

Preventing HIV Infection among Young Immigrant Latino Men: Results from Focus Groups Using Community-Based Participatory Research

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Latinos in the United States have been disproportionately affected by the intersecting epidemics of HIV and sexually transmitted diseases (STDs). Using a community-based participatory research (CBPR) approach to problem identification and exploration, a total of 74 Latino men (mean age 22.3, range 18–37) residing in an urban city in northwest North Carolina participated in one of eight focus groups on sexual health. Among the findings of this study, >75% of participants reported Mexico as their country of origin; other participants reported being from Central and South American countries. Qualitative data analysis identified 13 themes, which were grouped into the following three domains: 1) psychosocial factors identified as influencing sexual risk health behaviors; 2) system-level barriers to sexual health; and 3) characteristics of potentially effective HIV prevention intervention approaches. The study findings suggest that community-based, male-centered interpersonal networks that provide individual and group education and skill-building and incorporate *curanderos* (Latino healers) and bilingual experts may be important elements of potentially effective intervention approaches to reach Latino men, who have been inaccessible to conventional HIV prevention programs.

Keywords: Latinos ■ men's health ■ HIV/AIDS ■ sexually transmitted diseases

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HIV and sexually transmitted diseases (STDs) are major health problems disproportionately affecting vulnerable populations in the United States, including immigrant communities, who tend to be politically, socially and economically disenfranchised.^{1,2} Latinos in the United States have been disproportionately affected by the intersecting epidemics of HIV and sexually transmitted diseases (STDs). Latinos have the second highest rate of AIDS diagnoses of all racial and ethnic groups.³ Although Latinos represented 14% of the continental U.S. population in 2004,⁴ they accounted for 20% of the total number of new AIDS cases reported, almost four times greater than that for non-Latino whites.⁵

Rates of reportable STDs also are higher among Latinos than among non-Latino whites. In 2003, the rates of gonorrhea, chlamydia and syphilis each were 2–4 times higher among Latinos than among non-Latino whites.⁶ Between 2000–2003, primary and secondary syphilis rates increased by more than 20% among U.S. Latinos each year, while dramatically declining among African Americans.⁶

Many southern U.S. states, including North Carolina, which has one of the fastest-growing Latino populations in the United States,^{4,7} consistently lead the nation in reported cases of AIDS, gonorrhea, chlamydia and syphilis.⁸ In 2004, HIV and STD infection rates for Latinos in North Carolina were 3 and 4 times that of non-Latino whites, respectively.⁹

The objectives of this exploratory study were to: 1) develop a better understanding of potential determinants of sexual health among newly arrived, non-English-speaking, less acculturated Latino men living in a region of the United States that is experiencing both the fastest-growing Latino population and disproportionate HIV and STD infection rates, and 2) explore potential intervention approaches to HIV and STD prevention.

To enhance the study's authenticity of methods and trustworthiness of findings, an existing community-university research partnership engaged the

local Latino community in following the principles of community-based participatory research (CBPR).

Community-Based Participatory Research

Complex health problems persisting into the 21st century, including racial and ethnic disparities in HIV outcomes, have been noted to be ill suited for traditional “outside-expert” approaches to practice and research and often result in ineffective interventions.¹⁰⁻¹⁸ Health professionals, including providers and researchers, with their expertise as “outsiders,” need to establish partnerships with community members and representatives from community-based organizations (CBOs) and agencies,^{10,13,19,20} all of whom possess expertise as “insiders.”²¹ Hence, research aimed at understanding and eliminating health disparities and promoting community health has begun to focus attention on research approaches that emphasize community-university partnerships as an integral element within the research enterprise.^{13-15,22,23}

CBPR is one such partnership approach. CBPR is a collaborative research approach designed to ensure and establish structures for participation by members from the communities affected by the issue being studied, representatives of CBOs and agencies, healthcare providers and researchers in all aspects of the research process to improve health and well-being through taking action, including interventions and social change.^{18,21} Briefly, CBPR ensures that: 1) bridges are created and trust built between community stakeholders (e.g., representatives from the lay community, CBOs and public health agencies) and providers and researchers from academic institutions (e.g., schools of medicine and public health); 2) research is authentic to community experiences; 3) research questions are relevant; 4) research design and methods are culturally and educationally appropriate; 5) knowledge is incorporated into action based upon the lived experiences of community members; 6) research is translated into informed policy; and 7) infrastructure is built to promote successful implementation and longer-term sustainability when appropriate. Through CBPR, community-university partnerships can enhance the quality, use, relevance and interpretation of the data and ensure appropriate dissemination of study findings.^{13,14,18,21,24,25}

This study was conceived and conducted by a community-university partnership that included community members and representatives from local CBOs, such as an AIDS service organization (ASO) and religious organizations; the local public health department; and Wake Forest University School of Medicine. This partnership serves as a catalyst for identifying priorities and approaches to meet locally identified HIV/AIDS prevention and care needs.

Guided by partnership principles, including agreement upon mission, establishment of trust, and sharing resources and decision-making responsibilities, the partnership has prioritized CBPR to promote a colearning, empowering and collaborative process that moves beyond communities “informing” or offering “consultation” and to increase the level of decision-making that allows negotiation and trade-offs with traditional power-holders¹⁹ (e.g., university researchers) and community members and CBO and agency representatives.

METHODS

Focus groups were chosen for this study because the methodology provides the opportunity to investigate participant responses and reactions to issues related to sexual health more fully than methodologies that collect data from participants individually or have closed-ended questions with predefined response options. Focus groups also allow new areas of inquiry to emerge. This methodology can reveal key perspectives and nuances that researchers may not be able to foresee.²⁶⁻²⁸ Group interaction is an explicit component of this methodology. Rather than the moderator asking each person to respond to a question in turn, participants are encouraged to talk to one another, asking questions, exchanging anecdotes and commenting on one another’s experiences and perspectives.^{29,30}

Between September 2004 and March 2005, bilingual and bicultural professional focus group moderators, experienced in sexual health research, organized and conducted eight focus groups in Winston-Salem, NC. The focus groups were conducted according to established focus group methodology.^{21,27-30} The moderators used a moderator’s guide that was written and approved by the community-university research partnership to facilitate the focus groups, which averaged 90 minutes. The development of the moderator’s guide was an iterative process with the research partnership that included: ongoing review of the literature; brainstorming potential domains and constructs; and development, review and revision of potential questions and probes (for clarification) and prompts (for detail). The moderator’s guide was crafted with careful consideration to wording, sequence and content.^{31,32} Table 1 provides a brief description of the key questions outlined in the moderator’s guide. All focus group discussions followed the predetermined format of the moderator’s guide. To increase validity further, the moderator’s guide included a script to introduce the focus group process.^{33,34}

The moderator’s guide was translated into Spanish using a “committee approach” to translation and assessment,³⁵ promoted by the U.S. Census Bureau.³⁶

This innovative approach to translation addresses weaknesses of traditional translation/back-translation approaches by using a team whose members have skill sets beyond those of a translator. A group of individuals including two translators, a translation reviewer, two content specialists, a questionnaire design expert and an adjudicator with complementary skills was convened. The translation was completed by multiple translators independently. The committee met to discuss versions of the translation; a reconciled version was created and reviewed by an adjudicator prior to final approval by the research partnership and implementation by the moderators.

All focus groups were held in sites familiar to participants, which included an apartment complex group meeting space, a community college classroom, a church and a Latino *taquería* (taco stand) near a construction site. To facilitate the attendance of participants with varying work schedules, focus groups were held during the day and evening hours to facilitate the attendance of participants with varying work schedules. Recruitment of participants for each focus group was coordinated by the research partnership and the moderators. Eligibility criteria included being male, self-identifying as Latino or Hispanic, being ≥18 years of age and providing written informed consent.

Two male moderators were present during each focus group. All groups were led by the same moderator and observed by the same notetaker. The observer took notes of participant nonverbal reactions. Participants were served a meal during the

focus group and received a \$10 gift card to a local grocery store.

Analysis

After each focus group, the moderators documented initial general impressions about its process and content. Next, the moderators listened to the audiotaped discussion and took general notes. As more focus groups were completed, memos were written on recurrent patterns. Subsequently, it was transcribed in full detail by a professional transcriptionist. Transcripts were verified by reviewing each while listening to the audiotaped interview. After discussions were transcribed and verified, transcript data were entered into the Nvivo software (QSR International, Chicago, IL) for purposes of data management and analysis, with personal identifiers removed. Participant responses and text lines were tracked throughout transcripts and analyses. Using an induction method,^{31,37-39} the analysis focused first on the organization of transcript data into broad conceptual categories and then on more refined coding (e.g., knowledge about transmission, barriers to resources) within and across the different transcripts using constant comparisons. Next, codes were reviewed to generate initial themes.³⁸

Codes and themes were presented to members of the research partnership to confirm their accuracy and make modifications. This process was iterative with the CBPR research partnership providing technical analytic draft theme development and revising, developing and interpreting these themes.

RESULTS

Characteristics of Participants

Focus group participants varied by age, country of origin, marital/partnership status, documentation status and time in North Carolina and the United States. A total of 74 Latino men (mean age 22.3, range 18–37) residing in Winston-Salem, NC, participated in one of eight focus groups. Each group had 8–11 participants. Over 75% reported Mexico as their country of origin; other participants reported being from Central and South American countries, including Ecuador, El Salvador, Guatemala, Honduras and Venezuela. Participants reported working in building and construction, as auto mechanics, in restaurants and in landscaping. Literacy rates in Spanish were low. Use of spoken and written English was minimal. About one-quarter of participants reported currently living with their female partners (partnered); one-quarter reported having female partners in their country of origin (unaccompanied) and one-half reported being single. Length of time since arrival in the United States averaged 4.2 years, and ranged from one month to 10 years.

Although participants identified a variety of

Table 1. Abbreviated key questions excerpted from the focus group moderator's guide

1. Introduction to focus group methodology
2. What is the most important worry you have about your health?
3. When you hear of or think about HIV and AIDS, what do you think about?
4. What does one do if one gets a sexually transmitted disease?
5. How can someone protect himself from these types of illnesses?
6. Why do some people use condoms and others do not?
7. Why do some people take these risks?
8. Can you think of other reasons why Latino men would take sexual risks?
9. How could risk behaviors be changed among Latino men?
Where would we go to reach Latino men in the community?
10. Conclusions
Is there anything else you would like to share today?

health priorities that ranged from foodborne illnesses to occupation health concerns, they indicated that sexual health—particularly HIV and STDs—was their primary health-related concern. Many of the participants self-reported histories of STD infection; as a 22-year-old unaccompanied participant originally from Guatemala noted:

I hear many men talking about these types of diseases [STDs]; many immigrant men like us get these diseases but then don't know what to do.

Thirteen themes emerged from this exploratory study and have been organized within three domains: 1) psychosocial factors that contribute to sexual risk among young immigrant Latino men, 2) system-level barriers to sexual health, and 3) potentially effective HIV prevention intervention characteristics. Table 2 provides a list of these themes by domain. The following section reports the details for each theme.

Psychosocial Factors that Contribute to Risk

Low levels of knowledge about HIV and AIDS.

Participants lacked comprehensive knowledge of HIV, as was illustrated through participants themselves asserting that they lacked information about HIV. A 20-year-old, single participant originally from Guatemala stated, “There are many things about this [HIV] that I don't know yet.”

Besides participants asserting that they lacked information about HIV, participants illustrated this lack of information through fundamental assertions about HIV and questions about transmission that they asked. As a 23-year-old, single participant from Mexico suggested:

As far as AIDS is concerned, everyone has it. We all do. We are all sick with it, but some people just don't develop it. They are the lucky ones, but we all have it.

Another focus group debated how many people are living with HIV currently, and as a group decided that $\geq 70\%$ of the U.S. population is HIV positive or has AIDS. Participants also indicated that they lacked accurate information about other STDs besides HIV. As a 27-year-old participant originally from El Salvador noted:

I had a friend who become infected with a venereal disease, you know, sores and all; we didn't know what it was. He thought it was chemicals at his job, or stress. Then he heard about this unclean woman he was with and went to get cured.

Fear of being detained or deported if found positive. Although participants feared getting HIV, many expressed concern for what would happen to them if they tested positive for HIV. As a 34-year-old participant from Mexico noted:

If you go to the hospital and they discover that you have AIDS, that is where you are going to have to stay because they will not let you out. They will keep you there. They won't let you out.

During another focus group, participants agreed with a 30-year-old participant originally from Mexico who commented:

Latinos are afraid to know whether they have HIV because they believe that they will be deported.

Table 2. Qualitative determinants of sexual health by domain and theme

Psychosocial Factors that Influence Sexual Risk among Young Immigrant Latino Men

1. Low levels of knowledge about HIV and AIDS
2. Fear of being detained or deported if found to be HIV positive
3. Embarrassment
 - To buy and use condoms
 - To seek counseling and testing for HIV
4. Loneliness
5. Condom beliefs
 - Condoms decrease sensation
 - Condoms reduce spontaneity
 - Condoms are too much trouble to use
 - Condoms are not safe
 - Condom use conflicts with religious beliefs
6. Fatalismo
7. Masculinity
8. Distrust of U.S. healthcare system and lack of confidence in provider confidentiality

System-Level Barriers to Sexual Health

9. No knowledge of available services targeted to men
10. Limited bilingual healthcare services
11. High cost of services and confusion about insurance
12. Need for nontraditional outreach for counseling, testing and treatment

Characteristics of Potentially Effective HIV Prevention Intervention Approaches

13. Community-based, male-centered interpersonal networks that are informal, provide both individual and small group education and skill-building, and incorporate curanderos and bilingual experts

Embarrassment. Participants indicated that some Latino men are embarrassed to engage in preventive and health-promoting behaviors. As a 25-year-old participant originally from Mexico noted:

Some people are embarrassed to buy condoms. To actually go somewhere and look for them or ask for them is too much. I wouldn't because it just isn't easy. It is embarrassing, simply.

Some participants also indicated that men may be embarrassed to seek counseling, testing and treatment for HIV. Asking for help about such a personal subject was identified as a major challenge to seeking care.

Loneliness. Participants identified loneliness as associated with sexual risk behavior. Many men leave their immediate families and support networks and come to the United States. Missing their families and communities coupled with finding themselves in challenging living environments further leads to risk behavior as they attempt to deal with this loneliness. A 24-year-old participant from Honduras shared:

One really has no idea about how hard it is here until one arrives. We may have a brother or an uncle who helps, but everyone I need and rely on is not here, and that makes it more difficult. That makes my life more difficult. I just want to be comfortable, and I might find comfort in places or doing things that aren't the safest.

Loneliness also was identified by participants as contributing to increased alcohol consumption and episodic binge drinking that participants suggested leads to sexual risk behaviors.

Condom beliefs. A total of five major condom beliefs that limit condom use were identified by the men throughout the focus groups. First, the most commonly-mentioned barrier to condom use and the most adamantly held belief was that condoms decreased sensation for men. This was mentioned in each of the seven focus groups, although participants in one group posited that condoms increase sensation for the female partner. Next, condoms were reported to reduce spontaneity of sexual behavior. As a 25-year-old participant originally from Guatemala noted:

You can joke with [other Latino men] about carrying condoms, but you [other Latino men] don't want to have to stop during the heat of the moment and interrupt the mood.

Third, a participant originally from Mexico asserted, "[Condoms] are too much trouble to use."

For example, participants discussed challenges associated with using several condoms during one sexual encounter. Participants indicated that sometimes they may insert and withdrawal before ejaculation, engage in another sexual activity, such as oral sex, and then resume vaginal sexual intercourse. This engagement in multiple sexual activities during one sexual encounter may require multiple condoms and/or extra lubrication. A 29-year-old participant originally from Mexico explained that sexual intercourse is a process and not an event, saying:

Sex isn't just one activity. Sometimes it [sex] involves multiple activities and a man might need multiple condoms if he was truly going to be safe, but who can do that?

Fourth, two focus groups centered on the safety of condoms, concluding that condoms are not safe. Safety was operationalized two ways. Participants reported hearing that diseases can result from condom use. Both the lubricants (presumably spermicides, such as nonoxynol-9) and the condom material (e.g., latex) were identified as unsafe. Furthermore, participants did not believe in the effectiveness of condoms. Participants of one focus group asserted that condoms were only 80% effective at reducing pregnancy.

Finally, although most of the participants seemed to indicate that attending church did not play a key role in their lives in the United States, condoms were identified as conflicting with the religious beliefs of many Latinos. A 36-year-old participant originally from Mexico commented:

There is a line of thinking that says that we shouldn't use condoms because of religious reasons, and there are those of us who think that we shouldn't use prevention, because it is good and natural to have sex.

Fatalismo. Participants in all seven focus groups expressed strong feelings about fate, ultimately deciding whether one becomes infected with HIV. A 25-year-old participant originally from Mexico summed up this, saying:

I have to enjoy my life because we are all going to die. If it's your turn, it is your fate. There is no changing God's will.

Another 20-year-old participant, originally from Guatemala, was more flippant, saying

Some of us don't worry about AIDS because we say we have to die from something anyway, no?

Masculinity. Focus group participants also highlighted the role of socially constructed expectations of masculinity on risk behavior, including: 1) the role of sexual intercourse as a way for a man to show love and trust for one's partner; 2) the need for men to prove their manhood to themselves and others through engaging in sexual behavior; and 3) the positive attributes of being men.

Sexual intercourse to show love and trust. Men expressed the feeling that sexual intercourse can be a way for them to show love to a partner. Using protection or thinking of using protection conflicts with the notion that sexual intercourse is an activity to express love. A 34-year-old participant originally from Honduras noted:

Sex is about love. It isn't about being safe or thinking about more than the feeling two people have for one another. It is about giving oneself and being there. As a man, you have to trust and you have to be worthy of trust.

Proving one's manhood. Proving one's manhood was identified as an ongoing requirement of being a man. Participants identified various ways a man can prove his manhood, including having the reputation of having low sexual control and/or multiple partners. Although participants felt that men indeed have sexual control, an image to convey to others was that of being hypersexual. A 22-year-old participant from Mexico said, "As Mexican men, we are hot natured, and we have to prove it to others."

Participants also noted that asserting manhood was an ongoing process. One did not prove one's manhood to others through one action. Rather, proving one's manhood was a continual process, a constant obligation for men.

Positive aspects of being a man. Masculinity was not identified as uniformly negative. Participants identified positive attributes of being a male including respecting oneself and taking care of one's family. A 30-year-old participant from Venezuela commented:

Protecting yourself and your family is most important. Young men don't understand this because maybe they don't have families yet; they don't have people who rely on them as much. But I am here [in the United States] for my family back home. Without me, who will be responsible for my family, for my daughter? I have to protect myself before I protect them because if I am not healthy, how am I going to protect my family? So it seems to me, that is what it is all about. Men have to protect themselves more than anything.

Distrust of U.S. healthcare system and lack of confidence in provider confidentiality. The final psychosocial factor that was identified by the participants included their distrust of the U.S. healthcare system and their lack of confidence in provider confidentiality. Participants noted that many Latino men do not trust healthcare providers. A 29-year-old participant originally from Ecuador reported:

I don't trust doctors here. I have heard of doctors not maintaining confidentiality, and with something as private as sex, one has to be extra careful. If something gets out to the Latino community, people may think all types of negative things about you.

System-Level Barriers to Sexual Health

System-level barriers to sexual health are those barriers that are outside of the realm of the individual or the community and cultural in which they live. System-level barriers include impediments to realizing health-promoting and protective behaviors. Four primary system-level barriers were identified.

No knowledge of available services targeted to Latino men. Participants in all focus groups questioned the existence of services for Latino men. Participants reported seeking immediate healthcare through emergency departments but were unfamiliar with other options for prevention and treatment. A 28-year-old participant originally from Mexico reported:

Because we aren't even supposed to be here... or even for those who have papers [documentation], the [US] government doesn't want us here and doesn't offer us help. The government has nothing for Latino men.

Limited bilingual services. Similarly, participants noted the deficiency in bilingual healthcare services. A participant noted:

I know we have hospitals, and we can go there for an emergency, but it is difficult because many times no one speaks Spanish or I don't trust the interpreter. Other than that there is no one who can translate for us [at other locations.]

Because bilingual services are lacking, participants reported not being able to get the care they need and if they seek care, they assume that the care is jeopardized by communication issues. Inadequate care was identified as a result of miscommunication.

High cost of care and confusion about insurance. Participants offered examples of situations when they or someone they knew had sought services resulting in either denial of services or large

healthcare costs that they paid or pay out of pocket over time. Participants who reported familiarity with both public and private insurance options concluded that the processes were confusing and inadequate. As a participant from Mexico concluded:

We have better care when we are sick in Mexico than we do here, where one can't even get a check-up.

Another 25-year-old participant noted, "The United States is supposed to offer prevention, but in my opinion there is a lot missing here, more than other places, I'd guess."

Need for nontraditional outreach. Participants also noted that need exists within the Latino community for nontraditional outreach for counseling, testing and treatment. They reported that their work hours often conflict with the availability of services. Participants noted that transportation is often a limitation and a community-based service provision may be beneficial. They encouraged clinic staff to provide services in geographic areas with large concentrations of Latinos. These areas include housing communities and apartment complexes.

Potentially Effective Intervention Approaches

The last domain includes the characteristics of potentially effective HIV prevention interventions targeting Latino men from their own perspective. Participants suggested a range of intervention approaches. Electronic media outlets, such as local Spanish-language television and radio stations, were recommended to disseminate HIV information. Other venues noted were to provide outreach education in billiard halls, at local flea markets, in churches, during English-as-a-second-language (ESL) classes, through recreational and league sports teams (e.g., soccer teams), and at schools.

Participants disagreed, however, on who would be reached in these venues. For example, there was a consensus that Latino men who attend churches would be less likely to engage in risky sexual practices because their families are more likely to be in the United States with them. That is, within this Latino community, men living with their partners (accompanied) were not perceived to be at high risk for HIV infection. Participants also considered workplace HIV educational programs as a potential venue to reach Latino men. However, after substantial discussions, the conclusion was that many Latino men would not participate in supplemental workplace programs. As a 20-year-old participant originally from Honduras commented, "After a long day, I am not

staying around for education about AIDS."

Finally, participants suggested that a potentially effective approach to reach Latino men like themselves to promote HIV prevention would be through existing interpersonal networks. A 30-year-old participant originally from Mexico suggested:

We are always turning to each other for help and advice. I listen to my friends. I trust my friends. It's true, and I live in communities with other Latinos, communities where my friends live too.

Participants decided that trusted Latino men living within their communities could be trained to offer information about HIV to their friends and relatives. Trained men could serve as informal sources of health information, sharing accurate information about HIV and AIDS within their naturally occurring social networks that are formed around residential and workplace environments. However, participants also noted the fact that many Latinos have strong social ties to extended family members who live in the United States and members of the communities that they come from. For example, participants reported extended family units that were predominately male and included brothers, uncles and male cousins. Participants also noted that many Latinos identify and socialize by where they are from in their counties of origin, as a participant from southern Mexico noted:

I am here with few family members but I have a job because of the help of other men here who are from my same village back home.

Participants also identified that potential for trained Latino men to provide more than practical education to one another. A 35-year-old participant originally from Mexico commented:

Besides information about HIV, these men could give information about how to get tested for other diseases that men get.

Thus, participants felt that Latino men could serve as referral sources to one another.

Besides identifying and training Latinos to provide education and referral to their peers, participants also noted the need to incorporate *curanderos* and other bilingual experts (e.g., medical providers) into HIV prevention efforts. A 29-year-old participant originally from Ecuador conveyed this opinion, saying:

I can learn a lot from a trained Latino leader, but I want you to know how important curanderos are to me and other Latinos.

Participants felt strongly that involving *curanderos* and experts would be important in any local HIV prevention effort.

DISCUSSION

Qualitative methods are useful to collect data to further the foundation of understanding the contexts of specific behaviors—in this case, to identify possibly unexplored issues related to sexual risk behavior. This study tapped into a group of young Latino men and cannot be easily generalized; however, this study does provide some guidance for further qualitative and quantitative inquiry.

This study revealed 13 main themes that were grouped into three primary domains. Several findings deserve further attention. First, sexual health—particularly HIV—was identified as health priorities among these non-English-speaking, less acculturated Latino men. Second, participants had extremely low levels of knowledge about HIV (and STD) transmission, care and treatment. They lacked basic information and were not clear on modes of transmission and effective prevention options. Although knowledge does not imply behavior change, having a context in which to place prevention messages is required for those messages to be understood and acted upon.⁴⁰

Participants were at increased risk for HIV transmission not only based on their lack of knowledge but also based on psychosocial factors that included: fears about being detained or deported if found to be HIV seropositive, being embarrassed to buy and use condoms and seek counseling and testing for HIV, increased loneliness and alcohol use, negative beliefs about condoms, *fatalismo*, and notions of masculinity and what it means to be a man. Although some of these factors may seem somewhat reminiscent of what has been learned within other populations and communities within the United States, approaches that are authentic to the lived experiences of Latino men in the United States must be developed. For example, participants did not report condom-use errors as is found in some emerging literature,⁴¹⁻⁴³ but they did report a behavior that has not been explored in the literature: participants reported engaging in multiple sexual behaviors during one sexual episode, further complicating condom use.

Furthermore, approaches must be culturally relevant and gender specific. For example, it has been argued that men of color, who are economically and socially marginalized in U.S. society, are more likely to exhibit forms of masculinity that are detrimental to their health because they may feel powerless in most aspects of their lives.⁴⁴⁻⁴⁶ Nevertheless, a thorough understanding and a comprehensive operationalization of masculinity are absent from much of

the HIV and STD prevention literature for men in general and men of color specifically. Research utilizing constructs and measures that assess endorsement of beliefs and values about manhood are needed to test and build models that embed masculinity within a risk-reduction framework.

Participants also identified four system-level barriers to their sexual health that included limited knowledge of available services; limited bilingual services; high costs associated with service utilization; and the need for nontraditional outreach, including after-hours and community-based education, counseling and testing. These barriers may be reduced through increased community outreach, education and trust-building, reducing institutional barriers to accessing and utilizing services, and increasing Spanish-language skills of providers.

Finally, participants indicated the need for creative intervention approaches to reach Latino men to reduce their risk for HIV. Participants suggested that typical intervention venues (e.g., churches and workplaces) may not reach men most likely to engage in risk behavior. Moreover, although an HIV prevention intervention using a Latino soccer league for implementation has been proposed and is being implemented in Latino communities in rural North Carolina,²¹ focus group participants indicated that this approach may not be as effective for urban Latinos because their participation in sports may be less than Latino men living in rural communities.

Rather, participants proposed using naturally occurring social networks that are based within the geographic communities in which Latino men live as well as social networks based on community or village of origin. Participants expressed not only willingness but were eager to build an HIV prevention program founded on community assets and structure. For example, participants suggested that Latino men who are community leaders could be trained to provide information and referral to their peers. Because in the southeastern United States Latino community enclaves have developed and apartment complexes may be 95–100% Latino with a census of over 1,000 residents each, opportunities exist to reach Latino communities geographically for both HIV prevention education and clinical services. Participants also suggested that HIV prevention interventions should provide informal opportunities for individual and small group education and skill-building, and include *curanderos* and experts.

Limitations

Participant selection was based on a convenience sample and, therefore, the findings cannot be generalized to all young immigrant Latino men. However, the purpose of this exploratory research study was

not to generalize but rather to discover relevant factors potentially missing in existing models and identify intervention options.

Although the focus group format for soliciting perspectives on sexual risk within a community of Latino men generated rich data, the presence of peers may have prohibited discussion of stigmatized behaviors, such as same-sex sexual behavior. This methodological limitation would be difficult to overcome, even if one-on-one interviews had been conducted, given the devaluation and subordination of same-sex sexual behavior. However, because recruitment was eased due to CBPR, this approach also may have constituted a first step toward building trust to investigate issues shrouded in stigma and silence.

Furthermore, these focus groups did not identify the impact of age on the determinants of sexual health and potential intervention approaches, but clearly this should be explored in further research.

CONCLUSIONS

With increasing rates of HIV/AIDS, a need exists to explore, understand and intervene upon factors associated with exposure and transmission among Latino communities. Nowhere is this more urgent than in the region of the United States that is experiencing both the most rapid growth rate of the Latino community and bearing a disproportionate burden of HIV, AIDS and STDs. This study provides preliminary insight into the salient beliefs of young immigrant Latino men toward sexual health, but further research must be initiated to impact HIV exposure and transmission.

This study also identified the potentially effective use of a male-centered approach to HIV prevention intervention that uses community leaders to provide education and referral. Although intervention strategies building on social networks among men remain uncommon, such an approach should be explored and tested, especially given findings from prospective studies that have suggested that social support may have greater health effects for men than women.⁴⁷ Exploring and identifying effective approaches for disease prevention, including HIV prevention, is especially important given that the health of men of color has been traditionally neglected resulting in men of color constituting a significant part of the U.S. population most in need of health promotion, disease prevention and improved access to healthcare.

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