Latino Immigrant Men Who Have Sex with Men: Results of an HIV Prevention Needs Assessment

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EXECUTIVE SUMMARY

This report describes the results of a behavioral needs assessment conducted for Latino immigrant males who have sex with males (MSM). Thirty-six Latino immigrant MSM completed a detailed interview including questions about HIV and AIDS, sexual behaviors with male, female, and transgendered partners, drug and alcohol use, and opinions about how to do effective HIV prevention.

Major findings include:

- Most of the respondents were gay or bisexual, but five of the respondents (14%) identified as heterosexual.
- Sixty-one percent of respondents reported unprotected anal sex (receptive and/or insertive) in the last six months, and 36% reported unprotected receptive anal sex in the last six months.
- Four of the five heterosexually identified respondents reported unprotected vaginal sex with women and/or unprotected insertive anal sex with men, women, or transgendered persons in the last six months.
- Reported drug use in the last three months, both injection and non-injection, was relatively low among the sample, with the exception of alcohol (92%), marijuana (47%), and crack or cocaine (19%). None reported injection drug use in the last three months.
- Forty-seven percent of the respondents reported ever receiving an HIV test. Six percent (two individuals) were self-reported HIV-positive.
- Twenty-eight percent of respondents said they had ever used HIV prevention services, and none of the heterosexually identified men in the sample had used such services.

The results suggest that Latino immigrant MSM are at risk for HIV, but that testing and other HIV prevention services are not reaching this group effectively. The following recommendations for HIV prevention for Latino immigrant MSM are offered:

- **Recommendation 1:** Risks related to sex with men and transgendered persons should be explored with heterosexually identified Latino immigrant men who receive HIV testing or other HIV prevention services.
- **Recommendation 2:** Interventions for Latino immigrant MSM should assess and explore individuals' level of concern regarding HIV, reasons for concern (or lack of it), and how behavior change could reduce their concerns.
- **Recommendation 3:** Interventions should focus on sexual risks in general as well as sexual risks related to recreational drug use.
- **Recommendation 4:** Expand the scope of HIV prevention interventions beyond individual behavior change goals to community- and policy-level interventions that address homophobia/biphobia and economic insecurity among Latino immigrant MSM.

- **Recommendation 5:** HIV prevention interventions should meet people "where they're at" by addressing the life issues that are important for clients in addition to HIV-related topics.
- **Recommendation 6:** Anonymous HIV testing, during which no identifying information is collected, should be made accessible to this population. The availability of this type of testing is especially important for heterosexually identified Latino immigrant MSM, and outreach efforts to recruit these men for testing should be increased.
- **Recommendation 7:** Increase one-on-one counseling and other services that are sensitive to the unique needs of Latino immigrant MSM clients. These services should be based in the Latino community and use Latino Spanish-speaking men as the prevention messengers.
- **Recommendation 8:** Increase the capacity of health care providers, HIV-specialized agencies, and other non-HIV community-based agencies to provide HIV prevention services to this population. Ensure a good mix of agencies serving heterosexual and gay/bisexual men to accommodate the different subgroups of Latino immigrant MSM.
- **Recommendation 9:** Increase and widen outreach efforts to Latino immigrant MSM in order to recruit them for HIV testing and other HIV prevention services.
- **Recommendation 10.** Reduce reliance on the use of written ads and materials for HIV prevention for Latino immigrant MSM.
- **Recommendation 11.** Address community norms regarding unsafe sex among gay and bisexual Latino immigrant MSM.
- **Recommendation 12.** Increase components of interventions that serve young Latino men who are recent immigrants, as they may be a high-risk subgroup of the larger Latino population.

INTRODUCTION

In San Francisco, a great deal is known about HIV and AIDS among numerous populations. Frequent studies are conducted, yielding a wealth of data that are used to plan and improve HIV prevention efforts. Nevertheless, gaps in knowledge remain, particularly in the area of identifying populations on the verge of increasing numbers of new infections. This information is critical for HIV prevention planning and implementation, so that funds and programs can be targeted to populations most in need of prevention.

In Fall 2000, the San Francisco HIV Prevention Planning Council (HPPC) identified eight populations believed to be at risk but for whom there are few current HIV-related data. They prioritized these eight populations for behavioral needs assessments, and needs assessments were conducted in early 2001 with two of the eight populations. This report describes the results of the study among Latino immigrant males who have sex with males (MSM) and males who have sex with males and females (MSM/F), including those who identify as heterosexual. This group was one of the highest priority populations. (From here on, this group will be referred to as Latino immigrant MSM.) The formative research described here represents a preliminary inquiry into HIV prevention needs and issues for this population, with the goal of identifying recommendations for prevention.

Some studies among Latino MSM in San Francisco and other locales have explored risk factors, intervention effectiveness, and how to access this "hard-to-reach" population. Latinos have some of the highest prevalence of unprotected anal intercourse, between 40% and 52% (SFDPH 1998), supporting the need for HIV prevention efforts in this community. Other studies have explored cultural and social factors that contribute to behavioral risk. For example, Rafael Diaz's work identifies six such factors for Latino gay male populations: machismo, homophobia, family cohesion, sexual silence, poverty, and racism (Diaz 1997).

However, only a few studies have focused on the immigrant Latino population. Two such studies identified elements that are found in successful prevention programs for Latino immigrant MSM:

- A focus on sexual identity and practices in the context of cultural values (e.g., religion, cultural identity) improves the quality of client participation in HIV prevention efforts. (Castellanos, et al.1999)
- A harm reduction approach facilitates reachable goals for this population. (Castellanos, et al. 1999)
- For undocumented, monolingual immigrants, a culturally competent prevention case management intervention that includes one-on-one risk reduction counseling, service coordination, emotional support, and education can be effective in enabling participants to focus on their risk behaviors and empowering them to make changes in their lives. (Castillo 1999)

A potentially high-risk subpopulation among Latino immigrant MSM is heterosexually identified MSM. For this group, the effects of homophobia may be more intense, and having experienced homophobia has been associated with HIV risk behavior (Diaz 2001). This population can be more difficult to access than gay and bisexual Latino immigrant MSM because sexual secrecy may be even greater among this population. However, some have developed innovative strategies to reach this population. In Santa Clara County, in which 80% of all the AIDS cases among Latinos are Latino MSM who do not identify as gay, Latina male-to-female transgendered peer educators were hired to perform song and dance routines with HIV prevention messages at Latino straight bars. Although initial resistance was substantial, after months of persistence, men at the bars began to take condoms when before they would not (Salerno 1999).

In this needs assessment, the interviewees were all immigrant Latino MSM. The survey focused on assessing behavioral risks among the participants, in an attempt to document the HIV prevention needs of this group. Findings related to the heterosexually identified men in the sample are highlighted throughout the report.

METHODS

METHODS

In February/March 2001, a nonrandom (convenience and snowball) sample of Latino immigrant MSM was recruited from bars and other street and community locations in San Francisco (e.g., the Mission District, Cesar Chavez Street, Civic Center). In addition, the social networks of the interviewers and other key informants were used to identify potential respondents. (To protect anonymity, the key informants asked potential participants to contact us if they were interested, instead of key informants providing Harder+Company with names and contact information.) A team of interviewers with prior outreach experience or a history of working with the Latino community were hired and trained to administer a 30- to 45-minute interview. Interviews were conducted in Spanish. The survey (Appendix A) consisted of open- and closed-ended questions about basic demographics; HIV/AIDS knowledge and attitudes; HIV testing history and status; attitudes about HIV prevention services; sexual behaviors with male, female, and transgendered partners; drug and alcohol use; and opinions about how to do effective HIV prevention. A $25 cash incentive was offered in appreciation for the men's time.

The survey asked questions about sexual risk behavior in two ways: (1) by gender of partner, and (2) by "type" of partner. Therefore, respondents were asked about their sexual behavior with men, women, and transgendered persons. In addition, for each partner gender, they were asked about sexual behavior with primary or main partners, casual partners, and commercial sex worker (CSW) partners. Many of the findings are presented using these categories.

LIMITATIONS

This needs assessment has a number of limitations that should be considered when reviewing and interpreting its results. These limitations preclude making definitive statements or conclusions about the prevention needs of the San Francisco Latino immigrant MSM population. First, this needs assessment lacked a "control" or "comparison" group of non-immigrant Latino MSM, which would have improved our ability to identify the unique needs of the immigrant population compared with the non-immigrant population. Second, with the relatively small sample size, statistical significance could not be achieved. Third, nonrandom sampling techniques prevent the generalization of findings to the larger population. Fourth, interviewers reported that there may have been some "response bias" in which some respondents may have said what they thought the interviewer wanted to hear, due to difficulty in talking about sensitive issues or other reasons. Fifth, interviewers reported that economic necessity may have led some respondents to lie about having sex with men in order to receive the cash incentive. Finally, the survey explored sex-related risks in much greater depth than drug-related risks, and thus cannot be considered an exhaustive assessment of risk.

Given these limitations, this study should be thought of as a preliminary inquiry into HIV prevention issues for the Latino immigrant MSM population and not as a definitive comment on the prevention needs of this group.

RESULTS

DESCRIPTION OF THE SAMPLE

Forty-five men completed the interview, of which 36 were eligible Latino immigrant MSM.[1] The demographics of the sample are shown in Table 1. All respondents were Latino males; thus gender and race/ethnicity distribution are not presented. In general, the sample was predominantly gay (although there were also bisexual and heterosexual respondents), unmarried, in their twenties and thirties, and born in Mexico. Approximately one third (36%) of respondents moved to the United States in the last five years, and approximately half (47%) were monolingual Spanish speakers.

The survey respondents were predominantly gay (although there were also bisexual and heterosexual respondents), unmarried, under 30 years old, and born in Mexico.

The five heterosexually identified men were between 20 and 26 years old and were monolingual Spanish speakers. Four of the five were asked questions about length of time in the United States and San Francisco. All four were relatively recent immigrants (four years or less in the United States) and relatively new to San Francisco (three years or less in the city). One of the five was married to a woman.

[1] Nine respondents were excluded from the analysis because they did not report sex with men, did not identify as Latino, or were born in the United States.

Table 1: Demographics of Survey Sample

Demographic Characteristic	Number (% of sample)
Country of Origin	
Brazil	1 (3%)
Colombia	1 (3%)
El Salvador	5 (14%)
Guatemala	1 (3%)
Honduras	1 (3%)
Mexico	24 (67%)
Declined to answer	3 (8%)
Length of Time in United States	
<3 years	5 (14%)
3-5 years	8 (22%)
5-10 years	10 (28%)
>10 years	9 (25%)
Language(s) Spoken	
Spanish only	17 (47%)
Spanish and English	14 (38%)
Spanish, English, and Portuguese	1 (3%)
Spanish and French	1 (3%)
Age	
18-29	23 (64%)
30-39	11 (31%)
40-49	1 (3%)
50+	0 (0%)
Declined to answer	1 (3%)
Sexual Orientation	
Heterosexual/straight	5 (14%)
Bisexual	11 (31%)
Homosexual/gay	20 (56%)
Marital Status	
Not married	26 (72%)
Married to a woman	5 (14%)
Married to a man	3 (8%)
Other (separated, divorced, or widowed)	1 (3%)
Declined to answer	1 (3%)
Self-Reported HIV Status	
HIV-positive	2 (6%)
HIV-negative	15 (42%)
Never tested	17 (47%)
Test results unknown	1 (3%)
Declined to answer	1 (3%)

Note: Percentages that do not add up to 100% indicate missing data.

FINDINGS

HIV Awareness and Perceptions of Risk

> ***56% of survey respondents reported being somewhat or very concerned about HIV.***

When asked how concerned they were about HIV, 56% of respondents (n=20) reported being "somewhat concerned" or "very concerned." Thirty-six percent (n=13) reported being "only a little concerned" or "not at all concerned," and the remaining 8% (n=3) did not know if they were concerned. Only two of the heterosexually identified respondents reported being "somewhat concerned"; the others were "not at all concerned" (n=1) or did not know if they were concerned (n=2).

"Somewhat concerned" and "very concerned" respondents were asked why they were concerned. The three most common answers, followed by representative quotes, were:

- Do not want to die (n=6)
  "Because I'm scared that I'll get infected and die."
  "…there's nothing to stop this disease – we're all going to die."
  "Because HIV is a nasty disease and you can die from it..."

- Believe self to be at risk/have been exposed (n=6)
  "Because my boyfriend is contagious."
  "…I've had sex without condoms and that was stupid."

- HIV is "dangerous" (n=4)
  "Because of how dangerous it is."

When "only a little concerned" or "not at all concerned" respondents were asked why they were not concerned, the most common answer was that they always used condoms (n=5). Other answers included that they were already HIV-positive (n=1), may have been exposed (n=1), not at risk (n=1), and just not worried (n=1). Respondents who said they did not know if they were concerned said they did not think about it (n=2) or did not think they were at risk (n=1).

Sexual Partners of Latino Immigrant MSM

> ***Nearly half of the survey respondents had female and/or transgendered sexual partners in addition to their male partners in the last six months.***

Over half the sample (56%) reported having had sex with only male partners in the last six months. Just over one-fourth of the sample (28%) reported male and female partners in the last six months. In addition, 8% reported male and transgendered partners, and 8% reported male, female, and transgendered partners (Table 2). Eight men (22%) reported having sex with a partner where there was an exchange of money

or drugs; however, it was not asked whether the men gave drugs/money for sex or received drugs/money for sex. Of the five men who identified as heterosexual, one reported sex with men only, one reported sex with men and women, and three reported sex with men, women, and transgendered persons. Finally, 78% (n=28) of the total sample reported having had more than one sexual partner in the last six months.

Table 2: Sexual Partners of Respondents

Gender of Sexual Partners in Last 6 Months	Number (%)
Male partners only	20 (55.6%)
Male and female partners	10 (27.8%)
Male and transgendered partners	3 (8.3%)
Male, female, and transgendered partners	3 (8.3%)

Sexual Behaviors and Condom Use

Respondents were asked a separate series of questions about the sex they had in the last six months with males, females, and transgendered persons. In addition, for sex with each gender, respondents were asked about sex with main or primary partners, casual partners, and commercial sex worker (CSW) partners. The data are presented in Tables 3, 4, and 5. The main findings were:

- Overall, 61% of the respondents (n=22) reported unprotected anal sex (receptive and/or insertive) with men in the last six months.
- Thirty-six percent (n=13) of the entire sample reported unprotected receptive anal sex in the last six months. The prevalence of unprotected receptive anal sex among only those in the sample who reported having this type of sex (n=13 of 21) was 62%.
- Frequency of unprotected vaginal sex with female partners was high, with between 67% and 100% of respondents reporting unprotected vaginal sex, depending on the partner type.
- Four men reported having unprotected receptive anal sex with a male partner as well as unprotected vaginal and/or anal sex with a female partner in the last six months.
- Four of the five heterosexually identified respondents reported unprotected vaginal sex with women and/or unprotected insertive anal sex with men, women, or MTF persons in the last six months.

Frequency of unprotected receptive and insertive anal sex with men was high, as was frequency of unprotected vaginal sex with female partners.

Table 3: Sexual Risk Behaviors with Male Partners in the Last Six Months

Risk Behavior in Past Six Months	Sex with Male Main Partners: n (%)	Sex with Male Casual Partners: n (%)	Sex with Male Sex Worker Partners: n (%)
Number/percent reporting any type of sex	16 (44%)	20 (56%)	7 (19%)
Of those who had sex, number/percent reporting multiple partners	4 (25%)	13 (65%)	5 (71%)
Of those who had sex, number/ percent reporting insertive anal sex	15 (94%)	15 (75%)	6 (86%)
Of those who had insertive anal sex, number/percent reporting unprotected insertive anal sex	7 (47%)	9 (60%)	6 (100%)
Of those who had sex, number/ percent reporting receptive anal sex	11 (69%)	12 (60%)	0 (0%)
Of those who had receptive anal sex, number/percent reporting unprotected receptive anal sex	7 (64%)	7 (58%)	-

Table 4. Sexual Risk Behaviors with Female Partners in the Last Six Months

Risk Behavior in Past Six Months	Sex with Female Main Partners: n (%)	Sex with Female Casual Partners: n (%)	Sex with Female Sex Worker Partners: n (%)
Number/percent reporting any type of sex	7 (19%)	8 (22%)	2 (6%)
Of those who had sex, number/percent reporting multiple partners	2 (29%)	6 (75%)	1 (50%)
Of those who had sex, number/ percent reporting insertive anal sex	1 (14%)	1 (13%)	2 (100%)
Of those who had insertive anal sex, number/percent reporting unprotected insertive anal sex	1 (100%)	0 (0%)	2 (100%)
Of those who had sex, number/ percent reporting vaginal sex	7 (100%)	6 (75%)	1 (50%)
Of those who had vaginal sex, number/percent reporting unprotected vaginal sex	7 (100%)	4 (67%)	1 (100%)

Table 5. Sexual Risk Behaviors with Transgendered Partners in the Last Six Months

Risk Behavior in Past Six Months	Sex with Transgendered Main Partners: n (%)	Sex with Transgendered Casual Partners: n (%)	Sex with Transgendered Sex Worker Partners: n (%)
Number/percent reporting any type of sex	2 (6%)	0 (0%)	4 (11%)
Of those who had sex, number/percent reporting multiple partners	0 (0%)	-	3 (75%)
Of those who had sex, number/ percent reporting insertive anal sex	2 (100%)	-	3 (75%)
Of those who had insertive anal sex, number/percent reporting unprotected insertive anal sex	0 (0%)	-	3 (100%)
Of those who had sex, number/ percent reporting receptive anal sex	0 (0%)	-	0 (0%)
Of those who had receptive anal sex, number/percent reporting unprotected receptive anal sex	-	-	-

After reporting their frequency of condom use on a Likert scale,[2] respondents were asked (1) whether there was any talk about using condoms with their partner(s), and (2) if so, who initiated the conversation(s). The data are presented in Tables 6 and 7. Major findings include:

- On average, respondents were more likely to report *not* talking about using condoms than talking about using condoms with their partners.
- Talking about condoms was less likely with female partners (compared with male and transgendered partners), although not by a substantial margin.
- Talking about condoms was much less likely to occur with CSW partners (compared with main or casual partners).
- Among the respondents who talked about condom use with their partners, the most common response to the question about who initiated the discussion was "sometimes me, sometimes my partner."

On average, respondents were more likely to report* not *talking about using condoms than talking about using condoms with their partners.

[2] A Likert scale asks respondents to choose the most appropriate response from a list of ordered choices. For frequency of condom use, the scale items they could choose from were: always, most of the time, sometimes, rarely, and never.

Table 6. Talk About Condom Use

Partner Gender and Type	Talked About Using Condoms	Did Not Talk About Using Condoms
Male partner(s) (all partner types)	18 (46.2%)	21 (53.8%)
Female partner(s) (all partner types)	7 (41.2%)	10 (58.8%)
Transgendered partner(s) (all partner types)	3 (50.0%)	3 (50.0%)
Main partner(s) (all genders)	16 (64.0%)	9 (36.0%)
Casual partner(s) (all genders)	10 (41.7%)	14 (58.3%)
Sex work partner(s) (all genders)	2 (15.4%)	11 (84.6%)

Note: Data include more than one response from the same individual in cases where the person reported sex with more than one partner type or more than one gender.

Table 7. Initiation of Talk About Condom Use

Partner Gender and Type	Respondent Always Initiated Conversation	Partner Always Initiated Conversation	Sometimes Respondent and Sometimes Partner Initiated Conversation
With male partner(s) (all partner types)	4 (31%)	1 (8%)	8 (62%)
With female partner(s) (all partner types)	3 (43%)	1 (14%)	3 (43%)
With transgendered partner(s) (all partner types)	0 (0%)	0 (0%)	3 (100%)
With main partner(s) (all genders)	3 (25%)	1 (8%)	8 (67%)
With casual partner(s) (all genders)	4 (44%)	0 (0%)	5 (56%)
With sex work partner(s) (all genders)	0 (0%)	1 (50%)	1 (50%)

Note: Data include more than one response from the same individual in cases where the person reported sex with more than one partner type or more than one gender.

When asked why condom use was not discussed, respondents gave a variety of explanations. Responses were grouped as follows, with illustrative quotes:

- Did not think it was necessary/Not at risk (n=8)
  "When someone sucks me off, why use a condom? There's no need to…"
  "Because she's my wife."
  "I don't think it's necessary. I only sleep with my wife and [male partner's name], and I know that they aren't sleeping with anyone else."

- Always use a condom, so no need to discuss (n=4)
  "Because I always use condoms."
  "Because I never ask them, I just put one on."

- Heat of the moment/no time (n=4)
  "Because we did it in the alley over there and it was quick. There wasn't time to mention condoms."
  "It wasn't possible to…I live in his house, he gives me a place to stay but he has a wife and when we do it, it's hidden and quick."

Other reasons respondents gave included: sexual encounters were just flings (n=3), fear of arousing suspicion of female main partner (n=2), do not like to use condoms (n=2), CSW clients do not like to use condoms (n=1), and partner did not ask to use a condom (n=1). The respondent who talked about living in the house of a man and his wife and having "hidden and quick" sex described a pattern of sexual coercion throughout the interview, in which the man took advantage of the respondent's need for housing. This coercion appeared to limit his ability to practice safer sex. Another respondent described selling sex in exchange for money and how if condoms were not available in the moment they were not used. Although only two respondents described situations in which economic need was closely associated with unsafe sex, this finding is noteworthy, as it may indicate that economic security issues are relevant in the context of HIV prevention for the Latino immigrant MSM population.

Participants who reported discussing condom use with their partners were asked to summarize their most recent conversations with their partners about using condoms. The responses were varied and revealed no consistent patterns. However, several gay and bisexual respondents said that discussions about whether to use a condom included issues about being at risk or wanting to be "safe." None of the five heterosexually identified men stated that this was a topic of discussion. Other common discussion themes included: (1) the partner requested that the respondent use a condom, and (2) the respondent telling the partner that they did not like to use condoms because of the way they feel. Some participants talked about the various considerations involved in decisions about whether or not to use condoms. Some described how safer sex has become "a given" for them:

> *I am really strict about these things. I always talk about condoms with everyone I have sexual relations with and if some of them don't want to use them I say "bye."*

He and I always talk about it because we've heard on TV and from different information that that's the only way we're not going to get HIV. That was the last time we talked about how you always have to use condoms.

Others discussed the role that serostatus plays in their condom use behaviors. One person said, "…we decided not to use them since we're both negative." Another stated:

Well, it's not my fault. There have been times when I've said to them that I'm HIV-positive and that we should use a condom, but sometimes it doesn't matter to them and in the end we didn't use one.

Finally, one respondent described the role of economic necessity in decisions about condom use:

Well, these things happen. It's like sometimes I prostitute myself for sex or housing and when I've had sex it's been in a place where there are no condoms, and neither they nor I carry them. So if I have condoms I use them and if not then I don't.

Drug Use

Few respondents reported drug use in the last six months, with the exception of alcohol and marijuana. The most common drugs reported are listed in Table 8. Only two respondents reported ever injecting drugs, and none reported injection in the last three months.

Table 8: Drug Use and Injection History

Drug Use and Injection	n (%)
Type of Drug Used in the Last 3 Months	
Alcohol	33 (92%)
Marijuana	17 (47%)
Crack or cocaine	7 (19%)
Poppers	3 (8%)
Speed	2 (6%)
Injection History	
Ever injected drugs	2 (6%)
Injected in last 3 months	0 (0%)

Use of HIV Prevention Services

HIV Testing

Less than one half of the sample (47%, n=17) reported ever receiving an HIV test. Of those who had been tested, most received their HIV tests at San Francisco General Hospital (n=5), Mission Neighborhood Health Center (n=2), Kaiser (n=2), and City Clinic (n=2). Other San Francisco testing services used were Clinica Esperanza and a site in the Castro. Two other respondents were tested outside San Francisco, and a third was tested in Colombia, South America.

Less than half of the sample reported ever receiving an HIV test.

It is noteworthy that none of the heterosexually identified participants had been tested. In addition, gay men were slightly more likely to have been tested than bisexual men (65% versus 55%), although the sample size was too small to determine whether this finding can be generalized to the population.

Other HIV Prevention Services

Respondents were asked about which types of HIV prevention services they would use. Participants most favored HIV prevention services provided by a doctor, a health care agency, an HIV/AIDS-specialized agency, and a Latino community-based organization. They were less likely to report wanting services from an agency that serves gay and bisexual men, and only one-third said they would use services provided by a religious organization or a church. Table 9 lists the types of service providers from most to least favored.

Table 9. Use of Different Types of Service Providers

Type of Service Provider	Definitely or Probably Use	Maybe Use	Definitely Not or Probably Not Use
Doctor or health care agency	36 (100%)	0 (0%)	0 (0%)
Agency that specializes in HIV/AIDS	35 (97%)	0 (0%)	1 (3%)
Latino community-based organization	30 (91%)	3 (9%)	0 (0%)
Agency that serves gay and bisexual men	24 (69%)	10 (28%)	1 (3%)
Religious organization or church	11 (33%)	5 (15%)	17 (52%)

Regarding types of interventions, more than half of the respondents said they would use one-on-one counseling, a hotline, single or multiple session groups with other Latino men, and

outreach. However, outreach was the least favored of the intervention types, perhaps because of limited privacy during the encounter. Finally, the percent of respondents who said they would use HIV testing where you would not give your name was three times as high as those who said they would use testing where you would give your name (74% vs. 28%). Table 10 lists the types of services from most to least favored.

Table 10. Use of Different Types of Services

Type of Service	Definitely or Probably Use	Maybe Use	Definitely Not or Probably Not Use
One-on-one counseling*	28 (80%)	4 (11%)	3 (9%)
Telephone service or hotline	28 (78%)	2 (6%)	6 (17%)
Single or multiple session groups with other Latino men	23 (70%)	5 (15%)	5 (15%)
Outreach	21 (64%)	7 (21%)	5 (15%)

* One-on-one counseling includes prevention case management and individual risk reduction counseling.

Respondents were also asked about preferred provider characteristics. Participants clearly preferred male service providers over females (76% vs. 46%), and three-quarters of the sample said they would "probably" or "definitely" use services provided by someone from their community. Tables 11 lists the responses regarding characteristics of individual service providers.

Table 11. Use of Service Providers by Individual Provider Characteristic

Individual Provider Characteristic	Definitely or Probably Use	Maybe Use	Definitely Not or Probably Not Use
Man	26 (76%)	3 (9%)	5 (15%)
Woman	13 (46%)	5 (18%)	10 (36%)
Person from respondent's community	23 (74%)	5 (16%)	3 (10%)

The five heterosexually identified respondents largely agreed with the general sample regarding preference for different types of services. However, they were less likely to say they would "probably" or "definitely" use the services of an agency that serves gay and bisexual men. In addition, none of these men said they would "probably" or "definitely" meet in a single or multiple session group with other Latino men. Finally, all said they would "definitely not" use HIV testing services where they would give their name, but all said they would "definitely" use testing where they would not give their name.

When asked whether they had used any HIV prevention services, 28% (n=10) of survey respondents said "yes." All of the heterosexually identified respondents said "no." Aspects of the services the respondents who had used prevention services liked included the professionalism, staff that "treat you well," confidentiality, and that services gave the respondent "a lot of confidence." Only two respondents mentioned aspects they did not like: long wait times and agency had more interest in getting government money than doing HIV prevention.

Finally, respondents were asked to describe other HIV prevention services they would use. The following services were mentioned: community-based services or clinics (n=5), abstinence/safer sex services (n=2), risk reduction counseling (n=1), inexpensive services (n=1), and services provided by a doctor (n=1). In addition, two people expressed a willingness to use any services that were offered to them.

28% of the Latino immigrant MSM in the sample said they had previously used HIV prevention services.

Client Outreach and Recruitment

Bars and Community Venues

Participants from the survey were recruited primarily from the Mission district, particularly the parts of Cesar Chavez Street where the day labor population congregates (n=21), Civic Center (n=5), and the night clubs Esta Noche and Futura (n=6). As such, these venues may serve as areas for outreach and recruitment for Latino immigrant MSM.

The respondents were also asked to identify bars and other community venues where they hang out. The most commonly mentioned venues were:

- Esta Noche (75%, n=27)
- Futura (47%, n=17)
- Power Exchange (31%, n=11)
- El Sarape (28%, n=10)
- Divas (14%, n=5)
- El Tin Tan (14%, n=5)
- Up and Down (8%, n=3)

Other San Francisco and East Bay bars and community venues mentioned by only one or two respondents were: Liquid, Beauty Bar, El Treble, Bench End Bar (Oakland), Rockapulco, The Café, Universe, Power House, Blowbuddies, Steam Rooms (Berkeley), a Catholic church group, and a "soccer team marathon." A few respondents mentioned that they go to bars in San Jose. It is noteworthy that four respondents said they do not go to bars, two said they do not go to gay bars, two said they do not have any regular social hangouts, and three said their hangout is a street corner or corner liquor store. These data suggest that outreach should be done in indoor venues and on the streets to reach all segments of this population.

Newspapers, Magazines, and Newsletters

Respondents were asked about newspapers, magazines, and newsletters that they read, in order to identify publications in which HIV prevention ads could be placed. The respondents said they read:

- Bay Area Reporter (36%, n=13)
- El Mensajero (33%, n=12)
- Chronicle (25%, n=9)
- Guardian (20%, n=7)
- Examiner (6%, n=2)

Other local newspapers, magazines, and newsletters mentioned by only one or two respondents were: free newspapers, Mission News in Spanish, Cristina, Frontiers, magazines in Spanish, and Poz in Spanish. Eleven percent (n=4) said they do not read any newspapers, and three described barriers to reading newspapers or magazines: unable to read much English, do not have time or money, and do not have access to magazines.

"Gatekeepers"

Gatekeepers are individuals who can help prevention providers access hard-to-reach populations. To determine who some of the gatekeepers are for Latino immigrant MSM, the men were asked who would be the first person they would talk to if they thought they might have HIV or were worried that they might be at risk. Their responses have implications for how to reach this population. Responses were grouped as follows, with example quotes:

- Family member (e.g., mother, brother) (22%, n=8)
  "My brother – he knows everything because he is gay."

- Friend (22%, n=8)
  "I think first I would tell a friend of mine from Guadalajara. I trust him a lot."

- Doctor or hospital (17%, n=6)

- Social service provider (11%, n=4)
  "The first person would be someone at an organization or agency. I would go to a Latino agency that speaks Spanish."

- No one (8%, n=3)
  "…I wouldn't tell anyone. It would be a secret I would take with me to my grave."

- "I don't know" (14%, n=5)
  "I don't know because I don't have anyone here. I live with my friends in a room but I don't trust them…"

The majority of the heterosexually identified respondents did not declare with certainty who they would talk to. Two of the heterosexually identified respondents said "I don't know" regarding who they would talk to before speculating as to possibilities, and a third said he would not tell anyone.

Strategies for Reaching Latino Immigrant MSM

Respondents were asked for suggestions on how to reach Latino MSM not already using HIV prevention services and what would motivate them to participate in HIV prevention activities. Several strategies for informing Latino MSM about HIV and HIV prevention and encouraging their participation were offered.

Where to Reach Latino MSM

- Bars (n=1)
- Schools (n=1)

Methods for Reaching Latino MSM

- Media campaigns/ads (n=4)
- Increase presence of outreach workers/educators in the community (n=2)
- Use a "hot guy" to deliver the messages (n=1)

Type of Service

- Information and education (n=24)
- Counseling/support groups (n=6)
- Condom distribution (n=4)
- Social events (n=2)

Incentive or "Hook" for Participating in HIV Prevention Activities

- Money, food, or other free items (n=4)
- Provide a safe space (n=1)
- Make services affordable (n=1)
- Having a friend with AIDS or knowing someone who died of AIDS (n=1)

As respondents offered possible strategies for reaching Latino immigrant MSM, three notable themes emerged in participants' responses that are relevant to how HIV prevention is best approached for this population: (1) homophobia/biphobia, (2) barriers to prevention, and (3) other important issues for the Latino community.

Comments about homophobia/biphobia were varied. One participant advocated for services that address internalized homophobia/biphobia: "Give them more information so they know that being bisexual isn't bad." Another felt that homophobia should be addressed at the community level: "There should be more campaigns that support the gay community and people that understand [Latino MSM]." A third respondent alluded to fear of coming out as an issue to be addressed: "Give them the confidence, help them to trust that society won't be critical." A

fourth participant identified secrecy about sexual orientation as a barrier to prevention: "It's very hard to have a formula to attract gay Latinos to HIV activities because we're very discrete, quiet. We don't like for anyone to know that we're gay." Respondents were especially vocal about the role of homophobia, biphobia, and sexual identity issues among heterosexually identified Latino immigrant MSM. One participant stated, "First you have to convince them that they are accepted because these guys swear that they're straight, but they're not." One respondent highlighted the role that the gay community could play in HIV prevention for these men: "I think the gay community should take more responsibility for them and make them understand that they should take more responsibility for themselves."

Some participants identified barriers to HIV prevention other than homophobia, such as a lack of concern: "…Nobody wants to know about HIV, there are medicines now, it doesn't matter anymore." Others demonstrated barriers to prevention in the content of their comments. For example, one respondent said, "I don't get involved in other people's lives," implying that prevention is someone else's responsibility. Another expressed disparaging opinions about adults who engage in HIV risk behaviors, although this individual reported unprotected insertive anal sex with men in the last six months:

> *Let them get infected if that's what they want, because those who do, the heavens will curse them. But if they're minors, you have to prevent it, but if they're older and they contract it, it's because they're stupid.*

Such beliefs and attitudes could affect a person's ability to internalize positive health promotion messages. Finally, one respondent was unconvinced that prevention could be successful with this population: "Nothing will motivate them. Look, everybody wants to fuck and that's it. That's all."

Three participants discussed the importance of dealing with other more salient issues for the Latino community before HIV prevention. One participant said, "First you have to solve the problem of immigration and hunger and then think about HIV." Another expressed a similar sentiment: "I think you have to make people's lives better before thinking about HIV prevention." A third respondent commented, "There are many other social problems that come before HIV."

DISCUSSION AND RECOMMENDATIONS

The following recommendations for HIV prevention are grouped into four categories: risk assessment, content of interventions, type of interventions, and how to reach Latino immigrant MSM.

RISK ASSESSMENT

Recommendation 1: Risks related to sex with men and transgendered persons should be explored with heterosexually identified Latino immigrant men who receive HIV testing or other HIV prevention services.

> *Rationale:* It is clear that heterosexual identity among Latino immigrant MSM does not necessarily correspond to having sex with women only. Although there were only five heterosexually identified MSM in the sample, this is a subpopulation that may be at greatest risk due to internalized homophobia. An exploration of risks related to sex with men, as well as transgendered persons, among this subgroup of Latino immigrant MSM can act as a starting place for linking this group to appropriate HIV prevention services.

CONTENT OF INTERVENTIONS

Recommendation 2: Interventions for Latino immigrant MSM should assess and explore individuals' level of concern regarding HIV, reasons for concern (or lack of it), and how behavior change could reduce their concerns.

> *Rationale:* Those who reported being "somewhat" or "very" concerned about HIV were more likely to also report having engaged in unprotected sex in the last six months. In contrast, those who were only "a little concerned" or "not at all concerned" tended to be less likely to report unprotected sex. This finding indicates that level of concern was correlated with whether respondents had recently engaged in risk behavior. This result is important for two reasons: (1) a client who reports high levels of concern about HIV but no risk behavior may in fact have engaged in risk behavior but is not ready to discuss it, and thus the client still might benefit from an intervention; and (2) identifying the psychological reward (reduced anxiety/concern) of practicing safer sex with those who report high levels of concern may act as an incentive for behavior change. A few respondents indicated that concern about HIV infection may be on a downturn due to the availability of drugs and that the desire for sexual relationships overrides any level of concern about HIV. Interventions should address these and other barriers to prevention.

Recommendation 3: Interventions should focus on sexual risks in general as well as sexual risks related to recreational drug use.

> *Rationale:* Although this survey did not explore drug-related risk in depth, injection drug use was not reported by this sample in the last three months, and only two individuals reported lifetime use of injection drugs. Although this risk factor should not be ignored, it appears that sexual risk, and perhaps sexual risk related to recreational drug use (e.g., alcohol, speed, poppers), may be more salient issues for this population.

Recommendation 4: Expand the scope of HIV prevention interventions beyond individual behavior change goals to community- and policy-level interventions that address homophobia/biphobia and economic insecurity among Latino immigrant MSM.

> *Rationale:* Although mentioned by only a handful of participants, homophobia/biphobia and economic insecurity were identified as barriers to safer sex. Homophobia is an issue throughout many communities, including the Latino community, but may be especially relevant for recent immigrants who have not been in San Francisco long enough to internalize gay-positive messages. This internalized homophobia can affect how individuals approach sex and safer sex. A few participants mentioned economic issues as factors directly related to unsafe sex. In this sample, one individual stated that he engaged in sex work as a means to improve his economic situation. Another described a pattern of sexual coercion in which his housing situation was dependent on having sex with the male owner. Community-level (e.g., social marketing campaign) and policy-level (e.g., advocacy for living wage legislation) interventions that address homophobia and poverty are critical tools in the fight against HIV in this and other populations.

Recommendation 5: HIV prevention interventions should meet people "where they're at" by addressing the life issues that are important for clients in addition to HIV-related topics.

> *Rationale:* Three participants talked about the need to help people with their primary life concerns before talking about HIV. Issues such as immigration (e.g., fear of deportment), hunger, homelessness, joblessness, family issues, and drug addiction may be more immediate concerns than HIV risk. HIV prevention programs should develop the capacity internally or through referral to meet clients' various needs.

TYPES OF INTERVENTIONS

Recommendation 6: Anonymous HIV testing, during which no identifying information is collected, should be made accessible to this population. The availability of this type of testing is especially important for heterosexually identified Latino immigrant MSM, and outreach efforts to recruit these men for testing should be increased.

Rationale: Three-fourths of survey respondents said they would use HIV testing where they would not give their name, but only one-fourth of the sample said they had ever been tested. Some of those who had never been tested reported unprotected sex in the last six months. Participants preferred testing where one would not give a name over testing where one would give a name by a ratio of 3 to 1. In addition, the five heterosexually identified men in the sample all said they would "definitely" get tested in a setting where they would not give their name but would "definitely not" use a testing service where they would give their name. None of these five men had been previously tested. Therefore, efforts to increase the availability, accessibility, and use of anonymous testing to Latino immigrant MSM, through outreach and other means are needed, especially for those who are heterosexually identified.

Recommendation 7: Increase one-on-one counseling and other services that are sensitive to the unique needs of Latino immigrant MSM clients. These services should be based in the Latino community and use Latino Spanish-speaking men as the prevention messengers.

Rationale: A high percentage of respondents said they would use one-on-one counseling, a hotline, single or multiple session groups, and outreach. However, only 28% said they had ever used any of these services, perhaps indicating an unmet need. In addition, respondents (including the heterosexually identified men) showed a clear preference for a male service provider over a female. Three-fourths said they would use the services of someone from their community, and 91% said they would use the services of a Latino community-based organization. Therefore, an increase in interventions based in the Latino community using male Spanish-speaking Latino service providers is needed.

Recommendation 8: Increase the capacity of health care providers, HIV-specialized agencies, and other non-HIV community-based agencies to provide HIV prevention services to this population. Ensure a good mix of agencies serving heterosexual and gay/bisexual men to accommodate the different subgroups of Latino immigrant MSM.

Rationale: It is critical that the type of intervention be appropriate for the population, but it is also important who the service provider is. Doctors, health care agencies, HIV-specialized agencies, and Latino community-based organizations were strongly favored. However, the heterosexually identified men were the least likely to favor agencies serving gay and bisexual men. Heterosexually identified Latino immigrant MSM may be less likely to receive HIV prevention services in a health care setting, because they may not be recognized as being at risk. These men also may be less likely to connect with an HIV-specialized agency. Therefore, services based in non-HIV, non-health care settings are critical for reaching this MSM subpopulation. Finally, services provided by a church were not viewed as positively as other services and therefore are not a high priority.

REACHING LATINO IMMIGRANT MSM

Recommendation 9: Increase and widen outreach efforts to Latino immigrant MSM in order to recruit them for HIV testing and other HIV prevention services.

> *Rationale:* Only 28% of the sample said they had ever used HIV prevention services. Furthermore, many of those who reported unprotected sex in the last six months had never been tested for HIV or used HIV prevention services. Some of the low utilization of services despite high frequency or reported unprotected sex in this sample may be attributable to inadequate outreach efforts. In addition to increasing the outreach presence in the Latino community, non-traditional settings for outreach should be considered. Several men reported that they do not go to bars or gay bars or had no regular "hangouts." Therefore, creative means must be used to reach these men, such as doing outreach at grocery stores or liquor stores (one respondent mentioned the latter as his "hangout"). Non-HIV, non-gay venues for outreach may also be effective at reaching the segments of this population who do not frequent these locations.

Recommendation 10. Reduce reliance on the use of written ads and materials for HIV prevention for Latino immigrant MSM.

> *Rationale:* Although the majority of the sample named newspapers and magazines they read, a few said they do not read any newspapers or magazines or that they experience barriers to accessing reading materials, such as high cost. These men may be better reached through outreach as described in the rationale for Recommendation 9. However, it is clear that any written materials that are produced should be in Spanish and, if they are social marketing ads, should appear in Spanish publications.

Recommendation 11. Address community norms regarding unsafe sex among gay and bisexual Latino immigrant MSM.

> *Rationale:* Several respondents expressed skepticism about whether HIV prevention could work for their community. Sentiments such as "there are medicines now, it doesn't matter anymore" and "everybody wants to fuck and that's it" suggest that some gay community norms and beliefs may be supportive of unsafe sex. These findings reiterate the need for innovative approaches to HIV prevention in the Latino immigrant gay/bisexual community (as well as the larger gay/bisexual community) that address the influence of community norms on HIV risk behavior.

Recommendation 12. Increase components of interventions that serve young Latino men who are recent immigrants, as they may be a high-risk subgroup of the larger Latino population.

> *Rationale:* The five heterosexually identified respondents tended to be younger, more recent immigrants to the United States, and newer residents of San Francisco compared with the rest of the sample. Therefore, it can be posited that recent Latino immigrants, particularly those who are new to San Francisco, are less likely to have adopted a gay or bisexual identity, have more internalized homophobia, and thus have more barriers to safer sex. New immigrants are also more likely to experience language barriers in accessing social services than those who have been in the United States for a long time. Therefore, prevention efforts aimed at this younger, newer immigrant population are likely to reach some of the highest-risk men, including the heterosexually identified MSM.

CONCLUSION

Although this study represents only a preliminary inquiry into some of the issues related to HIV risk among Latino immigrant MSM in San Francisco, it appears that this group has a need for HIV prevention services based on the following themes:

- Reported levels of unprotected anal sex with men are substantial.
- Female and transgendered persons may be at risk for HIV infection through sexual contact with Latino immigrant MSM who have had unprotected sex with other men.
- High levels of demand for HIV prevention services, including testing, combined with low levels of service utilization indicate a gap in needed services.

Additional research is needed to explore in depth how the needs of Latino immigrant MSM differ from Latino non-immigrant MSM so that programs can be tailored or modified to meet the unique needs of the immigrant population.

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