The HIV epidemic has always hit some communities harder than others. Among the populations that have been most devastated by HIV in this country are men who have sex with men (MSM) and communities of color—specifically, Black and Latino Americans. When the National HIV/AIDS Strategy (NHAS) was released in 2010, it called for a renewed focus on populations most impacted by HIV, noting that men who have sex with men made up the majority (now 61 percent) of new infections.1 Similarly, in 2010, Black Americans made up 45 percent of new infections, and the HIV rate for Latinos was almost three times that of Whites.2 In particular, the NHAS called for interventions that sought to redress the health disparities for Black and Latino men who have sex with men, who are burdened with even higher HIV rates.1, 2

Since the 1990s, when the Centers for Disease Control and Prevention (CDC) conducted its Young Men's Survey, we have known that there is a disproportionately high prevalence of HIV infection among young Black and Latino men who have sex with men.3–4 Although this health disparity itself is not news, it is alarming how much it has grown over the last several years. Of all demographic subgroups tracked by the CDC, young Black men who have sex with men showed the sharpest rise in new HIV diagnoses, which increased 93 percent between 2001 and 2006.5, 6 Further, young men who have sex with men represent the only risk group for whom new infections are increasing (see Figure 1)—and this is due largely to increases in diagnoses of young Black men who have sex with men.5

This double-issue of Perspectives provides an update on the state of the epidemic among young Black and Latino men who have sex with men. It examines some of the factors, including social determinants of health, that contribute to the tremendous disparities in HIV infection rates they face, outlines some of the strategies that are being used to reduce HIV incidence in these communities, and reviews some of the ways that HIV test counselors can make a difference in their work with these young men. Young Black and Latino MSM are diverse, and no single article could attempt to completely describe their
situation, concerns, and strengths. To read additional information about these communities, access the following back issues of *Perspectives*: *Latinos and HIV; Youth, HIV, and Sexual Risk*; and *Young Black Gay and Bisexual Men*.

**Disparities**

Among young people aged 13 to 24 who were newly diagnosed with HIV, the vast majority (more than seven out of 10 cases) in 2010 were among young men who have sex with men. This figure is especially troubling because only approximately 4 percent of young men are believed to be men who have sex with men.

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Within the population of young men who have sex with men, racial and ethnic disparities mirror those of the larger population of people living with HIV in the U.S. The CDC reports that, although new HIV infections were fairly stable among MSM overall from 2006–2009, they increased 34 percent among young MSM—an increase largely due to a 48 percent increase among young black/African-American MSM aged 13 to 29.

Both Black and Latino men who have sex with men tend to be infected at a younger age than their White counterparts. According to 2009 data, the largest number of both Black and Latino men who have sex with men who are newly diagnosed were under 30—while the largest number of newly diagnosed White men who have sex with men were between the ages of 40 and 49. (See Figure 4.)

HIV-positive young men who have sex with men are much less likely than members of other groups to be aware that they are living with HIV. While approximately 20 percent of Americans living with HIV do not know their HIV status, nearly 60 percent of HIV-positive young people aged 13 to 24 did not know that they were living with HIV in 2008. Even more concerning were the results of the Young Men's Survey: of the 5,649 MSM respondents aged 15 to 29 who participated, 60 percent of White, 69 percent of Latino, and 91 percent of Black participants who were HIV-positive did not know they were living with HIV.

**What's Behind These Numbers?**

The question of why young MSM of color, and particularly young Black MSM, have become HIV-positive in such high numbers has been the subject of theory and research for more than a decade. In 2007, a meta-analysis of studies published between 1980 and 2006 compared HIV risks between Black and White men who have sex with men across studies. The researchers found that there were no statistically significant differences by race in rates of reported unprotected anal intercourse, commercial sex work, sex with a known HIV-positive partner, or HIV testing history. In addition, Black men who have sex with men reported less overall substance abuse and fewer sex partners than White men who have sex with men. The meta-analysis authors concluded that individual factors (such as the amount of “risky” sexual behavior Black MSM engaged in) did not provide an adequate explanation for the soaring HIV rates among Black men who have sex with men.

In 2010, a critical review of the literature adapted several of the hypotheses from the 2007 meta-analysis, examined how they applied to young MSM (between 13 and 29 years old), and broadened the research to include young Latino men who have
Many of the review findings mirrored those of the 2007 meta-analysis: young Black MSM were less likely to have unprotected anal sex, had fewer lifetime and current sexual partners, and were no more likely to exchange sex for money or shelter than young White MSM. And most of the studies reviewed found that young Black MSM were significantly less likely than young White MSM to use substances (including injection drugs and crack cocaine), while young Latino MSM were less likely or only as likely as young White MSM to use drugs. Similarly, most studies reviewed found that young Latino men who have sex with men were just as likely as young White men who have sex with men to engage in “risky” sexual behavior—such as unprotected anal sex and exchange sex.

Both the meta-analysis and the critical review concluded with a call for research into the role of sexual networks (who has sex with whom, and how all of those people are connected to each other) in HIV transmission among men of various races and ethnicities. Although little research has been done on sexual networks among young men who have sex with men, the critical review did find that young Black MSM were significantly more likely to have sex with partners in a different age group than other young men who have sex with men, and were more likely to have mostly Black partners. Sex with older partners has been associated in some studies with an enhanced risk of acquiring HIV. Given the high prevalence of HIV in Black MSM communities, having mostly Black partners was also considered a risk factor for HIV.

But sexual networks are only one aspect of the larger circle of factors that contribute to disparities in HIV prevalence rates. To get a fuller picture of the factors associated with HIV-related disparities by race, age, and sexual orientation, it is important to examine the influences on young men who have sex with men at multiple levels: individual, interpersonal, communal, and societal. Two models, called the social determinants of health and the ecological model, can help.

The Ecological Model and the Social Determinants of Health

Over the last several years, because individual behavioral explanations alone have proved lacking, the focus has shifted somewhat to a greater interest in the social determinants of health—those social factors that help shape health and illness in a person’s (or a group’s) life. A 2011 review of the literature examined the factors that predicted sexual risk taking in all young men who have sex with men, as well as protective factors for and interventions targeted to these young men. These researchers used...
Bronfenbrenner’s (1979) ecological theory of development to explain how young men who have sex with men are “nested” within different environments, each of which influences their risk for contracting HIV. The model uses a series of concentric circles, with the individual experiences of young men who have sex with men at the center, then their interpersonal relationships (families, sexual partners, friends) in the next layer; outward to the communities to which they belong; and, finally, by the influences of society at large.¹⁵

The ecological model is closely related to the social determinants of health, defined by the World Health Organization and the CDC as “the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.”¹⁶,¹⁷

This approach does not deny the importance of individual behavior, but it does assert that individual behavior occurs within larger contexts that the individual may have more or less control over—and that each layer of the system influences the others (particularly the ones closest to it). For example, racism, homophobia, and classism in the larger society are all “macro-level” factors that can make an individual’s health less of a priority and can have a powerful impact on how a young man who has sex with men is viewed by his communities, his school and family, and his partners—and how he sees himself. Individual factors such as low self-esteem and internalized homophobia can be affected by how a young man’s family and spiritual community receives him (community level), and can impact a young man’s ability to negotiate safer sex or other relationship dynamics with a partner (interpersonal level). Examples of some of these factors are depicted in Figure 5 (page 6).

This “nested” perspective is especially important when discussing young MSM of color for at least two key reasons. Young people rely on...
others in their system (for example, families and schools) even more than older people do. Second, young MSM of color belong to at least three groups that are often marginalized in U.S. society: young people, people of color, and men who have sex with men. This makes them vulnerable to social conditions and negative messaging about themselves at every level that can translate into negative health experiences, including an increased risk of HIV.

**Discrimination, Distress, and Risk**

In 2001, researchers from San Francisco State University published data from a probability sample of 912 Latino gay and bisexual men in Los Angeles, Miami, and New York. They found both comparatively high rates of psychological distress and a strong relationship between psychological distress and reports of social discrimination. From these data came a model of sexual risk that included variables such as economic hardship, and social discrimination including both racial/ethnic and sexual orientation-based discrimination as predictors. Authors found that the psychological distress that these men experienced often led to “difficult” sexual situations that were more likely to expose them to HIV. These situations include sex in relationships with unequal power between partners and sex under the influence of drugs or alcohol.

In 2012, findings from the *Brothers y Hermanos* Study (which included 1,081 Latino and 1,154 Black MSM from Los Angeles, New York, and Philadelphia, and used respondent-driven sampling) revealed that men who had unprotected anal sex with serodiscordant partners (or sex with partners of unknown status) reported more experiences of racism and homophobia than men who did not.

Latino men (but not Black men) also showed a relationship between financial hardship and unprotected anal sex with serodiscordant partners or partners of unknown status. Men having unprotected serodiscordant anal sex also reported a greater lack of social support than men who did not engage in unprotected anal sex with partners of serodiscordant or unknown HIV status. The authors noted that there were important differences between the groups of men sampled—for example, HIV-positive Black MSM behavior was affected more by homophobia, while HIV-negative MSM behavior was affected more by lack of social support, suggesting different intervention strategies for different populations. Nonetheless, the authors concluded that the effects of “macro-level” societal discrimination on the individual could be offset by four activities. These include creating areas where men of color who have sex with men could discuss their experiences; by using interventions that help Black and Latino MSM feel that they are supported by friends and family; by affording greater access to culturally competent sexual health services; and by offering men of color who have sex with men opportunities for social action.

**Community-Level Factors**

Although more research is needed to understand the relationship between community-level factors and HIV risk for young MSM of color, the Centers for Disease Control and Prevention identifies several factors as potentially related to the epidemic in young men who have sex with men. Two of these factors are the failure to reach these young
men with effective HIV prevention interventions in the community and the lack of comprehensive sexual health information in schools that is inclusive of the concerns of sexual minority youth.

Young men of color who have sex with men are the junior members of a minority within a minority, and as such, may be triply disenfranchised—a situation that may not only increase HIV risk, but also reduce the priority of HIV prevention for these youth. Racism within the gay community can add to psychological distress and isolation, and limit choice of sexual partners in a way that may increase HIV risk. At the same time, homophobia within communities of color (and particularly within significant religious institutions) can threaten key ties to social support and survival, and make it more difficult to acknowledge gay or bisexual identity—which can make a conscious thinking through and communication of risk reduction plans more difficult. Rejection by the community (which is sometimes experienced at the interpersonal level as bullying, harassment, family disapproval, and social isolation) can lead to emotional distress in the individual, suicide attempts, substance use, and HIV risk behaviors. In addition, the simple fact that young MSM of color have to deal with potential stigma and discrimination on so many levels—and the practical consequences it entails—may make HIV prevention seem less important. When they do seek services, they are often met with a lack of “youth-friendly” providers in their communities.

**Relationships**

At the interpersonal level, it is not uncommon for young men who have sex with men to have experienced trauma including violence and sexual abuse. A 2006 New York study of MSM aged 15 to 22 found that 68 percent of participants had experienced violence or threats from family members or partners. One-quarter of respondents had experienced violence or threats from both family members and partners.

![Figure 5](image-url)
Such threats and violence were associated with having been forced to have sex at some point and having run away from home. Young men who had experienced threats or violence by family and partners were significantly more likely than other participants to have had recent unprotected anal sex, and to have recently used club drugs. The authors suggest that interventions include not only a focus on reducing behaviors like substance use, but also address violence concerns and other mental health issues as a pathway to reducing HIV risk.\footnote{23}

Research suggests that childhood sexual abuse is more prevalent among young men who have sex with men than it is for young heterosexual men, and that rates of childhood sexual abuse are higher for young Black and Latino MSM than for young White MSM.\footnote{13, 24, 25, 26, 27} Further, a history of child sexual abuse is significantly associated with sexual risk behavior that can lead to HIV infection.\footnote{13, 28} It is unclear at this point why young men who have sex with men in general, and young Black and Latino MSM in particular, are so often victimized in this way.

As young men who have sex with men begin to choose their sexual partners, many become involved with men who are somewhat or significantly older. According to data published in 2011 from the \textit{Brothers y Hermanos} study, Black and Latino men who have sex with men who had older partners reported a higher prevalence of unprotected receptive anal sex, and had increased odds of having unrecognized HIV infection.\footnote{29} Further research might determine the links among these variables (for example, attitude toward risk taking or power dynamics in the relationship) that could be at play for younger men in partnerships with older men.

Families are the primary sources of support for children and adolescents, and interventions in the family system can facilitate the resiliency of both young people and their families. Over the past few years, partly in response to concerns about bullying of and suicide among sexual minority teens, there has been heightened attention on the importance of family support for sexual minority teens. According to the 2010 critical literature review cited above, young MSM who were rejected by their families were significantly more likely to have unprotected anal sex and use substances than those who were not rejected by their families. But research data are mixed as to whether Black and Latino families are any less accepting than White families of their children’s sexual orientation.\footnote{13} The Family Acceptance Project of San Francisco State University has done groundbreaking work to partner with families of sexual minority youth to increase family support (through education, counseling, and crisis support), and thus decrease the risks that come with family rejection, including homelessness, substance abuse, suicide, and HIV.\footnote{30} Since families are the primary sources of support for children and adolescents, interventions in the family system can foster both youth and family resiliency.

\section*{Adopting a Strengths-Based Approach}

Taking stock of the multiple layers of interpersonal, community, and social/cultural factors that contribute to HIV risk and poor health outcomes among young Black and Latino men who have sex with men can be overwhelming, and it can be difficult to know where to start to address the negative impact of these factors. And although it is true that research suggests that individual behavior should not be the only focus of HIV intervention strategies, HIV counseling, testing, and linkage offers an opportunity to intervene on an individual level in a powerful way. Using a “strengths-based approach” can help counselors acknowledge some of the social and environmental factors that contribute to HIV risk, and develop interventions that address these factors in a way that is empowering for young men who have sex with men.
factors that may be contributing to their clients’ risk for acquiring HIV, while at the same time identifying the unique coping skills, talents, and abilities of the clients who are testing.

The way that counselors ask questions in the session often determines if the assessment will focus on the client’s strengths or challenges (or a combination of the two). For example, asking a client, “Why don’t you use condoms every time?” or “Why don’t you ask your partners their status?” can be perceived as focusing on deficits in the client that the counselor has identified. Asking “What would you like to see different about this situation?” (which engages the client’s ability to positively imagine the future, and emphasizes that you, the counselor, believe the client can change). Asking “Where can you get support for [the risk reduction step you are identifying]?” or “You mentioned that you were going through a rough time in school last year. How did you get through that?” can help guide the session toward identifying (and making plans to build on) the client’s existing strengths and sources of support, and lead to concrete plans to build on both interpersonal and community strengths. The second article of this issue, “What Works?” lays out some effective tools for intervening at the individual, interpersonal, and community levels.

Client-centered counseling skills, such as affirmations and reflections, can be especially helpful in bridging the gap between the challenges a client has faced and the strengths that brought him in for testing. We may want to affirm clients for coming in to test, and it is tempting to say things like, “I’m so glad you came in,” which focuses on the counselor’s emotional reaction to the client’s behavior. In contrast, saying, “You had to take the bus across town, but you made it. Staying on top of your health must be really important to you,” identifies qualities of strength in the client (health is important to him; he persevered despite obstacles; he is able to do difficult things)—that can also underpin a risk-reduction plan and plans to maintain his health. Effective HIV counseling, testing, and referral is always about working in partnership with the client.

Recognizing the client as the key decision maker in his or her own life is an inherently empowering intervention.

What Can Counselors Do?

In addition to adopting a strength-based perspective as described earlier, there are a number of strategies that HIV test counselors can employ to engage and empower young men who have sex with men of color. These strategies can be divided into five areas: homework for you prior to counseling; recognizing the individuality of clients; respecting your client’s priorities, feelings, and experiences; linking your client to resources; and taking care of yourself.

Educate Yourself—Do Your Homework. Educate yourself about the impact of HIV on these communities of young men. Consider ways to use the brief intervention of test counseling to create a positive impact. Understand the role that social determinants play in facilitating risk and creating barriers to health. Learn about the multiple layers of stigma and oppression that many individuals face and how these layers may make HIV prevention more difficult.

At the same time, each session with a client is a learning experience—don’t be afraid to ask what he means if he uses an expression you don’t understand.

Recognize the Individuality of Clients. Remember that the person you are counseling is an individual. Although it is important to understand the influence of social determinants, your session should respond to your client’s particular concerns. Likewise, although this issue sometimes talks about “young Black and Latino men who have sex with men” as if they were a single group, there are tremendous individual and group differences within and between these communities. As part of individualizing the session, talk with
the client about his motivation for testing. Whether it is this young man’s first test or his 50th, acknowledge that testing means that he is taking control of his health in an important way. Explore why this is important to him, and what else he might like to do to maintain his health.

Create a testing atmosphere where his needs are respected and his feelings and experiences honored. When you do this, you make it more likely that he will feel comfortable testing again, and that he will regard the health care system as responsive to his needs. Creating a welcoming, supportive, respectful environment for clients helps reduce barriers to care and thus health disparities. Part of this is to be careful not to talk down to him if he’s considerably younger than you, or assume that he should listen to you because you are older.

Examine your own assumptions and reactions. For example, notice if you have become fatalistic. Sometimes counselors fall into assuming that it is only a matter of time before some young men become HIV-positive, because the prevalence in their communities is so high. It is important to balance a realistic understanding of some of the potential obstacles to health with a belief that behavior change is possible and (at least in terms of incremental harm reduction steps) can be successful in reducing risk. It is important that you let him know that you respect and support his ability to maintain his health, and that you want to help him explore the ways he wants to do that. Recognize any frustration you may have with a younger client’s resistance to change, including any resistance that is based on his belief that he is immortal; or conversely, based on his fatalism about avoiding HIV.

Make good referrals. Recognize that you are a crucial link in connecting young men who test HIV-positive to medical care and other supportive services. Health disparities exist not only in who is at risk for acquiring HIV, but in the care that people do or don’t receive once they test positive. By doing everything within your role to link all of your HIV-positive clients to care, you can help reduce the disparities in care and treatment that young Black and Latino MSM often face. This supports the health of these young men, and also is an important step in reducing transmission in the community. Know your community and make appropriate referrals for your HIV-negative clients as well. Where do young MSM of color socialize and get support in your area? With which communities does the individual you are counseling identify? Help him connect to supportive services that he believes would find helpful. Among the referrals to consider, when appropriate: testing for sexually transmitted infections. Screening for and treating these is a crucial part of HIV prevention. It helps HIV-negative clients to stay negative, and it helps reduce the potential for transmission of HIV in clients who are HIV-positive. In addition, treating STIs helps support the health of all clients, of whatever HIV status.

Take care of yourself and avoid burnout. You can help to do this by trusting the process, and using your rapport-building skills, but not expecting magic. HIV counseling and testing is a brief intervention, where your conversation may plant a seed that can support the client in making the changes he wants to make. Remember that just as people who are living with multiple layers of stigma and oppression can sometimes be overwhelmed by these circumstances, so too can counselors feel overwhelmed, and that their own efforts do not make a difference. Remember that your limited role can still have an important impact.

Conclusion

The rates of HIV infection for young Black and Latino men who have sex with men in this country remain alarmingly high. Although we still do not have a complete understanding of all of the factors that have led to the disturbingly high prevalence of HIV in these communities, it has become clear that individual behavioral choices are not the only contributor driving these numbers. The
multiple layers of stigma and other social and cultural factors that shape these young men’s experiences must be examined and addressed as part of a comprehensive intervention strategy to reverse this trend. HIV test counselors, who primarily work on the individual-level intervention of counseling, testing, and referral, nonetheless have a key role to play in countering the negative messages these young men often receive and forging a relationship with them that supports their efforts to maintain optimal health.

What Works?

Even though we need more research to explain the high rates of HIV among young Black and Latino men who have sex with men and to demonstrate effective interventions for these groups, there are some interventions that promise to empower young men to reduce HIV risk-related behaviors and take charge of their health. Among those are eight that may be particularly effective in working with young Black and Latino men who have sex with men:

- **MPowerment** is a community-level intervention for young MSM between the ages of 18 and 29, and has been used with young men from diverse backgrounds. A core group of 12 to 20 young men who have sex with men carry out all the program activities. The focus is on increasing HIV testing and decreasing sexual risk behavior through the use of informal (discussions within social networks) and formal outreach (educational and social events), discussion groups, and social marketing. Participants can be HIV-negative, HIV-positive, or unaware of their HIV status. Research suggests that the intervention has helped participants significantly decrease their rates of unprotected anal intercourse. This intervention was revised and updated in 2010 to include lessons learned through work with young gay men of color.\(^3\)

- **d-up: Defend Yourself** is a community-level intervention for Black MSM. It is an adaptation of the Popular Opinion Leader (POL) intervention, which uses key informants and systematic observations to understand the target population’s social network and identify opinion leaders in that community. These opinion leaders are then taught skills that help them to promote social norms of condom use within their social networks, and to assist other Black MSM in recognizing and handling risk-related racial and sexual bias. Research suggests that the intervention has helped participants to have less unprotected anal sex (both insertive and receptive), use condoms more consistently, and decrease the number of partners with whom they had unprotected anal sex.\(^3\)

- **Many Men, Many Voices (3MV)** is a seven-session, group-level intervention for gay men of color (including Black and Latino MSM, though it has been mainly used with Black participants). It addresses behavior-influencing factors including cultural and social norms, and the dynamics of sexual relationships. The exploration of the social influences of racism and homophobia includes an understanding of the tension between racial/ethnic identity and gay identity. It is appropriate for both men who identify as gay or bisexual and those who do not (but have sex with men). Research on the original intervention, which included 12 75- to 90-minute sessions, suggested that it helped participants reduce their frequency of unprotected anal sex, and increase their use of condoms more than men who were not in the intervention.\(^3\)

- **Personalized Cognitive Counseling (PCC)** is an individual-level, single-session counseling intervention to reduce unprotected anal sex among MSM who are repeat HIV-testers, and who have had unprotected anal sex with a man who is not their primary partner (and whose HIV-status was unknown or positive) since their last HIV test. PCC focuses on the self-justifications (thoughts, attitudes, and beliefs) the man has used when deciding whether or not to engage in unprotected anal sex. PCC is a 30- to 50-minute intervention conducted as a component of Counseling, Testing, and Referral Services for MSM who meet the screening criteria. Research suggests that the intervention helped participating men to reduce the number of times they had unprotected anal sex.\(^3\)
Community PROMISE (Peers reaching out and modeling intervention strategies) is a community-level HIV and STD intervention that can be used within any target population. It has been tested with at-risk youth, MSM, and Black and Latino communities. Based on behavioral theories including Stages of Change, it relies on role model stories and peer advocates from the community. The original research establishing PROMISE as an effective intervention suggested that participants moved toward consistent condom use, carried condoms more often, and were more likely to use bleach to clean their works.

Partnership for Health (PfH) is a brief, clinic-based, individual-level intervention for HIV-positive patients. It is designed to improve patients’ communication with their providers about safer sex, disclosure of HIV serostatus, and other ways of preventing HIV transmission. The goal is to increase HIV-positive patients’ knowledge, skill, and motivation to practice safe sex. A key aspect of the intervention is extensive staff training so that they can create an environment where prevention is a critical component of patient care. All staff are included in the intervention, and the media and messaging in the clinic reinforce this message as well. Research on the efficacy of the intervention suggested that patients who had two or more sex partners or at least one casual partner and who received “consequences-framed messages” were significantly less likely to have unprotected anal or vaginal sex.

Popular Opinion Leader (POL) is a community-level intervention that identifies, recruits, and trains individuals who are trusted, influential members of their communities to encourage safe sex norms and behaviors within their social networks of friends through risk reduction conversations. POL can be used with various populations, including Black people, MSM, Latinos, youth, and people of differing HIV-statuses, in a variety of settings.

Project Start is an individual-level, multi-session intervention that uses the Incremental Risk Reduction framework. It is designed for any individual who is being released from a correctional facility and is returning to the community. The same staff member continues sessions with the client once the individual returns to the community. The intervention is meant to increase the client’s awareness of their HIV, STI, and hepatitis risk behaviors and provides them with tools to reduce those risks. In the original research on this intervention, fewer men reported unprotected sex six months after release from the correctional facility.

What Else Is Being Done?

In 2010, the CDC released The Adaptation Guide: Adapting HIV Behavior Change Interventions for Gay and Bisexual Latino and Black Men. This resource is designed to help local agencies serving Black and Latino men who have sex with men to select and adapt effective interventions that they believe will be a good fit with their target communities, including young men who have sex with men.

Among the initiatives to address the needs of young MSM of color in particular, in September 2011, the CDC awarded $55 million to 54 community-based organizations (CBOs) throughout the U.S. (including CBOs in Oakland, San Diego, and Los Angeles, California). These monies are being used to expand HIV testing, linkage to care, and other prevention services for young men of color who have sex with men and their partners, as well as another at-risk sexual minority: young transgender people and their partners.

Media campaigns to encourage HIV testing and increase pride in being a young MSM of color as a community norm are also underway. The CDC’s “Testing Makes Us Stronger” campaign, for example, is aimed at Black gay and bisexual men between the ages of 18 and 44, and includes images of younger Black MSM in banner ads and posters. This campaign was developed as part of the CDC’s “Act Against AIDS” initiative. Black gay and bisexual community leaders throughout the country worked with the CDC to help develop the campaign, whose ads have been featured in both national and local print media, as well as websites and outdoor media, with an emphasis on key cities currently experiencing high levels of HIV infection in Black gay and bisexual men.

Southern California health care provider AltaMed offers another example of a media campaign for community engagement: the web series “Sin Vergüenza” (Without Shame). The series employs a traditional
telenovela (soap opera) to encourage people to test as a routine part of their medical care and to seek HIV medical care should they test positive. The story, available in Spanish or English, follows characters that include both an openly gay young man, Enrique (actor JM Longoria II, pictured above), who is a law student in a supportive partnership, and another family member who is hiding his sexual relationships with men.

On the testing front, the CDC is currently near the end of the three-year Expanded Testing Initiative to increase HIV testing among Black Americans. The initiative includes 30 health jurisdictions nationwide and focuses on increasing HIV testing among African Americans and Latinos, and men who have sex with men and injection drug users of all races and ethnicities. Funding for the program was increased from $36 million per year to more than $50 million per year.

What Still Needs to Be Done?

Despite these efforts, much remains to be done to address the health and HIV prevention and care needs of young MSM of color at all levels of intervention—individual, interpersonal, communal, and societal.

Part of what underpins these efforts is sufficient research to guide interventions. Currently, there are a mix of definitions of who “young people” are in the literature, including adolescents, minors, people between 13 and 25 years old, and sometimes even people in their late 20s. Acceptance of a greater uniformity of age categories in research would facilitate the comparability of statistics.

In addition, our understanding is hampered by the fact that it is difficult to study MSM of color under 18 years of age, and as a consequence, most research has been done on young men who have sex with men over the age of 18. As Brian Mustanski points out, this is problematic for many reasons. The developmental changes that occur at 18 are significant, often including leaving a parental home, and thus changing the degree of parental influence; cognitive changes that increase a young person’s capacity for self-regulation; and the differential effects of substances on the under-18 brain. Mustanski argues that it is not sufficient to ask older “young” people to recall their lives before 18 because such recall is often biased, and even if it were accurate, changes in social and cultural attitudes toward homosexuality mean that the retrospective experiences of those over 18 may not match the current reality of those under 18. Thus, despite the obstacles to their inclusion, Mustanski calls for the inclusion of young MSM participants under the age of 18, and to strive for samples of greater size and representativeness.

In addition to the Effective Behavioral Interventions (EBIs) that are already being employed in prevention and care work with young Black and Latino men who have sex with men, most of which were originally studied on other populations (for example: older MSM, Black heterosexuals, White MSM). More specialized interventions must be developed specifically for and demonstrated effective with young Black and Latino men who have sex with men. For more information about interventions with young people by population (gender, race/ethnicity, sexual orientation, age), visit the National Resource Center for HIV/AIDS Prevention Among Adolescents, at https://preventyouthhiv.org.

References for This Issue


Test Yourself

Review Questions
1. **True or False:** It is estimated that in 2008, approximately half of the young people living with HIV did not know their status.

2. The article refers to a 2007 meta-analysis. According to this research, Black MSM are more likely than White MSM to engage in which of the following behaviors? a) Unprotected anal intercourse; b) Commercial sex work; c) Test less often for HIV; d) Sex with a greater number of partners; e) None of the above.

3. Which of the following is NOT a finding from the Brothers y Hermanos study? a) Men who engaged in unprotected anal sex with serodiscordant partners reported greater experiences of racism and homophobia and a greater lack of social support than men who did not; b) Latino men showed a relationship between financial hardship and unprotected anal sex; c) Black and Latino MSM who had older partners reported less prevalence of unprotected receptive anal sex; d) The behavior of HIV-positive men was more affected by homophobia than that of HIV-negative men; e) The behavior of HIV-negative men was more affected by lack of social support than that of HIV-positive men.

4. At the community level, young MSM of color typically face which of the following? a) Racism in the gay community; b) Homophobia within communities of color; c) Lack of comprehensive and inclusive sexual health information; d) All of the above.

5. The idea that individual behaviors are influenced by interpersonal relationships, communities, and society is consistent with: a) The ecological model; b) The social determinants of health model; c) Both the ecological and social determinants of health models; d) Neither the ecological nor the social determinants of health models.

6. **True or False:** young men who have sex with men who have had traumatic experiences of violence or sexual abuse from family members and/or partners are significantly more likely than those who had not to have had recent unprotected anal sex and drug use.

Discussion Questions
1. What do you feel are the most crucial interventions for preventing HIV among young Black and Latino men who have sex with men? What level would these interventions occur at—individual, interpersonal, community, or societal?

2. What Evidence-Based Interventions are available in your agency or your community targeting young men of color who have sex with men?

3. How can counselors balance an understanding of some of the Social Determinants of Health that may be influencing their clients’ behaviors and experiences with an individualized approach to the counseling process?

4. How do you incorporate a “strengths-based approach” into your test counseling sessions?

Answers
1. True
2. c.
3. c
4. d.
5. c.
6. True