AN ABSTRACT OF THE DISSERTATION OF

Doris I. Cancel Tirado for the degree of Doctor of Philosophy in Human Development and Family Studies presented on December 8, 2011.

Title: Family Planning and Sexual Risk-taking Among Mexican Immigrant Men: How Does Fatherhood Matter?

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Men are frequently left out of the picture in the study of family planning and sexual risk behavior. This approach means few programs and policies address men's family planning and sexual health issues. There is also a lack of understanding of the role fatherhood plays in men's development and in family planning and sexual health. For Mexican immigrant men, the picture is even worse given their disadvantaged position and the unique obstacles they face (e.g., language barriers, acculturation issues) that put them at risk for experiencing unintended pregnancies and contracting Sexually Transmitted Infections (STIs). Grounded in *symbolic interactionism* and *life course theory*, I explored how social roles (e.g., partner, father), individual factors (e.g., education, cultural values), and health systems influence the family planning and sexual risk-taking experiences of young Mexican immigrant men paying particular attention to differences and similarities between fathers and nonfathers.

To answer the research questions, a qualitative study was conducted using secondary data from the *Latino Health Project: Men Only*. The sample was comprised of 21 fathers and 25 nonfathers ages 18 to 30 ($N = 46$), all of whom had lived in the United States for 10 years or fewer, thus being considered recent immigrants. Data for the project were collected using a semi-structured interview guide with open-ended questions followed by directive probes. The analysis process used grounded theory methodology techniques (LaRossa, 2005). Key findings suggest that both fatherhood status and partners play an important role in men's experience with sexual and reproductive health, with partners playing a more influential role. Fatherhood plays a more active role in men's ideas about family planning while partners seem to play an influential role in men's actual behaviors such as engaging in family planning services and using birth control other than condoms. The influence that fatherhood and partners have on men's experiences with family planning and sexual risk-taking was shaped by a unique combination of accurate information, different levels of knowledge, and misinformation. Access to services was shaped by health systems that prevented men from seeking services due to documentation issues and economic barriers. Cultural factors such as *machismo*, *marianismo,* and *personalismo* also influenced some attitudes and behaviors related to birth control use, vasectomies, risk-taking, and services utilization. Findings suggest these men are exposing themselves and their partners to unintended pregnancies and sexually transmitted infections. Beyond these being public health concerns, it is crucial that researchers, policy makers, and service providers remember that current sexual risk behaviors have a direct impact on the fertility and family formation patterns of the fastest growing population in the United States.

Family Planning and Sexual Risk-taking Among Mexican Immigrant Men: How Does Fatherhood Matter?

by

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

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Doris I. Cancel Tirado, Author

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DEDICATION

In loving memory of my father Francisco A. Cancel Cancel who instilled in me passion for community service.

Family Planning and Sexual Risk-taking Among Mexican Immigrant Men: How Does Fatherhood Matter?

Introduction

Women have received unbalanced attention in the study of family planning and sexual risk behavior, with men frequently left out of the picture. This unbalanced approach has caused there to be few programs and policies that address men's family planning and sexual health issues. There is also a lack of understanding of the role fatherhood plays in men's development and in family planning and sexual health, despite the link between family planning, sexual behaviors, and fatherhood. For Mexican immigrant men, the picture is even worse given their already disadvantaged position and the particular set of obstacles that they face such as language barriers, limited access to health care, and acculturation issues. These conditions put them at a higher risk for experiencing unintended pregnancies and contracting Human Immunodeficiency Virus (HIV), and other Sexually Transmitted Infections (STIs). This study examines how social roles (e.g., partner, father), individual factors (e.g. education, cultural values), and health systems influence the family planning and sexual risk-taking experiences of young Mexican Immigrant men, along with comparing how these experiences differ for fatherhood and partnership status. To achieve these aims, a qualitative study using secondary data from the *Latino Health Project: Men Only* was conducted.

This dissertation is divided into five chapters. The first chapter presents an introduction to the problem under study, a brief description of the methodology, and the definitions of key concepts. The second chapter is divided into two main sections: theoretical background and literature review. The third chapter explains in detail the used

methodology, including a description of the Latino Health Project, a rationale for the use of qualitative methods, and the limitations of the study. Chapter four describes the key findings of the study, and chapter 5 includes a discussion of the findings, limitations, strengths, future implications, and conclusions. Also included are a series of appendices that contain study instruments and Institutional Review Board (IRB) related materials and a description of the participants in the study.

Fatherhood status is an important variable in men's development (Eggebeen & Knoester, 2001). Previous research has shown that fatherhood is a life changing experience for men that can motivate them to reevaluate their life goals, stop or decrease risky behavior, and strive for healthier life styles (Kerr, Capaldi, Owen, Wiesner, & Pears, 2011; Nelson, 2004; Palkovitz, 2002). Fatherhood does not occur in a vacuum; the experiences associated with fathering are shaped by sociocultural factors such as age, marital status, and father's residential status. Fatherhood is also a life course process that starts long before conception, adoption, or social fathering. It starts with men's ideas of their roles in the process of becoming a father and continues with their family planning and sexual behaviors.

Men's involvement in family planning tells us about their ideas around fatherhood and family formation, and may shed some light on their future behaviors as fathers. For example, some literature has linked unintended pregnancies with lower levels of father involvement (Bachrach & Sonenstein, 1998), suggesting the pathways that lead men to fatherhood will influence the type of fathers they will be in the future. These pathways may influence or be influenced by the types of relationships men have with their partners,

the mothers of their children, and their children. Ultimately, pathways to fatherhood will link men's trajectories to the life trajectories of their children and their children's mothers.

Fatherhood as a life transition may lead men to negotiate family planning and sexual behaviors differently (Carpenter, 2010). Men's interaction (or lack of interaction) with their children may shape men's ideas of the number of children they want, when they want them, and in what kind of relationship they want to have them. The experiences with their children and the salience of new identities and roles may also influence their relationships with their partners, including the negotiation of birth control and sexual behaviors.

Despite the importance of fatherhood and family planning in men's lives, the literature on fatherhood has mainly focused on the impact of father involvement on children's lives and development (Settersten & Cancel-Tirado, 2010) whereas the literature on family planning has been tilted toward women's experiences (Bachrach & Sonenstein, 1998). The impact of family planning and fatherhood in a man's life course process has been ignored, leaving important gaps in both the family planning and fatherhood literature. Furthermore, some have argued that there is a serious need for the inclusion of fatherhood as an important variable in men's health and in public health studies (Barlett, 2004) along with studies of men's development (Palkovitz, 2002; Settersten & Cancel-Tirado, 2010).

When literature does focus on men, Latinos and immigrant fathers are often not included. In the case of Mexican immigrant men, studies that explore these issues are

scarce or nonexistent. These men often face more disadvantaged situations that may negatively impact their experiences with fatherhood, family planning, and sexual risk behaviors. The social inequalities (e.g., lower educational attainment, immigration and documentation issues), and cultural differences (e.g., language barriers, family values, gender norms) faced by Mexican immigrant men will influence their experiences with family planning and sexual risk behaviors differently. Their pathways to fatherhood will also differ from the pathways to fatherhood of men in more privileged conditions. Their relationships with partners and children will also differ. For these men, the immigration process creates the negotiation of new roles, new identities, and new norms that sometimes may be incongruent from their country of origin.

The combination of all these factors may be setting these men up to become fathers at an earlier age, putting them at higher risk for unintended pregnancies and/or of having more children. For some men, these factors may also contribute to an increased risk of acquiring HIV and other sexually transmitted infections. When research, policies, and services are designed without a clear understanding of these issues or without taking these differences into account, the needs of these men are mostly unmet, misunderstood, and ignored (Betancourt, Green, Carrillo, & Maina, 2004; National Council of La Raza [NCLR], 2006).

This study fills three important gaps in the literature: first, it integrates fatherhood as an important variable in the study of men's developmental issues; second; it explores the link between fatherhood, family planning, and sexual risk behaviors; and third, it increases our understanding of Mexican immigrant men's experiences with family

planning and sexual risk behaviors. Specifically, the study explores how social roles, social relationships, individual factors, and health systems influence the family planning and sexual risk-taking experiences of young (ages 18 to 30) Mexican immigrant men, with explicit attention to the similarities and differences between fathers and nonfathers.

Aim 1: To describe the family planning and sexual risk-taking experiences of young Mexican immigrant men.

Aim 2: To compare the family planning and sexual risk-taking experiences of young Mexican immigrant fathers and nonfathers.

Aim 3: To explore how individual factors influence the family planning and sexual risk-taking experiences of fathers and nonfathers (e.g., cultural beliefs, sexual partner relationships).

Aim 4: To understand how experiences with various health services influence the family planning and sexual risk-taking experiences of fathers and nonfathers (e.g., family planning clinics, county health programs).

This study describes the experiences of Mexican immigrant men with family planning and sexual risk behaviors and how individual and systemic factors influence these experiences. The study also compares these experiences for fathers and nonfathers. The dissertation findings shed light on areas that are in need of further study, along with informing policy makers of better ways to allocate funds for sexual and reproductive health for men, in particular for Mexican immigrant men. This dissertation also raises new questions for family studies scholars about what could be the implications of men's family planning and sexual risk behaviors for their future behaviors as fathers and how

their partners and the different type of relationships men have influence family planning and birth control use.

Research Design Overview

To answer the research questions, a qualitative study was conducted using secondary data from the *Latino Health Project: Men Only*. This research project's main goal was to gain more understanding of the sexual and reproductive health needs among Latino immigrant men living in rural Oregon. In 2009, 49 men were recruited for the *Latino Health Project: Men Only*. For the purpose of this study, three participants from Guatemala were dropped from the analysis because I am focusing on Mexican immigrant men, for a total sample of 46 men. All participants have lived in the United States 10 years or fewer, thus being considered recent immigrants according to the Pew Hispanic Center (Suro & Tafoya, 2004). The sample was comprised of 21 fathers and 25 nonfathers.

Data for the project were collected using an interview guide with open-ended questions followed by directive probes. Questions in the interview included topics such as Latino men's experiences and satisfaction using family planning and sexual and reproductive health services, barriers and facilitators to accessing and utilizing family planning and sexual health services, and attitudinal and sociocultural factors that may influence family planning service utilization and sexual risk behaviors (e.g., family beliefs, gender, cultural influences). Sociodemographic data were also collected. Qualitative data was analyzed using MAXQDA software. The analysis process used grounded theory methodology techniques (LaRossa, 2005). After a systematic and

thorough analysis of the data was completed, findings have been presented in multiple forms including selections of representative segments of text to represent phenomena and experiences, men's stories, and alternative explanations for contradictions.

Definition of Terms

Although many of the key terms in this study are widely used in both lay and scholarly literature, for the purpose of elucidation I define these terms in relation to the goal and aims of this study. Concepts such as *family planning*, *sexual risk behaviors,* and *unintended pregnancies* are quite broad in nature; others, such as father or Mexican immigrant, often carry preconceived ideas or notions, therefore needing further explanation.

Young Mexican immigrant men. For the purpose of this study, *young Mexican immigrant men* refers to men ages 18- to 30-years-old who emigrated to the U.S. from Mexico. These men are also recent immigrants, meaning that they have lived in the United States for 10 or fewer years (Suro & Tafoya, 2004). The term immigrant itself needs to be clarified further. The U.S. Census defines immigrants and refugees as members of a foreign-born population, regardless of an individual's status with the Department of Homeland Security (DHS) and this is the definition used for the study. The Department of Homeland Security uses different terminology. *Alien* is the term used to define those who are not U.S. citizens or nationals (DHS, 2010); within this category, other subcategories can be used such as student, temporary worker, permanent resident, and so on. Immigrants can be further classified as documented or undocumented. Although there may be critical differences in the experiences of these two groups,

information about immigration status was not collected because of confidentiality, ethical, and recruitment issues.

Family planning. The World Health Organization (WHO) defines family planning as a process that "allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births" (WHO, over Family Planning Section, para. 1). It refers to the process of both contraception and conception. This study focuses on issues related to contraception, including use of birth control and family planning services. Issues around contraception are particularly important due to the high rates of unintended pregnancies among Latinos (Frost & Driscoll, 2006; NCLR, 2006; Zambrana, Cornelius, Boykin, & Salas Lopez, 2004). In the literature, *unintended pregnancy* is defined as unwanted pregnancy or pregnancies that are mistimed; abortions are generally also considered unwanted pregnancies (Santelli et al., 2003).

Sexual risk-taking behavior. A diverse set of behaviors can be considered sexual risk behaviors and various conceptual models (e.g., medical, public health) define such behaviors differently (Cohen, 2009). The Latino Health Project targeted the following behaviors: unprotected vaginal or anal intercourse, failure to use or the misuse of any kind of birth control method, alcohol or drug use associated with sexual risk behaviors, sex with multiple partners, and sexual encounters with sex workers. These behaviors are considered risk behaviors because they increase the chances of experiencing an unintended pregnancy or acquiring HIV and/or other types of STIs.

Family planning and sexual risk-taking experiences. Knowledge, attitudes, and behaviors are important components in understanding how individuals make and enact decisions about their health. These decisions however, do not occur in a vacuum. They are affected by our interactions with others and by societal and cultural norms, and are fostered or constrained by social institutions, such as our current health system. For the purpose of this study, family planning and sexual risk-taking experiences are defined as the combination and the interactions of these factors in the life of the population under study.

Fatherhood status (fathers and nonfathers). Fatherhood can be define as the role that comes from conceiving a child (biological fatherhood), but this role can also evolve from relationships with partners who have children, relationships that lead a man to assume the role of a father (social fathering), or from adoption (adoptive fathers). The literature on fatherhood is very broad and sometimes consensus about these definitions has not been reach by scholars. The available data in the study do not provide a way to identify the specific type of fathering relationship, thus the term *father* may include any of these types of fathering. For the purpose of this study, fatherhood status refers to whether a man identifies himself as father or a nonfather.

Theoretical Background and Literature Review

This chapter is divided in two major sections: theoretical background and literature review. The first section provides a brief description of the theories used to frame the study: *symbolic interactionism* and *life course perspective* and how they apply to the subject of study. The second section includes a review of the literature on Mexican Immigrant men focusing on family planning and sexual risk behaviors.

Theoretical Background

Symbolic interactionism (Blumer, 1969; Stryker, 1980) and the *life course* perspective (Giele & Elder, 1998) are two important schools of thought in sociology and family studies that are useful in understanding people's behavior and their interaction with the world around them. Combined, these two theories provide an excellent framework to understand how social roles, social relationships, and health systems influence the family planning and sexual risk-taking experiences of young Mexican immigrant men, and are especially useful in understanding the similarities and differences between Mexican immigrant fathers and nonfathers.

The following section describes and explains critical concepts and themes in *symbolic interactionism and life course* perspective. I also explain how these theories combined are an ideal conceptual framework to understand how social roles, social relationships, and health systems influence the family planning and sexual risk-taking experiences of young Mexican immigrant men. *Symbolic interactionism* focuses on the individual interpretation of symbols and how meaning is created from interactions in our social relationships at the microlevel (e.g., sexual partners, parent-child); it is particularly

useful for understanding how social roles and social relationships influence men's family planning and sexual-risk behaviors. *Life course perspective* broadens the analysis to the macrolevel by explaining further the relationship between human agency and health systems and how this interaction influences men's experiences. *Life course perspective* is also used to understand the role that immigration and significant relationships (i.e., partners, children, peers, family members) play in men's experiences through the concepts of *timing* and *linked lives.*

Symbolic Interactionism

Symbolic interactionism emphasizes the meanings individuals attach to their behaviors and thus any type of behavior must be understood from that meaning (LaRossa & Reitzes, 1993). *Symbolic interactionism* focuses on three major areas: (a) the interaction of symbols and the meanings that emerge from this interaction; (b) relationships and the self, and how we develop a sense of self through social interactions; and (c) how actors interpret their experiences and through these interpretations understand, develop, and enact different roles (White & Klein, 2002).

Symbols and interaction. At the core of *symbolic interactionism* are two major concepts: *symbols* and *interaction*. *Symbols* are representations with attached meanings that evolve from social interactions, language being the most powerful. Symbols are malleable and context-relevant. An *interaction* refers to the sharing of symbols between two or more people through which meanings are created. These meanings evolve in an interpretative process from interactions with others, new experiences, and the reinterpretation of these interactions that are negotiated with ourselves and with others

(LaRossa & Reitzes, 1993; Smith, Hamon, Ingoldsby, & Miller, 2009; White & Klein, 2002). The meanings Mexican immigrant men attach to fatherhood, family planning, and sexual behaviors emerge from their interactions with partners, children, peers, and health professionals, and from their experiences in a new cultural setting (U.S.) versus their experiences in their country of origin (Mexico).

Self: The "Me," the "I," and the "We." *"Me"* or the social self is formed by previous social behaviors and experiences and by learned social roles from prior interactions. The *"I"* is the unplanned, unpredicted self; it represents the behaviors that occur spontaneously. The *"We"* can be explained using the *looking-glass self* concept (Cooley, 1902/1956). It refers to a self-concept developed from individuals' interactions with primary groups (family, coworkers, friends), individuals' perceptions of what others think about them, individuals' self-assessments, and the integration of these three. The looking-glass self is the idea of perceiving or defining ourselves based on how others see us. The self can also take the role of the *generalized other,* meaning that one's self-concept can take diverse shapes or forms in different contexts and/or that emerging self contexts will be influenced by the responses of others (LaRossa & Reitzes, 1993).

These three concepts are important for understanding how the immigration process influences Mexican immigrant men's experiences. For these men, early development of self occurs within Mexican culture, and meanings are shaped by the social norms and structures within Mexican society. With the immigration process, Mexican men need to re-adapt their sense of self to new and often conflicting social norms and social structures. The acculturation process can be seen as a process where the

"I," through unplanned and unpredictable behavior, is reshaped by the interactions in the new context. A new sense of "Me" is developed and adjusted to the new context and social structures; in other words, the individual is going through a cultural learning process (acculturating) while developing new meanings and readjusting old ones.

Roles and identities. *Roles* and *identities* are closely associated with social norms and social expectations. *Roles* are systems of meanings and the expectations that individuals have for themselves or for specific situations. These systems change over time. A role may have different identities – *role taking* (understanding others' roles), *role making* (creating or reshaping a role), *role strain* (role is too demanding, or there are contradictory aspects or a lack of meaning to role, creating role conflict), and *role clarity* (difficulties to enact a role when there are no clear expectations). *Identities* are the self-meanings of the roles that are influenced by their salience (some roles are more important and individuals invest more in them) or by an individual's commitment to the role. One's identity is defined by one's most salient role(s). The salience of a role will determine investment in that role and the influence of that role on sexual and family planning behaviors.

The literature suggests that men reduce risky behaviors after becoming fathers (Kerr, Capaldi, Owen, Wiesner, & Pears, 2011; Nelson, 2004; Palkovitz, 2002). If salience of the father role is one of the factors influencing this change in behaviors, it can be expected that Mexican immigrant fathers who are highly identified with the father role will change risky sexual behaviors and/or may become involved in family planning decisions. In contrast, Mexican immigrant men with no children may be more invested in

other roles, therefore paying less attention to their risk behaviors. Gender is another example of the importance of *roles* and *identities* in understanding Mexican immigrant men's experiences with family planning and sexual risk behavior. The roles and identities associated with gender and masculinities, and the impact of acculturation processes on these men's ideas about gender will influence their experiences, particularly when their machismo values around sexuality are challenged by more egalitarian health systems. Role conflicts may arise when new meanings of sexuality are negotiated and when these new meanings contradict old ones or are too demanding. Men might feel conflicted or ambivalent about how to address family planning and sexual behaviors when new societal expectations or partners' expectations contradict their own.

Criticisms. *Symbolic interactionism* has been criticized for placing too much emphasis on individuals creating their realities and minimizing the fact that prescribed social rules have a tremendous impact on individual interactions (LaRossa & Reitzes, 1993; Smith et al., 2009). Another criticism of *symbolic interactionism* is the difficulty of operationalizing some of its concepts making the theory hard to apply and empirically test (LaRossa & Reitzes, 1993; Smith et al., 2009). Tied to this issue are critiques regarding the ambiguity of symbolic interactionism's assumptions and themes. It has been argued that the theory lacks a framework to understand larger social structures and systems (LaRossa & Reitzes, 1993; Smith et al., 2009).

Despite these concerns, *symbolic interactionism* is an excellent tool to explain Mexican immigrant men's experiences with family planning and sexual risk behavior because, as shown above, meanings, roles, and identities are key to understanding this

subject matter. To address critiques associated with the theory, such as lacking the tools to explain interactions with larger social and cultural structures, I also draw from *life course* perspective.

Life Course Perspective

Life course perspective is structured around four key elements (Giele & Elder, 1998): *sociohistorical context (location in time and place), timing, human agency, and linked lives.* Each of these concepts is linked to secondary concepts such as *age*, *life trajectories,* and *turning points* that are relevant depending on the research question. In this section, I discuss these four key elements and expand on those of interest for this study.

Age and life trajectories. Although these two concepts are not part of the four key elements in life course as presented by Giele and Elder (1998), they are essential in the understanding of life course. Although age is a simple concept to understand, the role it plays for individuals goes beyond measuring the amount of years a person has lived. Age is tightly linked to all four key elements in the life course perspective and is subtly embedded within almost all social interactions (Settersten, 2003). Elder and Johnson (2003) stated that "life course refers to age-graded life patterns that are embedded in social structures and historical change" (p. 54). Life trajectories are sequences or patterns embedded in social pathways and can be defined by social structures or institutions and the linkage of multiple states forms trajectories across time (e.g., residential location, employment) (Elder & Johnson, 2003).

Age is an important variable in understanding fatherhood, family planning, and

sexual risk behaviors because it determines aspects of the timing of transitions and variations in developmental stages. Becoming a father is a life transition that places men onto different trajectories suggesting that fathers and nonfathers will have different experiences, but the age at which a man becomes a father will also contribute to how he experiences fatherhood. An unintended pregnancy at an early age will set a man on a very different trajectory than an unintended pregnancy later in life. Age is also an important factor to understand risk-taking behaviors. Young men may also engage in riskier behaviors than older men as or may be more invested in using birth control if they think they do not yet want to be a father.

Sociohistorical context. *Sociohistorical context* refers to the ways in which historical conditions affect human development. The meaning of fatherhood including the roles of fathers and the expectations society places on them have expanded throughout the years, creating a wide spectrum of possibilities from the traditional breadwinner role to more egalitarian roles that include active caretaking roles (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000; Day, Lewis, O'Brien, & Lamb, 2005; Pleck, 2004). These changes will influence how men experience fatherhood and how they plan for it. For Mexican immigrant men, the picture is more complicated because they have to negotiate new meanings and adapt rapidly to new expectations that may be in conflict with the meanings and expectation of fatherhood in their country of origin.

Mexican immigrant men also are influenced by the sociohistorical context surrounding immigration. Immigration policy or patterns influence immigrant lives differently depending on the point in history. For instance, undocumented Mexican

immigrant men who came to the U.S. before the Immigration Reform and Control Act of 1986 may have different life trajectories from those who immigrated during the last 10 years when paths to citizenship have become harder. A path to citizenship or the opportunity of attaining permanent residency alters men's life trajectories and therefore their access to resources, including access to health services. Waves of recent immigrants have limited to no access to family planning services provide by the government due to citizenship eligibility requirements. These restrictions seriously limit immigrant men's access to appropriate family planning and sexual health services.

Timing. *Timing* refers to when in your life course an event or a transition occurs and it is important to understand the impact fatherhood may have on men's experiences. A man who becomes a father at a young age, say before completing high school, will be affected by the experience differently than a man who becomes a father in his late 20s. Of course, other variables also play a role, but it can be argued that the timing of this event will have a profound impact on men's life trajectories. The timing of the immigration process in a man's life will also have a significant effect on a man's life trajectories. If a man immigrated during adolescence and had the opportunity to attend school in the host country, he will learn the language and culture of the host culture at a faster rate than a man who immigrates during adulthood. The concept of *timing* can also be applied to other aspects of men's sexuality, such as timing of first intercourse and its impact on later sexual risk behavior.

Human agency. The concept of *human agency* and its relationship with institutions is very important and often a source of debate among theorists (Hitlin &

Elder, 2007). *Human agency* refers to one's capacity to decide, plan, or control one's life trajectory. Institutions refer to the social structures in which we are embedded – school, work, families, the State, organized religion, and so on. These concepts and the "dynamic of reciprocity" (both agency and institutions as mutually influential) are at the core of the life course perspective. The concept of human agency raises questions such as how Mexican immigrant men actively make decisions about family planning and sexual behaviors, how becoming a father shapes these decisions given that the well-being of others (children, partners) is linked to these decisions, and how immigration and the context of immigration reshape their goals around family planning and sexual behaviors.

Other questions can also reflect the tensions between the role of human agency and of social structures. In this case, it invites us to explore the role of institutions and health systems in this process and how much control Mexican immigrant men perceive they have over these processes. It also invites us to explore how fathers' and nonfathers' experiences differ. Fathers will interact with a different set of institutions such as schools that will influence their experience in a different way. But even the interaction with shared institutions such as health systems can be different due to potential variability in the level of interaction and the conditions for those interactions. When fathers are involved in their children's health care needs (e.g., vaccinations) they will be dealing with health systems more often than nonfathers. Other factors such as perceived discrimination and barriers to access faced by these men are important variables that can influence their interaction with health systems, and their perception of how much control they have over their health, fertility, and sexual behaviors.

Linked lives. The fourth element in life course as presented by Giele and Elder (1998) is the concept of *linked lives,* which refers to interdependence and shared relationships. Through the sharing of experiences, individuals integrate expectations and norms or maintain social institutions (Elder & Johnson, 2003). This idea of linked lives can be associated with *symbolic interactionism* because it is through *linked lives* that individuals develop meanings for new and shared symbols. This concept helps us understand the relationships and ties that Mexican immigrant men have with their partners, children, relatives, and peers. The level of involvement in and the kind of relationships men have with their partners and children will shape how they experience fatherhood, family planning, and sexual behaviors. A resident father's daily experience with his children may impact his family planning and sexual behaviors in a way not seen in a nonresident father whose children impact his life in less direct and less frequent ways. For a single Mexican immigrant man with multiple partners, using condoms may be a desirable protective measure against unintended pregnancies, HIV, and STIs, but an unnecessary measure for a man in a committed relationship or marriage. Similarly, the influence of peers could be greater for single men than for married or cohabiting men because of the different amount of time spent with peers.

Another important area to explore is the link to previous and following generations. As stated by Elder and Johnson (2003), "intergenerational ties link the experiences of one generation to the development of the next" (p. 69). Family planning ideas and behaviors can be influenced by our experiences with our parents. These ideas are also about the next generation. Planning or not planning the next generation shapes

our "link" to them. Drawing from Elder and Johnson's ideas (2003), I argue that immigrant men face a disruption from the social ties they have built in the communities of their countries of origin, including their own partners and family members. This disruption can change ideas and attitudes about their role in family planning and may also influence their behaviors. For example, a Mexican immigrant man whose wife and children are in Mexico may face feelings of loneliness that push him to risk behaviors such as having sex with a sex worker. For a nonfather, the unfamiliarity with the community or the lack of social connections may trigger feelings of social isolation resulting in minimal or no use of sexual and reproductive health services.

Symbolic interactionism helps to explain how men decide, plan, or control their life trajectories (human agency) through the ongoing negotiation of meaning and roles. A man's social self enacts decisions and behaviors about his life trajectories. The social self of Mexican immigrant men is developed in the context of Mexican society. It is in this context that they initially planned and made decisions about their life trajectories. After they immigrate, they face new social norms and values that require them to adjust and develop a new social self (through acculturation processes). This new social self will be negotiated with the old social self and through the interactions with others. Decisions about life trajectories, including decisions about family planning, are now readjusted to a new context and a new sense of self.

A *life course* perspective compliments *symbolic interactionism* by explaining age, timing, and cohort effects, as well as the role that other contextual factors may play. Stryker (1980), in his work on *symbolic interactionism,* recognized that social structures

influences individual' self-development and process. This influence is not a passive one though, and individuals actively participate and influence social contexts as well. For example, the negotiation of meaning and social self for younger Mexican immigrant men transitioning to adulthood or for men who immigrated at an earlier age may look different because the development of their social self has occurred in the U.S. context while for other men these processes happen in the Mexican context and they later have to be adjusted to the U.S. context. In both cases, the development of the self is influenced by the negotiations that happened in their surroundings but contextual variables such as education, income, and age will influenced these processes as well.

The negotiation of meanings as explained by *symbolic interactionism* and the concept of *linked lives* are tightly related. Symbols and meanings attached to fatherhood, family planning, and sexual risk-taking are negotiated via the interactions of Mexican immigrant men with their parents, partners, children, and peers, therefore linking their experiences to the lives of those surrounding them. Old and new negotiated meanings and roles however, are not solely the result of these interactions and of men's own decisions (*human agency*). Social norms and social institutions such as marriage, health systems, and immigration policies also reinforce meaning and roles. For Mexican immigrant men, the negotiation of new meanings and roles occurs in a sociohistorical context that constrains their options, current policies that limit access to family planning services being a good example. Therefore, *symbolic interactionism* and the *life course* perspective complement each other to better explain the dynamic between human agency and social structures and its influence on these men's lives.

The combination of *symbolic interactionism* and the *life course* perspective provides an excellent theoretical framework for understanding how social roles, social relationships, and health systems influence the family planning and sexual risk-taking experiences of young Mexican immigrant men and how fatherhood status shapes these men's experiences. A literature review of these factors follows, including discussions on the links between these factors and these two theoretical backgrounds.

Literature Review

In this section I discuss literature on family planning and sexual risk behavior, paying close attention to issues affecting Mexican immigrant men. I begin with a brief discussion of the context of the problem, a discussion about family planning and sexual risk behaviors, and issues related to Mexican immigrant men. I also explore how individual and institutional factors influence the experiences of these men.

Latinos are the fastest growing population in United States. Although established immigrant destinations continue to experience growth, newly settled areas, particularly in rural communities, have experienced the most rapid growth (Durand, Massey, & Capoferro, 2005; Kandel & Cromartie, 2004). Many of these rural and new settlement areas were not prepared for such high rates of growth, positioning Latinos in rural areas in a socially disadvantaged position due to the lack of resources to serve this population (Millard & Chapa, 2004). These settlement patterns have been very common in the Northwest, including Oregon (Mendoza & Gonzalez-Berry, 2010). These new patterns of settlement are also characterized by a large number of young, poor, poorly-educated men (Mendoza & Gonzalez-Berry, 2010).

Latinos overall, regardless of location, face social disadvantages that put them at risk of experiencing health disparities. For example, the prevalence of unintended pregnancies and sexual and reproductive health problems such as HIV and STIs among Latinos in the U.S. is influenced by contextual factors, including cultural values, family influences, the immigration process, and socioeconomic status (Amaro, 2002; Betancourt et al., 2004; Bowden, Rhodes. & Jolly, 2006; Frost & Driscoll, 2006; Zambrana, Cornelius, Boykin, & Salas Lopez, 2004). Other areas highlighted in the literature as central to understanding family planning and sexual and reproductive health risk behaviors among Latinos include acculturation level, health literacy, sexual education, misconceptions about sexual and reproductive health, gendered roles, partners' roles, and structural and language barriers (Amaro, 2002; Betancourt et al., 2004; Bowden, Rhodes, & Jolly, 2009; Frost & Driscoll, 2006; Harvey & Henderson, 2006; Zambrana, Cornelius, Boykin, & Salas Lopez, 2004).

Family planning. Family planning is a process through which individuals and partners make decisions about if and when to have children, and how many. It is a process so ingrained in American society that when we refer to pregnancies we often refer to them specifically as planned or unplanned. Ideas about the right timing for parenthood, spacing between children, and the ideal number of children are context relevant and will be influenced by cultural norms, sociohistorical times, and the shared experiences of groups and families (NCLR, 2006). Family planning is also a process through which families and individuals make decisions about events that are potential turning points in their life trajectories. These decisions affect people's lives in many

ways. They can represent changes in one's identity (from a nonfather to a father) and in one's relationships by adding new roles or creating new relationships (from partner to the father of a child). Changing in roles and identities will lead to negotiations of new meanings and the redefinition of a man's social self.

As discussed earlier, family planning is a family process that happens in the context of a relationship, albeit a casual-sex relationship, a long-term relationship, or a marriage. Family planning and its outcomes are also a public health concern. Reproductive and sexual health issues have an impact on society as a whole, from the number of unintended pregnancies that may lead to abortions or to unwanted children, to the number of new HIV and STI cases. These processes also occur in the context of gendered roles, where men and women face different expectations and social norms (Bachrach, & Sonenstein, 1998; Carpenter, 2010). Although we have some ideas about the effect of gender on family planning experiences, we know fairly little about men's experiences with family planning services and whether there are differences between fathers and nonfathers. We know that men overall use reproductive services less than women and that this pattern of use may be linked to the limited number of irreversible contraceptive methods men can use (Bachrach, & Sonenstein, 1998).

One issue that limits our understanding of men's family planning service utilization, trends in pregnancies, and intendedness issues is the limited sources of data addressing these issues (Bachrach, & Sonenstein, 1998). This situation is even worse for Latinos and Mexican immigrant men. Despite some attempts to gain a deeper understanding of the role of Latino men in decision making about family planning, few

attempts look specifically at how Latino men approach family planning (NCLR, 2006). Few studies suggest that ideas around masculinity and gendered roles are important in Latino men's decisions around family planning (Fernandez-Esquer, Diamond, Atkinson, 2010; Sable, Campbell, Schwarz, Brandt, & Dannabeck, 2006). The cultural ideas around gender and masculinities of Mexican immigrant men can be challenged by the norms of their new social environment. These men are caught between two worlds and the complexities of how they perceive and give meanings to old and emerging meanings may be a barrier to accessing services and to acquiring new protective sexual behaviors.

Family planning and unintended pregnancies among Latinos in the United States are a public health concern due to the increasing number of unintended pregnancies among this population. Experts argue that the incidence of unintended pregnancy among this group is related to the low rates of contraceptive use, including condom use, and family planning services overall (Heshaw, 1998; Jones, Darroch, & Heshaw, 2002; NCLR, 2006). For example, the percentage of Latinas at risk of experiencing an unexpected pregnancy that reported not using any kind of contraceptive methods has increased from 9% in 1995 to 12% in 2000 (Alan Guttmacher Institute, 2006).

Given that a pregnancy links the lives of at least two individuals (three if the pregnancy is taken to term), it is important to understand how both Latino men and women are contributing to an increasing number of unintended pregnancies and the low use or misuse of birth control among this population (Amaro, 2002; Frost & Driscoll, 2006; Zambrana, Cornelius, Boykin, & Salas Lopez, 2004). The commitment and

circumstances of the relationship also needs attention because people with the expectation of a long-term relationship will behave and plan differently than people who are ambivalent or who do not expect to be in a long-term relationship (Bachrach, & Sonenstein, 1998).

Sexual risk-taking. Unintended pregnancies are the result of risk-taking behaviors that also put men (and women) at risk of other sexual health issues such as HIV and STI's. Because this sexual risk-taking will differ depending on age group, gender, and cultural background, I focus this discussion on sexual risk-taking among Latinos. It is important to mention, however, that information about Latino men is very limited and when available it tends to focus on teenagers rather than adults (Foulkes, Danoso, Frost, & Singh, 2005). Information about Mexican immigrant men is very often hidden within information about Latinos, making it more challenging to disentangle issues affecting this population in particular.

In 2004, Latinos accounted for 18% of all new HIV and STI cases in the U.S. (Center for Disease Control and Prevention, 2007) while comprising just 14% of the overall population. Although rapidly rising HIV rates are a significant concern, this population is also at a higher risk of developing AIDS within a year of being diagnosed with HIV or of having AIDS at the time of the diagnosis. In 2004, Latinos had the second highest AIDS rate among all racial and ethnic groups in the U.S., nearly four times higher than the rates for Whites (CDC, 2005). Moreover, men are most affected by this high AIDS rate accounting for 79% of Latinos living with AIDS (CDC, 2005). These high rates of HIV and AIDS are not just an issue for men when we consider that 49% of

Latinas with AIDS acquired the virus through heterosexual contact.

Latino men also have higher rates of STIs when compared with White non-Hispanic men. Latinos have almost twice the risk for gonorrhea and syphilis when compare with non-White Latinos. The rate for Chlamydia among Latino men is three times higher than for non-Latino Whites. Although these three types of STIs are relatively easy to treat, the lack of screening and follow up among men make it difficult to reduce the number of infections (McConnell, Packell, Biggs, Chow, & Brindis, 2003).

The most salient risk behavior for Latino men is the relatively low condom use when compared with that of other racial and ethnic groups (Marin, Gomez, Hearst, 1993). Having multiple partners and having sexual encounters with sex workers also reflect risks associated with immigration and isolation. Parrado, Flippen, and McQuiston (2004) found that among the immigrant men living in North Carolina, 46% of single men and 40% of married men living apart from their wives have used the services of commercial sex workers. Although many reported using a condom in their first encounter, they also reported that once they are familiar with a sex worker, they reduce condom use. The use of alcohol has also been documented as increasing sexual risk behaviors in this population (NCLR, 2006).

Fatherhood status. In an extensive review of the literature on male fertility, family formation, and fatherhood, Bachrach and Sonenstein (1998) stated:

> the process of becoming a biological father begins with an act of sexual intercourse and the nonuse or ineffective use of contraception. To discern how men becomes fathers, it is therefore critical to understand better the sexual and

> contraceptive behaviors of males, the motivation underlying these behaviors and the factors influencing them (p. 57).

Men's role in family planning remains understudied. The family planning literature focuses on women and their experiences, and the literature on fatherhood seldom examines men's experiences with family planning. Gendered norms shape individuals' experiences around sexuality and parenting (Carpenter, 2010). Ideas about gender are context-relevant such that different social classes and cultures have different norms around these issues. Because norms are developed through the interaction of the individual with others and with institutions, they are malleable, as mentioned earlier, and experiences such as fatherhood can reshape them. It can be expected that a man who has experienced (biological or social) fatherhood will differ from a man who does not have children. Although the father may be aware of the challenges and the resources needed to raise a child, the nonfather may have only vague ideas of that specific social role. Another aspect that requires more attention is that some studies suggest that unintended pregnancies may be related to a lower level of father involvement later on (Bachrach, & Sonenstein, 1998). If studies continue to demonstrate this trend, then the understanding and promotion of family planning among men needs to be part of the fatherhood research and policy making agenda.

Young Mexican immigrant men. It is well known that Latinos are the fastest growing population in the United States. This growth in population has been catapulted by two main factors: high fertility rates and the influx of immigrants from Latin America, particularly from Mexico (Hernandez, Denton, & McCartney, 2008; U.S. Census, 2002).

In the last decade, this immigration has been characterized by a large number of young men (Suro & Tafoya, 2004), many of whom have low income and education levels (Hernandez, Denton, & McCartney, 2008). Many of these men are undocumented workers, making them vulnerable to unstable job conditions, poverty, and negative health outcomes. Also, they are not eligible for many health services or for free family planning services.

Culture is another important variable influencing these men. Culture can be defined as a collection of thoughts, ideas, values, beliefs, and actions that characterize and differentiate racial, ethnic, or other groups (e.g., religion). These sets of beliefs, thoughts, and ideas are learned early in life and are reinforced through life experience. They are ingrained in our personal systems of beliefs and ideas and will guide our behavior and our worldviews (National Alliance for Hispanic Health, 2000). Because they are ingrained in who we are, they are difficult to see and change.

Another major cultural difference is language. Spanish is the primary language of this group. Although many are bilingual, recent immigrants with low educational attainment do not speak English (Hernandez, Denton, & McCartney, 2008). When health systems are not prepared to address language barriers, health disparities increase (Betancourt et al., 2004). Here culture and social determinants (low education) influence the severity of the problem.

Cultural Factors

Acculturation. Mexican immigrant men have to learn new cultural values to integrate to the new society. This cultural learning process is often referred to as

acculturation, which has been defined as the acquisition of Euro American cultural values and practices. Acculturation is a process of learning and behavioral adaptation that takes place as a result of exposure to a non-native culture. Acculturation processes and phenomena occur at macro- and micro-levels, are multifaceted and multidirectional, and encompass bicultural and multicultural processes (Cuellar, Nyberg, Maldonado, & Roberts, 1997; Miranda et al., 2000; Rodriguez, 2002). Different patterns of acculturation affect health outcomes in different ways. For example, high acculturation levels are associated with increases in sexual risk-taking (Afable-Munsuz & Brindis, 2006). Mexican immigrant men who have been in the U.S. for a longer period of time or who immigrated at an earlier age may have higher levels of acculturation. As mentioned earlier, during the acculturation process, role conflict and ambivalence may arise between old and new meanings and in the roles associated with family planning and sexual behaviors. This conflict and ambivalence may result in decisions and behaviors that put men at risk of experiencing unintended pregnancies, HIV, and STIs.

Familism. Cortes (1995) described *familism* "as a belief system, [that] refers to feelings of loyalty, reciprocity, and solidarity toward members of the family as well as the notion of the family as an extension of the self" (p. 249). It "is a construct that reflects the collectivistic nature of Latino culture, in other words, the orientation toward the welfare of the group" (Romero et al., 2004, p. 3). Cultural values associated with *familism* have been often linked to different health outcomes but they are especially important for family planning and sexual risk behaviors (Amaro, 2002; NCLR, 2006). *Familism* is associated with positive health outcomes due to the emphasis on a collective

approach to family problems, close social networks, inclusion of extended family, and interdependence in carrying out daily responsibilities (NCLR, 2006). It has been found, for example, that prevention efforts with Latinos that focus on family consequences of HIV and contraceptive use are more effective than interventions that focus on individual consequences (NCLR, 2006). Values associated with *familism* in Mexican immigrant men foster tight relationships with partners, children, and other extended family members. These strong links with family members may serve as motivation for men to avoid risk behaviors. Living with their partners and/or living with their children may become a protective factor, which may be one difference between fathers and nonfathers.

Machismo, gender, and masculinities. Ideas around masculinity, gender, and fatherhood are culturally specific (Mundigo, 1995) and study conducted by Sobralske (2006) showed that these ideas have a strong influence on Mexican American men in health care seeking. Others have stated that gender and the meaning of masculinity are important influences on health and need further study (Kimmel & Messner, 2001). In the Latino culture, many of these ideas arise from values associated with machismo. *Machismo,* in general, refers to the belief in male dominance as a culturally preferred mode (Mirandé, 1997; Vega, 1995) but it also refers to men's responsibility for their families and society as a whole (NCLR, 2006). These values, although generally seen as negative, also can be seen as positive when they emphasize men's responsibility of protecting and taking care of family members (Rodríguez & González, 1997). The problem with some of the values associated with machismo, or male dominance, is the development of identities around the idea of a hyper sexual risk-taker, which may

contribute to the increasing number of HIV and STIs cases among this population (NCLR, 2006).

Health systems. Health system is a broad term and its definition goes beyond simply that of health care. A health system refers to how a country provides health care, but also to the way services are financed, including prevention and rehabilitation. Within all these systems, different sets of values around health can be found (Evans, 1984). As a complicated subsystem of a whole society, health systems also represent the social disparities found in society at large. Latinos in the U.S. face an array of health disparities that reflect the inequalities in our current health system (Betancourt et al., 2004). These disparities include the disproportionate number of unintended pregnancies and the increasing number of new HIV and STI cases in the U.S. (Betancourt et al., 2004; NCLR, 2006).

Social structures such as health systems play an important role in men's experiences with family planning and sexual risk behaviors. Through the interaction with social structures such as health systems, men negotiate new meanings or modify old meanings attached to family planning and sexuality. Mexican immigrant men's first interactions with health systems in the U.S. are crucial for the development of positive new meanings in the host country. If family planning clinics created services for these men using culturally appropriate practices, men would be able to adjust to new meanings of their sexuality, and to develop a sense of "Me" where family planning is a positive and expected behavior. On the contrary, if family planning clinics fail in their interactions, these men may resist new meanings and may retain old meanings or continue unplanned

and unpredictable behaviors. The understanding of these interactions and how they influence men's family planning and sexual risk behaviors is important when crafting health policy and health programs because they can have a direct impact on men's experiences.

Some of the discourse around sexual and reproductive health disparities has been around culture-related issues and cultural competency in the health care system. But why is culture so important to reduced health disparities? Culture is manifested in the way we think and act, our values and beliefs. Health from a holistic point of view is a value itself. Because health can be considered a value, it can be argued that health will also be defined by our cultural ideas of health. Values and ideas about health will shape our attitudes and practices and how we relate to health systems. At the same time, it can be argued that health systems are institutions that also have their own values and ideas about health. Unfortunately, health systems may privilege values and ideas of certain groups over others, leading to a set of health disparities such as the ones mentioned earlier.

Values associated with *respeto* (respect) are a good example of how the interaction between culture and health systems may lead to health disparities. *Respeto* is defined as differential behavior toward another based on age, sex, social position, economic status, and authority (National Alliance for Hispanic Health, 2000). *Respeto* as an important cultural value for Latinos is reflected in the relationships they developed with health care providers. Because health care providers are given a high level of respect, when interactions with health care providers are negative, this can have a significant impact on the meanings Mexican immigrant men attach to heath systems and

family planning services.

Respeto values are also related to *personalismo* (the importance of personal over institutional relationships) and *confianza* (trust, or the belief that a person is looking out for the person's best interest). These values together can lead to mistrust of the medical system when less personalized services, physician rotation, short office visits, and bureaucratic processes characterize medical care. Mistrust then become a barrier for health care that later on will influence health disparities for this group (Betancourt et al., 2004). Mexican immigrant men who experienced or perceived discrimination may also mistrust the system (Betancourt et al., 2004). Unauthorized workers may also approach the system with mistrust due to their immigration status and may refrain from accessing and receiving services (Arcury & Quandt, 2007; Heyman, Nuñez, &Talavera, 2009). For a considerable number of Mexican immigrant men, these three circumstances combine to create serious barriers to accessing family planning and sexual health services.

A critical systemic barrier for Mexican immigrant men is the language barrier (Arcury & Quandt, 2007). Spanish is the primary language of this group, making it a critical cultural issue. Many Latinos are bilingual. Studies have shown that some Latino groups are able to maintain language abilities for up to three generations (Portés & Rumbaut, 2004), but recent immigrants with low educational attainment have extremely limited English abilities (Hernandez, Denton, & McCartney, 2008). Currently, the U.S. faces a shortage of health professionals in a variety of sectors, and the unmet need for bilingual and bicultural health professionals is yet another systemic issue contributing to sexual and reproductive health disparities affecting Latinos (Betancourt et al., 2004;

Heshaw, 1998; NCLR, 2006).

Another systemic barrier is access to health care (Arcury & Quandt, 2007; Cristancho, Graces, Peters, & Mueller, 2008). Nearly a third of Latinos are uninsured and a large number of those are immigrants (U.S. Department of Health and Human Services, 2000). Poor and low-income Mexican immigrant men (documented and undocumented) face difficulties accessing public health services under current Medicaid standards. Requirements established by the Deficit Reduction Act to obtain family planning are a major barrier as well. Current policies limit federally funded family planning services to U.S. citizens and impose strict documentation requirements. These limitations have prevented naturalized Mexican immigrants from utilizing family planning services due to difficulties with meeting the strict documentation requirements and have excluded unauthorized immigrants from services altogether (Planned Parenthood, 2007).

Summary

As part of the processes associated with immigration, young Mexican immigrant men experience the emergence of new roles and negotiation of new meanings attached to fatherhood, family planning, and sexuality. Fatherhood is a major life transition that will shape men's experiences in ways different from those of nonfathers. The challenges and opportunities faced by fathers will differ from the experiences of nonfathers, in part because the links that these men have to others (e.g., children and children's mothers) and to institutions (e.g., family planning services, schools) influence their interactions and the negation of meanings differently. The symbolic interactionism theory and a life course perspective combined provide a framework to understand these men's experiences at the

micro- (e.g., meaning and roles) and macro-level (e.g., sociohistorical and institutional context).

The role that fatherhood plays in men's experiences with family planning and sexual risk behaviors is not well understood, despite the clear link between fatherhood and family planning and the impact that fatherhood has on men's life trajectories. Even less in known about the role that fatherhood plays in young Mexican immigrant men's experiences. It is known that this group of men is affected by a worrisome number of unintended pregnancies and increasing rates of HIV/AIDS and other sexually transmitted infections. Several factors have been associated with their risk including: acculturation issues, cultural variables (e.g., familismo, machismo), socioeconomic disadvantages (e.g., poverty, low education attainment), and institutional barriers (e.g., health care access, lack of bilingual health care providers).

Method

This chapter is organized into two major sections. The first section describes in detail the *Latino Health Project: Men Only* and covers (a) introduction to the project, (b) recruitment, and (c) data collection procedures. The second section describes in detail the dissertation study design, including (a) rationale for a qualitative analysis strategy, (b) description of the research sample, (c) overview of the research design, (d) data analysis, (e) role of the researcher and other ethical considerations, and (f) issues of trustworthiness.

Latino Health Project: Men Only

This dissertation study was conducted using qualitative data from the *Latino Health Project: Men Only*. Dr. Marie Harvey, at Oregon State University, was the primary investigator and a team of researchers in the Department of Public Health at Oregon State University was involved with the project. The overall goal of was to explore the sexual and reproductive health needs and the service utilization patterns of heterosexual Latino men living in rural areas in Oregon. Oregon is considered a new settlement area where Latino populations have grown at a rapid pace, especially in more rural areas (Suro & Tafoya, 2004).

Recruitment efforts targeted counties classified as nonmetro rural or as metropolitan areas with a rural census track. Participants in this study had to meet the following criteria: (a) be a recent immigrant Latino heterosexual man living in the United States for fewer than 10 years, (b) be sexually active during the three months prior to participation, (c) have a sexual partner(s) who was not pregnant at the time of the

interview, (d) not plan to get their partner(s) pregnant in the next year, and (e) not be HIV positive. In 2009 a total of 49 interviews were conducted for this project. A detailed description of the recruitment process follows.

Recruitment. The research team used a purposive sampling strategy (Patton, 1990) to recruit research participants. Recruitment took place in the counties of Benton, Linn, Lane, Marion, and Polk with half (50%) of the interviewees residing in Marion County. Bilingual bicultural male recruiters/interviewers conducted the screening for eligibility and also conducted the interviews. The research team used several passive and active recruitment strategies addressing the challenges associated with recruitment of men and minorities into research. Passive recruitment strategies incorporated the use of printed material, including posters, brochures, and flyers. These materials were strategically placed at community locations such as grocery stores, soccer fields, apartment complexes, and other community locations that Latinos regularly frequent.

Active recruitment strategies were also used. Recruiters approached possible participants at community locations such as farms, health clinics, and health fairs using a standard script describing the project. They also provided a brochure with the project's information. Screening and interviews were conducted at the recruitment sites when appropriate or participants selected another time and location to conduct the screening and/or the interview (See Appendices A and B). Potential participants also had the option of calling a toll-free number and completing the screening by phone. A standard script was also used for phone screenings. Participants in the project received $20 as compensation for their time.

Data collection procedures. Before the recruitment and data collection stages began, an interview guideline was developed in English (see Appendix C). This version was then translated to Spanish (see Appendix D) and translated back to English to guarantee the accuracy of the translation. Using open-ended questions followed by directive probes, this instrument explored topics such as Latino men's experiences and satisfaction using family planning and sexual and reproductive health services, barriers and facilitators to accessing and utilizing family planning and sexual health services, and attitudinal and sociocultural factors that may influence family planning service utilization and sexual risk behaviors (e.g., family beliefs, gender roles, cultural influences such as *familismo, respeto, machismo*). Data were also collected regarding household demographics, housing and living arrangements, employment and education, family of origin, community of origin, and the number of years living in Oregon and in the United States. The quantitative component of the interview included a set of scales to measure acculturation level and cultural norms. It also included questions regarding attitudes and behavior about birth control use, HIV and STI risk factors, and health care access and utilization.

Eligible participants were invited to participate in a 60- to 90-minute interview conducted by a bilingual (English and Spanish) bicultural (Mexican American) male interviewer. Research suggests that having interviewers from the same or similar cultural background facilitates rapport, cultural understanding, and trust (Marin & Marin, 1991). Considering the sensitive nature of the topic under study and the comfort level of the participants, it was decided to hire male interviewers. Interviews were conducted in ways

that protected the participants' privacy and measures were taken to guarantee confidentiality. Participants were asked to read and sign an informed consent that was available in English and Spanish at a 5th grade reading level (see Appendices E and F). Participants could choose to do their interviews in Spanish or English. Completed interviews were transcribed and translated by bilingual translators.

Overview of the Research Design

Qualitative data from the *Latino Health Project: Men Only* were used to answer the research questions and aims of this dissertation. Due to the exploratory and descriptive nature of this dissertation, qualitative analysis was most deemed suitable, first, because very little is known about this group of men and their attitudes, ideas, and behaviors related to family planning and sexual risk behaviors; and second, because this study was concerned with these men's perceptions, their reflections on these experiences, the meanings they assign to them, and how they negotiate these meanings in the context of immigration.

Another important reason for choosing qualitative methods is that they are useful for conducting exploratory research with racial and ethnic minority groups or hard to reach populations (Madriz, 2003). The nature of qualitative research reduces the distance between participants and researchers by allowing participants to be the expert in the subject under study with the potential to reduce mistrust and fear of exploitation in communities of color or communities that have been discriminated against and/or exploited before (Madriz, 2003; Marin & Marin, 1991; Umaña-Taylor & Bamaca, 2004). Qualitative methods also can reduce issues with literacy by allowing participants to use

their own language and terminology to explain the phenomenon under study and to reduce problems associated with surveys and standardized instruments such as lack of cultural appropriateness or literacy levels (Marin & Marin, 1991; Umaña-Taylor & Bamaca, 2004). Qualitative methods are also useful when inadequate frameworks or concepts have been used to understand a population or phenomenon. Most of the time, our understanding of Latino families, and in this case, our understanding of Mexican Immigrant men, fatherhood, family planning, and sexual risk behavior, has been framed using Anglo European models (Cabrera, 2002; Hidalgo, 1998; Weaver, Umaña-Taylor, Hans, & Malia, 2001).

To answer the research questions described above, secondary data analysis was used. The use of secondary data was once not considered appropriate for qualitative research because of concerns about the potential of already generated data to answer new questions or be reanalyzed (Thorne, 1994). Today the use of secondary data in qualitative research is common but the issues associated with it are rarely made explicit or acknowledged (Hinds, Vogel, & Clarke-Steffen, 1997). Nevertheless, use of secondary data in qualitative research has been identified as a successful tool when certain methodological considerations have been addressed. Secondary qualitative data analysis can be a cost effective tool and has been successfully used in fields including education, health, nursing, and family sciences (see Hinds, Vogel, & Clark-Steffen, 1997; Santacroce, Deatrick, & Ledille, 2000; Szabo & Strang, 1997).

Hinds et al. (1997) identified two methodological issues to consider when conducting secondary qualitative data analyses:

> (a) the degree to which the data generated by individual qualitative methods are amenable to a secondary analysis and (b) the extent to which the research purpose of the secondary analysis can differ from that of the primary study without invalidating the effort and the finding (p. 411).

I considered both issues seriously. The data available for this project were appropriate for analysis; researchers from the original project provided verbatim transcriptions and translations, survey data, instruments, and procedures, including Institutional Review Board materials. The principal investigator was available to answer questions at all times. I also met with one of the project interviewers to clarify information about data collection procedures and how certain questions were asked. Although the purpose of this dissertation study did not differ considerably from the original project's goal, this dissertation study included new categories of analysis (fatherhood, age, intimate relationship status, and health services) to understand family planning and sexual risk experiences of recent Mexican immigrant men, which were variables of interest in the original project.

Sample. A total of 49 men were interviewed for the *Latino Health Project: Men Only*. Of these 49 men, three participants from Central America were dropped from the sample because cultural variables specific to Central America could confound the findings. The dissertation study's final sample included a total of 46 men (see Table 1), 21 fathers and 25 nonfathers. Although one participant was born in the U.S., his parents were Mexican migrant workers who spent time between the U.S. and Mexico. Because he spent many years living in Mexico, this participant's experience possibly represented

another facet of the migration phenomenon and his inclusion in the study's sample could potentially enrich the results. All other participants had lived in United States 10 or fewer years and were considered recent immigrants based on the Pew Hispanic Center definition (Suro & Tafoya, 2004).

Participants in the study had a mean age of 24 years old and had lived in the United States for an average of 6 years. Overall, participants had low education levels, with a mean of 9.39 years of education. Most men (46.0%) were single, followed by men who lived as married or cohabited (19.5%); married men totaled 15.2%. Men who defined themselves as single but living with a partner comprised 15.2 % of the total sample. Of those married, 42.6% had a spouse living in Mexico. Of the total sample, 45.6% of men had children but just 38.0% were living with their children. The average annual household income was $13,000, meaning that a considerable number of these men were living in poverty, particularly if we consider that their incomes supported an average of 3.59 individuals. Many of the men in the sample worked in agriculture and farming jobs (38.0%). The percentage of those working in the service industry and social services was 14.3% each and a small number (9.5%) worked in the construction sector.

Table 1. *Demographic Data (*N = *46)*

	Total sample		Fathers		Nonfathers	
	N	%	*n*	%	*n*	%
	46	100	21	46	25	54
M age (years)	24.0	100	25.2	100	23.0	100
18 – 24	27.0	59	11.0	52	16.0	64
24 – 30	19.0	41	10.0	48	9.0	36
M years living in the U.S.	6.2		6.5		6.0	
M income	$11,000		$10,000		$13,000	
M years of education	9.4		8.4		10.2	
Sexual relationship status						
Married	7	15.2	5	23.8	2	8.0
Cohabiting	9	19.5	6	28.6	3	12.0
Single living with partner	7	15.2	4	19.1	3	12.0
Single	21	46.0	5	23.8	16	64.0
Divorced	2	4.3	1	4.7	1	4.0
N of children						
1			11	52.4		
2			6	28.6		
3			3	14.3		
6			1	4.7		

Data analysis. A bilingual bicultural male interviewer recorded interviews using a digital voice recorder, and bilingual professionals then transcribed and translated the interviews into English. To maintain the trustworthiness and validity of the translated qualitative data, the bicultural bilingual project interviewers verified all translated interview data and crosschecked the accuracy of the transcription and fidelity of the translation with the audio files. McLellan, Macqueen, and Neidig (2003) used a similar approach to verify the accuracy of transcriptions.

Qualitative data were analyzed using MAXQDA software. The analysis process used grounded theory methodology techniques (La Rossa, 2005). To be consistent with this approach, I made as few assumptions as possible during the coding process

regardless of the theoretical perspectives guiding my research questions. First, I immersed myself in the data by reading each transcript two times. After becoming familiarized with the data, I reread the transcripts once more while doing a thorough identification of the emerging themes from the raw data (open coding) (La Rossa, 2005; Strauss & Corbin, 1990); a coding scheme was developed at this time. I also developed summaries of each participant that include information about sociodemographic characteristics, sexual and reproductive health attitudes and behaviors, along with any other additional information pertaining to the dissertation aims.

All transcripts were then systematically coded using the emergent coding scheme that included seven main themes: culture and immigration, fatherhood, sexual and reproductive health meanings, sexual and reproductive health behaviors, social relationships, sociodemographics, and structural context. A matrix was developed to maintain a systematic record of codes by participants and of characteristics essential for the analysis (e.g., fatherhood status, age, type of intimate relationship, number of children).

Based on the theoretical background and the main emergent themes, an initial preliminary conceptual framework (categories and descriptors) was developed with the purpose of understanding how themes were related (La Rossa, 2005; Strauss & Corbin, 1990). Using this initial conceptual framework, new codes and subcodes were then integrated into the coding scheme and transcripts were recoded. The code for sexual behaviors was broken down into two separate codes, protective factors/behaviors versus risk factors/behaviors. Then sub codes were created including *machismo* and

personalismo, meaning surrounding STIs, HIV, family planning and birth control, influence by type of social relationship, perceived discrimination and mistrust, access to health care, access to information (including sex education), economic barriers, geographic barriers, and comparisons of Mexico and the US. New codes and subcodes were then integrated into the matrix.

After a second coding scheme was developed, participants' transcripts were divided by fatherhood status (fathers vs. nonfathers) and the coding process continued. Then I conducted another round of coding examining intimate partner status. Partners play an important role in family planning and sexual risk behaviors (Harvey et al., 2002). The type of intimate partnership also influences the role fatherhood plays in family planning and sexual risk behavior. Participants were divided into two groups: single men and men in a recognized partnership. This last group included single men living with their partners, men who identified themselves as living as married, and married men living with and without their wives. The inclusion of various types of partnerships is in line with the idea of fluid partner living arrangements instead of rigid categories (cohabiting, married, divorce, single) (Manning & Smock, 2005).

I repeated the process one more time for age differences, dividing fathers and nonfathers into two groups, 18 to 24 (younger men, transitioning to adulthood) and 25 to 30 (young adult). Based on the literature on the transition to adulthood and the impact of fatherhood on men's development (Palkovitz, 2002; Settersten & Cancel-Tirado, 2010), I argued that the experiences of older fathers and nonfathers transitioning to adulthood is different from the experiences of young adults and that these differences in turn influence

the role of fatherhood in family planning and sexual health behaviors in different ways.

After no new themes emerged I re-examined all the themes and concepts. This process, also known as selective coding (La Rossa, 2005), helped to facilitate the understanding of how variables are connected and how they influence each other. In other words, this process allowed me to discover the theoretical story (La Rossa, 2005) of the data and to answer the research questions. During this process, I used the participants' matrixes to identify patterns and describe the family planning and sexual risk-taking experiences of young Mexican immigrant men, to compare the experiences of fathers and nonfathers, and then to identify how individual factors and health services influence these experiences.

Triangulation of findings was reached by comparing transcripts of the men's interviews, the researcher's reflective journal, survey data, and information provided by one of the project's interviewers (who is a Latino man himself), and findings from the original study. This process enhanced the validity and trustworthiness of the conclusions. More details on validity and trustworthiness of the conclusions are discussed in the section below and later in the discussion chapter.

Researcher's Role and Other Ethical Considerations

In any kind of qualitative research, it is important to discuss the role of the researcher and how her role may be influenced by contextual and personal characteristics (Marshall & Rossman, 1998). Although I was not involved in the data collection process, I am still an instrument through which the qualitative inquiry occurs. I approached the secondary qualitative data from my perspective, which I can describe as that of an

educated, middle-class, heterosexual, bilingual, bicultural, Puerto Rican woman who has lived in the U.S. for eight years. I also came to this process with professional and life experiences as a counselor, wife, daughter, and friend, which also influenced my perspective and my understanding of men's experiences.

I share with this group of men the context of being an immigrant and some of the challenges associated with it such as with acculturation, discrimination, and integration. I also share similar cultural values such as *familismo*, and was raised in a culture where *machismo* and *marianismo* were tangible. These values inherently influenced my ideas about family planning and sexuality. Even though I share some of these experiences, I am in a more privileged position given my social class, education level, and my American citizenship, which make me an outsider relative to the participants. Although my gender also makes me an outsider, it can be tempered by my experiences with Latino men (my husband, my father, my friends) and with Mexican immigrant men (friends, colleagues, and other community members), which helps me gain somewhat of an insider perspective.

Another important aspect to be disclosed is my role as a community leader and an advocate for Latino families. This role is rooted in a strong sense of social responsibility, which as Foley and Valenzuela (2005) explained, "comes precisely from my social and political location as a community member of a community lacking in voice, status, and representation at all levels" (p. 225). My motivation to do this project goes beyond my interest in the field and from researcher curiosity; it also comes from my strong commitment to give voice to this group of men and to bring attention to some of the

issues affecting them.

Issues of Trustworthiness

Guba and Lincoln (1998) have given serious attention to issues of trustworthiness and highlight four areas: credibility, dependability, confirmability, and transferability. In the following section, I describe how these four areas were addressed to assure the trustworthiness of the findings.

Credibility. Acknowledging your own bias and subjectivity and finding ways to examine and challenge your own interpretation are important for establishing your credibility as a qualitative researcher and for the trustworthiness of the findings. (Creswell, 2003; Marshall & Rossman, 2006). In the previous section, *Researcher's role and other ethical considerations,* I explored how my life experiences and social location might influence my perspectives on the study's topic. To address these biases, several steps were taken.

First, I kept a reflective journal throughout the study. In this journal, I monitored my thinking process and registered ways in which my bias might be influencing my ideas. Second, I immersed myself in the data as much as possible even when secondary data were used. I held meetings with the primary investigator, project coordinator, and one interviewer to clarify questions about methods, design, and data collection. Third, I used triangulation techniques and validation of my interpretation. To triangulate findings, I used data transcripts and translations, screening forms, survey data, advisors' reflections, and researcher's journal entries. Fourth, I carefully recorded discrepant information, information that challenged emergent themes, or cases that did not follow

general trends (Bloomberg & Volpe, 2008). Fifth, "peer debriefing" was used to examine my assumptions and to contemplate alternative interpretations (Bloomberg & Volpe, 2008). One of the people selected for peer debriefing was a bilingual bicultural researcher assistant for the *Latino Heath Project*. Another selected peer was a bilingual bicultural with a doctorate in Public Health with special interest in migrant health issues. The third peer was a bilingual doctoral student in Human Development and Family Sciences.

Dependability and confirmability. Dependability refers to the extent to which your interpretation and procedures can be traced back; it is equivalent to reliability in quantitative research (Bloomberg & Volpe, 2008; Lincoln & Guba, 1985). An *audit trail,* as described by Bloomberg and Volpe (2008), was kept. The audit trail for this study included the researcher's reflective journal, which also includes a coding log, data matrices, and the use of MAXQDA software.

Tied to the concept of dependability is the concept of confirmability. It is similar to the idea of objectivity; that is, results should reflect the data and the participants and not the researcher's personal perspective or agenda. The audit trail is particularly useful for making results traceable to the original data. Ongoing reflection of one's own bias and the use of advisors' reflections, peer debriefing, and colleagues' validation of results were used in conjunction with the audit trail to achieve confirmability of the results.

Transferability. Transferability refers to how research findings can explain similar phenomenon in other contexts or with other populations (Guba & Lincoln, 1985). To assist the reader in deciding whether the results of this research project apply to or explain a similar process in other contexts, I have provided a matrix of participants'

context and background. Demographic information about the participants is included along with any other information relevant to understanding the variables under study.

Summary

To answer the research questions, a qualitative phenomenological study was conducted using secondary data from the *Latino Health Project: Men Only*. This research project's main goal was to gain more understanding of the sexual and reproductive health needs among Latino immigrant men living in rural Oregon. The sample was comprised of 21 fathers and 25 nonfathers for a total sample of 46 men that have lived in the United States 10 years or fewer. Data for the project were collected using an interview guide with open-ended questions followed by directive probes and sociodemographic data were also collected. Qualitative data was analyzed using MAXQDA software. The analysis process used grounded theory methodology techniques (LaRossa, 2005). After a systematic and thorough analysis of the data was completed, findings have been presented in multiple forms including selections of representative segments of text to represent phenomena and experiences, men's stories, and alternative explanations for contradictions. Findings are discussed in detail in the next chapter.

Results

The purpose of this qualitative study was to explore how social roles, social relationships, individual factors, and health systems influence the family planning and sexual risk-taking experiences of young Mexican immigrant men, paying special attention to similarities and differences between fathers and nonfathers. This chapter discusses the key findings of the study and is divided into six major sections: (a) an overview of Mexican immigrant men's experiences with family planning and birth control, (b) broken webs of sexual and reproductive health knowledge, (c) the intersection of masculinities and birth control, (d) the complexities of sexual risk behaviors, (e) contextual influences, and (f) summary of main findings. To illustrate major findings, selections of representative segments of text are used. I also used narrative passages to represent phenomena and experiences, telling men's stories and illustrating how the combination of individual factors (fatherhood status, partnership status, cultural values) and social structures (health systems) influence Mexican immigrant men's experiences with family planning and sexual risk behaviors.

Overview of Family Planning and Sexual Risk Behaviors

In this section, I briefly discuss general trends of family planning and sexual risk behaviors as well as some sociodemographic characteristics of the study's participants. The purpose is to provide the reader with an overall picture of the lives of these men and a deeper understanding of the context of the findings discussed later in the chapter. Most of the men who participated in the study have life trajectories or stories very different from those typically found among mainstream middle-class men in the United States.

They were recent immigrants, typically with low educational attainment and limited English proficiency. Their low levels of educational attainment and limited literacy were often reflected in their responses, which were frequently short, limited in depth, and peppered with idiomatic phrases. These responses sometimes were difficult to translate into English, and on occasion confusing and unclear once translated.

Although the majority of these men were partnered, the type of relationship varied from married to casual dating; some were involved with multiple partners, and a few were married to women living in Mexico. The length of their relationship with their partners also varied from one month to several years. A little less than half of the men were fathers (21 men), with fewer than half of these (8 fathers) living with their children. Their living arrangements varied considerably as well, from men living with partners, younger men living with parents, some men living with extended family or friends, and a few men reporting being homeless and living in shelters or living with friends temporarily. More than half were unemployed and many were living below the poverty line. Most were uninsured and in many cases had not visited a health care provider in years. Their social location, not surprisingly, placed them at great disadvantage.

Given the difficult circumstances these men endure, it can be argued that their experiences with family planning and sexual risk was highly influenced by these disadvantages, possibly leading to behaviors that increase the chances of unintended pregnancies and of getting infected with HIV and/or other STIs. Many men reported loneliness (often associated with their partners living far away or not having family members living close by), alcohol and drug use, economic barriers, and lack of

information as reasons why Latino men engage in risk behaviors.

The men in the sample tended to be disconnected from family planning services or at least not clear about what family planning services are. For example, a majority of participants reported no use of family planning services in the U.S. An interesting finding was that of the three men who reported using Planned Parenthood's services, two reported they had never used family planning services in the U.S. This information hints at a disconnect between this population and service providers, given that Planned Parenthood, although it provides a varying array of services, is probably one of the best known family planning service providers in the U.S.

The low use of family planning services was also reflected in the inconsistent use of birth control other than condoms, and in the misinformation reported about methods of birth control, such as how to use them, possible side effects, and mistrust of their efficacy. A majority of men reported negative attitudes toward vasectomies and more than half of the men who were asked whether they used interrupt sexual intercourse (withdrawal) as a method of pregnancy prevention reported doing so even though many of them acknowledged that it is not effective.

More than half of the men reported positive or at least neutral attitudes toward men who have multiple partners, even when involved in a committed relationship. They also demonstrated accepting attitudes toward having sex with sex workers. These attitudes were also reflected in the high number of men who had engaged in these behaviors. Other types of risky sexual behaviors reported by the men in the sample involved inconsistent condom use and sex with multiple partners or sex workers,

sometimes without protection, with very few reporting either no condom use or consistent condom use. Men in general reported low perceived risk of STIs and HIV, with HIV a greater concern than the risk of STIs. Greater concerns about HIV were also reflected in the patterns of testing in that half the men in the sample had been tested for HIV whereas just 10% had been tested for STIs. This pattern may be attributed to the type of samples necessary for testing. HIV testing requires a saliva swab or a blood test, whereas tests for some STIs may require more complex and uncomfortable tests, which can also be more expensive. In a few cases, men reported they had been tested but it was not clear whether they were tested for various types of STIs, for HIV, or both.

The experiences of these men vary and are influenced by individual and structural factors as well as by social roles and social relationships. In the following sections, I discuss in more detail the complexities of men's experiences with family planning and sexual risk behaviors and aim to disentangle the role that variables such as fatherhood status, intimate partnership, and social structures play in these experiences.

Broken Webs of Sexual and Reproductive Health Knowledge and Information

Many of the complexities and inconsistencies reported by these men are, in one way or another, associated with misinformation, lack of knowledge, and access to information. The term *broken web of knowledge* is an analogy for the ways in which knowledge influences these men's experiences. Lack of sexual education at home and/or at school, limited access to accurate information, language barriers, and misinformation shared by word-of-mouth create webs of fragmented information and weave together accurate information with misinformation. The way this web of knowledge influences

risk behavior is illustrated by this participant's response when asked about concerns around birth control:

> Well, sometimes, I feel people get worried due to ignorance. Because they say that pills make women sterile or make them fat, but they say that because they heard that from other people who heard it from another person, so in [reality] they don't know if this is true or not. They never have spoken with a doctor about it. Perhaps [there] could be some truth behind these comments but they are not certain about anything and they don't use [birth control] and the result is that they get full of children and ultimately the woman, anyway, got fat because she had too many babies. [AT111, father]

Across interviews, the most salient theme was the lack of knowledge and education about sexual and reproductive health. Men in the sample of all ages, years of education, and language preference reported an overwhelming number of misconceptions and misinformation. Tied to the issue of lack of information was the fact that a majority of men reported receiving very little or no sex education from their parents, but about half reported some kind of formal sexual education. A few men were even surprised at being asked if their parents had talked to them about sex, as if it is normal and accepted that parents do not talk to their children about sex.

Although more than half of nonfathers reported some kind of sex education at school, misinformation was still found in their interviews. Fathers, regardless of their partnership type, were less likely than nonfathers to report that they received any kind of sexual education either at home or at school, with fewer than half reporting sex education

at school and only a fifth of fathers reporting that their parents talked to them about sex. One father even linked the birth of his first child to the lack of information about sexual and reproductive health. Another father pointed to "ignorance" or "lack of knowledge" as the root of sexual and reproductive health issues affecting Latino men. Comparing Mexico to the U.S., one man stated that men engage in risk behaviors due to lack of knowledge:

> Yes, lack of knowing; lack of knowing. Because out there, in Mexico when I was growing up, a little kid; you know, you don't hear about that. […] I mean, it's different; you know, going out and having sex; you really don't find out [referring to sexual risk behaviors] until like later on in life. […] You got to learn what sex is; you got to learn how to protect yourself because if you don't; you know, HIV and this and that. [AT125, father]

Findings suggest that lack of knowledge played an important role in the trajectories that lead these men to fatherhood, as reported by the father above who linked his early parenthood to lack of knowledge. The available data, however, did not provide answers as to why fathers may have received less sex education at home and/or at school than nonfathers. Additionally, the original study did not explore questions about planned or unplanned pregnancies, age at birth of first child, and factors contributing to early fatherhood.

Men's tendency to be uniformed or misinformed about sexual and reproductive health could be associated with a variety of issues, such as accuracy of the information received at home and at school, how many times they received sex education, and how

many sources of information to which they have been exposed. Personality characteristics may also make some men more interested than others in their sexual and reproductive health or their health overall. For example, one man reported that he was always seeking information and asking questions to health care providers because his health was a major concern for him.

These findings suggest that even when men reported having sex education at school or at home, the scope and the depth of the information received can vary significantly based on multiple factors such at the age at which they received sexual education, where they received the education (U.S. vs. Mexico), for how long, and so on. For example, a participant [AT111, father] touched on how sex education in the U.S. is different from sex education provided in Mexico: "There [in Mexico] in the school this subject [referring to sexuality] is barely touched, it is not like here [U.S.]. Here they are more open minded when it comes to teaching children about sex. And there [in Mexico], no. These issues are taboo."

Furthermore, it can be argued that some of these men may get caught between educational systems when they immigrate, leaving some without exposure to sex education in either the U.S. or in Mexico, due to the timing of their immigration. Language barriers during this transition can also be associated with this issue given that many of the men who immigrated at a younger age and received formal education in the U.S. may have had limited English proficiency at the time when sexual education was provided to them. These two circumstances may explain why some of the men who received sex education in the U.S., a system with sociocultural norms different from

those in Mexico, also reported or presented low levels of sexual health knowledge or misinformation in certain areas.

The majority of men in the sample reported misinformation and lack of knowledge about various aspects of sexual and reproductive health, including sexually transmitted diseases, HIV and AIDS, family planning and birth control, and sexual and reproductive health services. Even men who received some education in the U.S. and who are college educated showed either lack of information or misinformation in one or more of the areas of sexual and reproductive health mentioned above. One example illustrating the misinformation found across the interviews is a man who prefers that his partner use the patch instead of birth control pills because he sees the former as a "drug," unlike the patch:

> Ummm, the pill, the pill, I am not going with that; I am just going to use ummm nothing like that; you know, it's that just to take a pill is like a drug and it is not good for her. The patch, yes. [AT125, father]

Another important aspect associated with the lack of knowledge and misinformation was the absence of appropriate language to talk about this issue. Very often in the interviews men used incorrect terms, offered only basic explanations, or provided examples when they did not have the language or correct terminology to explain sexual and reproductive health issues. Lack of adequate terminology and health literacy are also hurdles for them when seeking services or understanding information when it is provided to them, and may be exacerbated by the language barriers these men are already facing.

Given that men consistently demonstrated they were misinformed and/or lacked information about family planning, birth control, STIs, and HIV, and that there are many issues associated with language barriers and health literacy levels, all other themes to be discussed in this chapter are in one way or another affected by this issue. For example, knowledge influences men's attitudes and behaviors, their perceived risk, the number of options for protection and birth control, and their capacity to access services. There were, however, a small number of men who seemed to be accurately informed about family planning and sexual health, and yet were engaging in risky behaviors. For this reason, it is important to recognize that information is just part of the equation when discussing risky sexual behaviors and that other factors also play important roles in these men's experiences with sexual and reproductive health.

Multiple and Ambiguous Meanings of Family Planning

Family planning encompasses a set of complex decisions, behaviors, and negotiations for the individuals involved in addition to access to services. In other words, family planning is a process that involves not just individual factors, but also interactions with partners and institutions. The majority of the men in the sample agreed that family planning is important for them; the meanings these men attached to family planning, however, differed between fathers and nonfathers. Furthermore, the meanings men attached to family planning often contradicted the meanings attached to family planning by current health systems and services providers. These contradictions may be rooted in a clash between a system geared toward certain life trajectories that facilitate family planning, and the more chaotic and sometimes unpredictable lives many Mexican

immigrant men experience. In this section, I discuss the key findings associated with the family planning and birth control experiences of Mexican immigrant men. The meaning and symbols men attach to family planning are discussed as well as the risk and protective factors. I also explore the differences between fathers and nonfathers and how ideas about fatherhood influence the meanings and symbols associated with family planning.

Entering family planning services: Too early or too late. During the interviews, men were asked what family planning means to them and how important family planning was for them. Men's reported meanings of, and experiences with, family planning and birth control were diverse and varied from case to case. Men overall, regardless of their fatherhood status, reported that family planning is important to them, but when asked what family planning means to them, differences in levels of knowledge were evident. Certain men were very knowledgeable about family planning and its benefits, whereas others provided misinformation and occasionally attached ambiguous meanings to family planning.

Findings suggest that the concept of family planning was seen from both a conception and a contraception perspective. For some men, however, the concept was unknown, or the meanings attached to it were not necessary related to conception and/or contraception. Nearly half of nonfathers defined family planning from a conception point of view and described family planning services as being too early for them because they were not yet ready to start family. For example, when asked what family planning means, AT04, a nonfather, responded: "Family planning means you, to plan, to have a family

you have to follow some steps to get there," and when asked if family planning was important for him, he added, "Umm yeah. Definitely. It is if I'm ready, ready to make that choice. Yeah."

Another interesting finding was that within nonfathers, single men were more likely to report not knowing what family planning was when asked what family planning meant to them. For example, AT201 explicitly stated, "I don't know," whereas another nonfather reported, "No, I haven't heard anything about family planning." In other occasions, single nonfather's responses were ambiguous. AT007 responded that family planning means "to have a lot of children" whereas other nonfathers attached meanings not related to conception and contraception. For example, AT127 reported that family was about taking your family on vacation.

Not all nonfathers felt that family planning was only for when a couple is ready to have children, and some highlighted the importance of planning births carefully. For example, this nonfather talked about the importance of planning ahead:

> Family planning is about the decision of how big of a family are we wanting to have, why, and for what, and to think of a future. If possible, give them the best. […] I've talked to my wife and we plan to have two, maybe adopt a third […] but before that to be a little stable money wise. [AT006, nonfather]

For this man, his wife seemed to be an important influence on family planning, birth control, and his sexual health overall. He mentioned several times that he carefully makes sexual and reproductive decisions with his wife. Also contributing to his understanding of, and approach to, family planning was the fact that he has some college

education and that he reported his parents frequently talked with him about the importance of family planning. This case, then, serves as a good example of how knowledge interacts with other variables (partner) to protect (in this case) against risk or in other cases to make men more vulnerable to risky behaviors. It also suggests that partners may play an important role in the adequate use of family planning services or at least the use of birth control other than condoms. Unfortunately, the way the questions about family planning were asked (e.g., What does family planning mean to you? or How important was family planning for you?) did not necessarily lead men to expand on the role partners play in how they perceived family planning.

In contrast to men who have not fathered children, the majority of fathers, regardless of their relationship status, reported that family planning is important to them and that family planning is about not having too many children or having only as many children as one's economic situation allows. Interestingly, two fathers in the sample perceived family planning services as too late for them. These fathers talked about family planning services as either unnecessary or too late for them because they already have too many children or because they already have a child. This meaning attached to family planning becomes problematic when the same men who perceived that family planning is too late for them are still engaging in sexual relationships without consistent use of birth control. For example, when asked about family planning, [AT119], who became a father at age 13, has 6 children, has a wife in Mexico, and was having sexual relationships with women in the U.S., said:

> Yes, it is about not having many children. I mean that is that but when one is young, sometimes one doesn't think about that. And one [starts] to think about it when one is already more advanced; when one already is older [Interviewer: After we already have had the children is when we think about it.] Yes, but it's already late.

Other fathers reported that family planning is important to practice after having a first child or when attempting to control how births are spaced out, suggesting that even though some men do not see a need to plan the timing of a first birth, they are concerned with the timing and number of subsequent births. JA222's comments illustrated this view when asked about his experiences with and opinions about family planning:

> Family planning? It is coming to be when one gets married. One has a child and there is a need to plan. To try to give her/him some education; I don't know. To wait some time, some years, during the time the child is growing and wait. To use the pills and all of that so the family don't continue growing and if one gets pregnant, both should be in an agreement. [JA222, father]

This father also implied that family planning is for when people get married or find the right person with whom to have children. One third of the single nonfathers and two single fathers shared this view. This finding suggests that there may be a perception among some men that family planning is relevant only within a marriage or stable relationship, meaning that you have a "family" to plan.

Even though the data were not collected with the intention of exploring the contrast between fathers and nonfathers, findings suggest that once men become fathers,

they develop new meanings and renegotiate old meanings attached to family planning. Partners also played a role in the negotiations of new meanings. Considering that more than half of the fathers in the sample were in stable relationships (married, cohabiting, or engaged), it may be that the type of partnership men have plays an important role in men's ideas about family planning, but to what extent partners play a role in men's meanings of family planning, and whether their influence is more important than fatherhood, cannot be explored with current data. The interview guide did not include questions and probes that would prompt men to reflect on how fatherhood and their sexual partners influence their experiences with family planning (e.g., if and how fatherhood changed their meaning of family planning or what are their partners' ideas about family planning and how do their partners' ideas influence their own ideas).

Family planning as a tool for being a good father. The data also suggested that meanings attached to fatherhood, and the role of fathers overall, also influenced men's ideas about family planning. Often, among both fathers and nonfathers, family planning was seen as a tool that could allow them to strategically allocate their social and economic resources so that their children could have a better life, become educated, and achieve more than they did. A third of nonfathers and almost half of fathers attached meanings to family planning related to being a good father. For nonfathers, it meant planning for the future so they could become good fathers; for fathers, it was viewed as a tool that can enhance their ability to be a good provider, thereby allowing them to be successful fathers. When asked about the importance of family planning, [AT104], a nonfather, explained that he saw it as "the planning of having children when you want,

for the time when you are better prepared for having them" and later added, "I don't want to have a child when I don't think I can be a better father." Responding to the same question, another nonfather also discussed the importance of family planning to be a better father and provider:

> Planning, well, […] I think that if you plan, your, your, your family, how many children you want to have in this way you hope to live better. It's for, for -- If you have a child, what you want sometimes is to provide him what, what you were not able to have. Such as giving him a chance to study, have a career. If you plan your family, how many of them you want to have, I think then you will be able to provide them a better life, everything, better comfort. It's better. [JA217]

A fifth of the fathers reflected on their experiences when asked about the importance of family planning; of those, two fathers reflected on the fact that they did not plan their families, including a father of six whose first child was born when he was 13. When asked about family planning, AT119 reflected on the challenges of having many children and the importance of family planning to provide for and educate children better. "Well, because this way it will be enough -- if one has small family, one manages to give more; ummm the food, education, […] but having many [children] one can't, one can't."

The experiences these fathers have with their children may make them more aware of the benefits of family planning. Interestingly, being aware of the importance of family planning did not necessarily result in the use of family planning services. Although one would expect that both fathers and nonfathers who are aware of the

benefits of family planning would become involved in family planning services, or at least use some type of birth control, this is not always the case, as only three nonfathers and five fathers reported using family planning in the U.S.

For example, AT119, an older father who already had six children and whose wife was back in Mexico, was having sexual contact with a woman in the U.S. and was not using consistent birth control methods other than irregular condom use. In this case, for instance, his role as partner (to the woman in the U.S.) may be more salient than his role as father, resulting in more investment in the current relationship and not considering the consequences of having another child for his children and wife who are in Mexico. Not having his wife and children living with him may mitigate the influence fatherhood and marriage can have on men's sexual risk behaviors and the meanings they attach to family planning.

The issue of multiple and ambiguous meanings of family planning among young Mexican immigrant men is complex. If some nonfathers perceive that family planning services are only for men who are ready to become fathers, this may serve as a reason not to seek family planning services. The same is true for fathers who assume that family planning is too late for them. Perceiving family planning as not relevant to their situation may prevent them from seeking services, putting them at risk for having more children, possibly with multiple partners. These findings indicate that the role of fatherhood in men's lives and the ideas men have about fatherhood can potentially influence their utilization of family planning services even if they are not yet fathers. These findings also suggest that being in a stable relationship may also influence these men's ideas and

attitudes around family planning. The available data, however, did not allow for the disentangling of the specific influence of each social role in these men's ideas.

The Intersection of Masculinities and Birth Control

In many ways birth control is often associated with women, but men also play an important role in its use even though their options are often limited. Ideas about masculinity and gender and how these influence men's experiences with birth control are discussed in this section. The findings presented in this section arose mostly from a set of questions in the interview guide exploring men's attitudes and ideas about birth control, and another set of questions exploring men's birth control use with each reported sexual partner.

Controlling his own fertility. Men in the sample were often disconnected from family planning services, had multiple and ambiguous ideas about family planning, and sometimes believed that services were not appropriate for men at their point in the life course. They also commonly stated, however, that family planning is very important to them and for the well-being of their children. This web of assumptions, information, and misinformation may discourage these men from using family planning services but not necessarily prevent them from engaging in pregnancy prevention.

A majority of men reported they use condoms as their primary birth control method, with about half the men using condoms in addition to other types of birth control. Nonfathers were more likely than fathers to use condoms as birth control with two thirds using condoms as a birth control method, whereas just under half of the fathers did so. Fathers were more likely than nonfathers to use condoms in combination with other types

of birth control. It is not surprising that a majority of men reported their primary form of birth control was condom use when two factors are considered: access and control. Other types of birth control such as birth control pills and IUDs require access to an authorized health care professional and/or family planning clinic, and in many cases, access to health insurance. Furthermore, women are likely to be the recipients of the service, meaning that men may be even less persistent and interested in receiving such services. Here, the other factor, control, enters the equation.

Condoms are the most feasible way for men to control their fertility and this can explain why, across interviews, condoms were more frequently reported as birth control or pregnancy prevention than as protection against sexually transmitted disease. When asked about his experience with birth control, [AT11] expressed his desire for more birth control options for men so that women do not have all the responsibility:

> Well I like it [hormonal birth control] because one doesn't have to use a condom and one doesn't miss any sensation. […] I don't like that all the responsibility is on the woman about taking the pills and sometimes [she] can forget. And sometimes I think that if I were a doctor I would invent pills for men too, but I think that is a little more difficult; it's a different system.

Another man also highlighted that women have access to more birth control methods than men do:

> Birth control, not getting pregnant, is like a protection for you and your partner. Uh, it could be for you or it could be for her, but I am pretty sure that there are more methods for girls than for guys. [AT25]

Even when partners were using birth control methods, some men reported that using a condom provides them with another way of protecting themselves from unintended pregnancies and other men reported using condoms because they sometimes do not trust their sexual partners when they say that they use birth control. [AT104] talked about this issue, "because she still can have babies. I mean, on one hand she protects herself with her pills […] and on the other hand, I protect myself with condoms."

Nonfathers and men in casual or less stable relationships were more likely to use only condoms as a method of birth control, hinting again at the impact of relationships with partners on the type of birth control used. If men believe they do not have a way to control their fertility other than through condom use, and if they perceive that women have more options than they have, then the role partners play in decisions surrounding use of birth control other than condoms is critical. In this case, partnership status seems to be more important for understanding men's experiences with birth control than is fatherhood status.

Although some men reported issues of mistrust of the effectiveness of birth control methods or in their capacity to control their own fertility, the majority of fathers and nonfathers who were married or in more stable relationships had more positive attitudes toward birth control and reported that their partners were using various methods such as birth control pills, Norplant, and IUDs; two fathers reported their partners had had a tubal ligation. Most of the fathers in the sample were using birth control methods other than condoms (e.g., birth control pills and IUDs) but fathers in stable relationships were more likely to report the use of birth control than single fathers. In many of these

cases, partners were the ones who decided to use other birth control methods or were already using birth control when the sexual relationship began.

In addition to the issues of limited control associated with birth control methods other than condoms, a few fathers and nonfathers reported negative attitudes toward birth control and concerns about the side effects of certain types of birth control on their partners. Of those, two men thought women should be the ones who decide about birth control because of the possible effects birth control can have on women's health. When asked about his experience with birth control, one of the participants [JA221, nonfather] stated, "the pills, I did not like the pills because they make my woman vomit and no, no […] and patches [caused her] dizziness." He added that another concern was "if they didn't work" and later stated that women should decide. This concern about the efficacy of birth control methods suggests issues of mistrust toward birth control among this population.

Men in the sample often perceived they lacked birth control options, believed that birth control is something for women, demonstrated mistrust and negative attitudes toward certain birth control methods, and reported that their partners tended to be the ones making decisions about birth control other than condoms. Although findings suggests that men have a number of concerns around birth control, a majority of men in the study, regardless of the type of relationship and fatherhood status, reported that they were engaged in the decision process and that they used some form of birth control.

Vasectomy: What if I meet a prettier woman? One consistent finding across almost all cases was that men did not have positive attitudes toward vasectomies,

regardless of fatherhood status, age, or type of relationship. Men overall reported concerns around the possibility of starting families with new partners even when they already had multiple children. This father noted that he would regret having a vasectomy if he were to fall in love with another woman:

> Well the truth is maybe yes, yes, I would consider it, ha, ha, I have my partner, she can't have babies, but […] if you meet a woman who is prettier and if she talks nice to you, you can fall [in love] again with her and [then] you already made a mistake, ha, ha [AT114].

Other men also reported there are other more "natural" ways of preventing pregnancies, suggesting that there is not a need for this type of procedure. "With a vasectomy, I don't agree, however, I agree with contraceptive. Because this is a natural thing; why then to cut it?, remarked JA201. He later added, "[…] then you might want to start another family, then that's when problems arrive." Another father mentioned the possibility of not being able to have more children if his children were to die as another concern about the consequences of a vasectomy. This finding hints at the importance of the capacity to father a child for these men's identities. The available data suggest that for men, it is the capacity to father a child with a new partner and the fear of being rejected by a potential partner that leads men to have negative attitudes toward vasectomies.

A few men were more open to the idea of a vasectomy; a nonfather, for example, said that having children with another woman would not be a problem because he can adopt. The most dominant theme among men in the sample, however, was that they would not have a vasectomy because they are concerned about not being able to have

children if they have a new partner. Both fathers and nonfathers were often concerned about what others might think about them as a man if they were to find out that they have had a vasectomy. This finding suggests that these men's ideas about vasectomies are rooted in cultural ideas about masculinity and the importance of being able to father a child more than in ideas about family planning such as when to have children and how many children to have.

The Complexities of Sexual Risk-Taking

Men's engagement in sexual risk-taking behaviors involves a combination of knowledge, attitudes, perceived risk, social and cultural norms, skills, and the perception and interactions men have with their sexual partners. Two salient themes throughout the interviews were how men's perceptions of the women they have sex with influence their understanding of sexual risk, and men's perceptions that they are at low risk of sexually transmitted diseases, even when they are engaged in behaviors they themselves recognize as risky. A third theme was the role that cultural values of *personalismo* (cultural ideas where individuals value personal relationships over institutions) play in men's reluctance to get tested for sexually transmitted diseases, and how ideas influenced by *machismo* (beliefs in male dominance as a culturally preferred mode) and *marianismo* (counterpart of machismo, include beliefs that women should live up to the Virgin Mary, being sexually abstinent, pure, and submissive) may relate to some of these perceptions and meanings surrounding sexual risk-taking . The differences between fathers and nonfathers are also discussed in this section.

I feel good and I don't date "those women." Low perceived risk was another

salient theme across interviews. The majority of Mexican immigrant men interviewed in this study, regardless of fatherhood status, perceived they are at minimal or no risk of becoming infected with STIs or HIV or of having an unintended pregnancy. Single men were slightly more concerned about their sexual health with close to half of single men in the sample perceiving themselves at certain risk of or at least concerned about HIV and/or STIs.

Even when men reported what are considered high-risk sexual behaviors, such as having unprotected sex, having sex with multiple partners or sexual workers, frequent alcohol and drug use, and no birth control use, these men perceived themselves at low risk. For example, [AT05], a nonfather in a stable relationship, but who reported having sex with multiple partners in the last three months and who used condoms inconsistently with his partners, does not perceive himself at high risk because he does not show signs of infection and because he is not involved in multiple relationships at present:

> Um, you know I don't know the stats here in […] but there was a point where I was worried when I was having multiple relationships. Usually when I had multiple relationships or a rash on my penis or things like that, it would definitely make me think well, I need to go see the doctor. Um...but actually I have never, never really felt [worry] about it or [thought that] I could be infected or I could get infected. Um, yeah.

Another notable finding is that when men perceived their sexual partners were not like "those women" (referring to sex workers or women who have sex with multiple sexual partners), they also perceived themselves to be at a lower risk. Intimate partners

appear to influence the experiences of both fathers and nonfathers in similar ways, hinting that type of partnership is a more influential factor in men's sexual risk-taking than is fatherhood status.

The participants in the sample had relationships that range from one month to many years in duration, and the types of relationships included married with wives living in Oregon, married with wives living in Mexico, single, and divorced. Men in the sample, including partnered men, also reported having sex with sex workers, one-night stands, casual sex with friends, and sex with multiple partners. This variability in men's type of relationships influenced their behaviors and risk perception in different ways. For example, a fourth of the men in the sample reported they stopped using protection or decreased their condom use with increased familiarity with sexual partners, including sex workers, as reported by one man. Interestingly, fathers seemed to be more likely than nonfathers to report this change. This type of behavior is illustrated in the quote below from a participant who was asked about condom use with his current partner.

> Yes, I tried to look after myself or use protection and she did too. We spoke about using the condom the first two times, but after a week we decided to live together […] and that's why we stopped using the condom. [JA217, nonfather]

When asked why he uses condoms, AT105, a nonfather, reported that when he cheats on his girlfriend he uses condoms, but later he reported not using condoms with his partner, illustrating that men behave differently based on the type of relationship. He also hinted the importance of pregnancy prevention varies depending on the partner he is with.

> Yes umm because I don't want to get infected and also to prevent pregnancy with [a woman] you don't want to have a baby with. […] [I] use them when, when I cheat on my girlfriend, or if I would be with someone else that is not my partner. [AT105, nonfather]

A fifth of the fathers (mostly cohabiting and married) and a third of nonfathers (mostly single) reported they do not have sex with "those women" implying they believe their sexual partners would not engage in sexual behaviors that would put them at risk. After being asked about how to keep from getting infected with STIs, AT109 responded:

> Well um, I can keep from [not getting infected] by not being with women, right, unknown woman from the street, or like other women that I may not know well, sometimes one doesn't know […] if they have also had relations with someone else and they can get the disease from someone else.

Men may assume, based on these ideas, and especially when they perceive themselves as in a stable or committed relationship, their partner is not one of "those women" and their risk of getting infected with HIV and/or STIs is low. This view may also explain why men use condoms with certain partners and not with others as well as the decreased use of condoms given more familiarity with sexual partners. The decrease in condom use may also increase their risk for unintended pregnancies. If men are decreasing condom use with familiarity and commitment to sexual partners but do not feel committed enough to start conversations about family planning and methods of birth control other than condoms (as findings about family planning previously discussed

suggest), then the transition period between casual dating to a more formal or committed relationship may be a particularly risky time for unintended pregnancies.

A few men, however, were concerned about their partners' sexual risk behaviors even if they were in a stable relationship. One participant, who reported being in a monogamous relationship and that he and his partner were tested together, talked about some concerns that his partner may engage in sexual relationships with others and how he can also put his partner at risk if he engages in risky behavior:

> I try to not get involved with women that I don't know and get a disease, and by getting a disease I can transmit it to my partner right, or also I have precautions also that she can also go out somewhere else and get diseases and transmit it to me and that is not good. [AT114, father]

Although this man reported having a low level of education and no formal sexual education, he seems to have adequate information about sexual health risks and about how to protect himself. His partner, as he reported, is college educated and U.S. born. It is possible that, as other findings suggest, partners are very important for men's sexual health, and when partners have accurate information, men, even from disadvantaged situations, benefit. This example also illustrates the broken web of knowledge: In his case, although he has less than a high school education and he did not receive formal education, his partner can be a protective factor.

Fatherhood as a protective factor. Although partners tended to be a more influential factor for men's sexual risky behaviors than was fatherhood, for a few men, their status as fathers was a protective factor. This influence occurred when fathers

believed in the importance of protecting themselves and avoiding risk behavior for the well-being of their family, including their partners and children. For example, three fathers in committed relationships mentioned that getting infected with HIV or STIs would put their partners at risk or would cause psychological stress to their families and highlighted the importance of using protection. When asked how worried he was about getting an STD, a father with a wife and child in Mexico responded:

> More than anything because I have a child. I mean, if I had sex with a woman without protection and I got infected with AIDS and without knowing about it I came to my wife there in Mexico and I had sex with her and I infected her, then that would be very ugly.

Another man [JA222, father] also commented, "We should respect the family that we left back there. Because one doesn't know if you can get an infection or something, no! or a disease, no!

For two fathers in the sample, fatherhood became a protective factor when men were exposed to health services after their partners get pregnant. AT125 reported getting tested for HIV and STIs after his partner got pregnant and was surprised to find out he had an STI. He not only was tested but also received treatment and now understands and is concerned with how his sexual health may impact the health of his children: "if you get infected while your partner is pregnant, there is a risk that the baby [could get infected too]."

Clear ideas about not being ready to become a father may also serve as protective factors for some men. Findings indicate that nonfathers who clearly stated not wanting to

have children at the time of the interview or who did not want to have children with the current partner were likely to report condom use always or most of the time. JA204, a nonfather, when asked who made the decision of using a condom responded, "Well, the decision, I made it because right now I am not prepared." JA220, a nonfather, when asked about condom use with his girlfriend, reported that he always used condoms after an experience with unprotected sex led to the use of the morning after pill, also known as Plan B, as a birth control method. "I told her, I don't want to have a child. I don't want to now because I feel I can't have a child yet, and it is better that we take care of ourselves." By using condoms consistently, even if their intention is primarily pregnancy prevention, these men are also protecting themselves from HIV and STIs.

Fear of what others will think: *Personalismo* and *Respeto*. Cultural factors that played an important role in men's sexual risk-taking, regardless of their fatherhood status and type of relationship, were *personalismo* and *respeto* (deferential behavior based on age, sex, social position, economic status, and authority)**.** A fourth of all fathers and a fifth of nonfathers reported fear of and/or embarrassment from getting tested for sexually transmitted diseases, which may be associated with *personalismo.* These cultural ideas may lead men to experience ambivalence when in need of services because a "good person" would not need to get tested for HIV or other STIs and this testing can affect how others perceive them and their relationships. Health care professionals are not necessarily seen as members of a health institution but as individuals who may judge them and potentially affect their reputation in the community and the *respeto* they have from the community. One nonfather, AT104, talked about this issue and linked it to a

lack of knowledge. When asked what would make it easier for him to get tested for STI he answered,

> Probably, having more knowledge about this. Perhaps if I were taught when I was younger that nothing will happen [there is nothing wrong with going to get tested]. That it is ok to go for a test. Or having general tests done on me more often would make it easier."

When asked about language issues and access to translation services, one man reported that the problem with interpreters is that many people are involved when seeking services and this can be embarrassing:

> Sometimes it is a problem because sometimes one has a problem […] or wants to talk, but they get embarrassed to tell the translator because he's going to tell the doctor. And how embarrassing. What will he say? […] He is going to say that I am very nasty […] and what are they going to think? I think that is maybe the case. The embarrassment that he [the translator] is going to hear. And what concern is my body to him? [AT116]

If men come from small communities back in Mexico or are living in small rural communities in the U.S., they may perceive that everyone in town knows who they are and what is going on in their life, intensifying their ambivalence about testing. Even though confidentiality in health treatment is required by law, and health care providers must assure clients of confidentiality, men who require interpreters and bilingual/bicultural professionals may feel uneasy about someone other than the "doctor" having information about their sexual health.

In rural communities in Oregon, this problem may be even greater because of a scarcity of bilingual health professionals and the likelihood that they may know these men from other contexts in their communities. Normalizing the testing and making it part of a routine exam may help these men to feel more comfortable with testing and not to feel there is something "wrong" with them, possibly eliminating some of the embarrassment men reported as a barrier to being tested.

Another area where *personalismo* and *respeto* might be playing a role is in the tensions between stigma of and concern over being infected with HIV and the expectations that cultural ideas impose regarding hypersexuality and fathering children. Much of the inconsistent use of condoms and birth control and disconnections between knowledge and risk behaviors may be related to men trying to fit the *macho* model while also maintaining *respeto* in their community and within personal relationships. Men might have the information to protect their sexual and reproductive health but the prescribed models available to them do not necessarily line up with the meanings and symbols tied to a *macho* image.

As this section illustrates, sexual risk-taking among the men in this study is complex and goes beyond men's lack of knowledge and information. Sexual risk-taking for these men involves the interaction of complex sexual relationships, the old and new cultural rules that govern these relationships, men's perceived risk from their behaviors, and cultural ideas about the importance of what others think. It also involves perceptions of their roles as fathers and the importance of taking care of themselves as ways to protect partners and children. These multiple factors are woven together to create patterns

in men's risk behaviors. These behaviors, however, do not occur in a vacuum; they are also influenced by contextual factors. These factors are discussed in more detail in the next section.

Contextual Influences: The Other Web

The social inequalities (e.g., lower educational attainment, immigration, and documentation issues) and cultural differences (e.g., language barriers, family values, gender norms) faced by Mexican immigrant men influenced their experiences with family planning and sexual risk behaviors. One particularly salient theme discussed earlier was how the lack of education and knowledge negatively impacts men's experiences with family planning and sexual risk-taking. Across interviews, the lack of language to discuss sexual and reproductive health and the misinformation about these topics brings attention to limited access to effective sex education as a major structural barrier for these men. But this situation may be related more to the impact of low levels of educational attainment on men's lives and not just the lack of sexual education.

Many of these men had very low levels of education; slightly more than a fourth of the sample reported levels of education of eighth grade or less, and these patterns were similar for both fathers and nonfathers. It is not surprising, then, that many of these men reported no formal sex education. As mentioned in the discussion about *webs of knowledge*, however, lack of adequate information was not the only factor influencing participants' experiences with family planning, as some men with some level of sex education, and even men in the sample who have postsecondary education or who have been in the military, still engaged in risky behaviors.

The language barriers faced by these men exacerbate the problems that lack of knowledge or misinformation can cause. Some common themes among men were language barriers to accessing services and information, the limited number of Latino professionals, and/or issues with interpreters (e.g., limited availability). In reference to this issue, AT116, a father, said:

> They could have Latino people there that, I mean, someone who can explain you well about the birth control methods and all of that. Because one speaks English with difficulties and they put you with someone who only speaks English and he speaks to you very fast and you don't [understand] anything about what he said.

Cultural norms around sexuality may play another important role, including ideas about *machismo*, *marianismo,* and *personalismo*. More than half of the men in the sample reported negative attitudes toward *machismo* and indicated that *machismo* should not be taught to children. Men's negative attitudes toward *machismo* and/or more egalitarian ideas toward women may be a product of acculturation processes. A few men in the sample made distinctions about gender norms in Mexico and gender norms in the U.S., for the most part perceiving the U.S. as a more liberal culture in terms of gender norms, opportunities for women and sexuality. It seems that the immigration process exposes men to new ideas about gender and even though they may have internalized their culture's perspective on gender, they are also acquiring new views on gender and sexuality while negotiating new meanings in their new contexts (the host country). Referring to *machismo*, AT114, a father, reported, "because of [our] roots almost [all] Latinos think the same, but [during] the time that I have been in the United States, I have

changed the way of thinking."

This process of acculturation may also explain why some men showed inconsistencies between their ideas and behaviors. For example, the majority of men reported that family planning is important for them. When asked if they were engaged in family planning or using birth control, however, more than half of the men in the sample said no. Because of the recency of their immigration, it may be that many of these men are becoming aware of new cultural norms, but they may or may not have not adopted them or begun to question cultural norms from their country of origin. AT112 (nonfather), for example, when asked why men do not use family planning services, responded, "I feel it is because of information. And I feel that it is part of one's culture because in Mexico, nothing is planned." In his case, he recognized that there are different cultural norms in the U.S. around the use of family planning services, but that many Mexican immigrant men may be guided more by the cultural norms from their country of origin.

Multiple barriers to accessing services. Although Mexican immigrant men reported barriers that limit their access to services, none of these were surprises given the social disadvantages the men in the sample faced. Although only a few men mentioned it, documentation issues were reported as a barrier for some men, as was clearly stated by this father when asked what prevents men from seeking services:

> Social [social security card], social. They are always scared because they don't have medical; they don't have a social. Or scared to get deported because of some [paper] work. They see paperwork; you know, like fuck! […] That's what they are scared of, getting deported or caught. [AT111, father]

Others mentioned cost as a barrier and the availability of low cost or no cost services as the solution for everyone to get tested.

> […] Probably have the whole thing cheaper. I mean if it was free it would've been better because I will be like […] Can I get tested? I can now know and that is probably a kicker to help get a lot of people tested if it is free. [AT105, nonfather]

Others tied the lack of knowledge of services to lack of information distributed to or available in the community. In this sense, it seems that sexual health service providers' current efforts to reach out to these men are inadequate. A majority of men reported not knowing where to access services. Even when men reported having received services, for example at Planned Parenthood, some responded later in the interview that they did not know where to get family planning services.

A few men who knew where to get services and were able to identify specific places such as Planned Parenthood and other community clinics, tended to have been in the United States for longer periods of time and to have better English skills. The men who seemed most knowledgeable of services were fathers with children living with them, or men in longer and more stable relationships. Of the eight men who reported using family planning services, five were fathers and three were nonfathers, and all of them were in stable relationships (married or cohabiting). It may be that partners of men in more stable relationships are connecting them to services more often; however the data do not provide enough information to draw firm conclusions.

When men were asked what service providers could do to help them use services, many recommended to give out more information to the community. AT125 (father)

commented in this regard:

> […] just hand out flyers. You know just go around the community and be like, look we [have] this program; we'd really appreciate it if you guys show up. Because it doesn't hurt [anybody] to find out about something [referring to services].

Another man connected the lack of information and education in the community with the need to market services in places where members of the Latino community frequently visit or gather.

> The majority of Latino men, we are ignorant or uneducated and it is not about how aggressive we are, but it is that we never received the education of knowing that we have options on how not to get a woman pregnant, our partner. And the way I feel is the best on how to reduce this percentage is through – in places frequented by Latinos, they should place pamphlets or brochures and all of that. Not only in clinics, but also in Laundromats, in Latino stores, and all that.

The combination of lack of knowledge about services, language barriers, cultural norms (old and emergent ones), documentation issues, economic disadvantages, and isolation from services creates a web of circumstances that increases sexual risk behaviors and reduces their chances to protect themselves and their families. Health systems in the U.S. address some of these issues, sometimes more effectively than others. Current federal regulations restrict family planning services funded with federal dollars to U.S. citizens only, leaving states and communities with the burden of servicing this population with limited resources. Based on the lack of knowledge about services, it

appears organizations in Oregon have mixed results in reaching this population, although those who did utilize such services tended to be satisfied with them. Unfortunately, it seems many of the men in the sample were left behind while their sexual risky behaviors continued.

Summary

This study's main goal was to explore how social roles, social relationships, and health systems influence the family planning and sexual risk-taking experiences of young Mexican immigrant men, paying special attention to similarities and differences between fathers and nonfathers. Key findings suggest that both fatherhood status and partners play an important role in men's experience with sexual and reproductive health with partners playing a more influential role. The role that partners and fatherhood status played on men's experiences was simultaneously shaped by broken webs of knowledge created through an intertwining of accurate information, different levels of knowledge and misinformation, and lack of adequate terminology about sexual and reproductive health. These broken webs of knowledge influenced Mexican immigrant men's experiences with family planning and sexual risk behaviors as well as their access to services. Access to services, however, was also shaped by health systems that prevented men from seeking services due to documentation issues and economic barriers that prevent men from accessing services when they lack health insurance. Cultural factors such as *machismo*, *marianismo,* and *personalismo* also played a role in men's experience influencing some of their attitudes and behaviors related to birth control use, risk-taking and services utilization. Findings also suggest that through the immigration process men negotiated

new meanings and questioned old meanings attached to ideas about gender and masculinity.

Men's ideas about fatherhood as well as their status as fathers seem to influence men's experiences. Because the data were not collected with the intention of understanding the role that fatherhood plays in men's experiences, however, the impact of fatherhood was not always clear or salient in the results. Similarly, the role of partners, and the interaction between partners and fatherhood was not fully clear. Despite these limitations, findings suggest that partners play a more influential role in men's experiences with family planning and sexual risky behaviors.

In terms of family planning, findings revealed that fatherhood plays a more active role in men's ideas about family planning while partners seem to play a more important role on men's actual behaviors such as engaging in family planning services and using birth control other than condoms. Men attached multiple and ambiguous meanings to family planning and birth control that often discouraged them from accessing services and using birth control, thereby increasing their risk of experiencing unintended pregnancy. Fatherhood seems to play a role in men's ideas about family planning in that a few fathers perceived it was too late for them to enter family planning services and a few nonfathers perceived the opposite: that it was too early for them to engage in services. These findings suggest that the experience of fathering a child changes men's ideas and perceptions about family planning but not necessary their behaviors.

Findings also indicate that men's perceptions of their role as fathers or of their future role as fathers had an impact on men's ideas and perception of family planning.

Many participants perceived family planning as a tool to be good fathers in the future or to be better fathers and providers for their children, hinting that men's ideas about fatherhood may influence their views of family planning well before they become fathers. Even though fatherhood influenced their views of family planning, their actual behaviors did not necessary reflect these positive views about family planning unless they were in a committed relationship. Being in a committed relationship seems to lead men to perceive that they have a "family" to plan. Some men, however, reported that it is after having the first child that family planning becomes more important, suggesting that being a father in a committed relationship is what makes men more invested in family planning and birth control.

Findings also revealed that men's attitudes and behaviors about birth control were often influenced by type of relationship, their perceptions of control over their fertility, and cultural ideas about masculinity. Partners seem to have a more influential role in men's use of birth control other than condoms. When men reported the use of birth control other than condoms, their partners tended to be the ones making decisions, although men reported being engaged in the decision process. Men, however, reported the use of condoms as the primary method of birth control. This method was preferred in part because of its accessibility and the degree of control it offered men over their fertility. Participants also perceived that they lack birth control options, believed that birth control is something for women, and demonstrated mistrust and negative attitudes toward certain birth control methods. Men's roles as fathers, by contrast, were not as salient of an influence on attitudes and behaviors related to birth control as they were for men's ideas

about family planning. Vasectomies are not an option for these men, regardless of their fatherhood status and the type of partnership. Cultural ideas about masculinity and the importance of men's capacity to procreate seemed to prevent men from considering vasectomies as a viable form of birth control, even when many reported they lacked birth control options.

Men's experiences with sexual risk were influenced by their perception of their sexual partners, the type of relationship they have, and cultural factors such as *machismo* and *marianismo*. Men in the sample often perceived they were at low or no risk of getting infected with HIV or STIs because they do not date "those women," referring to women who have sex with multiple partners or sex workers. These perceptions may result in a decrease in frequency of condom use with increased familiarity with the sexual partners, including sex workers. On the one hand, men had positive or at least neutral attitudes toward men who have sex with multiple partners and sexual workers. On the other hand, they expected that women, especially those they date, would not engage in these types of sexual risk behaviors. This dual set of expectations may be rooted in ideas about *machismo* and *marianismo*. Other cultural factor influencing men's risk behaviors were *personalismo* and feelings of embarrassment, which discouraged men from accessing services and getting tested for STIs and HIV.

Fatherhood was sometimes a protective factor in that fathers were concerned about the impact their sexual health and the stigmas associated with HIV and STIs may have on their children's health and well-being. Here is another area where the available data did not allow further analysis about the role fatherhood plays in men's risky

behavior but findings suggest that men may be changing risk behaviors or at least thinking about changing behaviors as a result of their role as fathers.

These men's experiences with family planning and sexual risk behaviors were also shaped by contextual and systemic barriers that may lead men to engage in risk behavior and/or limit their access to services. The combination of broken webs of knowledge, language barriers, cultural norms (old and emergent ones), documentation issues, economic disadvantages, and isolation from services increased sexual risk behaviors and reduced men's chances of protecting themselves and their families. The combination of being in a stable relationship and being a father seemed to link men with services more frequently. Men who were fathers and in stable relationships (cohabiting, married) were more likely to be connected to services, hinting that service providers are reaching single men and nonfathers less often and that it is through partners that men get connected to services.

Fatherhood status and type of relationship influenced several aspects of men's experiences with family planning and sexual risk behavior, such as the meanings men attached to family planning and birth control, birth control use, the ways in which men access or are linked to services, and their motivations for avoiding sexual risk behaviors. Partners though, seemed to have a more salient role in these men's experience than did fatherhood, but the available data did not always provide sufficient information to disentangle how fatherhood and partners might influence these men's experiences with family planning and sexual risk behavior separately and in combination. The implications of these findings are discussed in more detail in the next chapter.

Discussion

Symbolic interactionism as well as *life course theory* served as theoretical frameworks to understand Mexican immigrant men's experiences with family planning and sexual risk behaviors. The application of these theoretical perspectives allowed us to understand how social roles (e.g., partner and father role), shared experiences with significant others (*linked lives*), and ongoing negotiation of meanings with self and others influenced these experiences. These two theoretical perspectives also allowed us to explore how individual factors such as education levels, culture, and the timing of events in men's lives, are embedded within current U.S. health systems and how the interaction of these factors influenced men's experiences with family planning and sexual risk-taking. These experiences, as the findings have shown, are complex and multifaceted. In this chapter, I address the study's original assumptions, interpret and analyze the study's findings using *symbolic interactionism* and *life course theory*, link the findings to the relevant literature, and discuss implications for policy, research, and practice. The chapter is divided into five main sections that address (a) the influence of fatherhood status and partners on family planning and sexual risk-taking and the importance of role clarity and salience, negotiation of meanings, and the concept of *linked lives* to understand this influence; (b) the interplay of individual factors and contextual influences and the *dynamic reciprocity* between human agency and social structures; (c) limitations and strengths; (d) research implications; and (e) conclusions.

Enacting Roles: Being Fathers and Partners

According to symbolic interactionism, roles are systems of meaning that allow

individuals to organize social norms that serve as a frame of reference for specific situations (LaRossa & Reitzes, 1993; Smith, Hamon, Ongoldsby, & Miller, 2009; Stryker, 1980; White & Klein, 2002). When roles are too demanding, contradictory, and/or unclear, individuals may feel ambivalent or may have difficulties enacting them. For the men in this study, expectations about their role in family planning and sexual risk-taking were not always clear, leading to a frequent disconnection between men's perception, ideas, and attitudes about family planning and sexual risk-taking and their reported behaviors. This disconnection between men's ideas and behaviors suggests that men in the sample may feel ambivalent or contradictory about enacting their role as partner and/or father and about the expectations regarding family planning and sexual risk-taking behaviors. In the next sections, I explain how fatherhood influences family planning and sexual risk-taking experiences for these men, as well as the importance of partners in men's experiences with family planning and sexual risk-taking.

Does fatherhood status matter for family planning and sexual risk-taking? It was expected men would develop new meanings of family planning through shared experiences with their children and these new meanings would shape the behaviors of fathers and nonfathers differently. This expectation was based on *symbolic interactionism*'s conceptualization of how individuals develop and negotiate meanings through shared experiences and our interpretations of those experiences (LaRossa & Reitzes, 1993; Smith, Hamon, Ingoldsby, & Miller, 2009; Stryker, 1980; White & Klein, 2002). Consistent with the literature (Nelson, 2004; Palkovitz, 2002), and in line with *symbolic interactionism,* the study findings showed that for some men, fatherhood

positively influence attitudes around sexual risk-taking by motivating men to protect themselves and use birth control, suggesting that after men become fathers they may negotiate new meanings of family planning and sexual risk behaviors through their experiences with their children. These new meanings may lead men to plan subsequent children more carefully, as some studies suggest (Maternowska, Estrada, Campero, Herrera, Brindis, & Votrejs, 2010), or to reduce sexual risk-taking to protect their families from possible negative consequences of their sexual behaviors. These new meanings and attitudes, however, were not always reflected in men's behaviors as both fathers and nonfathers engaged in sexual risk-taking behaviors such as having unprotected sex, having multiple sex partners, and inconsistent or no use of birth control.

Fatherhood status's influence on men's experience was not always as salient as expected. An explanation for why fatherhood did not seem as influential on these men's experience with family planning and sexual risk-taking may lie in the fact that a large number of fathers in the sample (67%) were not living with their children. From a *life course* perspective, the concept of *linked lives* (Giele & Elder, 1998) is important to understand the influence of those who are close to us on our own development, and why fatherhood status was not as influential as originally expected. When men are not living with and/or engaging with their children regularly, they are not routinely sharing life experiences and may not experience the challenges and rewards children may pose to fathers. It is through enacting their roles as fathers that men will engage with institutions and in social relationships expected of fathers (Eggebeen, 2002; Eggebeen & Knoester, 2010). Routine involvement with children, then, may contribute to *role clarity,* making

men more aware of the social expectations of fathers, including the reduction of risk behaviors that may endanger their children and family. These fathering processes may serve as a "jolt," a term used by Palkovitz (2002) to describe the process that leads men to reevaluate their priorities, to mature, and, for some, to engage in less risky behaviors. If men are not experiencing fathering on a regular basis, they may not completely benefit from the protective effect (decreasing risk behaviors after fatherhood) that fatherhood may provide, as has been previously found in other groups of men (Nelson, 2004; Palkovitz, 2002).

Symbolic interactionism emphasizes that individual identities are shaped by the salience of certain roles (Stryker, 1980). This may also explain why fatherhood was not as salient as expected given the low number of fathers living with their children in the sample. If men are not actively engaged with their children, their fatherhood role may not be as salient, therefore not as influential in their behaviors. When a man's role as a father becomes his main or most salient role, defining his identity, then men's behaviors will be more in line with the social norms and expectations attached to this role. This identification with the fatherhood role may result in men taking more protective measures and changing risky behaviors that can have a direct impact on the well-being of their children and family. For some fathers, if their main role is to provide for their children financially, as may be the case for men whose children are in Mexico or when engagement with children is limited, the fatherhood role is more about providing and not necessarily about parenting and being a caregiver. As a consequence, fatherhood would

not have the same protective effect as if fathers are living with their children or actively engaging with them.

I argued in Chapter 2 that men's ideas about fatherhood would influence men's family planning behaviors before becoming fathers, expecting that the meanings nonfathers may attach to fatherhood, such as what it takes to be a good father, can influence their use of family planning services and birth control. According to *symbolic interactionism*, meanings are negotiated through previous experiences and through interactions with others. Although some men in the sample were not yet fathers, socially, they have negotiated a meaning of fatherhood through experiences with their own fathers, other family members, and peers. Men in the sample, including both fathers and nonfathers, reported that family planning was important to them. They perceived family planning as a tool to be a good father and to provide for their children adequately. This meaning attached to fatherhood may guide and clarify their role in family planning and sexual risk-taking, motivating men to utilize family planning services and birth control more often than men who do not see family planning in this way. Men who think about family planning as a tool to be a good father may be more invested in their future or current role as a father and not just in fathering a child as an important component of their male identity, as previous findings about birth control have shown (Gunman, 2007; Sable, Campbell, Schwarz, Brandt, & Dannabeck, 2006).

Although fatherhood status was not the most influential factor in men's family planning and sexual risk-taking experiences, findings suggest that to understand men's ideas about family planning and their fertility behaviors, researchers need to integrate

fatherhood as an important variable for two main reasons. First, fatherhood can be a protective factor for fathers for whom the fatherhood role is more salient. Alternatively, fathers who experience fatherhood as a "personal jolt" may mature and reduce risk behaviors. Second, findings suggest that men's ideas about fatherhood may influence their family planning and sexual behaviors before conceiving a child by influencing the timing of the conception of the first child and the spacing between their subsequent children. These ideas about fatherhood and the perception of family planning as an important tool to be a good father can protect men from unintended pregnancies and may lead men to plan their families more carefully.

Role clarity through partners. One assumption of *symbolic interactionism* is that meanings evolve from social interactions, experiences, and the interpretations of these interactions and experiences (LaRossa & Reitzes, 1993; Smith, Hamon, Ongoldsby, & Miller, 2009; White & Klein, 2002). Based on this assumption, it was expected that men's interactions with their partners, and their interpretation of those interactions would influence their experiences with sexual behaviors and family planning due to the shared nature of these experiences. Study findings suggest that men in more stable relationships (cohabiting or married) were more likely than other men to be engaged in family planning services and/or to use birth control methods other than condoms. Based on *symbolic interactionism,* it can be argued that once men are involve in a stable relationship they share more experiences with their partners, integrate their partner's expectations, and from these interactions they negotiate new meanings of their fertility and sexuality.

Men's perceptions of their partner's expectations and ideas about family planning and sexual risk behaviors may become particularly important for them considering that men in the sample often perceived birth control as mostly a woman's issue. This perception of birth control as a woman's issue may lead men to seek role clarification from their partners or to try to meet their partner's expectations around birth control and family planning. Study findings were in line with expectations based on *symbolic interactionism's* ideas and the importance of role clarity to enact different roles, in this case, the role as a partner for men. In other words, partners may be the source of role clarification for men. This is consistent with the *looking-glass* self-concept and the assumption that individuals actively select others to validate and affirm meanings to their actions (Cooley 1902/1956). In this case, men are selecting their partners to validate and affirm their role in birth control and family planning. Study findings are also consistent with previous research that found sexual partners play an important role in men's birth control use and family planning overall (Harvey et al., 2004; Harvey, Bird, Galovotti, Duncan, & Greenberg, 2002; Harvey & Henderson; 2006).

The concept of *linked lives* also sheds some light on why partners are so influential in men's experiences with sexual risk-taking and family planning. According to *life course theory* and the concept of *linked lives*, significant others mutually influence an individual's life trajectories through shared experiences. Given the mutually influential relationship between men and their partners, and the potential consequences that their sexuality may have on their life trajectories, partners may become more

invested in facilitating the process of family planning for men and men may be more invested in meeting the social norms and expectations of their role as partners.

Another important finding was that men in the sample did not just develop new meanings of family planning and sexuality through interactions with their partners, but they also developed new meanings for the type of relationship they had. These new meanings attached to the type of relationship also impacted their behaviors. When men became more familiar with their partner through increased interactions and shared experiences, they tended to perceive their partner as not being one of "those women" (referring to women with multiple partners or sex workers) and therefore assumed their risk of getting infected with HIV and/or STIs was low. This variation in the perception that men have of the women they are dating (not "those women") and the meanings attached to the type of relationship may also explain why men used condoms with certain partners and not with others, as well as the decreased use of condoms as familiarity with sexual partners increased.

From a *symbolic interaction* perspective, it can be argued that during more transitional stages where familiarity has increased but the level of commitment has not necessary increased; men are not clear or may have conflictive expectation of their roles as partner. Men as well as partners may be in the process of creating or reshaping new roles and this lack of role clarity may result in *role strain*. For example, men and partners may think they are not at a level where it is expected to engage in family planning that often, because family planning was seen as something that you do when you are ready to have a family. At the same time, if men attached meanings to condoms related to trust,

then they may stop using condoms as an expected behavior when interactions with the same partner increases, while still defining and reshaping their roles as partners with increasing familiarity. This decrease in condom use with increased familiarity has been found in immigrant men whose partners are sex workers (Parrado et al., 2004), and with minority and nonminority heterosexual adolescents and adults, gay men, intravenous drug users, and commercial sex workers (Misovich, Fisher, & Fisher, 1997).

The findings discussed above suggest there might be a time window where men are at higher risk for unintended pregnancies and sexually transmitted infections. Once men start spending more time with a sexual partner, they may be engaging in what is considered *role making* (developing or reshaping role's expectation) from a *symbolic interactionism* perspective. Although men develop or reshape the meaning attached to a sexual relationship when becoming more intimate and familiar, they may feel ambivalent about the specific role they will play as sexual partners in family planning and birth control. This transition period characterized by a lack of role clarity becomes important to understand considering many of these men may be becoming fathers and starting new families during this period. This time window also has serious implications for the prevention of HIV and STIs. Unfortunately, there are not studies to my knowledge that seek to understand this particular time period hinting at the need to explore this phenomenon further.

A "family" to plan: The interaction of fatherhood status and partners. Findings suggest that the concept of family planning was seen from both a conception and a contraception point of view and fatherhood status and the type of partnerships men

had seemed to influence the meaning they attached to family planning. For some men, family planning was seen as something that men do when the right conditions allow them to plan a family or to have a family. These conditions usually consisted of being married or finding the woman with whom they wanted to have children. Some nonfathers perceive being in a stable relationship as a marker of the need to engage in family planning. This perception may explain why single nonfathers who saw family planning as an important tool to be, or to become, a good father did not engage in services and/or were not using birth control methods on a consistent basis. It may be then that the meaning men attached to family emerged from the meanings they attached to their roles as fathers and as committed partners. Through the shared experiences, or *linked lives,* with their partners and children, men develop an identity around their role as fathers and as long-term partners, and get a sense of having a "family" to plan and care for. When men are not enacting one of these two roles, they may not feel they have a "family" to plan and may be less likely to engage in services. This pattern may explain why some fathers thought family planning was about planning for children after having had their first child. This study is not the only one to find this view; other studies suggest the first child among Mexican immigrant couples tends to be unplanned, but after the first child is born, conversations about family planning begin (Maternowska et al., 2010). Another plausible explanation for these findings may come from *life course theory* and its emphasis on the importance of institutions in our lives. When men become fathers, they may become linked to institutions they otherwise would not. This connection may also occur for their partners. In summary, getting involved in a committed relationship and

then the life transition of becoming a father will give men a sense they have a "family" to plan or will link these men to services.

This study contributes to a limited but growing body of literature that suggests fatherhood status is an important variable to consider when studying men's development (Nelson, 2004; Palkovitz, 2002, Settersten, & Cancel-Tirado, 2010). Other studies, examining nonsexual risk-taking behaviors among Black and White non-Hispanic men, have also found that fatherhood can be a buffer for risk-taking behaviors (Kerr, Capaldi, Owen, Wiesner, & Pears, 2011; Nelson, 2004; Palkovitz, 2002). The current study also confirms previous findings that partners play an important role in men's experiences with family planning and sexual risk-taking behaviors (Harvey, Bird, Galavotti, Duncan, & Greenberg, 2002; Harvey et al., 2004). Although study findings suggest that partners may have a more active influence than fatherhood status on men's birth control use and sexual risk-taking, more studies are needed to disentangle the influence of fatherhood and partners on men's family planning and sexual risk-taking experiences.

Even though partners seem to have a stronger influence on men's experiences with family planning and sexual risk-taking, fatherhood may play a protective role by motivating men to reduce risk behaviors; the interaction of the fatherhood role and type of relationship is what may lead men to perceive they have a family to plan for as the study finding suggest. Fatherhood and partner status, however, were not the only influence on men's experiences with family planning and sexual risk-taking. Because both family planning and sexual risk-taking require the complex interaction of multiple influences, other elements such as knowledge, culture, and health systems also play a role.

The next section discusses how knowledge, culture, and health systems also interact to influence men's experiences and, when appropriate, addresses how they interact with fatherhood and partnership status.

The Interplay of Individual and Contextual Influences

Symbolic interactionism theorist Sheldon Stryker (1980) emphasized the influence of social structures have on our interactions and on the meanings we attach to symbols and role identities. In his interpretation of *symbolic interactionism,* he captured the mutually influential relationship between an individual's capacity to develop new meanings, behave in certain ways, and enact certain roles and the social conditions that surround the individual (e.g., education level and income). Stryker's ideas, in conjunction with the idea of *dynamic reciprocity* (Hitlin & Elder, 2007), which refers to the mutually influential relationship between human agency (one's capacity to decide, plan, or control one's life trajectory) and institutions, guided some of the assumptions of the study. It was expected that the interaction between *human agency,* the institutions involved in these men's lives (educational systems in the U.S. and Mexico, U.S. health system, immigration policies), along with the ongoing negotiation of meanings between two cultures experienced by these men would influence their experiences with family planning and sexual risk-taking. I discuss in the next sections how these men's capacity to decide and plan about their sexual risk-taking and fertility, was often influenced by constraints posed by social institutions and structures. I also discuss the role of cultural values and circumstances associated with immigration in these men' experiences.

The role of immigration and the sociohistorical context. The current sociohistorical context that surrounds the men in the study is characterized by anti-immigrant discourses and policies along with ongoing efforts to block or limit the services available for this population. Their immigration status can limit their eligibility for family planning services subsidized by federal dollars and/or their access to health insurance. For these men, the process of immigration does not just affect their access to services, but can potentially influence their access to education as well. The timing of immigration, particularly for those who migrated as teenagers, has the potential to disrupt these men's educational trajectories even if they continue their education in the U.S. (Blaum & Flores, 2011). Furthermore, the timing of immigration can also sever men's ties to their communities, families, and support systems. Once in their host countries, men will need to develop new ties and be linked to new institutions. If the immigration process alters men's access to education and weakens or eliminates their community ties, it can also negatively impact their access to trustable sources of health information and services, therefore limiting their capacity to make sound decisions about their health. This disruption of the educational process and the weakening of men's community ties is a good example of how the timing of the immigration process can affect these men's experiences with family planning and sexual risk-taking. Unfortunately, the data do not provide information other than how long these men have been in the United States; thus further conclusions about the timing of the immigration process cannot be drawn.

One of the most salient findings throughout the interviews was that men's understanding of sexual and reproductive health consisted of a combination of accurate

knowledge, misinformation, and lack of knowledge, creating a broken web of knowledge that influenced their attitudes, perceptions, and behaviors overall. These broken webs of knowledge were influenced by the social structures surrounding these men, directly impacting their capacity to make informed decisions about their sexual and reproductive health. The low levels of educational attainment, sometimes as low as third grade, and limited sources of information and services, often constrained their capacity to seek, obtain, and understand the health information that was available to them in schools, communities, and health systems.

Adding to these men's limited access to adequate health information are language barriers, which also seemed to interfere with their capacity to seek services. When Mexican immigrant men access services, they often depend on translators and interpreters, and even when they have some English proficiency they commonly experience difficulty understanding the information provided to them by health care providers (Betancourt, Green, Carrillo, & Maina, 2004; Foulkes, Danoso, Frederick, Frost, & Singh, 2004; Wu, Ridgely, Escarce, & Morales, 2007). Economic obstacles and current polices that block noncitizens from federal family planning services also limited access for some of these men. Study findings were consistent with the literature suggesting that structural barriers often reduce these men's opportunities to access services, resulting in low rates of service utilization (Betancourt, Green, Carrillo, & Maina, 2004; Wu, Ridgely, Escarce, & Morales, 2007), and seriously interfered with these men's capacity to plan and make decisions about their life trajectories. The implications of these structural barriers are not just important for Mexican immigrant men but for immigrant women as well. It is

important to highlight, however, that during the last decade, immigration in Oregon has been disproportionately skewed toward men (Mendoza & Gonzales-Berry, 2010), and programs that target men are in great need.

Cultural influences. It was expected that culture would play an important role in Mexican immigrant men's experiences with family planning and sexual risk-taking behaviors, considering that culture is a way of transmitting shared symbols and meanings between two or more individuals. This collection of shared meanings becomes a reference for the individual's "Me" or the *social self* formed by previous social behaviors, experiences, and learned social roles from previous interactions (LaRossa & Reitzes, 1993). The meanings and symbols attached to family planning and sexual risk-taking within an individual's culture will play an important role in their attitudes and behaviors. This expectation was confirmed by the findings that suggest that *personalismo* (cultural ideas where individuals value personal relationships over institutions) and *respeto* (differential behavior toward another based on age, sex, social position, economic status, and authority) (National Alliance for Hispanic Health, 2000) are influential in men's service utilization and their perception of the confidentiality of services. *Machismo* and cultural ideas about masculinity also play an important role in men's negative attitudes toward vasectomies. The role of *personalismo* and *respeto* in men's experiences with family planning and sexual risk-taking can be understood using the *looking-glass self* concept. This concept was developed by Cooley (1902/1956) to describe the individuals' self-concept that evolves from the interaction with primary groups, the perceptions of what others think about them, and individual's self assessments. For example, men in the

study did not access services, particularly testing services, often due to embarrassment or fear. One component was the fear of knowing they were infected, particularly with HIV, which many associated with a death sentence and social stigma.

Another cultural component tied to *personalismo* is the embarrassment and psychological distress they and their family may face if they contract a sexually transmitted infection because men may be concerned with losing *respeto* within their families and their communities. When these men seek services, health care professionals are not only seen as members of a health institution, but also as community members and individuals who may pass judgment on them (*personalismo*), resulting in a loss of *respeto* from the community. When language barriers are entered into the equation, the situation becomes even worse because translators might not be viewed with the same authority and trust as a doctor, thereby increasing mistrust and feelings of embarrassment. Even when men knew where to get services, and even if the services where provided in Spanish (or at least interpreters were available), men's concerns about the way others might see or perceive them may prevent them from getting services. It seems as though men in the sample were in conflict between the meanings they attached to what a "good man" will do, the perceptions of what other may think of them, and the risk behaviors they engage in, behaviors that are often encouraged by cultural norms of hypersexuality among men associated with *machismo*.

Men's negative attitude toward vasectomies also illustrates cultural influences and the interplay of the meanings men attach to manhood and their capacity to have children. Within the Latino culture, as part of the influence of *machismo*, men's capacity to

procreate is fundamental to a masculine identity (Gutmann, 2007; Pick, Givaudan, & Poortinga, 2003). Men were concerned about what others might think about them as a man if they find out they have had a vasectomy. Other researchers have found, for example, that men sometimes are ashamed of having a vasectomy and are hesitant to reveal this information to others. When men discover that peers and family members have had the procedure, however, then they begin carrying more positive attitudes toward vasectomies (Gutmann, 2007). Here again, the *looking-glass* self-concept (Cooley, 1902/1956) becomes important to understand men's attitudes toward vasectomies. When men perceive that their primary groups have negative attitudes toward vasectomies, and that these attitudes will negatively impact what others think about them, they probably will not attach positive attitudes toward vasectomy and will resist getting one, as was the case with men in the study.

The role of age and timing. Given the importance *life course theory* places on *age* and *timing* of events (e.g., immigration and fatherhood), it was expected that the younger men (18 to 24) in the sample might have had a different experience than the older men (25 to 30). Age is embedded in almost all social interactions (Settersten, 2003) and timing of events influences individual trajectories. Experiencing an unintended pregnancy at a younger age will set a man on a very different trajectory than if the pregnancy occurs when he is older. The timing of immigration in a man's life may also set him on a unique life trajectory as discussed earlier. Despite the theoretical rationale for why age and timing matters, the influence of these two variables were not salient or in many instances not present in this study. It is important to consider methodological issues

to explain why age and timing of events (immigration and fatherhood) were not salient themes in men's discourse of their experiences with family planning and sexual risk-taking experiences. Data for the *Latino Health Project* were not collected with the purpose of understanding the role of age and timing of events. Questions and probes did not necessarily lead men in the sample to reflect on their age, timing of events, or the influence of these two variables on their experiences. Although data were not collected with the intention of understanding the role of these two variables, some findings did vaguely refer to some of the consequences of fathering children at an early age for some men, while others discussed the timing of immigration as a disruption to educational process and family ties.

During the analytical phase, participant's transcripts were divided into two groups: ages 18 to 24 and ages 25 to 30, but no clear difference in patterns of men's experiences with family planning and sexual risk-taking by age emerged. An explanation for why age was not as salient as originally expected might be the role of age in the experiences of men born and raise in the U.S. where it might be expected that younger men are more disadvantaged than older men. Younger men in the sample attended U.S. educational systems and spoke both English and Spanish, circumstances that may advantage them over their older counterparts who did not have the opportunity to study in the U.S. For example, whereas an older man born and raised in the U.S. may benefit from more years of work experience through access to higher income and health insurance, for undocumented men, regardless of their age, these advantages may not exist.

Timing seems to matter specifically for transitions in commitment levels, condom use, and birth control. When men felt more familiar with their partners they stopped using condoms, although previous studies suggest that it is after having the first child that Mexican American couples start engaging in conversations about family planning (Maternowska et al., 2010). The time period between these two transitions (i.e., stopping condom using and having a first child) in the relationship suggest an important window for interventions in this population. Timing interventions early on for couples may be the key to prevent unintended pregnancies and decrease STIs among this population, but further studies are needed to understand how couples negotiate this transition and what is the most effective timing for intervention.

In summary, both symbolic interactionism and life course theory highlight the importance significant others play on our development along with the meanings we attach to symbols, behaviors, and roles. Social roles such as being a father can potentially influence men's experiences with family planning and sexual risk behaviors. Grounded in these ideas, this study uniquely compared and contrasted experiences for fathers and nonfathers. These findings contribute to the growing body of literature that suggests fatherhood can be a protective factor by decreasing risk-taking behaviors, in this case, reducing sexual risk behaviors. Another unique contribution of this study were findings that suggest men think about their role as fathers long before becoming fathers and often see family planning as a tool to be a good father. These ideas about fatherhood may have an impact on men's experiences with family planning and sexual risk-taking behaviors by reducing risk behavior or motivating men to engage in services

This dissertation project also contributes to the growing literature on the importance of partners in men's experiences with family planning and sexual risk-taking. From a *symbolic interactionism* framework, study findings suggest that once men are involve in a stable relationship, they share more experiences with their partners, integrate their partner's expectations, and from these interactions, negotiate new meanings of their fertility and sexuality. Partners also provide guidance and may connect men with services, therefore facilitating their role in family planning and sexual health. The role of both partners and fatherhood on these men's family planning and sexual risk-taking seemed to be shaped by their shared experiences, or *linked lives,* with partners and children. These experiences then led men to develop an identity around their role as fathers and as long-term partners, and gave them a sense of having a "family" to plan and care for.

Finally, this study also contributes to a body of research that points to structural barriers and context as main influences on Mexican immigrant men's limited use of sexual and reproductive health services. Among the barriers commonly cited in the literature, and also found in this research project, are language barriers, limited educational attainment, economic barriers, cultural barriers, immigration status, and limited access to health insurance. All of these factors have important implications for policy and practice. The current study also leaves many questions to be answered and identifies areas that need to be addressed further. Implications and possibilities for future research are discussed in more detail later in this chapter. The study, although an important step to understand how fatherhood influences men's family planning and

sexual risk-taking experiences, has its limitations. These limitations, as well as the study's strengths and implications, are discussed in the next sections.

Limitations and Strengths

Qualitative research is concerned with the explanation and understanding of the phenomenon under study and is not as concerned as quantitative research with the generalization of results. Because of the nature of the study, results cannot be generalized to the general population of Latino men and fathers. These findings, however, can still serve to better inform larger studies with the goal of understanding and integrating fatherhood into family planning and sexual health studies, and of understanding the experiences of Mexican immigrant men with family planning and sexual risk behaviors. One important fact to take into consideration is that men in the sample have similar demographic characteristics to those of the Mexican immigrant male population in Oregon (Mendoza & Gonzalez-Berry, 2010), making these findings relevant and, although not generalizable, worth considering when addressing sexual and reproductive health issues among this population.

Other limitations include those associated with secondary data analysis discussed earlier in the Method chapter, including the risk of using data that were not collected with the purpose of this research project in mind. Although the interview used to collect the data included questions that explored partner's influence in men's experiences, the main purpose of the study was not to understand the role of fatherhood or partners on men's experiences and their interaction, therefore leaving areas unexplored such as how these fathers' ideas and behaviors have changed after becoming a father or how committed

they are to current partners and how this commitment may influence their ideas and behaviors. Another limitation of the study was the limited insights in men's responses often due to low levels of educational attainment and literacy. This lack of insight was often reflected in their responses, which were frequently short and limited in depth. Although the original project was not designed to explore the role of fatherhood specifically and the quality of the response sometimes limited the depth of the analysis, findings can be insightful and can generate hypotheses for further studies given that findings suggest that fatherhood may influence these men's ideas and behaviors about family planning and sexual risk-taking and that ideas about fatherhood may influence men's behaviors even before fathering a child.

Finally, the fact that I am an educated Puerto Rican, middle-class woman can also influence or bias the analytic process. To minimize this limitation, several steps were taken such as the use of a reflective journal and debriefing with the original project's primary investigator, one project interviewer, bilingual and bicultural peers, and discussions with advisors. This limitation, however, is also a strength. My cultural background and my ongoing work with the Latino community, especially with the Mexican immigrant community, gives me the advantage of an insider in the community, therefore giving me the opportunity to identify cultural nuances that an outsider may overlook.

Despite these limitations, the study has multiple strengths and contributions that are important to mention**.** The most important strength is that the study explores sexual and reproductive issues in a population that can be hard to reach. As many have pointed

out, recruiting men for sexual and reproductive health research can be challenging and even more so recruiting men within a population in which sexuality can be taboo and who may have trust issues and vulnerabilities rooted in their experiences as immigrants such as issues with documentation.

Another strength of this study is that this is one of the first studies, to my knowledge, which explores the role of fatherhood in men's experiences with family planning and sexual risk behaviors among this population, demonstrating the importance of including fatherhood in health-related studies and as an important variable in men's development. The study's findings open possibilities for future research in the area, highlighting that fatherhood indeed influences men's experiences by sometimes becoming a protective factor for risk behavior around family planning and sexual risk behavior and by connecting men with services. The study also strengthens the growing body of literature on the role of partners in men's family planning and sexual risk-taking experiences by showing that the role partners play interacts with men's other social roles such as fatherhood, the type of relationship, and the perception men have of their partners.

Implications

Consequences for men's life trajectories. This study has important implications for the field of family studies as well as the field of public health. Family planning and sexual risk-taking have implications for men's life trajectories beyond immediate outcomes such as acquiring an STI or experiencing an unintended pregnancy, outcomes that are often perceived primarily as public health concerns. These outcomes, however, also have important implications for men's life trajectories and family lives.

Consequences of family planning and sexual risk-taking may result in the development of new relationships, in major life transitions, such as the transition to parenthood, and also may have consequences for current and future relationships. For example, when someone becomes infected with HIV, the quality and type of relationship with current or future sexual partners can be affected. An unintended pregnancy may result in the birth of an unexpected child, in the creation of new ties with sexual partners, and/or in the growth of a man's family, circumstances that will affect, not just the man, but other parties as well. These new or reshaped ties resulting from an individual's sexual risk-taking behaviors will influence family processes, for example, fatherhood involvement. Some researchers have suggested that the pathways that lead men to fatherhood may influence the level of involvement that they will have with their children in the future (Bachrach & Sonestein, 1997).

The study's findings, and the implications of these findings, are not just relevant for Mexican immigrant men, but for men overall. For these reasons, it is important that future research on understanding men's experiences with family planning and sexual risk-taking integrate fatherhood in their framework of analysis, both in qualitative and quantitative research. Future initiatives should also consider longitudinal studies that explore how ideas men have about fatherhood shape their family planning and birth control use and therefore, their life trajectories. For example, longitudinal studies on fatherhood involvement should explore how the different paths that lead men to fatherhood influence their future involvement and behavior as fathers. Parallel to studies on fatherhood involvement, research on men's development needs to integrate fatherhood

as an important life transition that can potentially protect men from risk behaviors as this study and previous researchers have suggested (Kerr, Capaldi, Owen, Wiesner, & Pears, 2011; Nelson, 2004; Palkovitz, 2002).

The importance of partners for interventions. Another area that requires further attention is the role of partners in men's experience with family planning and sexual risk behavior. Study's findings suggest that partners help men clarify their role in family planning and sexual health, although their influence seems shaped by the type of relationship and the perceptions men have of their partners. Therefore, future research should pay close attention to how men describe and perceive their partners and their level of commitment. The types of intimate relationships men reported in this study varied, including being married, married with wives in Mexico, living as married, single living with girlfriend, engaged, dating casually or exclusively, one night stands, friends with benefits, and paid sex. The ways in which men described these relationships suggest different levels of commitment, and this may be true for other groups of men. In the case of the men in the ,study researchers cannot assume that all types of cohabitation have the same level of commitment or represent the same type of relationship. This variability in the type of cohabitation, or in the commitment level of these men's relationships, reflect previous findings showing that cohabitation is a fluid process that is hard to define and that varies from relationship to relationship (Cherlin, 2004; Manning & Smock, 2005).

The fluid process of cohabitation needs to be considered when exploring the role of partners in men's sexual and reproductive health. Furthermore, the study's findings suggest that transitions in commitment levels may lead to sexual risk behaviors. During

these transition periods, men are decreasing condom use but not necessarily engaging in family planning; consequently, many of these men may become fathers, starting new families during this period. This period could be a window for intervention to prevent HIV and STIs but further studies need to take a serious look at this time period and at the best ways to address these issues. Interventions with couples may be an effective approach to reduce unintended pregnancies and STIs as some studies suggest (Harvey et al., 2004).). It may be the case that to reach out to men more effectively, healthcare professionals and community health workers need to consider couple interventions.

Addressing structural barriers. Study findings around fatherhood and partners can better informed researchers, policymakers, and health care providers who are addressing sexual and reproductive health needs of a broad group of men. Mexican immigrant men, however, face unique barriers that are mostly associated with immigration. Findings suggest the way immigration interacts with other factors is complex and any attempt to serve and inform this population will need to address multiple factors. This consideration is important not just for Mexican immigrant men, but for other immigrant populations as well, including women. For example, limited knowledge about sexual and reproductive health was associated with educational attainment and culture and language barriers, issues that in one way or another can be influenced by the experience of being an immigrant. In this case, researchers need to understand this phenomenon further by using more comprehensive assessments of sexual health knowledge and its impact on sexual risk behaviors among the immigrant population. This comprehensive assessment would benefit from tools that measure the

cultural relevance and the quality and quantity of exposure to sex education individuals have received in their countries of origin and host countries, at school, and from informal sources such as friends and other family members. This type of assessment is also important when evaluating sexual education programs for youth and adults. Furthermore, it is crucial for schools providing sex education to immigrant students to consider that even when students have already had sexual education in their country of origin, they are adjusting to new cultural norms and health systems and therefore will benefit from comprehensive sex education at school, particularly students in middle school and high school.

Given the language barriers and limited access to services this population faces, community health organizations need to reach out broadly and with culturally appropriate tools. When interventions are available, they most often target youth rather than young adult men (Lindberg & Sonenstein, 2000; Martinez-Donate et al., 2009) and much of the information and many of the programs available have been translated and adapted from materials designed for other populations such as European American homosexual men or intravenous drug users (NCLR, 2006). The limited number of bilingual health care professionals also exacerbates the problem with outreach to immigrant men (Betancourt, Green, Carrillo, & Maina, 2004; Foulkes, Danoso, Frederick, Frost, & Singh, 2004).

To effectively address these issues, community health services need to use native language speakers to convey information, use health promoters in work settings where these men interact, and disseminate information in places most frequented by these men. For example, they can consider reaching out to this population in work sites and bars.

Community health departments also should consider effective social marketing campaigns, including the use of radio as an effective medium to reach out to this population (Pew Charitable Trust, 2004).

Conclusion

The study findings have important implications for the understanding of Mexican immigrant men's experience with family planning and sexual risk-taking and for the integration of human development and family theories in the study of public health issues. The experiences of these men were shaped, as the study findings and previous literature suggest, by their social roles (partner, father), by individual factors (education, knowledge), and by contextual influences, including the health systems around them. The risk behaviors showed by this group of men are consistent with what other researchers have found in terms of patterns of family planning service utilization (Heshaw, 1998; Jones, Darroch, & Heshaw, 2002; NCLR, 2006), condom use (NCLR, 2006), and birth control use (Amaro, 2002; Frost & Driscoll, 2006; Zambrana et al., 2004). The results of their experiences are worrisome given these men are exposing themselves and their partners to unintended pregnancies and sexually transmitted infections. Beyond these being public health concerns, it is crucial that researchers, policy makers, and service providers remember that current sexual risk behaviors are having a direct impact on the fertility and family formation patterns of the fastest growing population in the United States. These patterns may set this population on disadvantaged life trajectories, either by having an unintended pregnancy or by the possibility of one's lifespan being shorten by an infections such as HIV.

This study also contributes to the understanding of the role of fatherhood in men's development, suggesting that indeed fatherhood can serve as a protective factor for men to reduce sexual risk-taking behaviors and that ideas men have about fatherhood can potentially influence their family planning and birth control use. The study also strengthens current evidence that partners are critical in the understanding of men's experiences with family planning and sexual risk-taking and expands our knowledge of this influence. It is not just the direct influence partners play in men's experience with family planning and sexual risk-taking, but also how men's perception of their partners and the type of relationship they have change over time and influence their behaviors. The transitional period from being familiar with a partner to being in a committed relationship can become a time window where men are at a higher risk due to decrease in condom use while not engaging yet in conversations about family planning and birth control. The consequences of this period of higher risk require further research because it might be during this time when men are fathering children and starting new families.

Finally, but not least important, the study has considerable implications for health care providers. Broken webs of knowledge, structural barriers such as limited access to health care services, and cultural differences influence Mexican immigrant men's experience with family planning and sexual risk-taking. Their circumstances are a clear example of how social structures, such as health care systems and immigration policies, constrain one's capacity to execute human agency. It is clear from the findings these men are not being reached by health care providers on a regular basis. When they do get

engaged in services, language and economic barriers as well as limited access to health insurance interfere with men's ongoing services, or the services are limited or inadequate.

Overall, this study illustrates that Mexican immigrant men's experience with family planning and sexual risk-taking are shaped by an interaction between the different roles men have (e.g., fathers, partners), their culture, and the social structures that surround them. Any attempt to address their sexual and reproductive health requires a closer look at the dynamics created by these multiple factors along with an understanding that when these men experience an unintended pregnancy and/or engage in sexual risk-taking, their life trajectories and the life trajectories of their family members begin to accumulate a series of disadvantages that may have lifelong effects.

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Appendices

Appendix A

Screening Form English Version

Date:	Interviewer:

SCREENING INSTRUMENT

Section I. Eligibility Criteria

***If someone refuses to answer a question, they are ineligible. "That is fine. As I mentioned, you can refuse to answer any questions that you don't want to. Thank you for taking the time to talk with me, but unfortunately we can't include you in this study. Thanks again, Good bye and have a nice day."**

***Any time someone is ineligible, "Thank you for taking the time to talk with me, but unfortunately we can't include you in this study. Would you be willing to answer just a few more questions? (Section II)**

1.Have you completed an interview for this project, *Proyecto de Salud Para Latinos*?

- O NO → *CONTINUE.*
- O YES → INELIGIBLE. Go to Section II.

2.How old are you?

- O *18-30 years old* → *CONTINUE.*
- O Younger than 18 or older than 30 → INELIGIBLE. Go to Section II.

3.How long have you lived in the United States?

- ☐ *Less than 10 years* → *CONTINUE.*
- ☐ More than 10 years → INELIGIBLE.

4. Have you had sexual intercourse with a woman at least once in the past three months? I want to clarify that by sex I mean vaginal intercourse. That is, when the man puts his penis in a woman's vagina.

- O *Yes* → *CONTINUE.*
- O No → INELIGIBLE.

5.* I'm going to read you a short list**. ***[Please don't answer anything until I've finished reading.]

- Have you tested positive for HIV? –or-
- You have a sexual partner that you know or suspect is currently pregnant – or-
- You are seeking to get your sexual partner pregnant in the next year

Do any of these situations apply to you? *[Just yes/no, I don't need to know which one]*

- O Yes → INELIGIBLE.
- O *No* → *CONTINUE*

6. Which one or more of the following would you say is your race or ethnicity?

- ❑ *Hispanic/Latino* → ***ELIGIBLE.***
- ❑ African-American/Non-Hispanic Black → **INELIGIBLE.**

- ❑ Non-Hispanic White → **INELIGIBLE.**
- ❑ Asian/Pacific Islander → **INELIGIBLE.**
- ❑ Native American → **INELIGIBLE.**
- ❑ Other → **INELIGIBLE.**

ELIGIBLE: □ *YES* □ *NO*

↓

Willing to participate?

YES → □ *Schedule appointment* □ *Conduct interview*

NO ↓

No: **Can I ask you why you don't want to take part in this study?** *Interviewers: Check all that apply*

- □ Are you not interested in the study topic?
- □ Is the study topic too sensitive and personal?
- □ Do you anticipate that you'll have scheduling problems or that you just won't have time?
- □ Are you concerned about confidentiality?
- □ Or is there something else?

List reason: _____

Interviewers: Go to Section II (if they are willing to answer a few more questions)

Section II.

1. Do you have children?

1 No
2 Yes
↘ a) How many? _____

2. Where were you born?

A) City: _____

B) State/Country: _____

3. How many years of school have you completed? _____

4. Are you currently:

1 Married
2 Divorced
3 Widowed
4 Separated, or
5 Never been married

FOR THOSE WHO DECLINED TO PARTICIPATE:

5. Why did you decide not to participate in this study?

1 Not interested in study topic
2 Study topic too sensitive/personal
3 Scheduling difficulties/no time
4 Concerned about confidentiality
5 Other:

_____

Thanks again for taking the time to talk to me today. Goodbye and have a good day.

INTERNAL USE ONLY:

Eligible: Yes No

Recruitment city:

Recruitment location:

Recruited how: (circle all that apply)

Approached by RI	Information table	Word of mouth	1-800 #	Flyer
Radio	Brochure/Poster	Other (specify)		

Appendix B

Screening Form Spanish Version

Date:	Interviewer:

Sección I: ***CRITERIOS DE ADMISIBILIDAD:***

***Si alguien se niega a responder una pregunta, ellos no son admisible. "Eso esta bien. Como había mencionado, puedes negar a responder cualquiera pregunta que no deseas contestar. Gracias por tomar el tiempo para hablar conmigo, pero desafortunadamente no te podemos incluir en este estudio. Gracias nuevamente, adiós y que tengas un buen día."**

***Si alguien no es admisible, "Gracias por tomar el tiempo para hablar conmigo, pero desafortunadamente no te podemos incluir en este estudio. ¿Estarías dispuesto a responder a unas cuantas preguntas más?" (Sección II)**

7.¿Has completado una entrevista anteriormente con este proyecto, El *Proyecto de Salud Para Latinos*?

- O NO → *CONTINÚE.*
- O SÍ → *NO ADMISIBLE.* Go to Section II.

8.¿Cuántos años tienes?

- O *18-30 years old* → *CONTINÚE.*
- O Younger than 18 or older than 30 → *NO ADMISIBLE.* Go to Section II.

9.¿Cuánto tiempo has vivido en los Estados Unidos?

- ☐ *Menos de 10 años* → *CONTINUE.*
- ☐ Más de 10 años → INELIGIBLE.

10. ¿Has tenido relaciones sexuales con una mujer, al menos, una vez en los últimos tres meses? Quiero claficar cuando digo sexo me refiero al sexo vaginal. Eso es, cuando un homber mete su pene a la vagina de la mujer.

- O *SÍ* → *CONTINÚE.*
- O NO → INELIGIBLE.

11. **Te leeré una lista breve**. [*Por favor no me de una respuesta hasta que haya terminado.]*

- Has obtenido un resultado positivo en la prueba de VIH.
- Tienes una pareja sexual que tú sabes o sospechas que podría estar embarazada – o-
- Estas intentando embarazar a tu pareja sexual durante el proximo año.

¿**Alguna de estas situaciones se aplica a tu caso?** [Solamente dime si/no, no tengo que saber la respuesta de cada pregunta]

- O Yes → INELIGIBLE.
- O *No* → *CONTINUE*

12. Razas u orígenes étnicos

- ❑ *Hispanic/Latino* → ***ELIGIBLE.***
- ❑ African-American/Non-Hispanic Black → **INELIGIBLE.**
- ❑ Non-Hispanic White → **INELIGIBLE.**
- ❑ Asian/Pacific Islander → **INELIGIBLE.**

- ❑ Native American → **INELIGIBLE.**
- ❑ Other → **INELIGIBLE.**

Admisible: ***SI*** ***NO***

↓

¿Estas interesado en participar?

SI → *Programe una cita* *Conduzca la entrevista*

↓

NO: ¿Puedo preguntarte por qué no deseas participar en este estudio?

- ¿No te interesa el tema del estudio?
- ¿Es el tema del estudio demasiado delicado y personal?
- ¿Prevé que tendrá problemas de horarios o que simplemente no tendrá tiempo?
- ¿Te préoccupa la confidencialidad?
- ¿Existe alguna otra razón?

Indique la razón: _____

Entrevistadores: Vaya a la Sección II (Si la persona permite que usted le haga mas preguntas)

Sección II.

6. ¿Tienes hijos?

1 No
2 Sí

a) ¿Cuántos? _____

7. ¿Dónde naciste?

C) Ciudad: _____

D) Estado/País: _____

8. ¿Cuántos años de estudios has completado? _____

9. Tu estado civil actual es:

1 Casado
2 Divorciado
3 Viudo
4 Separado
5 Nunca se casó

10. ¿Por qué decidiste no participar en este estudio?

1 No me interesa el tema del estudio
2 El tema del estudio es demasiado delicado/personal
3 Tengo dificultades con los horarios/no tengo tiempo
4 Me preocupa la confidencialidad

5 Otra razón: _____

Gracias nuevamente por tomar el tiempo para hablar conmigo hoy. Que tengas un buen día. Adiós.

INTERNAL USE ONLY:

Eligible: Yes No

Recruitment city:

Recruitment location:

Recruited how: (circle all that apply)

Approached by RI	Information table	Word of mouth	1-800 #	Flyer
Radio	Brochure/Poster	Other (specify)		

Appendix C

Interview Guide English Version

Recruitment Location:	
Benton County……	a
Lane County……	b
Linn County…….	c
Marion County…….	d
Polk County…….	e
Other……..	

Interviewer: _____
Date: _____
Start Time: _____
Stop Time: _____

PROYECTO DE SALUD PARA LATINOS
LATINO HEALTH PROJECT

PARA HOMBRES (01/14/09, 02/13/09, 03/10/09, 03/13/09 RevQual = 03-18-09, 4/14/09)

Once again my name is _____. Thank you again for agreeing to talk with me today. We are interested in learning more about what influences sexual risk behaviors and use of family planning and sexual and reproductive health services by Latino men in rural Oregon. But before we get to those questions, can you tell me a little more about yourself.

I. Social Context

1. Tell me how you came to live in Oregon?

   1a. Why did you move here?

   PROBE: (e.g. earn money and return to Mexico, better job, be with family)

   PROBE: Was it easy for you to move here?

   1b. How is life here different from your life in Mexico/your country?

2. What do you do for work?

   2a. What else do you do for work?

   2b. Tell me about your work hours, how you are treated, if you are exposed to hazards.

   2c. Do you change jobs throughout the year?

   PROBE: To what? Why?

3. Where do you live?

3a. Have you lived there long?

3b. How long do you plan to stay there?

3c. What do you like about living in Oregon?

3d. What don't you like about it?

4. Who do you live with?

PROBE: Your family? Who in your family? Do you have other family members nearby?

PROBE: Alone? Why is that?

PROBE: With other men? Who? Why? How did that happen?

5. Tell me more about your family.

5a. Do you have a wife or a girlfriend?

5b. Tell me more about that.

PROBE: How long have you been together?

5c. Is she in Oregon with you?

5d. Do you have children? Are they here with you?

5e. Tell me more about others in your family, are they here? Still in Mexico/your country?

PROBE: Who in your family is still in Mexico/Latin America? – What kind of relationship do you have with your family? How do you stay in contact?

II. Social and Sexual Relationships

6. Let's talk about your friends in Oregon. Who do you turn to when you need something?

7. Where do you go and what do you do for fun?

PROBE: Dances, bars, bowling, soccer, libraries, etc.

8. What do single men do when they feel lonely?

8a. What do they do when they want to be with a woman and they don't have a girlfriend?

8b. How do single men who live here meet women?

8c. <u>If single</u>: How do you meet women?

8d. If single: What do you do if you want to be with a woman and you don't have a girlfriend?

8e. If single: What do you do when you feel lonely?

9. Sometimes Latino men who have wives in Mexico/their home country have sex with women here in the US. Do you think that happens here?

   9a. What about men you know?

   9b. What do you think about this?

   9c. If unaccompanied by wife/partner: What about you? Is this true for you?

10. Some Latino men who are married or living as married or in committed relationships, have sex with other women. Why do you think this happens?

   10a. What about you? You are [married, living as married, unaccompanied].

   10b. Has this happened to you?

   10c. Why?

   10d. So what do you think of men who are in a committed relationship who are having sex with multiple partners?

11. How common is it for Latino men to have sex with prostitutes?

   11a. How available are prostitutes?

   11b. What is exchanged for sex?

      PROBE: money, drugs, alcohol, other

   11c. Are drugs/alcohol involved?

   11d. Have you been with a prostitute in Oregon?

      PROBE: If not in Oregon, in the U.S.?

   11e. If YES, tell me more about this.

      PROBE: Prefer/seek out one certain prostitute? Why or why not?

   11f. If YES, do you use a condom when you have sex with a prostitute?

11g. Why or why not?

12. How common is it for Latino men to have sex with other men here in the U.S.?

12a. Have you had sex with a man and can you tell me more about that?

III. Cultural Values

13. What does the word "machismo" mean to you **and** how would you describe a man who is macho?

13a. Do you think of yourself as macho?

13b. Why or Why not?

14. Do you think it is important to teach the role of machismo to children?

15. How are intimate relationships between men and women different here in the U.S. in comparison with back home?

16. How does one get to be respected in their community?

IV. Health

Now, I want to talk with you about your health.

17. What is the most important worry you have about your health?

18. When I say, "sexual and reproductive health," what does that mean?

19. What kinds of health concerns do you have about your sexual health?

PROBE: Do you have any concerns about STI, HIV, penile pain, contraceptives, or anything else?

20. When you have concerns like this, where do you go?

PROBE: Do you go see a doctor, go to a clinic? Why or why not?

PROBE: How do you decide whether to see a doctor? When do you not?

21. Have you ever gone to a Curandero for a sexual health problem?

21a. Why or why not?

V. STDs/HIV Prevention, Testing and Treatment

STDs – Knowledge, attitudes and practice

22. There are some diseases that you can get from having sex. These are called sexually transmitted diseases, or STDs. Tell me what you have heard about these types of diseases.

By STDs we mean different infections that people get through sexual contact. They are also called venereal diseases.

23. How can you tell if a man or a woman is infected with a STD?

24. Why do you think Latino men take these risks?

25. How worried are you about getting an STD?

    25a. Why or why not?

26. How can you keep from getting infected?

27. What would you do if you got an STD?

    27a. Where would you go to get tested for STDs and/or treated?

28. We are interested in knowing more about your use of STD services since living in Oregon. Have you used STD services, including counseling, testing and treatment for STDs, in Oregon?

    If Yes (you have used STD services in Oregon):

    28a. Where did you go?

    28b. Tell me about that experience.

    28c. What could the clinic/health care provider have done to improve your experience?

    28d. Would you go back? Why or why not?

    28e. Would you recommend getting STD services at that clinic to a friend?

    If No (you have NOT used STD services in Oregon):

    28Xa. Why not?

    28Xb. What do you think keeps you away?

    28Xc. What could the clinic/health care provider do to make it easier for you to go?

HIV/AIDS – Knowledge, attitudes and practice; testing

29. Tell me what you have heard about HIV/AIDS?

30. What causes HIV/AIDS?

This is what we mean by HIV and AIDS: HIV is a virus that leads to Acquired Immune Deficiency Syndrome (AIDS), which reduces the body's ability to fight off infections.

31. How can you tell if a man or a woman is infected with HIV/AIDS?

32. Why do you think Latino men take these risks?

33. How worried are you that you can become infected with HIV/AIDS?

    33a. Why or why not?

34. How can you keep from getting infected?

35. Where would you go to get tested for HIV/AIDS in Oregon?

36. Have you <u>ever</u> been tested for HIV/AIDS?

37. If YES, have you been tested for HIV/AIDS/used HIV/AIDS testing <u>since living in Oregon</u>?

    If Yes (you have used HIV/AIDS testing in Oregon):

    38a. Where did you go?

    38b. Tell me about that experience.

    38c. What could the clinic/health care provider have done to improve your experience?

    38d. Would you go back?

    PROBE: Why or Why not?

    38e. Would you recommend being tested at that clinic for HIV/AIDs to your friends?

    If No (you have NOT EVER been tested for HIV/AIDS):

    38Xa. Why not?

    38Xb. What do you think keeps you away?

    38Xc. What could the clinic/health care provider do to make it easier for you to go?

VI. Family Planning Services

Attitudes about Family Planning

39. We are interested in your experiences and opinions regarding family planning. Could you describe for us what family planning means to you?

What we mean by family planning is planning if and when to have children and using contraceptive methods, also called birth control.

40. How important is family planning to you?

41. Tell me how you learned about sex?

    PROBE: How much did your parents talk to you about sex?

    PROBE: Through your friends? Through relatives? (An older brother or male cousin?); through school, internet, TV, women, married friends?

Birth Control use and concerns

42. We are interested in your experiences and opinions regarding birth control. Could you describe for us what birth control means to you?

    42a. How did you learn about birth control?

        PROBE: Through your friends? -Through relatives? (An older brother or male cousin?); through school, internet, TV, women, married friends?

43. Have you **ever** used birth control? Yes or No.

    43a. IF YES, What birth control methods have you used to prevent pregnancy?

    43b. IF YES, what methods do the women you have sex with use?

    43c. IF YES, Tell me your experiences with those methods, such as what did you like and with did you not like?

    43Xa. IF **never used** birth control with any woman, Why not?

        PROBE: Why would you say that?

        PROBE: What else would you say?

44. What are your concerns about using birth control?

45. What do you think about using withdrawal to prevent pregnancy?

One birth control method available for men is having a vasectomy. A vasectomy is a permanent method of <u>birth control</u> for men, and it involves having surgery.

46. Would you consider having a vasectomy?

46a. Why or why not?

47. Does using birth control, like the Pill or shot, or condoms, interfere with God's will/fate?

47a. Why or why not?

48. Would using birth control go against your personal religious beliefs?

Experiences with getting family planning services. We are interested in knowing more about your use of family planning services.

49. Have you **ever** used family planning services in the United States? Yes or No.

49a. **IF YES,** in what state(s)**? List here**: _____

49b. Have you ever used family planning services in **Oregon**? Yes or No.

If YES (you have used family planning services in Oregon)

49c. Where did you go?

49d. Tell me about that experience.

49e. What could the clinic/health care provider have done to improve your experience?

PROBE: What did you like or not like?

49f. Would you go back?

49g. Would you recommend this family planning clinic to your friends?

If NO (you have not used family planning services in Oregon)

49Xa. Why not?

49Xb. What do you think keeps you away?

49Xc. What could the clinic or health care provider do to make it easier for you to go?

49Xd. Where would you go to get family planning services if you needed them?

VII. Barriers/Facilitators to use of SRHS including structural and service delivery factors

We understand Latino men don't go to clinics for sexual health services, like STD and HIV counseling, testing and treatment as well as services for family planning.

50. Why do you think Latino men don't go to clinics for these services?

PROBE: Is it related to where the clinics are?

PROBE: Is it related to the clinic having translation services?

PROBE: Is it related to treating men with respect?
healthcare provider? Why?

We're trying to understand your experiences living here <u>in Oregon</u> as a recent immigrant.

51. Have you ever been discriminated against or made to feel unwelcome?

51a. What happened or can you tell me more?

52. Why do you think you were treated unfairly?

53. Have you ever been discriminated against or made to feel unwelcome at a clinic/hospital?

53a. What happened or can you tell me more?

53b. Why do you think you were treated unfairly?

54. How do you want to be treated when you get health care?

55. Have you been treated that way?

PROBE: What about respecto?

PROBE: What about confianza?

VIII. More specific information about recent sexual history

56. You told me earlier that you had sex with a woman in the last three months. We want to learn more about that. How many different women have you had sex with in the last 3 months? _____

57. I would like to ask you some more questions about this person. Remember that your answers will be kept private. **<u>Consider your most recent partner</u>**

<u>[Interviewers will convert Q57, Q58 and Q59 to the past tense if needed for any of the 3 partners]</u>

57a. How would you describe your relationship with this person? What does that mean?

PROBE: So then, would you say:

- Friends
- Dating Casually
- Dating Exclusively
- Engaged
- Married
- One night stand
- Someone you paid to have sex
    - Other (booty call, second wife, mistress, friend with benefits, lover)

Condoms

57b. When you and this person had sex, did you use a condom?

57c. Why or why not?

57d. Who decides whether to use or not use a condom?

57e. Can you tell me more?

Birth Control

57f. When you and this person had sex, did you use a method of birth control to prevent pregnancy?

57g. Why or why not?

[If a respondent says:

'They are using condoms as birth control' - then SKIP TO Q58

'**They are NOT using birth control' - then SKIP TO Q57i**

'**They are using a method other than condoms' - CONTINUE with Q57h]**

57h. What birth control method did you use and how often did you use it?

57i. Who decides whether to use or not use birth control?

57j. Can you tell me more?

2nd most recent partner – if applicable

58. I would like to ask you some more questions about this **second** person. Remember that your answers will be kept private.

[Interviewers will convert Q63, Q64 and Q65 to the past tense if needed for any of the 3 partners]

58a. How would you describe your relationship with this person? What does that mean?

PROBE: So then, would you say:

- Friends
- Dating Casually
- Dating Exclusively
- Engaged
- Married
- One night stand
- Someone you paid to have sex
    - Other (booty call, second wife, mistress, friend with benefits, lover)

Condoms

58b. When you and this person had sex, did you use a condom?

58c. Why or why not?

58d. Who decided whether to use or not use a condom?

58e. Can you tell me more?

Birth Control

58f. When you and this person had sex, did you use a method of birth control to prevent pregnancy?

58g. Why or why not?

[If a respondent says:

'They are using condoms as birth control' - then SKIP TO Q59

'**They are NOT using birth control' - then SKIP TO Q58i**

'**They are using a method other than condoms' - CONTINUE with Q58h]**

58h. What birth control method did you use and how often did you use it?

58i. Who decided whether to use or not use birth control?

58j. Can you tell me more?

3rd most recent partner – if applicable

59. I would like to ask you some more questions about this **third** person. Remember that your answers will be kept private.

[Interviewers will convert Q63, Q64 and Q65 to the past tense if needed for any of the 3 partners]

59a. How would you describe your relationship with this person? What does that mean?

PROBE: So then, would you say:

- Friends
- Dating Casually
- Dating Exclusively
- Engaged
- Married
- One night stand
- Someone you paid to have sex
  - Other (booty call, second wife, mistress, friend with benefits, lover)

Condoms

59b. When you and this person had sex, did you use a condom?

59c. Why or why not?

59d. Who decided whether to use or not use a condom?

59e. Can you tell me more?

Birth Control

59f. When you and this person had sex, did you use a method of birth control to prevent pregnancy?

59g. Why or why not?

[If a respondent says:

'They are using condoms as birth control' - then SKIP TO Quantitative Section

'**They are NOT using birth control' - then SKIP TO Q59i**

'**They are using a method other than condoms' - CONTINUE with Q59h]**

59h. What birth control method did you use and how often did you use it?

59i. Who decided whether to use or not use birth control?

59j. Can you tell me more?

QUANTITATIVE QUESTIONS 01/14/09

I am now going to ask you some questions where I will ask you to select your answers from a range of choices using these cards.

I. SOCIODEMOGRAPHICS/Social context

1. How long have you been living in the United States? …….. _____

2. How long have you been in Oregon (months, years)? ……___ months, ___ years

3. Before you came to Oregon (this time), did you live:

Somewhere else in the U.S. .... 1 **3a. List State(s): _____**

Or did you come to Oregon straight from Mexico/your country..... 2

4. How old are you? ……..... _____ years

5. Are you working right now?.....Y (1) / N (0)
[If 'NO' skip to Q8]

6. What do you do? ***[Check ALL that apply - do not read responses]***	**Y**	**N**
6a. Farming/Agriculture (food, trees***) [tell us what it is]***	1	0
6b. Service Industry, Sales (Restaurants, hotel, retail)	1	0
6c. Factory Work (furniture)	1	0
6d. Construction (framing crews, roofers)	1	0
6e. Technicians/Related support (computer technician, a member of a crew that installs heating systems)	1	0
6f. Precision Production/Craft/Repair (mechanic, custom cabinet maker)	1	0
6g. Transportation/Material Moving (commercial driver)	1	0
6h. Child Care	1	0
6i. Administrative Support, including Clerical (office assistant)	1	0
6j. Administrators and Managers (office manager, retail manager)	1	0
6k. Professional Specialty (nurse, therapist, teacher)	1	0
6l. Social Services (Head Start worker, health educator)	1	0
6m. Other	1	0

7. How many hours a week do you work? ……._____ hours per week

8. How many years of school have you completed? ***[If completed GED = 12]***....._____ years

9. Not counting classes to learn English, how many years of school have you completed in the U.S.? _____ years

10. Are you going to school now?..... Y (1) / N (0)

11. Not including yourself, how many people live in your home? Please count babies and children as well as adults.

[INTER: If necessary, explain that "lives in household" means "lives with you most of the time."]

number in household

12. What type of place do you live in? Is it:

A trailer	...1
A house	...2
An apartment	...3
A labor camp	…4
Or some other kind of place	...5

12 a. **(if 5)** Specify other kind of place _____

13. What is your current total yearly household income (including earnings, welfare, child support, etc.)?..... $_____

14. How many people does that total income support, including yourself?..._____

15. In an ordinary or usual month, would you say:

You are able to pay
all of your bills 1

Or are there some bills you are not
able to pay every month 2

16. Do you send money to family or relatives in Mexico/your country?

No 0
Yes 1

17. What is your race or ethnicity? *Would you say…. [read responses; mark all that apply]*

	YES	***NO***
17a. American Indian or Alaska Native.....	1	0
17b. Asian……..	1	0
17c. Black or African American……..	1	0
17d. Hispanic/Latino…….	1	0
17e. Native Hawaiian or Other Pacific 1	0	
17f. Islander……..	1	0
17g. White……..	1	0
17h. Other……..	1	0

18. What is your religious preference? *[do not read responses]* *(combines CDC2.14&15)*

Protestant……..1
Catholic…….. 2
Jewish…… 3
Other……... 4 **& please specify: _____**
None …… 5

19. How important is your religious faith to you? Would you say:

Not important……. 1
Slightly important……..... 2
Moderately important……... 3
Very important……... 4
Extremely important……. 5

20. Where were you born? *[Do not read responses]*

Mexico…… 1
Another country *outside of the US and Latin America*…. [Skip to Q23]……. 2 **& list here** _____
US……. [Skip to Q23]..... 3
Central America…….. [Skip to Q23]…….. 4
South America ……. [Skip to Q23]…….. 5
The Caribbean……. [Skip to Q23]…….. 6
Don't Know…… [Skip to Q23]..... 7

21. What state in Mexico? *[Do not read responses]*

Oaxaca……... 1
Chiapas…….. 2
Michoacan…… 3
Jalisco……. 4
Guanajuato…… 5
Other …….. 6 **& list here** _____

22. Think about the place where you grew up in Mexico/your country, or the place where you spent the most time as a child. Would you describe it as:

a *rancho* (rural area)... 1
a town 2
a small city 3
a large city, but not the Federal District 4
or the Federal District. 5

23. Where was your mother born? *[Do not read responses]*

Mexico……..…….. …… 1
Another country *outside of the US and Latin America*…… 2
US……..... …… 3
Central America……..…….. …… 4
South America …….. 5
The Caribbean……...6
Don't Know…… 7

24. Where was your father born? *[Do not read responses]*

Mexico……..…….. …… 1

Another country *outside of the US and Latin America*…..…… 2
US……..... ……. 3
Central America……..…….. ……. 4
South America …….. 5
The Caribbean…….…….. 6
Don't Know…… 7

25. What is your marital status?

Married and living with my wife 1
Married but my wife lives in Mexico/home country 2
Living as married 3
Single, living with my partner 4
Single 5
Other …… 6 **List**: _____

25a. If Single, are you currently in a sexual relationship? **Yes(1)/ No(0)** **[If No, Skip to Q26)**

25b. If Yes, with how many sexual partners ……. 0, 1, 2, 3, 4, etc.

26. How many children do you have? _____

27. How many children are living with you right now? _____

28. How would you describe your current health status?

Excellent 1
Good 2
Fair 3
Poor 4

II. ACCULTURATION

29. In answering the next several questions, please choose your answers from one of the choices on this card ***[Card #2]:***

a-Only Spanish
b-More Spanish than English
c-Both equally
d-More English than Spanish
e-Only English

	A	**B**	**C**	**D**	**E**
29a. In general, what language(s) do you read and speak?	1	2	3	4	5
29b. What was the language you used as a child?	1	2	3	4	5
29c. What language(s) do you usually speak at home?	1	2	3	4	5
29d. In which language(s) do you usually think?	1	2	3	4	5

29e. What language(s) do you usually speak with your friends?	1	2	3	4	5
29f. In what language(s) are the T.V. programs you usually watch?	1	2	3	4	5
29g. In what language(s) are the radio programs you usually listen to?	1	2	3	4	5
29h. In general, what language(s) are the movies, T.V. and radio programs you prefer to watch and listen to?	1	2	3	4	5

30. In answering the next few questions, please choose your answers from one of the choices on this card ***[Card #3]:***

a-All Latinos
b-More Latinos than Non-Latinos
c-About half and half
d-More Non-Latinos than Latinos
e-All Non-Latinos

	A	**B**	**C**	**D**	**E**
30a. Your close friends are…	1	2	3	4	5
30b. You prefer going to social gatherings/parties at which people are…	1	2	3	4	5
30c. The persons you visit or who visit you are…	1	2	3	4	5
30d. If you could choose your children's friends you would want them to be…	1	2	3	4	5

III. CULTURAL NORMS

Next I am going to read you some statements. For each one, please tell me how much you agree. Choose your answers from one of the choices on this card **[Card #4]:**

a-Do not agree at all
b-Somewhat agree
c-Moderately agree
d-Mostly agree
e-Completely agree

31. Machismo

	A	**B**	**C**	**D**	**E**
31a. A man should not marry a woman who is taller than him.	1	2	3	4	5
31b. It is the mother's special responsibility to give her children proper religious training.	1	2	3	4	5
31c. Boys should not be allowed to play with dolls, and other girls' toys.	1	2	3	4	5
31d. Parents should maintain stricter controls over their daughters than their sons.	1	2	3	4	5
31e. There are some jobs that women simply should not have.	1	2	3	4	5
31f. It is more important for a woman to learn how to take care of the house and the family than it is for her to get a college education.	1	2	3	4	5
31g. A wife should never contradict her husband in public.	1	2	3	4	5

31h. Men are more intelligent than women.	1	2	3	4	5
31i. No matter what people say, women really like dominant men.	1	2	3	4	5
31j. Some equality in marriage is a good thing, but by and large the father ought to have the main say so in family matters.	1	2	3	4	5
31k. For the most part, it is better to be a man than a woman.	1	2	3	4	5
31l. Most women have little respect for weak men.	1	2	3	4	5
31m. I would be more comfortable with a male boss than with a female boss.	1	2	3	4	5
31n. It is important for a man to be strong.	1	2	3	4	5
31o.Girls should not be allowed to play with boys' toys such as soldiers and footballs.	1	2	3	4	5
31p. Wives should respect the man's position as head of the household.	1	2	3	4	5
31q. The father always knows what is best for the family.	1	2	3	4	5
31r. Having children makes a woman more important in her family and community.	1	2	3	4	5
31s. If a woman has children, her family and friends will love her more.	1	2	3	4	5
31t. Women should have as many children as possible.	1	2	3	4	5
31u. Having children will make a woman's husband or boyfriend love her more.	1	2	3	4	5
31v. Having many children will make a woman's husband or boyfriend more loyal to her.	1	2	3	4	5
31w. If a family has a lot of children, they will somehow find a way to feed them.	1	2	3	4	5

Next I am going to read you some statements. For each one, please tell me how much you agree. Choose your answers from one of the choices on this card **[Card #4]:**

a-Do not agree at all
b-Somewhat agree
c-Moderately agree
d-Mostly agree
e-Completely agree

32. Familismo

	A	**B**	**C**	**D**	**E**
32a. Children should always help their parents with the support of younger brothers and sisters, for example, help them with homework, help the parents take care of the children, and so forth.	1	2	3	4	5
32b.The family should control the behavior of children younger than 18.	1	2	3	4	5

32c.A person should cherish the time spent with his or her relatives.	1	2	3	4	5
32d. A person should live near his or her parents and spend time with them on a regular basis.	1	2	3	4	5
32e. A person should always support members of the extended family, for example, aunts, uncles, and in-laws, if they are in need even if it is a big sacrifice.	1	2	3	4	5
32f. A person should rely on his or her family if the need arises.	1	2	3	4	5
32g. A person should feel ashamed if something he or she does dishonors the family name.	1	2	3	4	5
32h. Children should help out around the house without expecting an allowance.	1	2	3	4	5
32i. Parents and grandparents should be treated with great respect regardless of their differences in views.	1	2	3	4	5
32j. A person should often do activities with his or her family, for example, eat meals, play games, or go somewhere together.	1	2	3	4	5
32k. Aging parents should live with their relatives.	1	2	3	4	5
32l. A person should always be expected to defend his/her family's honor no matter what the cost.	1	2	3	4	5
32m. Children younger than 18 should give almost all their earnings to their parents.	1	2	3	4	5
32n. Children should live with their parents until they get married.	1	2	3	4	5
32o. Children should obey their parents without question even if they believe they are wrong.	1	2	3	4	5
32p. A person should help his or her elderly parents in times of need, for example, helping financially or sharing a house.	1	2	3	4	5
32q. A person should be a good person for the sake of his or her family.	1	2	3	4	5
32r. A person should respect his or her older brothers and sisters regardless of their differences in views.	1	2	3	4	5

IV. INTENTIONS – NOT PARTNER-SPECIFIC

33.We are now going to ask you questions about using birth control, including condoms. Please tell me how much you agree with the following statements using the choices on this card ***[Card #6]*:**

1 2 3 4 5

Not at all true Very true

33a. You intend to use a birth control method the next time you have sex.	1	2	3	4	5

33b. You intend to use a birth control method every time you have sex during the next 3 months.	1	2	3	4	5
33c. You intend to try to persuade your sexual partner to use condoms every time you have sex during the next 3 months.	1	2	3	4	5
33d. When having sex, you intend to always have condoms handy during the next 3 months.	1	2	3	4	5
33e.You intend to use condoms every time you have sex during the next 3 months.	1	2	3	4	5

V. CONTRACEPTION ATTITUDES & PERCEPTIONS

[Attitudes and Barriers to Using/Getting Contraception]

34. In answering the next few questions, please tell us how much you agree or disagree with the following statements about using birth control including condoms. Choose your answers from one of the choices on this card ***[Card #4]:*** a-Do not agree at all
b-Somewhat agree
c-Moderately agree
d-Mostly agree
e-Completely agree

[Denial/Knowledge/Ambivalence]

	A	**B**	**C**	**D**	**E**
34a. I just don't think about using birth control.	1	2	3	4	5
34b. I don't think my partner will get pregnant.	1	2	3	4	5
34c. I don't care if my partner gets pregnant.	1	2	3	4	5
34d. I don't have sex very often.	1	2	3	4	5
34e. It doesn't matter if I use birth control-when it's my partner's time to get pregnant, it will happen.	1	2	3	4	5
34f. I want to get my partner pregnant.	1	2	3	4	5
34g. I don't know how to get birth control.	1	2	3	4	5
34h. I don't know where to get birth control.	1	2	3	4	5

[Norms]

34i. It is wrong to use birth control.	1	2	3	4	5
34j. Birth control is the woman's responsibility.	1	2	3	4	5
34k. Using birth control is against my religious beliefs.	1	2	3	4	5

[Partner]

34l. Discussing birth control with my partner is embarrassing.	1	2	3	4	5
34m. My partner does not want me to use birth control *(revised from CDC2.27m)*	1	2	3	4	5
n.					

[Side Effects]

34o. I worry about the side effects of birth control.	1	2	3	4	5
34p. My partner worries about the side effects of birth control.	1	2	3	4	5

[Hassle]

34q. Having sex is sometimes unexpected.	1	2	3	4	5
34r. Sometimes there is no time to prepare for sex.	1	2	3	4	5
34s. Sex is more romantic when we don't use birth control.	1	2	3	4	5
34t. I am afraid to go to the doctor to get birth control.	1	2	3	4	5

[Cost]

34u. I don't use birth control because it costs too much.	1	2	3	4	5

35. How much do you agree or disagree with the following statements about your *ability to get* birth control now? ***[Card #4]***

a-Do not agree at all
b-Somewhat agree
c-Moderately agree
d-Mostly agree
e-Completely agree

[Access]

	A	**B**	**C**	**D**	**E**
35a. Clinic hours are not convenient for me.	1	2	3	4	5
35b. I have transportation problems getting to a clinic.	1	2	3	4	5
35c. It is hard for me to get time off work or school to go to a clinic.	1	2	3	4	5
35d. It takes too long to get an appointment to get birth control.	1	2	3	4	5
35e. There is too much waiting time at clinics.	1	2	3	4	5
35f. I have no one to watch my kids so I can go to a clinic.	1	2	3	4	5
35g. There is no clinic close to where I live.	1	2	3	4	5

[Embarrassment]

35h. Going to get birth control is embarrassing.	1	2	3	4	5

[Accommodation/Acceptability]

35i. Health care providers don't understand me.	1	2	3	4	5
35j. I feel put down by health care providers.	1	2	3	4	5
35k. Health care providers ask me questions that make me uncomfortable.	1	2	3	4	5
35l. If my partner didn't have to get a pelvic exam, she would be more likely	1	2	3	4	5

to get birth control.					

[Hassle]

35m. I am too busy to get birth control.	1	2	3	4	5
35n. Getting birth control is hard because you have to go to a clinic or doctor's office.	1	2	3	4	5

VI. PERCEIVED VULNERABILITY TO PREGNANCY AND HIV/STDS

36. Please answer the following questions using the scale on this **[Card #9].**

1 2 3 4 5
Not at all Likely — Extremely Likely

36a. If you did not use a birth control method how likely is it that you would get your partner pregnant in the next year?	1	2	3	4	5
36b. If you do not use a condom how likely is it that you could get HIV from having sex?	1	2	3	4	5
36c. If you do not use a condom how likely is it that you could get a Sexually Transmitted Disease other than HIV from having sex?	1	2	3	4	5

VII. CONDOM USE AND CONTRACEPTIVE SELF-EFFICACY – NOT PARTNER-SPECIFIC

37. Listed below are some statements about using birth control, male condoms in particular. Using the card ***[Card #16]*****,** tell us how confident you are that you could do each of these things.

a-Not at all confident
b-A little confident
c-Moderately confident
d-Very confident
e-Extremely confident

How confident are you……

	A	**B**	**C**	**D**	**E**
37a. …in your knowledge about the various ways to prevent or postpone pregnancy?	1	2	3	4	5
37b. …in your ability to protect yourself against unwanted pregnancy?	1	2	3	4	5
37c. … that you could stop intercourse if you or your partner weren't using birth control?	1	2	3	4	5
37d. … that you could discuss using birth control with your partner?	1	2	3	4	5
37e. … that you could use birth control correctly?	1	2	3	4	5
37f. … that you could buy or get condoms without feeling embarrassed?	1	2	3	4	5
37g. … that you could discuss using condoms with your partner?	1	2	3	4	5
37h. … that you could always have condoms handy in case you needed one?	1	2	3	4	5

37i. … that you could use condoms every time you have sex?	1	2	3	4	5
37j.… that you could refuse to have sexual intercourse if your partner would not use a condom?	1	2	3	4	5
37k. …that you could put a condom on correctly?	1	2	3	4	5

38. SKIP IF NEVER USED A CONDOM. When you use a condom when having sex, why do you use it? [read responses]

Pregnancy prevention …….. 1
Disease prevention ……2
Both pregnancy and disease prevention ……3
Other ……4

VIII. HIV AND STD RISK FACTORS - REPRODUCTIVE AND SEXUAL HISTORY

Now I'm going to ask you questions about your sexual and reproductive health. Some of the following questions ask about vaginal and anal sex. When a question refers to 'vaginal sex', that means sex where the man puts his penis in the woman's vagina. When a question asks about 'anal sex', that means sex where the man puts his penis in the woman's anus, or butt.

39. How old were you the first time you had vaginal or anal sex?.....age____

40. How many sexual partners have you had in your life?..... _____

41. How many times have you gotten a woman pregnant?..... _____

42. Have you ever gotten a woman pregnant who then had an abortion?..... Y(1)/ N(0)

42a. If YES, how many times? _____

43. Have you ever had a Sexually Transmitted Disease?..... . Y(1)/ N(0)

44. Have you been tested for a sexually transmitted disease during the past 3 months Y(1)/ N(0)

44a. IF YES: Have you been diagnosed as having a sexually transmitted disease during the past 3 months? … … … … … … … .. .. …… Y(1)/ N(0)

45. Have you ever been tested for HIV/AIDS?.....……Y(1)/ N(0)

45a. IF YES: Have you been tested for HIV/AIDS in the past 3 months? … Y(1)/ N(0)

46. Have you ever shared needles to inject (shoot up) anything such as drugs or steroids or vitamins? ……Y(1)/ N(0)

46a. IF YES, have you shared needs to inject (shoot up) anything such as drugs or steroids or vitamins in the last 3 months? ……Y(1)/ N(0)

47. Have you ever had sex with someone who shared needles to inject (shoot up) anything such as drugs or steroids or vitamins?..... Y(1)/ N(0)

47a. IF YES, have you had sex with someone who shared needles to inject (shoot up) anything such as drugs of steroids or vitamins in the last 3 months? …… Y(1)/ N(0)

48. Have you ever had sex with someone you knew or suspected had a sexually transmitted disease other than HIV?..... Y(1)/ N(0)

48a. IF YES, have you had sex with someone you knew or suspected had a sexually transmitted disease other than HIV in the last 3 months? …… Y(1)/ N(0)

49. Have you ever had sex with someone you knew or suspected had HIV or AIDS? Y(1)/ N(0)

49a. IF YES, have you had sex with someone you knew or suspected had HIV or AIDS in the last 3 months? …….. …… Y(1)/ N(0)

50. Have you ever had sex with a prostitute? …… Y(1)/ N(0)

50a. IF YES, have you had sex with a prostitute in the last 3 months? …… Y(1)/ N(0)

51. Have you ever given or received sexual acts for drugs, food, or money? …… Y(1)/ N(0)

51a. IF YES, have you given or received sexual acts for drugs, food, or money in the last 3 months? ……..……Y(1)/ N(0)

52. How frequently do you use Alcohol (beer, wine, liquor)

Never…… 1
1-3 times monthly 2
Once a week …….3
Several times weekly. 4
Daily……. 5

53a. Have you consumed 5 or more drinks on 1 occasion during the past month?.....Y(1)/ N(0)

53b.Have you Consumed 4 or more drinks in 1 instance any time in the previous 3 months? ...Y(1)/ N(0)

54. Have you used marijuana in the past 90 days? ……Y(1)/ N(0)

55. Have you used drugs other than marijuana in the past 90 days?.....Y(1)/ N(0)

IX. CONTRACEPTIVE USE

56. What, if anything, do you do now to not get a sexual partner pregnant when you have sex?*[Do not read list - Interviewer will record **all** methods reported by the participant]*

	YES	**NO**		**YES**	**NO**
56a. Abstinence	1	0	56k. Depo Provera *(the shot)*	1	0
56b. Birth control pills	1	0	56l. Patch	1	0
56c. Partner sterile - Tubal ligation (tubes tied)	1	0	56m. Withdrawal	1	0
56d. IUD	1	0	56n. Rhythm	1	0
56e. Diaphragm	1	0	56o. Self sterile - *vasectomy*	1	0
56f. Male condom	1	0	56p. Emergency contraception	1	0

56g. Female condom	1	0	56q. Other **(write in at Q57)**	1	0
56h. Spermicides *(jelly, cream, foam, film or suppository)*	1	0	56r. Nothing	1	0
56i. Sponge	1	0	56s. Don't know	1	0
56j. Norplant	1	0	56t. Refused to answer	1	0

57. Type in 'other' response from '**q**' ……[_____]

58. What is the main reason(s) you are not using any birth control now? *Please choose as many of the answers on this **[card #8]** that apply to you.* **YES NO**

58a. Not having sex…… 1 0
58b. Trying to get pregnant…… ……1 0
58c. Had her tubes tied/tubal ligation/hysterectomy……1 0
58d. Had vasectomy……1 0
58e. Do not want to use birth control ……1 0
58f. Birth control is against my religion……..1 0
58g. Don't like side effects, risks to health ……. 1 0
58h. Partner does not want to use birth control…… 1 0
58i. Cannot afford birth control……1 0
58j. Other……1 0

X. SEXUAL BEHAVIOR AND CONDOM USE

When a question asks about 'oral sex', that means a person uses their mouth to stimulate their partner's penis, vaginal lips or anus for sexual pleasure.

59. How many times have you had vaginal intercourse during the past 3 months? *[if respondent has trouble answering, ask 'What would you estimate?']*....._____

59a. During how many of those (#) times did you use a condom? *[if respondent has trouble answering, ask 'What would you estimate?']*……_____

60. How many times have you had oral sex with a woman during the past 3 months? *[if respondent has trouble answering, ask 'What would you estimate?']* ……_____

60a. During how many of those (#) times did you use a condom or barrier protection such as a dental dam? *[if respondent has trouble answering, ask 'What would you estimate?']*……....._____
_

61. How many times have you had anal intercourse with a woman during the past 3 months? *[if respondent has trouble answering, ask 'What would you estimate?']* ……

_____

61a. During how many of those (#) times did you use a condom? *[if respondent has trouble answering, ask 'What would you estimate?']*…….

_____

62. Have you ever had sex with a man?.....Y(1) / N(0)

62a. IF YES: Have you had sex with a man in the last 3 months? ……. Y(1) / N(0)

62b. IF YES: How many times have you had oral sex with a man in the last 3 months? *[if respondent has trouble answering, ask 'What would you estimate?']*.....

_____

62c. During how many of those (#) times did you use a condom or a barrier protection such as a dental dam? *[if respondent has trouble answering, ask 'What would you estimate?']*……. _____

62d. IF YES: How many times have you had anal sex with a man in the last 3 months? *[if respondent has trouble answering, ask 'What would you estimate?']*..... _____

62e. During how many of those (#) times did you use a condom? *[if respondent has trouble answering, ask 'What would you estimate?']*……_____

XI. HEALTH CARE ACCESS AND SERVICES

The next few questions are about how you get health care.

[Health Insurance]

63. Do you have medical coverage (health insurance) or a medical card for your health care right now?..... Y(1)/ N(0) **[*If no skip to Q65]***

64. What type of medical coverage (health insurance) do you have? *[read list]*

Medicaid/Oregon Health Plan	1
Private insurance through my job	2
Private insurance that I pay for myself	3
Don't know	4

XII. EXPERIENCE GETTING HEALTH CARE AND SEXUAL AND REPRODUCTIVE HEALTH SERVICES FROM PROVIDERS

[General]

The next set of questions asks about *your experiences in seeing health care providers in the US.* By health care providers, we mean doctors, nurses, nurse practitioners, or midwives.

65. Have you ever seen a health care provider when you were sick or needed a checkup?..... Y(1) / N(0) **[*If no, skip to Q75]***

66. How many times in the past year did you visit a health care provider for your own health?..... _____ times

67. Where do you usually go when you are sick or need a checkup – *to a doctor's office, a clinic, a hospital emergency room, or some other place*? (If "clinic" PROBE: Is it a private or a public clinic?) *[Do not read list]*

Private Doctor's office	1
HMO facility	2

Community health clinic, community clinic, public health clinic	3
Family planning or Planned Parenthood clinic	4
Employer or company clinic	5
School or school-based-clinic	6
Hospital outpatient clinic	7
Hospital emergency room	8
Urgent care center, urgi-care or walk-in facility	9
Some other place (*Specify*:_____)	10

68. In general, how satisfied or dissatisfied would you say you are with the services you have received from health care providers? *Would you say:* ***[card #15]***

Not satisfied……..	a	1
Slightly satisfied……	b	2
Moderately satisfied…….	c	3
Very satisfied……	d	4
Extremely Satisfied……..	e	5

XIII. REPRODUCTIVE HEALTH SERVICES

When we talk about Sexual and Reproductive Health Services for men, these services include STD and HIV counseling, testing and treatment and counseling and services for family planning.

69. Have you ever seen a health care provider for sexual and reproductive health services? ……Y(1) / N(0) / DK ___ [***If no, skip to Q75]***

70. How many times in the past year did you visit a health care provider specifically for sexual and reproductive health services?..... _____ times

71. Where do you usually go for sexual and reproductive health services? *[Do not read list]*

Private Doctor's office	1
HMO facility	2
Community health clinic, community clinic, public health clinic	3
Family planning or Planned Parenthood clinic	4
Employer or company clinic	5
School or school-based-clinic	6
Hospital outpatient clinic	7
Hospital emergency room	8
Urgent care center, urgi-care or walk-in facility	9
Some other place (*Specify*:_____)	10

72. How do you pay for sexual and reproductive health services? *[read list]*

Free services	1
Insurance	2
Oregon Health Plan	3

I pay for it myself	4
A family member or friends pays for it	5
Some other way	6

73. How comfortable are you in discussing ways to prevent pregnancy and HIV/STDs with a health care provider? *Would you say:* ***[card #11]***

Not at all comfortable……	a	1
A little comfortable……	b	2
Moderately comfortable……	c	3
Very comfortable……	d	4
Extremely comfortable……	e	5

74. In general, how satisfied or dissatisfied would you say you are with the sexual and reproductive health services you have received from health care providers? *Would you say:* ***[card #15]***

Not satisfied……	a	1
Slightly satisfied……	b	2
Moderately satisfied……	c	3
Very satisfied……	d	4
Extremely Satisfied……	e	5

XIV. INVOLVEMENT IN DECISIONS TO PREVENT PREGNANCY

75. Please tell us how much do you agree with these statements about your involvement in preventing pregnancy. Use the answer choices on the following card ***[card #4]*** to answer these next questions.

a-Do not agree at all
b-Somewhat agree
c-Moderately agree
d-Mostly agree
e-Completely agree

	A	**B**	**C**	**D**	**E**
75a. Preventing pregnancy is a private decision my partner will make so there is no need for me to be involved.	1	2	3	4	5
75b. I participate in our efforts to prevent pregnancy by helping my partner get to a clinic or doctor's office.	1	2	3	4	5
75c. I participate in our efforts to prevent pregnancy by helping my partner pay for services.	1	2	3	4	5
75d. I participate in our efforts to prevent pregnancy by helping my partner use a method.	1	2	3	4	5
e.					

75f.I would like family planning clinics or doctor's offices to talk with my partner and me together about options to prevent pregnancy	1	2	3	4	5
75g.I prefer that my partner talk to family planning providers privately, without me there.	1	2	3	4	5
75h. I would like to talk to a family planning provider privately without my partner	1	2	3	4	5

76. In a perfect world, where would you prefer to go to get your sexual and reproductive health services?

1 No one usual place
2 Doctor's office or private clinic (not in a hospital)
3 Public health department, community clinic, or family planning clinic
4 Hospital emergency room
5 Hospital clinics
6 Other (specify) _____

XV. PREFERENCES FOR WHERE/HOW/WHEN TO RECEIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES (Q77-79)

Please tell us how much do you agree with these statements about your preference for receiving sexual and reproductive health services. Use the answer choices on the following card *[card #4]* to answer these next questions.

a-Do not agree at all
b-Somewhat agree
c-Moderately agree
d-Mostly agree
e-Completely agree

77. I would prefer to learn more about sexual and reproductive health services…:

	A	**B**	**C**	**D**	**E**
77a. by attending a class at a community location (e.g. library, community center).	1	2	3	4	5
77b. by attending a class at a doctor's office or clinic.	1	2	3	4	5
77c. by attending a class at my workplace.	1	2	3	4	5
77d. at a doctor's office or clinic.	1	2	3	4	5
77e. other	1	2	3	4	5

78. I would prefer to attend a class…:

	A	**B**	**C**	**D**	**E**

78a. With my sexual partner.	1	2	3	4	5
78b. With only men.	1	2	3	4	5
78c. With other couples (e.g. married or boyfriend/girlfriend)	1	2	3	4	5
78d. With men and women	1	2	3	4	5
78e. Other _____	1	2	3	4	5

79. I would prefer a class to be taught by…:

	A	**B**	**C**	**D**	**E**
79a. a doctor.	1	2	3	4	5
79b. a nurse.	1	2	3	4	5
79c. a health educator	1	2	3	4	5
79d. a promoter/a	1	2	3	4	5
79e. other _____	1	2	3	4	5

XVI. DISCRIMINATION & MEDICAL MISTRUST

This next set of questions asks about your *personal experiences with and perceptions about discrimination when getting health care*. The questions also ask about *your interactions with health care providers in general, not just family planning providers.*

[Experiences of Discrimination Scale]

For these next questions please choose your answers from the choices on this next card **[*Card #18*].**

a-Never
b-Rarely
c-Sometimes
d-Most of the time
e-Always

80. How often have you experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior in any of the following situations because of your race, ethnicity, or color?

	A	B	C	D	E
80a. At school?	1	2	3	4	5
80b. Getting hired or getting a job?	1	2	3	4	5
80c. At work?	1	2	3	4	5

80d. Getting housing?	1	2	3	4	5
80e. Getting medical care?	1	2	3	4	5
80f. Getting services in a store or restaurant?	1	2	3	4	5
80g. Getting credit, bank loans, or a mortgage?	1	2	3	4	5
80h. On the street or in a public setting?	1	2	3	4	5
80i. From the police or in the courts?	1	2	3	4	5

[Perceived Personal Discrimination in Interactions with Health Care Providers]

SKIP THE SECTION BELOW
IF PARTICIPANT NEVER USED HEALTH CARE SERVICE –
IF THEY ANSWERED NO to Q65

In answering these next questions I want you to choose your answers from **this same card #18**

a-Never
b-Rarely
c-Sometimes
d-Most of the time
e-Always

81. When getting health care of any kind, have you ever had any of the following things happen to you because of your race or ethnicity?

	A	B	C	D	E
81a. Been treated with less courtesy than other people.	1	2	3	4	5
81b. Been treated with less respect than other people.	1	2	3	4	5
81c. Received poorer service than others.	1	2	3	4	5
81d. Had a doctor or nurse act as if he or she thinks you are not smart.	1	2	3	4	5
81e. Had a doctor or nurse act as if he or she is afraid of you.	1	2	3	4	5
81f. Had a doctor or nurse act as if he or she is better than you.	1	2	3	4	5
81g. Felt like a doctor or nurse was not listening to what you were saying.	1	2	3	4	5

[Medical Mistrust]

82. Now *I am going to read you some statements regarding doctors and health care providers*. For each one, please *tell me how much you disagree or agree with each of the statements*. Choose your answers from one of the choices on this card ***[Card #4]*:**

a-Do not agree at all
b-Somewhat agree
c-Moderately agree

d-Mostly agree
e-Completely agree

	A	B	C	D	E
82a. People of my ethnic group cannot trust doctors and health care workers.	1	2	3	4	5
82b. People of my ethnic group should be suspicious of information from doctors and health care workers.	1	2	3	4	5
82c. People of my ethnic group should not confide in doctors and health care workers because it will be used against them.	1	2	3	4	5
82d. People of my ethnic group should be suspicious of modern medicine.	1	2	3	4	5
82e. Doctors and health care workers have sometimes done harmful experiments on people of my ethnic group.	1	2	3	4	5
82f. Doctors and health care workers do not take the medical complaints from people of my ethnic group seriously.	1	2	3	4	5
82g. People of my ethnic group receive the same medical care from doctors and health care workers as people from all other groups.	1	2	3	4	5
82h. In most hospitals, people of all ethnic groups receive the same kind of care.	1	2	3	4	5
82i. Doctors have the best interests of people of my ethnic group in mind.	1	2	3	4	5
82j. Doctors and health care workers have sometimes deceived or misled patients who belong to my ethnic group.	1	2	3	4	5
82k. I personally have been treated poorly or unfairly by doctors or health care workers because of my ethnicity.	1	2	3	4	5
82l. Clinics or health care centers that receive special funds for Latino health care sometimes do not use these funds to provide services.	1	2	3	4	5

83. Have you completed an interview for this project, *Proyecto de Salud para Latinos? (CDC-funded project with data collected between October 2007 and September 2008)*…Y(1) / N(0)

We're almost finished – I just have one more question for you.

84. How did you hear about this study? *[read list; check all that apply]*

	YES	**NO**
84a. Radio	1	0
84b. Flyer, poster, or other printed material	1	0
84c. Approached by a recruiter	1	0

~~84d. Referred by a (male/ female] partner who participated in the study~~		
84e. Referred by female friend	1	0
84f. Referred by a male friend	1	0
84g. Referred by a community agency	1	0
84h. Other (please specify)	1	0

That was your last question. Thank you so much for helping us out. *The information you gave us is very important to help us better understand* what influences sexual risk behaviors and use of sexual and reproductive health services by Latino men in rural Oregon. As I said in the beginning, everything you told me today will remain private. Your name will not be on any of the information.

Appendix D

Interview Guide Spanish Version

Recruitment Location:	
Benton County……	a
Lane County……	b
Linn County…….	c
Marion County…….	d
Polk County…….	e
Other	f

Interviewer:	_____
Date:	_____
Start Time:	_____
Stop Time:	_____

PROYECTO DE SALUD PARA LATINOS
LATINO HEALTH PROJECT

PARA HOMBRES (12/19/08; 01/09/09; 02/13/09; 3/11/09; RevQual = 3/19/09**, 4/15/09 Q77p32**)

De nuevo, mi nombre es _____. Te agradezco nuevamente por aceptar hablar conmigo hoy. Nos interesa aprender más acerca de las influencias que afectan los comportamientos de alto riesgo relacionados con la actividad sexual y el uso de planificación familiar y los servicios de atención de la salud sexual y reproductiva por los hombres latinos en las áreas rurales de Oregon. Pero antes de pasar a las siguientes preguntas, me gustaría conocer un poco más de ti.

I. Social Context

6. ¿Dime como llegaste a vivir en Oregon?

   1a. ¿Por qué te moviste aquí?

   PROBE: (e.g. earn money and return to Mexico, better job, be with family)
   PROBE: ¿Fue fácil para ti hacerlo?

   1b. ¿Como es la vida aquí diferente comparada a tu vida en México/país de origen?

7. ¿En que trabajas?

   2a. ¿Trabajas en algún otro lado?

   2b. Háblame acerca de tu horario, tratamiento, si estas expuesto a riesgos.

2c. ¿Cambias de trabajos durante el año?

PROBE: ¿A que? ¿Por qué?

8. ¿En donde vives?

3a. ¿Has vivido allí por mucho tiempo?

3b. ¿Por cuanto tiempo piensas quedarte allí?

3c. ¿Qué es lo que te gusta acerca de vivir aquí?

3d. ¿Que es lo que no te gusta acerca de vivir aquí?

9. ¿Con quien vives?

PROBE: ¿Con tu familia? ¿Con quienes de tu familia vives? ¿Tienes algún otro pariente que vive cerca?

PROBE: ¿Solo? ¿Por que es eso?

PROBE: ¿Con otros hombres? ¿Quien? ¿Por que? ¿Por qué vives con ellos?

10. Háblame más acerca de tu familia.

5a. ¿Tienes esposa o una novia?

5b. Háblame más acerca de eso.

PROBE: ¿Han estado juntos por mucho tiempo?

5b. ¿También vive aquí?

5c. ¿Tienes hijos? ¿Están aquí contigo?

5d. Háblame mas acerca de otros miembros de tu familia, ¿están aquí? ¿Todavía en México/país de origen?

PROBE: ¿Quiénes de tu familia todavía viven en México/América Latina? – ¿Que tipo de relación tienes con tu familia? ¿Como te mantienes en contacto?

II. Social and Sexual Relationships

6. Háblemos más acerca de tus amigos en Oregon. ¿Con quien vas cuando necesitas algo?

7. ¿A dónde vas y que haces para divertirte?

PROBE: Dances, bars, bowling, soccer, libraries, etc.

8. ¿Qué hacen hombres solteros cuando se sienten solos?

   8a. ¿Qué hacen cuando quieren estar con una mujer y no tienen novia?

   8b. ¿Cómo es que los hombres solteros que viven aquí llegan a conocer mujeres?

   8c. If single: ¿Cómo llegas a conocer mujeres?

   8d. If single: ¿Qué haces cuando quieres estar con una mujer y no tienes novia?

   8e. If single: ¿Qué haces cuando te sientes solo?

9. A veces hombres latinos quienes tienen sus esposas en México/ su país de origen tienen relaciones sexuales con mujeres aquí en los Estados Unidos. ¿Piensas que ocurre eso aquí?

   9a. ¿Qué tal hombres que conoces?

   9b. ¿Que opinas acerca de esto?

   9c. If unaccompanied by wife/partner: ¿Y tu …estas en una situación similar ?

10. Algunos hombres latinos quienes están casados o juntados o están en relaciones comprometidas tienen relaciones con otras mujeres. ¿Por qué piensas que esto ocurre?

    10a. ¿Y a ti? Tu estas [casado, juntado, no acompañado]

    10b. ¿Te ha ocurrido esto?

    10c. ¿Por qué?

    10d. ¿Entonces que opinas acerca de los hombres quienes tienen una relación comprometida y tienen relaciones sexuales con múltiples parejas?

11. ¿Qué tan común es para los hombres latinos tener relaciones sexuales con las prostitutas?

    11a. ¿Que tan disponibles están?

    11b. ¿Qué se paga para el sexo?

        PROBE: dinero, drogas, alcohol, otra

11c. ¿Hay drogas/alcohol envueltos?

11d. ¿Has estado con una prostituta en Oregon?

PROBE: Si no en Oregon, en los Estados Unidos?

11e. If YES, háblame más acerca de esta.

PROBE: ¿Prefieres/buscas una prostituta particular? ¿Por qué o porqué no?

11f. If YES, ¿utilizas un condón cuando tienes relaciones sexuales con una prostituta?

11g. ¿Por qué o porque no?

12. ¿Qué tan común es para los hombres latinos tener relaciones sexuales con otros hombres aquí en los Estados Unidos?

12a. ¿Has tenido relaciones sexuales con un hombre y puedes hablar conmigo más acerca de eso?

III. Cultural Values

13. ¿Qué significa la palabra "machismo" para ti y como describirías un hombre que es macho?

13a. ¿Piensas en ti mismo como macho?

13b. ¿Por qué o por qué no?

14. ¿Crees que es importante enseñarles el machismo a los hijos?

15. ¿Cómo son las relaciones íntimas entre los hombres y las mujeres diferentes aquí en los Estados Unidos en comparación con tu país de origen?

16. ¿Cómo llega uno a ser respetado en su comunidad?

IV. Health

Ahora, quiero hablar contigo acerca de tu salud.

17. ¿Cuál es la preocupación más importante que tienes acerca de tu salud?

18. Cuando yo digo, "salud reproductiva y sexual", ¿que significa para ti?

19. ¿Qué preocupaciones tienes acerca de tu salud sexual?

PROBE: ¿Tienes algunas preocupaciones acerca de las enfermedades transmitidas sexualmente, el VIH, dolor del pene, anticonceptivos o alguna otra cosa?

20. ¿Cuándo tienes preocupaciones como estas, a donde vas?

    PROBE: ¿Vas con un medico o a una clínica? ¿Por qué o por qué no?

    PROBE: ¿Cómo tomas la decisión si necesitas ir con un doctor? ¿Por qué no lo harías?

21. ¿Alguna vez has ido con un curandero para un problema de salud sexual?

    21a. ¿Por qué o por qué no?

V. STDs/HIV Prevention, Testing and Treatment

STDs – Knowledge, attitudes and practice

22. Hay algunas enfermedades que puedes contraer teniendo relaciones sexuales. Estas se llaman enfermedades transmitidas sexualmente o ETS. Dime lo que has oído acerca de estos tipos de enfermedades.

Al decir ETS, nos referimos a diferentes infecciones que son transmitidas sexualmente. Las enfermedades transmitidas sexualmente también se llaman enfermedades venéreas.

23. ¿Cómo puedes notar si una persona tiene una ETS?

24. ¿Por qué crees que los hombres latinos toman estos riesgos?

25. ¿Qué tan preocupado estas que podrías infectarte con una enfermedad transmitida sexualmente?

    25a. ¿Por qué o por que no?

26. ¿Cómo puedes evitar ser infectado?

27. ¿Qué harías si te contagiarás con una ETS?

    27a. ¿A dónde irías para hacerte un examen para las ETS y/o para recibir tratamiento?

28. Nos interesa en conocer más sobre tu uso de servicios para las ETS desde que has vivido en Oregon. ¿Has usado servicios para las ETS incluyendo conserjería, un examen, y tratamiento en Oregon?

    If Yes (has usado servicios para las ETS en Oregon):

28a. ¿A dónde fuiste?

28b. Háblame acerca de esa experiencia.

28c. ¿Qué podría haber hecho la clínica/proveedor medico para mejorar tu experiencia?

28d. ¿Regresarías a esa clínica? ¿Por qué o por qué no?

28e. ¿La recomendarías a un amigo a recibir servicios para detectar las ETS en esa clínica?

If No (no has usado servicios para las ETS en Oregon):

28Xa. ¿Por qué no?

28Xb. ¿Que piensas que te impide o te desanima para que no vayas?

28Xc. ¿Que puede hacer la clínica/proveedor medico para que te sientas mas cómodo para que vayas?

HIV/AIDS Knowledge, Attitudes and Practice

29. Dime lo que has escuchado acerca del VIH/SIDA

HIV/AIDS – Knowledge, attitudes and practice; testing

30. ¿Qué causa el VIH/SIDA?

Es a esto a lo que nos referimos con las palabras VIH/SIDA: el VIH es un virus que se puede transformar al Síndrome de Inmunodeficiencia Adquirida (SIDA), que actúa a reducir la habilidad del cuerpo a combatir las infecciones.

31. ¿Cómo puedes notar si un hombre o una mujer tiene el VIH/SIDA?

32. ¿Por qué crees que los hombres latinos toman estos riesgos?

33. ¿Qué tan preocupado estas que podrías ser infectado con el VIH/SIDA?

33a. ¿Por qué o por que no?

34. ¿Cómo puedes evitar ser infectado?

35. ¿A donde irías para hacerte un examen para detectar el VIH/SIDA en Oregon?

36. ¿Alguna vez te has hecho un examen para detectar el VIH/SIDA?

37. If YES, ¿te has hecho un examen para detectar el VIH/SIDA/has usado servicios para detectar el VIH/SIDA desde que has vivido en Oregon?

    If Yes (has usado servicios para detectar el VIH/SIDA en Oregon):

    38a. ¿A dónde fuiste?

    38b. Dime acerca de esa experiencia.

    38c. ¿Qué podrían haber hecho la clínica/proveedor medico para mejorar tu experiencia?

    38d. ¿Regresarías a esa clínica?

    PROBE: ¿Por qué o por que no?

    38e. ¿La recomendarías a tus amigos que vayan a esa misma clínica para hacerse un examen del VIH/SIDA?

    If No (nunca jamás has recibido servicios para detectar el VIH/SIDA):

    38Xa. ¿Por qué no?

    38Xb. ¿Que piensas que te impide o te desanima para que no vayas?

    38Xc. ¿Que puede hacer la clínica/proveedor medico para que te sientas mas cómodo para que vayas?

VI. Family Planning Services

Attitudes about Family Planning

39. Nos interesa conocer tus experiencias y opiniones acerca de la planificación familiar. ¿Por favor me puedes describir lo que significa la planificación familiar para ti?

Al decir planificación familiar, nos referimos a planear acerca de tener o no y cuando tener hijos e utilizando métodos anticonceptivos también llamados control de natalidad.

40. ¿Qué tan importante es la planificación familiar para ti?

41. ¿Dime como aprendiste acerca de las relaciones sexuales?

    PROBE: ¿Qué o cuanto hablaron tus padres acerca de la relaciones sexuales?

PROBE: ¿Por tus amigos? - ¿Por parientes? (¿Por un hermano mayor o un primo?); ¿por la escuela, el internet, televisión, mujeres, amigos casados?

Birth Control use and concerns

42. Nos interesa en tus experiencias y opiniones acerca de los métodos anticonceptivos. ¿Por favor me puedes describir lo que significa los métodos anticonceptivos para ti?

    42a. ¿Como aprendiste acerca de los métodos anticonceptivos?

PROBE: ¿Por tus amigos? - ¿Por parientes? (¿Por un hermano mayor o un primo?); ¿por la escuela, el internet, televisión, mujeres, amigos casados?

43. ¿Alguna vez has usado métodos anticonceptivos con una pareja? Si o No.

    43a. IF YES, ¿Cuales métodos has usado para prevenir el embarazo?

    43b. IF YES, ¿Cuales métodos utilizan las mujeres con las que tienes relaciones?

    43c. IF YES, Háblame acerca de tus experiencias con estos métodos, ¿Cómo lo que te gusto y lo que no te gusto?

    43Xa. IF **never used** birth control with any partner, ¿Por qué no?

        PROBE: ¿Por que dirías eso?,

        PROBE: ¿que mas dirías?

44. ¿Cuáles son tus preocupaciones acerca del uso de métodos anticonceptivos?

45. ¿Qué piensas acerca de interrumpir el coito al momento de tu orgasmo para prevenir el embarazo?

Un método anticonceptivo disponible para hombres es hacerse una vasectomía. Una vasectomía es un método anticonceptivo permanente para hombres e incluye hacerse una cirugía.

46. ¿Considerarías hacerte una vasectomía?

    46a. ¿Por qué o por que no?

47. ¿Interfiere el uso de métodos anticonceptivos, como píldoras o la inyección, o condones, con la voluntad de Dios/el destino?

    47a. ¿Por qué o por que no?

48. ¿Utilizando métodos anticonceptivos iría contra tus creencias religiosas personales?

Experiences with getting family planning services. Nos interesa en aprender mas acerca tu uso de servicios de planificación familiar.

49. ¿Alguna vez has usado servicios de planificación familiar en los Estados Unidos? Si o No.

    49a. IF YES, ¿en cual estado(s)? **List here:**_____

    49b. ¿Alguna vez has usado servicios de planificación familiar en Oregon? Si o No.

    If YES (si has usado servicios de planificación familiar en Oregon)

    49c. ¿A donde fuiste?

    49d. Háblame acerca de esa experiencia.

    49e. ¿Qué podrían haber hecho la clínica/proveedor medico para mejorar tu experiencia?

        PROBE: ¿Qué te gusto o no te gusto?

    49f. ¿Regresarías a esa clínica?

    49g. ¿Recomendarías esta clínica de planificación familiar a tus amigos?

    If NO (you have not used family planning services in Oregon)

    49Xa. ¿Por qué no?

    49Xb. ¿Que piensas que te impide o te desanima para que no vayas?

    49Xc. ¿Que puede hacer la clínica/proveedor medico para que te sientas mas cómodo para que vayas?

    49Xd. ¿A dónde irías para conseguir los servicios de planificación familiar se las tendrías que usar?

VII. Barriers/Facilitators to use of SRHS including structural and service delivery factors

Estamos consientes que hombres latinos no van a las clínicas para los servicios de salud sexual como conserjería, exámenes para detectar y el tratamiento para las ETS y el VIH además para los servicios de planificación familiar.

50. ¿Por qué opinas que los hombres latinos no van a las clínicas para estos servicios?

PROBE: ¿Es relacionado por donde están localizadas las clínicas?

PROBE: ¿Es relacionado por si están disponibles servicios de traducción?

PROBE: ¿Es relacionado por tratando a los hombres con respeto? ¿Por el proveedor medico? ¿Por qué?

Queremos tratar de entender tus experiencias viviendo aquí en Oregon como emigrante recién.

51. ¿Alguna vez has sido discriminado o te hicieron sentir que estabas de mas/importuno?

51a. ¿Qué paso o me puedes decir mas?

52. ¿Por qué opinas que fuiste tratado injustamente?

53. ¿Alguna vez has sido discriminado o te hicieron sentir que estabas de mas/importuno en una clínica o un hospital?

53a. ¿Qué paso o me puedes decir mas?

53b. ¿Por qué opinas que fuiste tratado injustamente?

54. ¿Como deseas ser tratado cuando consigues atención de la salud?

55. ¿Has sido tratado en esa manera?

PROBE: ¿Y que acerca de respeto?

PROBE: ¿Y que acerca de confianza?

More specific information about recent sexual history.

56. Me dijiste anteriormente que habías tenido relaciones sexuales con una mujer durante los últimos tres meses. Deseamos aprender más sobre eso. ¿Con cuantas diferentes mujeres has tenido relaciones sexuales en los últimos tres meses?

_____

57. Me gustaría preguntarte algo más acerca de esta persona. Recuerda que tus respuestas se mantendrán confidenciales. **Piensa en tu pareja mas reciente.**

57a. ¿Cómo describirías tu relación con esta persona? ¿Qué significa eso?

PROBE: Entonces, dirías que:

- Son solo amigos
- Están saliendo en forma casual
- Están saliendo en forma exclusiva
- Están comprometidos
- Están casados
- Aventura de una noche
- Alguien a quien pagaste para tener sexo
- Otra (alguien con que tienes sexo cuando lo deseas, segunda esposa, querida, amiga con beneficios, amante)

Condones

57b. Cuándo tuviste relaciones sexuales con esta persona ¿utilizaste un condón?

57c. ¿Por qué no?

PROBE: ¿Es esto algo que hablan?

57d. ¿Quien toma la decisión acerca el uso o no del condón?

57e. ¿Me puedes decir más?

Birth Control

57f. Cuándo tuviste relaciones sexuales con esta persona ¿utilizaste un método anticonceptivo?

57g. ¿Por que o por que no?

(If a respondent says they are using condoms as birth control then SKIP TO **Q58**)

(If respondent says they are not using birth control skip to**Q57i** and continue)

(If respondent says they are using a method other than condoms continue with **Q57h**)

57h. ¿Cuál método utilizaste y con que frecuencia?

57i. ¿Quién toma la decisión acerca el uso o no del método anticonceptivo?

57j. ¿Me puedes decir más?

2nd most recent partner – if applicable

58. Me gustaría preguntarte algo más acerca de esta **segunda** persona. Recuerda que tus respuestas se mantendrán confidenciales.

58a. ¿Cómo describirías tu relación con esta persona? ¿Qué significa eso?

PROBE: Entonces, dirías que:

- Son solo amigos
- Están saliendo en forma casual
- Están saliendo en forma exclusiva
- Están comprometidos
- Están casados
- Aventura de una noche
- Alguien a quien pagaste para tener sexo
- Otra (alguien con que tienes sexo cuando lo deseas, segunda esposa, querida, amiga con beneficios, amante)

58b. Cuándo tuviste relaciones sexuales con esta persona ¿utilizaste un condón?

58c. ¿Por qué o por qué no?

58d. ¿Quien tomo la decisión acerca el uso o no del condón?

58e. ¿Me puedes decir más?

Birth Control

58f. Cuándo tuviste relaciones sexuales con esta persona ¿utilizaste un método anticonceptivo?

58g. ¿Por qué o por qué no?

(If a respondent says they are using condoms as birth control then SKIP TO **Q59**)

(If respondent says they are not using birth control skip to **Q58i** and continue)

(If respondent says they are using a method other than condoms continue with **Q58h**)

58h. ¿Cuál método utilizaste y con que frecuencia?

58i. ¿Quién tomo la decisión acerca el uso o no del método anticonceptivo?

58j. ¿Me puedes decir más?

3rd most recent partner – if applicable

59. Me gustaría preguntarte algo más acerca de esta **tercera** persona. Recuerda que tus respuestas se mantendrán confidenciales.

59a. ¿Cómo describirías tu relación con esta persona? ¿Qué significa eso?

PROBE: Entonces, dirías que:

- Son solo amigos
- Están saliendo en forma casual
- Están saliendo en forma exclusiva
- Están comprometidos
- Están casados
- Aventura de una noche
- Alguien a quien pagaste para tener sexo
- Otra (alguien con que tienes sexo cuando lo deseas, segunda esposa, querida, amiga con beneficios, amante)

59b. Cuándo tuviste relaciones sexuales con esta persona ¿utilizaste un condón?

59c. ¿Por qué o por qué no?

59d. ¿Quien tomo la decisión acerca el uso o no del condón?

59e. ¿Me puedes decir más?

Birth Control

59f. Cuándo tuviste relaciones sexuales con esta persona ¿utilizaste un método anticonceptivo?

59g. ¿Por qué o por qué no?

(If a respondent says they are using condoms as birth control then SKIP TO **Quantitative section**)

(If respondent says they are not using birth control skip to **Q59i** and continue)

(If respondent says they are using a method other than condoms continue with **Q59h**)

59h. ¿Cuál método utilizaste y con que frecuencia?

59i. ¿Quién tomo la decisión acerca el uso o no del método anticonceptivo?

59j. ¿Me puedes decir más?

QUANTITATIVE QUESTIONS 12/17/08

Ahora voy a hacerte preguntas donde te voy a pedir que elijas tus respuestas de una variedad de opciones utilizando estas tarjetas.

I. SOCIODEMOGRAPHICS/SOCIAL CONTEXT

1. ¿Cuánto tiempo has vivido en los Estados Unidos? ……._____
2. ¿Cuánto tiempo has estado en Oregon (meses, años)? ……___ months, ___ years
3. Antes de venir a Oregon (esta vez), viviste en:

Otro lugar en
los Estados Unidos..... 1 **3a. List State(s):**
_____
o veniste a Oregon directamente de México/tu país 2

4. ¿Cuántos años tienes?.....…… …. _____
5. ¿Ahora estas trabajando?.....Y(1) / N(0)

[If 'NO' skip to Q8]

6. ¿En que trabajas? ***[Check ALL that apply - do not read responses]***	YES	NO
6a. Farming/Agriculture (food, trees) ***[Dime lo que es]]***	1	0
6b. Service Industry, Sales (Restaurants, hotel, retail)	1	0
6c. Factory Work (furniture)	1	0
6d. Construction (framing crews, roofers)	1	0
6e. Technicians/Related support (computer technician, a member of a crew that installs heating systems)	1	0
6f. Precision Production/Craft/Repair (mechanic, custom cabinet maker)	1	0
6g. Transportation/Material Moving (commercial driver)	1	0
6h. Child Care	1	0
6i. Administrative Support, including Clerical (office assistant)	1	0

6j. Administrators and Managers (office manager, retail manager)	1	0
6k. Professional Specialty (nurse, therapist, teacher)	1	0
6l. Social Services (Head Start worker, health educator)	1	0
6m. Other	1	0

7. ¿Cuántas horas trabajas a la semana? _____ horas por semana

8. ¿Cuántos años de estudios ha completado? ***[If completed GED = 12].....*** yrs_____

9. No incluyendo clases para aprender inglés, ¿cuántos años de estudios has completado en los Estados Unidos? _____

10. ¿Actualmente vas a la escuela?..... Y(1) / N(0)

11. No incluyendo a ti mismo, ¿cuántas personas viven en tu hogar? Por favor cuenta bebes y niños además de adultos.

[INTER: If necessary, explain that "lives in household" means "lives with you most of the time."]

number in household

12. ¿En que tipo de lugar vives? Es:

Una tráiler .. 1
Una casa .. 2
Un apartamento .. 3
Un campo de labor ..4
U otro tipo de lugar .. 5

12 a. **(if 5)** Specify other kind of place _____

13. ¿Cuál es el total ingreso familiar anual (incluyendo ganancias, asistencia social, pensión alimenticia de hijos, etc? ..... $_____

14. ¿Cuántas personas son mantenidos con ese ingreso total, a ti incluido? ..._____

15. En un mes usual u ordinario, dirías que:

Puedes pagar
todas tus cuentas 1
o hay algunas cuentas las cuales no
las puedes pagar cada mes 2

16. ¿Envías dinero a miembros de tu familia o parientes en México/tu país?

No. 1

Sí 2

17. ¿De que raza u origen étnico perteneces? *Dirías…. [read responses; mark all that apply]*

	YES	NO
17a. Indio americano o nativo de Alaska.....	1	0
17b. Asiático …….	1	0
17c. Negro o afro americano …..……	1	0
17d. Hispano/latino……. .	1	0
17e. Nativo de Hawai o de otra	1	0
17f. isla del Pacífico …….. .	1	0
17g. Blanco……	1	0
17h. Otro…….	1	0

18. ¿Cuál es tu preferencia de religión? *[do not read responses]* *(combines CDC2.14&15)*

Protestante……1
Católico……2
Judío……3
Otra……4 **y por favor especifícalo**: _____
Ninguna……5

19. ¿Qué tan importante es para ti tu fe religiosa? Dirías:

Para nada importante…… 1
Un poco importante…….. 2
Moderadamente importante..... 3
Muy importante……. 4
Sumamente importante……... 5

20. ¿Dónde naciste? *[Do not read responses]*

México…….. 1
Otro país *fuera de los EE. UU.*
y América Latina …. [Skip to Q23] …….2 **& list here**

_____
EE. UU. ……[Skip to Q23]..... 3
Centroamérica……...…..[Skip to Q23]…….. 4
Sudamérica……..[Skip to Q23]…….. 5
El Caribe……[Skip to Q23]…….. 6
No sabe……. [Skip to Q23]..... 7

21. ¿En qué estado de México? *[Do not read responses]*

Oaxaca……... 1
Chiapas…….. 2
Michoacan……. 3
Jalisco……. 4
Guanajuato…… 5

Other …….. 6

& list here _____

22. Piensa acerca del lugar en donde creciste en México/tu país, o el lugar donde estuviste por la mayoría de tu niñez. Lo describirías como:

Un *rancho* (área rural) 1
Un pueblo 2
Una ciudad pequeña 3
Una ciudad grande pero
no el Distrito Federal……..……...…….4
O el Distrito Federal ....…..5

23. ¿Dónde nació tu madre? *[Do not read responses]*

México……..……1
Otro país *fuera de los EE. UU.*
y América Latina ..……...…….. .2
EE. UU…….....3
Centroamérica……..…….. 4
Sudamérica……..……..... 5
El Caribe……...……..... 6
No sabe……..... 7

24. ¿Dónde nació tu padre? *[Do not read responses]*

México…… 1
Otro país *fuera de los EE. UU.*
y América Latina ..……...…….. 2
EE. UU……..... 3
Centroamérica……...……4
Sudamérica……..……..... 5
El Caribe……...……..... 6
No sabe……..... 7

25. ¿Cuál es tu estado civil?

Casado y viviendo con mi esposa 1
Casado pero mi esposa vive en México/mi país 2
Juntado 3
Soltero, viviendo con mi pareja 4
Soltero 5
Otro …….. 6 **List**: _____

25a. If Single, ¿actualmente estas en una relación sexual?**Yes(1)/ No(0) [If No, Skip to Q26]**

25b. If Yes, ¿con cuantas parejas estas teniendo relaciones sexuales ……0, 1, 2, 3, 4, etc.

26. ¿Cuántos hijos tienes (en total)? _____

27. Actualmente, ¿cuántos hijos viven contigo? _____

28. ¿Como describirías tu estado de salud actual?

Excelente 1
Bien 2
Adecuado 3
Mal 4

II. ACCULTURATION

29. *Al responder las siguientes preguntas, elija como respuesta una de las opciones que aparecen en esta tarjeta.* ***[Card #2]:***

a-Solo español
b-Más español que inglés
c-Los dos por igual
d-Más inglés que español
d-Solo inglés

	A	**B**	**C**	**D**	**E**
29a. En general, ¿qué idioma(s) lees y hablas?	1	2	3	4	5
29b. ¿Qué idioma usabas cuando eras niño?	1	2	3	4	5
29c. ¿Qué idioma(s) hablas generalmente en tu hogar?	1	2	3	4	5
29d. ¿En qué idioma(s) piensas generalmente?	1	2	3	4	5
29e. ¿En qué idioma(s) hablas generalmente con tus amigos?	1	2	3	4	5
29f. ¿En qué idioma(s) se habla en los programas de televisión que ves generalmente?	1	2	3	4	5
29g. ¿En qué idioma(s) se habla en los programas de radio que escuchas generalmente?	1	2	3	4	5
29h. En general, ¿en qué idioma(s) se habla en las películas, los programas de televisión y los programas de radio que prefieres ver y escuchar?	1	2	3	4	5

30. *Al responder las siguientes preguntas, elija como respuesta una de las opciones que aparecen en esta tarjeta.* ***[Card #3]:***

a-Todos(as) de origen latino
b-Más de origen latino que de origen no latino
c-Aproximadamente mitad de origen latino y mitad no
d-Más de origen no latino que latino
e-Todos(as) de origen no latino

	A	B	C	D	E
30a. Tus amigos cercanos son…	1	2	3	4	5
30b. Prefieres ir a reuniones sociales/fiestas en las que las personas sean…	1	2	3	4	5
30c. Las personas a quienes visitas o que te visitan son…	1	2	3	4	5
30d. Si pudieras elegir los amigos de tus hijos, desearías que fueran…	1	2	3	4	5

III. CULTURAL NORMS

A continuación, voy a leerte algunas declaraciones. Para cada declaración, dime en qué medida estas de acuerdo. Elija como respuesta una de las opciones que aparecen en esta tarjeta. ***[Card #4]:*** a-Para nada de acuerdo
b-Relativamente de acuerdo
c-Medianamente de acuerdo
d-En gran medida de acuerdo
e-Totalmente de acuerdo

31. Machismo	**A**	**B**	**C**	**D**	**E**
31a. Un hombre no se debe casar con una mujer más alta que él.	1	2	3	4	5
31b. Es la responsabilidad de la madre dar a sus hijos un entrenamiento religioso apropiado.	1	2	3	4	5
31c. No se debe permitir que los niños varones jueguen con muñecas o con otros juguetes de niñas.	1	2	3	4	5
31d. Los padres deben tener un control más estricto sobre sus hijas que de sus hijos.	1	2	3	4	5
31e. Existen algunos empleos que, sencillamente, no deben ser para mujeres.	1	2	3	4	5
31f. Es más importante que una mujer aprenda a ocuparse de su hogar y de su familia, en vez de una educación universitaria.	1	2	3	4	5
31g. Una mujer nunca debe contradecir a su esposo en público.	1	2	3	4	5
31h. Los hombres son más inteligentes que las mujeres.	1	2	3	4	5
31i. No importa lo que diga la gente, a las mujeres realmente les gustan los hombres dominantes.	1	2	3	4	5

31j. Es bueno que haya cierta igualdad en el matrimonio, pero en general, el padre debe tener la última palabra en los asuntos familiares.	1	2	3	4	5
31k. En general, es mejor ser hombre que mujer.	1	2	3	4	5
31l. La mayoría de las mujeres tienen poco respeto por los hombres débiles.	1	2	3	4	5
31m. Me sentiría más cómodo si tuviera un jefe (de trabajo) en lugar de una jefa.	1	2	3	4	5
31n. Es importante que un hombre sea fuerte.	1	2	3	4	5
31o. No se debe permitir que las niñas jueguen con juguetes de niños como soldados o pelotas de fútbol.	1	2	3	4	5
31p. Las esposas deben respetar la posición del hombre como jefe de familia.	1	2	3	4	5
31q. El padre siempre sabe qué es lo mejor para la familia.	1	2	3	4	5
31r. Tener hijos hace que una mujer sea más importante en su familia y en su comunidad.	1	2	3	4	5
31s. Si una mujer tiene hijos, su familia y sus amigos la querrán mucho más.	1	2	3	4	5
31t. Las mujeres deben tener la mayor cantidad de hijos posibles.	1	2	3	4	5
31u. Si una mujer tiene hijos, su esposo o novio la amará más.	1	2	3	4	5
31v. Si una mujer tiene muchos hijos, su esposo o novio le será más fiel.	1	2	3	4	5
31w. Si una familia tiene muchos hijos, encontrarán la manera de mantenerlos.	1	2	3	4	5

A continuación, voy a leerte algunas declaraciones. Para cada declaración, dime en qué medida estas de acuerdo. Elija como respuesta una de las opciones que aparecen en esta tarjeta. ***[Card #4]:***

a-Para nada de acuerdo
b-Relativamente de acuerdo
c-Medianamente de acuerdo
d-En gran medida de acuerdo
e-Totalmente de acuerdo

32. Familismo	**A**	**B**	**C**	**D**	**E**
32a. Los hijos siempre deben ayudar a sus padres en el cuidado de los hermanos y las hermanas menores, por ejemplo, ayudándolos a hacer la tarea, cuidándolos, etcétera.	1	2	3	4	5
32b. La familia debe controlar el comportamiento de los hijos menores de 18 años.	1	2	3	4	5
32c. Una persona debe valorar el tiempo que pasa con sus parientes.	1	2	3	4	5
32d. Una persona debe vivir cerca de sus padres y pasar tiempo con ellos frecuentemente.	1	2	3	4	5
32e. Siempre que sea necesario, una persona debe apoyar a la familia extensa, por ejemplo, a tías, tíos y parientes políticos, aunque esto implique un gran sacrificio.	1	2	3	4	5
32f. Una persona debe contar con su familia si aparece la necesidad.	1	2	3	4	5
32g. Una persona se debe sentir avergonzada si algunos de sus actos deshonran el nombre de la familia.	1	2	3	4	5
32h. Los hijos deben ayudar con los quehaceres domésticos sin esperar un pago.	1	2	3	4	5
32i. Se debe tratar a los padres y abuelos con mucho respeto, sin importar que tengan diferentes puntos de vista.	1	2	3	4	5
32j. Una persona debe involucrarse, frecuentemente, en actividades con los miembros de la familia, como por ejemplo, compartir una comida, jugar o salir juntos.	1	2	3	4	5
32k. Los padres ancianos deben vivir con sus parientes.	1	2	3	4	5
32l. Una persona debe defender siempre el honor de su familia, cueste lo que cueste.	1	2	3	4	5
32m. Los hijos menores de 18 años les deben dar a sus padres la mayor parte de sus ingresos.	1	2	3	4	5
32n. Los hijos deben vivir con sus padres hasta que se casen.	1	2	3	4	5

32o. Los hijos deben obedecer a sus padres sin cuestionarlos, aunque consideren que están equivocados.	1	2	3	4	5
32p. Una persona debe ayudar a sus padres ancianos en tiempos difíciles, por ejemplo, económicamente o compartiendo el hogar donde viven.	1	2	3	4	5
32q. Una persona debe ser buena para el bien de su familia.	1	2	3	4	5
32r. Una persona debe respetar a sus hermanos o hermanas mayores, sin importar que tengan diferentes puntos de vista.	1	2	3	4	5

IV. INTENTIONS – NOT PARTNER-SPECIFIC

33. Ahora voy a preguntarte preguntas sobre usando control de natalidad, incluyendo condones. Por favor dime en que medida estas de acuerdo con las siguientes declaraciones utilizando las opciones que aparecen en esta tarjeta. ***[Card #6]*:**

1 2 3 4 5

No es cierto en absoluto Muy cierto

33a. Intentaras usar un método anticonceptivo la próxima vez que tengas relaciones sexuales.	1	2	3	4	5
33b. Intentaras usar un método anticonceptivo cada vez que tengas relaciones sexuales durante los próximos 3 meses.	1	2	3	4	5
33c. Intentaras convencer a tu pareja sexual de utilizar condones cada vez que tengan relaciones sexuales, durante los próximos 3 meses.	1	2	3	4	5
33d. Al tener relaciones sexuales, siempre intentaras tener condones a la mano durante los próximos 3 meses.	1	2	3	4	5
33e. Intentaras usar condones cada vez que tengas relaciones sexuales durante los próximos 3 meses.	1	2	3	4	5

V. CONTRACEPTION ATTITUDES & PERCEPTIONS

[Attitudes and Barriers to Using and Getting Contraception]

34. Al responder las siguientes preguntas, indique en qué medida está de acuerdo o no con las siguientes declaraciones acerca del uso de métodos anticonceptivos, incluidos los condones. Elija como respuesta una de las opciones que aparecen en esta tarjeta. ***[Card #4]:***

a-Para nada de acuerdo
b-Relativamente de acuerdo
c-Medianamente de acuerdo
d-En gran medida de acuerdo
e-Totalmente de acuerdo

[Denial/Knowledge/Ambivalence]

	A	B	C	D	E
34a. Simplemente no pienso en usar métodos anticonceptivos.	1	2	3	4	5
34b. No creo que mi pareja vaya a quedar embarazada.	1	2	3	4	5
34c. No me preocupa si mi pareja queda embarazada.	1	2	3	4	5
34d. No tengo relaciones sexuales con mucha frecuencia.	1	2	3	4	5
34e. No importa si uso métodos anticonceptivos. Cuando mi pareja tenga que quedar embarazada, sucederá.	1	2	3	4	5
34f. Quiero que mi pareja quede embarazada.	1	2	3	4	5
34g. No sé cómo se obtienen los métodos anticonceptivos.	1	2	3	4	5
34h. No sé dónde se obtienen los métodos anticonceptivos.	1	2	3	4	5

[Norms]

34i. No es correcto usar métodos anticonceptivos.	1	2	3	4	5
34j. El control de natalidad es responsabilidad de la mujer.	1	2	3	4	5
34k. El uso de métodos anticonceptivos va contra mis creencias religiosas.	1	2	3	4	5

[Partner]

34l. Hablar con mi pareja acerca del control de natalidad es vergonzoso.	1	2	3	4	5
34m. Mi pareja no quiere que use métodos anticonceptivos. *(revised from CDC2.27m)*	1	2	3	4	5
34n. BLANK for OPA project					

[Side Effects]

34o. Me preocupan los efectos secundarios de los métodos anticonceptivos.	1	2	3	4	5
34p. A mi pareja le preocupan los efectos secundarios de los métodos anticonceptivos.	1	2	3	4	5

[Hassle]

34q. A veces, las relaciones sexuales no son planeadas.	1	2	3	4	5
34r. A veces, no hay tiempo de prepararse para tener relaciones sexuales.	1	2	3	4	5
34s. El sexo se disfruta más cuando no usamos métodos anticonceptivos.	1	2	3	4	5
34t. Tengo miedo ir al médico para obtener un método anticonceptivo.	1	2	3	4	5

[Cost]

34u. No uso métodos anticonceptivos porque son muy costosos.	1	2	3	4	5

35. ¿En qué medida estas de acuerdo o no con las siguientes declaraciones acerca de tu *capacidad para obtener* métodos anticonceptivos en la actualidad? ***[Card #4]***

a-Para nada de acuerdo
b-Relativamente de acuerdo
c-Medianamente de acuerdo
d-En gran medida de acuerdo
e-Totalmente de acuerdo

[Access]

	A	**B**	**C**	**D**	**E**
35a. Los horarios de las clínicas no son conveniente para mí.	1	2	3	4	5
35b. Tengo problemas de transporte para ir a una clínica.	1	2	3	4	5
35c. Es difícil faltar al trabajo o a la escuela para ir a una clínica.	1	2	3	4	5
35d. Toma demasiado tiempo conseguir una cita para obtener un método anticonceptivo.	1	2	3	4	5
35e. En las clínicas hay que esperar mucho tiempo.	1	2	3	4	5
35f. No tengo a nadie que cuide a mis hijos para que yo pueda ir a una clínica.	1	2	3	4	5
35g. No hay una clínica cerca de donde vivo.	1	2	3	4	5

[Embarrassment]

35h. Me avergüenza ir a obtener métodos anticonceptivos.	1	2	3	4	5

[Accommodation/Acceptability]

35i. Los proveedores médicos no me entienden.	1	2	3	4	5
35j. Me siento despreciado por los médicos de salud.	1	2	3	4	5
35k. Los proveedores médicos me hacen preguntas que me incomodan.	1	2	3	4	5
35l. Si mi pareja no tuviera que hacerse un examen pélvico, sería más probable que ella obtuviera métodos anticonceptivos.	1	2	3	4	5

[Hassle]

35m. Estoy demasiado ocupado para obtener métodos anticonceptivos.	1	2	3	4	5

35n. Obtener métodos anticonceptivos es difícil porque hay que ir a la clínica o al consultorio médico.	1	2	3	4	5

VI. PERCEIVED VULNERABILITY TO PREGNANCY AND HIV/STDS

36. Por favor responde a las siguientes preguntas utilizando la escala en esta tarjeta ***[N.º 9]*,**

1 2 3 4 5
No existen probabilidades Extremadamente probable

36a. ¿Si no usaras un método anticonceptivo qué tan probable seria que tu pareja se embarazara el próximo año?	1	2	3	4	5
36b. ¿Si no usaras un condón qué tan probable es que podrías contraer el VIH al tener relaciones sexuales?	1	2	3	4	5
36c. ¿Si no usaras un condón qué tan probable es que podrías contraer una enfermedad transmitida sexualmente que no sea el VIH al tener relaciones sexuales?	1	2	3	4	5

VII. CONDOM USE AND CONTRACEPTIVE SELF-EFFICACY – NOT PARTNER-SPECIFIC

37. A continuación, siguen algunas declaraciones acerca del uso de métodos anticonceptivos, particularmente, sobre el uso de condones masculinos. Utilizando la tarjeta ***[Card #16]*,** indique en qué medida te sientes seguro que podrías hacer cada una de estas cosas.

a-Para nada seguro
b-Un poco seguro
c-Moderadamente seguro
d-Muy seguro
e-Sumamente seguro

¿En qué medida te sientes seguro:

	A	**B**	**C**	**D**	**E**
37a. … en tu conocimiento acerca las varias maneras para prevenir o posponer el embarazo?	1	2	3	4	5
37b. … en tu habilidad de protegerte contra el embarazo no planeado?	a	b	c	d	e
37c. … de poder detener la relación sexual si tu o tu pareja no están utilizando un método anticonceptivo?	a	b	c	d	e
37d. … de poder hablar sobre el uso de métodos anticonceptivos con tu pareja?	a	b	c	d	e
37e. … de poder usar correctamente un método anticonceptivo?	a	b	c	d	e
37f. … de poder comprar o conseguir condones sin avergonzarte?	a	b	c	d	e

37g. … de poder hablar sobre el uso de condones con tu pareja?	a	b	c	d	e
37h. … de poder tener condones a la mano si acaso se necesitan?	a	b	c	d	e
37i. … de poder utilizar condones cada vez que tengas relaciones sexuales?	a	b	c	d	e
37j. … de poder negarte a tener relaciones sexuales si tu pareja no usara un condón?	a	b	c	d	e
37k. … de poder ponerte correctamente un condón?	a	b	c	d	e

38. SKIP IF NEVER USED A CONDOM. Cuando tienes relaciones sexuales y utilizas un condón, ¿por qué lo usas? *[read responses]*

Prevención de embarazo ……. 1
Prevención de enfermedades ……. 2
Prevención de embarazo y enfermedades 3
Otra……... 4

VIII. HIV AND STI RISK FACTORS - REPRODUCTIVE AND SEXUAL HISTORY

Ahora voy a hacerte preguntas acerca de tu salud sexual y reproductiva. Algunas de las siguientes preguntas se tratan sobre el sexo vaginal y anal. Cuando una pregunta se refiere a "sexo vaginal", significa relaciones sexuales en las cuales el hombre mete su pene en la vagina de la mujer. Cuando una pregunta se refiere a "sexo anal", significa relaciones sexuales en las cuales el hombre mete su pene en el ano, o cola, de la mujer.

39. ¿Que edad tenias la primera vez que tuviste sexo vaginal o anal?.....edad____

40. ¿Cuántas parejas sexuales has tenido en tu vida?.....
_____

41. ¿Cuántas veces has embarazado a una mujer? ..... _____

42. ¿Alguna vez has embarazado a una mujer que luego tuvo un aborto? S(1) / N(0)

42a. IF YES: ¿Cuántas veces?.....

43. ¿Has tenido alguna vez una enfermedad transmitida sexualmente? .....S(1) / N(0)

44. ¿Te has hecho un examen para detectar una enfermedad transmitida sexualmente durante los últimos 3 meses? ..... S(1) / N(0)

44a. IF YES ¿Te han diagnosticado alguna enfermedad transmitida sexualmente durante los últimos 3 meses? ..... S(1) / N(0)

45. ¿Te has hecho un examen para detectar el VIH/SIDA? ..... S(1) / N(0)

45a. IF YES: ¿Te has hecho un examen para detectar el VIH/SIDA durante los últimos 3 meses? .....S(1) / N(0)

46. ¿Has compartido alguna vez agujas para administrarte (inyectarte) drogas o esteroides o vitaminas? ……..…… S(1) / N(0)

46a. IF YES: ¿Has compartido agujas para administrarte (inyectarte) drogas o esteroides o vitaminas en los <u>últimos 3 meses?</u> .....S(1) / N(0)

47. ¿Has tenido alguna vez relaciones sexuales con alguna persona *<u>que haya compartido</u>* agujas para administrarse (inyectarse) drogas o esteroides o vitaminas? .....S(1) / N(0)

47a. IF YES: ¿Has tenido relaciones sexuales con alguna persona <u>que haya compartido</u> agujas para administrarse (inyectarse) drogas o esteroides o vitaminas en los <u>últimos 3 meses?</u> ..... S(1) / N(0)

48. ¿Has tenido alguna vez relaciones sexuales con alguien *<u>que tu sabias o sospechabas que tuviera</u>* una enfermedad transmitida sexualmente que no sea el VIH? .....S(1) / N(0)

48a. IF YES, ¿Has tenido relaciones sexuales con alguien <u>que tu sabias o sospechabas que tuviera</u> una enfermedad transmitida sexualmente que no sea el VIH en los <u>últimos 3 meses</u>? …… S(1) / N(0)

49. ¿Has tenido alguna vez relaciones sexuales con alguien *<u>que tú sabias o sospechabas que tuviera</u>* el VIH o SIDA? ……..…… S(1) / N(0)

49a. IF YES, ¿Has tenido relaciones sexuales con alguien *<u>que tu sabias o sospechabas que tuviera</u>* el VIH o SIDA en los <u>últimos 3 meses</u>? …… S(1) / N(0)

50. ¿Has tenido alguna vez relaciones sexuales con una prostituta? …… S(1) / N(0)

50a. IF YES, ¿Has tenido relaciones sexuales con una prostituta <u>en los últimos 3 meses</u>? ……..…….. S(1) / N(0)

51. ¿Alguna vez has dado o recibido actos sexuales para drogas, alimentos, o dinero? ……..S(1) / N(0)

51a. IF YES, ¿Has dado o recibido actos sexuales para drogas, alimentos, o dinero en los <u>últimos 3 meses</u>?..... S(1) / N(0)

52. ¿Con que frecuencia usas alcohol (cerveza, vino, licor)?

Nunca…… 1
1-3 veces mensuales 2
Una vez por semana …….3
Algunas veces semanales. 4
Diariamente……. 5

53a. ¿Consumiste cinco o más bebidas en una ocasión durante el mes pasado? S(1) / N(0)

53b. ¿Consumiste cuatro o más bebidas en una instancia durante cualquier tiempo en los últimos 3
meses? ……..S(1) / N(0)

54. ¿Has usado marihuana en los últimos 90 días? …..S(1) / N(0)

55. ¿Has usado drogas que no sea marihuana en los últimos 90 días?..... …S(1) / N(0)

IX. CONTRACEPTIVE USE & CONSISTENT USE

56. ¿Qué método utilizas actualmente, si utilizas alguno, para no dejar embarazada a tu pareja cuando tienen relaciones sexuales? *[Do not read list - Interviewer will record **all** methods reported by the participant]*

	YES	**NO**		**YES**	**N**
56a. Abstinencia	1	0	56k. Depo Provera (inyección)	1	0
56b. Píldoras anticonceptivas	1	0	56l. Parche	1	0
56c. Esterilización de pareja - Ligadura de trompas	1	0	56m.Coito interrumpido	1	0
56d. DIU	1	0	56n. Método del ritmo	1	0
56e. Diafragma	1	0	56o. Esterilización de si mismo - vasectomía	1	0
56f. Condón masculino	1	0	56p. Anticonceptivo de emergencia	1	0
56g. Condón femenino	1	0	56q. Otros **(write in at Q57)**	1	0
56h. spermicidas (jalea, crema, espuma, película o supositorio vaginal)	1	0	56r. Nada	1	0
56i. 56j. Esponja vaginal	1	0	56s. No sabe	1	0
56j.Norplant	1	0	56t. Se niega a responder	1	0

57. Si su respuesta es "otro" ,
especifique ……[_____]

58. ¿Cuáles son las razones principales por las que en este momento no utiliza ningún método anticonceptivo? *Elija todas las respuestas de esta tarjeta **[#8]** que correspondan a su caso.*

	YES	***NO***
58a. No tengo relaciones sexuales……	1	0
58b. Quiero quedar a mi pareja embarazada ……	1	0

58c. Le ligaron las trompas/le hicieron la histerectomía a mi pareja……..	1	0
58d. Me hice la vasectomía……..	1	0
58e. No quiero usar métodos anticonceptivos ……	1	0
58f. El uso de métodos anticonceptivos va contra mi religión…….	1	0
58g. Le temo a los efectos secundarios y a los riesgos para la salud…….	1	0
58h. Mi pareja no quiere usar métodos anticonceptivos……..	1	0
58i. No estoy en condiciones de comprar ningún método anticonceptivo…	1	0
58j. Otra …….	1	0

X. SEXUAL BEHAVIOR AND CONDOM USE

Cuando una pregunta se refiere a "sexo oral", significa que una persona usa su boca para estimular el pene, labios vaginales o ano de su pareja para el placer sexual.

59. ¿Cuántas veces has tenido sexo vaginal durante los últimos 3 meses? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]*…… ……_____

59a. ¿En cuántas de esas veces utilizaste un condón? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]*……

_____

60. ¿Cuántas veces has tenido sexo oral durante los últimos 3 meses? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]*…… ……_____

60a. ¿En cuántas de esas veces utilizaste un condón o protección que ofrece una barrera como una presa dental? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]*…… _____

61. ¿Cuántas veces has tenido sexo anal durante los últimos 3 meses? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]*…… ……_____

61a. ¿En cuántas de esas veces utilizaste un condón? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]*……

_____

62. ¿Has tenido alguna vez relaciones sexuales con un hombre?..... S(1) / N(0)

62a. IF YES: ¿Has tenido relaciones sexuales con un hombre en los últimos 3 meses? …… S(1) / N(0)

62b. IF YES: ¿Cuántas veces has tenido sexo oral con un hombre en los últimos 3 meses? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]* …….. _____

62c. ¿En cuántas de esas veces utilizaste un condón o protección que ofrece una barrera como una presa dental? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]…… _____*

62d. IF YES: ¿Cuántas veces has tenido sexo anal con un hombre durante los últimos 3 meses? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]…… ……_____*

62e. ¿En cuántas de esas veces utilizaste un condón? *[Si el encuestado tiene problemas para responder, pídale que le dé una respuesta aproximada.]…… _____*

XI. HEALTH CARE ACCESS AND SERVICES

Las siguientes preguntas se tratan sobre la forma en que obtienes atención de la salud.

[Health Insurance]

63. ¿Cuentas, en este momento, con cobertura médica (seguro médico) o con una tarjeta médica para la atención de la salud? ..... …… S(1) / N(0) **[*If no skip to Q65]***

64. ¿Qué tipo de cobertura médica (seguro médico) tienes? *[read list]*

Medicaid/Plan de salud de Oregon (*Oregon Health Plan*)	1
Seguro privado a través de mi empleo	2
Seguro privado que pago yo mismo	3
No sé	4

XII. EXPERIENCE GETTING HEALTH CARE AND SEXUAL AND REPRODUCTIVE HEALTH SERVICES FROM PROVIDERS

[General]

El siguiente grupo de preguntas se trata sobre *tus experiencias en las consultas a proveedores médicos en los EE. UU*. Al decir proveedores médicos, nos referimos a médicos, enfermero/as, enfermero/as practicantes o parteras.

65. ¿Alguna vez has consultado con un proveedor médico cuando estuviste enfermo o para obtener un chequeo médico? ..... S(1) / N(0) ***If no, skip to Q75]***

66. ¿Cuántas veces durante el año pasado visitaste a un proveedor médico para consultarle sobre tu propia salud? ……veces _____

67. ¿A dónde te diriges normalmente cuando estas enfermo o necesitas obtener un chequeo médico: *a un consultorio médico, a una clínica, a una sala de emergencias de un hospital o a algún otro lug*ar? (Si la respuesta es "a una clínica", INDAGUE: ¿se trata de una clínica pública o privada?) *[do not read list]*

Consultorio médico privado	1
HMO	2
Clínica de salud comunitaria, clínica comunitaria, clínica de salud pública	3
Clínica de planificación familiar o de paternidad planificada	4
Clínica del empleador o de la empresa	5
Clínica de la escuela o ubicada en la escuela	6
Consultas externas en un hospital	7
Sala de emergencias de un hospital	8
Centro de atención urgente o establecimiento de consulta médica sin cita previa	9
Otro lugar (Especifique:_____)	10

68. En general, ¿en qué medida te sientes satisfecho con los servicios que has recibido por parte de los proveedores médicos? *Dirías**:*** ***[card #15]***

Insatisfecho ……	a	1
Ligeramente satisfecho ……	b	2
Moderadamente satisfecho ……..	c	3
Muy satisfecho ……	d	4
Sumamente satisfecho ……	E	5

XIII. REPRODUCTIVE HEALTH SERVICES

Cuando hablamos acerca de salud reproductiva y sexual para hombres, estos servicios incluye conserjería, exámenes para detectar, y tratamiento para ETS y el VIH y conserjería y servicios para planificación familiar.

69. ¿Alguna vez visitaste con un proveedor médico para recibir servicios de salud sexual y reproductiva? [*If no, skip to Q75]* …….S(1)/ N(0)/No sabe (¿)

70. Durante el año pasado, ¿Cuántas veces visitaste con un proveedor médico específicamente para obtener servicios de salud sexual y reproductiva? ……..... veces _____

71. ¿A dónde te diriges regularmente para obtener servicios de salud sexual y reproductiva? *[do not read list]*

Consultorio médico privado	1
HMO	2
Clínica de salud comunitaria, clínica comunitaria, clínica de salud pública	3
Clínica de planificación familiar o de paternidad planificada	4
Clínica del empleador o de la empresa	5

Clínica de la escuela o ubicada en la escuela	6
Consultas externas en un hospital	7
Sala de emergencias de un hospital	8
Centro de atención urgente o establecimiento de consulta médica sin cita previa	9
Otro lugar (Especifique:_____)	10

72. ¿Cómo pagas para los servicios de salud sexual y reproductiva? *[read list]*

Servicios gratuitos	1
Seguro	2
Plan de Salud de Oregon	3
Yo mismo pago por ellos	4
Un miembro de la familia o un amigo paga por ellos	5
Otra forma	6

73. ¿Qué tan cómodo te sientes hablando con un proveedor médico acerca de los métodos para prevenir el embarazo y prevenir contraer el VIH y otras ETS? *Dirías:* ***[card #11]***

Totalmente incómodo ……a
1
Ligeramente cómodo …… b
2
Moderadamente cómodo …… c
3
Muy cómodo ……d
4
Sumamente cómodo …… e
5

74. En general, ¿en qué medida te sientes satisfecho con los servicios de salud sexual y reproductiva que has recibido de los proveedores médicos? *Dirías:* ***[card #15]***

Insatisfecho …… a
1
Ligeramente satisfecho …… b
2
Moderadamente satisfecho …… c
3
Muy satisfecho ……d
4

Sumamente satisfecho …… e
5

XIV. INVOLVEMENT IN DECISIONS TO PREVENT PREGNANCY

75. Por favor dime que tanto estas de acuerdo con estas declaraciones sobre tu participación en la prevención del embarazo. Utilice las opciones que aparecen en la tarjeta **[card #4]** para responder las siguientes preguntas.

a-Para nada de acuerdo
b-Relativamente de acuerdo
c-Medianamente de acuerdo
d-En gran medida de acuerdo
e-Totalmente de acuerdo

	A	**B**	**C**	**D**	**E**
75a. La prevención del embrazo es una decisión personal que mi pareja tomará; por lo tanto, no es necesario que yo esté involucrado en ello.	1	2	3	4	5
75b. Participo en nuestro esfuerzo de prevenir el embarazo llevándola a una clínica o un consultorio médico.	1	2	3	4	5
75c. Participo en nuestro esfuerzo de prevenir el embarazo ayudando a mi pareja a pagar los servicios.	1	2	3	4	5
75d. Participo en nuestro esfuerzo de prevenir el embarazo ayudando a mi pareja a usar un método anticonceptivo.	1	2	3	4	5
75e. CDC2.96e was removed from OPA					
75f. Me gustaría que las clínicas de planificación familiar o los consultorios médicos hablen con mi pareja e yo, juntos acerca de los métodos para prevenir el embarazo.	1	2	3	4	5
75g. Prefiero que mi pareja hable con los proveedores de servicios de planificación familiar en privado, sin que yo este presente.	1	2	3	4	5
75h. Me gustaría hablar con un proveedor de servicios de planificación familiar en privado, sin mi pareja.	1	2	3	4	5

76. En un mundo perfecto, ¿a donde prefieres que vayas para obtener tus servicios de salud sexual y reproductiva?

1 No hay ningún lugar particular

2 Oficina del doctor o clínica privada (no en un hospital)
3 Departamento de salud publica, clínica comunitaria, o clínica de planificación familiar
4 Sala de emergencia de un hospital
5 Consultas externas en un hospital
6 Otro (especificar) _____

XV. PREFERENCES FOR WHERE/HOW/WHEN TO RECEIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES (Q77-79)

Por favor dime que tanto estas de acuerdo con estas declaraciones sobre tu preferencia en recibir servicios de salud sexual y reproductiva. Utiliza las opciones que aparecen en la tarjeta ***[card #4]*** para responder las siguientes preguntas.

a-Para nada de acuerdo
b-Relativamente de acuerdo
c-Medianamente de acuerdo
d-En gran medida de acuerdo
e-Totalmente de acuerdo

77. Prefería aprender más acerca de los servicios de salud sexual y reproductiva…:

	A	**B**	**C**	**D**	**E**
77a. asistiendo a una clase en un lugar comunitario (por ejemplo una biblioteca, centro comunitario).	1	2	3	4	5
77b. asistiendo a una clase en un consultorio médico o una clínica.	1	2	3	4	5
77c. asistiendo a una clase en el lugar de mí empleo.	1	2	3	4	5
77d. en un consultorio medico o una clínica.	1	2	3	4	5
77e. otra: 77e1:_____	1	2	3	4	5

78. Prefería asistir en una clase…:

78a. con mi pareja sexual.	1	2	3	4	5
78b. con solamente hombres.	1	2	3	4	5
78c. con otras parejas (por ejemplo, casados o novios/novias).	1	2	3	4	5
78d. con hombres y mujeres.	1	2	3	4	5
78e. Otra: 78e1:_____	1	2	3	4	5

79. Prefería asistir en una clase enseñada por…:

79a. un medico.	1	2	3	4	5
79b. una enfermera/un enfermero	1	2	3	4	5

79c. una educadora/un educador de salud	1	2	3	4	5
79d. una promotora/un promotor	1	2	3	4	5
79e. Otra: 79e1:_____	1	2	3	4	5

XVI. DISCRIMINATION & MEDICAL MISTRUST

El siguiente grupo de preguntas se trata acerca de tus *experiencias personales y percepciones en relación con la discriminación sufrida al obtener atención de la salud*. Las preguntas también se tratan sobre *tus interacciones con proveedores médicos en general, no solo los proveedores de servicios de planificación familiar*.

[Experiences of Discrimination Scale]

Al responder las siguientes preguntas, elija como respuesta una de las opciones que aparecen en esta tarjeta **[*Card #18*].**

a-Nunca
b-Rara vez
c-A veces
d-La mayoría de las veces
e-Siempre

80. ¿Con qué frecuencia has experimentado discriminación, te impidieron hacer algo, o te molestaron o hicieron sentir inferior en alguna de las siguientes situaciones debido a tu raza, origen étnico o color?

	A	**B**	**C**	**D**	**E**
80a. ¿En una institución educativa?	1	2	3	4	5
80b. ¿Al ser contratado o al presentarte para un trabajo?	1	2	3	4	5
80c. ¿En el trabajo?	1	2	3	4	5
80d. ¿Al conseguir una vivienda?	1	2	3	4	5
80e. ¿Al obtener atención médica?	1	2	3	4	5
80f. ¿Al ser atendido en una tienda o restaurante?	1	2	3	4	5
80g. ¿Al solicitar un crédito, un préstamo bancario o una hipoteca?	1	2	3	4	5
80h. ¿En la calle o en un lugar público?	1	2	3	4	5
80i. ¿Por parte de la policía o en los tribunales?	1	2	3	4	5

[Perceived Personal Discrimination in Interactions with Health Care Providers]
SKIP THE SECTION BELOW IF PARTICIPANT NEVER USED HEALTH CARE SERVICE –
IF THEY ANSERED 'NO' to Q 65 (p. 28)

Al responder las siguientes preguntas, elija como respuesta una de las opciones que aparecen en la misma tarjeta

a-Nunca
b-Rara vez
c-A veces
d-La mayoría de las veces
e-Siempre

81. Al obtener atención de la salud de cualquier tipo, ¿alguna vez te sucedió alguna de estas cosas debido a tu raza u origen étnico?

	A	B	C	D	E
81a. Te trataron menos amablemente que a otras personas.	1	2	3	4	5
81b. Te trataron menos respetuosamente que a otras personas.	1	2	3	4	5
81c. Recibiste un servicio peor que el que les brindaron a los demás.	1	2	3	4	5
81d. Un médico o enfermero se comportó como si pensara que no eras inteligente.	1	2	3	4	5
81e. Un médico o enfermero se comportó como si te tuviera miedo.	1	2	3	4	5
81f. Un médico o enfermero se comportó como si fuera mejor que tu.	1	2	3	4	5
81g. Sentiste que un médico o enfermero no estaba escuchando lo que tú decías.	1	2	3	4	5

[Medical Mistrust]

82. Ahora *voy a leerte algunas declaraciones acerca de los médicos y los proveedores médicos*. Para cada declaración, *indique en qué medida estas de acuerdo o no con cada uno de ellas*. Elija como respuesta una de las opciones que aparecen en esta tarjeta ***[Card #4]*:**

a-Para nada de acuerdo
b-Relativamente de acuerdo
c-Medianamente de acuerdo
d-En gran medida de acuerdo
e-Totalmente de acuerdo

	A	B	C	D	E
82a. Las personas de mi grupo étnico no pueden confiar en los médicos ni en los trabajadores de salud.	1	2	3	4	5
82b. Las personas de mi grupo étnico deben sospechar de la información que obtienen de sus médicos y trabajadores de salud.	1	2	3	4	5
82c. Las personas de mi grupo étnico no se deben confiar a los médicos ni a los trabajadores de salud porque lo que les digan se usará en su contra.	1	2	3	4	5
82d. Las personas de mi grupo étnico deben sospechar de la medicina moderna.	1	2	3	4	5
82e. Los médicos y los trabajadores de salud a veces han hecho experimentaciones dañosas a las personas de mi grupo étnico.	1	2	3	4	5
82f. Los médicos y los trabajadores de salud no se toman en serio los reclamos médicos de las personas de mi grupo étnico.	1	2	3	4	5
82g. Las personas de mi grupo étnico reciben la misma atención médica de los médicos y de los trabajadores de salud que las personas de otros grupos.	1	2	3	4	5
82h. En la mayoría de los hospitales, las personas de diferentes grupos étnicos reciben el mismo tipo de atención.	1	2	3	4	5
82i. Los médicos tienen en cuenta lo que es mejor para las personas de mi grupo étnico.	1	2	3	4	5
82j. A veces, los médicos y los trabajadores de salud ocultan información a los pacientes que pertenecen a mi grupo étnico.	1	2	3	4	5
82k. Personalmente, he sido maltratado o tratado injustamente por los médicos o trabajadores de salud debido a mi origen étnico.	1	2	3	4	5
82l. Clínicas o centros de salud que reciben fondos especiales para salud de Latinos a veces no usan estos fondos para proveer servicios.	1	2	3	4	5

83. ¿Has completado una entrevista para este proyecto, Proyecto de Salud para Latinos? *(CDC-funded project with data collected between October 2007 and September 2008)…* ……..S(1)/ N(0)

Prácticamente, hemos terminado la entrevista. Solo me falta hacerte una pregunta más.

84. ¿Cómo te enteraste de este estudio? *[read list; check all that apply]*

	YES	NO
84a. Por radio	1	0
84b. Por folleto, cartel u otro material impreso	1	0
84c. Fue informado por un reclutador	1	0
~~84d. Se lo recomendó una pareja [de sexo masculino/femenino] que participó en el estudio~~		
84e. Se lo recomendó una amiga	1	0

84f. Se lo recomendó un amigo	1	0
84g. Fue referido por una agencia comunitaria	1	0
84h. Otra (Specify)	1	0

Esa fue la última pregunta. Muchas gracias por su ayuda. *La información que nos dio es muy importante para ayudarnos a comprender mejor las influencias que afectan los comportamientos de alto riesgo relacionados con la actividad sexual y el uso de servicios de salud sexual y reproductiva de los hombres latinos en áreas rurales de Oregon*. Como te dije al principio, todo lo que me dijiste hoy se mantendrá confidencial. Tu nombre no aparecerá en ninguna parte de la información.

Appendix E

Interview Guide English Version

INFORMED CONSENT FORM

TITLE: SEXUAL AND REPRODUCTIVE HEALTH SERVICES: REACHING LATINO MEN IN RURAL AREAS

Principal Investigator: Dr. Marie Harvey, Department of Public Health
Co-Investigator: Dr. Ann Zukoski, Department of Public Health

WHAT IS THE PURPOSE OF THIS STUDY?

You are being invited to be part of a study to learn more about what influences sexual risk behaviors and use of family planning and sexual and reproductive health services by Latino men in rural Oregon. Latinos as a group have more unplanned pregnancies and sexually transmitted infections and problems getting health care than other groups. We are looking for 80 Latino men who live in rural Oregon to take part in an interview about these topics. For example, we would like to find ways to make it easier to get birth control and reproductive health care, as well as reduce sexual risk taking. We will use the answers from you and others we interview to help to develop sexual and reproductive services and programs that will lead to increased use of these services and reduce sexual risk behaviors among Latino men in rural areas. Study results will be published in academic journals and reported at research conferences and given to local community agencies.

WHAT IS THE PURPOSE OF THIS FORM?

This consent form gives you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask any questions about the research, the possible risks and benefits, your rights as a volunteer, and anything else that is not clear. When all of your questions have been answered, you can decide if you want to be in this study or not.

WHY AM I BEING INVITED TO TAKE PART IN THIS STUDY?

You are being invited because you are a Latino man living in rural Oregon who is between 18 and 30 years of age, who came to this country in the last 10 years. Also, you are able to speak either English or Spanish. Also, you have had sexual intercourse with a woman within the past three months, and are not seeking to get a sexual partner pregnant within the next year. We will exclude anyone who reports any one of these: has tested positive for HIV/AIDS, has a sexual partner who he knows or suspects is pregnant.

WHAT WILL HAPPEN AND HOW LONG WILL IT TAKE?

We will ask you to talk one-on-one with a trained male interviewer for about 1 ½ hours. The interview will take place in a private place like an empty office. The interviewer will ask you about topics like birth control, HIV and sexually transmitted diseases, sexual behavior and decision-making, access to health care, and things you and/or your sex partner(s) may do to prevent pregnancy.

We will also need to audio record the interview. We can't write fast enough to record everything you say, so we'd like your permission to record the interview. If you do not agree to be recorded we cannot interview you. If you say it is OK, your interviewer will tape record the interview and give the audio files to a professional "transcriber." The transcriber will type everything you and the interviewer say. When he/she does this, he/she will leave out your name and anything else that might let people guess who you are. The audio files will be held for 5-7 years and then destroyed.

WHAT ARE THE RISKS OF THIS STUDY?

These topics are very personal, we know. You do not have to take part in this study. If you do agree to take part, you may feel uncomfortable or embarrassed because of some of the questions we ask. You are free to skip any questions that you would prefer not to answer. And if you don't want to go on, you can stop at any time and still receive the money promised to you. If you are upset after the interview and need to talk with someone, you can call Marie Harvey at (541) 737-3824. In addition, you will get a list of referrals to social services agencies and health care providers that may be able to help you with certain problems.

WHAT ARE THE BENEFITS TO ME? WHY SHOULD I TAKE PART?

Many people feel good about helping others, and we can learn so much from you. We hope that this study will benefit Latino males in rural Oregon and elsewhere, because it will help us better understand the sexual and reproductive health services needs of Latino men. This information will then be used to inform the design of services, programs and health policies that will reduce sexual risk taking and improve the delivery of reproductive health services.

WILL I BE PAID FOR PARTICIPATING?

You will be paid $25 in cash if you decide take part in this study. If needed you may also get money -$10 - to pay for your transportation to and from the interview. You'll get the money as soon as the interview is done. The money is our way of saying THANK YOU FOR YOUR TIME.

WHO IS PAYING FOR THIS STUDY?

The United States Department of Health and Human Services (Office of Population Affairs) is giving funds to Oregon State University to do this study.

WHO WILL SEE THE INFORMATION I GIVE?

Your privacy is very important to us. Because we want you to feel comfortable when you talk about yourself and your opinions, we have taken several measures to protect you:

- We won't tell anyone if you take part in this study or not.
- Interviews will take place in a private place, like an empty office, where no one can accidentally hear what you say.
- Your name and what you tell us in the interview will be kept private to the extent permitted by law. (By "kept private" we mean that the names of people who take part in the study will not be given to anyone else. And it means that we will only write or talk about what you say in a way that no one could ever guess or know it was you who said it.)
- Only staff from this research project will know what you say in your interview.
- Audio files and transcripts (paper copies), as well as your name and contact information, will be kept in a locked file cabinet in Dr. Harvey's locked research offices or in a locked file on a password protected computer so that no one other than the research staff will be able to see them. For example, this form (which has your name on it) will be kept in a locked file cabinet. A number, not your name, will be used to identify the answers you give us in your interview. Your study number on your interview will not be linked to your name.
- Only professional transcribers who have signed a confidentiality agreement will have access to the audio files. The audio files will be held for 5-7 years and then destroyed.
- The transcripts (paper copies) will be held for 5-7 years and then destroyed.
- When we write or talk about what we learned in this study, we will leave out your name and other personal information so no one will be able to tell who we are talking about.

DO I HAVE A CHOICE TO BE IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. You will not be treated differently if you decide to stop taking part in the study. You are free to skip any questions that you would prefer not to answer. If you choose to withdraw from the interview before it ends you will still be paid. The researchers may keep information collected about you and this information may be included in study reports.

ANY QUESTIONS?

If you have any questions about this study or this form, you can talk with Ann Zukoski at (541)737-5313 or by email at ann.zukoski@oregonstate.edu. If you can't reach her or would like to talk with the people in charge of the study, you can talk with Marie Harvey at (541) 737-3824 or by email at marie.harvey@oregonstate.edu. If you have questions regarding your rights as a participant, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator, at (541) 737-4933 or by email at IRB@oregonstate.edu.

IF I SIGN THIS FORM, WHAT DOES IT MEAN?

Your signature below means that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

I agree to have my interview audio recorded ____ (initial here)

Participant's name (print): _____

Participant's Signature: _____ Date: _____
Recruiter/Interviewer Signature (required only with short form) _____Date _____

Appendix F

Informed Consent Spanish Version

FORMULARIO DE CONSENTIMIENTO INFORMADO

TITULO: SERVICIOS DE SALUD REPRODUCTIVA Y SALUD SEXUAL: ALCANZANDO HOMBRES LATINOS EN ÁREAS RURALES

Investigadora Principal: Dra. Marie Harvey, Departamento de Salud Pública
Co-investigadora: Dra. Ann Zukoski, Departamento de Salud Pública

¿CUÁL ES EL PRÓPOSITO DE ESTE ESTUDIO?

Usted esta invitado a participar en un estudio para aprender más sobre que influencias hay que afectan los comportamientos de alto riesgo relacionados con la actividad sexual y el uso de métodos de planificación familiar y servicios de salud reproductiva y sexual por parte de hombres latinos en áreas rurales de Oregon. Los Latinos, como un grupo, tienen mas embarazos no planeados y enfermedades transmitidas sexualmente y problemas consiguiendo servicios de salud que otros grupos. Estamos buscando por 80 hombres latinos que vivan en áreas rurales de Oregon para participar en una entrevista acerca de estos temas. Por ejemplo, desearíamos encontrar nuevas maneras para facilitar la obtención de métodos anticonceptivos y atención de la salud reproductiva, así como reducir los riesgos relacionados con la actividad sexual. Usaremos sus respuestas y las de los demás entrevistados para crear nuevas formas para desarrollar servicios y programas sobre la atención de la salud reproductiva y sexual que aumentaran el uso de estos servicios y reducir los comportamientos de alto riesgo relacionados con la actividad sexual entre hombres latinos en las áreas rurales. Los resultados de este estudio serán publicados en revistas académicas y reportados en conferencias investigadoras y distribuidas a agencias comunitarias locales.

¿CUÁL ES EL PRÓPOSITO DE ESTA FORMA?

Este formulario de consentimiento le proporciona la información que necesitará para ayudarle ha decidir si desea o no participar en el estudio. Por favor, lea atentamente el formulario. Podrá hacer cualquier pregunta acerca de la investigación, los posibles riesgos y beneficios, sus derechos como voluntario, y sobre cualquier otro tema que no esté claro. Cuando todas sus preguntas hayan sido respondidas, podrá decidir si desea o no participar en este estudio.

¿POR QUÉ ESTOY INVITADO A PARTICIPAR EN ESTE ESTUDIO?

Usted esta invitado porque usted es un hombre latino viviendo en áreas rurales de Oregon que tiene entre 18 a 30 años de edad, que vino a este país en los últimos diez años. También, usted puede hablar español o inglés. Además, usted ha tenido relaciones sexuales con una mujer entre los últimos tres meses, y no esta intentado embarazar ha su pareja sexual entre el próximo año. Ocultaremos cualquiera persona que reporta alguna de estas situaciones: tiene un resultado positivo de la prueba de VIH/SIDA, tiene una pareja sexual que él sabe o sospecha que esta embarasada.

¿PASARÁ Y CUANTO TIEMPO SE TOMARÁ?

Le pediremos que hable frente-a-frente con un entrevistador entrenado por aproximadamente una hora y media. La entrevista se llevará a cabo en un lugar privado como en una oficina desocupada. El entrevistador le preguntará acerca de temas como métodos anticonceptivos, VIH y enfermedades transmitidas sexualmente, comportamiento y toma de decisiones, acceso a la atención de la salud, y cosas

que usted y/o su(s) pareja(s) sexual(es) pueden hacer para prevenir el embarazo.

También tendríamos que hacer grabaciones de audio de la entrevista. No podemos escribir tan rápido para grabar todo lo que usted diga, entonces le pedimos por su permiso a grabar la entrevista. Si usted no esta de acuerdo que de nos deje grabar la entrevista, no podríamos entrevistarlo. Si usted nos da su permiso, el entrevistador hará una grabación de la entrevista con una grabadora de cinta y daría los archivos de audio a un transcriptor profesional. El transcriptor imprimirá todo lo que usted y el entrevistador digan. Cuando el/ella haga esto, el/ella ocultará su nombre y todo lo demás que pueda asistir que otras personas adivinen que es usted. Los archivos de audio se mantendrán por 5 a 7 años y luego serán destruidos.

¿CUÁLES SON LOS RIESGOS DE ESTE ESTUDIO?

Sabemos que estos temas son muy personales. Usted no está obligado a participar en este estudio. Si acepta participar, es posible que se sienta incómodo o avergonzado debido a algunas de las preguntas que le haremos. No está obligado a contestar a ninguna pregunta que no desee contestar. Además si usted no desea continuar, puede interrumpir su participación en cualquier momento y recibir, de todos modos, el dinero que se le prometió. Si después de la entrevista se siente frustrado y necesita hablar con alguien, puede llamar a Marie Harvey al (541) 737-3824. Además, recibirá una lista de organizaciones que quizás puedan ayudarlo con problemas en particular.

¿CUÁLES SON LOS BENEFICIOS PARA MÍ? ¿POR QUÉ DEBERÍA PARTICIPAR?

Muchas personas se sienten bien al ayudar a los demás, y podemos aprender mucho a través de su participación. Esperamos que este estudio beneficie a los hombres latinos de Oregon y de otros lugares, dado que nos ayudará a comprender mejor las necesidades de los servicios de salud reproductivo y sexual para hombres latinos. Luego, esta información se usará para desarrollar los servicios, programas, y pólizas de salud que puedan reducir los riesgos relacionados con la actividad sexual y mejorar la entrega de servicios de salud reproductiva.

¿ME PAGARÁN POR PARTICIPAR?

Recibirá $25 si decide participar en este estudio. También recibirá dinero —$10 como máximo— para pagar sus gastos de transporte hacia y desde el lugar de la entrevista. Recibirá el dinero al fin de la entrevista. El dinero es una forma de AGRADECERLE POR SU TIEMPO.

¿QUIÉNES ESTAN PAGANDO POR ESTE ESTUDIO?

El Departamento de Salud y Servicios Humanos Estadounidense (por la Oficina de Asuntos de Población) esta proporcionando fondos a la Universidad Estatal de Oregon para hacer este estudio.

¿QUIÉNES VERÁN LA INFORMACIÓN QUE YO PROPORCIONE?

Su privacidad es muy importante para nosotros. Dado que deseamos que se sienta cómodo al hablar acerca de usted y sus opiniones. Por esta razón hemos tomado varias medidas para protegerle:

- No le informaremos a nadie si participa o no en este estudio.
- Las entrevistas serán conducidas en una sala privada, como en una oficina desocupada, donde nadie podrá oír accidentalmente lo que diga.
- Se mantendrá la privacidad de su nombre y de la información que nos proporcione en las entrevistas, en la medida en que la ley lo permita. (Al decir "se mantendrá la privacidad", nos referimos a que los nombres de las personas que participen en el estudio no se proporcionarán a ninguna otra persona. Además, significa que solo revelaremos la información que nos proporcione de forma tal que nadie pueda deducir ni saber que fue usted quien la proporcionó.)
- Solamente el personal de este proyecto de investigación sabrá lo que usted diga en sus entrevistas.

- Todos los archivos de audio y transcripciones (copias de papel), además su nombre e información de contacto, serán conservados en un gabinete de archivos cerrado con llave en las oficinas de investigación cerradas de la Dra. Harvey o en un archivo bloqueado en una computadora, de modo que ninguna persona ajena al personal de la investigación pueda verlos. Por ejemplo, este formulario (que incluye su nombre) se conservará en un gabinete de archivos cerrado con llave. Un número, no su nombre, será utilizada para identificar las respuestas que usted nos dará en la entrevista. Su número de estudio en su entrevista no será relacionada a su nombre.
- Solamente los transcriptores profesionales que han firmado un acuerdo de confidencialidad tendrán acceso a los archivos de audio. Los archivos de audio se mantendrán por 5-7 años y luego serán destruidos.
- Las transcripciones (copias de papel) se mantendrán por 5-7 años y luego serán destruidos.
- Cuando escribamos o hablemos sobre la información obtenida en este estudio, no incluiremos su nombre ni otra información personal, de modo que nadie pueda saber a quién hacemos referencia.

¿TENGO LA OPCIÓN DE PARTICIPAR EN EL ESTUDIO?

Si usted decide participar en el estudio, seria porque usted realmente quiere hacerlo voluntariamente. Usted no piedra algún beneficio o derecho que normalmente tendrá si no elige voluntar. Usted puede interrumpir su participación en el estudio en cualquier momento y mantendrá, de todos modos, los beneficios y los derechos que usted tuvo antes de voluntar. No se tratará diferente si usted decide interrumpir su participación en el estudio. No está obligado a contestar a ninguna pregunta que no desee contestar. Si usted decide retirarse antes de que se termine la entrevista, de todos modos, será pagado. Los investigadores podrán mantener información colectada acerca de usted y esta información será incluida en reportajes del estudio.

¿TIENE ALGUNA PREGUNTA?

Si tiene alguna pregunta acerca de este estudio o este formulario, puede hablar con Ann Zukoski, al (541)737-5313 o por correo electrónico a ann.zukoski@oregonstate.edu. Si no puede comunicarse con ella o si desea hablar con las personas encargadas del estudio, puede hablar con Marie Harvey, al (541)737-3824 o por correo electrónico a Marie.Harvey@oregonstate.edu. Si tiene alguna pregunta acerca de sus derechos como sujeto de una investigación, comuníquese con el Administrador para la Protección de Sujetos Humanos de la Junta de Revisión Institucional (*Institutional Review Board*, IRB) de Oregon State University, al (541) 737-4933, o por correo electrónico a IRB@oregonstate.edu.

¿QUÉ IMPLICA EL HECHO DE QUE FIRME ESTE FORMULARIO?

Su firma a continuación significa que este estudio de investigación a sido explicada a usted, que sus preguntas han sido respondidas y que esta de acuerdo a participar en este estudio. Usted recibirá una copia de este formulario.

Estoy de acuerdo que graben mi entrevista por grabación de audio _____ (escribe sus iniciales aquí)

Nombre, en letra de imprenta: _____

Firma: _____ Fecha: _____
Firma de reclutador/entrevistador (requerido solamente con la forma corta)