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## Utilization of HIV prevention, care, and treatment services among young men who have sex with men and transgender persons of color in the U.S. South: A qualitative analysis

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### Abstract

To better understand utilization of HIV prevention, care, and treatment services by young men who have sex with men (YMSM) and young transgender persons (YTG), of Black race or Hispanic/Latino/Latina ethnicity in the U.S. South, we conducted semi-structured interviews with 127 clients at one of four Community Based Organizations (CBOs) in Miami, Atlanta, New Orleans/Baton Rouge, or Columbia, South Carolina. Across sites, the service that most commonly drew respondents into the CBO was HIV and STD testing. Other services commonly used included HIV/STI treatment, counseling services/support groups, and PrEP services. Social/organizational/structural facilitators of service utilization include the welcoming climate/culture of the CBOs, ease of access to the services, and transportation services to reach the CBOs. Suggested service enhancements include broader range of comprehensive, navigational-type services beyond HIV testing and service co-location. Research on how to reduce stigma in the surrounding communities may help reduce health disparities experienced by these populations.

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## Keywords

young MSM; young transgender persons; U.S. South; HIV service utilization; Black/African American; Hispanic/Latino/Latina

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## Introduction

An estimated 1,189,700 persons aged 13 years and older were living with HIV infection in the United States (U.S.) at the end of 2019 (Centers for Disease Control and Prevention [CDC] 2021a). Across the U.S., the rate of infection is highest in the South (15.2/100,000 persons) compared to other regions (9.4 in the Northeast, 9.2 in the West, and 7.0 in the Midwest) (CDC 2021b). Gay, bisexual, and other men who have sex with men (MSM) and Black/African American (hereafter referred to as Black) and Hispanic/Latino persons continue to be disproportionately affected by HIV (Pitasi et al., 2021); these disparities are even more pronounced among the young (Koenig, Hoyer, Purcell, Zaza, & Mermin, 2016). In 2019, Black and Hispanic/Latino men accounted for 51% and 30%, respectively, of diagnoses of HIV infection among young MSM (YMSM) aged 13–24 years. Among MSM aged >24 years, Black and Hispanic/Latino men each accounted for 33% of diagnoses of HIV infection, indicating that over-representation of Black MSM was particularly pronounced among the younger age group (CDC 2021b). Prevalence of HIV is also high among transgender women, particularly Black and Hispanic/Latina transgender women (Becasen, Denard, Mullins, Higa, & Sipe, 2019; CDC 2021c). In 2019, among transgender persons, the largest percentage of diagnoses of HIV infection were observed in transgender women aged 20–24 years (24%), followed by those aged 25–29 years (23%) (CDC 2021b).

Research shows many factors that underlie the disparities noted above, including HIV-related stigma, lack of access to healthcare services, low health literacy, HIV discrimination, poor treatment experiences, and fear of confidentiality breaches may inhibit YMSM and young transgender persons from accessing HIV preventative services (Crim, Tie, Beer, Weiser, & Dasgupta, 2020; Mathews et al., 2020; Nelson, Underhill, & Carey, 2020; Quinn Dickson-Gomez, Zarwell, Pearson, & Lewis, 2019). The environmental context of the South (e.g., poverty, low income, lack of public transportation, reduced availability of medical and social services [CDC 2019]) may further exacerbate effects of many of these barriers (e.g., stigma, HIV and other [e.g., racism, homophobia, transphobia] discrimination). To provide comprehensive and effective HIV prevention, care, and treatment to Black and Hispanic or Latino/Latina YMSM and young transgender persons (YTG) in the South, it is important to understand and address the factors that influence utilization of HIV prevention and treatment services that may be available to them in their communities.

To this end, we conducted a qualitative study of 127 clients and 12 staff receiving or providing HIV prevention or treatment services at four Community Based Organizations (CBOs) located in the southern region of the U.S. where HIV incidence and prevalence is high. These locations included Miami, FL, Atlanta, GA, New Orleans/Baton Rouge (New Orleans hereafter), LA, and Columbia, SC. (See Table 1 for services provided at each CBO). These CBOs were funded by CDC Cooperative Agreement, PS17–1704: “Comprehensive

High-Impact HIV Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color,” which aimed to implement comprehensive HIV prevention programs to reduce morbidity, mortality, and health disparities among YMSM and YTG of color and their partners, with an emphasis on reducing new infections, increasing access to care, and promoting health equity. All of these CBOs offered HIV-related services for YMSM and YTG of color. Some served predominantly Black or Hispanic or Latino clients (e.g., Miami site served mostly Hispanic or Latino clients while the Columbia site served mostly Black clients) and each provided services to YMSM or YTG populations to a different degree (e.g., Atlanta and New Orleans sites had well-established services to transgender clients).

This study examined multilevel/nested factors that influence behavioral patterns through a social-ecological lens. As such, we utilized an established macro-level social-ecological model (SEM) (Brofenbrenner, 1977; Dahlberg & Krug, 2002) as a conceptual framework to guide our study. We therefore explored a broad array of influences (i.e., structural, community, peer, and personal experiences) that potentially contribute to variation in accessing and utilizing prevention, care and treatment services. Prior to data collection, formative research in collaboration with the sites was conducted to inform study implementation including interview items. Our Community Advisory Board served as an excellent partner throughout study conceptualization and implementation to ensure that we captured the array of facilitators and barriers of broader external relevance.

In this paper, we provide a descriptive summary of cross-site findings from the client interview component of the study (staff interview data will be presented in a separate paper), specifically focusing on social, organizational, and structural factors that may facilitate or impede utilization of HIV services among the population of focus. The following research questions were explored: 1) How do YMSM and YTG of color in the South utilize HIV prevention, care, or treatment services offered at the CDC-funded CBOs? 2) What specific social, organizational, and structural aspects of CBOs would make it easier or more difficult for YMSM and YTG of color in the South to utilize these services? 3) How do racial/ethnic identity and stigma associated with HIV or sexual orientation affect their service use? 4) What do YMSM and YTG of color in the South wish to see improved in these HIV prevention, care, or treatment services?

## Methods

### Respondent recruitment, eligibility, and consent

Purposive sampling was used to recruit YMSM or YTG, of Black race or of Hispanic or Latino/Latina ethnicity from the aforementioned four CBOs. CBO staff members played a key role in client recruitment, presenting the study to potentially eligible clients and disseminating study flyers in CBO offices and on social media platforms. Clients were directed to contact study staff for screening once they expressed interest in study participation.

Potential client participants were screened for eligibility by study staff. Eligibility requirements included age (18–24 years at time of interview), self-identified as MSM or

transgender/non-binary/not cisgender, and self-identified as either Black, Hispanic or Latino/Latina, or both. Eligible participants also had received one or more HIV prevention, care, or treatment services at the participating CBO within the previous 12 months and were able to speak English well enough to consent and participate in an interview. Two hundred forty-two individuals were screened for client interviews, of which 164 were found eligible, and 127 were interviewed after providing written informed consent (26 were lost to follow up and 11 found ineligible at the time of interview). Respondents received \$40 in cash at the end of the interview. The study protocol was approved by the CDC's Institutional Review Board.

### Data collection

Data collection took place from July 2019 through March 2020. Information on respondents' sociodemographic and other behavioral characteristics were collected through in-depth interviews (IDIs). Semi-structured open-ended questions were asked related to respondents' experiences with HIV services at the CBO (e.g., how they first learned about the CBO, what HIV prevention or treatment services they have used or were currently using from the CBO, any suggestions for the CBO for improvements) as well as their experiences of stigma related to sexual orientation, gender identity, HIV status, and racial or ethnic identity associated with service use. IDIs were conducted by trained interviewers and lasted approximately 60 minutes. They were audio-recorded, and the audio-recordings were transcribed verbatim. Personally-identifying information was redacted from the transcripts.

### Data analysis

IDI transcripts were coded for themes present in the data using a qualitative content analysis approach (Schreier 2012). A total of 6 coders (all study staff) were involved. The coding process was facilitated by NVivo qualitative data analysis software (NVivo 11, QSR International [Americas] Inc., Burlington, MA). An initial codebook was developed based on questions from the interview guide and was later augmented with emerging themes as coding progressed. Inter-coder reliability was assessed on the preliminary codebook with a random sample of transcripts (n=4) representing each site and respondent type (YMSM and YTG). Each of these transcripts was independently coded by all coders. Agreement was measured by calculating Cohen's Kappa (Hruschka et al., 2004). The average Kappa score across all codes in comparison was 0.74–0.88. Agreement scores lower than 0.8 were resolved via consensus. After intercoder reliability was achieved, all data were coded with a codebook including 78 distinct codes that were hierarchically organized. Following coding, a team-based thematic analysis was conducted to identify and summarize the most common respondent ideas, experiences, insights, and opinions.

## Results

### Characteristics of Respondents

Table 1 describes the characteristics of the 127 client respondents. Twenty respondents were from Atlanta, 34 from Columbia, 36 from Miami, and 37 from New Orleans. Overall, although respondents ranged from 18–24 years of age, the sample included a higher percentage of persons aged 22–24 (57%) vs. 18–21 (43%). The race and ethnicity categories were not mutually exclusive. A third of the respondents (30%) identified as

Hispanic or Latino/Latina; of Hispanic respondents, 84% were from the Miami site. Eighty percent identified as Black (including those who identified as Black and another race). Most respondents (81%) identified as gay or bisexual, but 13% identified as “something else.” Overall, 20% of respondents identified as transgender or gender non-conforming; of these, the majority (60%) were from the Atlanta site that offered services specifically for the local young transgender population.

Most respondents (>90%) reported that they had told their family, friends, and sex partners that they identified as gay, bisexual or transgender, but a lower percentage (80%) had disclosed this identity to their medical providers. However, there was variability across sites, whereby in New Orleans virtually everyone (97%) was reportedly out to their medical providers; and in Miami, a slightly lower percent (83%) were out to family members compared to other sites. A majority of the respondents had a high school education or higher (91%), were employed at least part-time (74%), had health insurance (65%), and did not report experiencing homeless in the past 12 months (79%); however, Atlanta respondents showed lower percentages in all of these socioeconomic categories. A quarter of respondents reported living with HIV, nearly half (47%) of whom were from the New Orleans site, a site that provided medical treatment for persons with HIV. Virtually all of the respondents with HIV (n=31, 97%) reported taking antiretroviral therapy (ART).

**How do YMSM and YTG of color in the South utilize HIV prevention, care, or treatment services offered at CDC-funded CBOs?**—Across sites, the service that most commonly drew respondents into the CBO was HIV and STD testing. In Miami, where mobile testing units are available, some respondents said that they were not even thinking about getting tested or using services until they came across mobile testing units in their community. In New Orleans and Columbia, several respondents noted that they were motivated by the fact that HIV testing services were free. Also in Columbia, many respondents specifically mentioned the offer of financial incentives, such as gift cards to accompany free testing services, as motivating factors. In Atlanta, the most common reasons noted for the first CBO visit were HIV/STD testing and transgender-related services.

Respondents learned about the CBOs and their services in a variety of ways, including testing and outreach events, Pride and other LGBTQ+ community events, CBO advertising, internet searches, social media pages, and dating apps. When asked how CBOs should market their services to YMSM and YTG, social media was the most common suggestion from respondents across all four sites. Many also suggested increasing the CBO’s physical presence on college campuses. Word of mouth was also very important as many respondents first started using services at the recommendation of someone they trusted.

“The females, the friends, the people that I know...they talk good about this place. That made me come here.”

(Respondent from Atlanta)

“I first learned about them through friends...I was asking around, like where can I get services for testing for STDs and they recommended me here, so I came over here...”

(Respondent from Miami)

“One of my friends told me that he got tested here before. So, I just decided to come here to get tested, too... Oh, just because I usually get tested on a regular basis and then when I moved to Columbia I didn’t really know where exactly I could go to get free testing. And then he told me that this is one of the places here.”

(Respondent from Columbia)

Across sites, the services respondents reported using most were HIV and STI testing, PrEP services, counseling/group interventions/support groups, and STI/HIV treatments. HIV and STI testing were the primary services most clients reported utilizing. PrEP services were also commonly noted among HIV negative respondents, with many indicating that they were informed about or offered PrEP during testing visits or provided information about PrEP to consider for the future. Several transgender respondents from Atlanta discussed initiating PrEP as a requirement to access the CBO’s free hormone services. Of those, some seemed enthusiastic about the opportunity to take PrEP, whereas others only accepted PrEP services in conjunction with receiving free hormone services.

Respondents at all sites spoke about the interventions and formal and informal counseling services offered, but specific client experiences and types of counseling services used varied by site. In Columbia, respondents cited the “Many Men, Many Voices” (3MV) intervention <https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/rr/cdc-hiv-intervention-rr-best-3mv.pdf> (one of 7 evidence-based High Impact Prevention interventions supported by the overarching funding support [PS17–1704]) and other support groups aimed at prevention as well as individual counseling and case management. Respondents from New Orleans mentioned receiving therapy or mental health services, informal counseling during testing, as well as individual counseling and case management. In Miami, some respondents mentioned participating in an HIV-related support group. Respondents in Atlanta mentioned group and individual counseling, including a transgender support group.

STI treatment, referral, or support was another commonly used service across sites. Respondents from New Orleans noted receiving testing and treatment on site, while clients from Miami noted receiving referrals for STI treatment elsewhere. Some Miami respondents talked about frustration felt with this referral model and wished the services were provided at the CBO.

“They referred me to the [name of clinic] because the services that they have here, which was also really stressful. I wish they provide more of the services that the [name of clinic] has because they’re a bigger facility, because they have actual doctors there working for free, a lot of people do gravitate towards that area. And it’s just a longer waiting process. I remember coming in at like 10 o’clock in the morning, I didn’t leave until like four o’clock. So, I wish they provided, I was more comfortable here than I was going over there. It was just a lot, very stressful...”

(Respondent from Miami)

HIV-positive respondents in New Orleans described their need for HIV treatment services as the most common reason for their first visit. They reported using a wide range of services, including HIV care and treatment, laboratory tests and medication, counseling and therapy, primary care, and dental services. They also reported receiving transportation and housing assistance, access to food pantry and personal care items, and incentives for reaching undetectable viral load status. They talked about the convenience of coming in for doctors' appointments and labs, having access to the pharmacy on site for medications, and general support from the CBO.

“Well, [name of CBO] I have a primary care doctor and I also have a HIV doctor. Well, they're basically, it's one doctor but they take care of both. So, when I first moved here, they set me up to meet up with a doctor. And we basically talked about my HIV situation, how long I had it, my counts, my numbers, all those things. And after that, they took bloodwork. You know, they just took bloodwork and asked me if I wanted to do any type of STD testing and stuff like that, which I knew I didn't need to. So, yeah, they just took my blood and asked me what medicines I was taking and you know, just kind of got me on track with my medicine and my bloodwork...”

(Respondent from New Orleans)

“So, if she'll prescribe the medicine there first, so it'll be convenient for me to get it while I'm there or whatever because I don't have...my own transportation. So, I have to...try to get everything while I'm in the area....” (Respondent from New Orleans)

**What specific social, organizational, and structural aspects of CBOs would make it easier for YMSM and YTG of color in the South to utilize these services?**—Facilitators of service utilization most cited across sites include the welcoming or accepting climate and culture of the CBOs, ease of access to the services, and transportation services offered to reach the CBOs. Respondents commonly described each of the CBOs as open, safe, and welcoming. Respondents often noted that this brought them back and sometimes even encouraged them to come to the organization without specific need for services that day (e.g., coming to hang out and socialize).

“Yeah. I mean, I come here to honestly just to destress and to socialize. Often, like, the guys around here are busy so I just like chill. So, I come here even sometimes when I don't need testing. Like I don't need testing today. I just decided to come here to hang out.”

(Respondent from Miami)

Respondents also noted the ease of accessing services at each of the organizations and noted that this factor encouraged continued service utilization. Most respondents noted that if they needed help with transportation (e.g., Metrocard, Uber/Lyft), the CBOs were typically able to assist with that cost or reimburse them once at the organization. Respondents shared that when they became aware of this service, it was easier for them to seek services because it eliminated the barrier of transportation cost. Across the four CBOs, cost and insurance coverage did not appear to be a significant facilitator or barrier to accessing and utilizing services. Most respondents shared that the services they utilize (e.g., HIV/STI testing,

treatment services, PrEP) were covered by the organization, regardless of the respondent's insurance status.

**How do racial/ethnic identity and stigma associated with HIV or sexual orientation and affect their service use?**—Respondents shared that the race or ethnicity of their CBO's staff members was not of particular importance to them, as long as the staff treated them with respect and were able to provide the services they wanted. This was common across all four sites, with most respondents indicating that race or ethnicity of staff members did not matter especially as it related to utilizing services. However, they also recognized the inherent impact that having staff of their race/ethnicity had on them as clients. Specifically, respondents appreciated talking with staff members who had similar experiences regarding shared demographics and could easily understand their point of view. When asked whether they wished the staff were more diverse, respondents often mentioned that greater representation among staff members would likely encourage larger segments of the LGBTQ+ population to seek services at the organization, and the organizations should encourage greater representation and market services to clients of all races/ethnicities.

Stigma did not appear to be a significant barrier to service utilization for respondents, possibly due to selection bias as clients who agreed to participate were those already utilizing the CBO services. However, across sites, respondents indicated that they knew people who were reluctant to utilize services offered by the CBOs. They noted the potential stigma of visiting the CBOs, noting that their peers may be nervous and anxious about seeking services at an organization recognized in the community as serving persons with HIV or persons who are LGBTQ. Several described friends who didn't want to find out their HIV status. Others noted that people are afraid their families and friends will find out they have visited the CBO.

“I think they [the CBO] do the best that they can, especially with, like, Facebook, Grindr, trying to reach out to people. I think the big issue... is not so much the organization... a lot of them (potential clients) are either closeted or if they are out, they're not socially out, so coming here kind of like outs them. And I feel like a lot of them are either not ready for that or they don't want to do that. They want to remain discreet. I feel like that's the issue why people don't come.”

(Respondent from Miami).

A few respondents tried to counter this type of resistance by being open about their own service use. However, they believed that some people, particularly those in the African American community, were scared of getting tested due to either the general stigma of HIV testing or the perception of the CBO being associated with HIV.

“HIV – it's 1984 here... It's not 2020. So, attitudes are what they were in 1984, sheer unbridled terror at the mention of HIV, and the stigma affects significantly the way people respond to being here. There are patients who don't want to be seen here because they're afraid someone will know they have HIV.”

(Respondent from New Orleans)



For respondents with prior experience at other organizations and facilities, negative experiences at these other organizations and facilities were common and typically involved experienced or anticipated stigmatization by providers or other staff members, poor organizational management or customer service, and/or lack of availability of needed services. They described poor service received at local hospitals and healthcare facilities and a perception that these facilities and their staff did not know, understand, or care about providing holistic, non-stigmatizing, care. They reiterated experiences of stigmatization and judgement which led them to prefer services provided by LGBTQ+-focused CBOs. Respondents shared that non-LGBTQ-focused organizations often provided services or interactions which left them feeling awkward and stigmatized. For many respondents, representation of the staff within the LGBTQ+ community was important because LGBTQ+ staff could “relate” to them with the firsthand knowledge of some experiences clients were going through. Some clients also emphasized the importance of being able to speak freely about sex with the CBO staff while being tested. They often spoke about the comfort they felt from the CBOs to emphasize why they continued to utilize services there rather than at other organizations. Some discussed how experiences of feeling stigmatized and judged by other organizations and healthcare facilities resulted in them either pulling away from services entirely (e.g., not getting HIV tested, not attending support groups) or having to search for organizations which were more welcoming and targeted towards people like them.

“I feel like other places, it’s like they don’t, it’s like general public, not really sexual orientation-based, like here. So, then they kind of don’t, like, they ask you all these questions but you feel so uncomfortable. Have you had sex with a woman? Have you had sex with a trans person? Have you had sex with a man? So fast, you’re like damn. It’s weird. Here, you come here and like you know, they’ll set you down and talk to you.”

(Respondent from Miami)

**What do YMSM and YTG of color in the South wish to see improved in HIV prevention, care, or treatment services?**—Most youth interviewed were very positive about how services are provided at their CBO and had no suggestions for improvement. Several respondents were also relatively new to care, prevention, or treatment and did not have much experience on which to base their responses for this research question.

When responses were provided, it was often shared that the hours of operation at some of the CBOs did not provide much flexibility for clients who may be working during the day or have other priorities throughout the week. Respondents often felt that greater flexibility in service hours would be beneficial to ensure they were able to utilize the available services. They also talked about the importance of providing STI treatment and PrEP on site in cases where it was referred out. They noted the extra task of having to go to another organization or clinic just to receive the medications and treatment. They also talked about the longer wait time and discomfort felt at those other organizations/clinics, as they were not familiar with the staff and clientele. Some respondents also shared difficulty in receiving counseling services due to scheduling issues. Others spoke about the importance of providing food and shelter to all clients who need it in a status-neutral manner. For example, some respondents, especially those in Atlanta, noted the lack of availability of services for HIV negative

persons beyond the typical HIV prevention services (e.g., testing, condoms, lubricant, PrEP). Specifically, this was noted in reference to the organization providing housing assistance for transgender persons living with HIV.

“This is about every trans organization that I have seen in my life. They do not house HIV negative people. And that needs to change[...] I feel like that’s just kind of f\*\*\*ed up because you know, that gives the girls the impression of, well, why not just go out there to get positive too so I can get somewhere to sleep?”

(Respondent from Atlanta)

Some respondents described services that were already provided by the CBO as being needed, demonstrating a need to make more clients aware of the services (including information about past and upcoming events) that are offered by the CBOs.

## Discussion

Among the YMSM and YTG of color receiving services in these four southern CBOs, HIV/STI testing was identified as the most used service and primary reason many of them first visited their respective CBOs. HIV testing is an important service particularly for youth, as they continue to have the lowest rates of HIV status knowledge (CDC 2020; Koenig et al., 2016), and our findings indicate that these CBOs prioritized provision of this critical service to this population. Our findings suggest that CBOs consider testing as a “window of opportunity” to build a positive organizational relationship with the client that might bring them back for continued use of prevention services. This is consistent with the “status neutral approach” that promotes ongoing engagement in HIV prevention, care, and treatment regardless of a person’s HIV status, with HIV testing serving as the gateway to services for HIV prevention or treatment (CDC, 2022; Myers et al., 2018).

Respondents also reported utilizing other services, including PrEP services, counseling/group interventions/support groups, and STI/HIV treatment. Given that PrEP uptake is relatively low in the South compared to other regions of the country, and among young people (Kamitani et al., 2020), it is encouraging that PrEP service use was commonly cited across sites. Many respondents reported that they were offered or provided information about PrEP as they were tested for HIV, suggesting that HIV testing and PrEP services were well coordinated and offered in tandem at these organizations. It is also possible that clients may have felt more comfortable discussing PrEP while getting tested because of the openness, lack of judgment, and similar experiences shared between the staff and clients during HIV testing. Consistent with the ‘status neutral’ model (CDC, 2022; Myers et al, 2018), a negative HIV test result can be an opportune time to engage clients in conversations about strategies to remain HIV-negative, including discussion about PrEP.

Although respondents noted they learned about services in a variety of ways, they often recommended using social media to reach others. However, hearing about a service via social media or other ads/flyers is not enough, as they often indicated that it was word-of-mouth from a trusted source that motivated them to first visit the CBO. Availability of free HIV/STD testing at the CBOs also appeared to be a strong motivator for them to be tested

frequently, suggesting that cost may be an important consideration among our YMSM and YTG respondents (only 40% reported having full-time employment).

Consistent with prior research on HIV prevention and service provision for youth and other populations (Fortenberry et al., 2017; Mizuno, Higa, Leighton, Mullins, & Crepaz, 2019; Tanner et al., 2014), our findings suggest several organizational or structural facilitators to enhance clients' access to services. These include expanding hours of operation to better accommodate work and school schedules, providing transportation for those have trouble getting to the CBOs, service co-location (e.g., offering HIV/STI treatment and other clinical services on site so clients won't need to go elsewhere to receive these services) or provision of service navigation support (in cases where they are referred to other organizations), and offering essential social services, including housing assistance, regardless of HIV status. It is notable that even when these services were available at the CBO, not all clients seemed to be aware of them. Thus, enhanced communication around the full range of services offered by CBOs (that is, other than HIV/STI testing) could increase use of many non-testing CBO services by these youth.

Respondents did not identify stigma as a barrier to utilization of services at their respective CBOs. However, they indicated that prior negative experiences at other organizations, particularly local hospitals and other health care facilities in which providers were perceived as less accepting or even judgmental, left them feeling stigmatized and deterred service utilization at those locations. Respondents commonly described each of the participating CBOs as culturally competent, noting that this was a reason why they kept going back to these organizations. Although respondents indicated that culturally competent care, and not race/ethnicity of staff at the CBOs, was important when it came to their service utilization, having staff of the same race/ethnicity served to enhance their level of comfort and willingness to use services. Respondents also talked about knowing someone who would not access services at the CBOs due to stigma and fear (e.g., they did not want their family members to know that they were using services at the CBO as the CBO is known in the community to be associated with HIV or MSM/transgender persons.) Thus, even though respondents' service utilization at their current CBO was not overtly or consciously affected by stigma, it does not mean stigma was not a significant barrier to service utilization of YMSM and YTG of color in these Southern cities, highlighting the continued need to address facility-based stigma in organizations where HIV testing, prevention and treatment are provided.

Limitations of this study are as follows. Findings from each site present a snapshot of YMSM and YTG of color served by a site at a given point in time. The study sites were selected carefully with the intention of broader application, but the local demographic profiles or other site-specific circumstances of each site limit generalizability of the findings to other CBOs, cities, or populations, or to rural areas in the U.S. It is also important to mention that these CBOs were selected because they were funded specifically to serve these populations and thus may not be representative for understanding issues such as stigma encountered within the service delivery experience. While this paper focused on common themes across sites, site differences, potentially reflecting cultural/contextual differences among the sites, cities and clients served may be further warranted, albeit confounded in

our results by the services offered at each site. Although we asked about transportation, examination of urban versus rural residency of clients and how that affects service utilization may still be another important consideration. Only persons who could speak English well enough to understand the consent were included, so the study may have excluded some Hispanic or Latino clients whose service utilization experience may be different. Additionally and essential to note, only respondents who were receiving services from these CBOs were interviewed; thus, views from those who were disengaged from service use were not included. Respondents could speak about their past experiences of disengagement, or those in their peer group who were disengaged from care, but they could not speak from personal experience about any current disengagement from services. As with all studies, the potential for social desirability bias exists. Finally, data were collected through March 2020, prior to national protests for racial justice that elevated conversations about systemic racism in the US. As a result, attitudes and beliefs related to the race/ethnicity of care providers among this predominantly African American sample may have changed.

In addition, data were collected just before the COVID-19 pandemic hit and interrupted HIV prevention and care activities in the U.S. Qiao and colleagues (2021) found in South Carolina in March 2020 that HIV service interruption was correlated with the percentage of uninsured persons in the service catchment areas, demonstrating the socioeconomic disparity of HIV service interruptions due to COVID-19. HIV programs have since adopted COVID-19 mitigation strategies including tele-health, home HIV/STI self-testing, and remote group/individual support groups and counseling (Beima-Sofe, Ortblad, Swanson, & Graham, 2020). CDC reported that the number of CDC-funded HIV testing sites was reduced almost by half (Carter, Spikes, Rakestraw, & Dunbar, 2021; Patel et al., 2021); detailed documentation and analysis of how activities at CBOs serving YMSM and YTG in the South have been affected and its effect on their service utilization and HIV outcomes since the completion of this study is warranted. Coverage of the COVID-19 vaccines is not uniform across race/ethnicity and geographic regions; Black and Hispanic or Latino/Latina persons report lower vaccine coverage (Pingali et al., 2021), and uptake of the vaccine is also lower in Southern states. It is conceivable that YMSM and YTG of color in the South might be disproportionately affected by COVID-19 as well as HIV. Future research might quickly investigate how best to address these issues and identify services and service delivery models (e.g., telemedicine and home-based testing) that can address HIV and COVID-19 simultaneously for these young minority populations.

Despite limitations, this study provides important insights for organizations serving YMSM and YTG of color in the Southern U.S. Social, organizational, and structural facilitators of service utilization identified by our respondents can further enhance the quality of service provided at the CBOs where the study was conducted and potentially other organizations in the South serving similar populations. Specifically, our findings suggest the need for CBOs serving YMSM and YTG of color in the South to provide a broader range of comprehensive, navigational-type services beyond HIV testing. It would be ideal if a CBO can provide these services onsite; if that is not possible, a robust referral system with a network of culturally competent service providers is essential. Further, more research on how to reduce stigma in the surrounding communities may help reduce health disparities experienced by these populations.

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## References:

- Becasen JS, Denard CL, Mullins MM, Higa DH, & Sipe TA (2019). Estimating the prevalence of HIV and sexual behaviors among the US transgender population: A systematic review and meta-analysis, 2006–2017. *American Journal of Public Health*, 109(1), e1–e8. Doi: 10.2105/AJPH.2018.304727
- Beima-Sofe WAK, Ortblad KF, Swanson F, Graham SM, Stekler JD, Simoni JM (2020). NOTES FROM THE FIELD “Keep it going if you can”: HIV service provision for priority populations during the COVID-19 pandemic in Seattle. *AIDS and Behavior* (2020) 24:2760–2763 10.1007/s10461-020-02902-513 [PubMed: 32385679]
- Brofenbrenner U (1977). Toward an experimental ecology of human development. *American Psychologist*, 32, 513–531.
- Carter JW Jr., Spikes P, Rakestraw A, and Dunbar E, “Impact of COVID-19 on HIV Prevention Services among CDC-funded CBOs.” United States Conference on HIV/AIDS, Washington, D.C., December, 2021.
- Centers for Disease Control and Prevention. (2019). Issue Brief: HIV in the Southern United States. September 2019. <https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-in-the-south-issue-brief.pdf>. Accessed February 15, 2022.
- Centers for Disease Control and Prevention. (2020). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2018. HIV Surveillance Supplemental Report 2020;25(No. 2). <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2020. Accessed February 15, 2022.
- Centers for Disease Control and Prevention (2021a). Estimated HIV incidence and prevalence in the United States, 2015–2019. HIV Surveillance Supplemental Report 2021;26(No. 1). <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2021. Accessed February 15, 2022.
- Centers for Disease Control and Prevention (2021b). HIV Surveillance Report, 2019; vol. 32. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2021. Accessed February 15, 2022.
- Centers for Disease Control and Prevention (2021c). HIV and Transgender People Fact Sheet. <https://www.cdc.gov/hiv/pdf/group/gender/transgender/cdc-hiv-transgender-factsheet.pdf>. Published April 2021. Accessed February 15, 2022.
- Centers for Disease Control and Prevention (2022). Issue Brief: Status Neutral HIV Care and Service Delivery Eliminating Stigma and Reducing Health Disparities ([cdc.gov](https://www.cdc.gov)). Accessed September 20, 2022.
- Crim SM, Tie Y, Beer L, Weiser J, & Dasgupta S (2020). Barriers to antiretroviral therapy adherence among HIV-positive Hispanic and Latino men who have sex with men - United States, 2015–2019. *MMWR. Morbidity and Mortality Weekly Report*, 69(40), 1437–1442. 10.15585/mmwr.mm6940a1 [PubMed: 33031362]
- Dahlberg LL, Krug EG (2002). Violence: a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization, 1–21.
- Fortenberry JD, Koenig LJ, Kapogiannis BG, Jeffries CL, Ellen JM, & Wilson CM (2017). Implementation of an integrated approach to the National HIV/AIDS Strategy for improving HIV care for youth. *JAMA Pediatrics*. 171(7):687–693. [PubMed: 28531268]
- Hruschka DJ, Schwartz D, St. John DC, Picone-Decaro E, Jenkins RA, & Carey JW (2004). Reliability in coding open-ended data: Lessons learned from HIV behavioral research. *Field Methods*, 16(3), 307–331. 10.1177/1525822X04266540

- Kamitani E, Johnson WD, Wichser ME, Adegbite AH, Mullins MM, & Sipe TA (2020). Growth in proportion and disparities of HIV PrEP use among key populations identified in the United States National Goals: Systematic review and meta-analysis of published surveys. *Journal of Acquired Immune Deficiency Syndromes*, 84(4):379–386. [PubMed: 32205721]
- Koenig LJ, Hoyer D, Purcell D, Zaza S, & Mermin J (2016). Young people and HIV: A call to action. *American Journal of Public Health*, 106(3), 402–405. doi: 10.2105/AJPH.2015.302979 [PubMed: 26794156]
- Mathews A, Farley S, Conserve DF, Knight K, Le'Marus A, Blumberg M, Rennie S, & Tucker J (2020). “Meet people where they are”: a qualitative study of community barriers and facilitators to HIV testing and HIV self-testing among African Americans in urban and rural areas in North Carolina. *BMC Public Health*, 20(1), 494. 10.1186/s12889-020-08582-z [PubMed: 32295568]
- Mizuno Y, Higa DH, Leighton CA, Mullins M, & Crepaz N (2019). Is co-location of services with HIV care associated with improved HIV care outcomes? A systematic review. *AIDS Care*, DOI: 10.1080/09540121.2019.1576847.
- Myers JE, Braunstein SL, Xia Q, Scanlin K, Edelstein Z, Harriman G, Tsoi B, Andaluz A, Yu E, & Daskalakis D (2018). Redefining prevention and care: A status-neutral approach to HIV. *Open Forum Infectious Diseases*, 5(6): ofy097. doi: 10.1093/ofid/ofy097
- Nelson KM, Underhill K, & Carey MP (2020). Consent for HIV testing among adolescent sexual minority males: Legal status, youth perceptions, and associations with actual testing and sexual risk behavior. *AIDS and Behavior*, 24(2), 373–378. 10.1007/s10461-019-02424-9 [PubMed: 30747330]
- Patel D, Williams WO, Wright C, et al. HIV testing outcomes in CDC-funded health departments during COVID-19. Poster presented at: 2021 United States Conference on HIV/AIDS (USCHA); December 2–3, 2021; virtual.
- Pingali C, Meghani M, Razzaghi H, et al. COVID-19 vaccination coverage among insured persons aged 16 years, by race/ethnicity and other selected characteristics — Eight integrated health care organizations, United States, December 14, 2020–May 15, 2021. *MMWR Morbidity and Mortality Weekly Report* 2021;70:985–990. DOI: 10.15585/mmwr.mm7028a [PubMed: 34264911]
- Pitasi MA, Beer L, Cha S, et al. (2021). *Vital Signs*: HIV Infection, diagnosis, treatment, and prevention among gay, bisexual, and other men who have sex with men — United States, 2010–2019. *MMWR Morbidity and Mortality Weekly Report*, 70:1669–1675. DOI: 10.15585/mmwr.mm7048e1externalicon [PubMed: 34855721]
- Qiao S, Li Z, Weissman S, et al. (2021). Disparity in HIV service interruption in the outbreak of COVID-19 in South Carolina. *AIDS and Behavior*, 25, 49–57. 10.1007/s10461-020-03013-x [PubMed: 32856176]
- Quinn K, Dickson-Gomez J, Zarwell M, Pearson B, & Lewis M (2019). “A gay man and a doctor are just like, a recipe for destruction”: How racism and homonegativity in healthcare settings influence PrEP uptake among young Black MSM. *AIDS and Behavior*, 23(7), 1951–1963. 10.1007/s10461-018-2375-z [PubMed: 30565092]
- Schreier M (2012). *Qualitative content analysis in practice*. Sage Publications. Thousand Oaks, CA.
- Tanner AE, Philbin MM, Duval A, Ellen J, Kapogiannis B, Fortenberry JD, & Adolescent Trials Network for HIV/AIDS Interventions. (2014) “Youth friendly” clinics: considerations for linking and engaging HIV-infected adolescents into care. *AIDS Care*, 26(2):199–205. [PubMed: 23782040]

**Table 1.**

Service Provided by CBO, Utilization of HIV Prevention and Treatment Services among YMSM of Color and YTG of Color, Living in the Deep South Study, July 2019 - March2020

Services	Miami, FL	Atlanta, GA	New Orleans, LA	Columbia, SC
Walk-in HIV/STI Testing	✓	✓	✓	✓
HIV/STI Treatment		✓	✓	
HIV/STI Treatment referrals/linkage	✓			✓
HIV education and counseling	✓	✓	✓	✓
PrEP services	✓	✓	✓	✓
Support Groups	✓	✓	✓	✓
HIV Intervention Programs	✓	✓	✓	✓
Case management	✓	✓	✓	✓
Condoms and Lubricant distribution	✓	✓	✓	✓
Administrative assistance for ADAP and Ryan White programs	✓	✓	✓	✓
Hormone Therapy		✓	✓	
Housing Assistance		✓		
Job Assistance		✓		
Medical Assistance	✓	✓	✓	
Primary Care		✓	✓	
Mental health services		✓	✓	
Dental services			✓	
Supplemental Food and Aid		✓	✓	
Substance Abuse Assistance		✓		

**Table 2.**

Descriptive Characteristics of Respondents, Utilization of HIV Prevention and Treatment Services among YMSM of Color and YTG of Color, Living in the Deep South Study, July 2019 - March 2020

Characteristics	Atlanta N=20	Columbia N=34	Miami/Ft Lauderdale N=36	New Orleans/Baton Rouge N=37	Total N=127
<b>Age in years</b>					
18 – 21	12 (60%)	19 (56%)	11 (31%)	13 (35%)	<b>55 (43%)</b>
22 – 24	8 (40%)	15 (44%)	25 (69%)	24 (65%)	<b>72 (57%)</b>
<b>Hispanic/Latino/Latina</b>					
Yes	1 (5%)	2 (6%)	32 (89%)	3 (8%)	<b>38 (30%)</b>
No	19 (95%)	32 (94%)	4 (11%)	34 (92%)	<b>89 (70%)</b>
<b>Race</b>					
Black or African-American	20 (100%)	33 (97%)	12 (33%)	36 (97%)	<b>101 (80%)</b>
<b>Sexual Orientation</b>					
Gay	5 (25%)	23 (68%)	30 (83%)	20 (54%)	<b>78 (61%)</b>
Straight	4 (20%)	0 (0%)	0 (0%)	3 (8%)	<b>7 (6%)</b>
Bisexual	2 (10%)	9 (26%)	5 (14%)	9 (24%)	<b>25 (20%)</b>
Something else	9 (45%)	2 (6%)	1 (3%)	5 (14%)	<b>17 (13%)</b>
<b>Gender Identity</b>					
Transgender or non-conforming	15 (75%)	2 (6%)	1 (3%)	7 (19%)	<b>25 (20%)</b>
Cisgender	5 (25%)	32 (94%)	35 (97%)	30 (81%)	<b>102 (80%)</b>
<b>Out as gay, bisexual or transgender to...</b>					
<b>Family Member</b>					
Yes	18 (90%)	30 (88%)	30 (83%)	36 (97%)	<b>114 (90%)</b>
No	2 (10%)	4 (12%)	6 (17%)	1 (3%)	<b>13 (10%)</b>
<b>Friends</b>					
Yes	18 (90%)	33 (97%)	35 (97%)	36 (97%)	<b>122 (96%)</b>
No	2 (10%)	1 (3%)	1 (3%)	1 (3%)	<b>5 (4%)</b>
<b>Sexual Partners</b>					
Yes	18 (90%)	34 (100%)	35 (97%)	37 (100%)	<b>124 (98%)</b>
No	2 (10%)	0 (0%)	1 (3%)	0 (0%)	<b>3 (2%)</b>
<b>Medical Providers</b>					
Yes	14 (70%)	23 (68%)	28 (78%)	36 (97%)	<b>101 (80%)</b>
No	6 (30%)	11 (32%)	8 (22%)	1 (3%)	<b>26 (20%)</b>
<b>Highest level of education completed</b>					
Less than high school	3 (15%)	3 (8%)	2 (6%)	4 (11%)	<b>12 (9%)</b>
High school diploma/GED	14 (70%)	23 (68%)	21 (58%)	26 (70%)	<b>84 (66%)</b>
Greater than high school	3 (15%)	8 (24%)	13 (36%)	7 (19%)	<b>31 (25%)</b>
<b>Homeless in the last 12 months</b>					
Yes	10 (50%)	6 (18%)	3 (8%)	8 (22%)	<b>27 (21%)</b>
No	10 (50%)	28 (82%)	33 (92%)	29 (78%)	<b>100 (79%)</b>



Characteristics	Atlanta N=20	Columbia N=34	Miami/Ft Lauderdale N=36	New Orleans/Baton Rouge N=37	Total N=127
<b>Health Insurance at Time of Interview</b>					
Yes	9 (45%)	23 (68%)	21 (58%)	30 (81%)	<b>83 (65%)</b>
No	10 (50%)	10 (29%)	14 (39%)	7 (9%)	<b>41 (32%)</b>
Don't know	1 (5%)	1 (3%)	1 (3%)	0 (0%)	<b>3 (3%)</b>
<b>Employed at Time of Interview</b>					
Yes, Part Time	6 (30%)	14 (41%)	11 (31%)	13 (35%)	<b>44 (35%)</b>
Yes, Full Time	5 (25%)	11 (32%)	20 (56%)	13 (35%)	<b>49 (39%)</b>
No	9 (45%)	9 (27%)	5 (13%)	11 (30%)	<b>34 (26%)</b>
<b>HIV Diagnoses</b>					
HIV Negative	17 (85%)	23 (68%)	33 (92%)	22 (59%)	<b>95 (75%)</b>
HIV Positive	3 (15%)	11 (32%)	3 (8%)	15 (41%)	<b>32 (25%)</b>
<b>If Yes, Taking HIV Medications?</b>					
Yes	3 (100%)	10 (91%)	3 (100%)	15 (100%)	<b>31 (97%)</b>
No	0 (0%)	1 (9%)	0 (0%)	0 (0%)	<b>1 (3%)</b>