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Youth-Serving Professionals' Perspectives on HIV Prevention Tools and Strategies Appropriate for Adolescent Gay and Bisexual Males and Transgender Youth

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SUPPLEMENTARY MATERIALS

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Abstract

Introduction: HIV disproportionally burdens adolescent men who have sex with men (AMSM) and transgender youth. This study explores barriers and facilitators that professionals face in delivering HIV preventive services and education.

Methods: Adolescent health providers (nurse practitioners, physicians, and other), school nurses, youth workers, and school educators were recruited nationally for this qualitative study.

Results: Thirty-four professionals participated. Common categories identified across professional group were (1) effective strategies for building trust with youth, (2) perceived barriers/facilitators to sexual health communication, (3) perceived barriers/facilitators to effective HIV prevention, and (4) preferred content for HIV prevention tools.

Discussion: Key elements for developing multidisciplinary resources to support AMSM and transgender youth should include (1) web-based or easily accessible sexual health educational materials, (2) resources for referrals, (3) trainings to support competence in caring for sexual and gender minority youth, and (4) guidance for navigating policies or eliciting policy change.

Keywords

HIV prevention; sexual health; adolescent men who have sex with men; transgender youth; multidisciplinary professionals

INTRODUCTION

In the United States, HIV disproportionately burdens adolescent men who have sex with men (AMSM), especially those who are black and Latinx (Ocfemia, Dunville, Zhang, Barrios, & Oster, 2018). Whereas HIV diagnoses have declined among many groups of adults since 2005, the same declines have not been observed among AMSM (Centers for Disease Control and Prevention [CDC], 2016). HIV incidence is on the rise among black and Latinx youth; new infections among 13–24-year-old black and Latinx AMSM rose by 87% between 2005 and 2014 (CDC, 2016). These racial/ethnic disparities persist along the HIV continuum of care in that black and Latinx youth are less likely to receive treatment than white, non-Hispanic youth (CDC, 2017a; CDC, 2017b). Sex at birth and current gender identity data are not collected systematically in the U.S. HIV surveillance system, which limits information about HIV infection among transgender people (Conron, Landers, Reisner, & Sell, 2014). However, findings from community-based studies indicate high rates of HIV infection among transgender people, particularly among black and Latinx transgender youth (Reisner et al., 2017) and transgender women (Herbst et al., 2008).

More effective approaches are needed to promote health and well-being and to reduce HIV infection among youth, particularly among AMSM and transgender youth of color. Adults who have relationships with youth outside of the home, such as primary care providers,

school nurses, youth workers, and educators, all have roles that may affect adolescents' sexual health knowledge, attitudes, experiences, and access to health care. Previous studies have shown evidence of the positive impact adults can have on youth by increasing their sexual health knowledge and awareness of clinical services (Borawski et al., 2015; Doll et al., 2018; Fisher, Fried, Macapagal, & Mustanski, 2018; Mroz, Zhang, Williams, Conlon, & LoConte, 2017) and related outcomes such as suicidality (Goodenow, Szalacha, & Westheimer, 2006). However, many of these studies have focused only on the role of health care providers in promoting sexual health (Doll et al., 2018; Fisher et al., 2018). In this study, we seek to examine the multidisciplinary perspectives of a variety of professionals who play important roles in promoting sexual health among AMSM and transgender youth.

Disclosure of sexual orientation by youth to a health care provider and open discussions about HIV prevention and sexual health facilitate positive sexual health outcomes for sexual and gender minority (SGM) youth (Johns et al., 2018; Stupiansky et al., 2017). SGM youth who reported that their health care provider initiated a sexual heath discussion were significantly more likely to receive appropriate HIV prevention services and testing (Fisher et al., 2018). However, many health care providers report feeling uncomfortable and/or underequipped to discuss sexual health or provide SGM-affirming health care (Hafeez, Zeshan, Tahir, Jahan, & Naveed, 2017). In addition, health care providers in schools (e.g., school nurses) may lack knowledge about issues that affect the health of SGM youth, and schools themselves often miss opportunities to provide sexual health services to youth because of barriers such as limited targeted health information (Rose & Friedman, 2017). Nonclinical community-based youth-serving professionals could also play a role in educating youth about sexual health and referring them to sexual and reproductive health care. A study of youth workers found that 63% talked with young men about sexual and reproductive health in the past month, and one third referred them to care (Marcell et al., 2017).

This study's aim was to elicit youth-serving professionals' (adolescent primary care providers [nurse practitioners, physicians, others], school nurses, youth workers, and educators) perceived barriers and facilitators to providing education, care, and services to reduce HIV risk among AMSM and transgender youth. Results will help inform development of a common set of HIV prevention tools and strategies useful for a variety of youth-serving professionals.

METHODS

Study Population and Procedures

A convenience sample of youth-serving professionals was recruited through a combination of postings on professional LISTSERVs and/or advertisements on professional organizations' Twitter or Facebook pages. These organizations included (1) Society of Adolescent Health and Medicine, a national society of physicians, nurses, and others who care for adolescents; (2) National Association of School Nurses; (3) Gay, Lesbian & Straight Education Network, a national education organization that champions lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues; and (4) other local and national youth-serving organizations, such as the Boston Alliance of LGBTQ Youth. Eligibility criteria included (1)

aged 18 years or older; (2) employed as a school nurse, adolescent health care provider, educator, or school administrator (middle or high school), or youth worker (staff at youth-serving organization); and (3) live and work in the United States. Participants also needed to be able to understand and read English and have access to a computer with internet access.

Interested professionals were directed to an online eligibility screener and electronic informed consent. Eligible participants who provided informed consent and best reflected a diversity in geographic, professional, gender, and racial/ethnic groups were invited to participate in one of four two-hour online discussions. Participants were given login instructions on how to "attend" their assigned discussion. Study reminders were sent via email and immediately before the assigned discussion, participants were provided a unique link to enter the study secure online platform that assigned a pseudonym to ensure that all data remained anonymous and de-identified.

Qualitative synchronous text-based discussions, moderated by study investigators, were conducted between June 22 and July 26, 2017. During the discussions, InsideHeads, owners/operators of the online platform, provided technical support, and participants were given instructions on how to direct message the moderator privately if needed. Participants provided all demographic information via Qualtrics. Study protocols and procedures were approved by the Fenway Health Institutional Review Board, and each participant was remunerated for their time.

Measures

Demographic data included age, sex assigned at birth, gender identity, race/ethnicity, state, urbanicity, level of education, occupation, sexual orientation, level of experience working with AMSM and transgender youth, and the race/ethnicity and age of youth they serve. Semi-structured discussion guides were developed for each group of professionals. Questions elicited the context and content of sexual health conversations with youth, perceptions of barriers and facilitators to sexual education and HIV prevention, and opinions on needed HIV prevention tools (see Box 1). Probes enhanced clarity and helped participants expand on their thoughts.

Analysis

De-identified transcripts were downloaded from the online platform. Data were managed using NVivo version 11 (QSR International, Melbourne, Australia) and analyzed using conventional content analysis (Cresswell, 2007; Hsieh & Shannon, 2005). Four investigators (S.R.C., H.B.F., T.M.W., and S.R.G.) initially immersed themselves in the data, reduced data into preliminary codes, and developed a codebook. Then three of these investigators (H.B.F., T.M.W., and S.R.G.) coded the complete data set and routinely met to review data, definitions, and concepts to ensure accuracy across coders. The entire team met again to review the coded data, examine relationships, and combine codes into broader categories. Ongoing reexamination and discussion of the data yielded the final categories. Demographic data were downloaded into Microsoft Excel for management and analysis. Descriptive analysis including mean and standard deviations for continuous variable and percentages for nominal data.

FINDINGS

Demographic Characteristics

The final sample consisted of 34 youth-serving professionals, which was comprised of eight school nurses, nine adolescent health providers (three nurse practitioners and six physicians/other), eight youth workers, and nine school educators and administrators. The majority were female (68%), white (59%), non-Hispanic (88%), identified as straight or heterosexual (62%), worked in an urban setting (59%), had a master's or doctoral degree (65%), and believed the youth they worked with to be at risk for HIV (77%; Table 1).

Qualitative Analysis

Data were analyzed across all groups and, despite the use of different interview guides, four categories emerged: (1) effective strategies for building trust, (2) perceived barriers and facilitators to sexual health communication, (3) perceived barriers and facilitators to effective HIV prevention, and (4) preferred content and format for HIV prevention tools. Categories unique to each set of professionals were also described. See Table 2 for additional illustrative quotations.

Effective strategies for building trust—Participants discussed strategies they found helpful in their practice to build trust with SGM youth. These included creating inclusive environments, providing affirming care, and facilitating open, honest, and confidential communication. Inclusive environments were described as having posters with same-sex youth holding hands, rainbow flags, and SGM-inclusive educational handouts. One youth worker expressed how they signaled a trans-affirming environment: "I introduce myself, I always say my pronouns… and I don't really explain why, many teens don't understand why, but the ones who do, 'get it' and right away realize that I am a safe person." One health provider described a way to facilitate open and confidential communication with a youth: "I let my patients know that I am there to help them be as healthy as possible and in order to do so I need to know who they are and what behaviors they engage in. I also highlight state confidentiality laws."

Perceived barriers and facilitators to sexual health communication—Participants described barriers to effectively communicating sexual health information including school or institutional policies, political climate, concerns from parents, and stigma. Several educators voiced frustration that, in the state where they teach, schools use "abstinence only" sexual health curricula. One youth worker stated that "political climate" was a barrier in determining "whether or whether not higher ups [administrators or boards] feel like [sexual health] is a territory we should cover." Another youth worker said, "Dealing with stigma and family pressures take more of a front seat [for SGM youth] than with hetero and cisgender youth," and many described how stigmas and fear of family rejection created barriers for youth in seeking services. Participants described that different work settings had different barriers but said that professionals could work together to create resource lists for youth, such as lists for online or local health resources.

Across all groups, respondents consistently endorsed school clubs (gay–straight alliances [GSAs]), clear inclusive language, and permissive policies or access to additional resources would facilitate sexual health communication. One educator stated that in the GSA, “we talk plenty about sexual orientation and gender identity,” and that GSAs might be a great place to disseminate information on health resources. Use of clear and inclusive language was viewed as imperative. One youth worker said, “I ask my clients to define what parts [genitalia] are used [in sex acts] and how. I do not define it [sex] for them.” Health providers also described the importance of clear and inclusive language when asking questions about sexual behaviors. One educator described great benefit from referring youth to a local organization that started an SGM teen support group: “They brought in [a local health center] and a local domestic violence center to discuss both sexual health and dating violence in lesbian, gay, bisexual and transgender-specific ways. But nothing like these conversations happens at school, however.”

Perceived barriers and facilitators to effective HIV prevention—Barriers to effective HIV prevention included knowledge, resources, confidentiality, and stigma. Participants, especially educators and youth workers, described having limited knowledge of HIV prevention strategies such as pre-exposure prophylaxis (PrEP) and nonoccupational postexposure prophylaxis (PEP) for HIV prevention, plus limited referral resources for affirming health services. One youth worker stated, “Lack of knowledge of PrEP/nonoccupational PEP on behalf of the medical provider or outreach worker can lead to a lack in trust and awareness.” Barriers related to confidentiality were reported by school nurses and health providers; “outing is a huge fear” for youth when seeking health care. Participants also described how stigma was a barrier to accessing HIV prevention. One health provider said that a belief that “these youth are promiscuous, or that being on PrEP will make them more promiscuous” was a barrier for SGM youth to access HIV prevention services.

Facilitators included supportive adults and peers, SGM-affirming services, availability of referrals for services, and supportive institutional policies. One health provider noted, “In a perfect world, parents [supportive parents] will help guide their children in establishing healthy relationships.” This belief, that youth would greatly benefit if parents were supportive, was echoed across groups. One educator noted that “asking students their pronouns, supporting GSAs [promoting existing GSAs and facilitating GSA development in their schools], calling them [students] by their preferred names and pronouns, not treating them differently, not out [ing] students” were all strategies for creating an affirming environment. Participants viewed referring youth to affirming services as a responsibility. One school nurse said, “I used to provide the handy card with a list of resources. Now I often help the student call and make an appointment, or I call to see what is available [for an appointment for them].” At one school, which was supportive of increasing HIV preventive resources, policy discussions occurred at a GSA meeting. This educator described facilitating conversations between students and staff in which students were able to “talk about policy changes [they would] like to see made and present them.”

Preferred content and format for HIV prevention tools—Participants in all groups wanted tools to improve care/access to care and be tangible, easily implemented, and directly beneficial. They wanted learning materials, handouts, and brochures that were free, accessible, available in various formats, evidence-based, and up-to-date. One youth worker discussed formatting of materials as "depends on the venue," noting resources for youth in detention settings "have to be paper," but "on the outside, electronic" is preferable. Participants suggested youth would benefit from peer educators/role models and resources with youth representation. One health provider said, "…peer health educators add an important dimension to our prevention efforts. I think what I say as a provider, and what they say as the peer educator, is very synergistic." Educational tools should use popular technologies. One participant noted, "Social media is how most young people get their news and information."

Participants also requested online continuing education (CE) trainings to enhance their confidence and competence in caring for SGM youth, with several health providers stating that CE credits would be a helpful motivator. School nurses and educators, in particular, wanted guidelines for effecting institutional and local policy change, such as "a module on policy and intervention/strategies for dealing with local boards/administrations," plus opportunities to learn from others how to navigate existing policies instead of "all reinventing the wheel." They believed that policy information would be most effective if it was endorsed by national professional organizations like the National School Nurses Association. Participants in all groups also expressed interest in learning strategies "to broker parent and teen connectedness around sexual and reproductive health."

Categories unique to each set of professionals—School nurses described how many SGM youth visit the nurse's office frequently. They viewed frequent visits as an alert to further explore health or social issues, including mental health. One stated, "Most of the students who have gender identity issues have come in to the nurse's office and are depressed and reaching out for help. Half of those have told me they are suicidal." However, nurses said that schools often prioritize referral to outside treatment over the incorporation of preventive measures to promote positive mental health within the schools. School nurses also mentioned the impact institutional policies have on transgender student health. One noted, "our school board is presently arguing" over allowing children bathroom access according to their gender identity and discussed how this persistent stigma negatively affects health.

Youth workers described experiences with and knowledge of strategies for supporting youth with trauma and complex medical and mental health histories. They emphasized the importance of creating safe, youth-led spaces for SGM youth. Youth workers specifically voiced a need for greater education about PrEP. One said, "PrEP around here is pretty rare, so I just think access and lack of education is a barrier when it comes to using it."

School educators and administrators cited rigid curricula and school policies as major barriers to providing comprehensive sexual health education. Several educators noted that "kids can ask questions and you can answer, but you cannot independently bring up things like contraceptives, etc." Another noted that opt-out policies may disadvantage some

students' ability to access sexual health information; "sexual health is a branch of the required course, but several students…were denied it by parental choice." Some expressed ideas for solutions including better partnerships with school nurses (if available) and actionable referral systems to link youth to health services and education that they are unable to provide. For example, one educator described an example they thought of during the discussion, "PrEP and PEP information is not available at my school; however, two agencies in my community…provide this information."

Adolescent health care providers demonstrated greater PrEP knowledge and expressed comfort and skills in providing affirming care and risk reduction counseling. However, health providers said that competence and stigma associated with prescribing PrEP varied among colleagues. Many believed more options (assessment tools or electronic medical record prompts) for gathering sexual orientation/gender identity and HIV risk data were needed.

DISCUSSION AND RECOMMENDATIONS

Findings from this study provide support for the development and testing of HIV prevention tools with a multidisciplinary focus to establish synergy and common ground across all professional groups who work with AMSM and transgender youth. Participants identified many common barriers and facilitators needed to support youth and demonstrated significant knowledge of the complex challenges that SGM adolescent youth often experience. Participants elucidated effective strategies for building trust with youth and the barriers and facilitators they currently face in providing sexual health and HIV preventive clinical services and education in a variety of settings. Participants provided key insights toward tool development that would be of direct benefit. Ideas for tools included (1) web-based or easily accessible educational materials, (2) resources for referrals, (3) trainings to support competence in caring for SGM youth, and (4) guidance for navigating policies or eliciting policy change.

Our approach identified common multidisciplinary needs and identified ways to equip professionals to deliver effective synergistic HIV prevention education and services across professional settings. Specifically, educational materials should be free, disseminated in a variety of formats (online and downloadable), and evidence-based. In addition, if tools were specifically developed for youth, participants believed they should involve peer education and resources with youth representation and use popular technologies.

Participants viewed the ability to refer youth to SGM-affirming health and social services as essential to eliminating discrimination in health care and eliminating health disparities. They also discussed ways to increase connectivity to local SGM-affirming community resources. Surveys have documented SGM discrimination in health care and have noted this as a barrier to accessing routine preventive services (Apaydin et al., 2018; James et al., 2016; Legal, 2010). If youth-serving professionals are unable to provide affirming services for SGM youth within their own organizations, they should identify external (community-based and online) resources for referral.

Participants across groups indicated a need for training programs that include basics about sexual orientation, gender identity, and approaches for HIV risk reduction to enable the provision of affirming services. Disclosure of sexual orientation and behaviors is important for receiving appropriate, timely, and high-quality sexual health care and HIV preventive services (Fisher et al., 2018; Legal, 2010). Our participants noted stigma as a barrier to HIV preventive services, including PrEP. Providers' reluctance to prescribe PrEP to willing patients has highlighted missed opportunities to engage patients in HIV preventive care (Arrington-Sanders et al., 2016; Raifman, Flynn, & German, 2017). Therefore, additional and ongoing CE trainings for professionals are needed to enhance skills and encourage reflection on biases in providing comprehensive HIV preventive care.

School nurses and educators noted that restrictive policies could exacerbate sexual health disparities, whereas comprehensive sexual education programs have demonstrated significant effects in delaying initiation of sex and increasing condom and contraceptive use (Kirby, 2008). In addition, school nurses and educators discussed inclusive school policies and curricula as important for improving the overall health of SGM youth. School nurses voiced specific concerns related to prevalence of depression and suicidal ideation, and these qualitative findings are parallel to the 2017 Youth Risk Behavior Survey, which found that 23.0% of lesbian, gay, and bisexual respondents reported attempting suicide, compared with 5.4% of heterosexual youth (Kann et al., 2018). Policy tools should address micro and macro level barriers to affecting policy change. By creating and publishing tools, nursing and educational professional associations can provide institutional endorsement, assist with dissemination, and serve as agents of change for institutional and professional-level policies. They can also offer guidelines for effective communication with youth, parents, and institutional leadership.

Study Limitations and Strengths

Findings from this qualitative study must be viewed in terms of its limitations. Our participants were primarily white, heterosexual females recruited from professional organization LISTSERVs, which may introduce the potential for bias. In addition, despite diversity in participants' professions, which gave voice to a wider range of stakeholders who all work with SGM youth, this approach limited the within sample size for each group, which likely reduces generalizability of our findings. Despite these limitations, the online methodology allowed us to recruit a national sample, enhancing geographic diversity of participants and provided greater convenience for participation. Finally, the approach allowed us to uncover important commonalities across professional roles needed for multidisciplinary intervention development. Understanding the common needs of youth-serving professionals is the first step in the development of collaborative HIV prevention strategies and tools.

Recommendations for Policy and Future Research

School nurses, as part of the both the educational and health care community, are in an outstanding position to lead the dissemination of tools and resources and other multidisciplinary interventions to support SGM youth. Future research should explore best practices (uncovering facilitators and barriers) to support school nurses in building and

strengthening networks in their local communities to support SGM youth. Research should delve deeper with each professional group to further explore barriers and facilitators to HIV prevention among youth associated with geographic region/state and local policies, current programmatic/educational strategies, and communication strategies with parents or legal guardians.

The network of nurses who are concerned about adolescent health is vast. These nurses are members of both nursing and multidisciplinary professional organizations focused on the health and well-being of adolescents. Using this network of nurses to develop channels of communication and/or build coalitions across multidisciplinary professional organizations would be a powerful way to synergize policy statements to promote health for SGM youth.

CONCLUSION

Findings from this study highlight common barriers and facilitators for providing HIV preventive care and education for SGM youth across professional groups. Results will inform development and testing of HIV prevention tools useful across professional groups. Tools developed should include (1) easily accessible online educational materials, including online trainings to support competence and skills for providing comprehensive and SGM-affirming health care and education, (2) referral resources to connect youth with adolescent SGM-focused services, and (3) guidance for implementing evidence-informed school health policies to promote health for SGM youth endorsed by professional organizations.

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BOX 1.

Example qualitative questions

Adolescent Health Providers (Nurse Practitioners, Physicians, MDs, Others)

1. How often do you see adolescent sexual minority males? How often do you see transgender adolescents?
2. How do you find out the sexual orientation of a patient? Their gender identity? How do you integrate information about sexual orientation into the care that you provide? How do you integrate information about a patient's gender identity into the care you provide?
3. How do you take a sexual health history? What do you say to patients?
4. Can you provide an example of sexual health conversations that you have had with sexual and gender minority youth that went really well? Really badly?
5. What advice do you provide to sexual and gender minority youth about HIV and STI prevention? Adolescent males who are attracted to males? Transgender youth? What strategies do you recommend, if any, to reduce sexual risk?
6. How knowledgeable are the youth whom you treat about HIV and STI prevention? To what extent do they know about pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)?
7. What services and resources do you provide to sexual and gender minority youth to help them prevent HIV and STI infection and transmission?
8. What services and resources do you wish that you could provide to sexual and gender minority youth to help them prevent HIV and STI infection and transmission? What barriers do you face? How about supports? What barriers do the sexual and gender minority youth that you care for face?
9. What training or tools would support you in providing comprehensive services, including sexual health education, HIV/STI prevention, and HIV/STI testing to sexual and gender minority youth?
10. What else could support sexual and gender minority youth's utilization of services, including sexual health education, HIV/STI prevention, and HIV/STI testing, if you could offer everything that you might wish?
11. What advice do you have for other adolescent health providers who wish to care for sexual and gender minority youth and help them to prevent HIV and STI infection?

School Nurses

1. As a school nurse, how often do you address sexual health with your students?

2. Do you feel like you have a sense of which students are members of sexual and/or gender minority groups? As a school nurse, how do you learn the sexual orientation of a student? Their gender identity?
3. As a nurse in the school system, how easy is it to provide sexual health information to students that is inclusive of sexual and gender minority youth (including HIV and STI prevention strategies)?
4. What, if anything, might prevent a sexual or gender minority youth from getting tested for HIV and STIs? What, if anything, might prevent a sexual or gender minority youth from getting and using pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)? What barriers, if any, prevent sexual and gender minority youth from getting and using condoms and lubricant? Barriers might come from families, peers, schools, communities, states, or other groups/institutions.
5. Please tell us about community resources to which you refer sexual and gender minority youth for services or resources that you are unable to provide.
6. What training or tools would support you in providing services, including sexual health education and HIV/STI testing and counseling, to sexual and gender minority youth?
7. What advice do you have for other school nurses to help them best serve sexual and gender minority youth and prevent HIV and STI infection?

Youth Workers

1. Think of a time you had a conversation with a sexual or gender minority youth. To what extent did you discuss dating and relationships? Tell us about that conversation.
2. When you use the word sex (in the context of sexual activity), what do you mean? What is sex? What counts as sex?
3. To what extent do conversations about relationships/dating include conversations about sex (in the context of sexual activity)? How to avoid HIV and STIs? How about pregnancy prevention? If you do not have conversations about these topics, why not?
4. When you do have conversations about HIV and STI prevention, how do they come up?
5. What increases the likelihood that adolescent males who have sex with males will get tested for HIV and STIs? Tell us about a time you helped an adolescent male who has sex with male get tested for HIV and/or STIs.
6. What increases the likelihood that a transgender youth will get tested for HIV and STIs? What decreases the likelihood? Tell us about a time you helped a transgender youth get tested for HIV and/or STIs.

7. What training or tools would help you provide services, including sexual health education, to sexual and gender minority youth?

8. Is there anything else you want to add that you do as a youth worker to support youth (including sexual and gender minority youth) in their growth and development as individuals?

School Educators and Administrators

1. What are your school's policies related to sexual health education?

2. Please describe your sexual health curriculum.

3. To what extent do you feel that schools have a responsibility to teach sexual health? Please explain.

4. What services and resources do the school provide related to HIV and STI prevention?

5. To what extent is information about pre-exposure prophylaxis (PrEP) for HIV prevention (taking HIV medications to prevent HIV infection instead of to treat it) and post-exposure prophylaxis (PEP; taking HIV medications after one has been exposure to HIV to reduce the chances of infection) available to your students at school or in your community? How about access to pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)?

6. What community resources can you refer sexual and gender minority youth to HIV and STI prevention services?

7. So far, we've been talking about services and education that are available to all youth in your schools. Now I'd like you to think more specifically about the sexual and gender minority youth in your schools and some of their unique needs and experiences.

8. Does your school have a gay/straight alliance (GSA) or similar club for students? If so, to what extent are faculty members involved with gay/straight alliance clubs or other LGBT clubs? Are there school regulations about what can be discussed or occur in the club setting? If so, what are these regulations? What types of activities does the club offer, and how active or well-attended is it?

9. Does your school have an organized group or safe space for sexual and gender minority staff or allies? If so, to what extent are faculty and staff involved with these groups?

10. Throughout our discussion, we have talked about a lot of specific topics, such as sexual health education, HIV/STI prevention services, and community resources. Now, we would like you to take a step back and think across that broader set of topics.

    a. What training or tools would support your school in providing sexual health resources and services that are inclusive of sexual

minority males and transgender youth, including sexual health education and HIV/STI prevention and testing that addresses same-sex behavior?

b. How might these trainings and tools be designed and delivered to best meet the needs of educators and administrators like you?

11. What else would support the use of these services by sexual and gender minority youth? What barriers might stand in their way?

12. What advice, if any, do you have for other school administrators who wish to support sexual and gender minority youth and help them to prevent HIV and STI infection?

TABLE 1.

Descriptive characteristics of youth-serving professionals

Characteristics	School nurses (*n* = 8)	Adolescent health providers (*n* = 9)	Youth workers (*n* = 8)	School educators and administrators (*n* = 9)	Total (*N* = 34)
Sex assigned at birth					
Male	0	3 (33.3)	1 (12.5)	5 (55.6)	9 (26.5)
Female	7 (87.5)	6 (66.7)	7 (87.5)	4 (44.4)	24 (70.6)
Did not answer	1 (12.5)	0	0	0	1 (2.9)
Gender identity					
Male	0	3 (33.3)	1 (12.5)	4 (44.4)	8 (23.5)
Female	7 (87.5)	5 (55.6)	7 (87.5)	4 (44.4)	23 (67.6)
Transgender male	0	1 (11.1)	0	0	1 (2.9)
Transgender female	0	0	0	0	0
Genderqueer	0	0	0	1 (11.1)	1 (2.9)
Other	0	0	0	0	0
Did not answer	1 (12.5)	0	0	0	1 (2.9)
Sexual orientation					
Lesbian, gay, or homosexual	0	2 (22.2)	1 (12.5)	1 (11.1)	4 (11.8)
Straight or heterosexual	7 (87.5)	4 (44.4)	5 (62.5)	5 (55.6)	21 (61.8)
Bisexual	0	1 (11.1)	1 (12.5)	2 (22.2)	4 (11.8)
Other	0	1 (11.1)	1 (12.5)	1 (11.1)	3 (8.8)
Do not know	0	1 (11.1)	0	0	1 (2.9)
Did not answer	1 (12.5)	0	0	0	1 (2.9)
Race					
White	5 (62.5)	6 (66.7)	5 (62.5)	4 (44.4)	20 (58.8)
Black/African American	0	1 (11.1)	0	4 (44.4)	5 (14.7)
American Indian/Alaska Native	0	0	0	0	0
Asian	1 (12.5)	1 (11.1)	1 (12.5)	0	3 (8.8)
Native Hawaiian/Pacific Islander	0	0	0	0	0
Multiracial	1 (12.5)	1 (11.1)	2 (25.0)	1 (11.1)	5 (14.7)
Other	0	0	0	0	0
Did not answer	1 (12.5)	0	0	0	1 (2.9)

Characteristics	School nurses (*n* = 8)	Adolescent health providers (*n* = 9)	Youth workers (*n* = 8)	School educators and administrators (*n* = 9)	Total (*N* = 34)
Hispanic					
Yes	0	0	1 (12.5)	2 (22.2)	3 (8.8)
No	7 (87.5)	9 (100)	7 (87.5)	7 (77.8)	30 (88.2)
Did not answer	1 (12.5)	0	0	0	1 (2.9)
Educational attainment					
Associate's degree	1 (12.5)	0	0	0	1 (2.9)
Bachelor's degree	4 (50.0)	0	2 (25.0)	5 (55.6)	11 (32.4)
Master's degree	3 (37.5)	0	6 (75.0)	3 (33.3)	12 (35.3)
Doctoral or professional degree	0	9 (100)	0	1 (11.1)	10 (29.4)
Client race/ethnicity: Most prevalent					
White, non-Hispanic	7 (87.5)	3 (33.3)	1 (12.5)	4 (44.4)	15 (44.1)
Hispanic/Latinx	0	3 (33.3)	1 (12.5)	4 (44.4)	8 (23.5)
Black/African American	0	3 (33.3)	4 (50.0)	1 (11.1)	8 (23.5)
American Indian/Alaska Native	0	0	0	0	0
Asian	0	0	1 (12.5)	0	1 (2.9)
Native Hawaiian/Pacific Islander	1 (12.5)	0	0	0	1 (2.9)
Multiracial	0	0	0	0	0
Other	0	0	1 (12.5)	0	1 (2.9)
Primary work setting					
Urban	2 (25.0)	7 (77.8)	6 (75.0)	5 (55.6)	20 (58.8)
Suburban	4 (50.0)	2 (22.2)	2 (25.0)	3 (33.3)	11 (32.4)
Rural	2 (25.0)	0	0	1 (11.1)	3 (8.8)
Clients at risk for HIV					
Yes	7 (77.8)	9 (100)	6 (75.0)	4 (44.4)	26 (76.5)
No	0	0	0	1 (11.1)	1 (2.9)
I don't know	0	0	2 (25.0)	4 (44.4)	6 (17.6)
Did not answer	1 (12.5)	0	0	0	1 (2.9)

Note. *Values are n (%).*

TABLE 2.

Illustrative quotations

Category	Professiona
Useful strategies for building trust	
Create welcoming and inclusive environments	
"Youth shut down if they feel they are being judged."	AH
"Our health room is a safe haven for LGBTQ [students], we listen, talk…"	SN
Provide LGBT-affirming care	
"…calling them by their preferred names and pronouns, not treating them differently."	EA
"The rainbows and pamphlets are good, but it is important that the staff is knowledgeable and sensitive to back it up. The kids have told me that they hate seeing someone wearing a rainbow pin who has no idea what it means to be trans."	AH
"When staff is part of the LGBTQIA community themselves, it has a big positive impact on the speed of how much trust can be made."	YW
Open, honest, and confidential communication	
"Have an open mind, self-reflect, but biases aside, patient centered care is essential."	AH
"I feel any conversation about sex or gender between myself and a student is confidential, unless the student is in danger of harming themselves or others."	SN
Perceived barriers and facilitators for sexual health communication	
Barriers	
School or institutional policies	
"I don't think we have a set policy, but my principal is squeamish about sexuality being discussed."	EA
"My parochial school does not address [HIV and STD prevention] just teaches abstinence."	SN
Political climate	
"Cultural, language, political climate of stakeholders for the program, whether or whether not its higher ups feel like that [sexual health] is a territory we should cover"	YW
Parent concerns	
"I feel the main barrier is fear of reprisal from parents and administrators…"	EA
"Parents are often unequipped to discuss sexual health with LGBT children."	EA
Stigma	
"There is the addition of stigma for being 'other,' a lack of support in developing healthy relationships, cultural role frustration for my [gender non-conforming and trans] clients."	YW
Facilitators	
School clubs (GSA)	
"GSA club discusses sexual orientation and gender identity, but I am unaware of [these discussions in] our health class."	EA
Open and supportive adult figures	

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Category	Professiona
"Showing my patients that I am comfortable with the conversation, I am there to partner with them, and not there to judge - makes a huge difference. You can see a physical change in posture, almost visible relief."	AH
Clear and inclusive language	
"There is a whole cultural language barrier, but basic anatomy and understanding the risks of pregnancy and infection is easy to discuss. I believe we need to call it what it is - and not be uncomfortable (or let them know it)."	SN
"I use really inclusive language in my education and assessments."	YW
More permissive policies on sexual health education	
"We made a big step last year having an LGBTQ+ student panel come talk to faculty for professional development. I had a lot of positive faculty feedback on that."	EA
Perceived barriers and facilitators for effective HIV prevention	
Barriers	
Limited PrEP/HIV prevention knowledge	
"I actually had a youth tell me yesterday he was afraid to start [PrEP] because his friend told him he would have to take it for the rest of his life."	AH
"There is zero information about it. "	EA
Resources & Access to *care*	
" [describing barriers] availability of transportation, price, knowing where to go, how to get there, stigma"	EA
Real and perceived confidentiality	
"…fear of being publicly outed. "	EA
Stigma	
"There's definitely stigma around PrEP, and I find it not only around the youth, but also among some providers. "	
"Some think it encourages continued risky sex. "	AH
Facilitators	
Supportive adult and peers	
"If parents are aware of their child's orientation and/or identity they can be a valuable asset, but usually parents aren't aware or aren't supportive so that is a barrier."	AH
SGM-affirming services	
"We have an excellent clinic that is LGBT and youth focused. They keep a certain amount of appointment slots open for drop ins."	SN
"I also think most trans youth are afraid they will experience discrimination when accessing any health care service. "	YW
Referrals for services	
"We also have community folks who act as patient navigators to help patients get PrEP. "	AH
"I think we owe it to our students to know the local resources and requirements or barriers so they can pursue help."	SN
Supportive institutional policies	
"In my state our minor consent law has been interpreted that it [PrEP] can be included under minor consent if the patient has a history of any STI in the past"	AH
"I have a toolkit of ways to help youth pay [for PrEP]."	AH

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Category	Professiona
Preferred content for HIV prevention tools	
Web-based or easily accessible education materials	
Free, easy to access, various formats	
"Depends on the venue. When I'm working with youth in detention, they HAVE to be paper resources. On the outside, electronic."	YW
Evidence-based and up-to-date	
"I have the capacity to run groups in my school setting, however they have to be evidence-based and most options are focused on heterosexual relationships and cisgender people. I wish there were more options that are affirming and inclusive."	AH
Trainings to support SGM competence	
Continuing education	
"Because providers need the credit…and an online module CME would allow them to work through it at their pace."	AH
LGBT and youth-affirming care	
"Approaches that are good for LGBT+ students are good for ALL students."	EA
"My youth need to feel safe, respected, and honored for their opinions."	YW
Guidelines for navigating policy or eliciting policy change	
General ideas for navigating policies	
"Would be nice to have the school advocates help one another on these issues, instead of all reinventing the wheel. Also a module on policy and intervention/strategies for dealing with local boards/administration."	SN
Strategies for effective communication with parents and institutional leadership	
"I think that we need to broker parent and teen connectedness around sexual and reproductive health to be able to do our best jobs as clinicians."	AH
Resources for referrals	
Peer educators/youth representation	
"I'd love to have the peer educators/community health worker set up."	AH
"…peer educator in-person training so kids can learn and be able to pass it on to other kids"	EA
"It is hard to describe as youth culture changes, but something that shows youth and is relatable. I think youth would need to be involved in the design."	AH
"I think current interventions focus on health deliverable and less on including the youth's opinions/thoughts and desires."	YW
Utilize popular technologies	
"My clients are using YouTube as a referral source to learn about disclosure and sex while transitioning."	YW
"Maybe something really simple, is to create a playlist of different pooled good videos on YouTube for them to digest on their own time."	YW

Note. AH, adolescent health provider; CME, continuing medical education; EA, school educator and administrator; GSA, gender sexuality alliance or gay–straight alliance; LGBTQIA, lesbian, gay, bisexual, transgender, queer, intersex, and asexual; PrEP, pre-exposure prophylaxis; SGM, sexual and gender minority; SN, school nurse; YW, youth worker.