

A Community-Based Intervention to Increase HIV Pre-Exposure Prophylaxis Use among Individuals Receiving Re-Entry Services: Results from a Formative Evaluation

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Research Article

Keywords: HIV prevention, incarcerated individuals, community partnership, qualitative

Posted Date: October 21st, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-11234686/v1>

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Additional Declarations: Competing interest reported. AEN receives research funding from Gilead Sciences. DK received research funding from Gilead Sciences and personal funds from Medscape, PRIME Education, and UptoDate, Inc., to develop medical education content, and funds from the University of Pennsylvania for research consulting.

Abstract

Introduction

Criminal-legal populations have a disproportionately higher risk of acquiring HIV. Clinical partnerships with community-based organizations have been shown to be effective in overcoming multiple challenges to awareness and linkage to pre-exposure prophylaxis (PrEP).

Aims

Report findings from a formative evaluation and describe how these data refined our approach to a health coaching intervention designed to enhance linkage to PrEP and embedded in a community-based organization that provides re-entry services.

Methods

We conducted a formative evaluation using interviews with criminal-legal individuals (clients) and staff of a community-based organization serving greater Dallas County, Texas. Interviews explored knowledge and beliefs about HIV and PrEP, perceived risk, barriers to care, and need for support. Two analysts conducted rapid and thematic content analysis; the research team selected and interpreted representative quotes.

Results

We completed interviews with ten clients and six staff. Analysis revealed that clients: (1) need social support and mental health care but minimize these needs, often not seeking related services unless their concerns impede daily life activities; (2) have low perceived risk of acquiring HIV and associate HIV with 'being gay,' but are open to discussing PrEP; (3) face competing needs that can impede focus on one's health, limited proficiency with technology, and mistrust and misinformation barriers; and (4) recommend using humor, plain and respectful language, and dispelling myths in HIV prevention education.

Conclusion

HIV prevention with criminal-legal populations must address preventive health, social support, erroneous beliefs about HIV risk and transmission, and stigmas. Encouragingly, we found an openness to discussing and using PrEP as an HIV prevention strategy, even among those who perceive their personal HIV risk to be low. Any such prevention effort will benefit from taking steps to address common misperceptions about HIV and barriers to prevention, and employing culturally competent messaging in non-judgmental, destigmatizing ways.

INTRODUCTION

Individuals currently or formerly incarcerated in jails and prisons (criminal legal-involved populations) have a disproportionately higher risk of HIV (Spaulding et al., 2009), especially in the southern US, where HIV incidence rates are highest (Centers for Disease Control and Prevention, 2022). In 2023, the prevalence of HIV in correctional facilities was an estimated 3–4 times higher than the general United States (US) population (Bureau of Justice Statistics, 2025; U.S. Census Bureau, 2023). Providing HIV prevention education and services to criminal-legal populations is therefore a meaningful opportunity to contribute to the goal of reducing HIV risk toward Ending The Epidemic (EHE)(U.S. Department of Health and Human Services, 2026) in the US.

While antiretroviral pre-exposure prophylaxis (PrEP) is a highly effective intervention to decrease HIV transmission, formerly incarcerated individuals face competing needs integral to daily living, such as housing, income, transportation, and re-establishing social relationships, that are often prioritized over attention to one's health (Lee et al., 2025; Ramaswamy et al., 2015; Zaller et al., 2020). These structural challenges can exacerbate individuals' lack of knowledge about HIV, underestimation of HIV risk, and lack of awareness of what PrEP is and where it is available (Brinkley-Rubinstein et al., 2020; Rutledge et al., 2018; Zaller et al., 2020). For these reasons, creating a health ecosystem to sustain awareness of and engagement in PrEP care, thereby preventing HIV, is challenging yet essential following community re-entry (Horton et al., 2024).

In Texas, criminal-legal populations face additional hurdles. There is no evidence that jails and prisons in Texas currently provide PrEP to incarcerated individuals, so linking them to PrEP service providers in the post-release period is critical. Additionally, while newer long-acting injectable PrEP medications may offer adherence advantages over daily or event-driven use of pills, the post-release availability and affordability of long-acting formulations of PrEP among safety-net providers has been limited thus far, particularly since Texas is a non-Medicaid expansion state. Although several specialized insurance and pharmaceutical reimbursement programs offer financial coverage for some PrEP medications and related care services, many require extensive enrollment paperwork, posing yet another barrier to care (Eichenwald et al., 2025).

Despite these challenges, when criminal-legal populations are told about PrEP, studies show there is considerable interest in using it (Banyas et al., 2024; Lee et al., 2025; Murphy et al., 2024). Successful models exist for providing HIV treatment to recently incarcerated individuals (Goldhammer et al., 2025). Clinical partnerships with community-based organizations (Andrade et al., 2023; Ross et al., 2023), navigator interventions (Creasy et al., 2024; Ramsey et al., 2021), and interventions using peer "buddy systems"(Young et al., 2018) have demonstrated effectiveness, in part because they specifically address educational needs, structural drivers of health disparities, and factors that impact HIV care engagement and accessibility. Likewise, similar approaches may be successful in increasing PrEP care in recently incarcerated populations.

Amid this landscape, we designed a study to improve HIV and PrEP knowledge and enhance linkage to PrEP services in partnership with a community-based organization focused exclusively on serving

individuals with a history of criminal legal involvement. Our goal was to incorporate HIV prevention, including PrEP, into the context of a community agency focused on assisting individuals with comprehensive needs during this critical transition period. The objective of this manuscript is to report findings from our formative evaluation and to describe how these data refined our approach to the HIV prevention education and health coach intervention embedded in this community-based organization and currently undergoing testing.

METHODS

Study Design and Setting

We conducted a formative evaluation (Cucciare et al., 2026) consisting of semi-structured interviews with criminal-legal individuals and staff of a community-based organization that provides re-entry services to inform a health coaching intervention focused on PrEP. Founded in 2010, [organization] is a non-profit organization offering linkage to social support services to individuals formerly incarcerated or on parole (“clients”) in and around Dallas County, Texas. Clients of [organization] work one-on-one with an individual counselor (“Reentry Broker™”) to identify their daily living, emotional, and health needs and to link them to appropriate service providers. Our goal was to integrate HIV prevention and related community-based PrEP navigation services through the introduction of a health coach within the social and structural infrastructure of [organization].

Instrument Development

Our semi-structured interview guide drew on concepts from the Health Belief Model (Becker, 1974; Rosenstock, 1974). The Health Belief Model posits that behavior change occurs when individuals appropriately perceive susceptibility, severity, benefits, barriers, self-efficacy, and threats. The client interview guide explored topics such as knowledge and beliefs about HIV and PrEP, perceived HIV risk and need for PrEP, barriers to care, experiences with re-entry, and need for support with initiation and retention in PrEP services. The guide for interviews with [organization] staff explored similar topics, asking participants to comment on their experiences serving clients, the challenges clients face in enacting behavior change, and best practices and lessons learned in overcoming these challenges.

Sampling, Recruitment, and Data Collection

We interviewed a purposive sample of clients and all staff of [organization], including Reentry Brokers™, leadership, and administrative staff. Sampling and recruitment of clients was facilitated by Reentry Brokers™, given the close-knit nature of the existing client-Reentry Broker™ relationships and the need to identify clients not in acute distress. To be eligible for interviews, clients were age ≥ 18, had a history with the criminal-legal system (e.g., arrested, formerly incarcerated in jail or prison on probation or parole), and received services currently or at some point in the past as a client of [organization]. Once potential

client participants were identified by Reentry Brokers™, administrative staff at [organization] scheduled interviews to take place at the organization at a time convenient for clients. Two research staff trained in qualitative methods with no former incarceration history [initials] conducted the interviews. Interviews lasted an average of 37 minutes (range 30–45 minutes) for staff and 47 minutes (range 29–61 minutes) for clients. All interview participants were compensated with a \$50 gift card. All audio files were transcribed verbatim by an institutionally approved vendor with HIPAA protection.

Data Analysis

Following each interview, researchers documented findings in a structured rapid analysis document, the purpose of which was to promote consistent data capture, facilitate real-time conversations about findings among members of the research team, and assist in the determination of thematic saturation. After saturation was deemed to have been reached through weekly discussions of findings, the lead qualitative investigator [initials] drafted a codebook corresponding to the major themes identified in the rapid analysis. Two members of the research team [initials] then thematically analyzed transcripts and selected representative quotes for each theme using NVivo 15.0 (Lumivero). Two additional members of the research team [initials] then reviewed transcripts and coded passages to affirm representativeness of the quotes. Findings and quotes were interpreted in team meetings. We report adherence to the Standards for Reporting Qualitative Research (SRQR) as **Supplementary Material 1**.

RESULTS

We interviewed 10 clients and 6 [organization] staff; see **Table 1** for a description of their sociodemographic characteristics.

Table 1. Self-reported Sociodemographic Characteristics of Interview Participants

	Clients	Staff
	N=10	N=6
	n (%)	n (%)
Race/ethnicity		
Hispanic (any race)	1 (10)	1 (17)
Black	3 (30)	0
White	3 (30)	4 (67)
More than 1 race/ethnicity	3 (30)	1 (17)
Gender		
Female	1 (10)	2 (33)
Male	9 (90)	4 (67)
Age		
<40 years	3 (30)	3 (5)
40-49 years	2 (20)	0
50-59 years	3 (30)	1 (17)
≥60 years	2 (20)	1 (17)
Declined to respond		1 (17)
Number of years receiving services or working at Unlocking Doors®		
<1 year	6 (60)	1 (17)
1-3 years	2 (20)	3 (50)
>3 years	2 (20)	2 (33)
Highest level of education		
High school graduate or less	4 (40)	not asked
Some college/Associate's degree	3 (30)	
College graduate or more	2 (20)	
Declined to respond	1 (10)	

Theme #1: Client health and service needs

- a) Many clients reported a need for encouragement and the value of resources and social support.

"[I need] somebody to talk to in, in confidence, you know? When I got out...there were some resources, but nothing like here [at [organization]], where you can come and they give you a list of places you can go that will accept you for your past and give you a chance." – client, White male, age 64

"Friends get out, they go to the halfway house. They tell you a little bit about what the experience is like, what's going on, how to get things done, those kinds of things....you actually get more from the people you know than the staff." – client, White male, age 59

b) Both clients and staff recognized the importance of addressing mental health needs, most often related to self-described depression, anxiety, and post-traumatic stress disorder (PTSD).

"I need probably a therapist to talk about, like, the stuff I went through, you know, my PTSD and all that, and depression and stuff." – client, Black male, age 19

"It's been really difficult, a lot of mental health, I feel like, has been very bad. In the past couple of months, people have just been really aggressive lately. Not aggressive in wanting to fight or anything, but aggressive as in, they want things and they want them now." – staff

c) Despite recognizing these needs, many clients minimized or did not prioritize preventive healthcare. They often did not seek health services unless the concerns impeded their daily life activities.

"I've kind of put my personal health needs on the back burner for one because I don't think nothing is pressing at the moment. I feel fine, I feel able." – client, mixed race male, age 43

"I was in a car wreck in 2016. It was pretty bad. I was in a coma, had my ankle broke, crushed my elbow. So, my right ankle has a whole lot of metal and so on and so forth. But to my knowledge, I don't have any pressing or major, major health concerns. It's just the average. I'm getting up in age, I'm 43, so high blood pressure, little stuff like that." – client, mixed race male, age 43

Theme #2: Knowledge and Attitudes toward HIV and PrEP

a) All clients accurately recognized that HIV is a sexually transmitted disease; however, many clients were less sure of their broader knowledge about HIV/AIDS. Regarding HIV transmission, they said:

"From what I understand, it can't be caught through the air." – client, White male, age 62

"I don't know if there's a cure for it or not"- client, Black male, age 19

"I don't know if, when you're nondetectable, if you're safe and there's less chance of them catching it – I don't know if that's true or not" - client, Hispanic male, age 56

Others reported knowing about the disease progression and survivability of HIV.

"I know it [HIV] leads to AIDS...but it's not the death sentence is used to be" – client, Hispanic male, age 56

"It used to be a death sentence, but it's not anymore." - client, White male, age 64

Some were familiar with HIV-related medications and treatments.

"I understand there's some kind of medication out now for HIV positives that prevent them from being to transmit it...With the medications, I don't know if there's some kid of blockers or whatever...you're a carrier but you won't be capable of transmitting." – client, White male, age 62

"I know that there's medications now that, instead of taking 600 pills, you can take one or two pills." – client, Hispanic male, age 56

b) Most clients felt their risk of acquiring HIV was low.

"I don't think my personal risk is high at all because I'm married." – client, Black male, age 51

"I would most likely have sex...but I think it [risk for HIV] might be low."- client, Black male, age 19

One participant, who was living with HIV, felt that many people, especially those who are younger or heterosexual, probably underestimate their risk.

"I think most people think they just don't need it because they don't mess around with people that often... they don't understand that [people are] only negative the last time they got tested, and a lot of people are less than truthful about when they got tested because it's such a hassle to get tested." – client, White male, age 59

c) Most clients associated HIV with the gay community or being gay. Many were surprised when they were shown information about the prevalence of HIV in formerly incarcerated individuals who reported exposure through heterosexual contact.

"The commercials I saw [for HIV-related medications], if I'm not mistaken...is for homosexual activity. I don't believe in homosexuality." – client, Black male, age 51

d) Most clients had little to no understanding of PrEP. Although most reported a belief that they were at low risk, many were still open to discussing and being on PrEP.

"I used to think [PrEP] was just for people who were gay and stuff like that...Once people get to know more about it, even just a few minutes, I think they would change their mind and be more willing to hear about it because there's a lot of guys out there, including myself, that don't like to use condoms." – client, White male, age 64

Theme #3: Barriers to Promoting PrEP and HIV Prevention Education

a) Both clients and staff reported barriers that echoed what is known about how post-incarcerated populations' need to prioritize basic needs over health.

"[I need] a place to live, a job, and food – pretty much in that order." – client, Hispanic male, age 56

"Housing and employment are the most urgent needs." – staff

b) Importantly, both clients and [organization] staff reported that clients are less proficient with technology, which was a barrier to accessing supportive services for health care and PrEP.

"So, the transition is very, very hard because all we deal with is cell phones, Internet, the media. They're not very intelligent about that...Back in the day, you're able to walk into a building and they give you [an] application, you fill it out. Here you go. Same day." – staff

"The biggest thing I can say is that technology has passed them by. They will get out and they've been in for 20 years, and they don't know how to use a cell phone. They don't know how to make an email...they're in their 50s but it's like if they were fresh and new out in the world because they don't know anything about things that are going on." – staff

c) Staff also identified getting medication refills as a barrier, especially since clients are usually given only a 30-day supply of any medication upon release.

"A lot of people will come out and say that they're finishing up prescriptions that they received while they're in prison. But now they need to go somewhere to refill those prescriptions, because once they run out, they don't have any anymore." – staff

d) When discussing PrEP, client concerns centered primarily around side effects and medical and pharmaceutical trust.

"[I'd want to know about] side effects, does it interfere with your sex life, does it affect your health in the long run." – client, Black male, age 51

"[I'd want to know about] side effects, the medical and chemical ingredients in PrEP." – client, White male, age 62

"Clients may be skeptical about receiving care from [that was approved by], the government, like the COVID vaccine." – staff

Theme #4: Strategies to Promote PrEP and HIV Prevention Education

a) Clients and staff provided several helpful suggestions about how best to talk about HIV and PrEP when asked how the health coach intervention could be optimized.

"Just like how we show what car crashes are like without a seatbelt, and that tells you to wear seatbelts. Use that metaphor. [Convey that] only stupid people don't do this [get tested and use PrEP]...Don't tell people to ask their provider – they won't. And providers don't talk about it. Until HIV is a routine test like cholesterol, it's not happening in the doctor's office." – client, White male, age 59

Clients emphasized speaking in plain language, “like a 5-year-old can understand”, reassuring people that everything they say is confidential, using videos and activities to make sessions more interactive.

At the same time, staff emphasized not “speaking down” or disrespecting clients:

“Speak casually, don’t talk above them. Dispel the ‘system is always against them’ attitude.” – staff

b) Several clients suggested directly addressing misconceptions around HIV risk and transmission.

“Address myths, like the ways you can and can’t get [HIV]. Talk to people on the street to get misunderstandings and address them...Like, is it true it won’t show up for 7 years? Is it true the virus can’t live outside the body, and it dies if it’s exposed to air?” – client, mixed race male, age 44

“[I’d want to know,] Can you get it if you have sex with just one person? If you had HIV and it was not treated, how would you know you were infected” – client, Black male, age 19

Several clients also specifically suggested directly dispelling the myth that only non-heterosexuals are at risk for HIV.

“[I’d suggest,] stats...the risk of HIV for straight people.” – client, White male, age 62

“[Say,] It matters if you wear [condoms] because HIV doesn’t care if you’re straight or bi or gay or transgender.” – client, Black male, age 32

Relatedly, some clients suggested directly addressing the issue of men – regardless of their sexual orientation – being at elevated risk because of having had sex with other men without a condom in the jail.

“When in prison, there are people that will do things that they wouldn’t normally do out of prison...It happens.” – client, Hispanic male, age 56

“You can be bi in jail and straight when you get out and you’re at risk.” – client, Black male, age 32

c) Clients and staff emphasized the importance of trust and confidentiality in the health coach relationship.

Some clients advocated the health coach be either a formerly incarcerated individual or someone who is familiar with the challenges many carceral populations face.

“You need someone who’s been on the street, who knows what we went through, someone we can trust, either formerly incarcerated or grown up in a messed-up environment like me. [client reported earlier that his father was a drug dealer.]...I don’t want to hear from a doctor who was raised with a silver spoon in their hand.” – client, mixed race male, age 44

“You need to acknowledge that the coaches may not be like us, but also say, ‘I am familiar with what your life is like’...like, ‘I’ve been to the barbecue’ – so you’re not totally ignorant of what goes on in the ‘hood.’” – client, Black male, age 32

Some staff recommended directly addressing the fact that HIV is still a stigmatized disease. For example, any association with HIV, including taking PrEP, may constitute a barrier.

“Make sure to mention that the medication won’t show up on their drug testing.” – staff

One emphasized the need for clients to have an anonymous way to receive information.

“People will say ‘nah’ to the education sessions but later will think more about it and be more open to getting tested and maybe want to take PrEP. So, it’s important to say, ‘the door is always open’...let people know who to call and where to go to get tested and get on PrEP, and make a phone line available for information because people want to talk without being seen or judged.” – client, mixed race male, age 44

d) At the same time, in terms of starting the conversation, some clients felt that humor would be a good approach.

“Be mature but be humorous...like, ‘don’t be silly, wrap your willy!’” – client, Black male, age 32

“Start off with a joke about the commercials [for PrEP]...the moon eyes the couples do...and point out the straight couple.” – client, Hispanic male, age 56

DISCUSSION

Our findings underscore that delivering HIV prevention and PrEP education is challenging during the re-entry period because of intensive and wide-ranging competing life priorities. Important unmet health and social support needs may be overshadowed during this time by more immediate concerns about housing, employment, relationships, food access, and other issues. Further, criminal-legal individuals may have basic knowledge of HIV, but substantial gaps in understanding can persist, particularly around HIV risk perception. Encouragingly, we found that even those who perceive their HIV risk to be low may be open to discussing and using PrEP as a prevention strategy.

Our interviews with clients and staff of a community-based organization serving greater Dallas County also yielded important insights about how to improve efforts to enhance HIV and PrEP knowledge, and linkage to PrEP services, among criminal-legal individuals. Participants offered actionable suggestions for enhancing our health coach intervention, including taking steps to address common misperceptions about HIV and psychological barriers to prevention, enlisting the help of peer advocates with relevant lived experience, drawing on humor and cultural analogies, addressing side effects and medical trust, and employing culturally competent messaging in non-judgmental, destigmatizing plain language. We explore these suggestions in more detail below and the unique role they can play in HIV prevention and PrEP linkage initiatives targeting criminal-legal involved populations.

First, our findings highlight that the widespread perception of HIV as a “gay disease” and its associated stigma continues to persist in this context. Indeed, some clients that we interviewed reported that men who identify as heterosexual may engage in sex with other men during incarceration without identifying as gay and may not disclose having had sex with men (e.g., to female partners or healthcare providers) upon being released. This presents a challenge for education about risk perception as messaging that frames HIV as a health issue predominantly affecting men who have sex with men (MSM) may not resonate with clients who do not identify as gay. Whereas HIV incidence in the general population is greater in MSM than in heterosexual men, the opposite is true among incarcerated populations (Wise et al., 2019). For these reasons, educational interventions with criminal-legal involved populations must separate sexual behavior from sexual orientation to emphasize risk as behaviorally-driven, not identity-driven. Education must also explicitly emphasize differences between the criminal-legal involved population and the general population in incidence by HIV transmission and demographics.

Second, participants suggested using non-judgmental, culturally competent messaging that includes humor (e.g., “don’t be silly, wrap your willy!”) and plain language analogies (e.g., using a condom is like wearing a seatbelt). They also suggested directly addressing medical mistrust, especially regarding the perceived newness of PrEP medications, side effects, and the role of pharmaceutical companies in marketing and advertising. Some felt that a peer – an individual with similar criminal-legal experience or demographic characteristics – might be viewed as more trustworthy and thus more appropriate to serve as a health coach, whereas others felt that the most important quality in a health coach is being genuine, friendly, and forthcoming in communication.

Third, in addition to their focus on meeting basic necessities more so than preventive health, participants openly expressed a need for mental health care, encouragement, and social support. This is also noteworthy considering that men in the criminal-legal system have reported being reluctant to request assistance with psychosocial needs due to social stigma, systemic distrust, and fears of legal repercussions (Howerton et al., 2007). In particular, unlike employment or housing, which many clients in our study had succeeded in securing, obtaining adequate mental health and social support were ongoing issues. These results suggest that truly ending the HIV epidemic in criminal-legal involved populations will require broader social initiatives, akin to those supported by our community-based organizational partner, [organization], if preventive health and HIV prevention are to be embraced as true priorities.

Based on our formative evaluation findings, we made several refinements to the content of our health coaching and HIV prevention training interventions. First, we ensured that training facilitators and coaches used an informal, non-assuming, non-technical tone to promote trust and a “safe space” for open discussion. Sessions used an interactive format and included ample time for client questions. Content focused on dispelling myths, clarifying knowledge of HIV transmission and risk, and included multiple opportunities for participants to share experiences and ask questions, including confidentially, by submitting written comments on an index card.

We also refined our referral and eligibility criteria for the coaching intervention based on early findings. First, we initially enlisted the assistance of [organization] staff for referral of clients, given the assumption that it may be best to leverage their existing relationship. However, we learned that some clients felt “targeted” by such an approach; therefore, we modified our recruitment strategy to have [organization] refer all clients to the study and have the health coaches complete the eligibility screening. Second, our intervention initially screened clients using the Center for Disease Control and Prevention’s clinical criteria for PrEP eligibility, which included men who have sex with men, having a recent sexually transmitted infection (STI), or having multiple sexual partners of unknown HIV status (HIV Nexus: CDC Resources for Clinicians, 2026). However, many clients were unaware of recent STIs or were not forthcoming with this information. When we eliminated this item such that enrollment eligibility was based solely on interest in PrEP and negative HIV status, we were able to reach a larger proportion of clients. This approach aligns with the “PrEP is for everyone” messaging recommendation (Macapagal et al., 2025; McCoy et al., 2025), which is consistent with the national Ending the HIV Epidemic strategy, and helps to directly address our findings regarding the prevailing stigma in this context toward men having sex with men.

Strengths and Limitations

Insights and lessons learned in this study are limited in their transferability to other settings given that our work was conducted as part of a partnership between a single academic medical center and community-based organization in a Southern U.S. city. Second, [organization] staff introduced clients to the study and the opportunity to participate in interviews, which may have biased our sample; however, this method of recruitment was important to build on the trusting relationship that staff had already established with clients. Third, it is possible that findings may have differed if the interviewers had personal incarceration experience; however, clients described the interviewer as “genuine” and “really cares.” The study’s strengths included resources from a strong academic-community partnership, diverse participation from our community-based organization, and adherence to established standards for reporting robust qualitative research.

CONCLUSIONS

Our findings from this formative evaluation have demonstrated that, in the case of criminal-legal involved populations, HIV prevention and linkage to PrEP services cannot be fully realized without first accounting for the most basic necessities faced by individuals upon release and reentry to the community. Addressing such needs may, in time, make it possible to raise preventive health, including HIV prevention, in the list of competing priorities that criminal-legal involved individuals face. Interventions and services intended to enhance linkage to PrEP must recognize the unfortunate persistence of HIV-related stigma and work to dispel those misperceptions through culturally competent messaging, build trust with individuals, and consider innovative ways to further integrate those with relevant lived experience into efforts to enhance knowledge and use of PrEP to end the HIV epidemic.

Declarations

Competing Interests

AEN receives research funding from Gilead Sciences. DK received research funding from Gilead Sciences and personal funds from Medscape, PRIME Education, and UptoDate, Inc., to develop medical education content, and funds from the University of Pennsylvania for research consulting.

Author Contribution

DK and AEN conceptualized, designed, and obtained funding for the study. RTH and SG collected and analyzed the data. LH, ZP, DK, and AEN managed the project. RTH, TPH, DK, and AEN made significant contributions to the original writing of the manuscript. All authors contributed to interpretation of findings, critically reviewed and intellectually contributed to the manuscript, gave final approval of the manuscript, and agreed to be accountable for all aspects of the work.

Acknowledgement

The authors wish to acknowledge the staff and clients of Unlocking Doors® in Dallas, Texas.

Data Availability

Selected data generated and analyzed during this study are included in this published article; additional de-identified data are available from the corresponding author, upon reasonable request.

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