Published in final edited form as:
AIDS Educ Prev. 2011 June ; 23(3): 236–248. doi:10.1521/aeap.2011.23.3.236.

Exploring the Sexual Health Priorities and Needs of Immigrant Latinas in the Southeastern US: A Community-Based Participatory Research Approach

Rebecca Cashman, MPH[1], **Eugenia Eng, Dr.P.H.**[2], **Florence Simán, MPH**[3], and **Scott D. Rhodes, Ph.D., MPH**[4]

Rebecca Cashman: rcashman@nursing.upenn.edu; Eugenia Eng: eugenia_eng@unc.edu; Florence Simán: florence@elpueblo.org; Scott D. Rhodes: srhodes@wfubmc.edu

[1]HealthIntervention Specialist, Center for Health Equity Research, University of Pennsylvania School of Nursing; Claire M. Fagin Hall. 418 Curie Boulevard, Philadelphia, PA 19104-4217 Ph: (617)312-1417

[2]Professor, Department of Health Behavior and Health Education, University of North Carolina Gillings School of Global Public Health; 360 Rosenau Hall. 135 Dauer Drive, Campus Box 7440 Chapel Hill, NC 27599 Ph: (919)966-3909 Fax: (919)966-2921

[3]Directora, Health Programs/Programas de Salud El Pueblo, Inc. 4 N. Blount Street, 2nd floor Raleigh, NC 27601 Ph: (919)835-1525 Fax: (919)825-1526

[4]Associate Professor, Department of Social Sciences and Health Policy, Division of Public Health Sciences; Section on Infectious Diseases, Department of Internal Medicine; The Maya Angelou Center for Health Equity, Wake Forest University School of Medicine. Medical Center Boulevard, Winston-Salem, NC 27157-1063 Ph: (336)713-5080 Fax: (336)716-7554

Abstract

Latinas living in the United States are disproportionately affected by HIV/AIDS and sexually transmitted infections (STIs). However, few effective interventions currently exist that are designed to meet the priorities and needs of recently arrived and less acculturated immigrant Latinas who are settling in the southeastern US. To identify sexual health priorities, gaps in information and skills, and key intervention characteristics to improve sexual health among immigrant Latinas, a community-based participatory research (CBPR) partnership conducted four focus groups with Latinas, in central North Carolina. Findings revealed: a lack of knowledge about sexual health; shame and embarrassment related to clinical exams and conversations about sex; multi-level barriers to sexual health; and disease transmission misinformation. Findings also suggested that interventions should include information about a broad range of sexual and reproductive health topics and skill-building. Such interventions could serve to assist in diminishing health disparities experienced among this vulnerable population.

Keywords

Hispanic/Latino; women's health; community-based participatory research; intervention; sexual health; southeastern US; focus groups

---

Latinos accounted for nearly 20% of the total number of new AIDS cases reported in the United States (US) in 2008, almost four times greater than that for non-Hispanic/Latino whites (Centers for Disease Control and Prevention [CDC], 2009). In 2006, HIV/AIDS was the fourth leading cause of death for Latinas, ages 35–44 years (CDC, 2006). Furthermore, Latinas have increasing rates of chlamydia and gonorrhea (CDC, 2007; CDC, 2009), higher

incidence of cervical cancer, and a 50% higher cervical cancer mortality rate than their non-Hispanic white counterparts (DATA, 2010; Wasserman, 2007).

Latinas in North Carolina and the Southeast

Since 1990, the size of the Latino population in North Carolina (NC) has more than quadrupled (US Census Bureau, 2008). Most of these Latinos immigrate for employment opportunities (NC Institute of Medicine, 2003). Currently, NC has the third fastest-growing Latino population in the US (US Census Bureau, 2007); much of this growth is in rural communities (Southern State Directors Work Group, 2008). Jobs in farm work, construction, and factories, coupled with dissatisfaction with the quality of life in traditional US destinations, lead many immigrants to leave higher-density regions and relocate to the Southeast (Kasarda & Johnson, 2006; Rhodes et al., 2007).

Increasingly, however, immigrants are coming to the Southeast directly. Their demographics differ from Latinos who traditionally immigrated to California, Arizona, Texas, or New York; for example, they tend to be more recently arrived and less acculturated, come from rural communities in southern Mexico and Central America, and have less formal education. Moreover, they are coming to communities without developed infrastructures to meet their needs. NC Latinos are younger compared to the general population (Kasarda & Johnson, 2006; North Carolina Institute of Medicine, 2003; Rhodes et al. 2007; Rhodes, Hergenrather, Wilkin, Alegria-Ortega & Montaño, 2006; US Census Bureau, 2007).

This study was designed to qualitatively explore the sexual health priorities and needs and identify characteristics of potentially effective sexual health interventions designed for immigrant Latinas. To enhance authenticity of study methods and trustworthiness of findings, an existing community-university partnership followed the principles of community-based participatory research (CBPR) in partnership with the local Latino community.

Methods

This study was conceived and guided by an ongoing CBPR partnership comprised of representatives from public health departments, AIDS service organizations (ASOs), universities, the local Latino community (including immigrant Latina women), and Latino-serving community-based organizations (CBOs), many of whom have been working together for > 8 years. This partnership is committed to CBPR because blending lived experiences with sound science has potential to develop deeper understandings of phenomena, and developed interventions are more likely to be more relevant, and thus, successful (Minkler and Wallerstein 2003; Cashman et al. 2008). The initiation of this partnership and its structure and governance has been described elsewhere (Rhodes et al., 2007; Rhodes et al., in press); the CBPR process closely adheres to previous conceptualizations of CBPR (Israel, Schulz, Parker, & Becker, 1998; Minkler and Wallerstein 2003; Cashman et al. 2008; Viswanathan, Eng, & Ammerman, 2004). This partnership has broad experiences in developing, implementing, and evaluating interventions designed to reduce sexual risk among Latino men (Rhodes et al. 2006; Rhodes et al. 2007; Rhodes et al. 2009). Latina women, including the girlfriends, wives, partners, sisters, and cousins of male participants, expressed a need for, and an interest in, participating in similar intervention programming designed to meet their sexual health priorities and needs.

Focus Groups

The partnership chose to conduct focus group interviews with Latinas to gain emic perspectives about Latinas' concerns and priorities related to sexual health and because the

methodology allows new areas of inquiry to emerge, as well as unforeseen perspectives and nuances revealed through group interaction and discussion (Balch, 1998; Rhodes & Hergenrather, 2002). Focus group questions were designed to provoke conversation about women's sexual health concerns, challenges, and fears; perceptions about optimal ways to care for their health; and recommendations for developing an intervention. Rather than the moderator asking each participant to respond to a question, participants were encouraged to talk to one another, ask questions, exchange ideas, and comment on one another's experiences and perspectives (Kitzinger, 1994, 1995).

A native Spanish-speaking Latina, who was trained in recruitment, focus group methods, and human subject protection, used a guide to moderate the focus groups. Development of the moderator's guide was an iterative process that included literature review; main content area brainstorming; and development, review, and revision of questions and probes (for clarification) and prompts (for detail). The moderator's guide, outlined in Table 1, was crafted with attention to wording, sequence, and content (Patton, 1990; Seidman, 1998). Translation into Spanish used a "committee approach" (Behling & Law, 2000). A group of individuals, including translators, content specialists, and an adjudicator with complementary skills, was convened. Translation was completed independently by multiple translators; a reconciled version was created and reviewed by an adjudicator before final implementation.

A short Spanish-language demographic assessment was administered to each focus group participant. Items included: age, country of origin, current employment status and job type, educational level, living situation (living with male partner, single, partner in country of origin, other), length of time living in NC, and number of children in the home.

Participant Selection and Recruitment

Recruitment of focus group participants was coordinated by members of the CBPR partnership. Participants were part of naturally existing social networks, which resulted in a broad age range, but was a deliberate recruitment strategy consistent with CBPR principles and designed to be culturally congruent and inclusive. Partners contended that immigrant Latina women would be more likely to participate and engage in a discussion if the approach was authentic to their existing social structures.

Four focus groups were conducted in Fall 2008, according to standard focus-group research methodology. The focus groups were held at three locations: a convenient off-campus Wake Forest University School of Medicine conference room; a YMCA facility; and a local Latino church. Eligibility criteria included being female, self-identifying as Latina or Hispanic, being 18 years or older, and providing informed consent.

A female notetaker, proficient in Spanish language, documented participants' nonverbal reactions, and tracked participant dialogue. Each focus group was audio-recorded and averaged 90 minutes; participants were offered refreshments and received $20.00 compensation for their time. Each audio-recorded discussion was transcribed verbatim and translated by a professional bilingual transcriptionist.

Oversight and protection of human subject approval were provided by the Institutional Review Boards (IRB) of Wake Forest University Health Sciences and the University of North Carolina at Chapel Hill.

Analysis

Grounded theory, which relies on an inductive approach to data analysis, was used. Rather than beginning the inquiry process with a preconceived notion of what was occurring, the

approach focused on understanding a wide array of experiences and building understanding grounded in real-world patterns (Glaser & Strauss, 1967). Verbatim transcripts from the focus groups were analyzed to identify common themes (Miles & Huberman, 1994) through coding text (Glaser & Strauss, 1967). To optimize reliability of coding, two members of the CBPR partnership analysis team completed a multistage inductive interpretive thematic process. They separately read each focus group transcript to identify potential codes, created a coding system and data dictionary, and then assigned agreed-upon codes to relevant text. Codes were divided and grouped according to similar concepts; categories formed from the concepts were the basis for the emergence of themes. Subsequently, themes were developed, refined, and interpreted.

Results

Participant Characteristics

A total of 43 women participated in one of four focus groups; each group had between nine and 13 participants. Participant ages ranged from 19 to 64 years old with a mean age of 36 years old. Select demographic characteristics of participants are presented in Table 2. More than one-half reported Mexico as their country of origin. Participants worked in factories and restaurants, and as house cleaners, childcare providers, and salespeople. Approximately one-quarter reported having completed elementary/middle school; another one-quarter reported completing some or all of high school. Nearly one-half of the participants noted living with a male partner, one-third reported being single, and one-fifth reported either living alone but with a partner in their country of origin or having a living situation categorized as “other,” which included living with a female partner or relatives. Length of time since arrival in the US averaged 7 years and ranged from 6 months to 17 years.

Qualitative Findings

Seven themes emerged from the data, as presented in Table 3.

Sexual Health is a Priority for Immigrant Latinas—Participants had a broad range of definitions for sexual health including being well educated about one’s body, contraceptives, fertility, and pregnancy; not having certain diseases, specifically HIV and other sexually transmitted infections (STIs); going to a healthcare provider for exams; having a healthy sex life; and communicating with sexual partner and children about sex. Participants reported that safeguarding one’s sexual health was a priority. They discussed the benefits of being able to recognize signs that indicate a health problem. Participants reported that the best way to take care of one’s sexual health is to be informed about disease transmission, prevention, and testing; and reproductive processes.

Latinas Value Health Screenings and Disease and Pregnancy Prevention Strategies—Participants recognized the importance of visiting a clinic if something seemed abnormal or “painful;” being tested for HIV and STIs or female-specific cancers; and receiving screenings such as breast exams, and general women’s health exams. Several participants doubted their male partner’s fidelity and thus stressed the importance of being screened for HIV and STIs. A participant noted,

“As a woman… she has to get tested even if she has a partner because one doesn’t always know if one’s husband or boyfriend, is involved with another person and that person might have a disease. When he comes home, he can give it to you. So, you always have to be in control.”

In addition, participants described the utility of condoms as providing some protection against disease. As a participant commented, “I use condoms; I too think I am the only one with my partner, but one never knows.”

Latinas Cite a Lack of Available Information about Sexual Health—Participants stated that discussions about sex may be culturally taboo for some Latino families, and that sexual education in their communities is insufficient. As a participant shared,

“I think that sometimes we, as Latinas, feel the taboo that generally our parents didn’t give us education [about sex], and there are a lot of girls who had their babies… young girls… because no one told you that this would happen to you, and that was a problem.”

Participants also noted a lack of readily available information about HIV and STI transmission and prevention, contraception, and reproductive processes. They asserted that inadequate sexual education is associated with a lack of preparation for sex which may have negative repercussions. A participant noted,

“Because it seems like every month we become aware of a new disease. Do we know how to prevent it? No, because we are not equipped with that information. Information isn’t available.”

Misinformation and Myths about Sexual Health May be Pervasive—Although participants acknowledged the importance of sexual health and many had some level of knowledge about health screenings and disease prevention strategies, the majority had knowledge gaps and held misconceptions about sexual health. This lack of correct information was illustrated by assertions that STIs are transmitted easily in public spaces and are always visible on the body, that douching or “cleaning well” after sex offers protection from disease, and that a range of contraceptives prompt side effects that could jeopardize one’s health.

Participants also suggested that misinformation about sexual and is passed within their social networks, evidenced by a participant’s report of how an informal Latino leader in her community advises community members that the use of contraceptives causes abortion.

Multiple Barriers Exist that Prevent Immigrant Latinas from Meeting Sexual Health Priorities and Needs—Participants identified a range of challenges associated with trying to take care of their sexual health priorities. Barriers included embarrassment and fear, male partner disapproval, language and discrimination, and multiple structural and environmental obstacles.

Embarrassment and fear: Participants discussed feeling vulnerable during, and embarrassed by, physical examinations, especially when seeing a male practitioner. As a participant explained, “I hate to go… and, open my legs to a man, I hate that!”

Participants also described their fear of utilizing healthcare services due to anti-immigration policies. As a participant reported,

“And fear that when you get to a place, they are going to ask you for your Social Security number and you don’t have one. Fear of immigration. You are sick or need help to go to a hospital, and it’s the first thing they will ask you for.”

Male partner disapproval: Participants reported that their interest in visiting a healthcare provider may be stymied by their male partner’s discomfort. Commenting on her friend’s

experience, a participant shared, “I have known many women who don’t go to the doctor… their husbands don’t like for the wife to go and have another man see her.”

Language and discrimination: Participants also noted that language and perceived discrimination were barriers affecting their comfort attending to their sexual health. As a participant noted,

“We need more Latino doctors in the Latino community, so we can communicate in Spanish and talk openly about the problems we have. We come to a place and no matter how hard we try, there are very few interpreters who can explain what’s happening.”

Participants also reported that their experiences with discrimination when accessing healthcare services lead to hesitation regarding whether to subsequently seek care. Participants explained how discrimination may even be directed toward them by fellow Latinos; one participant described how a Latino health center employee treated her disrespectfully due to her speaking Spanish, not English, when visiting the center.

Structural and environmental factors: Participants identified structural factors that inhibit their ability to access and utilize sexual health services for which they are eligible including a lack of transportation, inconvenient clinic hours in relation to work schedules, and lack of childcare. As a participant described,

“I don’t have a car. I have to take the bus. I have to look for a ride. And the [clinic] schedule doesn’t help. So, it’s transportation and it’s also the scheduling.”

Additionally, participants suggested that a lack of health insurance and the associated costs of healthcare, and difficulties related to immigration status and documentation, impede their ability to utilize healthcare. Participants reported that as non-US citizens or undocumented immigrants, they have restricted access to health services, and that healthcare clinics that might provide them with low cost or free services may not offer high quality care.

Latinas Consider Communication to be Key to Facilitate Sexual Health—

Participants also indicated that open communication about sexual health with sexual partners, medical and health providers, children, and friends is critical in facilitating better sexual health. Although some participants suggested that Latinas are less inhibited than previous generations regarding conversations about sex, most maintained that Latinas do not communicate as much as they should about their sexual health concerns. They asserted that improved communication about sex could serve to avert adverse health outcomes. As a participant suggested:

“There were words that we could not say at home. ‘Penis,’ that could not be mentioned at all, but let’s not do it with our children. Let’s open up more because education is what will be important.”

Latinas Recommend that a Sexual Health Intervention Include Fundamental Reproductive Health Information and Be Broad in Scope—

Because this CBPR partnership was committed moving towards action, the moderator’s guide explored intervention characteristics that participants prioritize. Participants identified twelve characteristics that should be included in sexual health interventions to meet their priorities and needs, as presented in Table 4. Participants indicated that an intervention designed to improve the sexual health of immigrant Latinas should provide information that is both simple and explicit to build a foundation of knowledge. They acknowledged the importance of clarifying misunderstandings about basic anatomy and reproductive health. They wanted

interventions to be sex positive and help them overcome socio-cultural taboos related to sexuality and reproduction. Participants recommended that an intervention include information about how pregnancy occurs and how pregnancy can safely and effectively be prevented through proper contraceptive use. This approach also would overcome the stigma associated with HIV and STIs, framing these issues within the larger realm of sexual and reproductive health.

Participants also wanted to learn more about STIs, routes of transmission, associated risk behaviors, signs and symptoms, and how to protect oneself from infection. As a participant commented,

"[We] should know more and get more informed about sex, what sex is, what consequences there are, what happens. Also, about sexual diseases, what they are, about each one of them, and what affect it can have in us."

Participants suggested that an intervention should equip them with information and practical skills, such as how to correctly use a condom and negotiate its use with a partner, and what is entailed when accessing sexual health services in terms of cost and the physical examination itself. Participants suggested that through skills development, a sexual health intervention should enhance their ability to communicate about sex with partners. Participants noted that because Latinas rely on one another, they need guidance about how to communicate and support other women in their families and communities. They also suggested that an intervention should build their skills for how to talk to providers and make the most of medical visits. Finally, participants expressed a commitment to meeting their children's needs and wanted to learn how to communicate effectively with their children about sexual health.

Participants asserted that an intervention should take advantage of existing and informal social networks. Participants reported that as they rely on one another for practical support, they could help one another learn about sexual health. Participants also suggested that Latinas similar to themselves, who understand both cultural and immigration contexts, have mastery of both sexual and reproductive health information, are compassionate and non-judgmental, and are trustworthy, would be appropriate to train to serve as community health workers, peer educators, or lay health advisors.

Participants reported that an intervention should include a variety of teaching strategies to meet diverse needs and learning styles. Videos and other interactive materials were highlighted as potentially making an intervention more engaging. Finally, participants also suggested venues for program delivery including schools, churches, community centers, housing community clubhouses, or health departments.

Discussion

Many Latinas in NC are part of a new trend of immigration to the southeastern US, and little about their sexual health priorities and needs has been well documented. These findings illustrate that despite the challenges of reaching a vulnerable population; working with Latinas in this region of the US to gather information about their health concerns is feasible. Furthermore, the use of CBPR facilitated trust and recruitment of a vulnerable and "hard-to-reach" population. Although findings from this study may not be relevant for all Latinas, this study provides key preliminary data, using an authentic research approach, on a population about whom little is currently known.

Findings from this study have important implications for the development of a sexual health intervention to reduce their risks. First, participants considered sexual health to be important

and a priority and they recognized the need to become better informed. Participants also valued health screenings and disease and pregnancy prevention strategies. They affirmed that it is important to protect and promote their sexual health, noting the benefits of visiting a clinician, getting screened for HIV and STIs, and using barrier methods during sex. Although some participants mentioned their screening practices, it was unclear whether their statements reflect their own behaviors and the behaviors of the majority of Latinas or illustrate a social desirability bias. Such a bias seems plausible, given participants' recognition of the wide range of challenges associated with meeting their health priorities and needs. Future studies should explore participants' utilization of available services and resources for health.

Participants noted a lack of available information about sexual health. They reported that sexual health may not be discussed within Latino families, which, coupled with a lack of sexual health education offered in Spanish language from other sources (e.g. school, educational programs, television, radio), may result in negative health consequences, including infection with HIV and STIs. This finding is congruent with other research conducted with NC Latinas suggesting that a lack of knowledge about reproductive processes may be associated with a lack of sex education (Talmi, Shryer, Billings & Gordon, 2005).

Participants revealed misinformation and myths about sexual health, including HIV and STI transmission and protection. Latinas' misinformation about sexual health has been identified in other literature (Byrd, Peterson, Chavez & Heckert, 2004; Garces-Palacio, Altarac & Scarinci, 2008; McMullin, De Alba, Chavez & Hubbell, 2005; Romo, Berenson & Wu, 2004; Scarinci, Beech, Kovach & Bailey, 2003), and could potentially contribute to increased rates of infection and to misuse or non-use of barrier methods. Effective intervention efforts must focus on dispelling such myths and clarifying topics that may be confusing and about which misunderstandings are common.

Because multiple obstacles may impede Latinas' ability to meet their sexual health priorities and needs, effective intervention efforts may reduce barriers by clarifying the documentation required to access services, what a physical examination entails, and how to use contraceptives correctly. Other intervention approaches may include reducing structural barriers that impede access and utilization of healthcare services, bolstering interpreters' skills, and advocating for more bilingual and bicultural female clinicians. Interventions that address gender dynamics and educate males about the importance of women's healthcare may mitigate the negative impact of unequal decision-making power between men and women on women's health. Moreover, interventions may benefit from acknowledging both the social and cultural issues that put women at risk, and the strengths that can keep them healthy.

Participants considered open communication about sexual health to be important, although rare, noting that more open discussions about sexual health with informed trusted others would help meet their needs. Although research suggests that sexual silence is a pervasive cultural norm that translates to minimal discussions about sex among Latinas (Davila, 2005; Marin, 2003; Moreno, 2007), participants suggested that potentially restrictive cultural influences may not be insurmountable. They recognized that it may be difficult to talk freely about sex, but wanted to break this barrier and create new norms around sexual health communication with sexual partners, medical and health providers, children, and friends. This is a key finding given presumptions about what is considered to be culturally appropriate among Latinos. Immigrant Latinos and younger Latinos may be more willing to "break" cultural norms given that they immigrated to the US for a "better" life. Thus, they may be less likely to adhere to traditional cultural norms and expectations. Similarly,

although religious beliefs have been noted to influence discussions of sexuality (Sterling & Sadler, 2009; Zambrana, Cornelius, Boykin, & Lopez, 2004), during these focus groups, religion was not identified as a potential barrier. Again, this may result from the types of Latinas currently immigrating to the southeastern US.

Participants recommended that a sexual health intervention for Latinas include education about a range of topics, pointing to the value of a program that is broad in scope. Their recognition that discussions about sex are often taboo, and their interest in developing improved sexual communication and negotiation skills is particularly pertinent findings, as interventions may directly address this need through incorporating specific skill-building activities. Participants' enthusiasm about a program that allows them to gather repeatedly with women to discuss sexual health suggests the need for structured opportunities for Latinas to share their experiences, concerns and questions about sensitive health topics within a supportive context.

Overall, participants wanted a women's health intervention lead by a facilitator who is compassionate, non-judgmental, culturally-aware, and knowledgeable about the subject matter, underscoring the need for the program to be culturally responsive. An intervention might benefit from being co-facilitated by a peer who understands Latinas' lived experiences and a health educator with professional expertise who lends additional credibility to the messages.

Limitations

Convenience sampling was used and included a relatively small sample size; therefore, the findings cannot be generalized to all immigrant Latinas. Nevertheless, this study's results may be transferrable to communities in the southeastern US that are experiencing similar immigration trends and applied to inform the design of a sexual health intervention with and for immigrant Latinas in NC.

Although the focus group format for soliciting perspectives on sexual health within a community of immigrant Latinas generated rich qualitative data, the presence of peers may have limited discussion of stigmatized or otherwise sensitive behaviors. This methodological limitation would be difficult to overcome using focus groups; however, establishing a CBPR partnership may be a first step toward building trust to investigate issues that may be associated with shame, fear, and discomfort.

Conclusion

Our findings suggest that there is a desire and need for an intervention that offers easily-understood, accurate, culturally congruent sexual health intervention for Latinas. Such an intervention should incorporate basic information about sexual and reproductive health, particularly to dispel and clarify myths and misinformation that exist among this population. An intervention should be crafted using a multi-session format and address a range of sexual health topics.

An intervention also should incorporate skill-building activities for condom use and negotiation in a way that acknowledges gender dynamics and power differentials that may complicate such conversations and weaken Latinas' assertiveness. Participants should be given adequate time to practice using their skills and to receive constructive feedback and support from facilitators and peers. An intervention should offer practical advice about healthcare services and how precisely to access them.

A sexual health intervention inherently provides a critical opportunity for recent-immigrant Latinas, many of whom may experience vulnerability and fear, to build a social network,

offer each other social support, and to share ideas and resources related to sexual health. The value of such an opportunity must not be underestimated, especially given the inherent challenges faced by individuals navigating new policies, systems and practices.

Acknowledgments

The authors thank the multiple community partners for helping to make the implementation of this study possible, as well as the Latina community members who participated in focus groups and shared their insiders' perspective about sexual health. Support for this study was provided by the North Carolina Department of Health and Human Services with a Centers for Disease Control and Prevention grant (02885-08).

References

Balch GI. Exploring perceptions of smoking cessation among high school smokers: Input and feedback from focus groups. Preventive Medicine. 1998; 27(5PB):55–63.10.1006/pmed.1998.0382

Behling, O.; Law, KS. Translating questionnaires and other research instruments: Problems and solutions. Sage; 2000.

Byrd TL, Peterson SK, Chavez R, Heckert A. Cervical cancer screening beliefs among young hispanic women. Preventive Medicine. 2004; 38(2):192–197.10.1016/j.ypmed.2003.09.017 [PubMed: 14715211]

Centers for Disease Control and Prevention. HIV/AIDS surveillance report. Atlanta, GA: US Department of Health and Human Services; 2009.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. 2006. Retrieved from: www.cdc.gov/ncipc/wisqars

Centers for Disease Control and Prevention. Sexually transmitted disease surveillance 2006. Atlanta, GA: US Department of Health and Human Services; 2007.

Centers for Disease Control and Prevention. Sexually transmitted disease surveillance 2007. Atlanta, GA: US Department of Health and Human Services; 2009.

DATA 2010, the Healthy People 2010 Database. The Centers for Disease Control and Prevention; Retrieved from: http://wonder.cdc.gov/data2010

Davila, YR. The social construction and conceptualization of sexual health among Mexican American women; Research and Theory for Nursing Practice. 2005. p. 357-368.Retrieved from: www.cinahl.com/cgi-bin/refsvc?jid=2320&accno=2009083187

Garces-Palacio IC, Altarac M, Scarinci IC. Contraceptive knowledge and use among low-income Hispanic immigrant women and non-Hispanic women. Contraception. 2008; 77(4):270–275.10.1016/j.contraception.2007.12.008 [PubMed: 18342650]

Glaser, BG.; Strauss, AL. The discovery of grounded theory: Strategies for qualitative research. Chicago IL: Aldine; 1967.

Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: Assessing partnership approaches to improve public health. Annual Review of Public Health. 1998; 19(1): 173–202.10.1146/annurev.publhealth.19.1.173

Kasarda, JD.; Johnson, JH. The economic impact of the Hispanic population on the state of North Carolina. Chapel Hill, NC: Frank Hawkins Kenan Institute of Private Enterprise; 2006.

Kitzinger J. Qualitative research: Introducing focus groups. British Medical Journal. 1995; 311:299–302. [PubMed: 7633241]

Kitzinger J. The methodology of focus groups: The importance of interaction between research participants. Sociology of Health & Illness. 1994; 16(1):103–121.

Marin BV. HIV prevention in the hispanic community: Sex, culture, and empowerment. Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society. 2003; 14(3):186–192.10.1177/1043659603014003005

McMullin, JM.; De Alba, I.; Chavez, LR.; Hubbell, FA. Influence of beliefs about cervical cancer etiology on pap smear use among Latina immigrants; Ethnicity & Health. 2005. p. 3-18.Retrieved from: www.cinahl.com/cgibin/refsvc?jid=1323&accno=2005087881

Miles, MB.; Huberman, AM. Qualitative data analysis: An expanded sourcebook. 2. Thousand Oaks, CA: Sage; 1994.

Moreno CL. The relationship between culture, gender, structural factors, abuse, trauma, and HIV/AIDS for Latinas. Qualitative Health Research. 2007; 17(3):340–352.10.1177/1049732306297387 [PubMed: 17301342]

North Carolina Institute of Medicine. NC Latino Health, 2003: Executive Summary. Durham, NC: North Carolina Institute of Medicine; 2003 February.

Patton, MQ. Qualitative evaluation and research methods. 2. Newbury Park, CA: Sage; 1990.

Rhodes, SD.; Benfield, D. Community-based participatory research: An introduction for the clinician researcher. In: Blessing, JD., editor. Physician assistant's guide to research and medical literature. 2. Philadelphia, PA: FA Davis; 2006. p. 105-18.

Rhodes, SD.; Eng, E.; Hergenrather, KC.; Remnitz, IM.; Arceo, R.; Montaño, J.; Alegria-Ortega, J. Exploring Latino men's HIV risk using community-based participatory research; American Journal of Health Behavior. 2007. p. 146-158.Retrieved from: www.cinahl.com/cgi-bin/refsvc?jid=182&accno=2009559741

Rhodes SD, Hergenrather KC. Exploring hepatitis B vaccination acceptance among young men who have sex with men: Facilitators and barriers. Preventive Medicine. 2002; 35(2):128–134.10.1006/pmed.2002.1047 [PubMed: 12200097]

Rhodes SD, Hergenrather KC, Griffith D, Yee LJ, Zometa CS, Montaño J, Vissman A. Sexual and alcohol use behaviors of Latino men in the south-eastern USA. Culture, Health & Sexuality. 2009; 11(1):17–34.10.1080/13691050802488405

Rhodes SD, Hergenrather KC, Montaño J, Remnitz IM, Arceo R, Bloom FR, Leichliter JS, Bowden WP. Using community-based participatory research to develop an intervention to reduce HIV and STD infections among Latino men. AIDS Education and Prevention. 2006; 18(5):35–89.10.1521/aeap.2006.18.5.375

Rhodes SD, Hergenrather KC, Vissman AT, Stowers J, Davis AB, Hannah A, Alonzo J, Marsiglia FF. "Boys must be men, and men must have sex with women": A qualitative CBPR study to explore sexual risk among African American, Latino, and white gay men and MSM. American Journal of Men's Health. In press.

Rhodes SD, Hergenrather KC, Wilkin A, Alegría-Ortega J, Montaño J. Preventing HIV infection among young immigrant Latino men: Results from focus groups using community-based participatory research. Journal of the National Medical Association. 2006; 98(4):564–573. [PubMed: 16623070]

Romo LF, Berenson AB, Wu ZH. The role of misconceptions on Latino women's acceptance of emergency contraceptive pills. Contraception. 2004; 69(3):227–235.10.1016/j.contraception.2003.10.020 [PubMed: 14969671]

Scarinci IC, Beech BM, Kovach KW, Bailey TL. An examination of sociocultural factors associated with cervical cancer screening among low-income Latina immigrants of reproductive age. Journal of Immigrant Health. 2003; 5(3):119–128.10.1023/A:1023939801991 [PubMed: 14512766]

Seidman, I. Interviewing as qualitative research: a guide for researchers in education and social sciences. New York, New York: Teacher's College Press; 1998.

Southern State Directors Work Group. Southern States Manifesto: Update 2008. HIV/AIDS and Sexually Transmitted Diseases in the South. Birmingham, AL: Southern AIDS Coalition; 2008.

Sterling SP, Sadler LS. Contraceptive use among adolescent Latinas living in the United States: the impact of culture and acculturation. Journal of Pediatric Health Care. 2009; 23(1):19–28.10.1016/j.pedhc.2008.02.004 [PubMed: 19103403]

Talmi, D.; Shryer, R.; Billings, D.; Gordon, R. The sexual and reproductive health of Latinas in North Carolina: A five county needs assessment. Chapel Hill, NC: Ipas; 2005.

US Census Bureau. American Community Survey Data Profile Highlights: North Carolina Fact Sheet. Washington, DC: United States Department of Commerce; 2005.

US Census Bureau. American Community Survey Data Profile Highlights: North Carolina Fact Sheet. Washington, DC: United States Department of Commerce; 2007.

US Census Bureau. American Community Survey Data Profile Highlights: North Carolina Fact Sheet. Washington, DC: United States Department of Commerce; 2008.

Viswanathan, M.; Eng, E.; Ammerman, A. Report/Technology Assessment No. 99. Rockville, MD: Agency for Healthcare Research and Quality; 2004. Community-based participatory research: Assessing the evidence.

Wasserman M, Bender D, Lee SY. Use of preventive maternal and child health services by Latina women: A review of published intervention studies. Medical Care Research and Review. 2007; 64(1):4–45.10.1177/1077558706296238 [PubMed: 17213456]

Zambrana, RE.; Cornelius, LJ.; Boykin, SS.; Lopez, DS. Latinas and HIV/AIDS risk factors: Implications for harm reduction strategies; American Journal of Public Health. 2004. p. 1152-1158.Retrieved from: www.cinahl.com/cgibin/refsvc?jid=114&accno=2005029432

Table 1

Focus Group Questions Excerpted from the Moderator's Guide

1	What does sexual health mean to you?
2	What does it mean to you to be 'sexually healthy'?
3	What important concern/worry do you have about your sexual health?
4	What do you do to maintain/care for your sexual health? What makes it easy or possible for you to take care of your sexual? • With whom do you feel comfortable talking about these issues? • What clinic or health center do you feel comfortable going to?
5	What do you do when you have a concern about your sexual?
6	What are the challenges that make it difficult for you to take care of your sexual?
7	What sexual health issue/topic would you like to learn more about? • For you, what is an important topic you would like to receive more information about through an educational program?
8	What would be a comfortable, pleasant place for an educational program about sexual and reproductive health with a group of women?
9	What characteristics should a person have who offers an educational program about Latinas' sexual health?

1	¿Qué significa para usted salud sexual?
2	¿Qué significa para usted estar sexualmente saludable?
3	¿Cuál preocupación tiene usted sobre su salud sexual?
4	¿Qué hace usted para mantener una buena salud sexual? ¿Qué facilita o hace posible que usted cuide su salud sexual? • ¿Con quién se siente usted más cómodo/a cuando habla de estos temas? • ¿A qué clínica o centro de salud se siente usted más cómodo yendo?
5	¿Qué hace usted cuando le concierne o preocupa su salud sexual?
6	¿Cuáles son los retos que hacen difícil tratar de cuidar su salud sexual?
7	¿De cuál tema de salud sexual quisiera aprender más usted? • ¿Para usted, cuál es el tema más importante relacionado con la salud sexual—que tipo de informaciónón quisiera recibir a través de un programa educativo?
8	¿Dónde sería un buen lugar/espacio para participar en un programa educativo sobre la salud sexual con un grupo de mujeres? ¿Cuál sería un lugar/espacio agradable?
9	¿Cuáles características deben tener la persona que ofrecería un programa educativo sobre la salud sexual de la mujer latina?

Table 2

Select Demographic Characteristics of Focus Group Participants (N=43)

Characteristic	Mean or n (%), as appropriate
Age in years	36 (range 19–64)
Country of Origin	
Mexico	24 (55.8)
Puerto Rico	5 (11.6)
El Salvador	4 (9.3)
Dominican Republic	3 (7.0)
Other	7 (16.3)
Years in North Carolina	7 years (range 6 months–17 years)
Education	
Less than grade 6	8 (18.6)
Grades 6–8	11 (25.6)
Some or all of high school	11 (25.6)
Beyond high school	13 (30.2)
Living Situation	
Living with male partner	21 (48.8)
Single	13 (30.2)
Living alone but reporting partner in country of origin	1 (2.3)
Other	8 (18.6)
Employment	
Unemployed	17 (39.5)
Employed	26 (60.5)
Number of Children Living in the Home	
0	8 (18.6)
1–3	29 (67.4)
4–6	3 (7.0)
More than 6	1 (2.3)
No response	2 (4.7)

Table 3

Themes Identified Related to Sexual Health of Immigrant Latinas

1	Sexual health is a priority for immigrant Latinas
2	Latinas value health screenings and disease and pregnancy prevention strategies
3	Latinas cite a lack of available information about sexual health
4	Misinformation and myths about sexual health may be pervasive
5	Multiple barriers exist that prevent immigrant Latinas from meeting sexual health priorities and needs
6	Latinas consider communication key to facilitate sexual health
7	Latinas recommend that a sexual health intervention include fundamental reproductive information and be broad in scope

Table 4

Identified Key Intervention Characteristics

A sexual health intervention for Latinas should:
• Be explicit and simple to build a firm foundation for understanding
• Clarify misunderstandings about anatomy and increase accurate knowledge base around sexual and reproductive body parts and their functions
• Be sex positive to help overcome socio-cultural taboos related to sexuality and reproduction
• Outline and describe how pregnancy occurs and safe and effective contraceptive use
• Include information on HIV and STI transmission and prevention
• Offer skills building around condom use and negotiating condom use
• Provide guidance on how to access available resources and what to expect during sexual and reproductive health screening visits and testing
• Build skills among women to effectively and safely communicate with partners, peers, adult family members, providers, and children
• Build on informal networks of Latina women
• Be natural helper based
• Utilize a variety of teaching strategies
• Take place in community locations, including schools, churches, community centers, housing community clubhouses, or health departments