Sex Res Soc Policy (2016) 13:202–214
DOI 10.1007/s13178-016-0219-z

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Sexual and Gender Diversity Within the Black Men Who Have Sex with Men HIV Epidemiological Category

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Published online: 10 February 2016
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Abstract Epidemiological categories not only reflect existing frameworks for public health, but also reify how subpopulations are defined, understood, and targeted for interventions. The sweeping categorization of Black men who have sex with men (BMSM) used in HIV research and intervention work is one such example. The current paper builds upon previous critiques of the "MSM" nomenclature by delineating the sexual and gender diversity embedded in the term as it pertains specifically to Black peoples. The emphasis is on developing greater specificity about the sociocultural and structural factors that may be shared among these subgroups, such as racism and poverty, and the factors that are likely to distinguish the groups, such as levels of sexual minority identification; access to lesbian, gay, bisexual, and transgender (LGBT) services and community; and experiences with anti-bisexual or anti-transgender bias. The aim then is to provide a framework for HIV health policy work for Black sexual minority cisgender men (SMCM) and gender minorities (GMs).

Keywords HIV · Sexual and gender minorities · African American

Introduction

As an epidemiological category, Black men who have sex with men (BMSM) have remained the most significantly impacted group by HIV/AIDS in the USA throughout the epidemic. This is a group that represents only 0.2 % of the US population[1] and yet comprises approximately 22 % of all HIV cases (CDC 2012a). The sexual behavioral category with the highest rate of HIV is MSMs, and rates of HIV infection among young Black MSM (13–24 years) in particular are up to 2.5 times higher than what is found among young MSM of other ethnic groups (CDC 2012b). To date, the rates of new infections among BMSM are not declining. Multiple scholars and advocates have written about the need to address structural determinants of the HIV epidemic among Black sexual minority men in the USA for decades as a way to address the failures of individualized approaches (Mays et al. 2004; Peterson and Jones 2009; Robinson 2012; Bruce and Harper 2011). As part of this body of work, a few have noted that one problem is the use of the term "MSM" itself (Boellstroff 2011; Harper 2007; Reddy 2005; Young and Meyer 2005). The argument in this paper extends that area of critique and research further by focusing on the ways that the lack of differentiation among subgroups of BMSM impedes our ability to understand the varying levels of risk at the intersections along the axes of sexual and gender identity and how risk changes with various structural and sociocultural conditions.

The aim here is to provide a framework for health policy work directed at addressing the HIV/AIDS epidemic for Black sexual minority cisgender men (SMCM) and gender minorities (GMs). We define sexual minorities to include individuals whose sexual identity, attractions, or behavior differ from the US heterosexual norm and GMs to include individuals whose gender identity and expression do not fall within a masculine/

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[1] Based on unpublished analyses of Gallup Poll data estimating the population of Black gay and bisexual identified men by Angeliki Kastanis and Gary Gates (2015), conducted upon request of first author. These data do not include those that engage in same sexual behavior or have same sex attractions but do not identify as LGBT.

feminine binary or those whose current gender identity is different from their sex assigned at birth. We do this by examining what is meant by the term or category "BMSM" with regard to sexuality and gender and through identifying the potential subpopulations that have been historically included and excluded, intentionally or unintentionally. Our objective in specifying the (often implicit) relevant subgroups under the BMSM rubric is to provide a lens for thinking through potentially similar and different mechanisms among subgroups which may affect HIV/AIDS rates and inform HIV prevention and treatment strategies. The more we understand the underlying mechanisms with specificity to the subgroups, the more tools we have available for thinking through solutions to the epidemic. The goal of this paper is to identify a framework to pull apart the BMSM category.

A Revised Framework for Understanding the BMSM Category

Clarifying the multiple subgroups of BMSM is the first step to identifying subgroup-specific factors affecting HIV transmission. There are contextual factors impacting HIV risk, prevention, and treatment such as racism, poverty, and gender expression that are likely to be shared across many Black males and Black individuals assigned male at birth (MAB) and yet that there is a need to identify where the groups may differ. We could splice the ambiguous BMSM category into many types of subgroupings—for example, along lines of age, class, geography, musical and fashion subcultures, etc. However, we propose starting with an analysis using the definitional language of sexuality and gender embedded in the term MSM.

The challenge to delineating subgroups of BMSM is that in trying to define them, we are quickly confronted with a set of implicit cisgender and heteronormative assumptions that historically underlay the BMSM terminology. Who counts as a man in the subject (B<u>M</u>SM) or object (BMS<u>M</u>) of the term? Is manhood or maleness defined genetically, physiologically, psychologically, or socially? What kind of sex matters? Does a penis have to be involved in the sexual act? Does the involved penis have to produce seminal fluid? Is the issue purely sex or does the existing potential for relational and emotional attraction matter? Though rarely explicitly explained, the unspoken answers to these questions have informed who has been studied and targeted for HIV preventions under the BMSM rubric. Historically, HIV prevention practice and research among those labeled BMSM would suggest that the term has been used to represent anyone who was assigned MAB and has or could have sex involving a penis that releases seminal fluid with another person assigned MAB. Summing up this implicit definition, anthropologist Boellstroff (2011) argues the following:

> … as originally formulated the MSM category took the constituent terms "men" and "sex" as stable and self-evident. The notion of "men who have sex with men but do not identify as gay" treats identity as a social construction, but reifies "men" and "sex" as prediscursive, conflating sex with penetration (above all, anal–penile intercourse) and maleness with biology. (p. 294)

The implicit working definition of who "counts" within the term is evident in the dominant focus of BMSM-related HIV research and prevention efforts on sexual minority men who are assumed to be cisgender (as seen in the absence of discussion and measurement of transgender men in the writings and data on this group), as well as a minor focus on transgender women who have been traditionally included (incorrectly so) in this category because of their sex assigned at birth. Further, the emphasis on the sexual act as a mode of transmission rather than an emphasis on identity implicitly conveys that the potential for or interest in emotional and relational attraction to men and the meaningfulness of social, political, and sexual communities are not significant to how we think about HIV risk among Black SMCM and GM.

Prior reviews and critiques of the MSM terminology have aptly highlighted the problems created by it, including (1) reduction of sexual experience to sexual behavior, (2) disrespect of people's chosen sexual identities, and (3) lack of attention to the communities and cultures in which gay, bisexual, and other sexual minority men participated (see, Boellstroff 2011; Harper 2007; Reddy 2005; Young and Meyer 2005, for both genealogy of the term MSM and critiques of its broad usage). The aim of the current paper is not to review the existing critiques, but to propose a framework for how to address these critiques through use of a specific lens. Namely and specifically in the context of the BMSM rubric, we offer a way to think through the diversity of lived experience and HIV risk among those that have traditionally or could possibly be included in this group. By explicating the variability in gender, gender expression, sexual identification, and participation in sexual minority communities between possible subgroups that have been or could be categorized under the term BMSM, we aim to provide a useful heuristic for research and intervention that takes cultural and contextual differences and similarities between subgroups into consideration (see Fig. 1). While we expect that several of the resulting subgroupings reviewed would apply to other ethnic groups of MSM, we err toward ethnic specificity as research on any of these gender/sexuality subgroups has specific historical, cultural, and structural dimensions to them. We provide a review of what we know about HIV-related factors in the context of this gender and sexual diversity. In doing this, we further highlight the framing

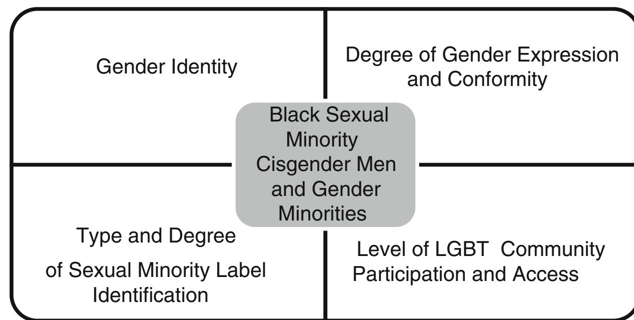

Fig. 1 Black sexual minority cisgender men and gender minorities: intersections of sexual and gender diversity

problem created by the over reliance on this BMSM schema, demonstrating that the simple terminology has run its course. It fails to describe a population that we now understand to be quite diverse, particularly at the intersections along the very axes of gender and sexual identity and behavior that construct the literal term.

Shared Structural Factors Among Black Sexual Minority Cisgender Men and Transgender Women and Men

There are several common factors relevant to rates of HIV transmission that have been identified across all US subpopulations in previous reviews (Kalichman et al. 2005; Rotheram-Borus et al. 2009). Relevance of these factors for MSM generally can be found elsewhere (Global HIV Prevention Working Group 2008; Stall 2007), including important critiques of the field's heavy reliance on individually focused efforts at impacting change in social cognitive factors to decrease HIV infection in general (DiClemente et al. 2007; Glass and McAtee 2006; Peterson and Jones 2009; Schensul 2009) and among Black MSM in particular (Peterson and Jones 2009; Williams et al. 2009). The critiques of those models tend to center on the limitations of individual-level interventions in demonstrating reductions in community-level HIV rates and that such efforts fail to account for the larger social and structural factors which impact HIV risk, such as racism and socioeconomically related health disparities. Given the high rates of HIV and problems observed with individualized approaches, a need for an examination and attention to structural and sociocultural factors impacting HIV/AIDS among BMSM has been highlighted (Peterson and Jones 2009; Williams et al. 2009). As such, we begin by recognizing that there are likely a number of structural factors shared among Black sexual minority cisgender men (SMCM) and gender minorities (GMs), namely racism and poverty.

Racism

Among the multiple extra-individual-level factors impacting HIV transmission rates among Black peoples, the structural interlocking systems of racism and poverty stand out as significant meta-factors. Systemic racism and its interpersonal forms of minority stress are likely to be a factor in the overall health and HIV risk of Black SMCM and GM. Theoretical and empirical research has indicated several pathways along which racism creates risks of HIV transmission among Black people in the USA more broadly, including through reduced access to health care (Robinson 2012). Others have demonstrated the effects of race- and sexuality-related minority stress on HIV risk behaviors among socio-economically diverse samples of Black and other sexual minority people of color by way of increased psychological distress and participation in sexually risky behaviors (Díaz et al. 2004; Han et al. 2015; Hamilton and Mahalik 2009; Hatzenbuehler et al. 2008; Logie et al. 2011).

With regard to Black SMCM and GM, previous research has demonstrated experienced racism not only within the larger society, but also within LGBT communities (Choi et al. 2011). Black SMCM and GM participation in predominantly White LGBT communities is complicated by a long history documenting the racism experienced by Black LGBT people in these settings (Bérubé 2001; Han 2008; Teunis 2007). A recent study of sexual minority men of color found that 70 % of participants reported experiencing racism in the gay community while only 57 % reported experiencing racism within the general community (Choi et al. 2013). This has led some individuals to disassociate from social settings identifying with mainstream gay culture (Han et al. 2015). Though many Black sexual minority men, as well as Black transpeople across sexual orientations, form communities composed of people of these racial, sexual, and gender intersections (see, e.g., Meyer and Ouellette 2009; Wilson and Miller 2002), many still continue to interact with the dominant LGBT community spaces and organizations which tend to be predominantly White, thereby exposing them to LGBT racism and its effects within the communities assumed to be valuable resources in coping with sexual and GM stress.

Poverty

Globally and nationally, HIV rates have been strongly correlated with poverty. Structural pathways to HIV transmission rates include many of the risk conditions associated with poverty, such as incarceration rates, poor housing, and lack of access to quality health care (Russell et al. 2012). In the USA, Black men disproportionately experience poverty and economic instability compared to men of other ethnic groups. This racial disparity pattern persists among sexual minority Black men. For example, African American male same-sex couples were found to have lower incomes, lower college

completion rates, and higher unemployment rates compared to White and Asian/Pacific Islander male same-sex couples in a population-based survey (Kastanis and Wilson 2014; Kastanis and Gates 2013). Black male same-sex couples experience these same disparities when compared to Black men in different-sex couples, indicating that as both racial and sexual minority men (ibid), they are uniquely vulnerable to poverty and economic instability. The research on economic instabilities among Black sexual minority men has been limited by a lack of measurement of transgender status and implicitly refers to cisgender men only, as seen through the lack of acknowledgement of transgender identities. Research with Black transgender women and men also indicates that poverty is a major issue to consider in the context of HIV risk, prevention, and treatment. Structural discrimination in housing, employment, education, and health care contributes to high rates of poverty among transgender women (Miyashita et al. 2015; Operario and Nemoto 2010), which leads many transwomen to engage in sex work for economic reasons, which is then related to elevated HIV risk. Another study identified higher rates of poverty among Black transmen and transwomen compared to other ethnic groups in the study (Grant et al. 2011).

Differences in Structural and Sociocultural Factors Necessitating Revision of the BMSM Frame

Gender Identity, Expression, and Conformity

The literature on HIV and BMSM is rarely explicit about the precise gender identity, gender expression, and levels of gender conformity of their research participants. Yet, gender and all its dimensions are core components of the concept of MSM and a lack of examination of this component has historically led to the inclusion of people who do not fit the term, exclusion of those who do, and near silence around the significance of gender conformity in HIV risk.

Until 2011, Black transgender women who have sex with men were classified as BMSM in CDC HIV surveillance. Though the CDC began to include transgender identity separately in HIV surveillance data collection (Cahill et al. 2013), HIV surveillance data among transgender women are not yet consistently tracked across state and local health departments (CDC 2015a, b). Nonetheless, preliminary research currently indicates that Black transgender women have especially high rates of infection, both when compared to cisgender males and transwomen of other ethnic groups (Baral et al. 2013; Herbst et al. 2008).

There are a few factors that have been identified which are likely connected to observed HIV disparities among Black transwomen that are relevant to consider as HIV risks and in the process of designing interventions. Structural discrimination in housing, employment, education, and health care contributes to high rates of poverty among transgender women (Miyashita et al. 2015; Operario and Nemoto 2010), which leads many transwomen to engage in sex work for economic reasons (Herbst et al. 2008; Wilson et al. 2009). In studies of adult and youth transgender women, most of whom identified as African American, participants reported that condom use was affected by pressure from their partners and concerns about losing partners that validated their gender identity (Garofalo et al. 2006; Poteat et al. 2016). More work in this area is needed to better understand this group that was previously miscategorized into the BMSM category, including research on the experiences and behaviors of the sex partners of transgender women (Operario et al. 2008a, b). De Santis notes that existing research studies "have not successfully explained the attitudes, behaviors, or social dynamics that contribute to the increased risk for HIV infection in ethnic minority transgender women" (2009, p. 370). Additionally, applying the currently proposed framework would include attending to the intersection of sexual and gender identity by examining how HIV rates and risk factors vary with regard to the sexual orientation and gender identity of sexual partners of Black transgender women (see, e.g., Poteat et al. 2016).

Unlike Black transgender women who had for decades been incorrectly included under the BMSM category, Black transgender men who have sex with men meet the literal criteria of the terminology but are almost never considered a part of the targeted BMSM population. This may be in part because it has been historically assumed that transgender men only have sex with cisgender women who identify as lesbian or bisexual (Kenagy and Hsieh 2005). HIV studies that have included transgender men have either not identified the gender of participants' sexual partners or have samples primarily composed of heterosexuals (Sevelius 2009). Although what is known about HIV prevalence and risk among transgender men indicates relatively low HIV rates (Operario & Nemoto), some transgender men may take part in high-risk behaviors.

While not specific to Black transgender men, several qualitative studies have begun to study HIV risk among transgender men who have sex with non-transgender men (Kosenko 2011; Rowniak et al. 2011; Sevelius 2009). In one such study, adult transgender men were asked about HIV-related risks and protective behaviors. Participants reported inconsistent condom use during receptive vaginal and anal sex with non-transgender men (Sevelius 2009). Their ability to negotiate HIV risk taking was affected by alcohol and drug use driven by anxiety about their bodies, behavior to seek affirmation of their gender identity through sex with non-transgender men, and to unequal power dynamics in their relationships. Another study identified themes within the experiences of transgender men situated in the gay community which includes many factors that can increase vulnerability to HIV risk (Rowniak et al. 2011). These include the dynamics between gay-identified transgender men and non-transgender male

partners, underlying assumptions about risk by both parties, the impact of testosterone used in the transgender man's transition, and sex work (Rowniak et al. 2011). Again, while overall rates of HIV among Black transgender men seem to indicate that they are likely a low HIV-risk subgroup, only improved HIV surveillance that distinguishes gender identity of both the men being surveyed and the transgender or non-transgender status of their sex partners can assess the accuracy of these assumptions and also identify subgroups of Black transmen that may have elevated risk.

Some of the factors relevant to HIV risk among transmen, as well as among Black SMCM, highlight the significance of not just gender identity, but gender expression and levels of gender conformity in HIV/AIDS research, policy, and practice. Gender expression includes how an individual sees their own mannerisms and appearance with regard to dominant notions of masculinity and femininity, as well as how others might see them. Gender conformity is how closely a person behaves or appears in line with dominant gendered expectations for their sex assigned at birth. By nature of their transgender status, Black transgender men and transgender women can be considered gender nonconforming due to resisting the gender expression expectations for their sex assigned at birth, regardless of whether they are highly gender conforming in the relationship to their current gender identity. Gender expression and levels of conformity for Black cisgender men may also be relevant to examine HIV risks and interventions.

Black SMCM and GM in the USA have all at some point in their life had to negotiate a set of dominant masculinity expectations, and further, this dominant masculinity ideology has been identified by other scholars to have unique racial characteristics (West and Zimmerman 1987; Connell 1995; Courtenay 2000; Lemelle and Battle 2004; Wilson et al. 2010). The expectation to conform to a socially imposed Black masculine ideal in a partner can lead to choices to engage in high-risk behavior, such as not using a condom as a receptive partner because the insertive partner does not want to, in the interest of keeping the status of being with highly masculine sex partners (Malebranche 2003). The preference for Black masculine cisgender male partners has also been documented among Black transgender women (Poteat et al. 2016). These types of race-specific masculinity expectations are likely to be experienced across several subgroups that have historically fallen under the term BMSM, though in distinct ways.

Sexual Identity and Levels of Sexual Minority Community Participation

Embedded in the term MSM is the concept of sexuality, and as noted in the review of the origins of the category, explicit in, it is the assumption that sexual identity is less relevant than sexual behavior in the context of HIV. Among cisgender Black men[2] engaged in same-sex sexual behavior, the spectrum includes sexual identities whose variability has potential significance for how we think about HIV risk and interventions. The extent to which they identify with a sexual minority and adopt a mainstream versus other type of sexual minority identity label and whether they socially or politically participate in sexual minority communities are relevant distinguishing factors with implications for known HIV rates, HIV risk behaviors, and intervention development.

When discussing BMSM who do not identify with any sexual minority label such as gay or bisexual, a range of terms have been used, including men on the down low or "DL," non-gay-identified (NGI), and closeted (Malebranche 2008; Mays et al. 2004). DL is a highly contested term used to refer someone being very discreet about their homosexuality or same-sex sexual behavior. In popular culture and in many public health circles, it is used in a relatively negative way and conjures the image of a traditionally masculine man who engages in sex with women and men, but only publicly acknowledges their sexual relationships with women. Some research has indicated that BMSM and other men of color are less likely to identify as gay or bisexual and more likely to identify as DL, than White MSM (Wolitski et al. 2006). Yet, it is unclear how much race-focused public discourse on the term DL has influenced the adoption of this label among Black men as an actual label. Further, the very term, DL, as it is relegated primarily to Black males, is inseparable from US racism and tendencies to stigmatize Black male sexuality (D'Emilio and Freedman 1997; Lewis and Kertzner 2003; Malebranche 2007). Further, a recent population-based survey suggests that Black or African American people in the USA identified as LGBT at higher rates than other ethnic groups (Gates and Newport 2013), which complicates popular assumptions about rates of gay, bisexual, and lesbian identification among African Americans.

With regard to the relationship between HIV risk and not claiming a sexual minority label, there is a lack of consensus on whether observed differences in gay or bisexual identification matters for HIV risk (Bond et al. 2009; Millett et al. 2006; Peterson and Jones 2009). Therefore, there is no resolution on whether identification with a sexual minority identity, like gay or bisexual, is related to more HIV risk, nor is it clear that Black SMCM are more or less likely to identify as heterosexual or NGI than other ethnic groups. Nonetheless, a set of factors specific to a subgroup of Black men who engage in sex with other men and identify as heterosexual or with no sexual minority identity can and should be specified to assist in HIV prevention work targeting this group. There are several

[2] We address this axis with regard to cisgender BMSM because, as described above, most research on BMSM is conducted with cisgender men in mind, regardless of whether this assumption is made explicit. However, we acknowledge that Black transmen and transwomen are also diverse in sexual orientation identity.

contextual risk factors, such as connection to gay communities and levels of social support, which should be considered in the design of efforts to track the epidemiology of HIV among this group and in design of HIV prevention efforts.

One distinct issue to consider is that the transmission route, sex with men, does not indicate an explicitly acknowledged community in which social marketing messages and other prevention efforts can be directly channeled. HIV prevention efforts among sexual minorities, as with other groups, use targeted efforts that rely on people's sense of shared membership in a group that is likely to have shared values and norms (Harper 2007; Wilson and Miller 2003). This sense of shared membership in a group or community, also known as sense of community (McMillan 1996), is required for HIV prevention targeting of that group to be effective. For example, in a social media campaign launched on busses and billboards showing an image of two Black men embracing or relating in ways that are potentially romantic, the Black SMCM viewer has to see themselves in the schema that includes emotionally romantic intimacy between men for them to see its relevance to their life. Without a sense that "this ad is talking to me," it fails to expose recipients to the message despite having seen it. As such, the degree to which a Black SMCM conceptualizes himself as part of this community of men engaged in romantic (not just sexual) relationships with other men would reasonably influence the effectiveness of similarly gay men's-focused interventions.

Furthermore, there may be unique HIV risk factors among NGI Black SMCM, such as lower levels of social support around one's sexual behavior (Lauby et al. 2012; Wohl et al. 2013) and internalized heterosexism that leads Black SMCM to avoid adopting a sexual minority identity in an effort to avoid stigma (Peterson and Jones 2009). Also, some studies have identified that men who identify with dominant sexual role labels, such as top or insertive partner, are more likely to not identify as gay (Doll and Beeker 1996; Hart et al. 2003). Supporting the connection between being non-gay or bisexual identification and stigma, men who identify as tops exclusively are less likely to identify as gay and have been found to report higher levels of internalized homophobia (Hart et al. 2003). Also, a stigmatized view of one's sexuality has been associated with patterns of unplanned sex behaviors (Operario et al. 2008a, b) and substance use (Harawa and Adimora 2008) that may put NGI Black SMCM at more risk for HIV.

Several of the plausible subgroup-specific factors affecting NGI Black SMCM that have been presented in the literature to-date require us to assume a level of purposeful secrecy led by shame of one's sexual behavior. However, this assumption may not be accurate. Some scholars have argued that the lack of gay identification is less about shame of a gay-like identity and more about sexuality not necessarily being central to someone's core identity (Grov et al. 2006). Understanding reasons why people do not identify with a sexual minority identity label would provide further insight, particularly with regard to prevention efforts. Some of the factors identified here, such as sexual role and levels of community support and affiliation for one's sexuality, may be relevant to NGI Black SMCM regardless of the reason that they do not adopt a sexual minority label of any kind. Yet, other factors, such as, heightened levels of internalized heterosexism/homophobia, would only be relevant to those that do not adopt a sexual minority label because of perceived stigma associated with their sexual behavior. Therefore, when designing prevention interventions, it is important to account for the varying levels of importance that individuals ascribe to sexuality and sexual identity—negatively, positively, or neutrally.

In addition to the various forms of non-identification with sexual minority labels, there is also variability in the sexual orientations and labels chosen among those that do explicitly claim such identities. Though the nomenclature of BMSM is often used, most research with this group is actually studying the behaviors and attitudes of men who psychologically and socially identify with a mainstream sexual minority label that denotes same-sex sexual attraction and behavior, such as gay or bisexual (see, e.g., Voetsch et al. 2012, where 96 % of MSM identify as homosexual or bisexual). There are specific factors to consider in the study of factors predicting HIV prevalence among Black men who identify as gay. Black gay community cultures and the process of consciously navigating multiple identities (gay, Black, etc.) and oppressions (racism, dominant masculinity ideologies, and heterosexism) are among the issues to consider in HIV-related work and research among explicitly gay-identified Black men.

One issue related to community and cultural dating norms is the viral load of Black gay men's sexual networks. One theory of high rates of HIV among Black gay men has been that their sexual networks are a significant factor in high HIV rates among Black SMCM. This theory that connects sexual networks to HIV rates among BMSM posits that the combination of high viral load among Black MSM combined with tendencies to date exclusively within these racial networks creates a higher risk to HIV transmission than is seen among other ethnic groups of MSM (Raymond and McFarland 2009). Though census data on Black same-sex couples provide evidence of a lower likelihood to be coupled with someone outside of Black social networks compared to other ethnic minorities (Kastanis and Wilson 2014), the theory that intra-ethnic dating matters for HIV rates has only moderate support. An earlier analysis concluded that there is still only tenuous evidence available to support the "high-risk sexual network" theory (Millett et al. 2006), yet a more recent empirical study supports this hypothesis among gay and bisexual men specifically (Raymond and McFarland 2009).

Other studies, not directly assessing HIV risk-related behaviors, indicate that Black gay men's communities exist

(Meyer and Ouellette 2009) and may have distinct cultural components, such as the ways in which Christian spirituality is integrated into daily life (Miller 2007). Also, for many Black gay-identified males of various ages, the house ball scene is another aspect of Black gay culture that has implications for sites of HIV prevention efforts and for proposed prevention strategies (HIV knowledge increasing workshops, community building, social marketing, etc.) as these cultural rituals involve an intricate hierarchy of non-biological familial relationships and social and sexual networks (Murrill et al. 2008; Holloway et al. 2012). But, little research has been done to further explore how our understandings that Black gay men's communities exist and how shared beliefs, norms, and values may be examined as resources and potential challenges in HIV prevention efforts. The lack of research on culturally and contextually specific HIV-related factors is part of a larger problem in the field in which there are very few HIV prevention programs for Black gay men that have ever been rigorously tested, particularly for youth, the hardest hit group (Maulsby et al. 2013; Williams et al. 2009).

In addition to community culture, the need to navigate multiple social identities and their associated forms of oppression also directly impact Black sexual minority-identified cisgender men. Though any Black SMCM are likely to need to navigate both racism, heterosexism, and the often ignored struggle of internalized oppression inherently by participating in sexual behavior that runs counter to heteronormative expectations, Black SMCM who consciously claim a non-heterosexual identity (privately and/ or publicly) are likely to experience direct interpersonal heterosexism in multiple contexts and racism within predominantly White gay spaces that they enter (George et al. 2012; Logie et al. 2011; Murrill et al. 2008; Peterson and Jones 2009; Voisin et al. 2013; Wilson and Miller 2002).

Another subgroup that sits on the sexual minority identity continuum is bisexual-identified Black men. Because most studies of Black BMSM study both gay- and bisexual-identified men in the same spaces, it is likely that some of the cultural and contextual issues noted above as relevant for gay men also apply to bisexual men. Further, HIV services tend to target Black gay and bisexual men at one time. However, a needed area of future research is on whether the Black bisexual-identified men recruited in research within predominantly gay-identified spaces are somehow different from Black bisexual men who do not hang out in predominantly gay spaces. Given prior research on anti-bisexual bias (Dodge et al. 2012), it is quite possible that many Black bisexual men experience pressure or discrimination and exclusion by gay-identified men, some who see them as "on the fence," traders, or men who "would not admit that they are really gay."

As such, it is likely that bisexually identified men have a unique experience that distinguishes them both from gay men and NGI men. In general, research on the HIV outcomes of bisexual people indicates that they may be uniquely at risk compared to other sexual minorities (Miller 2007). Some of the differences observed between gay-identified and bisexual-identified people with regard to HIV have been explained as a function of anti-bisexual bias within gay communities and society at large as a driver of higher risk to sexual health issues (Miller et al. 2007). However, among BMSM, Millett et al. (2005) have noted that studies claiming to include bisexual men frequently ascribed that identity is based on behavior alone rather than self-identification. This indicates that we actually know very little about men who identify themselves as bisexual or with some other label representing a sexual minority group in which their sexual and/or relational partners are both men and women. Distinguishing between bisexuality as behavior, identity, and/or attraction is useful to develop more precise approaches to HIV prevention among bisexual Black men. For example, HIV prevention approaches designed to target Black men whose primary relationships with men are sexual and private, but with women are sexual, emotional, and publicly acknowledged, are not going to be the same as those targeting Black men whose romantic and publicly acknowledged relationships are open to being with either men or women.

Finally, when discussing sexual minority identities among non-heterosexual Black men, it is important to note that there are other terms used by some Black sexual minority men, such as same-gender-loving (SGL)[3] and queer, in which there is a claim to non-heteronormative sexuality as important to sexual identity, but reject mainstream language for sexual orientation. SGL and queer-identified individuals and communities resist mainstream terminology of the LGBT establishment, however, in two very distinct ways. Where queer is often used as a way to counter essentialist and reductive heteronormative ways of discussing and practicing sexuality (Levy and Johnson 2011), SGL was coined as a Black affirming and intentionally African-inspired alternative to "gay" and "lesbian." For SGL, the resistance is against what some Black men and women deemed Eurocentric sexual minority identities. Some studies reporting on the demographics of Black sexual minority people have indicated that some proportion of their sample identified as SGL or other terms besides gay or "bisexual" (e.g., Battle et al. 2002; Malebranche et al. 2004; Scott et al. 2004). For example, a study of health care experiences of BMSM asked them to self-identify their sexual orientation, and about half chose gay and the other half chose terms like bisexual, SGL, or two spirited (Malebranche et al. 2004).

[3] There are no peer-reviewed accounts detailing the origins of the term SGL. However, most anecdotal accounts experienced by the first author and community accounts, as seen by public entries to Wikipedia (https://en.wikipedia.org/wiki/Same_gender_loving), indicate that the term was coined by community activist Cleo Manago.

Though research shows that men who identify as queer or SGL or other non-Eurocentric terms denoting sexual minority status exist, there are no studies examining HIV-specific risk factors that may be unique to these subpopulations. We also do not know how prevalent the claim of these identities is at a population level, nor do we know if there are differences in HIV prevalence rates between those that claim queer or SGL vs gay/bisexual identities. Nonetheless, given what we know about organizations that intentionally use terms like SGL when focusing on health and well-being among Black SMCM (e.g., Black Men's Xchange and Adodi), we can garner a few key cultural and contextual issues to consider in HIV-related work with the SGL groups. For example, a focus on anti-racism and masculinity as central initiatives is indicators of a Black-centered approach to understanding sexuality that these organizations share. Also, it appears common that there is an acknowledgement of the significance of Black- and African-centered philosophies and traditionally male-centered iconography as part of building community and creating strong racialized sexual minority identities. Also, a unique factor for this group could be that they are quite likely a minority among Black sexual minority men, and therefore, we need to consider the mental health effects and resource availability of being a group that is distinguishable from and potentially in conflict with other Black sexual minority men who share different sociopolitical standpoints.

Incarcerated Black MAB

Though not necessarily NGI, incarcerated Black cisgender men and transgender women comprise another group who might be considered along the continuum of sexual expression and access to formalized sexual minority community resources. The institutional settings of jails, prisons, and juvenile detention comprise a unique sexual situation in which many MABs engage in sex with other MAB, regardless of whether they identify as gay, bisexual, another sexual minority label, or as heterosexual. Given the context of congregate settings, officially unacknowledged and unapproved sexual behavior between MABs, and heightened expectations of expression of masculinity, incarcerated Black cisgender men, and transgender women (who are forced into male prisons) can be classified as a potentially unique subgroup along the axes of sexual identification and expression (see, e.g., Robinson 2011). In 2011, Black cisgender men ages 20–24 were imprisoned at seven times the rate of White men (Carson and Sabol 2012). The overcriminalization of Black males not only affects men in jail or prison, but also affects the communities from which these men came and to which they return.

There are data to suggest that Black SMCM and transgender women experience disproportionately high rates of incarceration; in one study, 60 % of BMSM and 80 % of Black transgender women had been incarcerated at one point in their life (Brewer et al. 2014). Connecting stigma, risk, and incarceration, one study has shown that BMSM who have been previously incarcerated reported higher rates of experiencing family disapproval for their same-sex desires and engaging in unprotected anal intercourse than men who had not been incarcerated (Jones et al. 2008). However, the data do not support that these differences in incarceration explain disproportional HIV rates (Millett et al. 2006; Harawa and Adimora 2008). Yet, regardless of whether unprotected anal intercourse during incarceration partially explains disproportionately high HIV rates among the Black cisgender men and transwomen populations, it is nonetheless likely that the process of preventing the spread of HIV among those in prison presents unique challenges to the typical strategies employed in community settings. Therefore, the higher rates of incarceration of Black men and transwomen, combined with the unique sexual situation created by a single-sex congregate setting, indicate there may be a constellation of factors affecting reasons for being incarcerated or impacting HIV risk behaviors that are especially salient for Black SMCM. Yet, there is limited research about the experience of Black SMCM in prisons or jails.

Another core factor affecting HIV among incarcerated Black SMCM is level of consent and power in sexual situations. While some may engage in consensual sex resulting in exposure to HIV, others are subjected to non-consensual sex or sexual assault. Given that sexual assault may pose a greater HIV risk as a result of tearing of anal tissue, the level of HIV risk may be heightened for those incarcerated in men's prisons. (McLean et al. 2004). According to the 2012 National Inmate Survey, non-heterosexual incarcerated men who were Black, were Hispanic, or had less than a high school education were ten times more likely to have reported being sexual assaulted than heterosexual inmates (Beck et al. 2013). However, there are no data available regarding the rate of HIV transmission due to rape in prison. Pinkerton and colleagues (2007) estimated the prison rape HIV transmission rate through a model that considered existing data on number of assaults and HIV prevalence. Even under a very conservative estimate that 1 % of prisoners are raped, their model predicted that between 43 federal and 93 state MAB prisoners will acquire HIV during their incarceration annually.

Summary

Research on the specific and oft times overlapping subgroups that have been implicitly or explicitly included under the category BMSM reveals that members of these subgroups find themselves navigating sexual behavior and risk at the intersections of race, class, gender expression, sexual identity, gender identity, and LGBT community access and participation. Degrees of gender conformity and gender identity are key distinguishing characteristics between the subgroups of

Black SMCM and GM relevant to HIV risk and interventions. Black transwomen have known high rates of HIV prevalence and Black transmen have a relatively unknown risk, but both groups must contend with anti-trans oppression and still tend to be miscategorized and underserved in mainstream MSM HIV prevention efforts. Additionally, the degree to which there is claim of an explicit sexual minority label is another key distinguishing characteristic between the subgroups of Black SMCM and GM that is a likely relevant factor for risk to HIV and AIDS. Black gay- and bisexual-identified men likely participate in insular sexual social networks that may increase HIV risk, and yet have the available support and potential for sense of community that comes with being part of a group that shares an acknowledged sexual minority status.

Related to sexual identity is the extent to which Black SMCM and GM participate in communities bound by sexual and gender minority status. There is a range in the levels of interest and access to formal institutions, services, and geographic locations targeting LGBT people. Incarcerated Black cisgender men and transgender women who have sex with MAB, whether identified with a sexual minority label or not, have a particularly low level of access to these types of LGBT resources and support. Additionally, Black NGI and SGL SMCM may also have lower levels of access or participation in LGBT resources, either through empowered choice or exclusion, given a lack of connection with a predominantly White- and gay-identified culture that serves as a foundation for these mainstream LGBT organizations and spaces. In sum, these various subgroups of Black SMCM and GM including—(a) non-gay-identified SMCM; (b) gay, bisexual, SGL, and other identified SMCM; (c) incarcerated MAB; (d) transgender women; and (e) transgender men—navigate both overlapping and unique sexual, social, and structural contexts that matter for how we think about HIV risks and interventions.

Implications

The primary implication of a formalized acknowledgement of the sexual and gender diversity among Black SMCM and GM is that it highlights the need for HIV risk and intervention research focused on BMSM to more explicitly include measures of sexual identity, connections to sexual minority communities, gender identity, and expression. This would seem to be true both for implementing effective behavioral and biomedical interventions (e.g., Pre-Exposure Prophylaxis (PrEP)) in which there are similar concerns about the intersections of race, gender, class, and sexuality and their impact on health care access and community norms in ways that impact participation in and response to HIV interventions. For example, successfully implementing a PrEP strategy requires that the target population has the opportunity to learn about this prevention method, access to continuous health care, willingness to disclose their sexual health history to their health care provider, and ability to adhere to treatment protocol. The form and severity of the structural and sociocultural barriers to fulfilling these prerequisites are likely to differ across the subpopulations of Black SMCM and GM that we reviewed, due to varying levels of access to LGBT or sexual and GM-competent health care providers and identification with sexual and GM identities and communities. Then, even assuming that such prerequisites could be fulfilled, there are additional challenges to applying the CDC's Clinical Practice Guidelines (2014) to encourage providers to engage in discussions with their clients and determine "which MSM are at especially high risk of acquiring HIV infection, and for whom PrEP may be indicated." (p.20). The guideline document, including the accompanying "MSM Risk Index," provides no guidance to health care professionals on how they can accurately capture a patient's gender identity and sexual identity or how to determine whether a patient falls within the category of MSM to begin with. Thus, given that the term MSM can be drawn narrowly, not all Black SMCM and GM may receive the benefit of being screened for PrEP using an MSM framework.

Making explicit what we mean by the term BMSM must be followed by obtaining accurate data about Black SMCM and GM. The primary implication here is to treat sexual orientation identity and gender identity as key demographic variables in these health and infectious disease surveillance systems, much in the way that race/ethnicity and age group are employed. The current use of age and ethnicity/race as core surveillance reporting demographic variables for defining subpopulations and associated risks can be applied to the constructs of sexual orientation and gender identity, while also continuing to collect data on behavioral mode of transmission. Further consideration for how the CDC collects data, and their ongoing efforts to build capacity of state and local health departments to capture accurate gender identity and sexual minority status, will be key in addressing the needs of all Black SMCM and GM. Updating fields of inquiry to include both sexual orientation identity and gender identity for territory and state health departments that are sending annual CDC surveillance data would be a reasonable next step to acknowledging that a behavioral or transmission route alone is not enough for adequately tracking prevalence among key subpopulations of BMSM. Further, efforts to including these demographic items as part of the surveillance system would also need to involve development of guidance and tools for how to collect these data accurately, perhaps through the Surveillance Resource Center. Finally, inclusion of these identity variables in the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, TB and Prevention (NCHHSTP), much like the inclusion of race and age groupings, could be useful as a national, state, and local organization and health department resource to making data-informed decisions about how to address the needs of those that are HIV-affected or at risk of HIV.

In addition to the implications for HIV prevention and treatment and for HIV surveillance data, failing to reimagine how we conceive and think about the amoebic category BMSM limits our ability to identify the public policy effects. In the National HIV/AIDS Strategy ("NHAS"), for example, the document identifies "gay, bisexual and other men who have sex with men" as a key target population (Office of National AIDS Policy and the White House 2020, page 4). Throughout the remainder of the document, however, NHAS uses the terms "gay and bisexual men" or "gay men" to be inclusive of all men who have sex with men, even those who do not identify as gay or bisexual. This can become problematic when it comes to designing policies and actions stemming from the strategy. For example, increasing competency of providers in serving LGBT-identified individuals is listed in several contexts of NHAS' implementation plan (Office of National AIDS Policy and the White House 2020). Sexual identity and sexual minority community participation is assumed, and individuals that are non-gay and non-bi-identified, incarcerated individuals, and individuals who do not participate in LGBT-identified communities remain unseen. Similar challenges to reconciling HIV/AIDS policy with more nuanced understandings of who comprises the group denoted as Black MSM can be seen at local city and county levels as well. For example, in the City of Los Angeles 2013–2017 HIV strategic plan, in which Black MSMs are highlighted as an especially vulnerable group, it is useful that the planning group consistently acknowledges that the term MSM refers to both gay- and non-gay-identified men, notes several times that there are important subgroups that need to be targeted among MSM, and describes surveillance data for both transgender women and men (Division of HIV et al. 2013). However, the city's ability to make recommendations for distinct intervention strategies and measurable objectives for varying subgroups other than gay men is hampered by the lack of knowledge about how to do this, a concern reflected in their call for additional research and analysis on how best to address the needs of these subgroups (ibid).

Conclusion

Centering the analysis on the sociocultural and structural factors affecting SMCM and GM HIV risk and treatment, we aimed to provide a framework for HIV health policy work and practice for how to intentionally move beyond the behavioral transmission route approach that exists under the rubric of "Black men who have sex with men." This framework puts forth a way to think about the multiple subgroups embedded under the term along the axes of sexual identity, sexual minority community participation, gender identity, and gender expression. We propose the framework for delineating subgroups along these axes in a way that could be done for any ethnic group, but the results of applying the framework (i.e., the specific subgroups and associated sociocultural and structural factors) are likely to differ for cisgender men and GMs of other ethnic and racial groups. This would be an important area of future theoretical and empirical work among other ethnic and racial groups that are also highly impacted by HIV/AIDS. Applying the framework in an intentional way includes integrating measures of sexual orientation identity and gender identity into surveillance data, increased research on the subgroup-specific factors impacting HIV transmission and barriers to treatment, and translating this work to informing group-specific health policy and practice.

Acknowledgments The authors acknowledge and appreciate the work of behavioral health interventionist and socio-political TV commentator Dr. Cleo Manago for his leadership in initially proposing to us the need to revisit a discussion of the Black MSM framework as it related to HIV/AIDS. Further, we acknowledge Brad Sears and Drs. Ilan Meyer, Gary Gates, Gary Harper, and Greg Millett for willingness to review and provide feedback, as well as Soon Kyu Choi and Sheila Nehzad for assistance with formatting and literature reviews, on preliminary versions of the manuscript.

Compliance with Ethical Standards This article is a theoretical paper and does not contain any studies with human participants or animals performed by any of the authors.

Conflict of Interest Bianca Wilson and Ayako Miyashita declare that they have no conflict of interest.

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