a few years before my scare I had been to uh a [Community Health Center C] meeting and they went through it in detail and uh it was a really illuminating uh kind of session for me but um but I think again more kind of uh getting that information out I think and- and as much as there are like those scares for people to know that that is out there is a huge deal. (White Latinx gay man, late 20s, US born)

(*continued*)

TABLE 2. (CONTINUED)

CFIR domain and subdomain	*Barrier/facilitator theme*	*Illustrative quotes*
3.B. Culture	Identity-based affirmation and fit	Q23: [Responding to interviewer question: What would characterize an effective outreach program do you think for new immigrants?] Just letting them know that they're welcome, that they don't have to worry about immigration when they're coming to get health care. That a lot of our Federal Qualified Health Centers have become part of—they're interwoven into the community. They're part of the community. People that live in the area know about them. They have those deeper connections. Something that I've found is really important, again, in reaching Latino men who have sex with men is just those interpersonal connections. They're more likely to go to a place if they hear it from a friend, if they hear it from a family member, a coworker. (Stakeholder, Sexual Health Education Program Consultant)
		Q24: It was a little bit more open [the community clinic compared to their PCP]. It was a little bit more welcoming. There was one in South Beach. I don't recall the name 'cause it was so long ago. There was one in South Beach, and the other one was around that area too, in North Miami. Again, it was very much welcoming, more acceptance. It wasn't so much—I didn't feel ashamed, in a sense. Yeah. That would be the word. (Multiracial Latinx gay man, mid 20s, South American born)
	Trust, connection, and personalism	Q25: I prefer the van because—I don't know. I feel like in the doctor is scarier for some reason. It doesn't feel—like, it's very clinical, you know? You've got the sense that, you know, something that could happen or whatever. If you are in the van, I know that something bad could still happen, but it's just the person that is doing the test with you is more—I don't know, seems to be more down to earth or they are too, like, keep you calm. It doesn't feel, yeah, it's not as scary. I don't know. Maybe because they're with you the whole entire time, like as is being processed and everything. Whereas, like, if you just get your blood drawn, and then it goes to the lab, and then it comes back, and you're having to wait, and all this stuff, and then you have to go back and go over it with the doctor…it's more nerve-racking, I guess. (White Latinx gay man, late 30s, US born)
3.C. Relative priority	Prioritization of patient needs	Q26: Well, the doctor that I just—that I had went to before, so I just recently switched doctors because the doctor I went to before, even if I wanted to go PrEP, she was not willing to—she just didn't think it would be a good idea for me to be on PrEP. Again, she was telling me that it wasn't—maybe that's what happened in my head, too. She was just saying that it wasn't for someone like me because I'm not promiscuous. I don't have many partners. (White Latinx gay man, late 30s, US born)
3.D. Available resources	Organizational resources	Q27: I've been on a waiting list, actually, to start therapy, cognitive behavioral therapy cuz I wanted to try that, but I've been on a waiting list for nine months, now, and I'm still waiting to get into this program. (White Latinx gay man, mid 20s, US born)
		Q28: I think the counselor—again, I don't mean to put more responsibilities on the counselor, but they are the first point of contact. I think definitely counselors should have more time per testing. I think if they have a specific ratio of how many people they should see in a day, it should be less so that they can spend more time with an individual person and be able to do all of this, plus ask them if they're on PrEP and things like that. I think that should be allotted. I don't think they should add more responsibilities. I think, yes, let's add more responsibilities, but let's give them enough time to do that—just FYI, 'cause I don't want to make it seem like we're putting more on them. (Stakeholder, Behavioral Health Therapists)

(*continued*)

TABLE 2. (CONTINUED)

CFIR domain and subdomain	*Barrier/facilitator theme*	*Illustrative quotes*
8. Characteristics of individuals 4.A. Individual stage of change	Readiness for change	Q29: I feel like a lot of Latinos, they don't seek out prevention. They don't think about it. I feel like they get exposed to it if they're actively reached out to, and they really have to try to get to them where they are because they're not gonna really look for it. They're not really looking. They're not really thinking about it. I don't really know why that is…Latino people and health has always been, I think, an issue, especially men. I don't think men, and particularly Latino men, really talk about their health, especially sexual health. They kind of just—it's private. It's my thing. It's whatever. They're not gonna think they have a problem. They're not gonna think of it like that. Why are they gonna search anything out then if they don't think there's a problem? (Multiracial Latinx gay man, mid 30s, Caribbean born)

HIPAA, Health Insurance Portability and Accountability Act; LGBT, lesbian, gay, bisexual, transgender; MSM, men who have sex with men; PCP, primary care provider; PEP, post-exposure prophylaxis.

culturally tailored. Participants recommended implementation strategies such as ensuring culturally relevant outreach efforts (e.g., using cultural references relevant to subgroups of LSMM, ensuring access for immigrant LSMM), communicating affirming and nonjudgmental values through outreach efforts, and ensuring that environments are LGBTQ-affirming, nonstigmatizing, and welcoming of individuals across immigration statuses (Q23, Q24).

Relatedly, LSMM preferred providers and organizations that provided a sense of *trust, connection, and personalism*, over medical, risk-focused, institutional settings (Q25). To address this, participants recommended training providers and staff in customer service skills and personalism, thereby creating warm and welcoming environments.

Relative priority. LSMM's service use often depended on providers and organizations *prioritizing patient needs*. LSMM described providers not initiating discussions about HIV prevention services, dismissing LSMM's concerns about their sexual or behavioral health, and not being thorough, therefore missing opportunities to link LSMM to HIV prevention or behavioral health services (Q26).

Available resources. Clinics and communities sometimes lacked *organizational resources* to meet LSMM's sexual and behavioral health care needs. In some communities, services were unavailable, while in others, organizations offering services were overburdened (Q27, Q28). It was also important that clinics were hygienic, clean, and aesthetically appealing.

Characteristics of individuals

Individual stage of change. LSMM explained a variety of factors related to their *readiness for change*. Low motivation, low perceived risk or need, fatalistic views on health, and low overall engagement in health care deterred service engagement (Q29). LSMM who understood their sexual behavior could lead to HIV acquisition or that their mental health concerns could be addressed through treatment were more likely to engage.

Discussion

This is the first study to the authors' knowledge to systematically document implementation barriers, facilitators, and potential strategies for scaling up and out four different types of needed health care services—PrEP, PEP, HIV testing, and behavioral health—to LSMM in a geographic HIV hotspot. This study further innovates by including the perspectives of stakeholders who work with LSMM, most of whom themselves identified as Latinx and drew on their own lived experience as well as their experience working with LSMM to contribute to the observed themes.

Given the impact of HIV-related syndemics on disparities among LSMM populations,[18] *both* evidence-based HIV prevention and behavioral health service delivery are critical to EHE. Potentially evidencing the syndemic nature of HIV and behavioral health concerns, the observed implementation barriers, facilitators, and strategies for reaching LSMM were shared across all health care service types, suggesting the feasibility of developing implementation strategies that collectively scale up and out combined HIV prevention and behavioral health services to LSMM.

Consistent with the EHE plan,[2] there is an urgent need to develop and test implementation strategies to facilitate equitable delivery of evidence-based HIV prevention services, as well as behavioral health services that address syndemic problems, among LSMM. SMM, including LSMM, initiating and adhering to PrEP will prevent HIV acquisition.[34–37] Similarly, evidence-based mental health and substance use treatments exist and are implemented to varying degrees in clinical practice.[38–44] Our findings suggest culturally relevant implementation strategies that could form the basis for multilevel strategies to improve service reach to LSMM.

Underscoring the need for multi-level implementation research and strategies to enhance the reach of evidence-based services to LSMM, a recent scoping review of racial and ethnic minorities' (REM) participation in HIV treatment and vaccine clinical trials found that in many cases REM individuals are not participating on account of not being informed or invited to participate by the health care workers.[45] As such, implementation strategies must target the systems in which

LSMM are embedded (e.g., health care systems) to enhance reach. Furthermore, interventions must be tailored to LSMM's specific barriers and facilitators. Highlighting this point, a recent study observed that Latinx individuals experience unique barriers to antiretroviral adherence, necessitating culturally tailored interventions to promote adherence.[46]

A potential multi-level, culturally relevant implementation strategy to improve *both* HIV prevention and behavioral health service access could be developed based on the current study's findings that would (1) facilitate LSMM's navigation of complex health systems while reducing system complexity, (2) address LSMM's syndemic problems and structural barriers through referrals to appropriate service providers, (3) leverage peer networks to enhance engagement and reduce stigma, (4) link LSMM to providers who fit with LSMM's preferences (e.g., warmth, affirmation) while also training providers to provide such warmth and affirmation, and (5) build LSMM's readiness for change (e.g., motivation, perceived need) to facilitate engagement while also training stakeholders to assess and intervene upon readiness for change. In turn, implementation research is needed to evaluate the impact of such strategies on the equitable delivery of HIV prevention and behavioral health services to LSMM.[47]

Although new implementation strategies may need to be developed to reach LSMM, prior research has also suggested the utility of adapting existing evidence-based interventions to reach new groups.[48] The Centers for Disease Control and Prevention manages a list of effective interventions aligned with the EHE goals, many of which could potentially be adapted to meet the current implementation challenges impeding LSMM's access to services. For instance, popular opinion leader approaches may be particularly useful for addressing stigma within LSMM communities about HIV prevention and behavioral health, while HIV navigation services—shown to be effective for people living with HIV—could be adapted to improve LSMM's access to HIV prevention and behavioral health services. Addressing the multi-level implementation challenges facing LSMM may also require integrating *and* adapting multiple existing approaches.

The current study is not without limitations. The findings are not generalizable given the limitations of qualitative research, although our findings provide initial insights into implementation barriers and facilitators to LSMM's uptake of services that can be assessed quantitatively. One such quantitative assessment is underway and was informed by the current findings. Although participants largely reported Spanish as their native language, most reported English as their preferred language, and as such, most completed the interview in English. There is therefore a need to expand this work with individuals who are monolingual Spanish speaking or who prefer Spanish, as there are likely differences in this population's experiences of accessing health care services.

In addition, we did not stratify our qualitative analyses by participant type (i.e., LSMM vs. stakeholder or US- vs. foreign-born LSMM) because participants were asked to comment on both their own (for LSMM) and other LSMM's (for LSMM and stakeholders) barriers and facilitators to service use, as well as suggestions for enhancing the reach for services. However, our subsequent quantitative analyses will be able to stratify by nativity, immigration status, and/or acculturation, better informing the need for tailored implementation strategies across subpopulations of LSMM.

This study documented implementation barriers and facilitators of PrEP, PEP, HIV testing, and behavioral health services in Latino MSM. The inclusion of LSMM of varying nativity and service-engagement levels, as well as stakeholders, provides a rich array of themes that we can further test in subsequent quantitative studies. Moreover, the findings underscore the complexity of factors that impact LSMM's access to HIV prevention and behavioral health services. As such, this study clarifies the need for multi-level implementation strategies to achieve the goals of *EHE* for LSMM, which then need to be rigorously evaluated for their impact on achieving health equity.

Authors' Contributions

Conceptualization (A.H.), data curation (A.H., D.M., and R.S.A.), formal analysis (A.H., S.S., D.M., and R.S.A.), funding acquisition (A.H. and S.S.), investigation (A.H., D.M., R.S.A., and S.S.), methodology (A.H., G.P., and S.S.), project administration (A.H., D.M., and R.S.A.), supervision (A.H., G.P., and S.A.S.), writing—original draft (A.H. and S.S.), and writing—review and editing (A.H., S.S., B.G.R., G.P., and S.A.S.).

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