Exploring sexual health among young Black men who have sex with men in New York City

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Abstract

Young Black men who have sex with men (YBMSM) account for approximately 10% of the total HIV infection in the United States but represent <1% of the population. Few interventions exist that address their unique needs, and those that do adopt a narrow, risk-based framework for prevention. Qualitative data from the Brothers Connect Study were analyzed to explore how a Sexual Health Model (SHM) developed by Robinson et al. (The sexual health model: application of a sexological approach to HIV prevention. Health Educ Res 2002; 17:43–57) could be used as a framework for HIV prevention in YBMSM. Content analysis identified five key themes within SHM: (i) race/ethnicity, including the cultural diversity and unique challenges of YBMSM; (ii) disclosure, as the ongoing process of self-identification rather than a single instance of ‘coming out’; (iii) sex, in terms of practices, behaviors and health; (iv) daily challenges, microaggressions and acute instances of discrimination; and (v) the self, resilience and identity. Technology represents a new component for the SHM that may be relevant to YBMSM. YBMSM are in need of comprehensive sexual health programs that go beyond typical HIV frameworks. A tailored SHM could be used for identifying and addressing the specific sexual health needs of YBMSM in research and intervention.

Introduction

The HIV epidemic has continued to disproportionately affect those who experience social marginalization and discrimination, especially Black men [1–3]. Black men who have sex with men (BMSM) account for nearly a quarter of all new HIV infections in the United States [4] even though estimates suggest they comprise <1% of the total US population [5]. Although men who have sex with men (MSM) are the only group to continue experiencing increases in HIV incidence, the greatest increases were found among young Black men who have sex with men (YBMSM) between the ages of 13 and 24 [6].

Further complicating this issue is the fact that there is a significant gap in HIV interventions designed for YBMSM [7, 8]. For example, Many Men, Many Voices (3MV) and Males of African American Legacy Empowering Self (MAALES) are the only two of the 93 interventions listed in the CDC’s compendium of evidence-based HIV behavioral interventions for risk reduction that are designed for BMSM, and none listed in the compendium is designed specifically for YBMSM [9]. The factors associated with the high prevalence of HIV among BMSM are dynamic and operate in multiple-levels, including limited access and utilization of quality health care, small sexual networks, low awareness of status, stigma, homophobia and discrimination [10]. Consequently, 3MV and MAALES approach behavior change from a position of comprehensive, sociocultural health
promotion by addressing HIV in the context of racism, homophobia, religion, intersectionality, historical discrimination and other social determinants of health [9]. Although many HIV and social science researchers have begun advocating extensively for comprehensive sexual health research and services [11–16], the needs of YBMSM remain largely unmet.

**Sexual health model for HIV risk reduction**

The Sexual Health Model for HIV Risk Reduction (SHM) was first introduced by a team of researchers from the University of Minnesota Medical School’s Program in Human Sexuality [17]. SHM was conceptualized through the triangulation of three sources of empirical and theoretical information: (i) a sexological, or sex-positive, approach to sexuality education; (ii) a review of literature on culturally specific and relevant models of sexual health; and (iii) qualitative and quantitative research on the sexual health perspectives of several key at-risk populations, including MSM [18], African-American women [19], transgender persons [20] and bisexually active women [21]. The findings from these studies developed into the 10 components of SHM that could potentially serve as a guiding framework for developing sexual health interventions across diverse populations. The components of SHM are: talking about sex; culture and sexual identity; sexual anatomy functioning; sexual health care and safer sex; challenges; body image; masturbation and fantasy; positive sexuality; intimacy and relationships; and spirituality [17]. These components are useful for linking issues from the individual (e.g. body image; sexual anatomy functioning), interpersonal (talking about sex; intimacy and relationships) and structural (culture and sexual identity; spirituality) levels, enabling SHM to examine the ways health and sexuality intersect within a variety of culturally relevant contexts.

SHM also describes how sexual health approaches can be applied to design culturally relevant interventions that improve both sexuality and HIV risk reduction outcomes. Sexuality outcomes include sexual satisfaction and sexual communication, whereas HIV risk reduction outcomes include condom use and substance use during sexual activity. SHM proposes that sexuality and HIV risk reduction outcomes are mutually reinforcing, such that improvements in either set can lead to improvements in the other.

SHM has been used as the theoretical basis for interventions focused on decreasing risk behaviors in high-risk groups [22–24]. In additional to increasing condom use, these interventions also resulted in significant improvements in sexual anatomy knowledge among African-American women [23] and safer sex self-efficacy among transgender individuals [22]. However, SHM has never been used for interventions specifically targeting YBMSM. Given that YBMSM account for such significant numbers and percentages of HIV infections [25], it is essential to consider their own culturally relevant understandings of health and sexuality in the context of HIV. SHM is vital in this regard because of its comprehensive approach to describing components of sexual health, and has been proposed as a guiding framework for exploring the sexual health needs of diverse populations prior to developing sexual health interventions [26]. As such, this study leverages the pre-existing framework of SHM to understand the dynamic and multi-level relationships between sexuality and health among YBMSM in New York City. The current study used qualitative data from in-depth interviews to explore the following research aims:

1. To use SHM as a framework to broadly describe sexuality and HIV risk reduction among YBMSM.
2. To identify the barriers and facilitators to improve sexuality and HIV risk reduction outcomes among YBMSM.
3. To update SHM with any new components of sexual health when applied to YBMSM.

**Materials and methods**

**Overview of study**

This study is a part of a larger mixed method and diary study that sought to describe the distal and
proximal risk and protective factors associated with HIV among YBMSM in the New York City area. The Brothers Connect Study explored the risk and protective factors associated with sexual risk-taking behaviors, as well as the barriers and facilitators to HIV testing, prevention and care in YBMSM. In-depth interview covered childhood experiences, sexual experiences throughout the lifecourse, distal factors related to sexual risk-taking behaviors, and potential barriers and facilitators to testing, prevention and treatment [27]. To safeguard the rights of human subjects, all study procedures were approved by the Columbia University Medical Center IRB.

Data for this study explore how SHM could be used to understand sexuality and HIV prevention. Although the purpose of the Brothers Connect Study was not to test SHM, participant responses explored issues that were pertinent to 9 of the 10 components of the Model (all but the component on sexual anatomy and functioning). We will therefore report how SHM fits within the study participants’ discussions of distal and proximal risk and protective factors associated with HIV.

In the Results section, we present our findings for each component of SHM so as to be consistent with our method of analysis (described below). In addition, we also highlight five cross-cutting themes that emerge differentially within each component. For this reason, we advise that no individual component be considered in isolation from the others because the components of sexual health among our study participant were not experienced in isolation. Furthermore, given the unique needs of YBMSM, our aim of this study was to gain a deeper understanding of their own lived experiences within sexuality and health.

**Participants and recruitment**

Participants were eligible for the Brothers Connect Study if they met the following criteria: assigned male at birth, identified as Black, African-American, Black Latino, Black Caribbean/West Indian, or mixed-race Black/African-American, and between the ages of 18 and 35 years. Participants also had to live in the New York City/Tri-State area, have access to a private, regularly checked email account, and have had oral or anal sex with a male partner in the 2 months preceding participation in the study. Internet and community-based recruitment specifically targeted youth-oriented and/or gay-friendly spaces such as gay clubs, community-based organizations, Facebook and Black Gay Chat. Those found to be eligible for the study were invited to participate in an individual orientation at a study office, where they received detailed information about the study and informed consent was obtained. Upon completing their individual orientations, participants were asked to provide the names and contact information of others who they believed to fit the study criteria. Women and members of other ethnic minority groups identified through snowball sampling were excluded for not fitting the study criteria. Also, based on eligibility for the larger quantitative study focusing on identifying discrete sexual encounters among participants, boyfriends/lovers of participants who would otherwise be eligible for the study were also excluded. Each participant was compensated $40 for participating in the in-depth interview.

**Qualitative study procedures**

A total of 228 participants were recruited into the larger quantitative study, of whom 30 completed in-depth interviews. Participants were invited to participate in the interviews as they completed the quantitative portions of the study (consisting of a one-time cross-sectional survey and an 8-week weekly sex diary), up until the 30th participant was recruited. After obtaining informed consent, in-depth interviews were administered by research staff (trained in qualitative research and analysis) between August 2011 and October 2011. Interviews lasted an average of 1 h and covered the following five topics: childhood relationship with parent(s), sexual and racial identity, support, motivation for sex with partner, and barriers and facilitators to HIV prevention, testing and treatment. All interviews were transcribed by a professional transcriptionist.
Measures
A series of core questions (see Table I) were used for each distal risk factor topic area. After asking each core question, interviewers were instructed to probe for additional information as needed. For example, for the section regarding sexual and racial identity, all interviewers asked the core question: ‘Some Black men have told us that they feel less accepted by the Black community because of their sexual identity. Does your sexual identity change your sense of acceptance, or level of involvement in the Black community?’ Depending on the participant’s response, interviewers would probe for depth and detail along how their experiences manifest as challenges in their lives, or how their experiences may be related to a specific cultural or ethnic background.

Qualitative data analyses
The transcripts were reviewed by a three-person team of researchers (including the second author) involved in the implementation of the larger study. The team used directed content analysis [28] during analysis because the larger study had been guided by prior research studies [27, 29]. This resulted in the relevant theoretical concepts (e.g. cultural, interpersonal and intrapsychic scripts from Scripting Theory) being incorporated into the initial coding scheme. Directed content analysis is often used to validate existing theory, prior research or hypotheses, to expound upon it, and to develop initial codes [30]. Additionally, the team read each transcript and used memoing to reflect upon the data, and notes were discussed in several meetings prior to the initial coding process in order to collectively deliberate upon our own individual reflexivity and discussed the commonly emerging themes. This form of reflexivity allowed for a critical understanding of how particular social and cultural issues affected the lived experiences of the participants [31]. Moreover, the memos were used to guide the development of the preliminary codebook and all transcripts were uploaded to Nvivo10. After the initial coding, the first and second authors extracted the ‘Sexuality’ code from NVivo on issues around sex, sexual health and sexual behaviors.

The first and second authors reviewed the 122-page ‘Sexuality’ code report and used the 10 components of the Sexual Health Model as secondary codes used in the current content analysis. The coding process included additional memoing and coding the Sexuality code report separately and meetings to discuss common issues identified. The transcripts were read verbatim to examine the salience of each of the sexuality components by highlighting the relevant text for each component. The first and second authors met weekly for a period of 6 months as a part of the coding process, which included corroborating and refuting coding inconsistencies. For example, upon recognizing a coding disagreement the first and second authors would each provide a rational for the codes included and excluded, debating the appropriateness of each until consensus was reached. They also met with the larger study team to discuss any potential changes to the Sexual Health Model as a part of the updating process.

Findings
Several themes emerged across all components of SHM. They include: (i) race/ethnicity, including both the cultural diversity and unique challenges of YBMSM in New York City; (ii) disclosure of sexuality, as the ongoing process of self-identification rather than a single instance of ‘coming out’; (iii) sex, in terms of practices, behaviors and health; (iv) daily challenges, microaggressions and acute instances of discrimination; and (v) the self, pertaining to resilience and identity. Although all five themes are evident within each component, the findings presented will focus on those that emerged most salient for each.

Additionally, after examining the original components of SHM among YBMSM, information technology and social media emerged as an important additional theme. Table II presents definitions of the 11 final components identified for YBMSM along with a summary of the salient topics for each. Sample quotes are also provided in Table II for all topics discussed throughout the following Results section.
Table I. Core questions from in-depth interviews of the Brothers Connect Study

**Childhood relationship with parent(s)**
1. Please describe for me what your family looked like. What about your living arrangement in early childhood?
2. Please describe your relationship with your parents as a young child if you could start back from as early as you can remember?
3. I’d like to ask you to choose five adjectives or words that reflect your relationship with your primary caregiver starting from as far back as you can remember in early childhood. I know this may take a bit of time, so go ahead and think for a minute...then I’d like to ask you why you chose them.
4. In general, how do you think your overall experiences with your parents have affected your adult personality?

**Sexual and racial identity**
1. How would you describe your racial and/or ethnic identity?
2. How would you describe your sexual identity?
3. Can you tell me about the moment you became aware that you were attracted to men?
4. How open are you about your sexuality with your family?
5. How open are you about your sexuality around your friends?
6. Many Black men have experienced challenges growing up due to their racial/ethnic identity and/or sexual identity. Would you say that you have experienced any challenges, big or small, due to your racial identity? Would you say that you have experienced any challenges due to your sexual identity?
7. As an adult, would you say that you experience day-to-day challenges, big or small... (A) In terms of your race? (B) In terms of your sexual identity? (C) In terms of both of those identities together?
8. How would you describe your relationship to... (A) The gay or bisexual community? (B) The [insert racial identifier] community?
9. Some Black men have told us that they feel less accepted by the Black community because of their sexual identity. Does your sexual identity change your sense of acceptance, or level of involvement in the Black community?
10. What about the other way around? Does your racial/ethnic identity as a [Black man change your sense of acceptance, or level of involvement, in the gay or bisexual community?]
11. Tell me about your friends or social group.

**Support**
1. When you hear the word support what comes to mind, in terms of your friends, family and community?
2. Let’s start with your friends: tell me about the last time you needed... (A) Financial support? (B) Emotional support? (C) Social support.
3. How supported do you feel by... (A) The gay or bisexual community? (B) The [insert racial identifier] community?
4. Do you feel supported by the Black community at all?
5. What other communities (if any) do you feel connected to? How supported do you feel by that/those communities?

**Motivation for sex with partner**
1. Are you currently in a relationship in which you are dating and having sex with this person only?
2. Have you even been in a relationship in which you were dating and having sex with that person only?
3. Have you ever had a female partner?
4. Thinking about your last sexual experience in your current or most recent relationship with a female partner, how did you feel right before your sexual encounter?
5. Thinking about your last sexual experience in your current or most recent relationship with a male partner, how did you feel right before your sexual encounter?
6. How do you feel after sex?
7. What is the most important reason for you to have sex with any partner? Can you please give me a specific situation in which you felt this way?

**Barriers and facilitators to HIV prevention, testing and treatment**
1. How would you generally describe your health?
2. When was the last time you went to the doctor? Why did you go?
3. Who do you talk to about your sexual health? Why?
4. Do you have insurance?
5. Do you engage in healthy activities (like going to the gym, eating well, etc.) on a frequent basis?
6. Have you ever participated in an HIV prevention program?
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<tr>
<th>SHM component and definition</th>
<th>Salient themes</th>
<th>Sample quotes</th>
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<tr>
<td>Talking about sex: the ability to talk comfortably and explicitly about sexuality, especially one’s own sexual values, preferences, attractions, history and behaviors</td>
<td>Talking about sex as ‘coming out’</td>
<td>Very open about my sexuality. I don’t discuss any details with her. She knows that I’m gay, so we don’t discuss—I don’t tell her anything about boyfriends or relationships and stuff.</td>
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<td>Outspoken opposition to sexual minorities</td>
<td>We were watching TV, and Queen Latifah came on the screen. And this family member said that, ‘I heard she was a lesbian. What a waste of life’. And that was—I don’t know exactly how old I was, but I remember hearing it and thinking, ‘Well, then I will never—I know how this person feels’. And that was case closed... For life, I know how this person feels. I don’t care if they say they’ve changed’.</td>
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<td>The benefits of a trusted individual</td>
<td>She’s like, ‘We’ve always been close and it is what it is. You have nothing to hide from me, I have nothing to hide from you’. There’s a mutual respect...whenever I need her for something, whether it be the most simple shit, like ‘Ma, I’m hungry’, to the most serious shit like, ‘Mom, I think I have an STD’ or something, I always go to her.</td>
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<td>Culture and sexual identity: the impact of one’s particular cultural heritage on their sexual identities, attitudes, behaviors and health; the cultural meaning of sexual behaviors</td>
<td>Ethnic diversity</td>
<td>Things are different in the Dominican Republic. The lifestyle is just different. Jumping right into things, sexuality is different, the Dominican Republic than it is here in America. I just feel like in DR, everybody is just so sexually fluid. I remember my first sexual experience in the Dominican Republic was with a male, and I was pretty young. I was like five and he was like seven. You know, things like that, it’s like you expect that to happen there.</td>
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<td>Gender norms</td>
<td>Because I can only equate it to I’m not masculine enough. So I’m seen as less of a man, or it’s from a male perspective, but from a female perspective I’m not female enough or I wasn’t born a woman regardless, so I would never be a real woman.</td>
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<td>Community engagement</td>
<td>Like if I’m in a predominantly white gay space, then it’s not just my race I’m thinking about. I’m still thinking about my sexuality because I’m thinking about how their—why they might be interested in me or not be interested in me, and sexually, racially, all that stuff. The lack of access I believe—the [Black] gay community is there, but I feel like there’s a lot more older people. I don’t find like younger people who I could interact with. It’s usually people in their 30s, 40s at these like programs or community centers in the area, so I don’t really go to that.</td>
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<td>Safe spaces</td>
<td>Just walking—like Flatbush is predominantly black, so when you’re walking with a feminine guy or like a feminine black guy, it’s two of us, you’re walking on the street, got to be extremely careful on how you walk, how you talk, versus you take a train and jump into Manhattan and you go to Chelsea you feel where there’s predominantly white community you feel free.</td>
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<tr>
<td>Sexual anatomy and functioning: a basic knowledge, understanding and acceptance of one's sexual anatomy, sexual response and sexual functioning, as well as freedom from sexual dysfunction and other sexual problems</td>
<td>N/A</td>
<td>Not discussed by YGBMSM participants.</td>
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<td>Sexual health care and safer sex: encompasses knowing one's body, obtaining regular exams for sexually transmitted diseases and cancer, and responding to physical changes with appropriate medical intervention; includes, but is not limited to, practicing safer-sex behaviours</td>
<td>Relationships with health professionals</td>
<td>I mean it's kind of a weird dynamic because XXX, the doctor I see in student health center, is actually my mentor, my LGBTQ mentor, so we've talked about basically everything. So nothing's really foreign with him. XXX always asks, 'So how's the sex life?' And I'm like, 'It's boring'. And we laugh about it. I'm like, 'No, really. It's fine'. And so it's like give or take. So, it got scary, but one of the things that it taught me in my adulthood—I look at it now as that I'm not invincible—that if I caught that, I could easily have caught HIV.</td>
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<td>Learning from experience</td>
<td>Nobody knows about anything, but you go with the same people everywhere. No wants to use a condom. Everybody's on drugs so their—all their inhibitions are just out the window. Then nobody talks about it afterwards and nobody will go get tested because they don't want the stigma. If you go to get tested you're gay.</td>
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<td>Complex, layered barriers</td>
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<td>Challenges: barriers to sexual health, such as sexual abuse, substance abuse, compulsive sexual behavior, sex work, harassment and discrimination</td>
<td>Bullying</td>
<td>I could defend myself very well and that is because as a child I just had a lot of fights with boys and girls because of being feminine or being called a fag. That's one thing that my mother did not like, so I had to fight a lot and I got beat up by my brothers. When I came out to her, she said she loves me regardless. She didn't agree with it but she loved me regardless and she'd be by my side and then that same day she told her husband and he told her how he felt about it and then she came back and told me she can't accept that and that she won't accept it and that I needed to change...I trusted that my mother would support me and everything since I'm her son. That was the first time my mother threw me out. I was so upset.</td>
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<td>Rejection/Homelessness</td>
<td>There's a difference to being gay and being a faggot. And it's funny how we apply that derogatory term to others in our community...There's no need for you to be wanting—just like being like a girl. 'Cause XXX was like a girl, and it's funny how his Facebook is now XXX. So now he's like full-blown, I don't know what he is now. But it's like, damn. My friends always tell me, 'Look, I don't have a problem with you being gay. Like you're cool. You're okay. You're not trying to be a girl. You're not imposing'.</td>
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<td>Internalized homophobia/Transphobia/Gender conformity</td>
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<td>Microaggressions</td>
<td>Because this happens on the train a lot. When they don’t like—two men don’t like to sit next to each other. If—a lot of the times they’ll—if I’m sitting down or whatever, they’ll just move to the next car.</td>
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<td>Religion</td>
<td>I always knew there was something different about me, but my dad being a pastor and my family being deeply religious, I did not feel comfortable expressing myself at all period. So I kept that part secret forever...I thinking keeping my life a secret for so long and when I was in high school I went to boarding school, and I had to keep the secret there, too, a Catholic school. So everything was a secret, and I when I got to college, I didn’t know how to have a relationship in the open.</td>
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<td>Body image: challenging the notion of one, narrow standard of beauty and encouraging self-acceptance</td>
<td>Weight</td>
<td>I had a little eating problem, and I was a very skinny, very skinny kid. My mom thought it was a problem and she took me to the doctor. They wanted to keep me—’cause I didn’t like eating for some reason, ‘cause it was a mental thing. Also she started like feeding me oatmeal or fattening shit and I became a fat kid. I became really fat. So I think that was a little bit of a setback because I didn’t lose the weight until college, where I lost like over 115 pounds.</td>
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<td>Racial difference</td>
<td>So, that kind of—I have a couple of close friends and acquaintances, but I always feel so awkward, and as a young kid I was teased a lot, because I was not white, my hair was curly, because I had big lips, because I was different. So, sometimes if I meet someone I always think that they might be judging me.</td>
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<td>Image management</td>
<td>So—and then I guess sometimes they judge me because I’m—’cause I can—like I would get my eyebrows done or I like to wear some things and, well, being thicker, it made me look extra fem because I probably got like thighs and hips and stuff, and they would just say, ‘Faggot’ this like that, but I’m really just being me.</td>
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The only problem that I have is a shaving problem. I shave like once a week, so I always have a scruffy face, that’s what I’ve been trying to improve though cause me and my friends have this theory that you can supposedly bag more people with facial hair as opposed to being like a baby’s ass. Oh, like letting my hair just be nappy or growing locks or not cutting it or brushing it in crazy ways or growing my beard out and letting it kinda stay

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<td>Masturbation and fantasy: a realistic appreciation of the important role of masturbation and fantasy in safer sex</td>
<td>Pornography: as leisure activity</td>
<td>When I’m horny, when I’m just watching porn—pornography. Sometimes it could be three times a week, sometimes—and when it builds up, I let it build up, then I could ejaculate a lot and that’s when I want to have sex.</td>
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<td>Pornography: as exploration</td>
<td>That was easy. It was probably, I was 11 years old, and had the internet, and I discovered porn. And, the next couple days later, I’m just like, ‘I wanna look at a guy site’.</td>
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<td>Positive sexuality: exploring and celebrating sexuality from a positive and self-affirming perspective</td>
<td>Resilience</td>
<td>I think I would have felt the same way without them, because I was prepared to say like, ‘Well, if they don’t accept me, then that’s fine. I’ll be ok. I was already in that phase where I was like, ‘This is who I am, and if no one accepts it, then I can’t do anything about it. ’</td>
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<td>Affirmation</td>
<td>It’s called XXXX, and the founder of it created it for a space for Black men who loved other men, which is totally—which I liked about it was it was Black men not necessarily having ‘sex with men, which may be what the CDC or other people call it, but men actually loving other men. And I realized—as I mentioned, when I started getting comfortable with my homosexuality and that—my love for men and wanting to have loving relationships with men, I realized that I wanted something that would help me perpetuate that type of behavior and that feeling. And I think that same gender loving helped me with that because it’s inclusive, where I could love somebody who may not have been born male but is male-gendered and love them.</td>
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<td>Positive sexuality (Cont’d); exploring and celebrating sexuality from a positive and self-affirming perspective</td>
<td>Sex as a health behavior</td>
<td>Interviewer: Is there anything else you engage in that you consider healthy? Interviewee: Sex. [Laughs] That’s healthy. It prevents heart attack. A good sweat, yeah.</td>
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<td>Sexual autonomy</td>
<td>We didn’t have sex, and it was a personal choice by me because he is what I would consider a top or whatever, and he loved me like crazy. He always tried to—he tried to get me to bottom for him, but I’m like, ‘No, that shit hurts. I’m not gonna fuck. I’m not gonna endure this pain just because you want your pleasure. I’m not’.</td>
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<td>Intimacy and relationships: intimacy is a universal need that all people try to meet through their relationships; can affect safer-sex decision-making</td>
<td>A combination of physical and emotional</td>
<td>It was very emotional, like we made out a lot, and it was mostly—it wasn’t, there wasn’t fucking. There wasn’t fucking, there wasn’t getting fucked... To me it’s not necessarily an important reason, its just sex, its an emotional understanding between 2 people, or more. But, its an emotional understanding, so to me it has to be passionate, ’cause I’m into realism, so I need to be there with you emotionally, for us to go to this place.</td>
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<td>Exploration of desires and boundaries</td>
<td>So, with that same friend, he wanted to start off with just dry humping, and he would meet me somewhere. And he would—we would just do some dry humping, and it was like our little secret thing that we did whenever we got...</td>
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<tr>
<td>Spirituality: a congruence between one's ethical, spiritual and moral beliefs, one's sexual behaviors and values; may or may not include identification with formal religions, but needs to address moral and ethical concerns</td>
<td>Sexuality not a matter of concern for God/religion</td>
<td>And I started to see that regardless of who I slept with my love for God didn’t change. And I could tell that his love for me didn’t change. But I guess because I don’t discuss it when I go there, so—I mean, my whole thing in religion is—I’m not there for my sexual orientation, so I don’t think it should even be a discussion. They actually have like—basically, it started a couple of years ago, and they have pastors and ministers that are gay and lesbian. They’re really cool with it.</td>
</tr>
<tr>
<td></td>
<td>Finding gay-friendly churches</td>
<td>Leaving judgment to God, not people</td>
</tr>
<tr>
<td>Information technology and social media: the role of new technologies in navigating sexual health, including access to information and services, facilitating communication and relationships, and exploring one’s own sexuality</td>
<td>Increased access</td>
<td>I’ve been to church where, you know, I would hear pastors stating, you know, homosexuality is wrong. I would always be the first to stay behind and I’d see—to show me where in the Bible it says that. You know? For years now no one could ever show me that. I mean, if they’re supposed to be a church and they’re supposed to be peace and loving people the Bible also says that leave all judgment unto God. Then, you know, do that, leave all judgment unto Him. For me being more social and networking and stuff, I don’t know if it’s a community, but I feel somewhat connected to the Internet community. I keep talking to people online and going in chat rooms and talking about stuff on Facebook. I’ve got connected in that way for a while. I didn’t even think of it, I just Googled it in and it’s like, what can I find out? But after I switched [my identity status online], I got encouragement from people on Facebook, and that got me through it. Because everybody tries to rush things. Everybody’s so quick to say, ‘I’m a top. I’m a bottom. I’m verse’. Not like 13 year olds on Facebook talking about, ‘I’m a verse. I’m a top’. I’m like, ‘You’re 13, go watch Teletubbies. What’s wrong with you?’ …You’re adding me on Facebook, a grown ass man. What’s wrong with you? Tell your mama about you. The church would kick me out. So, because of I was homosexual, they don’t accept people that’s homosexual. They would delete me on Facebook and then go gossip to the whole church about it.</td>
</tr>
</tbody>
</table>
Characteristics of this study

Of the 30 interview participants, there were only 27 participants for whom baseline quantitative data were available. Participants ranged from 18 to 35 years of age and had a mean age of approximately 25.5 years. Sixteen (59%) identified as African-American/Black, 6 (22%) as Black Hispanic/Latino, 2 (7%) as Afro-Caribbean/West Indian and 3 (11%) as mixed-race. With regard to sexual identity, 19 (70%) identified as gay or homosexual and 8 (30%) as bisexual. Twenty (74%) participants self-identified as HIV-negative, whereas seven (26%) self-identified as positive or unknown. Nearly all (26) participants had at least a high school diploma or General Educational Development (GED) diploma, with 19 (70%) having continued to at least some college.

The original components of the sexual health model

Talking about sex

For YBMSM participants in the study, ‘talking about sex’ was relatively uncommon and regarded as an uncomfortable conversation. For instance, nearly half (14) did not feel comfortable openly discussing sex and sexuality with family members, peers and potential partners. Even when ‘out’, these participants expressed discomfort in discussing with others their own attractions, sexual preferences, or the status of romantic partnerships. This silence provided protection against possible stigma and discrimination perceived by peers and others in their communities. As one participant noted when discussing the ‘Down Low’ within the Black community, ‘But then here’s a twist. They’re [Black community] not supportive of it, but they are heavily into it. It’s just not talked about at all. It felt blatantly obvious, but they don’t talk about it, so it’s “We don’t do that. We’re not supportive of that. We don’t condone that.” But yet, at night, this is what [men on the Down Low are] doing’.

The above quote encapsulates how race/ethnicity and disclosure (Themes 1 and 2) intersect within the ‘Talking About Sex’ component of SHM. The cultural phenomenon of the Down Low promotes a structure where same-sex behaviors are not to be discussed. And, although there may be protective factors associated with maintaining silence or even anonymity, on a social level this implicitly endorses social norms that perpetuate race- and gender-based stereotypes, stigma and homophobia [32]. Perceptions of masculinity, for example, have been shown to play a significant role in partner selection, sexual role among YBMSM and perceptions of one’s HIV status [33, 34]. These non-verbal gender cues often rationalize condom-use behaviors rather than partner communication, placing YBMSM who are not comfortable discussing sex and sexuality are at heightened risk. On the other hand, five participants highlighted the importance of identifying at least one other individual with whom they could trust and speak freely about matters of sex and sexuality. These individuals ranged from family members to medical professionals, and the relationships resulted in benefits of great public health significance. Not only did these individuals serve as an outlet for expressing their sexuality, participants would frequently seek and receive advice regarding protective behaviors, the availability of health resources and sexual decision-making.

Culture and sexual identity

This sample of YBMSM represented a diversity of ethnic and racial backgrounds from across the African Diaspora (e.g. Jamaica, the Dominican Republic, or Trinidad and Tobago). Most (6) participants with cultural heritages in other countries identified generally negative responses to sexual minorities on the societal level, if not explicit legal restrictions. As one participant put it, ‘It’s illegal to be homosexual in Jamaica. It’s not just a homophobic country but the law states that any intimacy between men public or private is punishable by 10 years in jail’. Others identified ways in which issues of sexuality were more easily navigated as compared with the United States. Finally, eight participants also discussed the rigid gender roles in the different communities to which participants belonged, and how these were simultaneously internalized and perpetuated within Black gay and bisexual
communities (discussed in greater detail in the Challenges domain).

In terms of the cultural and sexual identity domain, the majority of participants regularly navigated between the gay and Black communities. However, rather than draw upon these experiences to bolster a sense of self, participants more frequently discussed them in terms of navigating the challenges they presented (Theme 4). As one participant said, ‘I just think once you’re black, people kind of knock you down a couple notches. You’ve got to prove yourself sometimes to be on the same level. But being black and [gay] you never know who accepts it and who doesn’t. So it’s often a little iffy’. Feelings of marginalization within Black and gay communities are not new [35], but our data provide additional nuance to these experiences. With regard to the gay community, 10 participants indicated that they struggled to feel welcome, most frequently citing race (within White gay spaces) or age (within Black gay spaces) as the main barriers to engagement. Although race was a barrier to engagement for YBMSM in White gay spaces, White communities—whether perceived as gay or not—were generally perceived as safer or more welcoming to YBMSM than Black communities. One participant described his experiences in White Jewish communities as ‘nice and courteous’, but described bringing his sister with him in Black communities in order to ‘act like I’m going out with [a girl] to be accepted’. Additionally, participants discussed concerns with navigating different social spaces because of safety and lack of inclusion. These experiences resulted in a variety of strategies for avoiding potentially negative experiences.

Sexual anatomy and functioning
Although the sexual anatomy and sexual functioning domain was not discussed by any participants, this suggests that, given the infrequent and uncomfortable experiences talking about sex, YBMSM may have little understanding of the mechanics of sex between men (Theme 2). Although the New York City Department of Education includes human anatomy and physiology within the scope of their comprehensive sexuality education [36], it is quite reasonable to assume, for example, that the sexual anatomy lessons provided do not explicitly discuss the physiology of the anus with regard to penile penetration. It would be important to consider how the anus differs from the vagina with regard to the cell lining of surrounding membranes, self-lubrication, elasticity and hygiene. In the absence of such relevant sex education, YBMSM would need to rely heavily on conversations with trusted peers, adults, or professionals to gather reliable information on the mechanics of sex between men. Data from the present study indicate that very few have the opportunity to do so.

Sexual health care and safer sex
Sexual health care and safer sex was discussed by 12 participants. These young men described the complexity and barriers that often make safer sex practices difficult to maintain. Even if an individual has the intention to use a condom, they must contend with a social network in which condom use norms are not embraced, as well as small, overlapping social and sexual networks with limited knowledge of safer sex practices. In this study, participants’ sexual practices, behaviors and health promotion activities (Theme 3) often took a back seat to daily challenges introduced by social networks (Theme 4), which carried over in the form of stigma and homophobia when they tried to be proactive with their sexual health care use.

Relationships between YBMSM and health professionals varied greatly. However, a common point made by participants regarding disclosure of their same-sex sexual behaviors to providers can be summarized by one participant’s choice words: ‘Yeah, I guess he’d be pretty knowledgeable, but there’s no reason to’. These notions were generally rooted in the idea that sexuality was a private matter rather than a health concern, and it is here that we see how disclosure and sex (Themes 2 and 3) can directly influence health outcomes. Even if one recognizes a need for sexual health services, they may nonetheless avoid seeking out those services in order to evade the stigma associated with disclosure.
The benefits are evident for those who have successfully developed a strong relationship with their physician. The two most positive relationships discussed by participants referenced the ease with which they can access information about sexual health and resources. One said, ‘I ask her [doctor] questions about sex and stuff like that, and I ask her about different condom usage, what’s the best condoms... and I ask a lotta questions to her because I wanna know. I wanna learn. I wanna know what’s going on’.

The 12 participants who discussed issues related to the sexual health care and safer sex component also expressed the following: interests in increasing their partner trust and/or communication regarding sexual health issues, intentions to maintain consistent HIV and STI testing behaviors, or relevance increasing their access to sexual health services. Half of those participants related their interests in increased sexual health care and safer sex to past experiences that highlighted their own vulnerability to HIV and other STIs. One participant described being contacted by a recent sexual partner and told that they had seroconverted. The participant quickly got tested. ‘I feel like I just missed it’, he said, before describing how he and his friends have since put much more effort into adopting consistent condom use. Thus, although some described how their relationships with health care professionals helped them increase their protective behaviors, the more consistent trend appears to suggest that sexual behaviors are changing after HIV has entered into the sexual network.

Challenges

All participants experienced challenges and barriers to healthy sexual development, and these challenges were evident in all components of sexual health. However, YBMSM participants discussed lifetime experiences with bullying, victimization, rejection, homelessness and microaggressions (Theme 4). Racism was identified as a significant issue in the lives of most participants, and examples of how it emerged in relation to sexual health can be seen in the Culture and Sexual Identity component. The theme that garnered the most attention, however, related to the internalization of negative feelings, attitudes, or beliefs about oneself (Theme 5). Internalized homophobia appeared to be the primary source of negative feelings about the gay community or one’s own sexuality, though a strong sense of gender norms and expectations could also explain some of the comments. ‘I took that kind of behavior into my adult life’, said one participant, describing the long-lasting impact of feelings of shame and secrecy in childhood that left him afraid of being in a committed relationship. These feelings contributed to a preference for casual sexual relationships as a way to avoid commitment. He continued, ‘And it’s like that was a hard habit to break... [I was] like 27 before I could really break that kind of habit, slipping and tipping, as my friend would say’.

A common critique of the gay community or of specific gay individuals was gender nonconformity. The distinction between gay men who were ‘out there’ and those who were not would often revolve around the degree to which femininity was expressed, and underscored the significance of maintaining gender roles among participants. Consistent with previous research with BMSM [37], 18 of the 30 YBMSM participants conveyed negative internalized feelings, attitudes, or beliefs that reinforced a strict adherence to gendered norms. Along these same lines, and given the diverse ethnic background of study participants, experiences with a variety of religions were discussed (e.g. Catholicism, Islam, or Jehovah’s Witness) as contributing to negative internalized feelings. Half (15) of all participants identified churches or fundamental religions as the source of rejection, harassment, or shame relative to their sexuality. Repeatedly, the myriad social and structural challenges faced by YBMSM were internalized and reproduced as an outward devaluations of femininity and gender nonconformity.

Body image

Body image and its relationship to sexuality emerged as a topic of discussion for 11 YBMSM, constructing it as yet another component where challenges and the self (Themes 4 and 5) could intersect. For example, though not all participants who
discussed being overweight perceived it to be problematic, body size was often the cause for negative attention from others. Racial difference (Theme 1), particularly in relation to interactions with the White gay community, was another body image subtheme. Participants also talked often about conveying a particular image through style, persona, dress or grooming. This was linked directly to notions of what was considered vogue and accepted by the gay community, as well as maintaining a particular aesthetic and appearance.

Masturbation and fantasy

Masturbation and fantasy, though not frequently discussed, were consistently related to sex (Theme 3). Masturbation itself was only discussed by one participant, as a release of sexual tension. Although the topics of masturbation and fantasy were not explicitly described elsewhere, five YBMSM broached the topic of pornography. Two participants discussed exploring pornography at a young age, which served a different purpose for each. One of these discussed how his attraction to men was never recognized until viewing pornography, whereas the other, who had recognized his attraction to men but had maintained that he was still sexually attracted to women, ultimately concluded that he was not after viewing men in pornographic films. Similarly, two participants discussed viewing pornography leisurely in adulthood. However, one of these also suggested that an increase in his viewing of pornography would indicate to him that he needed to find a sexual partner. No participants linked pornography to any influence on risk or protective sexual behaviors. In all, masturbation and fantasy were predominantly ways in which participants explored their own sexuality and identified their own sources of pleasure and fantasy.

Positive sexuality

Positive sexuality was frequently expressed in terms of merging sex and the self (Themes 3 ad 5). This type of positive sexuality took the form of resilience, with nine YBMSM recognizing that self-affirmations were integral to any interpersonal relationships with others. As one participant put it, ‘It’s gonna be your burden to carry, it’s not mine. Life is too short’. Others joined groups that affirmed their sexuality and spoke of learning how to reframe their sexuality as more than sex acts alone. However, positive sexuality was also an important perspective to take with regard to sexual activity. Although participants recognized the potential risks associated with sexual activity, sex in and of itself was also viewed as a health behavior. These participants discussed increased emotional connectedness, reduced fear of same-sex attraction, and increased physical fitness as the result of sexual activity. Finally, positive sexuality emerged as a form of sexual autonomy. Participants who were well aware of their sexual desires and interests were able to advocate for themselves in sexual encounters so that they were not placed in compromising situations, for example with regard to coercive sexual partners. Positive sexuality was therefore a useful framework for navigating some of the sexual challenges (Theme 4) that they faced on a regular basis.

Intimacy and relationships

All participants discussed sexual and emotional experiences with other men, but 13 touched on the significance of intimacy in their romantic and sexual relationships. Among these, intimacy was a combination of physical and emotional closeness with their romantic and sexual partners. These relationships provided the opportunity to explore the desires and boundaries YBMSM had that would ultimately define their expressions of intimacy. One participant noted the tensions that arose in an early relationship when his interests shifted away from sexual activity and toward more intimate behaviors: ‘He got mad...I can have sex whenever, but I feel like I was over that stage of just having sex. I just wanna...I’d rather just cuddle or whatever, whatever’. This participant, like many others, perceived a greater appreciation for emotional closeness such as touch within intimate relationships as an example of personal growth. Furthermore, the self (Theme 5) could be developed through both sexual (Theme 3) and emotional relationships with others, and
intimacy within relationships was inextricably connected to these processes.

**Spirituality**

Spirituality was closely related to the self (Theme 5) and provided an opportunity for some participants to demonstrate their resilience to daily challenges. Although many participants struggled with organized religion (as discussed in the Challenges section), spirituality remained a significant factor in the lives of five YBMSM participants. Two were able to locate churches that were accepting of their sexuality, which simultaneously reinforced their spiritual convictions and sexual identities. Two others rationalized that sexuality was not a matter of concern for a higher power. Whether they were at an anti-gay church or reflecting upon their own spirituality, these participants were confident in their spirituality and understood anti-gay sentiments in religions and churches as the interpretations of fundamental doctrines and not a reflection of their God or spirituality.

Finally, one participant reflected upon his spirituality and concluded that only his God could pass judgment on his sexuality. He worked proactively to reject the judgment of other people until he could learn for himself how his God would view him. All five of these participants managed to maintain their spiritual convictions in the face of religious adversity. As such, maintaining a sense of spirituality was a way for many YBMSM to reaffirm their sexuality in the face of many negative messages received from organized religion.

**Additional sexual health component for YBMSM**

Technology is a relevant theme in understanding sexuality in YBMSM and thus we discuss it here as an additional component of a modified SHM for YBMSM.

**Information technology and social media**

New technologies and social media (e.g. Facebook) continue to be developed and grow in relevance to the sexual health of YBMSM. Eighteen participants shared how they use technology to increase their access to information, social services, peers and sexual partners (Theme 3), as well as to facilitate the coming out process (Theme 2). We found that participants felt comfortable using online social media to identify as gay or bisexual, to feel safe coming out anonymously to others, and build and strengthen a social support network through friendships with peers that they may have never had the opportunity to meet otherwise.

However, technology is not necessarily risk free. Participants also gave examples of experiencing harassment, rejection, or discrimination online (Theme 4), such as when one participant’s extended family left him comments online condemning him to hell after he came out on his Facebook profile. ‘My Facebook is full of bible verses from aunts and uncles posting it’, he said. Similarly, as younger age groups become better-acquainted with using the internet as a tool for exploring sexuality and sexual health, they simultaneously increase their opportunities for risk exposure. One participant discussed how early adolescent boys have approached him online claiming specific sexual roles such as ‘top’ or ‘bottom’. Whether being used to seek out sexual health information, locate sexual partners, build community, or come out, information technologies and social media have clear implications for both promoting and obstructing sexual health, and our data suggest that YBMSM are for the time being learning to navigate it independently.

**Discussion**

The findings from this study demonstrate that SHM is an important tool for exploring how vulnerable populations such as YBMSM interpret the relationship between sexuality and health in their lives. Consistent with previous reports on adapting SHM to diverse populations [22], we found these components were helpful in identifying the multi-level factors that influence YBMSM experiences with sexuality and health.

For example, the ‘Talking About Sex’ component could be useful to offer participants strategies for
identifying a trusted and supportive physician with whom to discuss matters of sex and sexuality, simultaneously fostering growth within the ‘Sexual Health Care and Safer Sex’ component. These sessions could be linked to communication self-efficacy activities that facilitate honest dialogue of one’s needs and concerns surrounding sex, sexual health, and sexuality. Martos [26] also recommends linking interventions based on SHM with critical pedagogy [38] in order to better address the social determinants of sexual health that the Model may identify. For example, interventions for YBMSM that incorporate SHM could offer opportunities for participants to foster change within their social and sexual networks around issues of peer condom use norms, HIV testing behaviors, and other sexual health promoting behaviors.

The above strategies specifically respond to the sexual health concerns discussed by YBMSM. However, YBMSM represent a culturally diverse population. Including multiple perspectives of YBMSM based on culture, language, religion, history, geography, and socioeconomic status could help improve the relevance of HIV prevention messages. Millett et al. [39] reported that BMSM across the African diaspora share common experiences such as discrimination, threats of violence or incarceration, micro-aggressions, and concerns of valuing extreme masculinity. The benefit of using SHM as noted in this study is to help YBMSM identify and understand their shared sexual health needs as well recognizing the diversity that exists within the population. Our data provide further evidence of the need for community-building within YBMSM networks.

A significant finding was how participants shared an interest in discussing safer sex with a trusted health professional. Sexual health researchers and healthcare providers have a critical role in improving the health outcomes of YBMSM, but we have very little understanding of social context and how cultural factors may impact the overall sexual health of YBMSM in relation to the doctor–patient relationship [40]. For example, one study of young HIV-positive Black and Latino MSM found that those engaged in effective and regular care were much more likely to adopt harm reduction strategies and to reduce their risk of HIV-related illnesses, substance abuse, and mental illness, and increase their secondary prevention behaviors [41]. SHM can be used to shift the focus from primary disease prevention to a more inclusive sexual health promotion [15], including the incorporation of harm reduction strategies that are responsive to social and spatial issues that contribute to daily experiences with HIV risk [42], such as employment, poverty, substance use, unemployment, and inequality, especially for YBMSM.

Additionally, our findings show that YBMSM are highly resilient and develop a variety of strategies to avoid stigma and discrimination from peers, family, or community members, and institutions. This same resilience can be applied to sexual health promotion. By drawing upon participants’ own resiliency stories, YBMSM can learn from each other how to resist barriers to their own sexual health. Study participants described exploring desires and fantasies alone and with others, as well as drawing upon spirituality to reject notions of deviance and sin, demonstrating their resilience across a variety of sexual and social situations.

Another significant finding is ‘Information Technology and Social Media’ as an additional component for SHM. Technology was viewed as an important tool to navigate sex and understand sexuality among YBMSM. Technology ought to be addressed in formal sexual health education. For example, recent studies have shown that BMSM routinely use information technology and social media for both sexual and non-sexual communications with other MSM, as well as to access sexual health information [43, 44]. Research has also begun to explore the feasibility and acceptability of HIV interventions using new technologies among BMSM and YBMSM [43–45]. Results indicate that YBMSM may be highly receptive to such internet-based strategies as discussion forums that enable them to connect and interact with each other and decrease a sense of isolation, post-anonymous question and answer, and submit these questions to trained staff that provide accurate sexual health information, and the use of global positioning systems and user reviews to locate gay-
friendly health providers. However, YBMSM in other another study were found to be significantly less likely than their White or Latino counterparts to use the internet specifically for obtaining HIV/AIDS information [46], and relatively little is known with respect to how the use of information technologies and social media affects their sexual development, sexual expression and sexual health. Modifying SHM to include technology would significantly improve its ability to inform sexual health interventions for YBMSM, but further research is needed to understand how this emergent component of sexual health can be utilized to influence both sexuality and HIV risk reduction outcomes long-term among YBMSM.

Although research for addressing the HIV epidemic in YBMSM has focused significant attention on the biomedical HIV prevention interventions to reduce the susceptibility or transmission of HIV, we strongly recommend that HIV prevention researchers incorporate the SHM in its entirety and consider the findings in this study when developing HIV prevention interventions for YBMSM. The fact that some topics were not discussed in greater detail is a significant finding in and of itself and can be understood in the context of the other components. As discussed, social and cultural barriers to talking about sex may hinder YBMSM from accessing information on sexual anatomy and function that is pertinent to their sexual lives. Further investigation into the relationship of each component with sexuality and HIV risk reduction outcomes among YBMSM is merited.

Limitations

This study had several limitations. The original study was not designed to specifically elicit data on SHM. The study only used semi-structured interviews which limit the ability to triangulate finding from different sources of data from the larger study, and there were no follow-up interviews to more explicitly and carefully explore the components with participants. Finally, data from the Brothers Connect Study were collected in 2011, before biomedical strategies to prevention such as Pre-Exposure Prophylaxis (PrEP) were widely disseminated and available for use among MSM. PrEP alone may well have had a significant impact on how YBMSM understand their sexual health today. In spite of these limitations, to our knowledge this is the first qualitative study that describes the sexual health of YBMSM in terms of both sexuality and HIV risk reduction. SHM proved to be a useful tool for synthesizing the complex sexuality experiences of this highly vulnerable population.

Conclusion

This study explored how SHM can be used to understand sexuality and HIV among YBMSM in New York City and inform sexual health interventions targeting this population. Efforts to improve existing HIV interventions for YBMSM should utilize SHM to address the intersections between race/ethnicity, disclosure, sex, daily challenges and the individual. Though comprehensive sexual health has not been a priority in HIV prevention interventions, this study identified ways to use SHM to make HIV prevention more relevant to YBMSM. YBMSM comprise not only a special population that could benefit greatly from sexual health interventions but also one whose sexual health needs simply cannot be met through individual behavior-change interventions. Finally, the use of new technologies and social media to support sexual development, expression and health is of great potential for YBMSM and should continue to be explored in future sexual health research and intervention.

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Conflict of interest statement

None declared.

References

44. LeGrand S, Muessig KE, Pike EC et al. If you build it will they come? Addressing social isolation within a technology-based HIV intervention for young black men who have sex with men. *AIDS Care* 2014; 26: 7–1.