

Bridging the Gap: A Systematic Review of Barriers and Facilitators to PrEP Adoption Among Black Immigrants in High-Income Countries

Thabani Nyoni

TNyoni@dal.ca

Dalhousie University <https://orcid.org/0000-0002-0100-6258>

Danilia Nellie Takang Fombang

Dalhousie University <https://orcid.org/0009-0007-6235-636X>

Andrae Banks

North Carolina Central University

Madeline Rae Hutchinson

Dalhousie University

Roger Antabe

University of Toronto

Wale Ajiboye

St. Michael's Hospital, Unity Health Toronto

Dominic Hakim Silvio

Dalhousie University

Systematic Review

Keywords: PREP, HIV prevention, Sexual Health, Black immigrants, high-income countries, socio-ecological model, structural racism, migration and health, Stigma

Posted Date: September 29th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-11157402/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

Additional Declarations: The authors declare no competing interests.

Abstract

Black immigrants in high-income countries experience a disproportionate burden of HIV yet remain underserved by pre-exposure prophylaxis programs. This systematic review synthesized evidence on barriers and facilitators to PrEP adoption among Black immigrants in high-income countries and mapped these determinants across socio-ecological levels. Following PRISMA 2020 guidelines and the Arksey and O'Malley framework, we searched seven databases, conducted citation chaining and grey literature searches, and included studies published from 2010 onward that reported empirical data on barriers and or facilitators to PrEP awareness, access, uptake, adherence, or continuation among Black immigrants, refugees, asylum seekers, or newcomers in high-income countries. Two or more reviewers independently screened records, extracted data, and synthesized findings thematically using a socio-ecological model. Forty-two studies met the inclusion criteria, including qualitative, quantitative, and mixed-methods designs from North America, Europe, and Australasia. PrEP adoption was hindered by low or inaccurate risk perception, limited awareness, concerns about side effects and pill burden, gendered power imbalances, partner conflict, stigma, moral and religious norms, provider knowledge gaps, lack of culturally and linguistically appropriate services, centralized clinic models, cost and insurance barriers, and immigration-related fears. Facilitators included trusted, culturally safe providers; community-based and Black-led education, navigation, and social support; and universal or highly subsidized PrEP coverage integrated into familiar services. PrEP inequities among Black immigrants are shaped less by individual willingness than by multilevel structures of racism, migration governance, and gendered power. Improving PrEP uptake will require culturally grounded community strategies alongside structural reforms to service delivery, eligibility, and financing.

INTRODUCTION

Black immigrants experience a disproportionately high burden of HIV in many high-income countries (HICs), reflecting persistent structural, social, and health system inequities. HICs are defined here using the World Bank classification, which designates countries as high-income when their gross national income per capita exceeds the annual threshold (more than 13,935 US dollars for the 2026 fiscal year). In Canada, African, Caribbean, and Black communities constitute approximately 2.5% of the population, yet represent 16% of people living with HIV, and similar disproportionalities are evident in the United States (US) and the United Kingdom (UK) [1, 2]. These disparities, often six to tenfold higher than national averages, underscore that HIV vulnerability among Black immigrants is produced within host country contexts and is driven by structural inequities in prevention access rather than individual risk alone [3]. Compared to white and other non-Black populations, Black people living with HIV (BLHIV) have poorer HIV care outcomes, including lower retention in care and suboptimal treatment adherence [4, 5]. In 2024, an estimated 40.8 million people were living with HIV globally, with approximately 1.3 million new infections recorded in the same year [3]. A substantial proportion of BLHIVs reside in HICs, including Canada, the US, and the UK, which together account for a significant share of the HIV burden among Black immigrant populations [2, 6, 7].

Although some Black immigrants arrive in HICs with a pre-existing HIV diagnosis, European surveillance and meta-analytic data suggest that roughly one-third to two-fifths of migrants diagnosed with HIV likely acquired infection after migration, within host-country contexts of racism, exclusion, and precarious work [8]. Studies from Europe and North America estimate that, among migrants from low- and middle-income countries who are living with HIV, up to half acquired HIV after arrival in these HICs, often in settings marked by unstable housing, disrupted social networks, limited access to prevention services, and constrained health-system navigation [9–12]. These patterns show that HIV risk is not simply “imported” but is produced and intensified after migration. Post-migration HIV vulnerability among Black immigrants is driven by intersecting structural and social determinants, including anti-Black racism, discrimination within healthcare systems, immigration related stressors, economic precarity, housing instability, language barriers, and limited access to culturally responsive care [13, 14]. These conditions heighten exposure to HIV while simultaneously undermining engagement with preventive and diagnostic services. Black immigrants frequently face significant barriers to HIV testing, including low perceived risk, limited knowledge of services, language and communication challenges, stigma, concerns about confidentiality or immigration status, and difficulties accessing primary care [15, 16]. As a result, they are more likely to present late to care compared with majority populations, contributing to onward transmission and poorer clinical outcomes [15]. Such inequities threaten achievement of global targets to end AIDS as a public health threat by 2030 and underscore the urgency of equitable, targeted prevention strategies [16].

Pre-exposure prophylaxis (PrEP) is a cornerstone of contemporary HIV prevention. Alongside post-exposure prophylaxis (PEP) and routine HIV testing, PrEP is recommended by the World Health Organization for populations at substantial risk of HIV acquisition, including men who have sex with men (MSM), sex workers, people in sero-discordant relationships, people with multiple sexual partners, and people who inject drugs [17]. When taken as prescribed, PrEP reduces the risk of HIV acquisition by approximately 99% via sexual exposure and by 74% through injection drug use, making it one of the most effective biomedical prevention tools available [18, 19]. However, the population-level impact of PrEP depends on timely access, awareness, uptake, and sustained adherence, conditions that remain unevenly distributed across non-white and immigrant communities.

Emerging evidence suggests that Black immigrants in HICs face distinct, compounding barriers to PrEP access and adoption. These include limited provider awareness and recommendation of PrEP, stigma tied to HIV and sexuality, mistrust of healthcare institutions, lack of culturally and linguistically appropriate information, financial and insurance barriers, and fears regarding immigration status, data sharing, and confidentiality [13,15,20]. Several reviews have examined barriers and facilitators to HIV prevention or PrEP uptake, often focusing on MSM, generalized “racial/ethnic minority” groups, or native-born or non-immigrant Black populations, and typically drawing on pre-COVID-19 data [21–30]. These syntheses provide important insights but rarely centre Black immigrants or explicitly examine how racialization, migration, and structural exclusion interact to shape PrEP engagement in HICs.

Several recent systematic reviews have synthesized barriers and facilitators to PrEP across populations that are highly relevant to Black immigrants but do not centre them directly. Together, these reviews show that Black women are rarely identified as PrEP candidates, seldom receive PrEP offers in routine care, and must navigate services poorly tailored to their social and structural realities [31–33]. Work on Black men who have sex with men in the United States shows a drop-off at every step of the PrEP continuum (i.e., awareness, linkage, uptake, and persistence), driven by structural racism, stigma, medical mistrust, and weak provider engagement [34]. Reviews of young people highlight confidentiality concerns, low risk perception, and service inaccessibility that disproportionately disadvantage racialized youth [35]. In the United Kingdom, a review of specialist sexual health services finds that PrEP pathways and clinic cultures are largely designed for white men who have sex with men, with migrants and Black communities facing limited targeted outreach and misaligned eligibility criteria [36]. Mwaturura and colleagues [37] provide the only prior synthesis that explicitly examines African migrants in high-income countries, identifying multilevel barriers including very low PrEP awareness, stigma, mistrust, cost, immigration precarity, and service inaccessibility.

Despite this evidence base, important gaps remain. Existing reviews are largely population-specific (for example, U.S. Black cisgender women, Black men who have sex with men, or youth) and predominantly U.S.-centric, thereby treating migration, racialization, and national context as background rather than analytic foci [31–35]. Even the review centred on African migrants excludes Caribbean and broader Black diasporic immigrants, offers limited comparison across high-income regions, and relies mainly on pre-COVID-19 studies, missing shifts in PrEP delivery linked to telehealth, community-based models, and new PrEP modalities [37]. The present review addresses these gaps by collating evidence up to 2025, including African and Caribbean Black immigrants in Canada, the United States, Europe, and Australasia, and organizing findings through a socio-ecological lens to show how individual, interpersonal, institutional, community, and policy-level forces interact to shape PrEP adoption among Black immigrants in high-income countries.

The COVID-19 pandemic further transformed HIV prevention, reducing in-person clinical encounters, disrupting HIV testing, and accelerating shifts toward telehealth and community-based service models [16, 38, 39]. Since 2020, empirical studies have examined how these changes affect PrEP awareness, access, and adherence, including in immigrant and racialized communities, but they have not been systematically synthesized for Black immigrants. Consequently, there remains a critical gap in consolidated, up-to-date evidence capturing both pre- and post-COVID-19 dynamics influencing PrEP adoption among Black immigrants in HICs.

To address this gap, this review synthesizes empirical evidence on barriers and facilitators to PrEP adoption among Black immigrants in high-income countries. Guided by the socio-ecological model (SEM), it examines influences at the intrapersonal (individual), interpersonal, institutional/health system, community, and policy levels. The SEM conceptualizes health behaviour as shaped by interacting social and structural forces and is widely used in HIV prevention research to identify intervention points beyond the individual level [40, 41]. By integrating evidence across ecological levels and time periods (pre- and

post-COVID-19), this review aims to generate actionable insights to inform equitable, culturally responsive HIV prevention strategies and strengthen PrEP implementation for Black immigrant communities in HICs.

METHODS

Study design

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines [42, 43] and the methodological framework outlined by Arksey and O'Malley [44], as further refined by Levac et al. [45]. This systematic review was prospectively registered in PROSPERO (CRD42024621634). The full protocol is available at <https://www.crd.york.ac.uk/PROSPERO/view/CRD42024621634>. Although originally conceptualized using elements of the scoping review methodology, this study employed full systematic review procedures, including comprehensive database searching, independent duplicate screening, duplicate data extraction, and formal quality appraisal using CASP tools for qualitative and quantitative studies. This approach was selected to map and synthesize the breadth of available evidence on barriers and facilitators to PrEP adoption among Black immigrants in HICs, across diverse study designs, conceptual frameworks, and settings. The review followed five stages: (1) identifying the research question; (2) identifying relevant studies; (3) selecting studies; (4) charting the data; and (5) collating, summarizing, and reporting the results.

The guiding research question was: *What are the barriers and facilitators to PrEP adoption among Black immigrants in high-income countries?* Specifically, the review sought to: (a) describe the scope and characteristics of empirical and gray literature on PrEP among Black immigrants in HICs; (b) identify multilevel barriers and facilitators to PrEP awareness, access, uptake, and adherence; and (c) highlight gaps to inform future research, policy, and practice.

Search strategy

Following PRISMA-2020 standards, a trained graduate-level reviewer (MRH) systematically searched seven electronic databases (i.e., Academic Search Premier, MEDLINE, Web of Science, EMBASE, Scopus, CINAHL Plus, and PsycINFO), with technical support from a professional health sciences librarian (DS) and conceptual guidance from TN, and conducted supplementary searches using citation chaining, grey literature, and targeted queries in Google Scholar. The initial search was conducted in July 2024. The strategy was designed to identify peer-reviewed and gray literature published from 2010 onwards, in English, that reported on barriers and/or facilitators to PrEP and/or PEP awareness, access, acceptability, uptake, or adherence among Black immigrants in high-income countries. Publications prior to 2010 were excluded because they precede the formal introduction and scale-up of PrEP within global HIV prevention policy [46, 47]. In February 2026, we repeated the database searches using the original

search strategy and limits, restricted to records published from January 2024 onward, to capture newly published evidence. This update identified two additional eligible studies focused on PrEP among African or sub-Saharan African immigrants in high-income countries, which were screened, data extracted and incorporated into the synthesis alongside the original 40 included studies.

Search terms combined controlled vocabulary (e.g., MeSH, subject headings) and free text keywords related to: (1) PrEP/PEP (e.g., “preexposure prophylaxis,” “PrEP,” “postexposure prophylaxis”); (2) population (e.g., “Black immigrants,” “Black migrants,” “African Caribbean Black,” “Black newcomers,” “African diaspora”); and (3) setting (e.g., “high-income countries,” “Canada,” “United States,” “United Kingdom,” “France,” “Germany,” “Australia,” “New Zealand,” “Europe,” “North America,” “Australasia”). The search strategy was tailored to each database to account for differences in indexing and syntax.

To enhance comprehensiveness, the reference lists of all included studies and related reviews were hand-searched to identify additional relevant publications. Gray literature, including reports and policy documents from international and national health organizations such as the World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), Centers for Disease Control and Prevention (CDC), European Centre for Disease Prevention and Control (ECDC), and national public health agencies, was also screened for eligible materials.

Study selection

All search results were imported into Covidence for deduplication and screening. At the title and abstract screening stage, three reviewers independently assessed records against pre-specified inclusion and exclusion criteria. Studies were eligible if they: (1) included Black immigrants, refugees, asylum seekers, or newcomers residing in high-income countries [48]; (2) reported primary data on barriers and/or facilitators related to PrEP (and, where relevant, PEP) awareness, access, acceptability, uptake, or adherence; and (3) used qualitative, quantitative, mixed methods, or intervention designs, or constituted gray literature with empirical or conceptual insights (e.g., program reports, policy briefs).

Studies were excluded if they: (1) included Black immigrants with generalized migrant populations without disaggregated data for Black participants; (2) addressed HIV prevention or sexual health more broadly without explicit reference to PrEP; (3) were systematic reviews, meta analyses, commentaries, or editorials without primary data; (4) consisted only of conference abstracts without accessible full texts; (5) were published in languages other than English or French with no translation available; or (6) examined populations exclusively in low or middle-income countries.

Full-text screening was conducted independently by at least two reviewers for all studies that met or potentially met the inclusion criteria at the abstract stage. Any disagreements regarding study eligibility were resolved through discussion, with a third reviewer consulted as needed. When full-text articles were not accessible through institutional subscriptions or interlibrary loan, corresponding authors were contacted to request access. Studies were excluded if the full text remained unobtainable.

Data extraction

Data from all included studies were charted using a standardized extraction form developed and piloted by the research team in Microsoft Excel. Extracted variables included: author(s), year of publication, country or region, study aims, design and methods, sample size and characteristics (e.g., age, gender, sexual orientation, migration background, immigration status), recruitment setting, and theoretical or conceptual framework. Key findings on barriers and facilitators to PrEP awareness, access, uptake, adherence, and retention were extracted and coded.

For qualitative studies, additional information was extracted on analytic approach (e.g., thematic analysis, grounded theory), emergent themes, and contextual details (e.g., service delivery models, community dynamics). Quantitative and mixed methods studies were coded for measures of PrEP awareness, willingness, uptake, adherence, and relevant correlates (e.g., socioeconomic status, health insurance, immigration status, stigma, provider communication). Intervention or implementation studies were coded for program design, target population, setting, PrEP-related components, and reported outcomes. Gray literature sources were extracted using the same template, with emphasis on programmatic, policy, and structural insights relevant to PrEP adoption among Black immigrants.

Data synthesis

Extracted data were synthesized using a narrative and thematic approach consistent with scoping review methodology. First, studies were grouped by geographical region (e.g., North America, Europe, Australasia) and study design (qualitative, quantitative, mixed methods, intervention, or gray literature). Within and across these groupings, findings were thematically analyzed to identify recurrent and divergent patterns in barriers and facilitators at multiple ecological levels.

The Social Ecological Model (SEM) [40] provided the primary analytic framework, with barriers and facilitators categorized at individual/intrapersonal (e.g., knowledge, attitudes, risk perception), interpersonal (e.g., partner and family dynamics, social support), institutional/health system (e.g., provider practices, clinic models, insurance and cost), community (e.g., stigma, cultural norms, community organizations), and policy/structural levels (e.g., immigration and health policies, PrEP eligibility criteria, data sharing regulations).

Findings are presented narratively and in summary tables that describe study characteristics, mapped barriers and facilitators across ecological levels, and highlight gaps in the evidence base (e.g., understudied subgroups, regions, or types of interventions). This approach enabled an integrated understanding of the social, cultural, and structural contexts shaping PrEP adoption among Black immigrant populations in high-income settings and identified opportunities for targeted interventions and policy reform.

Methodological rigour and transparency

To enhance rigour and reproducibility, all screening and data extraction procedures were conducted independently by multiple reviewers, with regular calibration meetings to reconcile discrepancies and refine coding. An audit trail documenting key decisions, modifications to inclusion criteria, and changes to the extraction framework was maintained throughout the review. The review adhered to PRISMA reporting standards, including the use of a PRISMA flow diagram (see Fig. 1) to depict the study identification, screening, eligibility assessment, and inclusion processes [43].

Figure 1. PRISMA flow diagram of the study selection process

To insert Fig. 1 here

We assessed methodological quality for all 42 included studies (26 qualitative, 18 quantitative) using the appropriate Critical Appraisal Skills Programme (CASP) checklists for qualitative [49] and cohort studies [50]. For each CASP item, reviewers selected one response option (Yes/No/Can’t tell), which was coded numerically (1 for the chosen option, 0 for the other two) to enable calculation of item-level and study-level scores. Each study was appraised independently by two reviewers working in rotating pairs (AB–DF, DF–TN, TN–AB), with a set of calibration studies rated by all three reviewers to harmonize the interpretation of CASP items and scoring. After independent rating, pairs compared their entries, discussed discrepancies, and, when needed, consulted the third reviewer to reach a consensus. Based on the pattern of CASP responses and accompanying comments, we then assigned an overall confidence judgement (high, moderate, or low) for each study; these appraisals informed interpretation of the evidence but were not used as exclusion criteria.

Quantitative CASP summary

Across the 18 quantitative studies examining barriers and facilitators to PrEP uptake among Black immigrants in high-income countries, the overall quality of evidence is moderate to strong, with most studies addressing a clearly focused research question, using acceptable recruitment strategies, and applying reasonably robust measurement of exposures, outcomes, and precision (Table 1). Cohorts were generally well defined and representative; key confounders were typically identified and accounted for in design and/or analysis, and follow-up was largely adequate in duration and completeness, supporting confidence in observed associations. While a small number of studies showed limitations in how confounding was handled or reported, the results were, in most cases, applicable to similar high-income settings and consistent with broader evidence, yielding a coherent quantitative picture of how structural, social, and clinical determinants shape PrEP awareness, access, and use among Black immigrant populations.

Table 1: CASP Quality Appraisal for Quantitative Studies (n = 18)

To insert Table 1 here

Qualitative CASP summary

Across the 26 qualitative studies on barriers and facilitators to PrEP uptake among Black immigrants in high-income countries, most met key CASP criteria, with clear aims, appropriate qualitative designs and methodologies, and recruitment and data collection strategies that were well aligned with their research questions (items 1–5). The majority also demonstrated adequate consideration of ethics, researcher–participant relationships, and rigorous analysis, and provided clear, valuable findings, although a small subset showed limited transparency around analytic procedures and reflexivity (items 6–10). Overall, the body of evidence can be considered moderate-to-strong in quality, offering a robust and credible qualitative foundation for synthesizing how structural inequities, racism, stigma, and community resources shape PrEP engagement among Black immigrants in high-income settings.

Table 2: CASP Quality Appraisal for Qualitative Studies (n = 26)

To insert Table 2 here

RESULTS

Study Characteristics

As shown in the PRISMA diagram (Fig. 1), we included 42 unique studies overall: 16 quantitative, 24 qualitative, and 2 mixed-methods studies [28, 51]. The two mixed-methods studies contributed both quantitative (2019a; 2023a) and qualitative (2019b; 2023b) components, which are reported separately in Table 3 (qualitative studies) and Table 4 (quantitative studies) but counted once at the study level. Across this body of work, qualitative and survey-based designs were most common, with relatively few mixed-methods or surveillance studies. North America and Europe together accounted for the majority of studies, with only a few conducted in Australia. PrEP was the primary focus in most studies (approximately four-fifths), while the remainder examined PrEP within broader HIV prevention activities such as PEP, HIV testing, and sexual health education. Participants were predominantly described as African, Caribbean, or Black (ACB) immigrants or migrants, with most samples focusing on sub-Saharan African ancestry and a smaller subset including Caribbean, African American, Afro-Latina, or broader “non-Western” migrant populations. About half of the studies explicitly reported a theoretical or conceptual framework, most commonly socio-ecological and intersectionality frameworks, as well as community-based and justice-oriented approaches, grounded theory, empowerment theory, social identity theory, and decision-making or behaviour change models. This theory was used to emphasize multilevel influences on PrEP adoption and to situate individual decision-making within racialized, gendered, and migration-related structures. Full study characteristics for the qualitative and quantitative sources contributing to this synthesis are shown in Tables 3 and 4, respectively.

Table 3: Characteristics of Qualitative Studies (N = 26)

Insert Table 3 here

Table 4: Characteristics of Quantitative Studies (N = 18)

Insert Table 4 here

Barriers and facilitators

Across the 42 included studies, 26 reported barriers and/or facilitators to PrEP adoption among Black immigrants in high-income countries. Qualitative and quantitative findings were synthesized using the socio-ecological model (SEM) and are presented across intrapersonal, interpersonal, institutional, community, and policy levels (Table 5).

Barriers

Intrapersonal/Individual-level barriers. Across qualitative studies conducted in Canada, the United States, Europe and Australia, the most frequently reported barriers to PrEP adoption were concerns about side effects [21, 52–59] and limited or inaccurate knowledge about PrEP. Participants described PrEP as “a drug [they] haven’t known for a long time” and worried about “damages that could happen to [their] body organs as a result of prolonged use”, highlighting anxieties about unknown or long-term harms [23, 26, 55, 60]. Low perceived HIV risk and uncertainty about the benefit–risk balance of PrEP also reduced motivation to initiate or continue use [21, 53, 56, 57, 60–62]. For example, women and men in several studies described believing they were “not at risk” because they were in long-term relationships, living in low-prevalence countries, or assuming that “healthy-looking” people could not have HIV [21, 26, 28, 55, 57, 58, 61, 63].

Additional barriers included medical mistrust and suspicion of Western medicines, apprehension about daily pill-taking or “medication fatigue,” and worries about reduced condom use and potential exposure to other sexually transmitted infections [21, 22]. Young Black gay, bisexual and other men who have sex with men (GBMSM) in Canada and Ghanaian immigrants in the United States described daily PrEP as “unnatural,” likened it to “taking painkillers without a headache,” and expressed preferences for “natural herbs” or faith-based protection over pharmaceuticals [21, 22, 28]. Some participants questioned what taking PrEP might “invite” into their lives or viewed it as a “gay medicine”, indicating how biomedical mistrust and culturally rooted beliefs intersect to discourage uptake [26, 55, 60, 62–65].

Gendered perceptions of PrEP also emerged as individual-level barriers. Black women in the United States, Canada and Europe reported that PrEP was “not for Black women” or assumed that it was targeted at white MSM, which contributed to low self-identification as candidates for PrEP and limited engagement with information or services [57, 59]. Concerns about adherence demands, the burden of daily pill-taking and the need for ongoing laboratory monitoring further inhibited interest, especially among immigrants juggling precarious work, caregiving or insecure legal status [21, 22, 26, 53, 54, 63, 65]. In France, sub-Saharan African women raise specific worries about using PrEP during pregnancy, while others in multiple settings reported that family members could misinterpret the nausea or vomiting from PrEP as pregnancy, potentially provoking conflict [54, 59].

Quantitative studies corroborated the central role of low perceived HIV risk as an individual-level barrier. In Toronto, many ACB men who met the clinical criteria for PrEP did not see themselves as at risk; low perceived risk, together with concerns about side effects, was a primary reason for rejecting PrEP [30]. Among Black women in the United States, “no self-perceived HIV-risk” was the most cited reason for unwillingness to use PrEP, even among those with expanded indications for eligibility [66]. In France and Belgium, only a small minority of newly arrived or precariously housed sub-Saharan African immigrants had heard of PrEP at baseline, despite relatively high testing rates, and awareness was particularly low among women [67, 68] and over half of African immigrants in a US sample were unaware of PrEP [69]. Similar patterns of low PrEP awareness were documented among African immigrants in the United States and among migrants in Australia and the UK, where participants often confused PrEP with PEP or assumed PrEP was only for “other groups” such as white MSM [25, 51, 69].

Concerns about side effects and medication burden also affected adherence among those who initiated PrEP. In a Canadian Cohort, greater side-effect burden was associated with lower odds of perfect adherence [70]. Qualitative participants similarly described not wanting to “add more pills” to their existing medication regimen and worrying about long-term organ damage, mood changes, or sexual dysfunction. In some populations, gender norms and psychological factors further complicated acceptability: among Black women in the United States, traditional gender role beliefs and “silencing the self” were associated with lower PrEP acceptability and expectations of increased sexual risk behaviour if taking PrEP, suggesting that women anticipated relational and behavioural consequences of PrEP use that constrained uptake [71].

Interpersonal-level barriers. Across qualitative studies, interpersonal barriers centred on partners, family and close social networks. Gendered power relations were prominent: women in Canada, the United States, the UK, and France described limited ability to negotiate HIV prevention or introduce PrEP into heterosexual relationships, particularly when male partners controlled sexual decision-making or household dynamics [57, 58, 62, 72, 73]. Service providers in Canada anticipated that getting a male partner to take PrEP in a sero-discordant relationship would be difficult if he was disengaged from healthcare or unwilling to discuss HIV, highlighting how men’s reluctance can constrain women’s options [23, 57, 58].

Partner-related concerns included lack of partner support, fears that discussing PrEP would signal infidelity or distrust, and anxiety about revealing a partner’s HIV status in healthcare settings [52, 61, 63]. In the interviews with Black women in the United States, several participants anticipated that partners would respond to PrEP with suspicion, pointing out that “He’d be like, ‘Why do you need that? You think I’m cheating?’”, and worried about conflict or violence if PrEP was discovered [52]. Among ACB men in Toronto, some participants emphasized needing to “talk to [a] partner back home” or to family members before deciding, illustrating how family expectations and transactional relationships shape decision-making [52].

Relationship dynamics also operated as barriers. Participants in UK and US studies described difficulties discussing PrEP with peers, even when they could talk openly about contraception or pregnancy prevention, because PrEP conversations were more likely to be interpreted as accusations of infidelity or indicators of “risky” behaviour [52, 61]. Young women in London and Glasgow worried that detailed discussions of PrEP would offend friends or partners, while focus group participants in the US feared that “people will think they got something, just because you are taking a pill” [59]. Fear of inadvertent disclosure through pills being seen at home, being observed collecting medication at pharmacies, or encountering acquaintances in sexual health clinics further discouraged PrEP consideration [64].

Quantitative evidence on interpersonal barriers was limited but pointed to important relationship -level dynamics. In a US-based study conducted among Black women, intimate partner violence was associated with expectations of greater sexual risk behaviour if taking PrEP, suggesting that women anticipated that PrEP might escalate suspicion or coercion in already unsafe relationships [71]. In French and Belgian studies of sub-Saharan African migrants, gendered differences in agency, such as lower reported ability among women to decide how to protect themselves during sex, were associated with lower use of condoms and HIV testing, suggesting that constrained negotiation power may also limit PrEP uptake [67, 68]. Taken together, these findings highlight how gendered power relations, partner suspicion, and fear of disclosure operate as key interpersonal barriers to PrEP adoption.

Institutional and health-system barriers. Institutional-level barriers clustered around limited cultural competence, provider-level PrEP knowledge gaps, weak or inconsistent PrEP promotion, and structurally inaccessible service models [27, 29, 53, 60, 62, 64, 73]. Across Canada, the US, the UK, France and Australia, participants described health-care encounters marked by judgment, stereotyping, and a lack of tailored information, which undermined trust and reduced willingness to initiate or continue PrEP [55, 60, 62, 65].

Limited cultural competence among healthcare providers was a central concern. Black immigrants in Toronto reported feeling judged when disclosing sexual histories, with one participant recalling that after telling a provider he was “playing around”, the provider’s “judgmental look” and an insinuation that he was “not being faithful” made him feel singled out [52]. Black immigrant women in the US similarly described medical mistrust rooted in historical and personal experiences, stating that “they don’t test things on us first” and voicing fears that health systems do not prioritize Black patients’ safety [60]. For some Black MSM in London, providers of the same ethnic background were perceived as potentially more judgmental or homophobic, leading participants to avoid clinics where they might encounter staff from their own communities.

Provider knowledge gaps and weak PrEP promotion further constrained uptake opportunities. In Canada, ACB participants reported that clinicians “didn’t really have much information” about PrEP, leaving them undecided and confused about benefits, side effects, and monitoring requirements [53, 62]. Service providers working with African, Caribbean, and Black communities in Toronto acknowledged their own uncertainties around PrEP efficacy, resistance, and side effects, which in some cases led to cautious or

inconsistent recommendations. Several studies noted that participants had to “seek out information about PrEP/PEP” themselves, “pick up a pamphlet somewhere and read about it”, because PrEP was rarely raised proactively in routine care [55, 60, 62, 65].

Quantitative studies showed that health system contact does not automatically translate into PrEP access. In France and Belgium, sub-Saharan African migrants reported high levels of HIV testing, yet only around 5% had heard of PrEP at baseline, indicating missed opportunities to integrate PrEP into routine care [67, 68]. In a US study of Black women, those who had not seen a doctor for more than a year were significantly less willing to take PrEP, suggesting that gaps in primary care access can obstruct prevention [66]. Among African immigrants in the United States, irregular healthcare use was associated with low PrEP awareness and lower willingness to use any PrEP modality [69].

Structural features of services also acted as barriers. Long wait times, inflexible appointment schedules, and complicated referral pathways discouraged engagement, especially among migrants juggling precarious work to support childcare [27, 52, 62]. Black MSM in London emphasized that they would be less likely to return to clinics with slow processing times or long queues, and stressed that “well-maintained facilities, quick test results, [and] short wait times” signalled high-quality care [27]. Language barriers and lack of interpretation reported by sub-Saharan African women in French family-planning centres and by migrants in Australian and European settings made it difficult to understand PrEP information or navigate consent and follow-up procedures [52]. Belgian data suggested that the centralized and specialized nature of PrEP services (i.e., located in specific clinics and requiring familiarity with the health system) may deter sub-Saharan African migrants, particularly those with limited health literacy or language skills [67]. French studies of precarious migrants further found that mobile, tent-based interventions still faced engagement challenges when participants could not afford to wait or did not perceive services as accessible, compounding legal and economic precarity [68, 74].

Participants also described ambivalent or coercive clinical communication that eroded trust. Some ACB clients in Canada felt pressured by providers who strongly promoted PrEP without addressing their questions or values, while others felt insufficiently supported when they expressed interest but did not receive clear guidance on access, dosing, or monitoring [27, 62]. Women in US focus groups reported that they had never been offered PrEP by their clinicians, despite reporting risk factors, interpreting this silence as a sign that PrEP was not meant for them [62]. Service providers themselves highlighted system-level barriers, including a lack of clear PrEP guidelines for heterosexual populations, limited availability of PrEP outside major urban centres, and insufficient time within consultations to provide detailed counselling, all of which contributed to patchy implementation in Black immigrant communities [27, 52, 62].

Community-level barriers. Community-level barriers operated through stigma, social norms, and exclusionary environments that shaped how Black immigrants understood and engaged with PrEP (Table 5). Stigma emerged as the most pervasive barrier, reported in multiple qualitative studies in North America, Europe, and Australia [26–30, 53–56, 61–63, 73]. Participants described intense HIV- and

PrEP-related stigma intersected with stigma around sexuality, gender, and migration, and was often intensified in small or tightly connected Black immigrant communities [56, 59]. People worried that taking PrEP would lead others to assume that they were “promiscuous” or already living with HIV, and several accounts highlighted fears of gossip, reputational damage, and social isolation if PrEP use became known [54]. Among women who migrated from sub-Saharan Africa to France, PrEP was often perceived as poorly aligned with their gendered social roles [54].

Restrictive religious and cultural norms also constrained PrEP acceptability. Haitian and sub-Saharan African participants in community focus groups described church teachings and spiritual leaders as discouraging “truthful sex education” and framing HIV prevention outside marriage as inappropriate, making it difficult to discuss PrEP openly or seek information without moral judgment [54, 57, 62, 72, 73]. In some cases, men’s authority over sexual decision-making was reinforced by these norms, further limiting women’s ability to act on their own prevention preferences [54, 72].

Negative or conspiratorial narratives about HIV and biomedical interventions formed another layer of community-level barriers. Sub-Saharan African migrants in France and Australia reported widespread beliefs that HIV was a “Western plot,” that PrEP was an experiment on Black bodies, or that government surveillance would intensify through PrEP monitoring [23, 54]. Such views fuelled medical mistrust and made PrEP seem risky or irrelevant, even when participants acknowledged ongoing HIV vulnerability in their communities. Finally, racism within gay and queer social spaces reported particularly by Black MSM in the UK and North America, left some participants feeling unwelcome, stereotyped as hypersexual, or excluded from mainstream MSM PrEP initiatives, weakening the potential of queer community venues to act as sites of PrEP information and support [64].

Quantitative findings reinforced the role of community positioning and structural marginalization in shaping PrEP outcomes. In Antwerp, nearly one-third of sub-Saharan African migrants met national PrEP eligibility criteria, but PrEP use remained very low, with eligibility concentrated among those who were undocumented, uninsured, and who had experienced forced sex [67]. The authors argued that stigma, mistrust and lack of community-tailored outreach limited engagement with PrEP services. In Australia, migrant participants reported high awareness of HIV/AIDS but very low awareness of PrEP medications, particularly among those outside MSM networks, suggesting that community-level HIV knowledge did not translate into PrEP familiarity [51].

Policy and structural barriers. Policy- and structural-level barriers centred on cost and coverage gaps, uneven geographic availability, restrictive eligibility and access pathways, immigration-related precarity, and non-inclusive public health planning [23, 26, 29, 53–55, 59–62, 72]. PrEP cost and lack of comprehensive insurance coverage were prominent obstacles for migrants in precarious or low-wage work and for those without stable benefits, who reported being unsure whether their plans would cover PrEP or stating that they “can’t afford another prescription” [13, 26, 29, 53, 55, 57, 59, 60, 63, 65]. Even where partial coverage existed, co-payments, laboratory fees, and transport costs created cumulative burdens that discouraged initiation or long-term use.

Limited availability of PrEP in certain regions and restrictive eligibility processes further constrained uptake. Service providers and community members in Canada and parts of Europe described PrEP as concentrated in specialized clinics in major urban centres, with complex referral pathways and bureaucratic requirements that disadvantaged migrants with limited time, documentation, or familiarity with the health system [54, 57, 59, 62, 63]. Mobile and tent-based outreach models used with precarious migrants in France partly mitigated geographic barriers but still struggled to maintain engagement when people could not afford to wait in queues or did not perceive the services as accessible or trustworthy [54]. In Belgium, the centralized and specialized nature of PrEP services was seen as a deterrent for sub-Saharan African migrants, especially those with limited health literacy or language skills [56, 62].

Immigration-related precarity and fears about surveillance also operated as structural barriers. Haitian and other migrant women in US focus groups described immigration status as an additional layer of perceived discrimination in healthcare, reducing exposure to mainstream HIV prevention messages and dissuading them from seeking services where they might be asked for identification or proof of insurance [26, 29, 53, 55, 58–60, 63, 65]. In France, difficulties accessing public health insurance for undocumented migrants meant that some participants delayed or avoided care altogether, limiting opportunities for PrEP counselling [54]. Participants in several settings expressed concerns that seeking HIV prevention or treatment might attract unwanted attention from authorities or jeopardize immigration processes, contributing to avoidance of formal health systems [55, 72].

Non-inclusive public health messaging and gendered prioritization of PrEP resources compounded these structural barriers. Across qualitative studies, Black women and some heterosexual men perceived PrEP campaigns as directed primarily at white gay men, reinforcing the view that PrEP was “not for people like us” and weakening motivation to seek more information or advocate for access [61]. Service providers echoed this critique, noting that guidelines, training, and funding streams often emphasized MSM populations, while Black migrant women, transgender women, and non-MSM men received comparatively little attention in policy and programme design [62]. Surveillance analyses from England showed that although commissioning PrEP services increased PrEP-to-need ratios overall, disparities widened: white men had the highest PrEP-to-need ratios before and after commissioning, whereas Black African women had the lowest, and the gap between these groups increased more than threefold, even as Black African women accounted for a growing share of non-late HIV diagnoses [75].

Other quantitative studies highlighted how immigration, insurance, and geography shape structural barriers to access. In France, sub-Saharan African migrants who were undocumented, uninsured, or recently arrived were less likely to know about PrEP and faced substantial economic and legal vulnerabilities that limited their ability to engage with prevention services [68, 74]. In the Netherlands, multivariable models showed that among non-Western-born MSM attending STI clinics, younger age, residence in less urban areas, lower education, and sub-Saharan African or Eastern European origin were independently associated with lower PrEP use, despite the availability of services [76]. A survey of providers in 14 European countries further indicated that undocumented status, language and cultural

barriers, uncertainty about entitlement to care, and partial or absent free PrEP coverage for migrants were viewed as major obstacles to prevention for migrant Black women [77].

Facilitators of PrEP adoption

Intrapersonal/individual level facilitators. Individual-level facilitators, including heightened HIV risk perception, motivation for greater control over prevention, and positive beliefs about PrEP's effectiveness and safety, were identified (Table 5). Across qualitative studies with African, Caribbean, and Black participants in Canada, the US, Europe, and Australia, individuals who recognized themselves as vulnerable, due to partners' behaviours, past sexually transmitted infections, or awareness of local HIV prevalence were more likely to describe PrEP as "important for women who are vulnerable to HIV" or as "something you can take for yourself" when you "can't always trust a man to tell the truth" [56, 63, 64]. People framed PrEP as a way to reclaim control over their sexual health, often contrasting it with reliance on partners to use condoms or disclose status, and some women explicitly linked PrEP to self-care, saying that if it were presented as "just like taking vitamins," more people would be willing to try it [58, 63, 64].

Positive beliefs about PrEP's effectiveness and safety, adequate knowledge of how it works, and confidence in one's ability to adhere also facilitated uptake. Participants who had received clear, credible information from trusted providers, community organizations, or peers reported feeling reassured about side effects, dosing, and monitoring, thereby reducing initial ambivalence [53]. Some expressed that knowing PrEP "really works" and understanding when it becomes protective made them more willing to start, while others emphasized that they could "follow the instructions" and incorporate a daily pill into existing routines, particularly if the regimen was framed as temporary or adaptable to changing risk [54].

At the same time, several individual-level facilitators were identified in quantitative studies. Across multiple surveys, higher self-perceived HIV risk was positively associated with PrEP acceptance or willingness, particularly among non-MSM African, Caribbean, and Black men in Canada [30] and among UK-based Black African participants who regularly tested for HIV [28]. In a US study of Black women, lower income, less education, and unmarried status were associated with greater willingness to use PrEP, suggesting that women who recognized themselves as more vulnerable in socio-economic or relationship terms may be more open to biomedical prevention [66]. Among women of colour, lifetime psychological and physical intimate partner violence were associated with higher PrEP knowledge and interest, indicating that experiences of violence can heighten perceived need for protection [71].

Higher HIV knowledge and more positive preventive health orientations also facilitated PrEP support. In a UK survey of gay men and Black Africans, greater HIV knowledge and a stronger preventive orientation were linked to more favourable attitudes toward PrEP [78]. Among Black Africans in the UK, HIV awareness was strongly associated with PrEP awareness and, among younger participants, with willingness to use PrEP [28]. In an African immigrant sample in the United States, those already aware of PrEP demonstrated high levels of accurate knowledge, which the authors suggest may support adherence and continuation once PrEP is initiated [69].

Interpersonal facilitators. At the interpersonal level, three main facilitators were identified: supportive peer and social networks, collaborative partner dynamics, and family-centred framings of PrEP. Supportive peer networks or community groups in which PrEP was discussed positively helped normalize its use, provided opportunities to share accurate information, and offered emotional support around decision-making [23, 55, 59–61, 63, 64]. In these contexts, participants described friends “making [them] curious” about PrEP or encouraging them to “consider it” after sharing their own experiences, which increased willingness to initiate or continue use [60, 61, 63]. Being in a heterosexual sero-discordant relationship where partners shared responsibility for HIV prevention was another important facilitator; several studies described couples jointly deciding to start PrEP to reduce anxiety, increase sexual freedom, and maintain intimacy while managing sero-difference [22, 23, 26, 55, 57, 73]. One study further noted that framing PrEP as a strategy to protect family well-being rather than only individual risk resonated strongly with women and caregivers, enhancing acceptability and perceived relevance when PrEP was presented as a way to “keep the family safe” [57].

Quantitative studies identified interpersonal factors that aligned with these qualitative themes. Among sub-Saharan African immigrants in France, having someone to rely on in the host country, a proxy for social support, was positively associated with knowledge of PrEP and PEP [68]. In addition, being in stable relationships and engaging in transactional sex were associated with higher awareness of PrEP and higher HIV-risk indices, patterns that may prompt consideration of biomedical prevention when accompanied by appropriate counselling [68, 79]. In several samples, willingness to use PrEP was higher among participants who reported supportive partners or positive norms within their social networks, although this was more evident in qualitative than quantitative data [28].

Institutional and health-system facilitators. Three institutional-level facilitators were identified: culturally safe care, trusted and continuous provider relationships, and accessible, well-organized service delivery. Access to culturally safe services, including Black or otherwise racially concordant providers and staff trained in anti-racist and trauma-informed approaches, was consistently linked to greater trust and willingness to consider PrEP [27, 29, 55, 63, 64]. Participants described feeling more comfortable asking questions and disclosing sexual histories when they perceived providers as respectful, non-judgmental, and knowledgeable about the specific experiences of Black immigrants [27, 53, 55]. Receiving PrEP from familiar clinicians (such as long-standing family doctors) and in settings where participants already received other forms of care helped normalize PrEP, reduce anxiety about being “singled out,” and position PrEP as part of routine health maintenance rather than a sign of exceptional risk [54, 60, 61, 63, 73].

High-quality counselling and practical supports further enabled initiation and adherence. Participants emphasized the importance of clear explanations of side effects, laboratory monitoring, and the time required for PrEP to become protective, as well as opportunities to ask questions without feeling rushed [54, 60, 61, 73]. Supportive communication, in which providers listened, avoided moralizing, and helped patients weigh benefits and risks in line with their values, was described as crucial to moving from ambivalence to informed choice [27, 53]. Practical supports, such as reminder systems, navigation

assistance, and straightforward refill processes, also facilitated sustained PrEP adherence [28, 29, 56, 57, 59, 65]. Work with African immigrants in the United States highlighted long-acting injectable PrEP as a promising option to reduce daily pill burden, disclosure risks, and adherence challenges, provided that delivery models attend to cultural beliefs, historical mistrust, and concerns about side effects [80]. Services characterized by shorter wait times, flexible appointment options (including evenings or walk-ins), and well-resourced facilities were seen as more trustworthy and worth returning to, in contrast to overburdened or disorganized clinics that participants associated with poor care [27].

Quantitative findings highlighted the importance of sustained, supportive service contact. In a French quasi-cohort among precarious migrants, cumulative exposure to a navigation-oriented social and health intervention produced large, statistically significant increases in PrEP knowledge at 3- and 6-month follow-up, highlighting how repeated, relationship-based engagement with health and social workers can build awareness and confidence over time [74]. Among African immigrants in the United States, having a regular healthcare provider and receiving services consistently were associated with higher PrEP awareness and greater willingness to use oral or injectable PrEP, pointing to the centrality of continuous care relationships for activating biomedical prevention [69]. In England, non-Western-born MSM attending STI clinics had similar or slightly higher overall PrEP use than Western-born MSM; within this group, higher education and residence in highly urban areas were associated with greater uptake, suggesting that when PrEP is fully integrated into accessible STI services and supported by robust local infrastructure, institutional facilitators can partly offset other disadvantages, even though important inequities remain [76].

Community-level facilitators. Three community-level facilitators were reported: community-based education and empowerment, stigma-reduction efforts, and collective health orientations, as detailed in Table 5. Community-based education and empowerment initiatives, particularly those delivered through trusted Black-serving organizations, faith communities, and diaspora networks, played a key role in increasing awareness and reframing PrEP in culturally meaningful ways [28, 29, 59, 65]. When PrEP was introduced in familiar settings such as churches, salons, or community centres, participants reported being more willing to listen and ask questions, and to perceive PrEP as relevant to “people like us” rather than only to white MSM [28, 56, 59, 63]. Empowerment-focused messaging that emphasized dignity, historical resilience, and community protection resonated particularly with Haitian and other Black diasporic communities, who linked HIV prevention to broader traditions of activism and mutual support [26, 63].

Stigma-reduction initiatives and collective health orientations further supported PrEP acceptability. Campaigns that normalized PrEP as routine prevention, rather than as a marker of promiscuity or HIV infection, were viewed as critical to changing community norms and reducing fears of gossip or social exclusion [23, 73]. Participants stressed that when key community influencers, such as faith leaders, organizers, or respected elders, publicly endorsed HIV testing and prevention, it helped counter conspiracy theories and moralizing narratives about sexuality [28, 29, 59]. A broader emphasis on collective wellbeing and “living healthy” also made PrEP more acceptable when it was framed as part of

a shared responsibility to protect families and communities, not just individual risk management [72]. Participatory action research with sub-Saharan African diaspora communities in Belgium similarly emphasized the importance of community-led dialogue, trusted lay facilitators, and co-designed outreach in normalizing PrEP and addressing fears about side effects and stigma [56]. Among women who migrated from sub-Saharan Africa to France, participants also identified family planning clinics as potential trusted settings for culturally sensitive PrEP counselling when providers were non-judgmental and aware of migration-related constraints [54]. A community-driven study with US-based African immigrants generated concrete recommendations for culturally aligned PrEP messaging, stressing the need to foreground collective well-being, spirituality, and migration experiences, and to use African diasporic community leaders as messengers [81].

Quantitative findings echoed the importance of supportive community positioning. In a UK study, Black African and other participants embedded in LGBTQ networks and with regular HIV testing showed substantially higher PrEP awareness and willingness to use PrEP than those who never tested, suggesting that participation in gay and activist communities can function as a community-level facilitator [28].

Policy-level facilitators. At the policy level, three facilitators were identified: culturally tailored PrEP programming, financial coverage, and streamlined access pathways (see Table 5). Culturally tailored PrEP services and promotion strategies, including campaigns explicitly designed for Black immigrant communities and information disseminated through trusted public-health websites, were seen as more credible and easier to engage with than generic or MSM-only messaging [26, 29, 56, 59, 63]. When official guidance and materials reflected Black women, heterosexual men, and migrants, participants were more likely to view PrEP as “for us” and to consider seeking it [59].

Public or private insurance coverage and cost-sharing schemes that minimized or eliminated out-of-pocket expenses were central enablers of sustained access. Public or private insurance that covered PrEP medication, laboratory monitoring, and clinic visits reduced concerns about affordability, particularly for people in low-wage or precarious work [52, 55]. Participants and providers alike framed free or highly subsidized PrEP as a prerequisite for equitable uptake, rather than an added “luxury” accessible only to those with comprehensive benefits [29, 54]. Finally, policies and programmes that simplified PrEP access, such as streamlined eligibility criteria, expanded prescribing rights beyond specialists, and integration into primary and community care, were associated with higher uptake among Black immigrants by reducing bureaucracy and making PrEP available in services people already use [29, 54].

Quantitative findings pointed to the importance of these policy-level enablers. In a multi-country European provider survey, respondents in settings where PrEP was available free of charge to all, including undocumented migrants, identified universal free access as a key facilitator for migrant women and other marginalized groups [77]. In the Netherlands, where PrEP was integrated into existing STI services and funded through national programmes, overall PrEP uptake among non-Western-born

MSM was comparable to, or slightly higher than, uptake among Western-born MSM, suggesting that universal coverage and full integration into routine sexual healthcare can mitigate some inequities, even though important gaps remain for specific subgroups such as sub-Saharan African MSM [76].

Table 5. Barriers and facilitators to PrEP organized by socio-ecological level.

Insert Table 5 here

DISCUSSION

This systematic review shows that PrEP adoption among Black immigrants in high-income countries is primarily constrained or enabled by multi-level barriers and facilitators, rather than by individual attitudes alone. Structural racism, migration-related precarity, and gendered power relations shape every point at which Black immigrants might engage with PrEP (i.e., awareness, access, decision making, uptake, and continuation). Across the included studies, findings show a recurring pattern in which high clinical eligibility and community-level HIV burden coexist with low perceived HIV risk, limited PrEP awareness, and service environments that implicitly position PrEP as “for other people,” especially white gay men. These findings extend existing knowledge by showing that, for Black immigrants, adoption is less about individual unwillingness and more about how health systems and social contexts make PrEP difficult to learn about, trust, and use.

At the individual level, the most frequently reported barriers were low or inaccurate risk perception, limited knowledge of PrEP, and concerns about side effects and medication burden, while facilitators included clear, credible information and framing PrEP as a tool for caretaking and future planning. These individual-level findings can be understood as reasonable responses to participants’ environments: many Black immigrants receive little targeted PrEP information, encounter mixed messages from providers, and face histories of medical exploitation and discrimination, making caution and skepticism understandable rather than simple “knowledge deficits.” Interpersonally, relationship dynamics and gendered power emerged as critical determinants of adoption. Women in particular described difficulties introducing PrEP without provoking suspicion, conflict, or potential violence, indicating that partner responses and household power structures can transform an otherwise accessible intervention into a source of risk. Supportive partners and peers, in contrast, were described as important facilitators who provided encouragement, practical help with adherence, and emotional validation.

Community-level findings highlighted the role of HIV and PrEP-related stigma, moral and religious norms, and exclusion from queer or activist spaces in shaping adoption. Fear that PrEP use would be interpreted as evidence of promiscuity or existing HIV infection or would trigger gossip within tightly knit Black immigrant communities, deterred many from seeking information or initiating PrEP. However, when community organizations and diaspora networks were actively involved in PrEP education and navigation, participants reported greater trust and willingness to consider PrEP, underscoring the facilitating role of community-led, culturally grounded approaches. Institutional and policy-level analyses reinforced that contact with health systems does not automatically translate into adoption. Central

barriers included limited provider PrEP knowledge, lack of culturally and linguistically appropriate counselling, centralized and bureaucratic clinic models, cost and insurance gaps, and fears that immigration status or documentation issues could be exposed through health system engagement. Facilitators at these levels, including universal or highly subsidized coverage, streamlined access pathways, and integration of PrEP into familiar primary or community-based services, were consistently associated with higher awareness and uptake, suggesting that structural design choices can either reproduce or mitigate inequities in PrEP adoption for Black immigrants.

Black immigrants in high-income countries encounter a PrEP landscape in which willingness and “choice” are strongly shaped by multi-level factors, including racism, migration governance, and gendered power relations, rather than by individual attitudes alone. Across 42 studies, this review found a consistent misalignment between high clinical eligibility and HIV burden on the one hand, and low perceived risk, limited awareness, and service and policy environments that implicitly prioritize white MSM on the other, leaving Black migrant women, heterosexual men, and non-MSM populations structurally “out of frame.”

Overall, these results are consistent with prior reviews that have documented low PrEP awareness, stigma, and structural barriers in related populations. For example, Black cisgender women, Black men who have sex with men, young people, and African migrants [21–30, 67–69]. However, this review extends the evidence by bringing those patterns into focus, specifically for Black immigrants in high-income countries and by mapping them across socio-ecological levels. By synthesizing barriers and facilitators in this way, our findings deepen scientific understanding of how multi-level contexts shape PrEP adoption among Black immigrants, identifying leverage points, particularly at the institutional and policy levels, where changes in information, service delivery, and coverage could substantially improve uptake and sustained use in this population.

Implications for practice

The multi-level barriers and facilitators identified in this review suggest several actionable directions for programmes, clinicians, and health systems seeking to improve PrEP adoption among Black immigrants in high-income countries. First, PrEP awareness campaigns need to be culturally grounded, community-engaged, and explicitly inclusive of African and Caribbean immigrants of all genders, rather than implicitly targeting only white gay men. Studies with African and Caribbean migrants in Canada, Europe, and Australia highlight the importance of co-designed, culturally resonant messaging delivered through trusted channels such as churches, community organizations, ethnic media, and diaspora leaders, and of framing PrEP as a positive sexual health and self-care tool rather than solely as a response to “high-risk” behaviour [26, 28, 29, 51, 54–56, 59, 63–65]. Campaigns should also directly address confusion between PrEP and PEP and normalize HIV risk beyond narrow behavioural stereotypes [28, 29, 51, 54, 61, 68, 69].

Second, provider-side changes are crucial. Multiple studies recommend structured decision support and routine, non-judgmental PrEP conversations that acknowledge racism, stigma, and migration-related

stressors, and help Black patients weigh benefits and risks in line with their values [22, 23, 52, 53, 55, 59, 61–63]. Cross-cultural and antiracist training, coupled with clear clinical guidance that moves beyond MSM-only eligibility, can improve providers' confidence and reduce anticipated discrimination, particularly for women, heterosexual men, and newcomers who may be unfamiliar with preventive medications [21, 25–27, 53, 55, 60–62, 65]. Integrating PrEP into primary care, community health centres, and other services that Black immigrants already use, including settlement, housing, and social service settings, can reduce the burden of navigating specialist clinics and create more opportunities for trusted providers to raise awareness of PrEP [23, 25, 27, 29, 51, 53, 56, 59, 67–70, 76].

Third, structural reforms around cost, eligibility, and legal precarity are necessary for equitable uptake. Empirical work with African and Caribbean migrants repeatedly shows that PrEP remains out of reach when it is tied to stable employment, private insurance, or proof of immigration status, and when basic needs such as housing and legal security are unmet [13, 26, 29, 51, 53–56, 59, 60, 63, 65, 67, 68, 74, 77, 79, 82]. Policies that provide free or highly subsidized PrEP (including laboratory monitoring and clinic visits), simplify administrative procedures, and guarantee access regardless of documentation status are likely to have a greater impact than information campaigns alone [67, 68, 74, 77]. At the same time, interventions should align HIV prevention with broader efforts to address structural determinants, including housing, employment, and legal support, so that PrEP is offered in ways that feel relevant and feasible in the context of migrants' everyday priorities [9, 10, 13, 14, 51, 68, 74, 77, 79].

Finally, because interpersonal and community dynamics heavily influence whether Black immigrants can safely initiate and sustain PrEP, programmes should include supports beyond the prescription. Recommendations from qualitative studies include couple and family-based education where appropriate, peer-led groups and community ambassadors to counter stigma, and trauma and violence-informed approaches that link PrEP services with intimate partner violence organizations for those who anticipate partner conflict [22, 23, 26–29, 52, 54, 59, 61–64, 71–73, 82]. Collectively, these practices and policy implications mirror the socio-ecological patterning of barriers and facilitators identified in this review and indicate that meaningful progress on PrEP adoption for Black immigrants will require coordinated action at community, clinical, and structural levels, rather than narrowly targeted, individual-level interventions.

Implications for research

Future research should move beyond documenting barriers and facilitators to designing, testing, and refining multi-level interventions that respond to the specific structural and social contexts of Black immigrants in high-income countries. Quantitative studies highlight the need to examine PrEP care continua separately for different subgroups, including MSM and non-MSM, women, heterosexual men, and people with experiences of intimate partner violence, to identify where drop-off occurs and which populations require tailored support [67, 71, 75, 76, 79]. Longitudinal and cohort designs are needed to track PrEP awareness, uptake, and persistence over time in relation to migration trajectories, length of residence, and changes in immigration or insurance status [9, 10, 67–70, 74–76, 79]. Studies should also quantify the impact of structural determinants, including housing instability, employment precarity, and

legal status, on PrEP outcomes, and assess how these interact with behavioural factors like chemsex and perceived safety in “known” partnerships [9, 10, 13, 14, 67–69, 74, 76, 79].

Qualitative and mixed methods work should deepen understanding of how intersecting identities and histories shape PrEP decision-making and experiences of care. Prior research calls for studies that centre Black immigrants who are youths, women, are from conflict-affected backgrounds, and that explicitly explore how trauma, gender norms, and community expectations influence risk perception and PrEP acceptability [21–23, 26, 29, 52, 54–56, 59–64, 71–73]. Finally, future studies should evaluate the effectiveness, feasibility, and equity impact of structurally oriented interventions, such as universal coverage models, trauma-informed PrEP navigation, community-led empowerment programmes, and integration of PrEP into settlement and social service contexts, in order to generate robust evidence on how best to reduce PrEP adoption gaps for Black immigrants in high-income countries [25–29, 51, 54–56, 59, 63–65, 67–69, 74–77].

Strengths and limitations

This review has several strengths. It is, to our knowledge, one of the first to synthesize both qualitative and quantitative evidence on barriers and facilitators to PrEP adoption specifically among Black immigrants in high-income countries using an explicitly socio-ecological lens. Including diverse designs (qualitative, cross-sectional survey, cohort, and mixed methods studies) and multiple geographic contexts enabled us to identify consistent multilevel patterns across settings and populations. Mapping findings across intrapersonal, interpersonal, institutional, community, and policy levels underscores the centrality of structural determinants and provides a coherent framework for designing multi-level interventions for Black immigrant communities.

However, the findings should be interpreted considering several limitations. The evidence base is dominated by cross-sectional and qualitative studies from North America and Western Europe, with relatively few longitudinal, experimental, or implementation studies and limited data from other high-income regions such as Australasia or non-Anglophone Europe [26, 70]. Many quantitative studies relied on convenience or snowball sampling of clinic-engaged participants, which may underrepresent Black immigrants who are disconnected from sexual health services or face the greatest access barriers [9, 10, 25, 51, 67–69, 74–76, 79]. Several surveys used self-reported measures of HIV risk, PrEP use, and testing, which are susceptible to recall and social desirability biases, particularly for sensitive topics such as intimate partner violence, chemsex, and immigration-related fears [22, 29, 75]. In addition, important variables such as ethnicity, immigration status, or education were missing or coarsely measured in some datasets, limiting the ability to disaggregate outcomes and potentially biasing estimates of PrEP need and uptake among specific Black immigrant subgroups [67, 70].

Heterogeneity in how “Black immigrants” were defined also constrains interpretation. Several studies used broad categories such as “non-Western”, “African-born,” or “Black and other racialized migrants,” which can obscure within-group differences by region and country of origin, language, religion, gender, sexuality, and legal status [26, 52]. Few studies explicitly examined gradients of vulnerability by time

since arrival, documentation status, or migration pathway, despite evidence that these factors shape access to health care and prevention [51, 67–69, 74, 77, 79]. Finally, our review was limited to English-language publications and to selected databases; relevant studies from non-English-speaking high-income contexts or the gray literature may therefore have been missed, and the patterns we report likely reflect a conservative picture of the barriers and facilitators faced by Black immigrants in relation to PrEP adoption.

Conclusion

This systematic review demonstrates that PrEP engagement among Black immigrants in high-income countries is constrained less by individual willingness than by interacting structures of racism, migration governance, and gendered power that determine who is informed about, offered, and able to sustain PrEP use. Barriers spanning intrapersonal, interpersonal, institutional, community, and policy levels collectively narrow opportunities for prevention, whereas facilitators such as culturally safe care, community-based education, navigation and support, and universal or highly subsidized coverage show that more equitable PrEP outcomes are achievable when systems are intentionally redesigned. To realize PrEP's prevention potential for Black immigrants, practice and programmes must move beyond information-only approaches to address relational and structural conditions, and policies must guarantee affordable, routine PrEP access within services that are co-produced with Black diasporic communities. Future research should rigorously test multilevel, anti-racist, and migrant responsive interventions across diverse welfare and immigration regimes and further develop theoretical frameworks that centre Black immigrants' own analyses of prevention, risk, and safety as foundations for reimagining PrEP implementation.

References

1. UK Health Security Agency. HIV: annual data. GOV.UK (2025)
<https://www.gov.uk/government/statistics/hiv-annual-data-tables>
2. Public Health Agency of Canada. Population-specific HIV/AIDS status report — fact sheet (2024)
Available: <https://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/pdf/factsheet-info-eng.pdf>
3. Joint United Nations Programme on HIV/AIDS (UNAIDS). Global HIV & AIDS statistics — Fact sheet (2025) Available: <https://www.unaids.org/en/resources/fact-sheet>
4. Filippone P, Serrano S, Campos S, Freeman R, Cluesman SR, Israel K et al (2023) Understanding why racial/ethnic inequities along the HIV care continuum persist in the United States: a qualitative exploration of systemic barriers from the perspectives of African American/Black and Latino persons living with HIV. *Int J Equity Health* 22(1):168. 10.1186/s12939-023-01992-6
5. Dasgupta S, Oster AM, Li J, Hall HI (2016) Disparities in Consistent Retention in HIV Care — 11 States and the District of Columbia, 2011–2013. *MMWR Morb Mortal Wkly Rep* 65. 10.15585/mmwr.mm6504a2

6. Kaiser Family Foundation. The Impact of HIV on Black People in the United States (2024) Available: <https://www.kff.org/hiv-aids/the-impact-of-hiv-on-black-people-in-the-united-states/>
7. National AIDS, Trust (2024) UK HIV statistics. Available: <https://nat.org.uk/about-hiv/hiv-statistics/>
8. Yin Z, Brown AE, Rice BD, Marrone G, Sönnernborg A, Suligoi B et al (2022) Intersecting Stigmas: Being Black African, Immigrant, and Living With HIV in the United States. *Am J Public Health* 112(S4):S367–S370. 10.2105/AJPH.2022.306734
9. Dombrowski JC, Corcorran MA, Carney T, Parczewski M, Gandhi M (2025) The impact of homelessness and housing insecurity on HIV. *Lancet HIV* 12(6):e449–e458. 10.1016/S2352-3018(25)00048-7
10. Nöstlinger C, Cosaert T, Landeghem EV, Vanhamel J, Jones G, Zenner D et al (2022) HIV among migrants in precarious circumstances in the EU and European Economic Area. *Lancet HIV* 9(6):e428–e437. 10.1016/S2352-3018(22)00032-7
11. Pantazis N, Rosinska M, van Sighem A, Chantal Q, Noori T, Burns F et al (2021) Discriminating Between Premigration and Postmigration HIV Acquisition Using Surveillance Data. *JAIDS J Acquir Immune Defic Syndr* 88(2):117. 10.1097/QAI.0000000000002745
12. Ross J, Cunningham CO, Hanna DB (2018) HIV outcomes among migrants from low-income and middle-income countries living in high-income countries: a review of recent evidence. *Curr Opin Infect Dis* 31(1):25. 10.1097/QCO.0000000000000415
13. Mbuagbaw L, Husbands W, Baidooobonso S, Lawson D, Aden M, Etowa J et al A cross-sectional investigation of HIV prevalence and risk factors among African, Caribbean and Black people in Ontario: The A/C Study. *Can Commun Dis Rep*. 48(10):429–437. Accessed February 3, 2026. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10730175/>
14. Tharao W, Nyoni T, Daftary A, Bullock S, Blot S, Pierre-Pierre V et al (2025) Post-arrival HIV acquisition patterns: Insights from African, Caribbean, and Black immigrant communities in Canada. *Can J Public Health* 116(2):194–208. 10.17269/s41997-024-00991-6
15. Ojikutu BO, Nnaji C, Dévieux JG (2021) HIV and Immigrants from Sub-Saharan Africa and the Caribbean Living in the United States. In: Ojikutu BO, Stone VE (eds) *HIV in US Communities of Color*. Springer International Publishing, pp 111–133. doi:10.1007/978-3-030-48744-7_7
16. Joint United Nations Programme on HIV/AIDS (UNAIDS). In Danger: Global AIDS Update 2022 (2022) Available: <https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update>
17. World Health Organization. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV (2015) Available: <https://www.who.int/publications/i/item/9789241509565>
18. Centers for Disease Control and Prevention. What Is HIV PrEP? Clinicians' Quick Guide (2022) Available: <https://stacks.cdc.gov>
19. National Institutes of Health. Pre-Exposure Prophylaxis (PrEP) (2025) Available: <https://hivinfo.nih.gov/understanding-hiv/fact-sheets/pre-exposure-prophylaxis-prep>

20. Young I, Flowers P, McDaid LM (2014) Barriers to uptake and use of pre-exposure prophylaxis (PrEP) among communities most affected by HIV in the UK: findings from a qualitative study in Scotland. *BMJ Open* 4:e005717. 10.1136/bmjopen-2014-005717
21. Young I, Flowers P, McDaid LM (2015) Key factors in the acceptability of treatment as prevention (TasP) in Scotland: a qualitative study with communities affected by HIV. *Sex Transm Infect* 91(4):269–274. 10.1136/sextrans-2014-051711
22. Patten S (2016) *Analysis report: ACB Service Provider Perceptions and Understanding of Biomedical Approaches to HIV Prevention*
23. Sears TS (2017) *Addressing the HIV Prevention Needs of Diverse Black Women of the African Diaspora via an HIV Empowerment Knowledge E-Health Video: Identifying Predictors of HIV Prevention Knowledge and Stage of Change for HIV Testing*. Ed.D. Teachers College, Columbia University; Available: <https://www.proquest.com/docview/1929221348/abstract/59655773A2184EFEPQ/1>
24. Ekong N, Braunholtz-Speight J, Mukelabai N, Evans A (2018) Awareness of pre-exposure prophylaxis (PrEP) in the black and minority ethnic (BME) community; a questionnaire survey in Leeds, UK. *HIV Med.* ;1
25. Mullens AB, Kelly J, Debattista J, Phillips TM, Gu Z, Siggins F (2018) Exploring HIV risks, testing and prevention among sub-Saharan African community members in Australia. *Int J Equity Health* 17(1):62. 10.1186/s12939-018-0772-6
26. Witzel TC, Nutland W, Bourne A (2018) What qualities in a potential HIV pre-exposure prophylaxis service are valued by black men who have sex with men in London? A qualitative acceptability study. *Int J STD AIDS* 29(8):760–765. 10.1177/0956462418755224
27. Di Giuseppe K, Kasoka K, Dunkley Y (2019) Investigating Preexposure Prophylaxis (PrEP) Uptake Among Black African Communities in East London and Hertfordshire: A Brief Report of a Mixed Methods Study. *Int J Sex Health* 31(3):291–296. 10.1080/19317611.2019.1634174
28. Okoro ON, Whitson SO (2020) Sexual Health, HIV Care and Pre-exposure Prophylaxis in the African Immigrant Population: A Needs Assessment. *J Immigr Minor Health* 22(1):134–144. 10.1007/s10903-019-00873-x
29. Zhabokritsky A, Nelson LE, Tharao W, Husbands W, Sa T, Zhang N et al (2019) Barriers to HIV pre-exposure prophylaxis among African, Caribbean and Black men in Toronto, Canada. *PLoS ONE* 14(3):e0213740. 10.1371/journal.pone.0213740
30. Boudreaux J, Valdebenito CM, Pichon LC (2025) Identifying Access Barriers to PrEP Among Cisgender Black/African American Women in the United States: A Systematic Review of the Literature. *Healthcare* 13(1):86. 10.3390/healthcare13010086
31. Smit F, Masvawure TB (2024) Barriers and Facilitators to Acceptability and Uptake of Pre-Exposure Prophylaxis (PrEP) Among Black Women in the United States: a Systematic Review. *J Racial Ethnic Health Disparities* 11(5):2649–2662. 10.1007/s40615-023-01729-9
32. Sims Haynes A, Markham C, Schick V, Suchting R, Parthasarathy N, Choudhury S et al (2025) A Systematic Review and Narrative Synthesis of Factors Affecting Pre-exposure Prophylaxis

- Willingness Among Black Women for HIV Prevention. *AIDS Behav* 29(1):101–132. 10.1007/s10461-024-04491-z
33. Russ S, Zhang C, Liu Y (2021) Pre-Exposure Prophylaxis Care Continuum, Barriers, and Facilitators among Black Men Who Have Sex with Men in the United States: A Systematic Review and Meta-Analysis. *AIDS Behav* 25(7):2278–2288. 10.1007/s10461-020-03156-x
 34. Warzywoda S, Fowler JA, Dyda A, Fitzgerald L, Mullens AB, Dean JA (2024) Pre-exposure prophylaxis access, uptake and usage by young people: a systematic review of barriers and facilitators. *Ther Adv Infect Dis* 11:20499361241303415. 10.1177/20499361241303415
 35. Coukan F, Murray KK, Papageorgiou V, Lound A, Saunders J, Atchison C et al (2023) Barriers and facilitators to HIV Pre-Exposure Prophylaxis (PrEP) in Specialist Sexual Health Services in the United Kingdom: A systematic review using the PrEP Care Continuum. *HIV Med* 24(8):893–913. 10.1111/hiv.13492
 36. Mwaturura C, Traeger M, Lemoh C, Stooze M, Price B, Coelho A et al (2021) Barriers and facilitators to pre-exposure prophylaxis among African migrants in high-income countries: a systematic review. *Sex Health* 18(2):130–139. 10.1071/SH20175
 37. Centers for Disease Control and Prevention. Clinical Guidance for PrEP. HIV Nexus: CDC Resources for Clinicians (2025) Available: <https://www.cdc.gov/hivnexus/hcp/prep/index.html>
 38. Centers for Disease Control and Prevention. Preventing HIV with PrEP (2024) Available: <https://www.cdc.gov/hiv/prevention/prep.html>
 39. McLeroy KR, Bibeau D, Steckler A, Glanz K (1988) An Ecological Perspective on Health Promotion Programs. *Health Educ Q* 15(4):351–377. 10.1177/109019818801500401
 40. Baral S, Logie CH, Grosso A, Wirtz AL, Beyrer C (2013) Modified social ecological model: a tool to guide the assessment of the risks and risk contexts of HIV epidemics. *BMC Public Health* 13(1):482. 10.1186/1471-2458-13-482
 41. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD et al (2021) The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 372:n71. 10.1136/bmj.n71
 42. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D et al (2018) PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann Intern Med* 169(7):467–473. 10.7326/M18-0850
 43. Arksey H, O'Malley L (2005) Scoping studies: towards a methodological framework. *Int J Soc Res Methodol* 8(1):19–32. 10.1080/1364557032000119616
 44. Levac D, Colquhoun H, O'Brien KK (2010) Scoping studies: advancing the methodology. *Implement Sci* 5(1):69. 10.1186/1748-5908-5-69
 45. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010 (2010) Available: <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm>
 46. World Health Organization. Pre-Exposure Prophylaxis (PrEP): Policy Brief (2015) Available: https://iris.who.int/bitstream/handle/10665/197906/WHO_HIV_2015.48_eng.pdf

47. World Bank. World Bank country classifications by income level for 2024–2025 (2025) Available: <https://blogs.worldbank.org/en/opendata/world-bank-country-classifications-by-income-level-for-2024-2025>
48. Critical Appraisal Skills Programme Qualitative Studies Checklist. Available: <https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/>
49. Critical Appraisal Skills Programme Cohort Study Checklist. Available: <https://casp-uk.net/casp-tools-checklists/cohort-study-checklist/>
50. Vujcich D, Reid A, Brown G, Durham J, Guy R, Hartley L et al (2023) HIV-Related Knowledge and Practices among Asian and African Migrants Living in Australia: Results from a Cross-Sectional Survey and Qualitative Study. *Int J Environ Res Public Health* 20(5):4347. 10.3390/ijerph20054347
51. Ajiboye W, Nelson L, Odhiambo A, Yusuf A, Djiadeu P, Turner DA et al (2022) Decision conflict and the decision support needs of HIV PrEP-eligible Black patients in Toronto regarding the adoption of PrEP for HIV prevention. *J Int Assoc Provid AIDS Care* 21:23259582211073399. 10.1177/23259582211073399
52. Ajiboye W, Debapriya Chakraborty JM, Lo Hog Tian K, McBain SB, Rourke LRE Nelson. 'Yes, I said No to PrEP because I would like to know more about the medication': Facilitators and Barriers to acceptance of HIV Pre-exposure prophylaxis in Black communities in Canada. *34th Canadian Conference on HIV/AIDS Research (CAHR 2025) 2025*(): 2025. Published online 2025
53. Liegeon G, Devlin SA, Manda V, Castaneda J, March C, Ridgway JP et al (2024) Knowledge, Attitudes, and Perspectives of Women Who Have Migrated from Sub-Saharan Africa to France Toward HIV Pre-Exposure Prophylaxis in a Family Planning Center. *AIDS Patient Care STDs* 38(11):507–516. 10.1089/apc.2024.0190
54. Grenfell P, Rafael S, Calliste J, Nutland W (2022) We go where we know': Reflections from Mobilizing for PrEP and Sexual Health (MobPrESH) – A peer-led PrEP education programme across England, for and by women and non-binary people. *Women's Health (Lond Engl)* 18:17455057221091727. 10.1177/17455057221091727
55. Van Landeghem E, Arbier A, Pratt CSA, Senga M, Scheerder G, Reyniers T et al (2024) PrEP Among Sub-Saharan African Diaspora Communities in Belgium – a Participatory Action Research Study. *J Community Health* 49(1):156–165. 10.1007/s10900-023-01269-7
56. Aidoo-Frimpong G, Collins RL, Agbemenu K, Orom H, Morse GD, Nelson LE (2022) Barriers to HIV Pre-Exposure Prophylaxis Uptake and Ways to Mitigate Them: Perspectives of Ghanaian Immigrants in the United States. *AIDS Educ Prev* 34(3):209–225. 10.1521/aeap.2022.34.3.209
57. Aidoo-Frimpong G, Orom H, Agbemenu K, Collins RL, Morse GD, Nelson LE (2022) Exploring Awareness, Perceptions, and Willingness to Use HIV Pre-Exposure Prophylaxis: A Qualitative Study of Ghanaian Immigrants in the United States. *AIDS Patient Care STDs* 36(1):8–16. 10.1089/apc.2021.0156
58. Etowa J, Tharao W, Mbuagbaw L, Baidoobonso S, Hyman I, Obiorah S et al (2022) Community perspectives on addressing and responding to HIV-testing, pre-exposure prophylaxis (PrEP) and

- post-exposure prophylaxis (PEP) among African, Caribbean and Black (ACB) people in Ontario, Canada. *BMC Public Health* 22(1):913. 10.1186/s12889-022-13093-0
59. Lee-Foon N (2021) *Exploring the State of Sexual Health Literacy among Young Black Gay and Other Men Who Have Sex with Other Men in Toronto, Ontario, Canada*. Ph.D. University of Toronto; Available: <https://www.proquest.com/docview/2555962677/abstract/5D2CCBBD10924496PQ/1>
 60. Nakasone SE, Young I, Estcourt CS, Calliste J, Flowers P, Ridgway J et al (2020) Risk perception, safer sex practices and PrEP enthusiasm: barriers and facilitators to oral HIV pre-exposure prophylaxis in Black African and Black Caribbean women in the UK. *Sex Transm Infect* 96(5):349–354. 10.1136/sextrans-2020-054457
 61. Demart S, Gérard E (2022) The Construction of Pre-exposure Prophylaxis (PrEP) by Prevention Professionals as a Tool for Black African Migrant Women ... or Not? *AIDS Educ Prev* 34(6):496–511. 10.1521/aeap.2022.34.6.496
 62. D'Angelo AB, Davis Ewart LN, Koken J, Bimbi D, Brown JT, Grov C (2021) Barriers and Facilitators to Pre-exposure Prophylaxis Uptake Among Black Women: A Qualitative Analysis Guided by a Socioecological Model. *J Assoc Nurses AIDS Care* 32(4):481. 10.1097/JNC.0000000000000241
 63. Nicholls EJ, Samba P, McCabe L, Gafos M, Philips AN, Trevelion R et al (2022) Experiences of and attitudes towards HIV testing for Asian, Black and Latin American men who have sex with men (MSM) in the SELPHI (HIV Self-Testing Public Health Intervention) randomized controlled trial in England and Wales: implications for HIV self-testing. *BMC Public Health* 22(1):809. 10.1186/s12889-022-13189-7
 64. Lee-Foon NK, Logie CH, Siddiqi A, Grace D (2022) Exploring young Black gay, bisexual and other men who have sex with men's PrEP knowledge in Toronto, Ontario, Canada. *Cult Health Sex* 24(3):301–314. 10.1080/13691058.2020.1837958
 65. Ojikutu BO, Amutah-Onukagha N, Mahoney TF, Tibbitt C, Dale SD, Mayer KH et al (2020) HIV-Related Mistrust (or HIV Conspiracy Theories) and Willingness to Use PrEP Among Black Women in the United States. *AIDS Behav* 24(10):2927–2934. 10.1007/s10461-020-02843-z
 66. Buffel V, Masquillier C, Reyniers T, Van Landeghem E, Wouters E, Vuylsteke B et al (2021) Who falls between the cracks? Identifying eligible PrEP users among people with Sub-Saharan African migration background living in Antwerp, Belgium. *PLoS ONE* 16(8):e0256269. 10.1371/journal.pone.0256269
 67. Coulibaly K, Bousmah M al, Ravalihasy Q, Taeron A, Mbiribindi C, Senne R (2023) Bridging the knowledge gap of biomedical HIV prevention tools among sub-Saharan African immigrants in France. Results from an empowerment-based intervention. *SSM - Popul Health* 23:101468. 10.1016/j.ssmph.2023.101468
 68. Aidoo-Frimpong G, Agbemenu K, Adzrago D, Akyirem S, Boateng S, Nelson LE (2023) The Promise of Pre-Exposure Prophylaxis – Examining Awareness, Knowledge, and Willingness to use Different Modalities Among US-Based African Immigrants. *J Immigr Minor Health* 25(6):1331–1338. 10.1007/s10903-023-01515-z

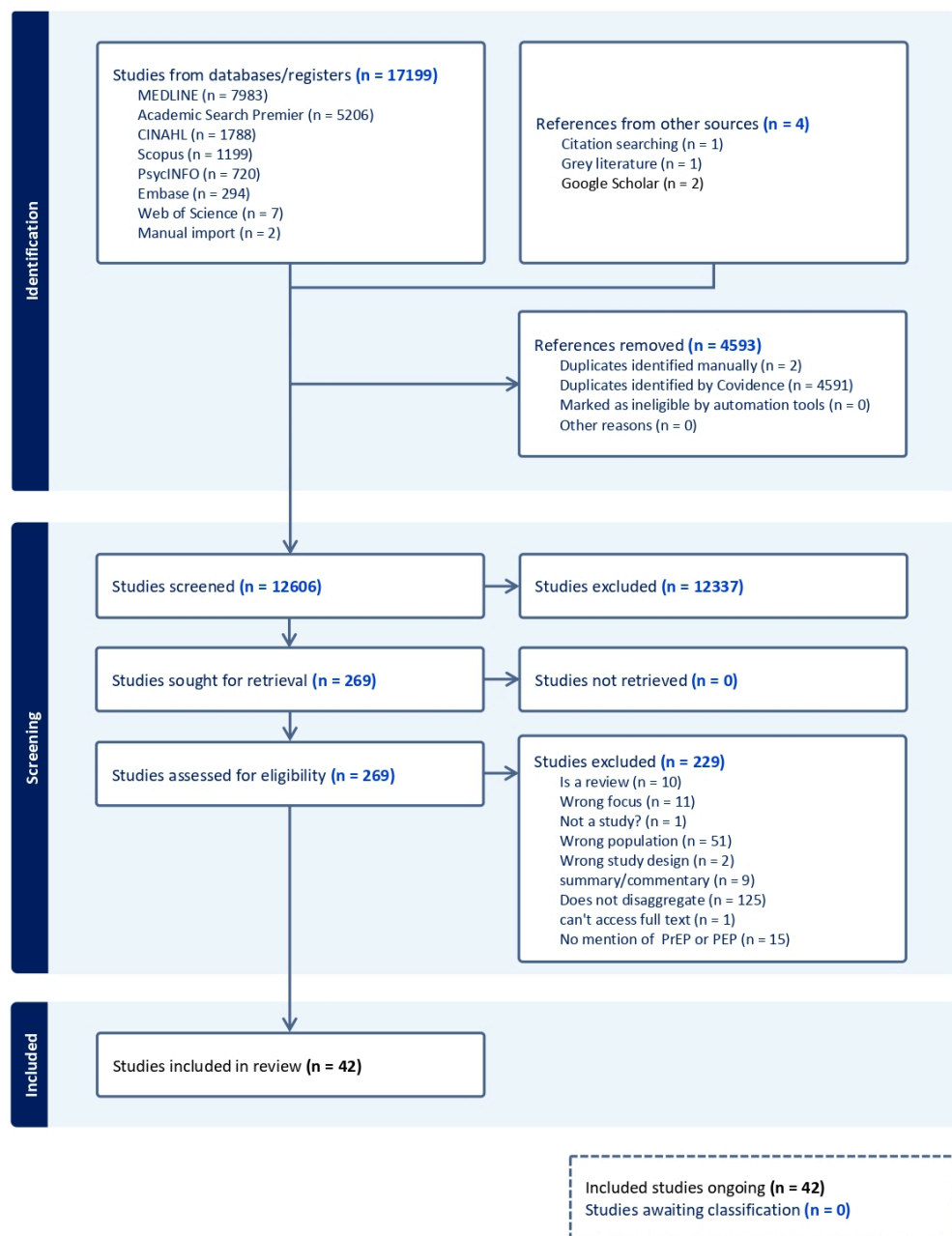
69. Rudd M, McGarrity M, Lisk R, MacPherson P, Knox D, Woodward K et al (2024) Reported Side Effects and Adherence of Daily HIV Pre-Exposure Prophylaxis Users in Ontario, Canada: An Analysis of the Ontario Pre-Exposure Prophylaxis Cohort Study. *AIDS Patient Care STDs* 38(9):382–392. 10.1089/apc.2024.0144
70. Villalba K, Jean-Gilles M, Rosenberg R, Cook RL, Ichite A, Martin P et al (2022) Understanding the Impact of Intimate Partner Violence Type and Timing on Pre-exposure Prophylaxis Knowledge, Acceptability, Sexual Behavior, and Gender Roles Among Women of Color. *J Interpers Violence* 37(15–16):NP12998–NP13017. 10.1177/08862605211001468
71. Cyrus E, Villalba K, Jean-Gilles M, Rosenberg R, Ichite A, Ullah E et al (2023) Barriers and Perceived Facilitators for PrEP Use Among Women of Color in South Florida: Findings from the Empowering Women to Take Control of Their Sexual Health Summit. *medRxiv*. 2023.05.23.23290385
72. Souleymanov R, Akinyele-Akanbi B, Njeze C, Ukoli P, Migliardi P, Kim J et al (2023) Migration and health study: a socio-ecological analysis of sexual health among migrants in Manitoba, Canada. *BMC Public Health* 23(1):2438. 10.1186/s12889-023-17379-9
73. Coulibaly K, Gosselin A, Carillon S, Taeron C, Mbiribindi R, Du Lou AD (2023) Low knowledge of antiretroviral treatments for the prevention of HIV among precarious immigrants from sub-Saharan Africa living in the greater Paris area: Results from the Makasi project. *PLoS ONE* 18(6):e0287288. 10.1371/journal.pone.0287288
74. Coukan F, Sullivan A, Mitchell H, Jaffer S, Williams A, Saunders J et al (2024) Impact of national commissioning of pre-exposure prophylaxis (PrEP) on equity of access in England: a PrEP-to-need ratio investigation. *Sex Transm Infect* 100(3):166–172. 10.1136/sextrans-2023-055989
75. Evers YJ, Goense CJD, Hoebe CJPA, Dukers-Muijters NHTM (2023) Newly diagnosed HIV and use of HIV-PrEP among non-western born MSM attending STI clinics in the Netherlands: a large retrospective cohort study. *Front Public Health* 11. 10.3389/fpubh.2023.1196958
76. Krankowska DC, Lourida P, Quirke SM, Woode Owusu M, Weis N, Group EMWW (2024) Barriers to HIV testing and possible interventions to improve access to HIV healthcare among migrants, with a focus on migrant women: Results from a European survey. *HIV Med* 25(5):554–564. 10.1111/hiv.13606
77. Jaspal R, Lopes B, Maatouk I (2020) Social Identity and Attitudes toward HIV Pre-exposure Prophylaxis: A Structural Equation Model. *J Social Service Res* 46(3):331–344. 10.1080/01488376.2019.1566196
78. de Araújo TME, Brito Magalhães LE, de L R, Valle ARM, da Borges C, de TM P, Almeida PD et al (2023) Sexual exposure to HIV in Angolan men who have sex with men immigrants: A cross-sectional study in Portugal and Brazil. *Int J STD AIDS* 34(12):876–883. 10.1177/09564624231185810
79. Aidoo-Frimpong G, Koku E, Okoro O, Gyamerah A, Johnson N, Schwartz S (2025) Sankofa! Leveraging Cultural Assets to Advance Long-Acting Injectable Pre-exposure Prophylaxis Among

- U.S.-Based African Immigrants. *J Immigr Minor Health* 27(5):652–657. 10.1007/s10903-025-01750-6
80. Aidoo-Frimpong GA, Adekunle T, Abu’Baare GR, Adu C (2025) Community-Driven Recommendations for Developing Culturally Aligned Messaging to Improve Pre-Exposure Prophylaxis Acceptability and Uptake Among US-Based African Immigrants. *AIDS Patient Care STDs* 39(5):178–186. 10.1089/apc.2025.0020
81. Aidoo-Frimpong G, Collins RL, Agbemenu K, Orom H, Morse GD, Nelson LE (2022) Barriers to HIV Pre-Exposure Prophylaxis Uptake and Ways to Mitigate Them: Perspectives of Ghanaian Immigrants in the United States. *AIDS Educ Prev* 34(3):209–225. 10.1521/aeap.2022.34.3.209

Tables

Tables 1 to 5 are available in the Supplementary Files section.

Figures



2nd March 2026



Figure 1

PRISMA flow diagram of the study selection process

PRISMA: Bridging the Gap: Enhancing PrEP & PEP Adoption Among Black Immigrants in High-Income Countries

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [BRIDGINGTHEGAPManuscriptTables.docx](#)