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Latinx Sexual Minority Men's Access to HIV and Behavioral Health Services in South Florida During COVID-19: A Qualitative Study of Barriers, Facilitators, and Innovations

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Abstract

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Author Contributions

A. Harkness was responsible for conceptualizing the study, creating a plan for data collection, overseeing formal analysis of the data, developing the methodology, providing supervision to team members, writing the original draft, and reviewing and editing the draft. E. R. Weinstein was responsible for data curation, formal analysis, co-designing the qualitative interview guide, writing the original draft, and reviewing and editing drafts. P. Atuluru was involved in data curation, formal analysis, and reviewing the manuscript draft. D. Mayo was involved in data curation, formal analysis, and reviewing the manuscript draft. R. Vidal was involved in data curation, formal analysis, and reviewing the manuscript draft. C. E. Rodríguez-Díaz provided mentorship and supervision to the first author and team regarding the overall conceptualization of the study and interpretation of the data, as well as reviewing and editing the manuscript. S. A. Safren provided mentorship and supervision to the first author regarding the overall conceptualization of the study and interpretation of the data, as well as reviewing and editing the manuscript.

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Despite the availability of HIV prevention and treatment tools, HIV disparities continue to impact Latinx sexual minority men (LSMM). Behavioral health concerns further exacerbate HIV disparities among LSMM. This study used rapid qualitative analysis to understand factors influencing LSMM's access to HIV and behavioral health services during coronavirus disease 2019 (COVID-19). Participants included LSMM with (n = 10) and without HIV (n = 10). The analysis identified 15 themes. Themes revealed that LSMMs' access was disrupted by new and worsening barriers resulting from COVID-19, such as anxiety about COVID-19 exposure, confusion and disruptions to services, and new structural challenges. Other themes highlight positive changes, such as telehealth and relaxed clinic protocols, which enhanced LSMMs' access to services during COVID-19. The findings suggest the need for HIV and behavioral health clinics to innovate and to ensure LSMMs' continued access to services during and beyond COVID-19.

Keywords

behavioral health; health disparities; HIV; Latinx sexual minority men; rapid qualitative analysis

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Coronavirus disease 2019 (COVID-19) has disrupted many facets of life for individuals throughout the world, with disproportionate medical and psychosocial impacts on racial and ethnic minority communities as well as sexual and gender minority communities (Bishop, 2020; Hooper et al., 2020; Rodriguez-Diaz et al., 2020). For instance, COVID-19 mitigation measures have led Latinx sexual minority men (LSMM) to experience worsened mental health and substance use concerns (Harkness et al., 2020, 2021). Some LSMM are also experiencing worsened minority stress experiences during the COVID-19 pandemic, as well as new forms of stigma related to COVID-19 and being a member of the LSMM community (Harkness, Weinstein, Atuluru, et al., 2021).

Over the years leading up to the emergence of the COVID-19 pandemic, HIV prevention and treatment tools, including pre-exposure prophylaxis (PrEP) and rapid antiretroviral treatment (ART), have led to decreases in or stabilization of HIV incidence among gay, bisexual, and other men who have sex with men (MSM) in the United States (U.S.; Centers for Disease Control and Prevention, 2020). However, the benefits of these tools have not equally reached all subgroups of sexual minority men (SMM). For instance, LSMM continue to experience increasing HIV incidence, while non-Latinx White SMM have shown a decreased incidence (Centers for Disease Control and Prevention, 2020). In addition to disparities in HIV incidence, Latinx people face HIV treatment disparities, including lower ART adherence and viral suppression, compared to non-Latinx White MSM, differences that are frequently attributed to the social determinants of health (Buchacz et al., 2018; Friedman et al., 2015; Martinez et al., 2020). Accordingly, the U.S. *Ending the HIV Epidemic* plan, established prior to the emergence of COVID-19, aims to ensure the equitable dissemination of HIV prevention and treatment tools to communities most impacted by HIV, including LSMM (Fauci et al., 2019).

In addition to these pre-COVID-19 HIV disparities, LSMM also experienced mental health, substance use, and structural challenges prior to COVID-19, forming a "syndemic," which refers to when multiple epidemics that are rooted in social inequities synergistically worsen

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one another, creating an even greater disease burden (Martinez et al., 2016). Syndemics research among LSMM has shown that, as the presence of "synergistic epidemics" or "syndemics" (e.g., depression, alcohol/substance use, discrimination, childhood sexual abuse, intimate partner violence, incarceration, unstable housing, poverty) increases, LSMM are more likely to engage in sexual behavior that can lead to HIV acquisition, and report lower PrEP adherence (Blashill et al., 2019; Martinez et al., 2016). Similarly, among SMM living with HIV, a greater number of syndemic indicators is associated with poorer ART adherence and higher viral load (Harkness et al., 2018). As such, there was a pre-COVID-19 need to scale up and disseminate behavioral health services to LSMM, a need that is potentially greater during the COVID-19 pandemic and its aftermath.

The ways in which the COVID-19 pandemic has affected general and LSMM-specific HIV and behavioral health service delivery is only beginning to be clarified. Disruptions such as clinic closures, changes to transportation services, unemployment, and inconsistent internet access may reduce access to HIV prevention and treatment (Sanchez et al., 2020; Shiau et al., 2020). The shift to telehealth may present new difficulties for HIV prevention and treatment, such as access-related issues and/or privacy and security concerns (Dorsey & Topol, 2016; Raine et al., 2016). However, it is also likely that COVID-19 has led to service delivery innovations that may enhance access to HIV and behavioral health services for LSMM. For example, many HIV and behavioral health clinics and health care providers moved their delivery models to virtual platforms, capitalizing on the benefits of telehealth (Rogers et al., 2020; Saifu et al., 2012). Identifying these innovations may reveal strategies that could continue to be invested in beyond the immediate COVID-19 crisis to help achieve *Ending the HIV Epidemic* goals.

As such, the current rapid qualitative study sought to identify barriers and facilitators to LSMM accessing HIV prevention (PrEP, PEP, HIV testing), HIV treatment (HIV care and ART), and behavioral health services (mental health/substance use) during the COVID-19 pandemic in South Florida. The findings may inform policy, practice, and research regarding the development and implementation of innovative approaches to meet LSMMs' HIV and behavioral health needs during and beyond COVID-19.

Methods

Study Design

Participants completed one-time interviews regarding their experiences of COVID-19 in three major domains: sexual behavior, stress/coping, and access to health care services. The last domain, access to health care services (namely, HIV-related and behavioral health services), was the focus of the current analysis. The domains in the interview guide were selected based on the primary areas of the lead author's ongoing research with LSMM in the greater Miami area (Harkness et al., in press), which evaluates LSMMs' sexual behavior/sexual health needs, behavioral health needs, and use of HIV prevention and behavioral health services. When COVID-19 emerged as a major public health threat, it became apparent that COVID-19 was potentially impacting all three areas. This motivated the lead author to develop a measure of COVID-19–related stress and behavior changes that showed, quantitatively, the major impacts of COVID-19 on LSMM (Harkness et al., 2020, 2021).

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Although this quantitative work was a useful starting point, it was apparent that LSMMs' experiences of the COVID-19 pandemic were likely more complex than the quantitative data could capture, leading our team to develop a rapid qualitative study that explored the impacts of COVID-19 on LSMM. At that point, we (first and second authors) developed an interview guide to explore LSMMs' sexual behavior, stress/coping, and access to health care services during COVID-19. The interview guide included both "core questions" and follow up prompts to facilitate equitable probing across interviewers.

Participants and Procedures

Participants included 20 LSMM (determined based on thematic saturation, described in the following section) living in South Florida. Participants were recruited from one of two parent studies, both of which were observational and sought participants' permission to be contacted for future studies. LSMM without HIV ($n = 10$) were recruited from the *DÍMELO* study, which is an ongoing longitudinal cohort study (Harkness et al., 2021). This observational study is examining LSMMs' engagement in HIV prevention and behavioral health services and potential predictors of service use (e.g., individual, interpersonal, and structural factors that could facilitate or impede use of services). LSMM living with HIV ($n = 10$) were also recruited from a different parent study, the *CHARM Community Survey.* This is a one-time survey to assess the needs and resources of individuals affected by HIV in the South Florida area and to build a "consent to contact" database of individuals willing to participate in future HIV-related research. Individuals from both studies who had provided their consent to be contacted for future studies were invited to participate in the current qualitative study. We purposively recruited for equitable representation by nativity (U.S.-born and non-U.S.-born) and HIV status. Eligible participants self-reported (1) identifying as gay, bisexual, or a man who has sex with men, (2) Latinx/Hispanic ethnicity, (3) living with HIV or not living with HIV, (4) living in South Florida, (5) being between the ages of 18 and 60 years, and (6) speaking English and/or Spanish. Those eligible were scheduled for an interview and remunerated $25. The study was conducted in Miami, Florida. The University of Miami Institutional Review Board (IRB) approved the study.

Research Team

Our team of seven interviewers was diverse with respect to race and ethnicity, gender identity, and sexual orientation, as well as professional experience and training (e.g., undergraduate, masters, and doctoral students, faculty, and volunteers in psychology, public health, medicine). All team members hold sexual and gender minority (SGM) and Latinx-affirming views.

The lead author provided an initial training in qualitative research and study objectives. Interviewer training included a structured workshop on general interview skills as well as implementing the interview guide for the current study. Training covered how and when to probe, both in general for qualitative research and in accordance with the semistructured interview guide designed specifically for this study. Data reduction (described below) and qualitative analysis training involved an overview of the rapid qualitative approach, as well as skills-based training in applying this approach (e.g., practice with feedback). Weekly

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meetings (approximately 1 hour) throughout data collection and analysis reinforced the training and involved interview supervision and analysis review.

Data Collection

Participants provided informed consent before beginning data collection. Following our IRB approved consent protocol, participants first viewed information about study procedures, potential risks/benefits, voluntariness, right to withdraw, study/IRB contact information before indicating their consent by checking, "Yes, I consent to participate." After consenting, participants proceeded to the pre-interview demographic survey and then the interview. Interviews were completed between June 11, 2020 and August 6, 2020. On average, interviews lasted 54 minutes (range 24–90 minutes). Participants completed semi-structured interviews with trained study staff in English ($n = 17$) or Spanish ($n = 3$).

Qualitative Analysis

Rapid qualitative analysis is an approach that was originally designed for implementation science research and is used in situations in which there is a need to rapidly collect, interpret, and use qualitative research findings to inform clinical practice (Hamilton & Finley, 2019). This method has been described both in peer-reviewed publication (Hamilton & Finley, 2019) and in a recorded tutorial on how to implement the method (Hamilton, 2013). Upon consultation with the Center for HIV and Research in Mental Health's (CHARM's) experts in qualitative analysis, rapid qualitative analysis was selected as the best approach for the current study to meet the urgent need to understand how COVID-19 was affecting LSMMs' engagement in health care services, mental health, and sexual behavior. This is because this approach balances rigor with efficiency; in previous research, it was found that there are equitable findings using rapid qualitative when compared to a lengthier thematic analysis process (Taylor et al., 2018). As such, we chose to follow Hamilton's (2013, 2019) guidelines for a rigorous qualitative approach.

Hamilton's guidelines for rapid qualitative research are to first engage in a process of "data reduction," which involves creating interview summaries based on the content of the interviews. As described by Hamilton, interview summaries are *non-interpretive*; they are meant to reduce the large amount of data captured in the context of a qualitative interview to a one- to two-page written summary. Following this guidance, the lead author created an interview summary document, which allowed research team members to summarize key points from interview recordings as well as quotations into one brief, structured document. Quotations were the only portion of the interviews that were transcribed, with quotations in Spanish translated— and audited—by two bilingual/bicultural team members prior to being included in the final structured document. The lead author also adapted, for the purpose of the current study, Hamilton's "interview summary document guidelines" to explain to research team members how to complete these summaries; these guidelines were also verbally reinforced in our ongoing team meetings. The process for completing interview summary documents was as follows: (1) the interviewer completed an original interview summary document, (2) a second team member audited the interview summary document, and (3) the lead author completed a final audit of the interview summary document, allowing for iterative feedback to research team members and checking for consistency across team

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members. The number of audits went beyond Hamilton's guidelines to further enhance the rigor (i.e., credibility and dependability) of our approach.

The next step in Hamilton's rapid qualitative analysis is to transfer the reduced data from the interview summary documents to a matrix. Through this process, data from each summary were extracted and placed into the matrix to analyze the breadth and depth of each domain (e.g., behavioral health services) and subdomain (e.g., barriers, facilitators; Averill, 2002; Miles et al., 2014). Using a matrix allows analysts to view all data across participants in relation to a particular domain (e.g., use of behavioral health services), instead of viewing all data from one participant across all domains. This is advantageous for identifying emerging themes within a specific domain. As such, a team of three analysts was then trained to view the matrices and independently (to enhance rigor, i.e., dependability, and confirmability) identify themes that emerged within each domain. After the analysts identified emergent themes from the first 10 interviews, we met as a team to review the consensus of the themes that they identified and discuss areas of non-consensus. This analytic team then repeated the process to identify emerging themes across three additional "batches" of participant data. To document that we had reached thematic saturation (Guest et al., 2016), we tracked the number of themes that emerged in each of the four rounds of thematic analysis. For the health services themes, we found that the vast majority of themes emerged in the first round of analysis, with two additional themes emerging in the second, and no additional themes emerging in the third or fourth rounds of analysis, suggesting we had reached thematic saturation by the second round of analysis. The final themes were then presented to the full team for cross-checking (Patton, 1999).

Issues of "trustworthiness" that were relevant to the current project included credibility (i.e., rigorousness), transferability (i.e., ability to transfer findings of a study to a new context), dependability (i.e., replicable approach), and confirmability (i.e., the subjectivity of the researchers; Morrow, 2005). To enhance trustworthiness, as previously described, we utilized a rigorous, yet efficient, established qualitative approach and clearly defined the steps for applying it, both internally and in reporting the findings. We also, as a team, are conducting ongoing community-engaged research (including clinical research) with LSMM in various contexts, facilitating prolonged engagement with the local LSMM population. We also used co-analysis (i.e., multiple team members contributed to interview summary documents and theme identification) to enhance the trustworthiness of the findings. Team members engaged in reflexive practice during ongoing meetings, for example, exploring how one's own cultural context and experiences may inform interpretations of the data to further enhance the trustworthiness of the analysis.

Results

Participant Demographics

Participants ranged in age from 19 to 57 years old ($M = 32.70$, $SD = 12.21$). Nearly all participants identified as White Latinx (90%), with the rest identifying as Black Latinx (10%). More than half (55%) of the participants were born outside of the United States (Brazil, Cuba, Honduras, Venezuela), as well as individuals born in Puerto Rico. On average, non-U.S.-born participants had lived in the United States for approximately 11

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years. The largest subgroups of participants were U.S. citizens (80%), college educated (60%), and had an income of $2,000 or more per month (65%). Complete demographics are reported elsewhere (Harkness, Weinstein, Atuluru, et al., 2021). Few participants reported using behavioral health services during COVID-19 ($n = 6$, 30%). Participants without HIV reported no to low engagement in HIV testing ($n = 3$, 30%), PrEP ($n = 3$, 30%), and PEP ($n = 0$, 0%) during COVID-19. In contrast, all participants living with HIV ($n = 10$) engaged in both HIV care and ART services during COVID-19.

Qualitative Findings

Analyses revealed 15 themes grouped, by consensus, into six categories: (1) COVID-19 safety and precautions in health care settings, (2) perceived need for services, (3) knowledge of how and where to get services during COVID-19, (4) trust and confidence in health care providers, (5) structural issues (e.g., financial, language barriers), and (6) service delivery models. Each category, and the themes included in each (denoted in italics), are described in the next section, with quotations to elucidate the themes. Complete results are presented in Table 1.

COVID Safety and Precautions in Health Care Settings

Participants expressed *fear of exposure to COVID-19 or spreading COVID-19* while seeking HIV and behavioral health services. Participants described performing cost-benefit analyses to determine whether potential COVID-19 exposure was worth seeking services. One participant explained,

> Just thinking about going to like a health environment or clinic during COVID, that would give me anxiety. I wouldn't go honestly. And that creates a snowball because you're having sex during quarantine, not being able to get [HIV] tested, worried about your [HIV] status. (White Latinx gay man without HIV, late teens, non-U.S.-born).

Fear of COVID-19 exposure frequently came up as a concern for HIV prevention but less for HIV treatment, suggesting this may function as more of a barrier for prevention than treatment.

Participants described the need for health care settings to have *COVID-19 safety measures in place* to feel comfortable getting services. LSMM wanted to know that clinics were following a COVID-19 safety protocol, including masking and social distancing, reducing the number of people in health care settings, requiring appointments instead of drop-in services, seating clients in ventilated locations, providing hand sanitizer, and reducing the time clients needed to be inside the clinic.

Perceived Need for Services

Some LSMM did not seek services due to a *low perceived need* during COVID-19. For instance, some felt that, despite increased anxiety related to COVID-19, their concerns did not rise to the level of needing behavioral health services. Some LSMM reduced their sexual behavior during COVID-19 and did not feel the need to seek HIV prevention services.

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Participants' desire to avoid exposure to COVID-19 interacted with lack of perceived need and resulted in HIV testing delays,

> It's something that I know I'm going to do. However, I'm not in a hurry to do so, and if it wasn't the pandemic I could get a sooner appointment or just walk into the lab, and this time I want to do that, I just want to schedule the appointment regardless of the time because I know I'm not in a hurry to get tested. I need to but I'm not in a hurry. (White Latinx gay man without HIV, mid 20s, non-U.S.-born)

Participants with a *high perceived need* for services were more inclined to seek them out, despite potential COVID-19 exposure. Some experienced worsened mental health concerns due to COVID-19, resulting in an increased perceived need for behavioral health services, "I knew I needed it more than ever, and all this stress and symptoms like heart racing, I didn't know what was going on, so I needed to get checked by a doctor," (White Latinx gay man without HIV, late 20s, U.S.-born). LSMM also described a commitment to their health care, including routine HIV testing (for those without HIV) or labs (for those living with HIV), viewing PrEP as an important part of their health regardless of their sexual activity, and describing a commitment to maintaining their ART regimen during COVID-19. This was summarized by one participant describing his ongoing engagement in HIV care, "My health is paramount, and COVID won't change that," (White Latinx gay man living with HIV, mid 50s, U.S.-born).

Knowledge of How and Where to Get Services During COVID-19

The degree to which LSMM knew where and how to access services during COVID-19 impacted their use of those services. Those with a *lack of knowledge about where or how to get services during COVID-19* were confused about which organizations were offering services during COVID-19. They explained that, for LSMM, especially those who immigrated or were new to Miami, lack of knowledge about where to get services was a critical factor in general, worsened by COVID-19, "Most of us haven't been here as long. So, you don't know the city or the resources available to you," (White Latinx gay man without HIV, mid 20s, non-U.S.-born). Clinic closures and reductions in services made it harder to get PrEP, even for those who were already on PrEP before COVID-19, with one participant feeling "…more uncertainty in the sense of like, 'Well, if my primary form of getting PrEP is closed, are they still going to help me out to get my PrEP?'" (White Latinx gay man without HIV, mid 20s, non-U.S.-born).

Participants observed that *COVID-19 caused disruptions to usual service delivery*, creating confusion about how and where to get HIV and behavioral health services even for those who were generally knowledgeable. One participant tried to begin behavioral health services, but was unable,

> I basically just got the numbers for a couple places and some of them were just like "well, leave a message" and one of them was fully disconnected so that was very discouraging of keeping that search. So basically, what I've done is leave messages and hope to get a response from the place. (White Latinx gay man without HIV, mid 20s, non-U.S.-born)

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Another explained, "The coronavirus has shaken up the whole system, so for minorities, it really affected getting services," (White Latinx gay man living with HIV, late 20s, non-U.S.-born). Another, accustomed to walk-in HIV care, found out his clinic no longer offered this option, disrupting his knowledge of where to access to care.

Participants felt that *access to information and support in navigating the health care system* during COVID-19 would be helpful. For example, one participant indicated that it would have been helpful to receive communication from behavioral health clinics, "Like an email saying, 'Hey, we're still open, taking appointments…If you have questions about appointments, we're here to help you. We're still open, we're here for you guys," (Black Latinx bisexual man without HIV, early 20s, U.S.-born). Another underscored the importance of communicating effectively to LSMM regarding where to get HIV testing, "Getting the right information for the resources where they can get those services, because if you don't know where to go or if it's actually available to you, won't go or use it," (White Latinx gay man without HIV, mid 20s, non-U.S.-born).

Some LSM who *continued engaging in services from before COVID-19* found it easier to continue services, as opposed to initiating services, during COVID-19 due to already having established a health care provider, having access to medications, or knowing how to navigate the medical system. For instance, one participant ran out of his ART medication during COVID-19, but "luckily, I had backups" (White Latinx gay man living with HIV, late 20s, non-U.S.-born) due to previous engagement in care. Another explained, "A lot of practices aren't accepting new patients right now," (White Latinx gay man living with HIV, mid 20s, U.S.-born), underscoring the difficulty for LSMM to initiate behavioral health services during the pandemic.

Trust and Confidence in Health Care Providers

LSMM described needing to trust and have confidence in service organizations and delivery models to obtain services. Participants described *privacy concerns* with respect to remote service delivery. One participant explained that having PrEP delivered to his home could mitigate COVID-19 exposure but would introduce privacy concerns, "Let's say you get medication delivered to your home, it would have to be a very hush hush thing because you don't want your family, or your neighbors, or your friends to know about it because some people are very secretive about it," (White Latinx gay man without HIV, late teens, non-U.S.-born). Some also expressed *discomfort with telehealth*, specifically for behavioral health services,

> I didn't want my first session to be online…I knew that most of the therapy would be online [during COVID-19], and I wanted to have some connection first. I wouldn't mind doing it online, but I would like to know the person first. (White Latinx gay man without HIV, mid 20s, non-U.S.-born)

LSMM described the continued importance of trust and affirmation when seeking HIV and behavioral health services during COVID-19. Foremost, many described preferring to seek health care services from *LGBTQ affirming, culturally relevant, trustworthy, and warm providers and organizations.* One participant normally accessed an LGBTQ-affirming organization but was unable to get tested in his preferred location due to COVID-19, "[Name

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masked for anonymity] is closed right now, so if I wanted to get tested in a very specific place, that would be an issue," (White Latinx gay man without HIV, early 20s, U.S.-born). Another described how COVID-19 detracted from the warmth of the organization where he gets HIV testing, "Just the way the whole place was set up, it was full with plastic covers and things like that, just basically signs to not sit in places. So, it was just…it feels very clinical and very unwelcoming," (White Latinx gay man without HIV, mid 20s, non-U.S.-born). Another explained that despite his HIV health care provider's transition to telehealth, provider warmth remained important in facilitating his care, "The way she treats me on the call and makes me feel like we are connected even though we are on video, it made me feel more comfortable in the idea of telehealth," (White Latinx gay man living with HIV, early 30s, U.S.-born).

Structural Issues

Although *structural issues* are always a barrier to health care services, participants described worsening structural issues impeding LSMMs' access during COVID-19. For example, the financial impact of COVID-19 reduced LSMMs' PrEP access,

> We're all having some financial challenges and that may be affecting the access to health care and if you don't have access to health maybe you cannot get all the tests you need in order for you to get PrEP…Especially for the Latino population, it's a minority. We face some extra challenges regarding the work environment, the language environment, and all of that. (White Latinx gay man without HIV, mid 20s, non-U.S.-born)

Another described problems during COVID-19 with insurance coverage and payment for behavioral health services, "I'm more stressed about payment and not really understanding how that's going to work for the copay," (White Latinx gay man living with HIV, mid 20s, U.S.-born). Some observed *changes that can address structural barriers* and enhance access for LSMM. The most prominent example was that Miami-Dade County made public transportation free during COVID-19, which could address transportation as a structural barrier to services for LSMM during and beyond COVID-19.

Service Delivery Models

Changes in service delivery models impacted LSMM's engagement in services during COVID-19. Participants explained that *remote service delivery options may facilitate LSMMs' access* to HIV and behavioral health services during COVID-19 and beyond. They appreciated the ease and safety (from COVID-19) of telehealth. Participants also appreciated being delivered HIV testing kits, PrEP, and ART during COVID-19, allowing them to easily access services while avoiding COVID-19 exposure. One participant explained that he would not have received HIV testing during COVID-19 had it not been for a PrEP delivery service that included HIV testing, "I would definitely not be getting tested if I didn't have these in-house kits," (White Latinx gay man without HIV, late teens, non-U.S.-born). Another appreciated that clinics began sending HIV testing kits to clients instead of requiring in-person visits, "The only one [positive change] I can think of is the agencies that didn't allow it before sending it home so people can do it from their houses," (White Latinx

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gay man without HIV, mid 20s, non-U.S.-born). Others were more open to remote service delivery as a result of COVID-19,

> "I feel with the desperation of it, the feeling like there is not available to you, it makes people more open to trying new things. I don't know if before quarantine I would've had accepted this completely disconnected [PrEP] service that's just depending on me to do it right. I don't know if I would love having these home test kits before quarantine. (White Latinx gay man without HIV, late teens, non-U.S.-born)

Another appreciated the reduced burden of remote HIV care, which was not available through his clinic before the pandemic, "I didn't have to travel an hour and a half to have a 15-minute appointment," (White Latinx gay man living with HIV, mid 20s, U.S.-born). Participants also found it helpful that organizations were *relaxing and adapting protocols to enhance service delivery* during COVID-19. For example, participants appreciated receiving 90-day instead of 30-day ART medication refills, which organizations were providing to prevent potential treatment gaps during COVID-19.

Discussion

With the emergence of COVID-19, LSMM experienced worsened and new barriers to accessing HIV and behavioral health services, such as anxiety about COVID-19 exposure, confusion about where to get services, and increased difficulty with service access. Despite these new barriers, some LSMM described how health care providers and clinics developed strategies to facilitate LSMMs' access to needed services, with some of these strategies potentially informing innovative health care practice to ensure LSMMs' access to services after COVID-19.

The current study suggests that, for many LSMM, COVID-19 worsened some barriers to health care services that existed before COVID-19. For instance, lack of knowledge about where to get HIV and behavioral health services was a barrier before COVID-19 (Horridge et al., 2019) but was worsened by COVID-19 due to agencies changing their operations or closing. Before the pandemic, lack of perceived need for HIV and behavioral health services was a barrier to getting these services (Horridge et al., 2019). In the context of COVID-19, LSMM are evaluating their perceived need for services against the risk of acquiring COVID-19 if seeking in-person care, creating worsened barriers. Additionally, although the importance of LGBTQ- affirming, culturally relevant HIV and behavioral health services for LSMM is established, accessing such services may be made more difficult during COVID-19 if clinics that LSMM trust are closed or less accessible. This underscores the importance of maintaining COVID-19 safety and LGBTQ-affirming, culturally relevant programming to ensure LSMMs' continued access.

LSMM also described factors that would make them feel more comfortable accessing HIV and behavioral health services during COVID-19. Although these factors may be particularly useful for clinics to attend to during COVID-19 to ensure continued access for LSMM, some may be useful to continue beyond COVID-19. LSMM felt it was important for clinics to provide clear information and guidance on accessing HIV and behavioral health

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services during COVID-19 because of disruptions to services. This type of communication and guidance from health care organizations can help to ensure that those who may be least likely to access needed HIV and behavioral health services are effectively guided through this difficult process (Carnevale et al., 2020; Marcus et al., 2016; Pinto et al., 2018). Adopting such measures would be consistent with previous recommendations of enhancing communication and patient navigation to engage LSMM in HIV and behavioral health services during *and* after the immediate impacts of COVID-19. Many participants felt that remote service delivery options could enhance LSMMs' access to HIV and behavioral health services, mitigating transportation, financial, and other structural barriers. At the same time, some expressed privacy concerns and discomfort with telehealth, especially for behavioral health services. Others expressed financial concerns related to remote service delivery, including confusion about whether their insurance would cover telehealth or delivery of larger quantities of medication. As clinics adapt to COVID-19, it will be important to leverage opportunities to innovate health care delivery models (e.g., offering remote service delivery), while also addressing the new barriers to care that may emerge as these innovations are rolled out.

As articulated by the *Ending the HIV Epidemic* plan, there is a need to rapidly scale up and disseminate evidence-based HIV services to those who stand to benefit the most but have, to date, been underreached. COVID-19 has brought on unprecedented opportunities for HIV and behavioral health organizations to rapidly implement new policies, programs, and service delivery methods. As changes are implemented, there is a need to develop implementation strategies to ensure that those most in need of services are reached. The Consolidated Framework for Implementation Research (CFIR) articulates factors that can facilitate or impede implementation of new innovations, such as remote service delivery, in health care settings (Damschroder et al., 2009). For example, the degree of complexity and cost of new innovations, such as remote service delivery, can impact implementation. Patients' needs and resources must be considered, and external policies must be in place to ensure effective rollout and maintenance. The current study suggests that each of these factors from the CFIR framework likely played a role in LSMMs' access to HIV and behavioral health services as clinics innovated in response to COVID-19 through developing remote service delivery options, relaxed protocols and policies to promote retention in care, and sought to find ways to continue reaching LSMM. As new innovations are rolled out in response to COVID-19, implementation strategies such as conducting ongoing training, creating learning collaboratives, developing detailed workflows, providing centralized technical assistance across clinics, altering client fees, and assessing LSMM consumers' needs may help to overcome these implementation challenges (Powell et al., 2015).

Along with the strengths and implications of the current study, we note its limitations. Although the participant demographics and sample size followed established guidelines (Guest et al., 2016), we appreciate the limitations of rapid qualitative research, foremost the lack of generalizability of the findings to broader contexts, which is a limitation with all qualitative research (Morrow, 2005). Our use of rapid qualitative analysis balanced rigor with efficiency, in response to an emergent public health crisis. Although it is possible that a more traditional and lengthier qualitative approach may have been more rigorous, previous

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research has shown that rapid qualitative research yields equitable findings compared to thematic analysis, a widely used and rigorous qualitative method (Taylor et al., 2018). Additionally, findings are based on LSMMs' perspectives, not the perspectives of those delivering HIV and behavioral health services. Future research should examine health care providers' perspectives, soliciting feedback from HIV test counselors, PrEP/PEP navigators, nursing and other medical providers, behavioral health providers, as well as administrative and leadership staff. Such research will help to further inform next steps for ensuring effective implementation of innovative HIV and behavioral health service delivery models in the context of COVID-19, and beyond, to address HIV and behavioral health disparities affecting LSMM.

In summary, the current study found that LSMM in South Florida, a location that has been both an HIV and COVID-19 epicenter, experienced anxiety about COVID-19 exposure, confusion about where and how to access HIV and behavioral health services during COVID-19, and reduced access to services during COVID-19. At the same time, some LSMM felt that provider and clinic adaptations, in response to COVID-19, such as remote service delivery and protocol flexibility, promoted access for LSMM. To achieve the goals of the *Ending the HIV Epidemic* initiative, it is essential to maintain momentum toward its goals of scaling up and disseminating HIV-related services to those most impacted by the HIV epidemic, including LSMM, during and beyond COVID-19. Therefore, the findings from the current study highlight the need for policy and practice changes that reflect the emerging needs of LSMM in the context of COVID-19.

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Key Considerations

- Overall, Latinx sexual minority men are facing new and worsening challenges in obtaining HIV-related and behavioral health care services in the context of COVID-19.
- Providers can respond to the identified barriers to improve access to services for Latinx sexual minority men during and beyond COVID-19 by providing clear and easy to access information about their services, offering patient navigation, and offering a range of service delivery options (e.g., telehealth, remote services, in-person with COVID-19 safety precautions).
- Despite the documented barriers, health care providers and organizations are also innovating in response to COVID-19, efforts that should receive continued investment to improve access for Latinx sexual minority men.

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Table 1.

Barriers and Facilitators to Health Care Access During COVID-19 With Example Quotations

Categories/Themes	BH	Test	PrEP	PEP	HIV Care	ART	Example Quotation
1. COVID-19 Safety and Precautions in Health Care Settings							
Fear of COVID-19 exposure or transmission to others	X	X	X	X	X		*I think contact with others is affecting going to get HIV tests. Seeing a doctor implies you will be exposed to contact with a lot more people, which is the fear. This fear has made people not go to clinics, be more afraid of testing, they are waiting for things to pass, like me, to get their tests done.* White Latinx gay man without HIV, late 30s, non-U.S.-born
COVID-19 safety measures are in place	X	X	X		X		*It would have to be something similar to what my job is doing - a controlled environment so that there is a limited amount of exposure…then I think that would make me feel extremely comfortable.* White Latinx gay man living with HIV, early 30s, U.S.-born
2. Perceived Need for Services							
Lack of perceived need for services	X	X	X	X			*You know Just trying to stay home. I didn't find it urgent, on the front burner, of things I had to do. Just trying to stay safe home.* White Latinx gay man living with HIV, early 30s, U.S.-born
High perceived need for services	X	X	X	X	X	X	*I need to keep up those [ART] refills, even if he would have forced me to go in I would have gone.* White Latinx gay man living with HIV, mid 20s, U.S.-born
3. Knowledge of How and Where to Get Services During COVID-19							
Lack of knowledge about where or how to get services during COVID-19	X	X	X	X			*Before it was hard to access and find the right resources, now it's even worse because you're not sure which ones are open or which ones are doing it from home. There's a lot of changes that may not be reflected on the websites or the right information may not be available at the moment because it happened so fast.* White Latinx gay man without HIV, mid 20s, non-U.S.-born
COVID-19 caused disruptions to usual service delivery	X	X			X	X	*It was so difficult to go through the system that I used [to get behavioral health services], not impossible, but it was very complex, there were too many hurdles.* White Latinx gay man living with HIV, late 50s, non-U.S.-born
Access to information and support in navigating the health care system	X	X					*Getting to know that they're taking my information, or if they're currently not operating just to know what other things can I do, what other services can I do, what other services can I reach to*? White Latinx gay man without HIV, mid 20s, non-U.S.-born
Continued engagement in services from before COVID-19			X		X	X	*I still had [PrEP] pills, so I didn't have the need to text or have an appointment via telemedicine with my doctor.* White Latinx gay man without HIV, mid 20s, non-U.S.-born
4. Trust and Confidence in Health Care Providers							
Privacy concerns	X		X				*Let's say you get medication delivered to your home, it would have to be a very hush hush thing because you don't want your family, or your neighbors, or your friends to know about it because some people are very secretive about it.* White Latinx gay man without HIV, late teens, non-U.S.-born
Discomfort with telehealth	X						*I would do all my appointments remotely...except therapy.* White Latinx gay man living with HIV, mid 20s, U.S.-born
LGBTQ-affirming culturally relevant, trustworthy, warm providers and organizations	X	X	X	X	X		*I feel they [company that provides remote PrEP care] have been reliable so far. I kind of trust them in a way, so they've built a trustworthy relationship.* White Latinx gay man without HIV, late teens, non-U.S.-born

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Categories/Themes	BH	Test	PrEP	PEP	HIV Care	ART	Example Quotation
5. Structural Issues							
Financial or insurance barriers exacerbated during COVID-19	X		X				*Problems with insurance probably. Not being able to know what's covered by insurance and what's not. Especially with unemployment rates going higher and higher, people [are] not wanting to spend money on these types of [HIV-prevention] services.* White Latinx gay man without HIV, early 20s, U.S.-born
Structural barriers are addressed			X	X			*During COVID-19, Miami transportation is free so that would make it easier [to get services].* White Latinx gay man without HIV, early 20s, U.S.-born
6. Service Delivery Models							
Remote service delivery options may facilitate LSMM's access	X	X	X	X	X	X	*It's more comfortable to have her talk to me via telehealth, in terms of that. I mean if she has already done a physical exam for me, I think there's no specific reason why I would have to physically go to the visit.* White Latinx gay man without HIV, mid 20s, non-U.S.-born
Relaxing and adapting protocols to enhance service delivery					X	X	*The pharmacy just called me and told me I was about to run out of medication, I didn't have to go my doctors' office to get a new prescription. It was just faxed over to the pharmacy and I got my refills. Before I had to go the doctor's, office pick up a paper, and take it to the pharmacy.* White Latinx gay man living with HIV, early 30s, non-U.S.-born

Note. Codes apply to services (BH = behavioral health treatment, test = HIV testing, PrEP, PEP, HIV care, ART medication) marked with an "x."

ART indicates antiretroviral therapy; COVID-19, coronavirus disease 2019; LGBTQ, lesbian, gay, bisexual, transgender, queer or questioning; LSMM, Latinx sexual minority men; PEP, post-exposure prophylaxis; and PrEP, pre-exposure prophylaxis.