AIDS and Behavior (2019) 23:1951–1963
https://doi.org/10.1007/s10461-018-2375-z

ORIGINAL PAPER

"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

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Published online: 18 December 2018

Abstract
Young, Black, gay bisexual or other MSM are significantly less likely to use PrEP than their White counterparts. These disparities may be due, in part, to medical mistrust and mistreatment within the healthcare system. This study aimed to uncover how young Black MSM's perceptions of, and experiences with, health care contribute to low engagement in the healthcare system and low PrEP utilization. In late 2017 and early 2018, we conducted six focus groups with 44 Black MSM ages 16–25 in Milwaukee. Focus group topics included participants' knowledge and perceptions of PrEP, perceptions and stereotypes about PrEP users, and general healthcare utilization patterns and behaviors. Focus group transcripts were transcribed verbatim and coded using MAXQDA qualitative analysis software. We used a team-based approach to thematic content analysis to understand how racism and homonegativity affected healthcare access and experiences. Results from this study help to characterize what contributes to mistrust of the healthcare system and healthcare providers to negatively affect PrEP use among young Black MSM. Focus group discussions revealed how previous and anticipated negative interactions with physicians and skepticism about the healthcare system have alienated young Black MSM from the health care system and created significant barriers to PrEP. Efforts to increase PrEP uptake and must address negative and discriminatory interactions with providers and the healthcare system.

Keywords Medical mistrust · Racial disparities · PrEP disparities · Young adults · Qualitative · Racism · Homonegativity

Introduction

HIV pre-exposure prophylaxis (PrEP) is a promising component of HIV prevention, particularly for gay, bisexual, and other men who have sex with men (MSM), demonstrating high efficacy among adherent users [1, 2]. Despite its success, uptake of PrEP outside of clinical trials has been relatively low [3–5], particularly among younger and racial and ethnic minority populations [6]. If disparities in PrEP use remain unaddressed, PrEP may become an HIV prevention mechanism accessible and utilized primarily by older, privately insured White MSM of higher socioeconomic status, further exacerbating HIV disparities [7, 8].

Most recent estimates suggest that less than 10% of individuals who could benefit are receiving PrEP [6]. There is also evidence of racial disparities in PrEP use; of the 1.1 million persons estimated to be indicated for PrEP, 45% are Black [9]. Yet, estimates of PrEP coverages indicate PrEP use is lowest among Black Americans [9, 10]. Furthermore, modeling studies indicate that with the current PrEP continuum of care, HIV incidence among White MSM could be halved in the next 10 years, but only reduced by 23% among Black MSM [10]. PrEP use is particularly low among Black adolescents [11] and individuals under the age of 25 [6], which is concerning given that youth aged 13–24 accounted for 21% of new HIV diagnoses in 2016 [12].

Some research has started to examine why there has been low PrEP utilization among at-risk Black individuals [13–15], yet questions remain. There is some evidence that medical mistrust, conceptualized as mistrust of doctors,

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health care providers, or drug companies, is associated with decreased willingness to take PrEP among young Black MSM [16].

Mistrust of medical institutions, health care providers, and the health care system is comparatively high among African Americans and LGBT persons [17, 18] and may pose a significant barrier to accessing biomedical HIV prevention [19, 20]. The United States has a dark history of medical mistreatment of African Americans including medical experimentation among African slaves, involuntary sterilization, the Tuskegee Syphilis Study, and continued unequal access to quality medical care, which may lead some individuals to be skeptical of accessing medical care [18]. Additionally, personal experiences of racism and discrimination in healthcare settings can contribute to the development and sustainment of distrust of physicians, medication regimens, and the broader health care system [21]. Such resistance to healthcare may be further complicated for LGBT individuals, who are also at risk for discrimination and mistreatment based on their sexuality. Intersectional stigma, or marginalization and discrimination rooted in multiple stigmatized identities (e.g. race, sexual orientation, HIV status; Logie et al. [22].) may make accessing needed healthcare challenging for Black MSM. LGBT individuals of color are more likely than non-Hispanic White LGBT individuals to lack a regular source of healthcare [23] and more likely to have had negative healthcare experiences or postpone care due to sexuality-related discrimination [24, 25]. Furthermore, Black MSM have reported experiencing high levels of healthcare-specific discrimination directed toward self, family, or friends [26], and are less likely than White MSM to disclose their sexual orientation to health care providers [27]. Awareness of patients' sexual identity and behaviors can help physicians provide tailored sexual health care, identify HIV/STI risk, and promote regular HIV testing and PrEP [28].

Although recent research has documented medical mistrust among both racial/ethnic minority and sexual minority communities [21, 24], additional work is needed to understand the nuances of medical mistrust and the experiences individuals have that contribute to medical mistrust and subsequently, decisions surrounding PrEP use. Medical mistrust is a broad term that fails to adequately capture the experiences of healthcare mistreatment, discrimination, and prejudice that contribute to mistrust of the healthcare system and providers among young Black MSM. There is a need to understand what contributes to medical mistrust and disengagement with the healthcare system in order to create a system that better meets the needs of underserved individuals. This study aimed to uncover how young Black MSM's perceptions of, and experiences with, healthcare contribute to low engagement in the health care system and low PrEP utilization.

Methods

Recruitment and Study Procedures

In late 2017 and early 2018, we conducted six focus groups with young Black MSM in Milwaukee. Inclusion criteria required that participants identify as Black or African American, were assigned male gender at birth, identified as gay, bisexual, or other men who have sex with men, were between the ages of 16 and 25, and reported an HIV-negative or unknown serostatus. Participants were recruited via a network of local social service providers that work with the young Black MSM community or offer HIV prevention and testing services, and through outreach on Facebook. Interested participants were screened for eligibility and scheduled for a focus group. Prior to the start of each focus group, individuals completed a brief questionnaire to capture prior PrEP use and demographic information and the informed consent process. Given the stigmatized nature of HIV, PrEP, and sexual orientation, we received a waiver of written consent. Focus groups were led by two research associate who identify as a Black gay men. Groups were held in community settings and conducted during weekend and evening hours to accommodate school and work schedules, and lasted approximately 90 min. Upon completion of the group, all participants received $50. The research protocol was approved by the Institutional Review Board at [Blinded for review].

Focus Group Content

Using a semi-structured focus group guide, we sought to understand social and structural barriers to PrEP use among the young Black MSM community. Content areas included (1) participants' knowledge and perceptions of PrEP, (2) perceived barriers to PrEP use, (3) perceptions and stereotypes about PrEP users, and (4) general healthcare utilization patterns and behaviors. Groups started with a short introductory video on PrEP to ensure a basic understanding about PrEP (https://ci3.uchicago.edu/blog-miprep-app/). This was followed by a structured focus group discussion to elicit participants' general attitudes toward PrEP and PrEP users and identify barriers to PrEP and healthcare utilization. We explicitly asked about experiences of discrimination, racism, and homonegativity from health care providers and sought to understand how these factors may affect PrEP uptake among young Black MSM.

Data Analysis

Focus groups were audio-recorded, transcribed verbatim, and coded using MAXQDA qualitative analysis software. Transcripts were initially coded using a combination of deductive and inductive coding to categorize the data [29]. We used a three-stage analytic coding strategy including open, axial, and selective coding [30]. We coded all six transcripts three times to refine codes and ensure adequate application of codes. The final codebook included barriers to PrEP (including stigma, lack of support, and perception of need), benefits of PrEP, medical mistrust, discrimination in healthcare settings, PrEP stigma, homonegativity (including 'down low', homonegativity within the Black community, internalized homonegativity, and anticipated homonegativity), and racism (including differences in healthcare treatment by race and racial discrimination). Coded focus groups were then analyzed using thematic content analysis [31] to identify emerging themes, highlight patterns in the data, and uncover meaning within the text. Data were analyzed to characterize medical mistrust among young Black MSM and determine the extent to which medical mistrust influences young Black MSM's perceptions of PrEP.

Results

A total of 44 young men participated in six focus groups. The size of the group ranged from five to eleven participants. The average age of participants was 22 (range: 18–25). Seventy-five percent (n = 33) identified as gay; others identified as bisexual (n = 8), pansexual (n = 1), no label (n = 1), and straight (n = 1). Twenty of the 44 participants (48%) had a high school diploma or equivalent; five had less than a high school degree, 14 had some college, 4 had college degrees, and one chose not to answer. Over two-thirds (n = 36; 81%) were working full or part-time; half the participants (n = 22) earned less than $10,000 per year. Ten participants (23%) had taken PrEP before. Per inclusion criteria, all participants identified as Black or African American; four were more than one race (White, Asian, and Native American) and five were also Hispanic/Latino. We acknowledge that race is a social construct. Yet, given racial disparities in HIV and the potential influence of racism on healthcare access, it is an important construct to consider. This study took place in Milwaukee, Wisconsin, a city that, like much of the United States, experiences significant racial disparities in HIV. In Milwaukee in 2016, the HIV diagnosis rate for Black MSM was four times higher than for White MSM, and the median age at which Black MSM were diagnosed with HIV was 23 [32]. Thus, we situate the experiences of the men in this study within the context of institutionalized inequity and historical and political patterns of power inequity and racism.

Eight participants (18%) noted in their demographic survey that they were currently using PrEP. There was one PrEP user in each group and groups 1 and 2 both had two participants on PrEP. However, it is important to note that these men did not all volunteer this information to the group. In fact, only four of these participants talked about their own PrEP use or experience obtaining a PrEP prescription during their focus groups. Thus, in many groups when individuals were describing PrEP users or perceptions of PrEP more generally, they were frequently doing so without knowledge that someone in the group was using PrEP.

Analyses aimed to understand how medical mistrust and perceptions of physicians and health care settings influenced Young Black MSM's thoughts about PrEP. Analyses revealed the continued effects of racial and economic disadvantage on health care access and the ways in which racism and homonegativity influenced young men's comfort discussing sexual behavior with physicians. Although there was certainly variation in experiences and views within each of the six focus groups, analyses did not reveal any differences in general perceptions or experiences across the groups. Excerpts from the six focus groups are used to demonstrate the primary themes.

Excerpts from the six focus groups are used to demonstrate six primary themes: trust and passive aggressive racism; the emphasis on participants' HIV risk among providers; structural disadvantage; cultural healthcare norms; patient-provider racial concordance; and resistance to providers' PrEP recommendations. Collectively, these themes illustrate how participants' relationship with the healthcare system has influenced their perceptions on PrEP and contributed to mistrust of providers, PrEP, and healthcare.

Trust and "Passive Aggressive Racism" in Healthcare Settings

In an effort to characterize perceptions of and barriers to PrEP, we initially wanted to understand young Black MSM's relationship with the broader healthcare system and comfort accessing preventive health care. Trust in health care providers was often central to those conversations, as young men described the need to have trusting relationships with providers prior to being willing to talk to them about sex or disclose their sexual orientation. Yet, they described how racism and discrimination fueled healthcare mistrust. While young men generally did not report experiencing overt racism or discrimination in health care settings, they did describe the ways in which they were treated unfairly and received substandard care.

P2: I feel like that long waiting time, that feeling neglected at the hospital, that just all go with the passive aggressive racism that happens in certain states like Wisconsin. Whereas like in the South there's more direct racism, I feel like in Wisconsin it's more passive aggressive. Smile in your face, 'Hey, how you doin'?' But I'm gonna hold you down, type of racism. So it's like, while you in our hospital, I could serve you if you came in at 2 p.m., but I ain't serve you until like 6 p.m. because I got all these other people that came in that I'm gonna attend to first. [Focus group five]

Descriptions of mistreatment and perceived racism frequently included descriptions of procedural and administrative duties that participants believed White individuals generally did not experience. For example, much like described above, another participant described having to wait for several hours in an Emergency Department to be treated for a stomach virus, which he perceived to be rooted in racial bias. Such perceptions were particularly evident when men described such treatment at hospitals or clinics located outside of the central city. Participants also felt their mistreatment stemmed from insurance. The young men in focus group six discussed how, because of their race, they are stereotyped as having public or inferior health insurance and are therefore receive inferior treatment compared to White patients.

P5: I honestly, I feel like that [White patients] get like that different and everything. (Group agreement) I think, like from the minute we walk in [the clinic], they just already know, like, "Okay, they probably of some type of Title 19 or state insurance or something" But when a White person come out, in my honest opinion, when a White person come in there, they look at them, like, okay, they know that they can probably get more money out of that White person than a Black person 'cuz they insurance only take them so far. But a White person, you know what I'm saying, they insurance probably can go further and things like that, so. [Focus group six]

Although in this excerpt they were discussing healthcare more generally, the perception of receiving inferior medical treatment can contribute to individuals' reluctance to start PrEP.

In discussing perceived substandard care for Black gay men, focus group three participants described how racism, homonegativity, discrimination, and poor medical care had become expected and accepted as part of their health care. Preceding the following excerpt from focus group three, several participants had just shared personal stories of discrimination and poor treatment:

Facilitator: Why do we, as a gay Black community, why do we allow situations like that to become a common thing?

P3: 'Cuz we feel like our reason for being there, we have no business for being there in the first place. Like we just get the services that we get, you know.

P4: As long as we're feeling better.

P2: 'Cuz dealing with it for so long and feeling unaccepted for so long. [Focus group three]

These sentiments were echoed in other groups. Participants felt undeserving of high-quality treatment because medical mistreatment and substandard care had become their norm. Through their own experiences and those of their family, friends, and community members, participants could recall so many experiences of stigma and mistreatment that they had come to expect and accept homonegativity, racism, and discrimination. This is not to say they did not identify the injustice in this or desire better care, but such experiences had become so commonplace that they were no longer shocking or unexpected.

Young Black MSM Reduced to Their Sexuality by Doctors

The perceived racism participants faced was complicated by the intersection of homonegativity. Throughout focus group conversations, participants described being hesitant to disclose same-sex sexual behaviors to physicians, which, subsequently, limited conversations about PrEP. While the lack of a trusted, regular provider was one factor in this, this discomfort was also rooted in anticipated homonegativity and poor treatment from physicians.

P1: I don't want to say it's all White doctors, 'cause I've had some good ones, but it's just that they treat gay men like we nasty… I even asked, "If you don't wanna do it, you can bring a woman nurse in here if you want to." Like, that's how I felt. It was hemorrhoids, but it was just like, how come they assume that because I'm gay, I'm just nasty? You don't know the half of it until you become a gay man.

P2: Yeah, I just feel like a gay man and a doctor are just like, a recipe for destruction. [Focus group five]

In every group, at least a few participants had similar experiences of being mistreated, talked down to, or feeling like they were perceived as 'nasty', and there was nearly universal recognition that such experiences were commonplace and to be expected if they disclosed their sexual behaviors. It is important to highlight that this was a conversation

specifically about White physicians, although in most discussions, 'physician' seemed to be synonymous with 'White man'. Participants generally noted they would feel more comfortable with an African American physician (although most had never interacted with one), whom they felt could understand them and would be less judgmental. The fear of both race- and sexuality-based discrimination and prejudice from White physicians contributed to the notion that a gay man and doctor is a "recipe for destruction."

In addition to fears about disclosure, these young men believed that physicians who asked too much about sexual behavior were "crossing boundaries" and they often felt like physicians were asking questions with mal-intent. In focus group five, for example, one individual explained why he was hesitant to discuss sexual behaviors with his doctor.

> **P7:** I would think they would either be going two ways. Like, A, trying to pull me out on some shit, trying to make me feel like I'm embarrassing myself or something, or B, they might be fetishizing the situation, to belittle me, to ask you these things, 'cuz they're fantasizing in their own mind. 'Cuz you wouldn't have asked, you wouldn't have anybody else, "you hit her from the back or is she gettin' on top?" [Focus group five]

Several others agreed. They suggested the information was generally irrelevant and believed that physicians just used their sexual behaviors to humiliate or eroticize them. Mistrust of physician motives for wanting to know about sexual behaviors often stemmed from past experiences of discrimination and homonegativity. In focus group two, for example, the young men described how, upon revealing their sexual behaviors to their doctors, they were stereotyped or not given appropriate treatment.

> **P5:** From personal experience, I went to a doctor and I kinda had to, like once I told him my situation, I think he stereotyped me, and I didn't like that.
> **Facilitator:** When you told him your situation as your sexual orientation, about being gay?
> **P5:** Mm hmm.
> **I2:** Okay. When you said he stereotyped you, what do you mean?
> **P5:** He like automatically assumed that because I was gay this was what was wrong.
> **P4:** And that is true!
> **P5:** And you see what was really wrong? He just assumed because I was Black and I was gay, that this is what happened… I really, to be honest, I don't know I've been to the doctor since then. [Focus group two]

These young men highlighted an important issue. As young Black MSM, they are at heightened risk for HIV and other STIs and recent public health efforts have pushed for physicians and other health care professionals to incorporate sexual health risk assessment and brief interventions. Yet, as a result, these young men expressed frustration over feeling reduced to their sexuality and physicians' emphasis on sexual health.

> **P3:** They're like so focused on STDs and stuff instead of like the pain, or what you're really going through. They just wanna test you, make sure you ain't got no STDs. [Focus group three]

The perceived sole focus on their sexuality severed trust with physicians and created a reluctance to receive healthcare all together. Participants noted that, upon revealing sexual behaviors, physicians only looked at them as young gay men at risk for HIV, rather than treating them as a whole person, with other healthcare needs. This was not only stigmatizing, but individuals in focus group two felt that it was a significant barrier to obtaining PrEP.

> **P1:** It can increase the stigma that we already have out here. It gives [doctors] the opportunity to add on some additional concerns that are gonna be lumped into the whole stigma bowl.
>
> **P3:** Right when you say you're gay it's like, STD check! Like right away it's like, I didn't come here for that. I gotta itch right here. (group laughing) Like, you know I got an itch on my head, do an STD check? What? No! (group laughing) [Focus group two]

Although several participants in the groups understood why a physician might need to ask about sexual risk behaviors (i.e. whether they have condomless sex or whether they have insertive or receptive anal sex), they still expressed concern that if they disclosed their sexual behaviors, they would only be looked at as at-risk for HIV. Context was also important; asking about sexual behaviors seemed appropriate if they were getting tested for STIs, but not if they were at the doctor for other health concerns. Furthermore, this conversation highlights the risks associated with being diagnosed with an STI or starting PrEP. These young men felt they were already stigmatized enough due to their race and sexuality that the potential for an STD diagnosis or PrEP prescription would just add to 'the whole stigma bowl' with which they were already contending.

Structural Disadvantage

YBMSM's distrust and discomfort seeking sexual health care or talking to their physician about PrEP stemmed, in part, from generations of medical mistrust, mistreatment, and disadvantage. Such experiences have shaped cultural norms about health care, the availability of quality and

affordable community-based care, and patient-provider interactions. Participants described feeling excluded from the larger healthcare systems and well-known quality clinics (both geographically and socially). Despite some benefits of local community-based clinics, there were notable disadvantages to receiving clinic-based care in their communities.

P2: I like [neighborhood clinic], cuz it's, like, more of my color, and then they don't hold back.

P3: It's convenient.

P6: Yeah. Yeah. It's convenient.

P4: That's why it's located in our community.

P5: But it's not that same level of attention in a hospital, 'cuz [the clinic] like, "Oh, are you dying? No, okay, all right, you fine."

P1: Convenient 'cuz of the hours.

P4: They also have sliding scales, sliding pay scales at clinics, and you don't get those options at, like, the hospital.

Facilitator: Do you think our community is more comfortable with the clinic aspect versus actually finding a primary care physician?
(group says yes)

P6: And then he was just gonna answer—I don't think everyone heard—he said that the clinics are in a place, like in the hood—and so that's what's there for us. It's like shit, the hospital, that's, how far?

P3: Like that's unfortunate, you know, that they play clinics against one another, 'cuz it's, like, they try to keep you away from the better, you know? Ultimately the better care at like hospitals and stuff like that. [Focus group four]

While participants in most focus groups cited more racially diverse, affordable, easily-accessible care at neighborhood clinics, they also perceived the care to be inferior to what they might get at a hospital or in a White neighborhood. Participants described how the clinics in the "hood" were intended to keep them out of hospitals or better health care options outside of the central city, despite the fact that there are hospitals located throughout inner-city neighborhoods in Milwaukee. Although participants rarely specified which neighborhood clinic or hospital they were referring to, they perceived healthcare outside of their neighborhoods to be of higher quality and intended primarily for White higher-income residents. This may reflect participants' awareness of the racial segregation and economic inequity faced by Milwaukee communities, and the unequal distribution of health care resources and resulting disparities in health. Focus group four participants discussed how this could be contributing to disparities in PrEP uptake.

P3: What about if you in a more, more like metropolitan area, and the majority of that community is White, then I feel like it's more attention brought to it 'cuz there's more money going into these people. And, you know, it's like if they have, you know, better doctors.

P5: They gonna push [PrEP] more.

P3: They have more knowledge about it. It's theirs. More like presented to them that it is, and, you know, a clinic in the hood… Like there's just so much, there's a lot going on in the hood. There's so much that's not going on in the hood. Like we don't have, you know, access to a lot of things, like, you know, dentist places and hospitals. Like we just don't have the resources that, that White people have in the hood, basically. [Focus group four]

This participant highlighted the effects of historical disinvestment in central city neighborhoods in Milwaukee, structural and systemic racism, and disadvantage. Participants in all groups readily acknowledged that their neighborhoods lacked the same investment and resources seen in primarily White neighborhoods, including healthcare. As a result, they felt that the "hood" had inferior doctors and resources and they had fewer opportunities to learn about and initiate PrEP. It's also notable that this participant described PrEP as 'theirs', referring to White people. While some participants expressed frustration over feeling as though PrEP was pushed on young Black MSM in particular, they simultaneously saw it as an intervention and opportunity created with the intention of helping White men. Among those who felt PrEP was being pushed on the Black gay community, there was skepticism about the effectiveness and intentions of PrEP. For example, in focus group five, participants discussed how they would feel if a doctor suggested they might benefit from PrEP:

P2: Yeah, like if I was confronted with, like, something like that I'd be like, whatcha mean? Like I'd be very offended.
Facilitator: You get offended?
P2: Yeah. Like I'm no test dummy.
P3: The doctor be sayin', because they be doin' a lot of experiments on people…
P2: They do.
P3: Like and on animals and stuff. They never know, like, you know, um, um, what's the actual benefit or outcome of you being on something that just the doctor said.

P5: All doctors don't be, you know, doctors for the right reasons. [Focus group five]

Explicitly questioning the benefits, legitimacy, and safety of PrEP occurred in four of the six focus groups. Specifically, several men raised concerns about the 'testing' of medications on Black and gay people and expressed skepticism about the targeting of PrEP toward Black MSM. Although they recognized that, as a community, Black MSM were at higher risk for HIV and therefore could benefit from PrEP, they were suspicious of efforts to get them to take a medication they did not feel they needed. These concerns reflect deep-seated medical mistrust and underlying conspiracy theories about HIV and fears of being tested on by physicians. This skepticism about physician intentions was amplified for these young men who were contending with racism and homonegativity in healthcare settings, which reinforced medical mistrust.

Cultural Healthcare Norms

In addition to structural barriers, there were cultural and social barriers to PrEP and healthcare. Few focus group participants received routine primary care from childhood through young adulthood, often citing their parents' mistrust of healthcare and the burden on families of high medical bills.

P4: I think we as a community, as our Black community, when it comes to, like, going to the doctor and getting check-ups, we don't do that too often. You know what I mean? Growing up your mama like, "You bust your head and I ain't take you to the hospital" type thing, you know. (group laughing) So we already have kinda that standoffish, we're not going to the doctor and not doing something, so it's like why take medication for something? I don't have HIV, so why do I need to be takin' things for it? [Focus group four]

Cultural norms around preventative healthcare made it difficult for many young men to understand why they would take medication preventatively, or, as this participant noted, why they would take PrEP if they didn't have HIV. Although participants were told PrEP was for HIV prevention, the use of Truvada as both HIV treatment and as PrEP lead many to question why they would take PrEP if they were not HIV-positive or if they used condoms.

Lack of routine care presented challenges to building trusted relationships with health care providers. Most participants only went to the doctor in more urgent situations or as infrequently as possible, which made it difficult to establish a trusting relationship with a primary care physician. This lack of trust reinforced participants' reluctance to discuss sexual healthcare with a physician. Participants who had long-term, established primary care physicians generally reported more comfort discussing sexual health with their doctors. The majority, however, did not have an established provider and reported more discomfort with and greater perceived homonegativity from physicians.

P4: It's just like, it's that bond you got with your doctor, too. Like if you ain't got no, like nowadays, like, doctors, you feel like you're just a number, you're just a bill. If you ain't got the right insurance they not messin' with you, you know what I'm saying? It's so hard to find. You gotta look for a clinic that takes your insurance. It's just like, it's just hard to get a personal relationship with, with your primary doctors now. [Focus group two]

Participants generally obtained healthcare in settings that were not LGBT-specific, which lead to greater discomfort and uncertainty about the consequences of disclosing their sexual orientation. Furthermore, they often saw a different provider at every appointment, contributing to impersonal care where they felt like "just a bill". Seeing a new physician at every visit meant that, if they were to disclose their sexual orientation, they would be 'coming out' over and over again and face the stress and risks associated with disclosure at every visit, as they anticipated homonegativity and mistreatment. These sentiments were also present in focus group five:

P5: We don't want nobody in our business. (group agreement)
P1: Yeah, it's hard to establish trust.
P6: Tryin' to get you to get on PrEP and stuff.
Facilitator: Okay. (group laughs) Okay, if you, but if you look at that person as the individual that kinda is the one that can do the most for you health-wise, why are we still as a community so closed off to reveal our lives to them?
P2: I feel like a lot of people in our community don't look at doctors like that though.
Facilitator: How do we look at 'em as?
P1: I look at my doctor like that. She, she's everything—like I love her. But I feel like a lot of people don't because, like I said, you go to the doctor, you got different doctors every single time that you go.
P5: You can't build that relationship with her.
P1:"I just had sex with three niggas last week." (group laughing) That, you not gonna do that, 'cuz you don't know this person. Like they just, you just here for like a check-up or whatever. You not about to tell them like your whole life story.
P6: Yeah, I think it's about trying to have that one consistent person you can build a relationship with,

that you can be open with. Like your hairdresser. You know, you only trust one person, so going to another person is scary, you know what I mean? [Focus group four]

Without a trusted provider, young men were skeptical about physicians' intentions to get them on PrEP or test them for HIV or other STIs. Lack of trust also contributed to perceptions of providers just being "in [their] business" rather than having their best interests in mind. Having an established physician that young men could build a relationship with over time could provide a pathway to a trusted relationship and greater opportunities to receive needed healthcare. Without the opportunity to build a trusting relationship, young men were less likely to talk about their sex lives.

Patient-Provider Racial Concordance

Discussions of medical mistreatment, mistrust, and disengagement frequently turned into discussions about the race of their physician. Although few participants had ever received care from a Black physician, they expected they would experience better treatment from someone of their same race. Young men in focus group two, for example, described how a Black provider would be more likely to be understanding and less judgmental.

P4: I would feel more comfortable with like a minority as my doctor, like a Black over White.

Facilitator: Why?

P4: I just feel like, White people don't know the tea. Like White people don't know, like, what's going on in this type of, like, you know, our group. It's like, you're not judgmental, but it's just like they don't know. Like it's not easy talking to a White person about stuff that we go through, versus talking to a-

Facilitator: So when you say that, you're meaning more like the stuff we go through, like the social, economic issues? Like I may have come from a single family and somebody may not, I may not have graduated?

P4: Yeah, they may not feel like they're not judging, but you're feeling judged, like, because, like you're a doctor, you went to whatever school. Like shit, I'm just getting out here making this amount of money. You know what I'm sayin'? I came from the dirt. It's like we, it's the different fabrics. But yeah, we don't understand each other. Like, we can't. [Focus Group two]

White doctors' inability to "know the tea", or know what's going on in their community, and understand the culture and experiences of Black people, made it difficult for participants to open up to a White doctor. The racial and historical trauma, cultural norms, and social and economic disadvantage that many Black families in Milwaukee face added a layer of discomfort for several participants. Young men also expected that they would be able to more easily build trust with a Black physician.

P4: For me it's the comfortability. With the Black doctor, okay, I can understand, she can understand me. She's Black. She knows the health concerns of the African American community. With the White doctor, okay, he knows the concerns, but he, he just doesn't relate to 'em.

Facilitator: Okay. Gotcha.

P2: So what may be wrong with me might not be happening with [a White doctor]. But with that Black doctor she probably know her auntie or, and I'm not necessarily saying, like, other people don't experience diabetes or all those other things, but it's, more, you know, when I with my doctor, like you said she like, "Boy, you know…" She just remind me of my grandma telling me to get up and check-up. And I've had great White doctors that were nice and, you know. It's just, it's, it's like family. [Focus group three]

The familiarity of and comfort with a Black physician, much like that of family members, suggests a level of trust and understanding that White physicians cannot provide to young Black men. Black physicians were perceived to be more understanding and relatable because of their shared racial and cultural background. As one focus group participant said of his discomfort with White doctors, "Just different walks of life. Different life battles and struggles." It is also noteworthy that the participant in focus group three, quoted above, referred to a female physician. Although gender was not as notable a factor as race, there were several participants who expressed preference for female providers, whom they perceived to be more motherly and less homophobic.

Resistance to Physicians' Recommendations for PrEP

Perceived racial and sexual stigmas, mistrust, and structural and social barriers collectively contributed to young men's reluctance to talk to physicians about PrEP. Overwhelmingly, young men did not want physicians suggesting they consider PrEP. Similar to their frustrations with providers pushing HIV and STI testing, participants found the idea of a doctor suggesting PrEP offensive and stigmatizing. Participants believed physician-initiated

conversations about PrEP revealed physicians' stereotypes about gay men, particularly Black gay men, as 'risky'.

> **Facilitator**: Okay, now I want you to think about, imagine a friend of yours who goes to the doctor, and his doctor suggests that he might be a good candidate for PrEP. Why might he decide not to go on PrEP? Even if the doctor-
> **P6:** First of all, I would be offended.
> **Facilitator:** So you would be offended?
> **P6:** Yeah! Why you gonna tell me that I'm a good candidate for PrEP? What does that mean, like?
> **P1:** They probably feel like they not at high risk, so like the doctor who, like, knows what they talkin' about, they tellin' you that you a good candidate, but you in your heart might not feel like.
> **P5:** No, I'm good. I'm a bad candidate.
> **P1:** Yeah, like I protect myself. Like I be safe, that type of stuff. [Focus group four]

Among these participants, the aversion to doctors suggesting PrEP was rooted in perceptions of being at low risk for contracting HIV. In general, most participants in all six focus groups did not feel they personally needed PrEP. They also had such engrained stereotypes about individuals who were taking PrEP that it was offensive for a doctor to even suggest that they too might benefit from PrEP. When asked why someone might not take PrEP if his doctor had suggested it, the men in focus group five, for example, were concerned with physicians' presumptions of promiscuity.

> **P6:** He [hypothetical young Black MSM] feels like it don't fit him or he don't need it, or he not the right candidate for it.
> **Facilitator:** Okay, like a Superman aspect, like okay, you talkin', but that ain't about me, okay.
> **P3:** Yeah, he might, depending on who it is, he might of woulda went off on him, like, "What do you mean I'm a candidate for PrEP?"
> **P9:** Yeah, like he a charity case.
> **P7:** Yeah, he tryin' to say I got HIV or something? (group agrees)
> **P9:** Like he a ho. [Focus group five]

This conversation reflects the underlying stereotypes they held about who is or should be taking PrEP. Much of the PrEP stigma among these men was rooted in fears about being perceived as HIV-positive and presumptions of promiscuity and riskiness. Although eight of the 44 participants (18%) were currently using PrEP, the majority of young men did not think they needed PrEP and stereotyped individuals on PrEP as being risky and needing something other than condoms.

Discussion

Previous research has documented medical mistrust among both racial and ethnic minority and sexual minority communities [21, 24]. Our study extends this work by unpacking what contributes to mistrust of the healthcare system to negatively affect PrEP use among young Black MSM. It was evident in our focus groups that the resistance to PrEP extended beyond PrEP stigma, HIV stigma, or discomfort discussing sexual health. Rather, much of these young men's resistance to PrEP was rooted in prior experiences of, or anticipated negative interactions with, physicians and skepticism about the healthcare system. Racism and homonegativity have alienated young Black MSM from the health care system and created significant systematic barriers to health care and PrEP.

As has been documented in previous research [33, 34], generations of medical mistreatment and historical disadvantage have contributed to structural and cultural barriers that made it difficult for these young men to establish care with a trusted physician. For example, participants felt judged and stereotyped by White physicians, whom, they perceived, were unable to understand the social and cultural backgrounds of these men. Additionally, young men expected substandard treatment in medical facilities, citing racism and homonegativity, inferior clinics in 'the hood', and being geographically and socially excluded from higher quality health care. Compared to White men, Black men are significantly more likely to live in neighborhoods characterized by racial segregation, poverty, and unemployment, which can limit access to quality healthcare [35–37]. Racial segregation can also contribute to disparities in the availability of providers, and provider quality has been found to be lower in neighborhoods with a higher concentration of Black or Hispanic residents [38]. Furthermore, unconscious racial biases among physicians can contribute to poorer healthcare experiences among Black patients [39], biased treatment recommendations, poor health outcomes, and poor patient-provider communication [40]. Regardless of the availability and quality of healthcare in participants' Milwaukee neighborhoods, participants had strong perceptions that they received inferior care and could receive higher quality care if only they were White, straight, or living in a wealthier neighborhood. As evident in their discussions, these perceptions of mistreatment were often attributed to administrative barriers and long wait times, but were often perceived to be rooted in racism.

Further fueling mistrust, perceived homonegativity from health care providers was a persistent barrier to sexual healthcare and PrEP use. Young men found physicians, particularly White male physicians, to be uncomfortable

treating LGBT patients and many had experienced prejudice and discriminatory treatment as a result of their sexuality. Anticipated discrimination, or the belief that you will be stigmatized or discriminated against, may be more influential than enacted or internalized stigma in affecting healthcare engagement [41]. Anticipated stigma from physicians can lead to alienation from the healthcare system and limited engagement in HIV prevention activities [42]. Most individuals in this study did not have a primary care provider, which is a significant barrier to obtaining PrEP [43]. Without a trusted provider, individuals expressed fears about having to disclose or 'come out' at every health care visit, and the anxiety and discomfort associated with not knowing how a provider may respond. This is significant, as disclosure of same-sex behaviors to healthcare providers is positively associated with PrEP awareness among young Black MSM [44]. Yet, even among those who have a primary care provider, racial biases and sexual stereotypes may contribute to inequitable PrEP access [45].

There have been recent efforts to incorporate sexual healthcare and PrEP services into primary health care settings [46], intended to fill a gap in sexual healthcare for young Black MSM. Yet, our results suggest that singling out Black MSM for PrEP or sexual health care screening and education may inadvertently sever trust with providers. Rather, such conversations should be universally incorporated into primary care, regardless of one's race or sexual identity. Furthermore, providers need to do more to let patients know why they are asking certain questions about risk behaviors, educating patients on all prevention options, and ensuring they and their practices are welcoming to sexual and gender minority patients. Interventions with primary care providers are needed to enhance cultural competence, improve their comfort with sexual health care and PrEP, and improve their understanding of the social and structural factors that contribute to an individual's decision to initiate or adhere to PrEP. For example, it is recommended that providers ask only relevant sexual health questions and explain the purpose of the information to avoid the perception of unnecessary intrusion or discrimination [47], which was seen among men in this study. Routinization of appropriate and culturally tailored sexual healthcare in medical settings may be an important way to reduce stigma and increase YBMSM's comfort with physicians [48]. Yet, such interventions must be done in a way in which young Black MSM do not feel stereotyped, targeted, or merely viewed as at risk for HIV.

Young men in this study also expressed an overwhelming resistance to physicians' recommendations of PrEP. Clinical practice guidelines state that PrEP is indicated for "MSM at substantial risk of HIV acquisition" [49, p. 33]. In this study, participants described PrEP users as promiscuous and unsafe, and clinical guidelines would seem to support this characterization. Thus, it is not surprising that young men thought the mere suggestion of PrEP by a physician was intended to further stigmatize or embarrass them and was an indication their doctor thought they were 'a ho'. The stigma surrounding PrEP was such that even considering PrEP for themselves would require acknowledging that that they were promiscuous or unsafe. Furthermore, asking a doctor about PrEP essentially 'outs' a man to his physician, revealing he has sex with other men, perhaps without a condom, and views himself at risk for HIV. There is a significant social risk in doing so that may prevent many young Black MSM from seeking out PrEP. Our findings support recent work that suggests that characterizing PrEP as an intervention for individuals at "substantial risk of HIV" alienates potential users and fuels the stigmatization of current PrEP users [50].

There is a clear need for more comprehensive training of physicians and other health care professionals. While efforts to incorporate HIV/STI testing and other sexual healthcare into primary care are laudable, they must be appropriately situated in the patient visit. The primary complaint among these young men was the experience of disclosing their sexual orientation to a physician and being stereotyped as merely an HIV or STI risk. PrEP is a lifestyle choice that necessitates a patient-centered approach and should be characterized as an empowering opportunity to improve one's sexual healthcare. Part of this effort also means moving PrEP out of clinics and formal healthcare settings in order to increase the comfort and trust of young Black MSM. Collaborations between health care systems and established, trusted, LGBT and youth-centered social service organizations and community health centers may provide avenues for young men to receive regular, comprehensive health care from providers who are knowledgeable and sensitive to the health and social needs of LGBT youth, while also increasing PrEP uptake [50]. Additional efforts should focus on enhancing LGBT cultural competence among providers to encourage inclusive language (e.g. asking about preferred gender pronouns) and create an environment that is welcoming and inclusive of LGBT patients (e.g. unisex restrooms) [51]. Additionally, educational efforts and medical school pipeline programs are needed to enhance the racial and sexual identity makeup of the healthcare workforce, increasing the number of Black providers, particularly those who are also gay and bisexual. Participants overwhelmingly expressed a preference for African American and/or gay providers, who they believed they could better relate to and receive better services from. Such preferences support previous research indicating that individuals prefer to receive HIV prevention and treatment services and report higher quality of care and trust from providers who share their racial and ethnic background [52, 53]. Our findings indicate that such

preferences can shape access to PrEP, disclosure of sexual identity to providers, and general healthcare utilization.

This study is not without limitations. The lead author, who also designed this study, is a White, heterosexual, cisgender female. Inevitably, this positionality influenced the design, execution, and data analysis in this study. That said, we acknowledge the importance of historical, structural, and political forces that influence the lives, experiences, opportunities, and health of young Black MSM and worked to acknowledge and address investigator bias throughout. The two research assistants for this study are Black MSM and in addition to leading the focus groups, they had significant input into focus group topics and question design and assisted with analysis. This study took place in Milwaukee, WI, a mid-size city with a relatively small population of young Black MSM. As a result, several individuals within the groups knew each other and one or both of the research assistants leading the groups. It is possible that this influenced what participants chose to reveal and the ways in which they talked about HIV risk and prevention. Additionally, many of the participants were referred to the study through their involvement at local community organizations. These participants may have known more about PrEP, have been more familiar with HIV prevention, and have greater familiarity and comfort with discussing sexual health care needs with providers. As such, awareness, trust, and acceptance of PrEP may be even lower among the general population.

With less than 10% of those behaviorally indicated for PrEP receiving it and evidence of racial disparities in PrEP use [6], there are increasing efforts to scale-up PrEP among priority populations. Yet, much of these efforts focus on awareness and access. Our findings indicate that even with awareness and access, young Black MSM may not be able to access PrEP given negative and discriminatory interactions with the health care system. Without significant efforts to engage young Black MSM in the broader healthcare system and efforts to reduce PrEP stigma, we are certain to see continued racial disparities in PrEP uptake and adherence and an exacerbation of HIV disparities.

Acknowledgements We are incredibly grateful to the young people who participated in this study and we were willing to share intimate details about their lives and healthcare experiences. This research would not have been possible without the community organizations and leaders who partner with us.

Funding This study was funded by the National Institute of Mental Health (K01 MH112412; PI: Quinn) and supported by the National Institute of Mental Health Center Grant (P30-MH52776; PI: J. Kelly).

Compliance with Ethical Standards

Conflict of interest The authors have no conflicts of interest to disclose.

Ethical Approval All study procedures were in accordance with the ethical standards of the Institutional Review Board at the Medical College of Wisconsin and with the 1964 Helsinki declaration and its later amendments.

Informed Consent Informed consent as obtained from all individuals who participated in the study.

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