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Mind the Gap: HIV Prevention Among Young Black Men Who Have Sex with Men

Errol L. Fields[1] · Sophia A. Hussen[2] · David J. Malebranche[3]

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Abstract
Purpose of Review Young Black men who have sex with men (YBMSM) suffer profound health inequities in new HIV diagnoses and clinical outcomes. While the evolution of HIV prevention options has become increasingly biomedical, inequities in access and uptake of these modalities persist.
Recent Findings Studies suggest that while YBMSM display interest and acceptability of varied HIV prevention options, uptake lags due to the lingering effects of intersectional oppression from racism and sexual prejudice, HIV stigma, institutional and provider bias, and unresolved health policy barriers. Promising avenues to address these barriers have yet to be fully explored.
Summary We have the tools to effectively prevent HIV transmission and acquisition among YBMSM, but we have not yet effectively implemented these tools for this priority population. To end the epidemic, we must tailor and adapt HIV prevention strategies to meet the unique intersecting needs, identities, and social contexts of YBMSM.

Keywords Young Black MSM · Sexual minority youth · HIV prevention · Adolescent and young adult · Sexual minority men · LGBTQ health

Introduction

Between 2012 and 2016, HIV diagnoses among adolescents and young adults (AYA), defined as individuals aged between 13 and 24 years, increased 6%, whereas HIV diagnoses among older adults declined or stabilized over the same period [1]. In 2018, 21% of the 37,832 new HIV diagnoses in the United States (U.S.) were among AYA. Moreover, men who have sex with men (MSM) made up 92% of cases among AYA, of which 51% were young Black men who have sex with men (YBMSM). Despite an 11% reduction in new HIV diagnoses among YBMSM from 2010 through 2017, racial disparities in HIV incidence and prevalence have persisted, highlighting a need for tailored approaches that match the specificity of the epidemiology and prioritize this vulnerable population.

In the past decade, several major advances have emerged in HIV prevention. Treatment as prevention (TasP) was introduced with the HIV Prevention Trials Network (HPTN) 052 study, which demonstrated that people living with HIV, when treated early with antiretroviral therapy (ART) and maintaining viral suppression, markedly reduced their likelihood of transmitting HIV to their heterosexual partners [2]. Subsequent studies found that serodifferent same-sex and heterosexual couples demonstrated no new HIV infections over 150,000 condomless sex acts, when the partner living with HIV demonstrated viral suppression on ART [3–5]. This evidence has resulted in the firm conclusion that treatment is prevention, and that those who maintain an undetectable HIV viral load do not transmit HIV to their sexual partners (i.e., undetectable = untransmittable [U=U]) [6]. Pre-exposure prophylaxis (PrEP) has also demonstrated impressive results in reducing HIV transmission, with daily oral pill regimens tenofovir disoproxil/emtricitabine (TDF/FTC) and tenofovir alafenamide/emtricitabine (TAF/FTC) reducing the risk of

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✉ David J. Malebranche
david.malebranche69@gmail.com

[1] Division of Adolescent/Young Adult Medicine, Johns Hopkins School of Medicine, 200 North Wolfe Street, Baltimore, MD 21287, USA

[2] Hubert Department of Global Health, Emory University Rollins School of Public Health, 1518 Clifton Road NE, Atlanta, GA 30322, USA

[3] Department of General Medicine, Morehouse School of Medicine, 720 Westview Drive, Atlanta, GA 30310, USA

HIV acquisition up to 99% with daily adherence, leading to a grade A recommendation from the U.S. Prevention Services Task Force (USPSTF) [7–11]. Emerging technologies, including long-acting injectable PrEP (cabotegravir) awaiting FDA approval, will further augment and diversify prevention modalities and strategies [12].

Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, noted in a 2016 op-ed, "we have the tools to end the HIV/AIDS pandemic… [but] our proven tools have not been implemented adequately or uniformly" [13]. This inequity is apparent in the disparate HIV burden that YBMSM experience. Despite the expansion of the HIV prevention toolkit, inadequate access to and/or uptake of these tools among YBMSM threatens to exacerbate rather than eliminate these inequities. The objective of this review is to describe the state of HIV prevention for adolescent (aged 13–17 years) and young adult (aged 18–24 years) YBMSM, including HIV testing and biomedical, behavioral, and structural approaches. We will highlight gaps in implementation of current tools and make recommendations for maximizing prevention strategies for this priority population.

HIV Prevention for YBMSM: Gaps in the Implementation of Available Tools

HIV Testing

HIV testing is an important initial step in both the HIV treatment and prevention cascades. Yet studies have described low rates of testing among AYA MSM in general and among YBMSM in particular. Testing rates may be higher among YBMSM compared with young MSM in other racial/ethnic subgroups [14], but relative to their higher relative HIV incidence, testing rates remain insufficient.

A number of factors associated with HIV testing among MSM have been examined. However, studies have often focused on subgroups defined by age or race/ethnicity and rarely the intersection of these subgroups where YBMSM populations are positioned [14]. Further delineations of adolescent (13–17) and young adult (18–24) YBMSM communities are rarer still. Nevertheless, several factors described in existing studies may be important considerations for YBMSM. National surveys of HIV testing in AYA MSM report individual and interpersonal level testing barriers including fear of judgment from peers and family, nondisclosure of sexual identity or behavior to parents/guardians or providers, limited sexual health communication with parents/guardians or providers, fear of a positive test result, and low risk perceptions and knowledge of HIV risk [15]. Structural level barriers include cost, transportation, limited access to inclusive, comprehensive, youth-specific sexual health services, and lack of inclusive sexual health and HIV-specific health education [16]. Smaller surveys and qualitative studies in YBMSM or older adult Black MSM have described similar barriers including concerns over issues of cost, accuracy, comfort within testing venues, and poor communication from providers related to sexual health [17–19]. These studies have also described the influence of social contexts (e.g., fear of stigma from families, friends and communities, and the potential consequences of positive test results) on HIV risk perceptions and testing practices [15]. Similar barriers have also been noted with newer testing modalities such as home or self-testing [20].

Biomedical Prevention Approaches

The efficacy of TasP and U=U depends on an intact and robust HIV care continuum including early diagnosis, care linkage, engagement, and sustained viral suppression among people living with HIV. However, YBMSM living with HIV are often less likely to be diagnosed, engaged in care, or virally suppressed compared with other age and race/ethnicity subgroups [21–24]. Several studies have examined barriers and facilitators of treatment engagement, adherence, and viral suppression in this population [21, 25–28]. Among YBMSM living with HIV, barriers to adherence and viral suppression include depressive symptoms and psychological distress [25], substance use [22, 25], housing instability, HIV stigma [28], and being uninsured or underinsured. Facilitators to adherence and viral suppression include access to social and tangible support, self-efficacy with communicating with providers, being insured, and higher education level. Consequently, due to gaps in the HIV care continuum, HIV-negative YBMSM may have sex with individuals in sexual networks with higher rates of undiagnosed/unsuppressed HIV, increasing their risk for HIV acquisition [29]. The prevention benefits of TasP and U=U can only be extended to YBMSM if these gaps in the HIV care continuum are addressed.

Similarly, the efficacy of oral daily PrEP depends on care engagement (i.e., PrEP uptake), medication adherence, and persistence. Both TDF/FTC and TAF/FTC have shown themselves to be durable and safe options for HIV prevention, being approved for use in adolescents weighing over 35 kg in 2018 and 2019, respectively. However, similar to TasP, issues with awareness, access, provider knowledge and bias, cost, medical distrust, and low risk perception may adversely impact medical engagement and adherence among AYA in general and YBMSM in particular [30]. Moreover, consent and confidentiality barriers have plagued widespread acceptance of PrEP among medical and public health communities who would promote PrEP use [31], due in part to concerns about adherence with follow-up visits and long-term effects on bone and kidney health [32].

Young MSM of all ethnicities demonstrate low levels of knowledge, but high levels of acceptability with regard to

PrEP [33–35]. PrEP interest, uptake, and usage are particularly low among YBMSM [36], even in the settings where they are aware of and able to access PrEP [37, 38]. Multilevel and system barriers to PrEP access exist in families, communities, and medical spaces. Pediatric and other medical providers are often limited in their ability to engage AYA in general and sexual and gender minority AYA in particular around their sexual health [39–43]. Many are also unaware of or unfamiliar with PrEP, leading to missed opportunities to discuss sexual health and other prevention strategies with YBMSM who may be at risk [44]. Provider bias has also been shown to decrease likelihood to prescribe PrEP to Black MSM, based on racialized beliefs that more sexual behavior risk compensation will ensue as a result of PrEP usage among Black MSM [45]. As a result, Black MSM have expressed experiencing heightened PrEP stigma, leading to distrust that affects agency in both medical decision-making and comfort discussing sexuality and behavior with medical providers [27, 46, 47]. Specifically, YBMSM and transgender women who have sex with men (TGWSM) express additional stigma surrounding promiscuity assumptions, cost, and other conspiracy beliefs as deterrents from PrEP use [48–52]. For those who do initiate PrEP, it has been found to be effective and well tolerated among adolescent populations, but adherence with quarterly visits may wane over time, particularly among YBMSM [49, 53].

Finally, issues related to adolescent ability to consent for HIV prevention services including PrEP and confidentiality pose significant barriers to PrEP uptake among AYA, including YBMSM. While no jurisdictions currently prohibit minor adolescents from consenting for PrEP, few have passed statutes that explicitly allow minor consent [54]. Where the legal statute is not clear and is subject to interpretation, adolescent access to PrEP may be limited. Young adults may remain covered on their parents' insurance until age 26, which increases their ability to access care but may create a barrier to HIV prevention, PrEP, and other sexual health services if confidentiality cannot be maintained. An explanation of benefits (EOB) and/or bills for laboratory or clinic visit co-pays may be sent to their parents, leading to unintentional disclosure of sexual activity, identity, HIV status, or specific sexual health services/diagnoses. For YBMSM, this may present particularly challenging additions to seeking health care when compounded by the persistent intersectional oppressive forces of racism and sexual prejudice.

Behavioral Approaches

Behavioral interventions targeting behaviors associated with HIV acquisition were once the cornerstone of HIV prevention. However, in today's increasingly biomedical HIV prevention landscape, behavioral considerations are often linked to biomedical modalities—with outcomes that focus instead on enhancing behaviors surrounding HIV testing, linkage, engagement, and adherence with services. Traditional behavioral interventions, such as those designed to promote condom use, improve communication with sex partners, or prevent sexually transmitted infections (STIs), still have an important role to play in counseling and supporting YBMSM. In fact, behavioral approaches may be even more important in this population due to logistical, financial, policy, and other barriers to obtaining PrEP, and thus should not be so easily discarded as an irrelevant prevention option.

Several behavioral HIV prevention interventions have been developed specifically targeting YBMSM, while others may have included YBMSM in their original study populations without restricting participation to that group [55]. These interventions, generally based in established social-behavioral theories (e.g., social cognitive theory), use strategies such as education, social support, and role-playing to decrease frequency of self-reported condomless anal intercourse [56], increase HIV knowledge, improve HIV/STI-related communication skills, and change attitudes and intentions around condom use [57]. A limitation of behavioral interventions for HIV prevention—regardless of the targeted behavioral outcomes—has often been insufficient consideration of the social context that influences behavior. Indeed, behavioral interventions that have been most effective at achieving sustained outcomes in Black MSM have incorporated and addressed the social determinants that contribute to HIV inequities and disparities experienced by this population. One notable example is Many Men, Many Voices (3MV), which was developed by and for Black MSM to specifically address the impact of racism, stigma, homophobia, familial, cultural, and religious norms on HIV risk behaviors and sexual relationship dynamics [58, 59]. 3MV is a CDC-designated evidence-based intervention that has also been tested specifically among YBMSM and was found to be effective for decreasing condomless sex acts [60].

Structural Approaches

Black MSM, including YBMSM, have a higher likelihood of living in neighborhoods containing various psychosocial stressors (e.g., neighborhood-level poverty, crime, drug use). These neighborhood- and community-level factors are associated with increased condomless sex and HIV risk [61]; thus, structural approaches to address these more distal social determinants could enhance HIV prevention efforts focused on YBMSM. Examples of structural approaches have included improving access to quality housing [62], policy change (e.g., laws related to HIV criminalization or syringe exchange), and economic empowerment (e.g., microfinance or conditional cash transfer interventions, primarily used with adolescent women in lower-middle income country settings) [63, 64]. Currently, no such structural HIV preventions have been developed and/or tested specifically for YBMSM.

Minding the Gaps: Tailoring and Maximizing HIV Prevention Strategies for YBMSM

A summary of recommendations for improving effectiveness of HIV prevention services for YBMSM is included in Table 1.

Expand Access to HIV Testing

Universal opt out HIV testing is a component of routine health care maintenance [65] and is recommended annually for sexually active AYA MSM in pediatric and adolescent primary care settings [66, 67]. However, in addition to the barriers with provider-patient communication described above, relatively low primary engagement among young men [68] (including YBMSM) suggests a need for increased access to testing in community settings. YBMSM prefer school-based and other community settings where HIV testing services are offered in a nonjudgmental, private, and confidential manner [69, 70]. Moreover, accessible, trusted, and frequently engaged community settings may be ideal for HIV testing. School-based health clinics [71], health department sexual health clinics [72], community-based organizations [73–75], and other community spaces may facilitate more open discussion and disclosure of sexual health practices and concerns over traditional medical settings [76]. Community locations may also be more conducive to pairing testing resources with peer educators or other evidence-based education and outreach strategies, serving as conduits to primary care through partnering with pediatric and adolescent providers to provide treatment and comprehensive care linkage [77]. HIV and sexual health outreach and education through community spaces where YBMSM feel welcome and comfortable may also increase uptake of HIV-related information, motivation, and behavioral skills and increase their utilization of community resources for HIV testing services [78] in addition to enhancing self-efficacy for discussing sexual health services with medical providers [14].

Table 1 Recommendations for improving effectiveness of HIV prevention for YBMSM

- Expand access to HIV testing for YBMSM, particularly in nonclinical settings.
- Train medical providers in cultural competence and humility.
- Develop innovative, culturally tailored models for HIV prevention and care.
- Address structural and policy barriers to pre-exposure prophylaxis (PrEP) uptake.
- Prioritize public health strategies to reduce undiagnosed/unsuppressed HIV in sexual networks.
- Foster synergies between behavioral and biomedical prevention approaches.
- Focus on distal social determinants of health.

Research on the specific factors associated with HIV testing in both adolescent and young adult Black MSM is limited. The persistent racial disparities in HIV incidence and prevalence affecting AYA Black MSM [79] despite higher testing rates warrant investigations that stratify study populations according to age and race/ethnicity to identify factors that influence testing in this priority population. Additional analysis is also needed to inform the design of testing strategies that account for unique barriers resulting from the intersection of age, race/ethnicity, and sexuality YBMSM often face [80].

Biomedical Approaches

Improve Provider Clinical and Cultural Competency/Humility

Given the current emphasis on biomedical aspects of HIV prevention and the limitations in AYA health care settings described above, improvements in clinical and cultural competencies related to sexual health are needed to ensure these settings are equipped to provide HIV prevention and other sexual health services to YBMSM [14]. Gaps in care of YBMSM and other sexual and gender minority youth have persisted [81] despite numerous policy statements and guidelines from the American Academy of Pediatrics (AAP) [82, 83] and the Society for Adolescent Health and Medicine (SAHM) [84]. These gaps endure because clinicians are often not sufficiently trained in how to care for racially diverse and LGBTQ youth [42, 43]. To ensure that AYA providers are consistently well prepared to provide clinically and culturally competent HIV prevention and sexual health care to YBMSM and other LGBTQ youth, appropriate health curricula should be integrated into medical education at undergraduate, graduate, and practice levels.

Develop and Expand Innovative HIV Prevention and Treatment Care Models Tailored to the Needs of YBMSM

Current and emerging prevention modalities can only be effective for a particular priority population when implementation processes are informed by members of that group. HIV prevention efforts targeting YBMSM should be developed and implemented based on the voices, perspectives, and priorities of YBMSM themselves [85]. Several models of community-informed practices including engaging priority populations in the development of prevention messages and campaigns [86], incorporation of youth or community advisory boards to inform clinical programming [87], and integration of peer or near-peer navigators with shared identity or experiences with YBMSM [88] have demonstrated promising effects.

While additional programmatic evaluation is needed to determine how to best tailor and implement HIV prevention modalities to YBMSM populations, existing data provides

some important insights on what program components are necessary. For instance, employing a holistic health approach, including attention to general wellness, mental health, and substance use as well as youth priorities essential to developmental tasks of adolescents (e.g., achieving education and employment goals, housing, navigating and exploring sexuality [89], developing healthy romantic and intimate relationships) can serve as a gateway to engaging youth in HIV prevention. Holistic approaches with frequent follow-up have been found to be successful in ensuring sustained adherence with PrEP among YBMSM and should be replicated widely [90].

Consideration and appreciation for the unique intersecting identities and experiences of YBMSM is also critical. Multileveled approaches that consider larger social/structural issues offer the best way to approach PrEP specifically, but few programs have fully embraced this reality [26, 89]. A sample of YBMSM ages 18 to 24 stated that family and friends, formal education, television, and the LGBTQ community were major sources for HIV prevention information [91]. However, motivation for adopting such information was hampered by apathy, homophobia, and racism. Emphasizing the understanding and deconstruction of more proximal social contexts like the desire to embody traditional masculine ideologies [92] could hold the key to more holistic sexual health efforts that umbrella education, interest, and eventual uptake of PrEP. Religion often represents a deterrent to sexual health and HIV prevention due to documented homophobia and sexual prejudice within varied Black faith communities [46, 75]. However, emphasizing affirming aspects of religion/spirituality and their relationship to health access and beliefs, sexual health, and perceived risk for HIV may offer avenues for future exploration [76, 77]. Sex work, whether chosen or in the context of food and housing insecurity, is a lived experience not unique to YBMSM, but represents an often-ignored circumstance deserving of consideration within our HIV prevention efforts. Finally, leveraging the role of chosen nonbiological families, houses, and other nonheteronormative communities will be key in reaching and addressing the sexual health and HIV prevention needs of YBMSM, many who may suffer displacement from their biological families because of their sexual orientation [78].

Medical spaces should also offer a menu of services, both in tailored approaches to HIV prevention (behavioral, biomedical, both) and how it would be best to deliver said services—traditional brick and mortar approach with scheduled appointment, telehealth consultations, home visits and delivery of meds, or some combination of any of these. Moreover, embracing technology in behavioral and biomedical HIV prevention approaches in the form of apps, telemedicine, and other unique interventions is a requirement for youth-based populations [55, 93••, 94]. As intergenerational differences may deter communication and uptake of HIV prevention services, it is crucial to ensure that an adequate representation of youth is present for HIV prevention navigation (TasP and PrEP), and that younger medical staff beyond the medical providers themselves are actively engaged and involved in patient care [95]. A team approach that emphasizes a collaborative and familial environment can provide AYA, specifically YBMSM, with the guidance they need to navigate a complicated medical system that is challenging even for adults.

Address Structural and Policy Barriers to PrEP Care Modalities

The Society for Adolescent Health and Medicine recently published a position paper on improving PrEP access for adolescents and young adults that highlighted three of the most significant policy and structural barriers to AYA PrEP engagement [96••]. First, AYA representation in clinical trial research at each stage of PrEP continuum is limited due to complexities of engaging adolescent minors in research. Second, whether adolescents under 18 can consent to PrEP care is unclear in most jurisdictions and confidentiality issues for AYA covered under insurance plans where their parents are the primary policyholders are largely unresolved. Third, there is limited financial assistance for expenses beyond prescription costs such as monitoring labs, STI/HIV testing, clinic visits, and other related expenses.

These are important gaps for YBMSM and represent policy considerations to consider when tailoring HIV prevention tools to this priority population. We cannot identify what approaches will work for at-risk populations if they are not included in research [97]. While engaging minor adolescents in sexual health research is complex and requires protections be put in place to ensure their safety, there is a growing body of evidence supporting that adolescents can freely consent to research, including research concerning sexual health and HIV prevention [98–100]. Requiring parental permission represents a unique barrier for YBMSM and other LGBTQ youth who may not have disclosed their identity or sexual behavior to their parents or otherwise lack parental support. Youth have reported being unwilling to participate in HIV-related research that requires parental permission [99, 101, 102], and parents have also acknowledged that requiring permission can place youth who are not "out" at risk [103].

Adolescents do, however, represent a vulnerable population in need of added research protections such as the inclusion of a peer advocate, a strategy that has been endorsed by LGBTQ youth [99]. Researchers have also called for the inclusion of structured time for youth to reevaluate their decision to participate in a study [104]. Youth may also need to be provided with additional information about randomization when participating in trials, and researchers must ensure they understand the distinction between participating in a research project and receiving personalized medical care [101]. Finally, the inclusion of youth who have yet to invite their families into

their sexual orientation/gender identity requires extra privacy considerations at all stages of research. Recruitment or study materials that mention their sexual identities or behaviors may lead to unintentional disclosures if materials are seen by relatives or peers, as may study activities that occur at locations associated with LGBT communities [104].

Minor consent laws are decided in states and local jurisdiction, so local HIV, LGBTQ and youth advocates, chapters of professional medical and civic associations, and communities should advocate for changes in minor consent laws that will allow adolescents to consent for HIV prevention services, particularly PrEP. As delivery options for PrEP continue to expand, ensuring that minor YBMSM can access the full array of HIV prevention options without parental consent will be critical. Similarly, for youth covered by their parents' insurance, developing protocols that ensure confidentiality in the nature of sexual health and HIV prevention lab testing is critical. YBMSM must feel comfortable accessing services, knowing that an EOB will not disclose their sexual behavior, lab tests, or HIV status to their parents. Current policies often require the covered individual to contact their insurer to request changes in either the details provided on the EOB or where this information is sent, a process that can be difficult to navigate for many YBMSM and most AYA.

While patient assistance programs have eased the financial burden for accessing both ART and PrEP medications, YBMSM may still be burdened with the cost of follow-up visits and lab testing. There are several potential sources for financial assistance for these additional costs. Some states have developed PrEP assistance programs to assist with these costs for those at risk for HIV acquisition [105]. Both insurance plans and patient assistance programs including those sponsored by pharmaceutical companies should also be approached to include provisions that ensure basic lab services and follow-up visits will be covered, as continued costs for these services serve as a deterrent for YBMSM to stay engaged in care and adherent to medications.

Prioritize Public Health Strategies to Reduce Undiagnosed/Unsuppressed HIV in Sexual Networks

YBMSM are at increased susceptibility to HIV partly due to exposure to sexual networks with undiagnosed/unsuppressed HIV and untreated STIs that facilitate HIV transmission [106–113]. Interrupting this cycle requires public health diagnosis, prevention, and treatment strategies that prioritize (1) identifying HIV transmission networks; (2) accessing and identifying individuals within these networks; and (3) linking these individuals to effective HIV prevention or treatment options. Innovative strategies for identifying transmission networks and individuals within these networks not currently linked to prevention or treatment are needed to reduce HIV risk for YBMSM in these networks.

Behavioral Approaches

Foster Synergies Between Behavioral and Biomedical HIV Prevention Approaches

Behavioral approaches that focus on PrEP or ART adherence are an important consideration for ensuring effective implementation of biomedical prevention strategies. However, it is also important to consider that PrEP medications are "indicated in combination with safer sex practices," [115] making the sexual behavioral targets of traditional HIV behavioral interventions continually relevant and important. Furthermore, given the challenges with heightened risk and effective implementation of TasP and PrEP among YBMSM, nonjudgmental behavioral approaches that focus on effective risk mitigation may have even greater importance. Whatever the behavioral target, behavioral interventions should also address complexities YBMSM face at the intersection of race, sexuality, and development, with reinforcement of affirming approaches to sexual health that acknowledge and target racial and sexual identification [58, 116].

Structural Approaches

Focus on Distal Determinants of Health

Addressing the distal social determinants of health and the syndemics that contribute to HIV inequities impacting YBMSM are important targets for structural interventions, but have not been explicitly explored in this population. As these inequities persist, the urgency of ongoing HIV burden demands trials of innovative strategies that have been effective in other populations or settings. In addition to what has been previously mentioned, from a societal perspective, we must acknowledge how the pervasive distal scourge of racism relates to HIV prevention, with medical and public health systems working on eradicating discrimination within medical spaces and acknowledging the impact of racism on health inequities among YBMSM [117]. Highlighting the intersection of racial and sexual identities is paramount as we know that embracing both is key to wellness among YBMSM [118]. Initiatives should also emphasize the roles that gender norms and religious doctrines/beliefs play in the overall health and lived experiences of YBMSM [92, 119] [27, 120] [121, 122].

Perhaps most critical for our consideration of distal forces influencing evolving HIV prevention efforts is our framing of sexuality among Black men itself, specifically, what sexuality and intimacy means beyond the over-biomedicalized, analytical, and often pathological defining of sexual acts as just sexual networking, condomless sex, and risk for HIV and STIs. Future HIV prevention models targeting YBMSM should reflect a more contemporary conception of same gender love, intimacy, and pleasure between Black men that acknowledges

how physical and sexual acts serve as vehicles of emotional connectedness in defiance of lived experiences with racism, sexual prejudice, and other social forces. They are not simply "risky encounters" that require immediate HIV testing, daily pills, or bimonthly injections. Creating affirming and nonjudgmental approaches within physical/virtual spaces that reflect these realities for YBMSM is crucial in this equation.

Conclusion

Effective HIV prevention options have expanded significantly, creating the tools necessary to end the HIV epidemic. Ensuring equitable and tailored access to YBMSM is the challenge that lies in front of us. More research and interventions are needed that specifically focus on YBMSM communities. Improving medical systems and provider attitudes will be invaluable to enhance clinical spaces that often judge and stigmatize them for simply being who they are. Advocating for policy change that facilitates easier access to HIV prevention modalities is essential. The young men who are the focus of this review are not just Black or same gender loving individuals. They are not just adolescents and young adults, nor are they simply statistics of an HIV epidemic. Their lived experiences embody the intersection of many social identities and external forces. Our approaches to HIV prevention must be equally holistic and integrated if we expect our scientific advances to translate to the successful eradication of health inequities suffered by these human beings.

Compliance with Ethical Standards

Conflict of Interest Errol L. Fields serves on an advisory board for Gilead Sciences, Inc. Sophia A. Hussen declares no conflicts of interest. David J. Malebranche serves on the PrEP speakers' bureau and advisory board for Gilead Sciences, Inc.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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