Edition 89 - Identifying the Factors Influencing Culturally Responsive HIV and PrEP Screening for Racial, Ethnic, Sexual, and Gender-minoritized Patients: A Scoping Review - BCPHR Journal

Citation

Xavier J, Ward MC, McDonald P, Kalita N, Corr P. Identifying the factors influencing culturally responsive HIV and PrEP screening for racial, ethnic, sexual, and gender-minoritized patients: A scoping review. *HPHR*. 2024;89. https://doi.org/10.54111/0001/KKKK6

Identifying the Factors Influencing Culturally Responsive HIV and PrEP Screening for Racial, Ethnic, Sexual, and Gender-Minoritized Patients: A Scoping Review

Abstract

Purpose of Review

The effect of structural barriers and screening deficits on human immunodeficiency virus (HIV) spread among historically marginalized groups is underestimated. Primary care practitioners can foster culturally responsive patient-clinician interactions that encourage effective screening conversations and reduce disparities and disease burden for marginalized populations. This scoping review identifies factors influencing culturally responsive HIV and pre-exposure prophylaxis (PrEP) screening practices for racial, ethnic, sexual, and gender-minoritized groups.

Methods

This scoping review follows Arksey and O'Malley's framework and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews (PRISMA-ScR).

Recent Findings

Forty-nine studies published between 2019-2022 were analyzed for factors influencing screening. After rigorous quality checking, factors fell into 4 categories of culturally responsive communication: culture of the patient, culture of the clinician, culture of medicine, and culture of racism. Key factors positively influencing screening included clinician competence, availability of inclusive messaging, effective service promotion, services addressing structural barriers, and clinician respect. Key factors negatively influencing screening included financial constraints, inadequate clinician competence, lack of trust in clinicians, clinician bias, and community stigma.

Summary

Culturally responsive communication is vital to reducing the HIV burden among minoritized populations. This scoping review identifies factors that promote or inhibit these screening conversations and identifies the need to support the intersectional needs of and provide social support to diverse individuals. These holistic approaches to solving structural inequities encourage patients to seek care. Further, clinicians need comprehensive, early training to actively oppose bias and oppression of minoritized patients and effectively prevent HIV. The primary study limitation was the challenge in quantifying and coding factors. Our findings have important multilevel policy implications for HIV and PrEP screening practices. Additionally, these results offer ways to tailor culturally responsive interventions to promote HIV and PrEP screening in the primary care setting.

Introduction

Primary care practitioners (PCPs)- used in place of the more common term 'primary care providers' to avoid reinforcing existing power imbalances between patients and clinicians- are called on to establish trusting relationships with patients to provide high-quality care to the populations they serve. There has been a shift in the provision of HIV care by PCPs due to the dwindling of the HIV workforce and the routinization of HIV care. Central to this work is the concept of cultural responsiveness. In our scoping review protocol, we described culturally responsive communication as the range of ways to appreciate the unique health perspectives of their patients and acknowledge the role of intersecting oppressions on health to work intentionally, continually, and effectively to improve the health of historically marginalized communities.[1]

Human immunodeficiency virus (HIV) and coronavirus disease 2019 (COVID-19) are two preventable, communicable illnesses with considerable burdens of disease, both highly stigmatized and disproportionately affecting individuals from racial, ethnic, sexual, and gender-minoritized groups.[1] In the landscape of existing disparities, these patients are harmed by the underutilization of culturally responsive screening practices in the primary care setting that prioritize their experiences and views.[1] Further, shifts in research and funding priorities during the height of the COVID-19 pandemic worsened HIV screening deficits.[2,3] This scoping review summarizes the state of recent literature to identify influences of culturally responsive HIV and pre-exposure prophylaxis (PrEP) screening.

Background

HIV transmission, morbidity, and mortality in the United States has always disproportionately affected those of minoritized backgrounds since the start of the epidemic, in particular racial and ethnic minorities. Today, more than 1.2 million individuals in the US are living with HIV, and Black and Hispanic or Latinx individuals made up almost 70% of new diagnoses in 2020, despite making up less than 40% of the US population together. [4,5] Though racial, ethnic, sexual, and gender-minoritized groups deal with a significantly greater burden of disease, they receive significantly less screening and prophylaxis.[1,4,5] Research supports that structural and systemic barriers to care influence these disparate rates more than individual risk behaviors might.[2]

For instance, data show that significant racial and ethnic disparities exist in coverage rates in the US for PrEP, a highly effective prescription medicine that prevents HIV transmission ,[6] and that primary care settings are particularly lacking in rates of HIV testing uptake.[7] Even when current standards of opt-out HIV testing are followed in the primary care setting, other investigational arms of this study have identified that testing without context makes minoritized patients feel disrespected and like their consent has been violated. Naturally, these feelings perpetuate the mistrust that marginalized groups have towards clinicians and healthcare institutions. As dedicated HIV services and specialties have been absorbed into the primary care scope to improve the continuity and reach of services in recent decades, the role of PCPs in HIV screening, or lack thereof, is of particular interest.

Clearly, reliance on a cohort of less specialized and experienced clinicians could compound the strain of existing gaps in PrEP and HIV screening and testing practices. Both disparately harm members of marginalized groups who are already disproportionately burdened by HIV. Given the broad gaps in preventative HIV services, we use the term "screening" to indicate those counseling and communication practices that empower informed HIV testing and connection to PrEP. We also recognize that while the CDC screening guidelines for PrEP are comprehensive, there is far less awareness and adherence to the strong recommendations offered. To further understand factors influencing HIV and PrEP screening in the primary care setting, a scoping review was conducted to map the landscape of existing literature. This review has two aims: 1) to identify factors influencing HIV and PrEP screening for racial, ethnic, sexual, and gender-minoritized groups and 2) to provide opportunities for future investigation.

Methods

As detailed in our protocol, this scoping review was performed according to the five-step framework first outlined by Arksey and O'Malley.[1,8] The PRISMA extension for scoping reviews (PRISMA-ScR) served as a guide.[9]

Step 1: Identifying a Research Question

The primary research question was: "*What factors influence culturally responsive HIV and PrEP screening for historically marginalized populations?"* A subquestion was: "*What themes and gaps exist in the literature regarding culturally responsive HIV and PrEP screening for historically marginalized populations?"* The terms "historically marginalized populations" and "minoritized groups" were operationalized during Step 1 as including individuals from racial, ethnic, sexual, and gender-minoritized backgrounds, so we use these phrases to refer to our population of interest moving forward.

Step 2: Identifying Relevant Studies

The scoping review was conducted across four databases. The full search strategy is presented in our published protocol.[1] We use author initials throughout the methods section to identify research roles.

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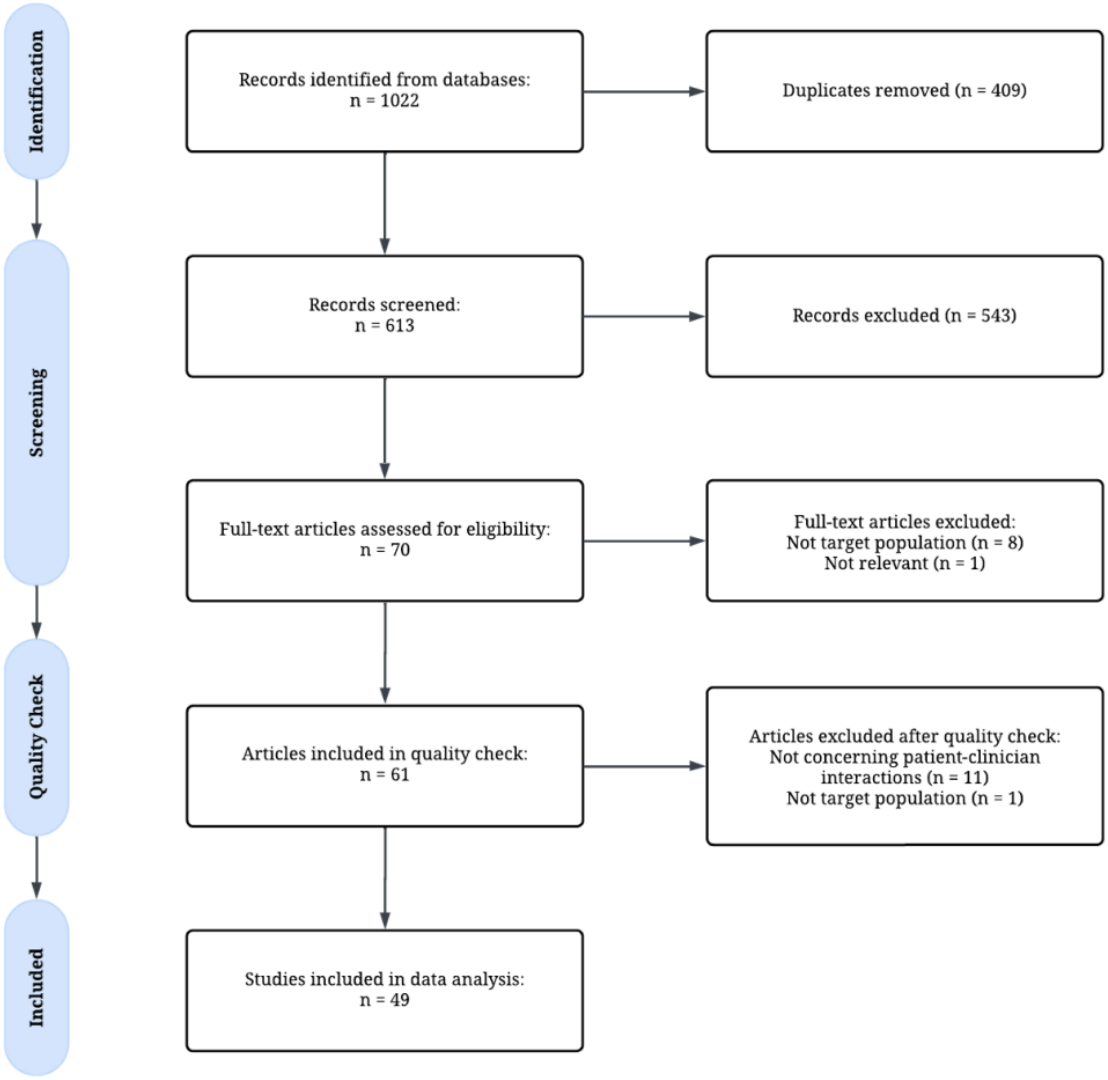
Step 3: Selecting Studies

Studies were included if they were peer-reviewed articles published in English that concerned HIV and/or PrEP screening in the context of U.S. health systems. Studies were excluded if they were book chapters or study protocols, if full-text articles could not be obtained, or if they did not focus on unknown/negative HIV status among our priority populations. Our review focused on studies published between 2019-2022 to mirror the timeframe of a second investigational arm studying COVID-19. The full inclusion and exclusion criteria are in our protocol.[1]

Results were uploaded to Covidence and a title and abstract screening was performed, followed by a full-text screening. The primary reviewers (JX, NK) screened results against the inclusion and exclusion criteria and senior reviewers (PM and PC) resolved disagreements.

Step 4: Charting the Data

Figure 1. PRISMA 2020 Flow Diagram. Adapted from Haddaway, et al. (2022)



After full-text screening, data were extracted and charted by nine reviewers. The extraction items were developed through an iterative process creating a working definition of each item. This initial list of factors included in the extraction tool was framed as "barriers" and "facilitators" and was generated by the primary reviewer (JX), informed by interviews with PCPs and patients, and contextualized within the social-ecological model.[10] A full overview of the types of data extracted is indicated in our published protocol.[1]

Next, the senior researchers worked with the primary reviewers to conduct a quality check to ensure that all data extracted and items marked had supporting evidence from each manuscript reviewed. This quality check included reviewing the work of student research assistants, discussing areas of disagreement, and pulling articles to find supporting evidence. Notably, within a given manuscript, extracted text could indicate both a barrier and facilitator or multiple barriers or facilitators. Because of this phenomenon, we allude below to a shift in our language to focus on "factors" and their implications rather than "facilitators" and "barriers." The flow diagram in Figure 1 details the article selection process. The findings below follow PRISMA-ScR guidelines.

Step 5: Collating, Summarizing, and Reporting the Results Study Characteristics

Table 1. Study Characteristics.

Characteristics of the Included Studies (n = 49)

Reference no.	Author, year	Study design(s)	Population(s) of Interest
11	Hines et al., 2019	Qualitative	Sexual/Gender-minoritized, Transgender

12	Hubach et al., 2020	Qualitative	Sexual/Gender-minoritized, MSM
13	Gailloud et al., 2022	Qualitative	Black/African American, Latine/x/Hispanic
14	Potea et al., 2021	Qualitative	Sexual/Gender-minoritized
15	Uhrig et al., 2019	Qualitative, Literature review	Sexual/Gender-minoritized, Transgender
16	Warylord et al., 2022	Qualitative	Black/African American, Latine/x/Hispanic
17	Nunn et al., 2020	Qualitative	Sexual/Gender-minoritized, MSM
18	Rogers et al., 2022	Qualitative	Sexual/Gender-minoritized
19	Jones et al., 2022	Qualitative, Cross-sectional	Sexual/Gender-minoritized, MSM
20	Bauermeister et al., 2019	Qualitative, Cross-sectional	Sexual/Gender-minoritized, MSM
21	Sherbuk et al., 2020	Qualitative	Latine/x/Hispanic
22	James et al., 2019	Qualitative	Physicians, trainees, and medical students
23	Furness et al., 2020	Qualitative	Sexual/Gender-minoritized, MSM, Transgender
24	Lelutiu-Weinberger et al., 2020	Cross-sectional	Sexual/Gender-minoritized, Transgender
25	Gray et al., 2020	Cross-sectional	Sexual/Gender-minoritized, MSM
26	Cianelli et al., 2019	Cross-sectional	Latine/x/Hispanic
27	Aurora et al., 2022	Cross-sectional	Physicians, trainees, and medical students
28	Meanley et al., 2021	Cross-sectional	Sexual/Gender-minoritized, MSM
29	Tordoff et al., 2022	Cross-sectional	Sexual/Gender-minoritized, Transgender
30	Russ et al., 2022	Cross-sectional	Sexual/Gender-minoritized, MSM
31	Griffin et al., 2020	Cross-sectional	Sexual/Gender-minoritized, MSM
32	Aisner et al., 2020	Literature review	Sexual/Gender-minoritized, MSM, Transgender
33	Aidoo-Frimpong et al., 2021	Literature review, Systematic review	Immigrant
34	Fields et al., 2020	Literature review	Sexual/Gender-minoritized, MSM, Black/African American
35	Goldhammer et al., 2022	Literature review	Sexual/Gender-minoritized, Transgender
36	Ramos et al., 2021	Literature review	Black/African American, Latine/x/Hispanic
37	Safer et al., 2019	Literature review	Sexual/Gender-minoritized, Transgender
38	Mayer et al., 2021	Literature review, Systematic review	Sexual/Gender-minoritized, MSM
39	Vaitses Fontanari et al., 2019	Systematic review	Sexual/Gender-minoritized, Transgender
40	Lee et al., 2019	Systematic review	AAPI
41	Gunn et al., 2022	Systematic review	Sexual/Gender-minoritized, MSM
42	Dang et al., 2022	Systematic review	Sexual/Gender-minoritized, Transgender
43	He et al., 2020	Cohort	Sexual/Gender-minoritized, Black/African American
44	Scott et al., 2020	Cohort	Sexual/Gender-minoritized, MSM, Black/African American, Latine/x/Hispanic
45	Connolly et al., 2020	Cohort	Sexual/Gender-minoritized, MSM, Transgender
46	Watson et al., 2022	Cohort	Black/African American
47	Young et al., 2019	RCT	Black/African American
48	Horridge et al., 2019	RCT	Sexual/Gender-minoritized, Transgender, Latine/x/ Hispanic
49	Desrosiers et al., 2019	RCT	Sexual/Gender-minoritized, MSM, Black/African American
50	Ho et al., 2022	Scoping review	Sexual/Gender-minoritized
51	Carter et al., 2019	Commentary	Sexual/Gender-minoritized, MSM, Black/African American
52	Adeagbo et al., 2021	Commentary	Sexual/Gender-minoritized, MSM, Black/African American

53	Tsuyuki et al., 2022	Mixed-method	Sexual/Gender-minoritized, MSM, Latine/x/Hispanic
54	Sen et al., 2021	Commentary	Sexual/Gender-minoritized, MSM, AAPI
55	Lee et al., 2022	Prevalence study	Sexual/Gender-minoritized, Transgender, Black/African American, Latine/x/Hispanic
56	Howson et al., 2021	Case report	Sexual/Gender-minoritized, Transgender
57	Alarcon et al., 2020	Mixed-method	Black/African American
58	Perucho et al., 2020	Mixed-method	Physicians, trainees, and medical students
59	Agwu, 2020	Perspective paper	Sexual/Gender-minoritized

MSM: Men who have sex with men, AAPI: Asian American and Pacific Islander, RCT: Randomized controlled trial

Table 2. "Barriers"* and "Facilitators"* identified during research process

Barrier* Code	Facilitator* Code
Financial constraints	Availability of inclusive messaging/services
Inadequate clinician training/education/knowledge	Clinician knowledge/ competence/ training
Lack of trust/comfort with clinician	Community engagement/effective promotion of services
Clinician bias/prejudice (unconscious, religious, cultural, including homophobia or racism)	Structural/systems support
Community sexual/gender discrimination/violence: real or perceived stigma and/or harassment from friends/family/community/public	Gender-affirming respect from clinician
Lack of culturally relevant messaging/services in Healthcare	Policies/mandates/requirements
privacy concerns: expressing concerns about confidentiality of testing sites/ methods, fears of being outed to community/parents/friends	Continuity of care with clinician
perceived irrelevance/ inconvenience/ harm/ incompatibility: expressing concerns about medication side effects, consequences of HIV test results, perception of low personal risk	Trust/comfort with clinician
Racial/ethnic discrimination/violence (from community)	Concern for own health
Comorbid mental health and/or substance use disorders	Desire to keep partners safe
Prioritization of other care over HIV screening (gender-affirming, etc.)	Clinician comfort asking about sexual health/ practice
Fear of knowing HIV status	Clinician willingness to educate self
Internalization of discrimination	Shared social identity between patient and clinician
Employment status/barriers due to job	Clinician stereotypes about minoritized group (i.e. perceptions of increased risk-taking behaviors)
Employment status/barriers due to job	Co-location of gender-affirming care and HIV services
Lack of clinician willingness to learn	Social support: feelings of support/connection from family/community or testing service
Lack of respect from clinician (misgendering, discrimination)	Perceived convenience/compatibility with lifestyle: convenience associated with testing service/ intervention
Clinician stereotypes about minoritized group (i.e. perceptions of decreased risk-taking behaviors)	Cues to action/provider recommendation: responsible PCP recommendations and referrals
Lack of open disclosure between sexual partners	Financial accessibility: affordable/free services, insured status
Inadequate clinic hours/lack of available competent clinicians/long wait times	
Language barriers	
Immigration status-related barriers	
Lack of transportation services	
Lack of linguistically appropriate messaging/services	
Screening guideline/policy issues	
Challenges filling prescriptions	
High arrest and incarceration rates	

Housing and financial instability
Lack of health literacy
Lack of social support
*The terms “barrier” and “facilitator” were later discarded in favor of “factors” to represent the data more accurately, as discussed in the text.

The 49 studies included were published between 2019-2022, and all studies were either conducted in the U.S. or discussed implications for U.S. health systems. Table 1 presents the study characteristics. The final data set included 13 qualitative studies,[11-23] 10 cross-sectional studies,[19-20,24-31] 8 literature reviews,[15,32-38] 6 systematic reviews,[33,38-42] 4 cohort studies,[43-46] and 3 RCTs,[47-49] among others.[50-59] Thirty-four studies focused on sexual and gender-minoritized individuals:[14,18,31-32,43,50,59] 18 studies investigated men who have sex with men (MSM),[12,17,19-20,23,25,28,30-32,34,38,41,44-45,49,51-54] while 11 studies focused on transgender individuals.[11,15,23-24,29,32,35,37,39,42,45,48,55-56] Twenty-eight studies focused on racial and ethnic minoritized groups:[18] 13 addressed Black/African American individuals,[13,16,34,36,43-44,46-47,49,51-52,55,57] 9 Latine/x/Hispanic individuals,[13,16,21,26,36,44,48,53,55] 2 Asian American and Pacific Islander (AAPI) groups,[40,54] 1 immigrant populations,[33] and 1 indigenous populations.[16] Three studies specifically looked at physicians, trainees, and medical students as their populations of interest.[22,27,58] Studies were quantified based on the study language captured by reviewers during the data extraction and charting process.

After charting data and consolidating our list of factors through our confirmation and elimination process, the research team conducted a multi-phase summation and analysis process. First, we conducted a frequency count of similar “barriers” and “facilitators”, which yielded 30 “barriers” and 19 “facilitators” to culturally responsive HIV and PrEP screening (Table 2). Then, author MW organized and wrote them according to the four tenets of culture identified within our framework of culturally responsive communication: culture of the patient, culture of the clinician, culture of medicine, and culture of racism.[60] This thematic analysis gives nuance supporting culturally responsive communication in the care of minoritized patients. Terms used below to refer to specific racial, ethnic, sexual, and gender-minoritized populations reflect the language used in corresponding studies.

Culture of the Patient

The values, preferences, and interests of patients are important to strengthening the patient-PCP relationship and integrating patient-centered HIV and PrEP screenings across healthcare settings.[60] Two key themes emerged related to this tenet.

Availability of inclusive messaging and services. Patient risk perception is socioculturally determined, so health messaging and services must follow suit.[11,33] These values should be reflected in all areas of the healthcare experience[51] and can look like trans-inclusive questions on symptomatology, anatomy, and surgical history during interviews;[29] PrEP visuals including cisgender women;[46] graphics showing insertive and receptive sex risks for MSM;[17] low-literacy Spanish-translated material;[48] and developmentally appropriate conversations with adolescent patients.[13,20,38,59] Hiring healthcare teams that reflect the identities of the patient populations served[35] will aid in developing such messaging if everyone is adequately trained in upholding general patients’ rights to confidential services and holistic referrals that address legal and social health needs.[23] Community-based participatory research (CBPR),[36] which amplifies the voices of community stakeholders alongside researchers, can elucidate these needs by acknowledging cultural viewpoints[18] alongside multi-level factors that shape clinical interventions.

Community engagement and effective promotion of services. Evidence-informed strategies to increase community visibility and trust include reliance on nurses in community settings[26] and the use of CBPR.[51] Key to these strategies is identifying community gatekeepers such as elders, faith-based figures, and other opinion leaders[33,48,54] within patients’ social networks to disseminate key messages on wellness. Additionally, expanding screening services beyond the clinic through street-based HIV testing in homes and mobile clinics[47] has increased access to care. The changing landscape of care necessitated by the COVID-19 pandemic has also popularized different types of access.[12] Patients, particularly adolescents, desire means of communication that increase confidentiality and convenience – namely text-based and mobile device-based access to clinicians, counseling, and follow-up.[12,34,49] Efforts like these are only as effective as the partnerships that exist between policymakers, schools, community-based organizations, and healthcare settings.[35,41] These partnerships are mutually beneficial and engage community members, including sexual and gender-minoritized patients, as mentors, peer educators, and healthcare workers.[15,23,38]

Culture of the Clinician

The values and beliefs of clinicians influence their patient encounters and the HIV and PrEP screening behaviors they practice.[60] Three key themes emerged, as follows:

Clinician bias/prejudice. Clinicians, like everyone, hold biases. Without careful reflection, clinicians may judge, discriminate, or mistreat patients seeking HIV testing.[24,32] When minoritized patients perceive or experience transphobia from clinicians[39] or discrimination based on their racial or gender identities, they are less inclined to talk openly, adhere to PrEP, or seek HIV screening, lab testing, and follow-up.[15,25,26,34,36] In addition to delaying care,[23] concerns of mistreatment exacerbate the misinformation patients believe about PrEP's adverse effects.[18] These negative outcomes are most pronounced for Black women and sexual and gender-minoritized patients, particularly Black MSM in southern U.S. states.[50,51]

Adequate clinician knowledge and competence. Naturally, clinicians perceived as proficient and understanding of the needs of minoritized groups encourage confidence and engagement from patients in HIV-related preventative care.[20,23] Additionally, understanding the basic and specific needs of LGBTQ+-identifying patients allows clinicians to actively counsel their patients.[37,39] Clinicians identifying as more competent about PrEP report more PrEP-related behaviors in their practice.[27]

Respect from clinicians for gender-affirming care. Minoritized individuals look for markers of inclusiveness in their healthcare experiences like any other patient. Often overlooked are simple and sincere efforts like asking a patient what name they would like to be called.[15] Sexual and gender-minoritized patients report an increased likelihood of accessing healthcare,[24,56] initiating PrEP,[17] and seeking HIV-related services[35,39] when clinicians are nonjudgmental,[17] do not presume sexual and gender identity,[23] know proper terminology and LGBTQ+-specific health disparities,[23,37] and maintain the confidentiality of HIV testing. For example, non-English speaking patients may feel more secure using telephone-based interpreters even when in-person interpreters are available due to fear of accidentally disclosing to clinic staff who are personally known to them.[22] While inclusive environments are important for all patients,[43] they are especially so for minoritized patients. Inclusivity can look like coupling HIV services with hormone therapy[35,39,42] – including for adolescent and young MSM.[28]

Culture of Medicine

Healthcare system design and operation matter for access. Available and affordable healthcare is as important as clinician relatability and health literacy.[60] Two key themes are represented in the literature, as follows:

Financial constraints. Patients feel challenged in accessing HIV testing or initiating PrEP if they expect out-of-pocket costs.[42] If patients are experiencing insecurity in income, housing, or employment, they are less likely to be employed and insured.[16,51,55] Even in regions like Miami, where HIV testing and PrEP are available for free to patients through the AIDS Drug Assistance Program (ADAP), a program of the Ryan White HIV/AIDs Program, there is an assurance that people with HIV have access to HIV services and medications regardless of their insurance status and/or ability to pay. This also includes programs like the Miami Department of Health's "Getting to Zero" and the national "Ready, Set, PrEP",18 limited knowledge of these programs and patients' *perception* of expenses deters PrEP and HIV testing uptake.[17] This is especially pronounced among undocumented patients[21] and those who have engaged in sex work.[24] Across studies, racially and ethnically minoritized patients expressed concerns about the costs of HIV testing, office visit copays, prescriptions, and additional "monitoring labs" for PrEP.[34] In some cases among LGBTQ+ patients, the inability to pay for gender-affirming care led to participation in dangerous and unregulated procedures overseas.[11]

Services that address structural barriers. The factors producing unfair racialized outcomes are structural. As such, we must focus on clinical interventions that address the structural inequities that patients face, in addition to patient counseling. For example, healthcare settings must include referrals focusing on resource allocation if their patients report poverty and food and housing insecurity,[47,51] as these are among the reasons minoritized patients have increased exposure to HIV or lower utilization of HIV testing and PrEP. Clinical interventions must rely on intersectional[14] and interdisciplinary best practices[36,52] to address mental health,[15] support adherence,[45] and promote adolescent-friendly services.[34] When the screening questions and visuals are cis-centered and heteronormative,[56] they may not engage or appeal to sexual and gender-minoritized patients, which negatively impacts the reach of interpreter services[21] and the capacity of healthcare teams to address macro issues like incarceration[44] that affect care continuity.

Culture of Racism

There must be deliberate attention to the ways that racism gets codified in interpersonal interactions and institutional policies,[60] because it operates in insidious ways that can make it feel natural.

Lack of trust and comfort with the clinician. Minoritized patients report experiences with mistreatment and discrimination as the primary reason they do not trust the healthcare system.[15,43] Such negative experiences make patients hesitant to share their sexual partner gender preferences.[30] Further, patients, having negative preconceptions about PrEP, anticipate that clinicians will not be honest about its adverse effects[42] or will condemn or judge them for initiating it due to the social implications attached to its usestigma attached to users of PrEP[18]. For instance, some minoritized patients associate PrEP with promiscuity.[51] These stigmas are exacerbated by the role of racism and medical trauma among racially and ethnically minoritized individuals. In one literature review on the state of HIV prevention among young Black MSM, "Black MSM expressed experiencing heightened PrEP stigma leading to distrust that affects agency in medical decision making and comfort discussing sexuality and behaviors with medical providers."[34] Clinicians must normalize and clarify the relevance of sexual history to avoid being perceived as judgmental or presumptuous.[16] Even clinicians admit that they feel challenged with how to best address the sociocultural views on HIV risk that maintain ongoing clinical mistrust.[22] *Inadequate clinician training, education, and knowledge*. Minoritized patients report that clinicians rarely offer information on safer sex or HIV prevention or ask relevant sexual health questions.[11] Further, they fear being mistreated by clinicians who are unfamiliar or inexperienced with gender-diverse patients.[32,39] Across social identities, patients desire clinicians who understand adolescent privacy,[53] transgender patients' hormonal needs,[15] and the needs of older patients' sexual lives.[38] Many patients are not aware that they can initiate conversations with their clinicians on sexuality, HIV testing, or PrEP.[18] Even when they do, studies indicate that clinicians are not adequately trained in HIV counseling or PrEP guidelines to answer patient questions, in particular when they are from these minoritized backgrounds.[16,27] As such, patients demand "PrEP literate providers"[49(p111)] to feel confident in HIV-related preventative care and guidance. Evidence supports that sexual history taking and HIV/PrEP counseling become more routine as clinicians have more training in these topics.[22,23,27] But content-based training alone does not prevent clinicians from acting on their biases.[31] For example, many clinicians still only initiate PrEP counseling with sexually minoritized patients, overlooking groups like cisgender and lesbian women despite clinical guidance to focus on HIV exposure risk over social identity.[46]

Sexual/gender-based community stigma and discrimination. An intersectional lens helps identify how racism overlaps with gender oppression, ageism, and ableism.[57] The daily toll of microaggressions on minoritized patients[38] in healthcare, housing,[50] and public transportation[15] remains unfair and exhausting. While affirming care is important, it must be combined with active opposition of every form of discrimination.[24] For example, societal norms on gender result in toxic masculinity[54] that prevents some AAPI MSM from disclosing their sexual status[48] out of fear of community rejection.[39] Community and institutional violence towards LGBTQ+ patients is at an all-time high, especially in the U.S. South.[51]

Discussion

Culturally responsive HIV and PrEP screening conversations between PCPs and minoritized groups are key to bridging HIV morbidity and mortality disparities in the U.S. This scoping review answered the gap we identified among existing literature prior to our study by allowing us to identify a range of factors that shape culturally responsive HIV and PrEP screening in the primary care setting. An iterative selection process narrowed the research articles included in our data analysis to those that focused on patient-clinician interactions for historically marginalized groups. The factors positively influencing HIV and PrEP screenings include trusting patient-clinician relationships, clinician competence, community engagement, inclusive messaging and services, and gender-affirming care. The factors negatively influencing these screenings include mistrust of clinicians, clinician incompetence and bias, community stigma, and financial costs.

We were also able to identify key themes and gaps in addressing culturally responsive screening practices. For instance, our study populations included racial, ethnic, sexual, and gender-minoritized individuals, but patients also identify with youth, rural, immigrant, elderly, or other communities. This underscores the importance of recognizing minoritized patients as fully human with a range of intersecting identities who benefit from referrals that address the other facets of their lives.[34] For instance, value social support including birthday calls, appointment reminders, and support groups.[53] Services must be accessible,[34] holistic,[45] and compassionate,[31] as well as designed to meet the ecological and intersectional needs of minoritized populations.[56]

Our findings also remind us that clinicians, like everyone, are human and have their own biases. Given deeply ingrained social norms, medical expertise is a prerequisite but on its own deficient facet of the therapeutic relationship and does not inherently protect against gender discrimination.[33] Therefore, clinicians need PrEP training alongside anti-bias training without being limited to continuing medical education topics. Education must begin in health professions schooling and continue throughout practice. The health workforce must unlearn outdated and stereotypical examples and messages in textbooks and case studies[36,42,51] to intentionally care for patients who have historically been failed by medical institutions. Additionally, clinicians must be trained on how to equitably incorporate patients' lived experiences and health needs into the medical decisionmaking. Our research team modeled how to communicate this skill during a training series for PCPs that included a lecture on how to share power with patients.61 Future research may include longitudinal evaluations that identify the impacts of health curricular

innovations like these on the practice and perceived effectiveness of clinicians.

Finally, our findings corroborate knowledge that medical mistrust remains a leading cause of why minoritized patients do not engage in health-seeking behaviors. Mistrust, learned or passed on, is often justified within the context of structural and systemic injustices. However, when the lived experiences of the most marginalized populations are centered,[54] screening efforts can effectively address the multicultural and multilevel factors that shape health.[48] In doing so, we can strengthen therapeutic relationships with PCPs to effectively advance the health of historically marginalized populations. Local and regional research on this topic may be beneficial to identify unique needs among different backgrounds and cultures.

The major study limitation was the process of coding barriers and facilitators. Despite operationalizing each code, some of the codes with varied implications counted as more than one barrier and facilitator. As such, we could not determine predominant themes by quantifying codes across studies, alone. Due to this limitation, we shifted our framework from a focus on quantifying *facilitators* and *barriers* to more accurately reflecting the *factors* and *themes* identified in HIV and PrEP screening. While this change slowed our process and data analysis, it allowed for a meaningful and accurate conceptualization of our findings. Another limitation was the restricted time frame of this review, which only includes literature available until 2022, as mentioned above.

This study has important implications for clinic and practitioner-level HIV and PrEP screening policies. Additionally, these results offer avenues to pursue effectively tailored, culturally responsive interventions to promote HIV and PrEP screening for historically marginalized groups.

Acknowledgments

We would like to acknowledge Thomas Harrod, Associate Director of Reference, Instruction, and Access at the George Washington University's Himmelfarb Health Sciences Library for his generous guidance and support in developing the search strategies for this scoping review and Stacy Brody, Reference and Instruction Librarian at the George Washington University's Himmelfarb Health Sciences Library for her guidance in creating the manuscript for this publication. We would also like to acknowledge Saylor Pershing, Darrell Bailey, Sheel Singh, and Abigail Konopasky for their assistance in the text screening and extraction process. The authors would also like to acknowledge Bobga Gang, Bailey Moore, and Hasina Chimeka-Tisdale for their assistance in the data coding process. Funding was made available by Gilead Sciences Inc. The grant funder had no role in the design of this program or in the research discussed in this article.

Disclosure Statement

The authors have no relevant financial disclosures or conflicts of interest.

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