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Experiences of Anticipated and Enacted Pre-Exposure Prophylaxis (PrEP) Stigma among Latino MSM in Los Angeles

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Abstract

Latino men who have sex with men (MSM) are a group critically affected by HIV. Pre-Exposure Prophylaxis (PrEP) is a biomedical prevention strategy that can help reduce new infections in this population. However, PrEP use may expose users to experiences of PrEP-related stigma. In-depth interviews conducted with Latino MSM PrEP users (N=29) were analyzed using thematic analysis to explore experiences of PrEP stigma. Six themes emerged related to anticipated and enacted PrEP stigma: (1) Perception that PrEP users engage in risky sexual behaviors; (2) PrEP-induced conflict in relationships; (3) Perception that PrEP users are HIV-positive; (4) Generational differences in attitudes toward HIV prevention; (5) Experiences of discomfort, judgment, or homophobia from medical providers; and (6) Gay stigma related to PrEP disclosure to family. Manifestations of stigma included disapproving judgment, negative labeling, rejection, and devaluing individuals. The social consequences associated with using PrEP may deter uptake and persistence among Latino MSM.

Keywords

Latino; Hispanic; men who have sex with men; pre-exposure prophylaxis; stigma

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Informed consent: Informed consent was obtained from all individual participants included in the study

INTRODUCTION

In the United States (US), Latino men who have sex with men (MSM) are a group disproportionately affected by HIV. In the most recent national HIV surveillance data, Latino MSM accounted for 85% of all new HIV diagnoses among Latino males and 74% among Latinos overall [1]. The Centers for Disease Control and Prevention (CDC) estimates the lifetime HIV risk is 1 in 4 for Latino MSM compared with a lifetime HIV risk of 1 in 11 for white MSM [2]. Additionally, while HIV incidence among all MSM saw a period of stabilization from 2011 to 2015, new diagnoses among Latino MSM increased by 14% [3]. In Los Angeles County (LAC), the site of the present study, Latino MSM account for the largest percentage (47%) of new HIV diagnoses among MSM of all racial/ethnic groups [4]. The high rates of HIV incidence among Latino MSM highlight the need to expand HIV prevention efforts in this heavily impacted population.

Pre-exposure prophylaxis (PrEP) is a proven efficacious biomedical prevention strategy with the potential to alter the course of the HIV epidemic in the US [5–7]. PrEP involves the daily use of Truvada® (emtricitabine/tenofovir disoproxil fumarate) to prevent HIV acquisition. The CDC has established clinical guidelines for administrating PrEP to high-risk individuals [8]. While evidence suggests that PrEP use is rising in the US, disparities persist in uptake among Latinos. In 2015, approximately 300,000 Latinos were eligible for PrEP based on CDC clinical guidelines, but only 7,600 prescriptions were filled [9]. In a study of high risk MSM in California, only 6.5% of Latino MSM reported using PrEP compared with 9.8% of Black MSM and 13.9% of white MSM [10]. In our research with Latino MSM in LAC, we also found that only 6% reported current use of PrEP (unpublished data). To achieve its full public health impact, the immediate challenge now is facilitating uptake of PrEP among all groups that might benefit from adoption.

Prior research has identified multiple barriers to PrEP uptake among racial/ethnic minority MSM. These barriers include structural factors such as cost and lack of insurance [11]; concerns related to side effects [12–13]; societal or contextual factors such as racism and homophobia [14–15]; and HIV/AIDS conspiracy beliefs [16]. In addition, the social stigma attached to PrEP has been identified as a potential barrier to PrEP uptake [17–19].

According to Goffman, stigma is defined as “an attribute that is deeply discrediting” that marks a person as socially devalued or deviant [20]. Stigma can be anticipated, enacted, or internalized [21]. Enacted stigma refers to lived experiences of discrimination, rejection, or violence, while anticipated stigma involves perceptions and expectations of future judgement or discrimination. In contrast to enacted and anticipated stigma, internalized stigma encompasses an individuals’ personal endorsement of negative beliefs or feelings about themselves [21].

PrEP stigma can have potentially significant negative consequences for PrEP adopters, including suboptimal medication adherence and PrEP discontinuation [18]. PrEP stigma can also affect an individual’s personal reputation and their interpersonal relationships with friends, family, sex partners, and medical providers [22–23]. The experiences and potential consequences of PrEP stigma among racial/ethnic minority MSM have not been fully

explored. For this study, we examined anticipated, enacted, and internalized PrEP stigma and how they are experienced by Latino MSM within their social and cultural context.

METHODS

Participants

Between January 2017 and October 2017, a purposive sample of Latino MSM PrEP users was recruited through gay-oriented sexual and social networking apps (i.e., Grindr and Growlr), community events, and community agency referrals to complete an in-person, semi-structured interview. Individuals were eligible to participate if they were 18 years of age or older, identified as Hispanic/Latino, had anal sex with a male partner in the previous six months, were currently taking Truvada® for PrEP, and resided in LAC. Study recruitment was terminated once data saturation was reached (i.e., interviews were no longer providing new information).

Data Collection

A semi-structured interview guide was developed to explore experiences of PrEP stigma. Participants were asked to describe: 1) reasons for initiating PrEP; 2) experiences with friends, family members, sex partners, or medical providers when disclosing PrEP use; 3) experiences where they did not disclose PrEP use because they thought they might be judged or treated differently; and 4) personal feelings about their PrEP use.

Interviews were conducted in English at a university-based research clinic by a trained interviewer. The interviewer's characteristics (i.e., race, gender, sexual orientation, and PrEP use) reflected those of the study population. Participants were assigned a unique identification number to maintain confidentiality. Interviews were audio recorded and lasted 30 to 60 minutes. An Audio Computer-Assisted Self-Interview (ACASI) survey was administered to gather information on demographic characteristics and PrEP adherence and disclosure practices. All interview audio files were transcribed verbatim and checked for accuracy by two research assistants. The Institutional Review Board of the University of California Los Angeles approved all study materials. All participants provided informed consent and received a $50 gift card for their participation.

Data Analysis

ATLAS.ti (version 8.0.42) was used for the management and analysis of qualitative data. Interview transcripts were iteratively coded, sorted, and analyzed using a thematic analysis approach [24]. Initial codes were developed from the interview guide, field notes, and multiple readings of the transcripts. The study team, comprised of the principal investigator and two research assistants, reviewed and discussed the codes and their definitions, refined and deleted codes, and identified exemplar quotes associated with each code before reaching consensus on the final codes. A subset of codes was selected for a test of inter-coder reliability. Two research assistants independently coded a randomly selected interview transcript. An inter-coder reliability score was computed for the codes (Cohen's kappa coefficient, $k = 0.92$). Final codes were entered into ATLAS.ti and attached to their associated quotations for all transcripts. Codes were then sorted into potential themes, and

coded data extracts were reviewed by the study team to refine each theme. Themes were selected based on their frequency across the dataset or the depth of the discussions [24].

RESULTS

A total of 29 Latino MSM completed the study interview. Table 1 provides a profile of the sociodemographic and PrEP use characteristics of the study sample. The average age of participants was 30 years (SD = 6.5; median = 29.8; range = 21-49). The majority identified as gay (86.2%) and reported completing at least some college (89.6%), working full or part-time (79.3%), and having an annual household income of $40,000 or less (79.2%). The mean length of time using PrEP was 17.1 months (SD = 16.2; median = 12.0; range = 0.25 – 68). Three-quarters (75.9%) reported their PrEP medication adherence as “very good” or “excellent.”

When asked about their primary reasons for initiating PrEP, participants described a range of motives, including a personal assessment of their sexual risk behaviors (e.g., preferring and engaging in condomless sex, having multiple sex partners) (Table 2, Quote 1); having had a sexually transmitted infection or a sexual encounter with potential HIV exposure (Quote 2); or being in an HIV serodiscordant relationship. Other participants were motivated by the encouragement and information they received about PrEP from peers and sex partners who were using PrEP (Quote 3). Participants did not identify the potential for experiencing stigma as a concern or a factor in their decision to initiate PrEP.

In describing their current PrEP use, participants generally reported extremely positive feelings about using the medication, such as feeling safe and protected, reduced anxiety around sex, greater sexual freedom, and an improved sense of responsibility. At the same time, participants also demonstrated an awareness of the stigma surrounding PrEP present within the gay community. Participants also reported concerns or experiences of both anticipated and enacted PrEP stigma. The main sources of stigma and discrimination included friends/peers, family, sex partners, and medical providers. Six themes related to both anticipated and enacted PrEP stigma were identified: (1) Perception that PrEP users engage in risky sexual behaviors, with a sub-theme of negative labels assigned to PrEP users; (2) PrEP-induced conflict in relationships; (3) Perception that PrEP users are HIV-positive; (4) Generational differences in attitudes toward HTV prevention; (5) Experiences of discomfort Judgment, or homophobia from medical providers; and (6) Gay stigma related to PrEP disclosure to family.

Perception that PrEP Users Engage in Risky Sexual Behaviors

What emerged from the data was the overarching perception that PrEP users engage in risky sexual behaviors, which included assumptions that they prefer condomless sex or have multiple sex partners (Table 3, Quotes 1-2). Because of these pre-existing views, disclosure of PrEP use was thought to unintentionally reveal personal information and lead to judgment about one’s sexual behaviors. As such, not disclosing their PrEP use emerged as an adaptive strategy to avoid the stigma attached to PrEP (Quote 1). Non-disclosure also allowed individuals to avoid the difficulty in negotiating condom use with sex partner who may assume that they engage in condomless sex because they are on PrEP. The belief that PrEP

users place sex partners at a heightened risk of contracting sexually transmitted infections (STIs) led some men to report experiences of rejection from potential sex partners (Quote 3). Similarly, PrEP users were thought to be responsible for the rise in STIs among gay men. Only a few men reported internalized PrEP stigma, usually expressed as conflicting personal feelings about their continuing risky sexual practices (Quote 4).

Negative Labels Assigned to PrEP Users—A consequence of the existing perception of risky sexual behaviors is that PrEP users are assigned disparaging labels and identities, such as “slut,” “whore,” or “promiscuous.” Of concern among participants was the potential for their PrEP disclosure to validate the use of these negative labels and identities (Table 4, Quote 1). While friends and family were a source of negative labeling, it was especially pervasive among romantic and casual sex partners (Quote 2). This type of enacted stigma led one participant to issue this cautionary warning to future PrEP adopters: “I think they should realize that they might encounter negative stereotypes from other people. I certainly have” (age 24, 26.5 months on PrEP).

PrEP-Induced Conflict in Relationships

Another theme identified was the conflict that PrEP use introduced in relationships, often resulting in one partner questioning the fidelity, commitment, or level of trust of the other partner (Table 5, Quotes 1-3). These conflicts – experienced in the form of anticipated or enacted accusations of promiscuity, arguments about fidelity, shaming, or termination of a relationship – appeared to result from the existing perception that PrEP users engage in risky sexual behaviors. A potential social consequence of this perception is the assumption that PrEP users are not interested in a serious relationship. Another source of contention was the expressed desire of some participants to continue using PrEP, even if in a monogamous relationship, as a way of maintaining their autonomy and control over their sexual health (Quote 3).

Perception that PrEP Users are HIV-Positive

The perception that PrEP users are HIV-positive, due to taking an HIV medication, was the next theme identified. To avoid this misunderstanding, some participants chose not to disclose their PrEP use or hid their medication (Table 6, Quote 1). When others saw the medication, it was often assumed that the person was HIV-positive and trying to conceal their status. This belief occurred when others knew that Truvada® was a medication used for HIV treatment or when “HIV” was visible on the prescription label (Quote 2). The misclassification of participants as HIV-positive led some to experience discrimination similar to what is experienced by Persons Living with HIV (PLWH), such as others suggesting they are not “clean” and avoiding physical contact for fear of contracting the virus.

Generational Differences in Attitudes toward HIV Prevention

Another theme suggested by the data was the generational differences in attitudes toward HIV prevention that emerged in light of the existing community view of PrEP as a new, condom-optional prevention method. Participants acknowledged that older gay men who experienced the devastation of the HIV/AIDS epidemic of the 1980s and early 1990s might

harbor a greater fear of the disease. They also recognized that this older cohort of gay men was conditioned to accept condoms as the only method for preventing HIV transmission (Table 7, Quote 1). However, for participants coming of age in the era of PrEP, HIV prevention is no longer limited to condoms. Because of the generational differences, some participants felt challenged in their exchanges with older gay men who insisted that condoms are needed to prevent HIV transmission and that those on PrEP are engaging in reckless behaviors (Quote 1).

Experiences of Discomfort, Judgment, or Homophobia with Medical Providers

The experiences of discomfort, judgment, or homophobia with medical providers also emerged as a theme. Some participants noted feeling “awkward” and “reprimanded” or described medical providers as “condescending” while discussing their same sex behaviors when first accessing PrEP or during ongoing medical monitoring (Table 8, Quotes 1-2). These experiences discouraged participants from openly communicating with medical providers about the sexual behaviors that make them appropriate candidates for PrEP (Quote 2). A primary complaint of participants was that medical providers exhibited discomfort with or lack competency in treating and appropriately communicating with LGBT patients.

Gay Stigma Related to PrEP Disclosure to Family

Another theme identified was the experience or anticipation of gay stigma related to disclosing PrEP use to family members. There was a general anticipation among participants that PrEP disclosure would lead to heightened tensions in family relationships that were already somewhat tenuous due to their gay identity and same sex behaviors (Table 9, Quote 2). This existing anti-gay sentiment is reflected in the experience of one participant: “[My mom] was like, ‘I didn’t know they were creating medicines like that [for prevention].’ But then she goes to, ‘I don’t like you having sex. Don’t have sex,’ because she wants me to be straight. And she’s like, ‘Having homosexual sex is going to make you ill’” (age 29, 12 months on PrEP). In addition, those who were not yet open to their family about their sexual orientation also expressed a concern of being “outed” if they were to disclose their PrEP use (Quote 1).

DISCUSSION

In this study, Latino MSM using PrEP experienced multiple forms of PrEP stigma within the context of PrEP disclosure, which manifested as disapproving judgment, negative labels and attitudes, rejection, and the discrediting of individuals who use PrEP. These experiences of stigma occurred across various settings and came from several different sources, such as friends/peers, family, sex partners, and medical providers. The stigma attached to PrEP is a socially constructed phenomenon that stems from the negative perceptions of PrEP and PrEP users that continues to exist both within and outside of the gay community [22, 26]. It is these existing community perceptions that have contributed to the development of a negative social identity ascribed to anyone who uses PrEP, much in the same way that Goffman (1963) describes the “spoiled identity” [20]. This social identity includes attachment of labels such as “whore,” “slut,” or “promiscuous,” and the perception that PrEP users routinely engage in elevated sexual risk behaviors (e.g., condomless sex, multiple sex

partners), place sex partners at heightened risk for STIs, and are incapable of having a serious, monogamous relationship. These findings are consistent with what have been reported in prior research with other PrEP using MSM populations [23, 25–27]. While previous studies have found that PrEP stigma may act as a barrier to the uptake and adherence of the medication [17–19], this was not the case among our participants. Instead, our findings highlight the personal and social consequences that can result from the disclosure of one's PrEP use.

One of the personal consequences of PrEP stigma is the conflict it may produce in relationships. Within HIV serodiscordant relationships, PrEP is viewed as both a necessary and acceptable HIV prevention method [22]. It is primarily within the context of HIV-negative seroconcordant relationships where experiences of conflict arise. As such, the introduction of PrEP in these relationships may require more open lines of communication and/or mutual decision-making between partners before one or both partners decide to initiate PrEP. In contrast, it is also important for individuals to understand the potential consequences of deciding to discontinue or not initiate PrEP while in a relationship (e.g., the potential for HIV exposure and seroconversion).

Another social consequence attached to the use of PrEP is the perception that a PrEP user is HIV-positive because they are taking an HIV medication. The association between HIV stigma and PrEP use, and the related experiences of discrimination, have been recognized in prior studies as important barriers to PrEP uptake and persistence among MSM [18, 27]. These experiences may be exacerbated in Latino communities where HIV stigma continues to persist and is manifested as an expressed fear of contracting HIV through physical contact with PLWH and in the belief that PLWH contracted HIV because of their sexually irresponsible behavior [28–30]. To increase PrEP uptake and prevent potential discontinuation, there remains a need to address HIV stigma in communities of color, while simultaneously increasing awareness and knowledge of PrEP and its purpose.

To our knowledge, this study is the first to document the generational differences in attitudes toward HIV prevention held by older versus younger gay men, which surfaced when participants discussed their PrEP use with older gay men. When reflecting on these encounters, participants demonstrated an understanding of the historical context of the HIV/AIDS epidemic and how it provided the basis for the disparate views that some older gay men had about HIV prevention. In their exchanges with older gay men, participants experienced hostility and disapproving judgment about their choice to adopt PrEP, suggesting that older gay men view this younger generation as being cavalier about HIV prevention and not recognizing the seriousness of the disease. It also highlights the trajectory of HIV prevention following the 1980s and early 1990s, when condoms and celibacy were the only HIV prevention methods available, and when AIDS mortality and the fear of contracting HIV were at their highest. This is a historical reminder of the legacy of the HIV/AIDS epidemic, of how the continuum of HIV prevention strategies continues to expand, and how new strategies may be received differently by generations or communities of gay men.

Participants in this study also suggested that some physicians are not LGBT competent or lack the capacity to communicate effectively with gay men about their sexual behaviors in the delivery of PrEP, particularly among providers outside of an LGBT healthcare setting. During ongoing monitoring visits, it appears that physicians may expect Latino MSM PrEP users to acknowledge that their sexual behaviors put them at high risk for HIV and to change those behaviors instead of continuing to use PrEP. For Latino MSM who are eligible for PrEP, these types of negative experiences may discourage them from first requesting and then later continuing PrEP. Prior research has already shown that many Latinos mistrust the medical community and that men have trouble discussing their sexual behaviors with providers, which may continue to serve as a barrier to scaling up PrEP among Latino MSM [15, 31–34]. There is a pressing need to address the lack of LGBT and PrEP competency among medical providers, particularly primary care physicians, the point in the healthcare system where Latino MSM should be discussing the need for PrEP with their providers.

Our findings also revealed that gay stigma present in Latino families may contribute to a lack of disclosure of PrEP use or sexual orientation to family members. Understanding gay stigma in Latino families is critically important now given the recent expansion of FDA eligibility requirements for PrEP to include at-risk adolescents [35]. Experiences of homophobia may be exacerbated for adolescent gay Latinos, potentially limiting PrEP uptake among youth who may require parental consent or parent's insurance to access PrEP. Further, the presence of gay stigma in Latino families may cause some young gay men to suppress their same sex attraction, and as a result, deter them from adequately evaluating and addressing their sexual health needs.

In the present study, participants noted a variety of adaptive responses employed to avoid or limit experiences of PrEP stigma. Primary among them was non-disclosure (concealment), situational disclosure (during sexual encounters), or selective disclosure (to individuals who would be supportive of their PrEP use). In addition to non-disclosure, participants noted other forms of concealment (e.g., hiding prescription bottle, removing label from bottle, not taking medication in public). In contrast, others found that a more proactive response to stigma (full disclosure and public education) was necessary to challenge both the existing stigma and those perpetuating negative views of PrEP users. We refer to these proactive PrEP users as "PrEP Champions," who we believe have the potential to create a more positive social view of PrEP users in their social networks and communities. PrEP Champions can also help disseminate PrEP information to other Latino MSM who may benefit from PrEP adoption. Researchers have suggested that, over time, individuals who experience stigma may advance from one coping strategy to another (e.g., using non-disclosure in the early period of the stigma experience and then progressing to a more proactive strategy later in the stigma experience) [36–38]. Until there is a shift in community perceptions of PrEP and those who use it, coping strategies to mitigate PrEP stigma will remain a necessity for Latino MSM and others who are using PrEP.

Strategies to address PrEP stigma should utilize a multi-level approach (e.g., individual, social networks, community) that would seek to deconstruct existing negative perceptions and foster new positive and supportive social views of PrEP users. In terms of dismantling PrEP stigma at the community level, some have suggested the need for public health

campaigns that focus on normalizing PrEP, providing targeted education to heavily affected communities, using local opinion leaders or celebrities to promote PrEP, and changing PrEP messaging to focus on sexual health or intimacy [26, 39–42]. In addition, Golub (2018) suggests that the current narrative that PrEP is "for people at very high risk for infection" (p. 194) and existing clinical guidelines requiring individuals be diagnosed, and therefore, labeled as "high risk" in order to receive PrEP are stigmatizing. She proposes, and our findings support, that a more affirming PrEP message emphasizing that PrEP is "for people who want to reduce their anxiety about HIV infection and take greater responsibility for their sexual health" is needed (Golub 2018, p. 194). This may help transform PrEP to be perceived by Latino MSM and the community as a socially responsible behavior.

Limitations

These findings should be interpreted in consideration of the study limitations. Our sample was recruited in Los Angeles, and results may not reflect the experiences of Latino MSM PrEP users in other settings. In addition, the sample consists exclusively of English-speaking Latino MSM and may not reflect the experiences of Spanish-speaking Latino MSM PrEP users. Research with monolingual Spanish-speaking Latino MSM is needed to assess if experiences and manifestations of PrEP stigma differ based on language. A potential bias in our sample is that the study population included men who had been on PrEP for more than a year and these men may have adapted to the stigma attached to PrEP users. Future research should seek to examine the experiences of Latino MSM PrEP users during the early period of initiating PrEP to assess if early experiences of PrEP stigma affect adherence, disclosure, or continued use of PrEP.

Conclusions

The potential negative social consequences that can result from using PrEP may deter some Latino MSM from initiating or continuing to use PrEP. In the current social context, Latino MSM who initiate PrEP are likely to experience PrEP stigma. Efforts to mitigate PrEP stigma will help to maximize the use of PrEP among those populations most vulnerable to HIV infection

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Table 1.

Demographic and PrEP Use Characteristics of Latino MSM PrEP Users (N=29)

Characteristic	N (%) or M, SD
Demographics	
Age (in years)	M=29.83, SD=6.53
Sexual orientation	
Gay/homosexual/queer/same gender loving	25 (86.2)
Bisexual	4 (13.8)
Highest level of education completed	
High school graduate or received GED	3 (10.3)
Some college, AA degree, trade/technical school	13 (44.8)
Bachelor's degree (BA, BS)	7 (24.1)
Some graduate school	2 (6.9)
Master's degree	4 (13.8)
Employment status	
Working full-time	17 (58.6)
Working part-time	6 (20.7)
On permanent disability	1 (3.4)
Unemployed	5 (17.2)
Annual income	
$0-9,999	7 (24.1)
$10,000-19,999	7 (24.1)
$20,000-39,999	9 (31.0)
$40,000-59,999	3 (10.3)
$60,000-99,999	3 (10.3)
Health insurance	
Does not have health insurance	1 (3.4)
Private medical insurance or employer-provided insurance	13 (44.8)
Medicare	6 (20.7)
Medi-Cal/Medicaid	5 (17.2)
Insurance through parent	2 (6.9)
Other insurance	1 (3.4)
Relationship status[1]	
Single and not dating anyone special	15 (51.7)
Dating someone in an open relationship	8 (27.6)
Dating someone in a closed relationship	1 (3.4)
Partnered or married in an open relationship	3 (10.3)
Partnered or married in a closed relationship	1 (3.4)
Other	1 (3.4)
HIV-positive partner (N=13)[2]	
Yes	5 (38.5)
No	8 (61.5)

Characteristic	N (%) or M, SD
PrEP Use Characteristics	
Length of time using PrEP (in months) (N=29)	M=17.09, SD=16.24
Number of people told about PrEP use	
No one	2 (6.9)
A few people	10 (34.5)
A lot of people	17 (58.6)
Disclosed PrEP use to (N=27)[3]	
My main partner or spouse[4]	12 (44.4)
One or more other sex partners	23 (85.2)
One or more family members	18 (66.7)
One or more friends	25 (92.6)
Health care providers	21 (77.8)
Other[5]	2 (7.4)
Adherence to PrEP medication past month[6]	
Very poor	0 (0)
Poor	0 (0)
Fair	2 (6.9)
Good	5 (17.2)
Very good	8 (27.6)
Excellent	14 (48.3)

[1] Open relationships were defined as having sex with other partners and closed relationships were defined as not having sex with other partners

[2] Includes only participants who indicated they were in a relationship

[3] Includes only participants who disclosed their PrEP use

[4] Includes only the 13 participants that indicated they were dating or in a relationship

[5] Other included: Strangers, friends of friends

[6] PrEP adherence was measured via self-report using a validated Likert scale from very poor to excellent [43]

Table 2.

Reasons for Initiating PrEP

1.	Because I was engaging in pretty risky behavior: drugs, alcohol, unprotected sex… They were classified as “high risk.” So I said if I’m going to be doing these things, I should have some sort of backup, kind of like a barrier to help prevent an infection. (Latino, age 22, 12 months on PrEP)
2.	It wasn’t until I tested positive for gonorrhea that I started taking it a lot more seriously that I should get on PrEP. (Latino, age 24, 4 months on PrEP)
3.	The people that really sold me on PrEP were guys that were on it… So I would hookup with guys and they would want to bareback and they told me like, ‘I’m on PrEP. It’s fine.’ And they told me about it and I would hear their stories about what they would do and it was just like, ‘If they’re doing this, why don’t you try it? It seems to be working for them.’ So I was learning from peers. (Latino, age 32, 42 months on PrEP)

Table 3.

Perception that PrEP Users Engage in Risky Sexual Behaviors

Anticipated Stigma
1. I think everybody understands that if somebody says they are on PrEP on Grindr, it means that I will most likely let you cum in me. It is a kind of stigma that I don't want, which is interesting because I don't put it on any of my social medias or any of my profiles because I don't want people to have that stigma toward us. (age 21, 33 months on PrEP)
Enacted Stigma
2. The only negative response I got was from someone who's HIV-negative who assumed that because I was on PrEP I was having a lot of sex… I think he assumed that I was getting gang-banged every weekend or something. (age 37, 23 months on PrEP)
3. There's people who have said, 'Well, you're on PrEP, so you most likely don't use condoms. So you mostly likely have some type of STI. So I don't want to hook up with you because you're on PrEP.' (age 26, 16 months on PrEP)
Internalized Stigma
4. [PrEP] generally makes me feel more responsible. Although, sometimes I still feel shame [because] I'm not having sex with a condom. (age 24, 8 months on PrEP)

Table 4.

Negative Labels Assigned to PrEP Users

Anticipated Stigma
1. [My friend] would probably call me a whore and all that stuff. He already does. If I tell him [I'm on PrEP], I think that gives him validation of how he views me already. (age 30, 9 months on PrEP)
Enacted Stigma
2. I tell most of my sex partners about it – most of my fuck buddies – some of them didn't like it and some of them did. Some of them told me, 'Oh, you're just going to be a slut the whole time. You're not going to want to have sex with me anymore. You're not going to want to have sex with other people.' So some of them do get mad. (age 25, 1 month on PrEP)

Table 5.

PrEP-Induced Conflicts in Relationships

Anticipated Stigma
1. I've actually had to hide the bottle from my husband… and I have to because I think if he knew I was on it, I think he would view it as a level of mistrust [that] I don't trust him. The reality is I don't. (age 30, 9 months on PrEP)
Enacted Stigma
2. [My ex] thought that it meant that I was trying to be promiscuous or not going to be monogamous with him, and that actually wasn't the case… [My ex] just said it made me look like a whore. (age 30, 10 months on PrEP)
3. I know that I've been talking to somebody recently about using it and he's like, 'Well, if we start dating, I wouldn't have a need for it.' I was like, 'I wouldn't get off it… and I would encourage you to get on it.' And we had a big argument and I was like, 'If you don't see the need for it, then I don't think that I'm the right person for you.' (age 26, 16 months on PrEP)

Table 6.

Perception that PrEP Users are HIV-Positive

Anticipated Stigma
1. I keep my medication in my room and not in the bathroom where I used to keep it because either my little brother or my mom might see it and they'd be like, 'Hmm, why is this person taking this?' Maybe they'll assume that I have HIV. (age 24, 26.5 months on PrEP)
Enacted Stigma
2. I think one of my friends I had to tell exactly what it was because they saw the bottle and I think they looked up what it was for and they thought I had HIV because it was an HIV med. (age 37, 23 months on PrEP)

Table 7.

Generational Differences in Attitudes Toward HIV Prevention Methods

Enacted Stigma
1. So he's ten years older than me, but he's also gay. We don't talk about our sexual behaviors, but I think our understanding of HIV is very different. So for him, being raised in the nineties at the height of HIV and things like that, I think he's got a bigger fear of it. And he comes from the mentality of like, 'It's always condoms or nothing.' Whereas with me, I'm a lot more flexible with it. And so I think with him in particular… there's almost like a resistance, challenging me on it, and I think that comes from his generation of what they went through and what they were taught to stay negative. (age 32, 42 months on PrEP)

Table 8.

Experiences of Discomfort, Judgment, or Homophobia from Medical Providers

Enacted Stigma
1. I have gotten some negative feedback from the physician's assistant, or I guess from physicians, because I'll constantly get asked, 'Are you still with multiple partners? Are you still having sex without a condom? Because that's dangerous.' I'm like, 'I'm here doing what I'm supposed to be doing, why are you reprimanding me for having multiple partners? That's not your job.' So I've had that kind of experience with the physician. (age 24, 9 months on PrEP)
2. I've had doctors who have sort of come off like condescending about the kind of sex that I have engaged in. It makes me want to be less communicative with them. I don't want to tell them things… so I think they need to be trained on communicating or even just being tolerant or open-minded about things. (age 24, 26.5 months on PrEP)

Table 9.

Gay Stigma Related to PrEP Disclosure to Family

Anticipated Stigma
1. I haven't come out to [my family] and I know mentioning this sort of thing, again, it'd be one way of coming out to them, essentially, and I'm just not ready for that. Not quite yet. (age 29, 8 months on PrEP)
Enacted Stigma
2. I feel like [my mom] doesn't trust me or she doesn't trust me being gay and so there's always this fear. So I didn't want to add to kind of this existing fear that she has anxiety by me saying, 'Mom, today, I'm going to see the doctor because I'm on this pill that prevents HIV and I have to go every three months…' My fear is that she's going to connect the dots. So kind of like, 'Why is he taking a pill to prevent HIV? You get exposed to HIV by having sex? Who's he having sex with?' (age 32, 42 months on PrEP)