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RECOVERY RESIDENCES ARE AN INNOVATIVE SITE FOR HIV PREVENTION INTERVENTIONS TARGETING PEOPLE WHO INJECT DRUGS: PRELIMINARY DATA FROM PROJECT HOMES

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Of 1.2 million Americans who would benefit from pre-exposure prophylaxis (PrEP), only 36% were prescribed PrEP in 2023. Project HOMES is an ongoing study that evaluates recovery residences for individuals in medication-assisted recovery from opioid use disorder across five Texas cities. Behavioral and psychosocial survey data and biomarkers were collected with a focus on the history of HIV testing, PrEP awareness, and willingness to engage in preventive treatments from a subsample of participants. Preliminary results demonstrated varying levels of HIV testing (83%), PrEP awareness (51%), and willingness to use PrEP (44%) among residents. Willingness to use PrEP was further differentiated by the method of administration, including the preference for pills (40%) and injections (40%). The findings underscore the critical role that recovery residences could play in PrEP access and addressing health care disparities among people with a history of injecting drugs.

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INTRODUCTION

In 2021, people who inject drugs accounted for 7% of all new HIV diagnoses among U.S. citizens aged 13 years or older (Centers for Disease Control and Prevention [CDC], 2022). HIV transmission is preventable when people living with HIV maintain undetectable viral loads or when individuals at risk of acquiring HIV consistently take pre-exposure prophylaxis (PrEP) (Alistar et al., 2014; Bender, 2013; Riddell et al., 2018; Rosenberg, 2013). However, in 2023, only 36% of the 1.2 million U.S. citizens eligible for PrEP received a PrEP prescription (CDC, 2022). That year, the U.S. Preventive Services Task Force (2023) joined the CDC (2021) in recommending PrEP for people who inject drugs. As part of the recommendation, they affirmed the potential public health benefits of PrEP availability for people who inject drugs outweigh concerns. These include some health care providers' hesitations to prescribe PrEP due to concerns about patients' abilities to pay, concerns about adherence to prescribed protocols, which include routine laboratory testing, and concerns about potential drug resistance (Riddell et al., 2018). While the recommendation is a positive step forward, much work remains to ensure access to PrEP for all people who inject drugs. Various factors contribute to the low uptake of PrEP. Health care providers often hesitate to prescribe PrEP, and people who inject drugs often lack knowledge about PrEP, experience payment concerns, and distrust of health care providers who frequently stigmatize people who inject drugs (Beyrer, 2017; Champion & Recto, 2023; Coleman & McLean, 2016; Guise et al., 2017; Walters et al., 2022). However, low uptake should not be construed as a lack of interest. When people who inject drugs are educated about PrEP, they express an interest in taking the medication (Champion & Recto, 2023; Escudero et al., 2015; Schneider et al., 2020).

The National HIV/AIDS Strategy for the United States 2022–2025, developed by the White House's Office of National AIDS Policy, sets forth comprehensive goals and plans for preventing HIV transmission, and portions of the plan specifically target PrEP access and people who inject drugs (The White House Office of National AIDS Policy, 2021). These goals include: (1) increase the awareness of HIV; (2) increase knowledge of HIV status; (3) expand and improve the implementation of prevention interventions; and (4) increase the diversity and capacity of health care delivery systems. Specifically, goal 1 calls for developing new options to expand PrEP access. Goal 4 calls for new partnerships between traditional HIV service providers and organizations that serve people at risk of acquiring or transmitting HIV but that primarily focus on issues other than HIV prevention and treatment. Together, these goals provide an opportunity for new collaborations across diverse settings to increase access to PrEP for people with a history of injecting drugs.

Recovery residences are sober living homes for people recovering from substance use disorders (Jason et al., 2020). There are four levels of recovery residences that exist and vary based on staffing and services offered (National Alliance for Recovery Residences [NARR], 2018). Residences range from democratically run homes to professionally staffed clinical environments offering integrated medical and social models of care. Each level provides varying degrees of peer support, structured programming, and therapeutic interventions tailored to meet the diverse needs

of individuals in recovery (Miles et al., 2020). Because recovery residence providers have a history of working with people at risk of acquiring or living with HIV, they might be the type of organizations with which HIV service providers want to collaborate to expand PrEP access (Polcin et al., 2018). A recent study demonstrated that among criminal justice-involved recovery residents, HIV risk was significantly reduced at 6- and 12-month follow-ups, likely associated with reduced use and needle sharing among people who inject drugs, demonstrating the feasibility of HIV prevention in this intervention setting (Polcin et al., 2018).

Conversely, another study demonstrated that among gay and bisexual men in recovery residences, HIV and PrEP services are not provided even in the context of LGBT-specific recovery housing, highlighting a significant opportunity to address co-occurring health outcomes (Mericle et al., 2020). Further research is necessary to understand opportunities to improve HIV outcomes for at-risk populations accessing recovery services. Therefore, this study aims to describe PrEP knowledge and willingness to take PrEP among people with a history of opioid use disorder living in recovery residences.

METHODS

STUDY DESIGN

Project HOMES is an ongoing, multiyear study intended to assess medication-assisted recovery housing for those with an opioid use disorder. The primary outcomes of interest include differences in residence retention and substance use recurrence between people living in a house in which everyone is taking medication as part of their recovery plan, people living in a house in which some residents are and others are not taking medication, and people taking medications but not living in recovery housing. Secondary outcomes of interest include differences in recovery capital and other psychosocial constructs, employment, and new criminal justice involvement between the people in the different living environments. The Project maintains 15 houses in five Texas cities: Austin, El Paso, San Angelo, Midland, and Houston. These houses meet the National Association of Recovery Residences Level II or III certification requirements. Level II residences are monitored homes with a house manager and peer-run groups. A facility manager supervises Level III residences, and the services in these homes typically include a life skills curriculum for residents.

Behavioral and psychosocial survey data and biomarkers (breathalyzer and 12-panel urine dipstick) were collected at baseline, 3 months, 6 months, and 30–45 days after moving out of a residence. A subsample of participants who live in one of the 15 houses was asked to respond to questions about HIV status, antiretroviral therapy medication adherence if living with HIV, or use of PrEP if not living with HIV. Before answering the questions, participants were provided an explanation of PrEP and postexposure prophylaxis (PEP) and told that it is a medication that, if taken regularly, can prevent HIV transmission. All survey data were collected in person or virtually between March 2021 and April 2022. Participants met with a UTHealth data collector who asked each question and recorded responses into REDCap (Harris et al., 2009, 2019). The surveys took about an hour to complete, and residents were compensated with \$25 for each survey. The University of Texas Health Science Center at Houston (UTHealth) institutional review board approved the study procedures.

MEASURES

Outcomes of Interest. Three outcomes were of interest for this analysis. The first was whether the participant had been tested for HIV in the last year, recorded as “no” or “yes.” The second was whether the participant had heard of PrEP before, also recorded as “no” or “yes.” The third was the participant’s willingness to take PrEP if it was free. Responses were dichotomized. Before asking participants about PrEP, the UTHealth data collectors read the following sentence to all participants: “One way to prevent HIV is called PrEP, which stands for pre-exposure prophylaxis. PrEP is a pill HIV-negative people can take to keep them from getting HIV.” Participants who indicated they were very unwilling, unwilling, or neutral were categorized as “no,” and participants who indicated they were willing or very willing were categorized as “yes.” Participants who expressed a willingness to take PrEP were also asked if they would be willing to take PrEP as a daily pill, take PEP when they thought they were exposed to HIV, or take PrEP as a monthly shot (this item was created and administered before the bimonthly cabotegravir injection was on the market) (CDC, 2021; Chou et al., 2023).

Demographic Characteristics. Participants’ demographic characteristics included age, categorical measures of race-ethnicity, marital status, and other relevant characteristics. Due to the small cell count for several racial and sexual demographic characteristics, some characteristics were collapsed and categorized either as racial and ethnic minorities or sexual minorities. Nine participants were identified as Black non-Hispanic. For analysis, these individuals were categorized as other non-Hispanic. Sexual orientation was recorded as straight/heterosexual or sexual minority (gay/lesbian, bisexual/pansexual). Relationship status was recorded as partnered (married, living as married/common law marriage) or unpartnered (single/never married, divorced, widowed, or separated). A history of homelessness was measured by asking participants if they had ever been without a permanent place to stay (yes/no). A history of involvement in the criminal justice system was measured by asking if the participant had ever been incarcerated or sentenced to community supervision (yes/no).

Sexually Transmitted Infection (STI) History. Participants were asked if they had been diagnosed by a doctor or health care provider in the last 6 months with chlamydia, gonorrhea, herpes, or syphilis. Participants were also asked if a medical provider had told them that they were living with hepatitis C. Participants were asked if they had ever injected any drug.

Mental Health. The frequency of anxiety and depression in the previous 2 weeks was assessed with the four-item Personal Health Questionnaire 4 (Kroenke et al., 2009). Levels were coded as none-minimal or moderate-severe. A lifetime history of PTSD was measured by the Brief Trauma Questionnaire (Schnurr et al., 1999) and was coded as “no” or “yes.”

Analyses. Range, mean, and standard deviation were computed for age. The association of age with each outcome was assessed with independent-sample *t* tests. Frequencies were computed for the remaining categorical variables. The association of these variables with each outcome was assessed with Pearson chi-square

tests. In logistic regression analyses, each outcome was regressed on variables associated with that outcome in the two-tailed bivariate analyses at the $p < .10$ level. A significance level of $p < .05$, two-tailed, was used to assess the results of the regression models.

RESULTS

Cross-sectional survey data were collected from 189 participants. One participant reported being diagnosed with HIV, and another participant was unsure of their status. Two participants identified as transgender, and gender was missing for one participant. After excluding these five participants to obtain a more homogeneous sample, the final sample size was 184.

Participant characteristics and bivariate data associated with each outcome are summarized in Table 1. The mean age of participants was 36.2 years. There were no substantial age differences across the categories of HIV testing, knowledge about PrEP, and willingness to take PrEP. Most participants were identified as male (65.2%), White non-Hispanic (66.3%), and heterosexual (93.5%).

Approximately 10% were currently partnered, and 6.3% had experienced recent homelessness. Nearly half (45.4%) reported recent criminal justice involvement. Seven percent had been diagnosed with an STD in the last 6 months, one-quarter (26.7%) were living with hepatitis C, and three-quarters (76.1%) were people with a history of injection drug use (IDU). One-quarter (23%) had experienced moderate to severe psychological distress, and most participants reported a lifetime history of post-traumatic stress disorder.

Most participants (83.1%) reported being tested for HIV in the last 12 months, and about half of the participants (50.8%) were aware of PrEP. Individuals with a recent STD diagnosis were considerably less likely to get tested ($p = .019$) as compared to people with a history of injection drug use ($p = .028$). However, people with a history of injection drug use were significantly more likely to know about PrEP ($p = .028$). Approximately 40% of participants expressed willingness to take PrEP, while 55% did not. Males were significantly more willing to take PrEP compared to females ($p = .036$). Despite having higher knowledge about PrEP (56% vs 43.2%), females showed lower willingness to take PrEP, with only 38.3% of females willing to take PrEP compared to males (54.2%).

In the bivariate analyses, testing was less common among those who had been diagnosed with an STD in the last 6 months and was more common among those who had a history of IDU. Each of these associations remained significant in the multivariate logistic regression analysis. Variables significant at $p < .10$ were entered into multivariate logistic regression models (Table 2).

HIV TESTING IN THE LAST 12 MONTHS

A total of 152 participants (82.6%) reported being tested for HIV in the previous year. Individuals with a recent STI diagnosis were significantly less likely to have been tested for HIV (aOR = 0.27, 95% CI [0.08, 0.93]) compared to those without a recent diagnosis. People with a history of injection drug use had higher odds of being tested (aOR = 2.37, 95% CI [1.02, 5.47]) compared to those with no history of IDU.

TABLE 1. Participant Characteristics (N = 184)

	Overall	HIV tested last 12 months			Knew about PrEP			Willing to take PrEP		
		No <i>n</i> = 31 (16.9%)	Yes <i>n</i> = 152 (83.1%)		No <i>n</i> = 90 (49.2%)	Yes <i>n</i> = 93 (50.8%)		No <i>n</i> = 99 (55.3%)	Yes <i>n</i> = 80 (44.7%)	
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>p</i>	<i>n</i> (%)	<i>n</i> (%)	<i>p</i>	<i>n</i> (%)	<i>n</i> (%)	<i>p</i>
Age, mean (<i>SD</i>)	36.2 (8.8)	37.7 (10.0)	36.0 (8.5)	.328	36.5 (9.6)	36 (8.1)	.718	36.3 (9.2)	36.1 (8.5)	.849
Gender				.604			.091			.036
Female	74 (40.2)	13 (17.6)	61 (82.4)		48 (44.0)	61 (56.0)		66 (61.7)	41 (38.3)	
Male	110 (59.8)	18 (16.5)	91 (83.5)		42 (56.8)	32 (43.2)		33 (45.8)	39 (54.2)	
Race/Ethnicity				.163			.339			.044
White, non-Hispanic	124 (71.3)	25 (20.3)	98 (79.7)		61 (49.6)	62 (50.4)		72 (60.0)	48 (40.0)	
Other, non-Hispanic	11 (6.3)	—	11 (100.0)		3 (27.3)	8 (72.7)		6 (54.5)	5 (45.5)	
Hispanic	39 (22.4)	5 (12.8)	34 (87.2)		20 (51.3)	19 (48.7)		14 (36.8)	24 (63.2)	
Sexual Orientation				.375			.327			.090
Heterosexual	156 (85.2)	28 (18.1)	127 (81.9)		79 (51.0)	76 (49.0)		89 (58.2)	64 (41.8)	
Sexual Minority	27 (14.8)	3 (11.1)	24 (88.9)		11 (40.7)	16 (59.3)		10 (40.0)	15 (60.0)	
Relationship Status				.250			.422			.811
In a relationship	19 (10.3)	5 (26.3)	14 (73.7)		11 (57.9)	8 (42.1)		11 (57.9)	8 (42.1)	
Not in a relationship	165 (89.7)	26 (15.9)	138 (84.1)		79 (48.2)	85 (51.8)		88 (55.0)	72 (45.0)	
Recent STI Diagnosis				.019			.061			.334
No	171 (93.4)	26 (15.3)	144 (84.7)		80 (47.1)	90 (52.9)		93 (56.0)	73 (44.0)	
Yes	12 (6.6)	5 (41.7)	7 (58.3)		9 (75.0)	3 (25.0)		5 (41.7)	7 (58.3)	
Living With HCV				.985			.163			.135
No	129 (71.3)	22 (17.2)	106 (82.8)		68 (52.7)	61 (47.3)		66 (52.4)	60 (47.6)	
Yes	52 (26.7)	9 (17.3)	43 (82.7)		21 (41.2)	30 (58.8)		33 (64.7)	18 (35.3)	
History of IDU				.028			.028			.641
No	44 (23.9)	12 (27.9)	31 (72.1)		28 (63.6)	16 (36.4)		23 (52.3)	21 (47.7)	
Yes	140 (76.1)	19 (13.6)	121 (86.4)		62 (44.6)	77 (55.4)		76 (56.3)	59 (43.7)	

HCV = hepatitis C virus, IDU = injection drug use, SD = standard deviation, STI = sexually transmitted infection.

KNOWLEDGE ABOUT PrEP

Approximately half the participants (50.5%) knew about PrEP. After adjusting for covariates, females were less likely to know about PrEP than males (aOR = 0.64, 95% CI [0.35, 1.19]). Additionally, participants with a recent STI diagnosis were less likely to be aware of PrEP (aOR = 0.32, 95% CI [0.08, 1.24]). In contrast, people with a history of injection drug use had higher odds of knowing about PrEP (aOR = 2.04, 95% CI [1.00, 4.16]).

WILLINGNESS TO USE PrEP

Of the 184 participants, 80 (43.5%) demonstrated a willingness to use PrEP. After adjusting for covariates, women were more likely to express willingness to take PrEP

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TABLE 2. Odds of Testing, Knowing About PrEP, and Willingness to Use PrEP (N = 184)

	HIV Tested Last 12 Months <i>n</i> = 152 (82.6%)	Knew about PrEP <i>n</i> = 93 (50.5%)	Willing to take PrEP <i>n</i> = 80 (43.5%)
	aOR [95% CI]	aOR [95% CI]	aOR [95% CI]
Gender			
Female	—	0.64 [0.35, 1.19]	1.59 [0.83, 3.05]
Male	—	Ref.	Ref.
Race/Ethnicity			
White, non-Hispanic	—	—	Ref.
Other, non-Hispanic	—	—	1.37 [0.39, 4.82]
Hispanic	—	—	2.46 [1.14, 5.30]
Recent STI Diagnosis			
No	Ref.	Ref.	—
Yes	0.27 [0.08, 0.93]	0.32 [0.08, 1.24]	—
History of IDU			
No	Ref.	Ref.	—
Yes	2.37 [1.02, 5.47]	2.04 [1.00, 4.16]	—

IDU = injection drug use, STI = sexually transmitted infection. Bold odds ratios are statistically significant at $p < .05$.

than men (aOR = 1.59, 95% CI [0.83, 3.05]). Willingness to take PrEP was also associated with race/ethnicity and sexual minority orientation. Hispanics were significantly more likely to be willing to use PrEP than White non-Hispanic individuals (aOR = 2.46, 95% CI [1.14, 5.30]).

PREFERENCE FOR PrEP OR PEP

Table 3 presents the preferences for the administration of PrEP or PEP. Among the 80 participants who were willing to take PrEP or PEP, 40% ($n = 32$) preferred to take PrEP as a daily pill. An equal proportion of participants (40% [$n = 32$]) preferred to take PrEP as a monthly shot, and 46.3% ($n = 37$) preferred to take PEP as a pill.

DISCUSSION

The study highlights the gaps in PrEP awareness and willingness among residents of sober living homes, who are at increased risk of HIV. Despite significant HIV testing rates (83.1% of participants had been tested for HIV in the previous 12 months), fewer than half (50.8%) of the participants were aware of PrEP, and only 44.7% indicated a willingness to take the medication to prevent HIV transmission. These findings are particularly concerning given that 76.1% of people reported a history of injection drug use, highlighting the need for targeted HIV prevention interventions in recovery residences. Moreover, there were gender differences in knowledge and willingness to use PrEP, which are important considerations for developing HIV-prevention interventions tailored to this population. In our analysis, females were

TABLE 3. Preference for Taking PrEP or PEP Among Those Willing to Take the Medication (N = 80)

	<i>n</i> (%)
PrEP as a daily pill	32 (40.0)
PrEP as a monthly shot	32 (40.0)
PEP as a pill	37 (46.3)

less likely to know about PrEP than males (aOR of 0.64, 95% CI [0.35, 1.19]). However, females showed higher odds of willingness to take PrEP compared to males (aOR = 1.59, 95% CI [0.83, 3.05]). These gender differences contrast with the descriptive data from Table 1, where males were more willing to take PrEP than females. The adjustment for covariates such as race/ethnicity and history of IDU suggests that other factors may contribute to this discrepancy, highlighting the complex interplay between gender, race, and other risk factors in shaping attitudes toward HIV prevention. A tailored approach to PrEP education, especially for people with a history of injection drug use, could improve uptake and adherence, particularly as they transition from recovery settings back to the community.

Furthermore, integrating a whole-person approach to health in recovery residences is critical for improving overall quality of life, particularly in securing and maintaining employment opportunities, key determinants of long-term recovery success. A holistic approach that includes job readiness programs helps individuals reintegrate into their community post-recovery while reducing the likelihood of substance use recurrence (Polcin et al., 2018, 2024).

A recent study found that 63% of people in recovery for an opioid use disorder experienced substance use recurrence within 5 weeks of discharge from short-term inpatient treatment without medication for opioid use disorder (MOUD) prescriptions or recovery support services (Nunes et al., 2018). While data on return-to-use rates among opioid users from a recovery residence is limited, studies have shown that around 55% of recovery residents return to drug or alcohol use within 6 months of entering the home (Polcin et al., 2018, 2024). This underscores the importance of monitoring and evaluating the initiation and maintenance of medications like PrEP and ART after individuals leave recovery residences. Developing strategies for follow-up care, such as peer support and linkage to community health resources, can help sustain medication adherence and reduce the likelihood of relapse to opioid use and risky behaviors that increase HIV transmission risk. Research has consistently shown that injection drug use practices and unprotected sex are closely tied to unemployment, job loss, and engagement in risky behaviors (Nolte-Troha et al., 2023). Addressing these issues through a comprehensive approach that includes HIV-prevention interventions, mental health support, and job readiness programs can improve overall health outcomes (Collins et al., 2021).

In recovery residences, participants often focus on improving their overall health and employment outcomes while strengthening substance use recovery skills (Polcin et al., 2018, 2024). This presents a unique opportunity to integrate HIV testing and PrEP/antiretroviral therapy (ART) linkage to care interventions. Initiating PrEP/ART for people with a history of injection drug use and other HIV risk behaviors, coupled

with establishing routine medication adherence within a supervised living environment, can significantly reduce HIV transmission. This approach ensures that when individuals transition out of recovery residences, they are protected against potential re-exposure to HIV through risky behaviors.

NARR Level II and III recovery residences require a life skills curriculum to maintain certification (NARR, 2018). An HIV-prevention life skills curriculum could focus on increasing routine testing behaviors, knowledge of PrEP/PEP, and willingness to take the medications to reduce the risk of acquiring or transmitting the virus. A well-designed intervention can quickly move people from pre-contemplation to medication initiation and maintenance. Examples of interventions that can be adapted to the recovery residence environment include decision support tools, short messaging service reminders, peer support groups, and counseling (Baron et al., 2020; Celum et al., 2022; Colombini et al., 2016; Haberer et al., 2021). Although this study did not assess the effectiveness of the life skills curricula in recovery residences, incorporating HIV prevention education into life skills training presents an opportunity to improve PrEP adherence. Future research should explore the impact of such curricula on health outcomes and readiness to take preventive measures like PrEP. Recovery residences provide a structured environment that facilitates health education, though their capacity to dispense medication, including PrEP, is limited. Recovery residences lack the resources to administer PrEP, although an increasing number of residences have protocols for securing and dispensing medications to residents. Additionally, reimbursement for PrEP in Texas, particularly for long-acting injections, could be a significant barrier.

This analysis is not without limitations. The cross-sectional data are from a convenience sample of people living in a recovery residence and taking MOUD. As a result, people were not engaging in HIV risk behavior at the time they completed the survey. It is possible that if we had asked participants about their willingness to take PrEP while actively using substances, they might have been more willing to take PrEP. When people were asked which form of PrEP they would be willing to take, we provided three response options: taking PrEP as a daily pill, taking PrEP as a monthly shot, and taking PEP as a pill after a known HIV exposure event. Had we asked participants about their willingness to take a shot every other month and the protocol for taking cabotegravir, the proportion indicating a willingness to take the injection might have differed (CDC, 2021).

In addition, the data are from a predominantly White non-Hispanic sample of people living in Texas, where African American and Hispanic people are at higher risk of acquiring HIV than White non-Hispanic people. If data were from a more ethnic and racial minority sample, results might have differed. Gender differences may also manifest differently in other racial/ethnic groups, suggesting the need for future research that includes more diverse populations to understand better the intersection of gender, race, and HIV prevention behaviors. Furthermore, a potential limitation is the absence of detailed information on participant's PrEP knowledge or the provision of standardized PrEP education in these settings. Without a uniform approach to delivering PrEP education, it is difficult to determine whether the variations in awareness and willingness are due to gaps in information or other factors. Future studies should consider incorporating a standardized HIV-prevention curriculum to ensure that all participants receive the same level of PrEP education. While the sample demographics align with HIV risk groups, they may not fully represent the broader population in recovery. The response options for PrEP preferences did not fully capture the complexity of long-acting PrEP protocols or the challenges of

missed doses. Despite these limitations, these data are significant because we know little about how to implement effective HIV-prevention interventions in recovery residences.

To ensure HIV-prevention interventions implemented in recovery residences are effective, additional research is needed. Researchers must better identify modifiable factors to increase willingness to test, initiate, and maintain PrEP/ART. Researchers also need to partner with recovery residence operators and HIV prevention clinical staff to identify the best method for delivering the intervention and obtaining evaluation data, which will increase the acceptability, feasibility, and usability of the resulting intervention. Future studies should focus on the inclusion of a diverse population with a history of substance use to provide a more comprehensive understanding of PrEP needs in recovery residences. Lastly, researchers need to partner with local and state policymakers to ensure residents who initiate PrEP have the financial assistance needed to maintain adherence.

CONCLUSIONS

In this manuscript, we highlight the need to increase knowledge and willingness to initiate PrEP among a sample of people living in MOUD-accessible recovery residences and people with a history of injection drug use. Data from this analysis are significant because the U.S. Preventive Services Task Force and the CDC now recommend PrEP for people with a history of injection drug use. These joint recommendations create new opportunities for researchers, practitioners, and policymakers to develop or adapt, implement, and evaluate HIV prevention interventions in novel settings. Recovery residences with a large population of people with a history of injection drug use are an ideal setting for an exciting new area of implementation research.

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