

Engaging Young Black Males in Sexual and Reproductive Health Care: A Review of the Literature

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Abstract

Young Black males (YBM) ages 18 to 24 years are more at risk of contracting sexually transmitted infections (STIs) and have a substantially greater need for sexual reproductive health (SRH) services than other groups. Despite this significant need, the extant literature does not provide a comprehensive picture of how YBM seek preventive care services (e.g., STI testing). Therefore, the purpose of this review is to address YBM's SRH access and use of STI/HIV testing and screening in this population, with a specific emphasis on young heterosexual Black males, by identifying barriers and facilitators of engaging with SRH care. An electronic search was performed using Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycInfo, PubMed, and Scopus online databases. Keywords were adapted to each database and included variations of "Black males," "sexual reproductive healthcare services," "youth (18-24 years old)," and "healthcare access and utilization." Studies from the review reported that barriers to engaging in SRH care included lack of health insurance, ideas of masculinity that conflict with SRH care, stigma related to accessing services, and lack of knowledge regarding available services and care options. The top facilitators for utilizing SRH care were engagement on behalf of health clinics, confidence gained from social support, access to quality health care in one's community, and trust in the health care system and providers. This review contributes to the current state of the science and is important to the improvement of high-quality services for this population, including respect, choice in care, confidentiality, and compassion.

Keywords

adolescent men, health care utilization, health inequality/disparity, sexual health, male reproductive health

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Introduction

Sexual reproductive health (SRH) care for all young people should be safe, effective, affordable, accessible, and equitable (World Health Organization [WHO], 2021). However, for young Black males between 18 and 24 years of age, SRH care has not always had this complete definition. The WHO (n.d.) defines sexual health as "a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity" and reproductive health is similarly defined to include the reproductive system. Best practices for SRH care include patient

education and counseling around contraception options and sexually transmitted infections (STIs), HIV testing and screening, and preventive physical examinations to screen for cancers (Marcell, Burnstein, et al., 2017). In some circumstances, this population's care has been inadequate and less inclusive, with this group experiencing less access to care than their non-Black peers (Armstrong et al., 2010). What's more, approximately 20 million individuals are diagnosed with an STI each year, with STIs occurring disproportionately in young people ages 13 to 24 years (Centers for Disease Control and Prevention [CDC], 2018a; Kann et al., 2018; Office of Disease Prevention and Health Promotion [ODPHP], 2020).



Young Black males carry a disproportionate STI burden, with rates of syphilis (4.7×), gonorrhea (6.5×), and chlamydia (7.5×) higher than their White peers (CDC, 2018a; Kann et al., 2018). Several factors account for the higher rates of STIs in this community, including racial and ethnic disparities, high numbers of sexual partners, and engaging in earlier sexual activity than their White and Latino peers (CDC, 2018a, 2018b; Office of Population Affairs, 2016; Pastuszak et al., 2017).

Significant stigma exists in the Black community that discourages members from engaging with STI/HIV testing and SRH education or prevention interventions (Berkley-Patton et al., 2013). The stigma or shame from their families and the impact of social determinants, such as community context and economic conditions, create significant barriers to accessing care (Conserve et al., 2017; Hines-Martin et al., 2003; ODPHP, 2020). Mistrust from the larger society is also another factor that may deter young Black males from engaging with SRH care (Conserve et al., 2017). Taken together, these factors combine to create a community that deserves more targeted attention and intervention to promote their overall SRH.

The existing literature on the SRH of young adults has focused on women's health or men who have sex with men due to increased exposure and health care cost; however, fewer programs have met the needs of young heterosexual Black males (Bowleg et al., 2013; Jemmott et al., 2017). Young males receive fewer SRH services than young women, with recent declines in instruction on contraceptives and STI/HIV prevention (Lindberg et al., 2016). A 2018 study of young males at a city clinic revealed that only one in 10 patients received all of the recommended SRH services (Marcell et al., 2018). There is a gap in knowledge for young heterosexual Black males despite their existence at the cross section of multiple high-risk groups for compromised SRH (Bowleg et al., 2014). Previous research has revealed that young Black males have concerns regarding privacy and confidentiality in clinical settings and that they "viewed available healthcare systems as formidable and unwelcoming and healthcare providers as judgmental and disrespectful" (Stewart et al., 2019). In addition to challenges that inhibit

engaging in a clinic setting, when young Black males try to access SRH services, there are often insurance barriers. Young Black males have higher rates of being uninsured from public or employee-based services than their White peers (Breslau et al., 2018). In general, young adults will eventually experience a wide range of SRH needs throughout their lifetime that may include contraceptive options, intimate partner violence, STI testing, vaccine uptake, and infertility (Keller & Sonfield, 2019). All things considered, accessing and receiving responsive and effective SRH care is necessary in building a complete and inclusive reproductive health plan among young heterosexual Black males (YHBM) and building. This lack of affordable health care further deters young Black males from receiving adequate care.

The purpose of this literature review is to address YHBM's SRH care access and use of STI/HIV testing and screening in this population by identifying the barriers and facilitators to engaging with SRH care. In addition, we will propose methods informed by the review to increase usage of health clinics, counseling, and testing among this population. The findings will provide insight into why YHBM are not seeking SRH services, how to better engage YHBM in care, and what potential interventions may be needed in the existing health care system to better meet this population's needs.

Method

A literature review was performed to identify barriers to and facilitators of engagement with SRH care among YHBM. According to Grant and Booth (2009), literature reviews examine the recent peer-reviewed literature to provide insight on the current state of research in this area and identify gaps for future consideration (Grant & Booth, 2009). A health sciences library informationist assisted with developing the search strategy. An electronic search was conducted using Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycInfo, PubMed, and Scopus online databases. Keywords and terms were adapted for each database. These terms included variations of the concepts of

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interest: (a) Black males, (b) SRH care services, (c) youth (18–24 years old), and (d) health care access and utilization. Examples of specific search terms include African American, Black, male, men, men’s health, fathers, clinic utilization, STI/HIV testing or treatment, young adult, young adulthood, young men, adolescent, reproductive health services, sexual health, health service accessibility, health resource utilization, and clinic utilization. The search was limited to peer-reviewed articles published between 2010 and 2020 to understand the recent body of literature. Together, these search terms yielded the most relevant articles, finding the most robust and current evidence around this review. Unfortunately, the term *heterosexual* was not valuable in improving the precision of the search and was removed. Instead, information about sexual orientation was manually reviewed by the research team and included in Table 1. Exclusion criteria were studies that were non-U.S.-based, exclusive focus on men who have sex with men, parent–adolescent sex communication (which is well covered in the literature; Akers et al., 2011; DiClemente et al., 2001; Jemmott et al., 2019; Hutchinson et al., 2003), and articles outside of the 10-year time frame. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used to create a flow chart of identified records for this review (Figure 1).

The informationist conducted the search and results were imported into the Mendeley reference management tool to remove duplicates. Two authors independently screened the titles and abstracts using the inclusion criteria. Additional studies that were initially identified in a previous search in 2018 were reviewed and added to the final selection. Full texts were retrieved for all potentially relevant articles and were further assessed for inclusion or exclusion by two authors. There were no disagreements between the authors that needed to be resolved.

Five authors retrieved the data using a table of evidence (Table 1). This table includes basic study information, such as the sample characteristics, level of evidence, purpose, clinic use, and findings. For the purposes of this article, clinic use was defined as young Black males who accessed health care services within the listed studies (Table 1). The authors developed a codebook to identify thematic patterns across the studies. A ground-up design included rereading the manuscripts and highlighting blocks of text to support potential themes (Watkins, 2012). The codebook included a list of parent codes, sub-codes, and definitions related to barriers and facilitators to testing, treatment, and SRH care. For this article, a facilitator was defined as “anything that makes a young Black man more likely to access SRH services” and a barrier was described as “anything that makes a young Black man wary of or less likely to access SRH services.” Codes were developed by using the software program

Padlet. This online program was used as a visual way to gather and share ideas as a group, similar to using a mind map. Blocks of text were organized to support potential themes; a list of codes and definitions were developed; and finally, themes were merged into Excel to systematically organize and define final themes. Three qualitative experts reviewed the content validity of the codes for ease of use, clarity, and relevance to identify barriers (Table 2) and facilitators (Table 3) to SRH service access for young Black males included in the articles. Overall, feedback was provided and any conflicting results or errors were reconciled (Alhojailan, 2012). Overlapping subthemes were merged, and idiosyncratic subthemes were eliminated.

Results

The literature search generated 847 references, with 171 duplicated removed, resulting in 676 articles for screening (Figure 1). Following the initial screen, 624 were excluded based on study criteria and 52 were included in the full-text review. Articles that were excluded following this stage were non-U.S.-based, related to parent–adolescent sex communication, pertaining to men who have sex with men, or published outside of the 10-year time frame. Accordingly, 13 publications were included in this review (see Table 1). Most of the studies targeted attitudes toward condom use, implications, and recommendations for testing/screening, trust, barriers to care, and strategies to attract young men to clinics. The sample populations ranged from ages 15 to 30 years. The sample representation of males within the 13 studies varied from 30% to 100%. Two studies recruited from nationally representative samples (Boyd et al., 2018; Conserve et al., 2017). Studies took place across U.S. regions, including cities in the mid-Atlantic (e.g., Baltimore), Midwest, South (e.g., New Orleans), Southwest, and on the West Coast (e.g., San Diego and San Francisco). The majority (10 of 13 studies) were located in urban areas. Participants were recruited from large metropolitan inner cities, areas of high crime and poverty, free and low-cost clinics, and family health centers. Five studies included qualitative synthesis and eight studies included quantitative synthesis. A total of 27 themes were identified within this review. The top barriers to engaging in SRH care were identified as lack of health insurance, ideas of masculinity that were perceived by YHBM to be incompatible with SRH care, stigma surrounding accessing SRH services, and lack of knowledge about available services and SRH care options (see Table 1—Table of Evidence). The top facilitators for utilizing SRH care were engagement by clinics within the community, confidence from social support received, affordable access to quality health care, and trust in the health care system and providers.

Table 1. Table of Evidence.

Authors (year)	Sample	Level of evidence	Purpose	Clinic use	Location	Findings
Weinman et al. (2011)	Ages 16–28, N = 1,606 males (70% YBM), no data on % heterosexual	Cross-sectional survey	To increase male participation in family clinics	Yes	Urban	The initial findings indicate that STI screening and treatment is the primary focus of males who access a male clinic. Ethnic differences in sociodemographic characteristics, referral sources, and topics of interest suggest that cultural awareness and sensitivity will be important for practitioners who work with males.
Veinot et al. (2013)	Ages 14–24, N = 75 AA (29% males), 88% heterosexual	Qualitative study	To understand young men's trust concerns to guide an informatics intervention focused on HIV/STI prevention	No	Urban	Participants expressed distrust in the reliability of condoms and the accuracy of HIV tests. They questioned the benevolence of many institutions, and some rejected authoritative HIV/STI information. Therefore, reputational information, including rumor, influenced HIV/STI-related decision-making.
Buzi & Smith (2014)	Ages 18–30, N = 48 YBM, no data on % heterosexual	Qualitative, descriptive study	To identify health issues that affect young men and the barriers they experience in accessing care	Yes	Urban	First, the authors identified STIs, mental health problems, and drug use as major health issues. Second, participants identified attitudinal and institutional barriers to accessing care. This included denial; fear; embarrassment; perception that it is not considered manly to seek help; cost; and accessibility. Third, focus group participants felt that services have to be augmented to address the specific needs of men. Fourth, participants suggested strategies to attract men to family planning clinics that are consistent with a youth culture.
Goyal et al. (2014)	Ages 13–19, N = 1,000, YBM (21%), no data on % heterosexual	Retrospective, cross-sectional study	To evaluate clinician adherence to guidelines for documentation of sexual history and screening for STI/HIV infection during routine adolescent well visits	No	Urban, Suburban & Rural	Male patients, non-Hispanic Black patients, and those with nonprivate insurance were more likely to undergo GC/CT testing. HIV testing was associated with older age, non-Hispanic Black race/ethnicity, and nonprivate insurance. Of the 1,000 patient visits, 212 (21.2%; 95% CI = [18.7, 23.7]) had a documented sexual history; of the 212 adolescents, 45 (21.2%; 95% CI = [15.7, 26.8]) were documented as being sexually active.
Morris et al. (2014)	Ages 15–24, N = 108 AA males, no data on % heterosexual	Cross-sectional study	To explore the relationship between stigma and shame associated with STIs and testing practices, partner notification, and partner-delivered treatment among young Black men using a self-administered survey	No	Urban	STI-related stigma had negative correlation to STI testing; STI stigma was also significantly associated with a decreased willingness to notify nonmain partners of an STI; participants with higher levels of stigma and shame were also significantly less likely to be willing to deliver STI medication to a partner.
Watson (2014)	Mean age 19.5 years, N = 37 YBM, no data on % heterosexual	Observational study - Qualitative	To explore and identify the barriers experienced by YBM males in accessing health care services while also creating a rare opportunity to give voice to young Black males	Yes	Urban	Results indicate that young Black males have multiple perceptions of barriers to health care services. These fell into three categories: the negative impact of environment or community, lack of finances or no insurance, and distrust of medical practices associated with race history resulting in accessing health care as a last resort.
Ricks et al. (2014)	Ages 15–23, N = 564 YBM males, no data on % heterosexual	Randomized control trial	To investigate whether YBM attending STI clinics who had ever been incarcerated reported recent sexual behaviors are more risky than their counterparts who had never been incarcerated	Yes	Urban	Participants with a history of incarceration were less likely to consistently use condoms and more likely to use drugs and/or alcohol before sex and to exchange sex for drugs.
Conserve et al. (2017)	Ages 15–44 (42% 18–24); N = 933 AA males, 97% heterosexual	Cross-sectional study	To examine the prevalence of never testing for HIV, reasons for never testing for HIV, and correlates of never testing for HIV	No	National Survey	Nearly a third of the sample had never been tested for HIV (ages 15–44). Younger men (ages 15–17), those who reported not visiting a doctor or health care provider, and who did not report any sexual risk behaviors in the past 12 months were more likely to never have been tested for HIV compared with men who have been tested.

(continued)

Table 1. (continued)

Authors (year)	Sample	Level of evidence	Purpose	Clinic use	Location	Findings
Fine et al. (2017)	All ages (50% of sample <30), N = 7,826 male client visits, 10% Black, no data on % heterosexual	Retrospective study	To assess the impact of staff, clinic, and community interventions on male and female family planning client visit volume and STI testing at a multisite community-based health care agency	Yes	Urban	Number of male visits to the clinic increased from pre- to postintervention by 109%. The majority of visits were for chlamydia testing ($p < .001$), an increase from 35% to 45% (intervention) and decreased 37% to 33% (control).
Marcell, Morgan, et al. (2017)	Ages 15–24, N = 70, 66% YBM, 83% heterosexual	Observational study - Qualitative	To explore perceptions of facilitators/barriers to SRH care use among an urban sample of YBM/AA and Hispanic young men aged 15–24 years	Yes	Urban	Results indicated young men's perceptions of facilitators/barriers to their SRH care use come from multiple levels of their socioecology, including cultural, structural, social, personal contexts, and dynamic interrelationships existed across contexts. Structural-level concerns included cost, long visits, and confidentiality; social-level concerns included stigma of being seen by community members and needs regarding health care provider interactions; and personal-level concerns included self-risk assessments on decisions to seek care and fears/anxieties about STI/HIV testing.
Pastuszek et al. (2017)	Ages 18–25, N = 258 males, 67% AA, 76% preferred female sexual partners	Cross-sectional study	To assess the overall health, including SRH knowledge and needs, sexual behaviors, and testicular health practices among young minority males	Yes	Urban	Results suggest study participants lack SRH knowledge related to pregnancy and condom effectiveness, and engage in risky sexual behavior, including not using birth control at their last sexual encounter. Although 21.6% of participants had an STI in the past year, approximately 80% perceived their STI/HIV risk as very low or low. Respondents had low engagement and lack of knowledge of testicular health practices.
Boyd et al. (2018)	Ages 15–24, N = 104, 39% YBM, 89% heterosexual males	Retrospective study	To examine the relationship between sexual health conversations and comfortability with talking about HIV with a partner, HIV general and prevention knowledge, and HIV testing among Black youth, and if there are differences by gender	No	National Survey	Among males, 43% of those 18 to 24 years of age reported being tested, whereas only 17% males 15 to 17 years of age reported being tested. Among females, 64% of those 18 to 24 years of age reported being tested, while only 13% of females 15 to 17 years of age reported being tested. Less than 20% of the sample reported having frequent conversations about HIV (males: 11%; females: 18%). Most were comfortable with talking about HIV with their partner (males: 49%; females 60%). Less than half strongly disagreed with it being difficult in talking about HIV with their partner.
Perin et al. (2019)	Ages 15–24, N = 253 males, 88% Black, 75% heterosexual	Cross-sectional study	To address SRH needs of young minority urban males. Specifically, to determine (a) the feasibility of Project Connect as adapted for young minority men, (b) whether the program increased SRH knowledge and resource sharing of YSPs working with young men, and (c) whether the program improved awareness and use of resources in an urban environment with high rates of STIs.	No	Urban	Project Connect Baltimore increased knowledge of SRH needs among YSPs and sharing of SRH resources by these professionals with young men. This program also demonstrated increases in awareness of SRH resources among young minority urban men; professionals demonstrated increased knowledge about SRH for young men at immediate posttest (60.6%–86.7%, $p < .05$), and reported more sharing of websites for SRH (23%–62%, $p < .05$) from pretraining to 3-month posttraining; 169 young minority men were surveyed and reported increased awareness of Connect over 3 and a half years (4%–11%, $p = .015$), although few young men reported using the website to visit clinics.

Note. YBM = young Black Males; STI = sexually transmitted infection; GC/CT = gonorrhea/chlamydia; AA = African American; CI = confidence interval; SRH = sexual and reproductive health; YSP = youth-serving professionals.

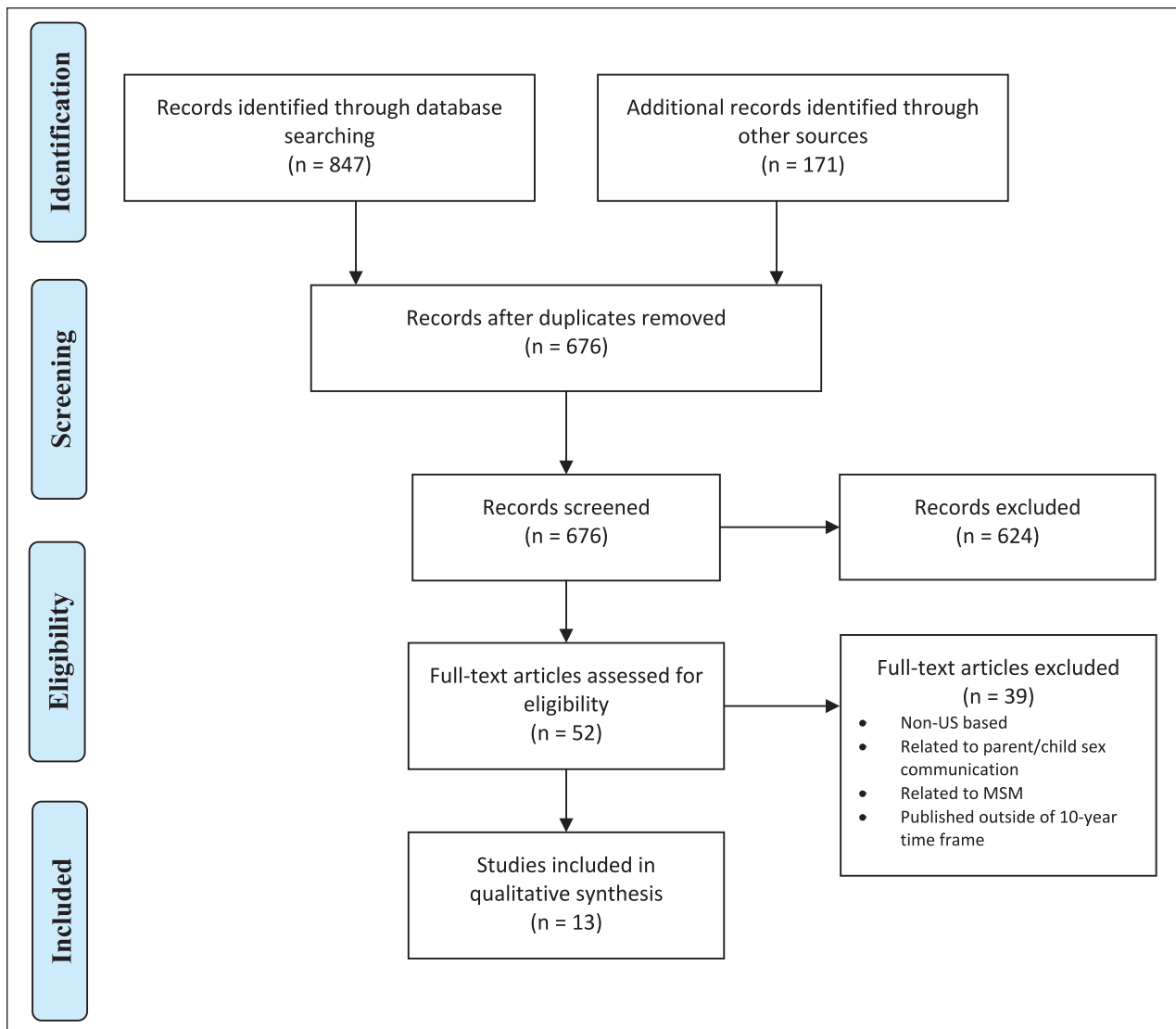


Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses Flow Diagram.

Barriers

In this review, lack of health insurance (defined as having no insurance, no health care, or no public or private health insurance coverage) proved to be a primary barrier for young Black males accessing SRH-preventive services (Buzi & Smith, 2014; Conserve et al., 2017; Goyal et al., 2014; Weinman et al., 2011). A prominent reason for not accessing SRH services in clinics appeared to be financial, including the cost of clinic visits and lack of alternative fee structures (e.g., sliding scale) for clinic services. Those with nonprivate insurance (e.g., Medicaid or uninsured) were reported to be less likely to undergo gonorrhea and chlamydia testing (Buzi & Smith, 2014; Goyal et al., 2014; Weinman et al., 2011). Lack of knowledge was also a persistent theme (Boyd et al., 2018; Buzi &

Smith, 2014; Goyal et al., 2014; Pastuszak et al., 2017; Ricks et al., 2014). A clinic survey ($n = 258$) suggested substantial gaps in SRH knowledge among participants, with 5% to 50% answering SRH-related questions incorrectly (Pastuszak et al., 2017). In another study, participants thought it was difficult to be monogamous and that condoms were not effective, which distorted their idea of safe sexual practices and contributed to the lack of willingness to seek health care (Buzi & Smith, 2014; Pastuszak et al., 2017). Marketing, societal norms, and societal expectations are often not geared toward YHBM SRH promotion (Buzi & Smith, 2014). Other barriers included fear of testing and alienation, feelings of embarrassment about being seen at a testing site (related to perceptions of masculinity), and stigma associated with positive test results (Conserve et al., 2017; Marcell et al.,

Table 2. Barriers.

Theme	Description	Source
<i>Lack of Health Insurance</i>	No public or private health insurance coverage	Weinman et al. (2011); Buzi & Smith (2014); Goyal et al. (2014); Conserve et al. (2017); Pastuszak et al. (2017)
Cost	Inability to pay for treatment or services (e.g., copay, office visits, treatment)	Weinman et al. (2011); Watson (2014); Marcell et al. (2017)
<i>Risky sexual behaviors</i>	Not using condoms, decreased safe sexual practices (having multiple partners, having sex under the influence of substances, not getting tested, having a high-risk partner, early sexual initiation, pay for sex, etc.).	Ricks et al. (2015); Marcell et al. (2017)
Low perception of Risk	Not understanding or ignoring the risk of engaging in unsafe sexual activities; optimism bias (“it won’t happen to me”)	Pastuszak et al. (2017)
Lower SES	Measure of combined economic and social status	Boyd et al. (2018)
HIV/STI testing	Lack of documentation, not offered a test, proximity to clinic, negative experience/stigma/dealing with judgment from health care providers	Weinman et al. (2011); Goyal et al. (2014)
Distrust of medical professionals	Based on history and prior visits, questioning the benevolence of health care institutions	Veinot et al. (2013); Watson (2014)
Prioritizing care	Conflict with school or work, financial insecurity	Weinman et al. (2011)
Social Determinants	No health insurance, no previous experience with medical professionals, financial issues, no reliable transportation, no accessibility, dealing with poverty, homelessness, substance abuse, loss of income, poor health, and so on	Weinman et al. (2011); Buzi & Smith (2014); Ricks et al. (2015)
<i>Fear</i>	Pain associated with tests, prior negative experience with informal help-seeking (e.g., asked for help and never received—fear of rejection)	Buzi & Smith (2014); Conserve et al. (2017); Marcell et al. (2017)
Unemployed	Having financial issues due to a lack of a job/being unable to find a job because of circumstances beyond one’s control (e.g., crashing economy or unemployment/not enough jobs available in one’s area)	Weinman et al. (2011)
<i>Masculinity</i>	Feeling weak or embarrassed by asking for help; not wanting to take care of yourself without a female presence in your life	Buzi & Smith (2014); Ricks et al. (2015); Marcell et al. (2017); Pastuszak et al. (2017)
Denial	Cannot acknowledge that their health issues are “serious” enough to go to a professional; difficulty accepting mental health issues as real, denial about diagnosis of STI/STD	Buzi & Smith (2014); Watson (2014)
<i>Stigma</i>	Feelings of disgrace over STD/STI-related diagnosis; having previous medical issues and not wanting to feel burdensome; associated with decreased odds of health care interactions	Veinot et al. (2013); Morris et al. (2014); Conserve et al. (2017); Marcell et al. (2017)
<i>Lack of knowledge</i>	Young men don’t know where to seek treatment or preventive care; sexual health information only gained from mainstream media where having multiple sexual partners is normalized; lack of marketing, societal norms, and expectations around SRH promoted as widely for young men; misperceptions about condom effectiveness	Buzi & Smith (2014); Goyal et al. (2014); Ricks et al. (2015); Pastuszak et al. (2017); Boyd et al. (2018)
Shame	A negative emotion associated with being judged by others; it is finding inadequacies in oneself that is thought to be seen and antagonized by others	Buzi & Smith (2014); Morris et al. (2014); Pastuszak et al. (2017)
Choice of provider	Not being able to choose a provider due to an underdeveloped neighborhood	Marcell et al. (2017)

Note. Italics indicate key themes from the literature review. SES = socioeconomic status; STI = sexually transmitted infection; SRH = sexual and reproductive health.

2017; Morris et al., 2014; see Table 2 for a complete list of barriers).

Facilitators

The most common facilitators revolved around engagement and access to care, including having male-focused programs to improve recruitment and retention of

patients, consistent with diverse circumstances and experiences of young adult males (Buzi & Smith, 2014; Weinman et al., 2011). Identified locations and transportation options were critical in showing this population where to find health care (Buzi & Smith, 2014). Additional facilitators included having health care providers integrate SRH education and discussion in their primary care visits and perform consistent STI/HIV screening in the

Table 3. Facilitators.

Theme	Description	Source
Education	Level of schooling or postsecondary degree	Morris et al. (2014); Perin et al. (2019)
<i>Testing</i>	Complete history taken, testing and otherwise; seeking out a HIV/STI test and/or treatment if positive	Weinman et al. (2011); Morris et al. (2014)
Confidence	Being comfortable with a significant other, in a health care setting to seek treatment or care, and having a positive perception of self	Weinman et al. (2011); Boyd et al. (2018); Perin et al. (2019)
<i>Engagement</i>	Working to increase awareness on various matters for young men; responsibility of the clinics and the community to put on interventions and programs for young men	Weinman et al. (2011); Buzi & Smith (2014); Goyal et al. (2014); Ricks et al. (2015); Fine et al. (2017)
<i>Addressing Stated Needs</i>	Includes male-focused programs that improve recruitment and retention of patients, access to free testing sites, access to advising/consultation about sexual health, have their choice of preferred provider, and maintaining confidentiality	Weinman et al. (2011); Conserve et al. (2017)
Access	Having affordable and proximate clinics for testing; access to/choosing health care providers and freely available educational materials. Using unique opportunities to make testing available (e.g., during/after incarceration, a faith-based organization)	Conserve et al. (2017); Marcell et al. (2017); Pastuszak et al. (2017); Fine et al. (2017)
Communication	Increased communication with (a) partner, (b) providers, and (c) peers	Boyd et al. (2018)
<i>Diversity</i>	Diversity in providers who look like or are from a similar background as young Black males and being inclusive of cultural norms (front office staff, physicians, nurse practitioners, etc.)	Weinman et al. (2011)
Knowledge	Previously known information on HIV/STI testing, outcomes, and safe sexual practices; understanding perception of risk, general sexual reproductive health, and their own body	Morris et al. (2014)
<i>Partner Support</i>	Support from a significant other, preferably female; presence of a female in a caring aspect	Weinman et al. (2011)
<i>Confidentiality</i>	Promotes privacy during visits	Marcell et al. (2017)

Note. Italics indicate key themes from the literature review. STI = sexually transmitted infection.

history-taking, as recommended by governing agencies such as the American Academy of Pediatrics and the CDC (Goyal et al., 2014). Access to quality health care services for YHBM means receiving health care from the provider of their choice and having the appropriate health insurance coverage (Conserve et al., 2017; Marcell et al., 2017). Advocating for and receiving proper services and treatment was associated with increased testing and screening among this population (Marcell et al., 2017). Other findings noted that periods of incarceration might offer a unique opportunity to provide HIV/STI testing, treatment, and the delivery of postrelease planning prevention messages that focus on high-risk behaviors outside of the incarceration setting (Ricks et al., 2015). Confidentiality and privacy are a must for care, as are expanding free testing sites and partnering with community health centers and faith-based organizations; this provides a level of trust and may capture the attention of those who do not routinely attend clinics (Conserve et al.,

2017; Fine et al., 2017; Marcell et al., 2017). Finally, the role of partner support, specifically female partners involved with a young male, may provide a sense of confidence for this population to seek out testing (Weinman et al., 2011). Collectively, the facilitators identified in this review suggest that strengthening programs by making them more inclusive of the cultural norms of YHBM, increasing trust and rapport, providing dignified care, and increasing the accessibility of services, including access to insurance and low-cost screening for Black males, will help to improve the health and wellness of Black males who seek SRH services (see Table 3 for a complete list of facilitators).

Discussion

The current review clarifies the broader connections among barriers and facilitators in sexual and reproductive health among young Black men. This is demonstrated on

multiple levels that include cultural, structural, social, and personal contexts and dynamic interrelationships that are situation-specific and exist across various contexts (Marcell et al., 2017). This review also provides an in-depth overview of what young Black males may face concerning the health care system and accessing SRH care. In all, the data from this research suggest that efforts to strengthen programming, train providers, improve trust and knowledge, and make resources explicitly available (when, where, and how to receive services) for YHBM may directly reduce the barriers that persist between young Black males and SRH.

Furthermore, the consequences of not understanding the systemic barriers (e.g., environment and errant policies that affect their health) experienced by this population may only prove harmful for this population's sexual health outcomes. For Blacks, racism has historically had a significant impact on both the distal and proximal factors affecting health (Noonan et al., 2016). Therefore, developing a roadmap is needed to understand how systemic racism affects preventive health care among this population (Doubeni et al., 2021). While the roots are deep and go beyond SRH care, it is the job of clinicians, the health care system, funding agencies, and policy agencies to collectively address the issues that perpetuate unequal and substandard care (Doubeni et al., 2021). The results mentioned above emphasize the need to develop innovative strategies to improve access to high-quality SRH services for YHBM.

Another critical aspect in decreasing STI/HIV disparities among YHBM is improving patient-provider communication (Sherman & Grande, 2019). Communication of this type has been shown to increase health knowledge (Rutten et al., 2014), and digital health technology is a highly effective way of communication between Black males and their providers (Sherman & Grande, 2019). Furthermore, creating a supportive community environment and tailored programs help build a rapport and a sense of trust between the health care system and young Black males seeking out SRH care. In addition, we must allow the opportunity for YHBM to lead in some areas of "best practices" that are beneficial to them and develop a rapport that instills trust and confidence in the health care system.

The findings in this review indicate that YHBM are more likely to be engaged in SRH when targeted in specific demographic areas and to clinics that uphold a youth-oriented environment (Buzi & Smith, 2014). When health care clinics focused primarily on male-only programs, they had better growth and retention of male patients (Weinman et al., 2011). Likewise, Fine and colleagues (2017) reported a significant increase in STI testing and screening among young Black males at family health clinics that specifically promoted and implemented

male services. The staff members at this clinic received training on the "culture of men" (e.g., gender differences in communication and decision-making, influences of socialization on male sexual health, and the possible impact of male stereotyping on services provided) and implemented this in their services. This was an effective strategy to eliminate barriers in seeking out care, increase engagement, and improve standards of SRH among young Black male patients.

Limitations of this review include being able to generalize our findings to YHBM across the United States. Most studies in this review focused solely on YHBM in urban centers, with only one study examining SRH service issues among suburban and rural subpopulations (Goyal et al., 2014). Several studies in this review included sample participants outside of our population of interest (YHBM); however, we limited our analysis to findings from the YHBM participants in these studies. In addition, this area of research is relatively new in its scholarship (compared with studies on young men who have sex with men), resulting in few studies available for the review. Thus, our construction of key themes into barriers and facilitators is limited by the relatively few studies published on this subject in the past 10 years. Future work may involve performing a scoping or systematic review to characterize the quantity and quality of the literature or combining the review's strengths with a more specific comprehensive search strategy (Grant & Booth, 2009). As a result, we sought to address these potential issues with the guidance of a health sciences library informationist. This review offers valuable insight into improving programs, clinic usage, and facilitators and barriers within SRH care despite its exploratory nature.

Implications

It is essential to consider the barriers and facilitators reported in this review for YHBM. Community health clinics that provide SRH services should adopt a youth culture environment, support immersing young men in their social context, implement a male-focused programs, and engage with YHBMs. For example, clinics should meet YHBM where they are, such as advertising their SRH services on social media platforms in language that is accessible to this population (Burns et al., 2021). Health care providers can be champions in the clinical setting by understanding their own biases, discomfort, and communication patterns. The hope is to create new spaces that appeal to YHBM, are less daunting in treatment and care, and focus on linking screening to better prevention practices. It should also be considered to investigate these practices beyond urban areas (as indicated in Table 1) and how these experiences affect YHBM in rural and suburban areas. At the same time, there is considerable room

for improvement in best practices for SRH among YHBM. Future studies must also seek guidance from YHBM to understand better how clinicians can improve substandard SRH services, increase engagement, provide dignified and equitable care, and produce better sexual health outcomes among this patient population. There is not a generalizable resolution to increasing the engagement of SRH among YHBM. It will take a myriad of endeavors from health care clinics, providers, and various community service organizations to collectively develop a thorough, comprehensive plan for engagement and retention of SRH for YHBM.

Conclusion

Despite the previous literature outlining challenges to SRH care among young Black males (Cheatham et al., 2008), this study's findings suggest that significant barriers remain in SRH equity. This review highlights the relationship between barriers and facilitators of SRH, particularly in terms of health care affordability, knowledge, and cultural congruence. In summary, the collective findings from this review contribute to the current state of the science of barriers and facilitators that remain. It is important to improve high-quality services for this population, including respect, choice in care, confidentiality, and compassion. Going forward, health promotion efforts must be tailored to the unique needs of YHBM, recognizing the importance of social and cultural contexts and the lived experiences among this population.

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