



Latino Sexual and Reproductive Health Needs Assessment (Linn and Benton Counties, OR)

Final Report

CONDUCTED BY THE LINN BENTON HEALTH EQUITY ALLIANCE

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Executive Summary

Oregon's diverse communities experience overwhelming and significant health disparities. Data also indicates that reproductive health services may be underutilized by Latinos and Latinas, particularly those who are foreign-born. In order to better assess the needs, barriers, and strengths of Latino communities in Oregon in regards to sexual and reproductive health, the Oregon Health Authority awarded grants to local coalitions. In Linn and Benton counties, the grant was awarded to the Linn Benton Health Equity Alliance (LBHEA), a cross-sectional partnership between several organizations that work to promote policy and system changes that support health equity.

This needs assessment had four goals: 1) to learn about the knowledge, needs, and barriers to accessing reproductive and sexual health services among Latinos and Latinas residing in Linn and Benton Counties; 2) to better understand the experiences that Latinos have while receiving sexual and reproductive health services; 3) to provide recommendations to local health departments and other health care providers, and 4) to advise the Oregon Health Authority on the development and provision of regional, culturally-appropriate strategies.

LBHEA worked closely with three local partner organizations committed to conducting this study. Focus groups respected the needs of participants; they were scheduled across the region during convenient times. Bilingual and bicultural moderators assessed participants of their same gender. Childcare and dinner was provided to all groups. We also worked closely with our partners to ensure that the study respected the sensitive nature of discussing sexual and reproductive health with a vulnerable population and to ensure the confidentiality of participants. Ultimately, our study included 42 participants, divided into five focus groups. Approximately 58% of the participants were female, and 65% of the participants reported being raised outside of the United States.

Four main **themes** were identified through data analysis:

- **Resources** – Sources of information about sexual and reproductive health and related health care services
- **Barriers** – Factors that make it hard for Latinos and Latinas to access health information and services
- **Interpretation and Privacy** – Key concerns among Latinos and Latinas when seeking health care services
- **Stories** – Past experiences of Latinos and Latinas while accessing sexual and reproductive health services

Key **recommendations** from this study are the following:

- **Invest in culturally-appropriate care**
- **Invest in linguistically-appropriate care**
- **Communicate health information in many different ways and places**
- **Ensure that patients' privacy and confidentiality is respected**

Background

According to the Oregon Health Authority, Oregon’s culturally and socially diverse communities experience overwhelming and significant health disparities. Specifically, recent program data indicates that reproductive health services in the state may be underutilized by Latinos and Latinas, particularly those who are foreign-born. Lack of access to health care and low usage of health services exposes the Latino population to a breadth of sexual and reproductive health risks, including higher infection rates for sexually transmitted infections as well as poor reproductive outcomes.

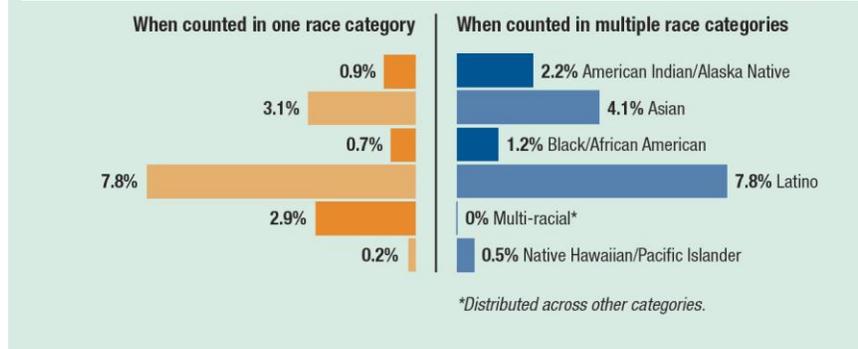
In order to better assess the needs, barriers, and strengths of Latino communities in Oregon in regards to sexual and reproductive health, the Oregon Health Authority awarded grants to local coalitions. In Linn and Benton counties, the grant was awarded to the Linn Benton Health Equity Alliance (LBHEA), a cross-sectional partnership between several organizations that work to promote policy and system changes that support health equity. Our mission is to work so that everyone in our region is able to lead a healthy life, and we believe that health begins where we live, learn, work, and play. The coalition’s four strategic priorities are capacity building, housing, education, and access to health and wellness. Therefore, the LBHEA was strategically positioned to achieve the goals of this grant - influencing issues of equity that impact health disparities among Latinos, and helping to advise the Oregon Health Authority on the development and provision of regional, culturally-appropriate strategies that address the sexual and reproductive health needs of the local Latino population.

Linn and Benton Counties

The LBHEA works to serve key underserved populations experiencing health disparities across Linn and Benton counties; Latinos and Latinas are among one of our key priority populations. Data from the most recent Regional Health Assessment of Linn, Benton, and Lincoln Counties (2015) indicates that Linn and Benton counties have approximately 204,000 residents, ¾ of whom live in urban center. Linn and Benton counties are also home to a diverse population in terms of race and ethnicity, as described in Figure 1; 7.8% of the counties’ population identifies as Latino(a). Around 9% of the population in our counties speak a language other than English at home (59% speak Spanish at home, and 41% speak another language).

In terms of socioeconomic status, both counties have lower median household and per capita incomes than the state of Oregon. In terms of income inequality, Linn County has a lower ratio than the state of Oregon, while Benton County has the highest income inequality in the state. About 1 in 5 residents of Linn County and 1 in 4 residents of Benton County live below the poverty line. In both counties, a higher percentage of non-White residents live below the federal poverty line, including over one third of the Latino residents.

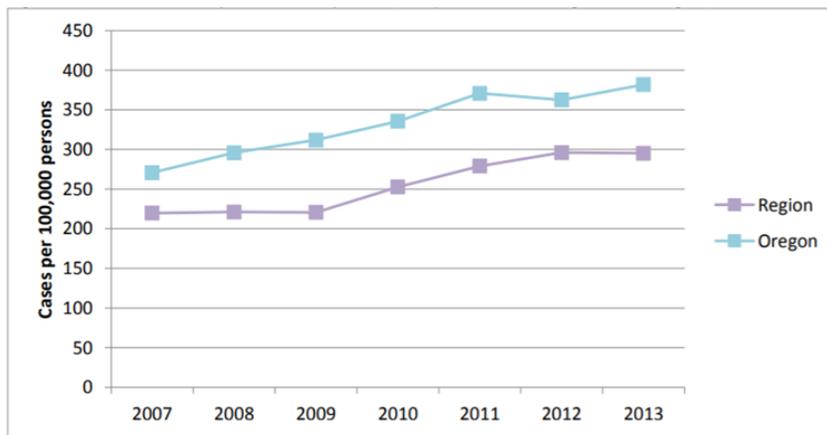
Figure 1. Communities of Color in Linn and Benton Counties



Sexually Transmitted Infections

Sexually transmitted infections (STIs) can be passed from one person to another through sexual contact. Although testing for STIs is a very effective mechanism for preventing their spread, not all individuals seek or receive testing and treatment; if left untreated, these infections can lead to infertility and even death.

Figure 2. Rate of chlamydia infection per 100,000 persons, 2007-2013

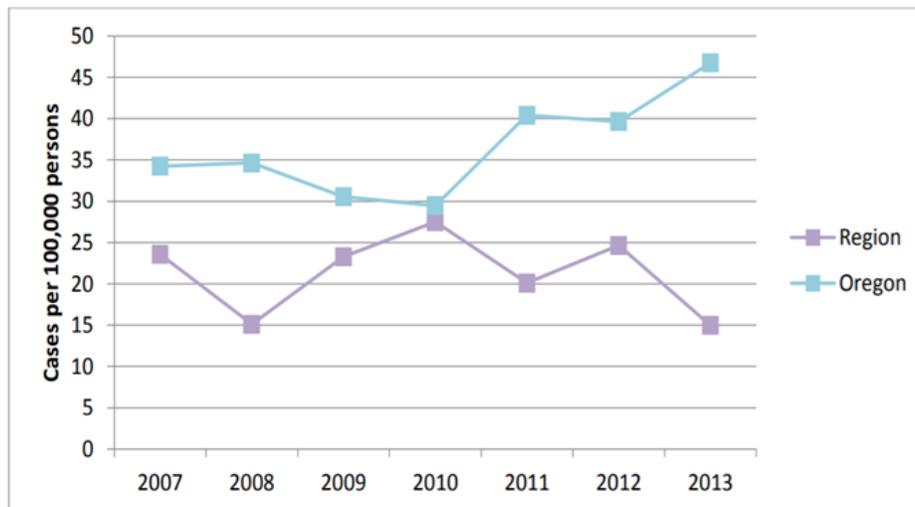


Source: Oregon Health Authority, Oregon Public Health Assessment Tool, 2007-2013

According to the most recent Regional Health Assessment, chlamydia and gonorrhea are the most common STIs in Linn and Benton Counties. Chlamydia is the most common reportable illness in Oregon, with infection rates steadily increasing over the past decade. In both Oregon and our region, reported rates of chlamydia are more than twice as high in women as in men. Overall, our region has had a lower rate of chlamydia than the state, although rates are increasing (see Figure 2);

Gonorrhea infection rates in the region have consistently stayed below the state rate (see Figure 3). A third STI of concern is HIV/AIDS. Between 2009 and 2013, 48 individuals were diagnosed in the region; this means that the 5-year incidence of HIV in the region was 4 cases per 100,000 persons per year, about two-thirds of the state's incidence in the same time period (6.5 cases per 100,000 persons per year).

Figure 3. Rate of gonorrhea infection per 100,000 persons, 2007-2013

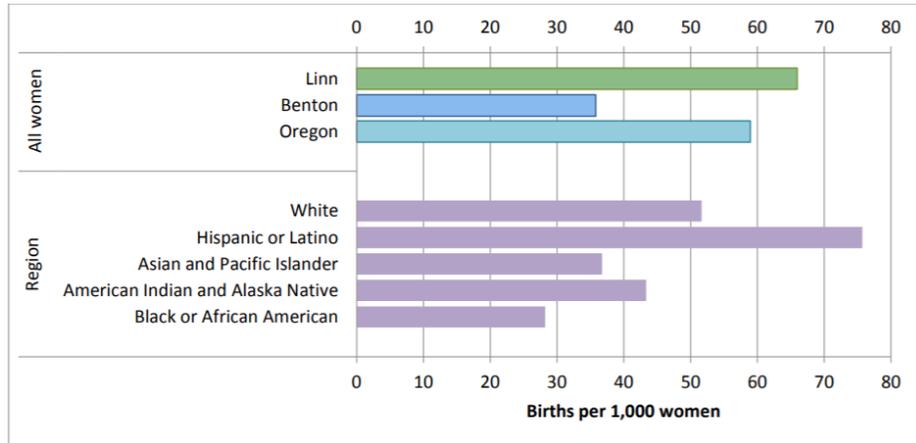


Source: Oregon Health Authority, Oregon Public Health Assessment Tool, 2007-2013

Pregnancy and Family Planning

The health of individuals starts at the beginning of their life; therefore, ensuring the health of mothers and infants during and immediately after pregnancy is key to ensuring healthy communities. According to our most recent Regional Health Assessment, the overall total fertility rate (that is, the total number of births per 1,000 women in a given year) in Linn County is higher than the state's and is nearly twice that of Benton County. Among racial and ethnic minority groups, Latina women have the highest total fertility rate in the region - about 1.5 times the fertility rate of women who identify as Non-Hispanic White (see Figure 4).

Figure 4. Total fertility rate by race and ethnicity, 2011-2013

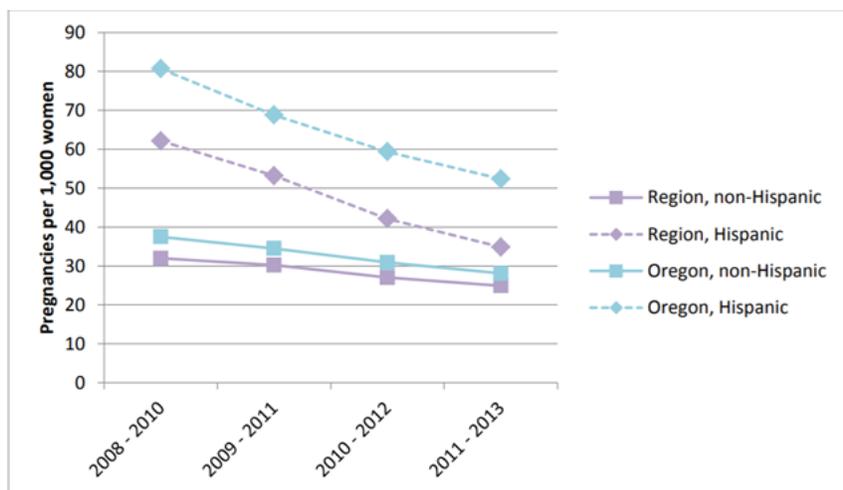


Source: Oregon Health Authority, Center for Health Statistics, Birth Certificate Data, 2011-2013
 Note: Fertility rate data is based on county of residence, not county of birth

Adequate prenatal care ensures that mothers and infants are healthy throughout and after pregnancy. Overall, the percentage of mothers able to access adequate prenatal care was slightly higher than that of the state of Oregon, hovering at almost 90%. Regional data, however, indicates that women under the age of 25 are nearly twice as likely to receive inadequate or no prenatal health care in our region, and that mothers who identify as members of a racial or ethnic minority tend to access adequate prenatal care less frequently when compared to Non-Hispanic White women.

Another area of concern are teen pregnancies, as teen mothers are less likely to receive early prenatal care and teen fathers are more likely to abuse alcohol and drugs. All teen parents are less likely to complete their education, and children of teenage parents are at risk of becoming teen parents themselves, being incarcerated during adolescence, dropping out of school, and experiencing health problems, abuse, or neglect. The most recent Regional Health Assessment suggests that teen pregnancy rates have decreased between 2009 and 2013. However, despite the overall decline in rates, disparities emerge between ethnic groups (Figure 5).

Figure 5. Pregnancy rate by ethnicity, three-year average, 2008-2013



Source: Oregon Health Authority, Center for Health Statistics, Birth Certificate Data, 2008-2013

Methods

Study Objectives

- Learn about the knowledge, needs, and barriers to accessing reproductive and sexual health services among Latinos and Latinas residing in Linn and Benton Counties, Oregon.
- To better understand the experiences that Latinos have while receiving sexual and reproductive health services in Linn and Benton counties.
- Provide recommendations to local health departments and other health care providers so they can better serve the sexual and reproductive needs of their Latino clients.
- Advise the Oregon Health Authority on the development and provision of regional, culturally-appropriate strategies that address the sexual and reproductive health needs of Latinos and Latinas.

Community Engagement Partnerships

As a coalition, LBHEA strongly believes in the importance of community engagement. According to the Task Force on the Principles of Community Engagement, this approach strives to promote fairness and justice, to empower individuals to participate in decision-making, and to allow for community self-determination (Clinical and Translational Science Awards Consortium, 2011). Community engagement can be used by agencies, institutions, and individuals to achieve a broad range of objectives, including but not limited to: promoting change at the individual, social, and environmental levels; developing partnerships and coalitions; and promoting systemic change in policies.

By its very nature, community engagement aims to change the hierarchical nature of program development, resource allocation, and policy-making, and requires that the community be as empowered as those in the government and other institutions to make decisions and affect change. The first premise of community engagement is capacity building, based on the belief that communities already possess strong resources that should be harnessed and built upon in order to achieve the common goal of improved health. The second premise is empowerment: institutions and organizations should empower the community to address its own issues. The third premise is long-term commitment: for local organizations and communities to be able to promote long-term change, they need to be developed, nurtured, and maintained over time.

In order to apply community engagement principles to this study, LBHEA chose to harness the power of its existing partnerships with local organizations. We invited partners that have a long history of serving Latinos in our area, and therefore have strong rapport with our target population, to be active participants in this study. This speaks to the importance of developing and maintaining sustainable, mutually beneficial partnerships, and reinforces the need to build on the existing strengths of our community. The following organizations agreed to participate in this study:

- **Casa Latinos Unidos de Benton County (CLUBC)** promotes the health and well-being of Latino families through leadership and capacity building, and empowers individuals and families to access resources. This organization meets several needs of Latino families, particularly first-generation, low-income immigrants. Because their clients find it difficult to access mainstream services, CLUBC provides them with linguistically appropriate and culturally specific basic-need services.



- **Strengthening Rural Families (SRF)** uses a collaborative approach to promote the health and well-being of individuals and families in rural communities. SRF serves rural Benton County through education, advocacy, coalition building, and community connections. They are community-centered in their approach in recognition of the unique needs and strengths of different service areas. In two of Benton County rural communities (Philomath and Monroe, OR), SRF has identified, engaged, and served Latino populations.



- **Albany InReach Services**, a project of Samaritan Health Services, addresses access to care by providing free primary care, mental health, and dental services to low-income, uninsured or underinsured populations in Albany, Millersburg, and Tangent, OR. In addition to ensuring health care access, Albany InReach believes in leveraging community resources and strengthening our networks where all community members can benefit.

In exchange for a community engagement stipend, these three partner organizations committed to assisting LBHEA with the following aspects of this study (see full list of partnership responsibilities in the Appendix):

- They revised study materials and provided feedback as needed.
- They reached out to a pool of potential participants (clients, community members, etc.) in person or over the phone; aimed to recruit enough participants to fill up to 6 focus groups with 6 to 10 participants each.
- They followed the recruitment guidelines when approaching potential participants (see Appendix).
- They kept track of participants' contact information, thus ensuring this information remained private; they used the potential participant list provided specifically for this study (see Appendix), and destroyed those lists after the completion of the study to respect participant's confidentiality.
- They identified appropriate spaces and times to hold focus groups in their area.
- They notified participants of the time and location of their focus group.
- Their staff interacted with participants and moderator for the first half hour of the session; this ensured that participants developed rapport with the moderator and were comfortable prior to the focus groups.

Focus Group Protocol

Participants were recruited according to the following eligibility requirements:

- Participants must be 18 years old or older
- Participants must identify as Latino or Latina
- Participants must reside in Linn or Benton counties

Focus groups were scheduled across the region, in Albany, Corvallis, and Philomath. They also took place on weekday evenings per the participants' request. Participants were assigned to focus groups based on their gender and language preference, and the gender of the bilingual/bicultural moderator matched that of the participants. Childcare was available on site during all focus groups (independent of the participants' gender or age) to facilitate the participation of parents. A culturally-appropriate healthy dinner was also served prior to the focus groups.

The structured part of the focus groups lasted between 60-120 minutes. Prior to asking any questions, focus group moderators requested oral informed consent from the participants (see Appendix); a script was used to notify them that their participation should be completely voluntary, that their answers would be kept confidential, that they did not have to answer any questions they did not want to, they could take breaks or leave the focus group whenever they wished, and that participation or nonparticipation would not affect any services they received from the partner organization. The moderator also reminded participants that the focus group would be audio-recorded and that handwritten notes would be taken by an assistant. Focus group moderators followed the Focus Group Guide to facilitate the discussion (see Appendix). At the end of the session, participants filled out demographic information sheets and were compensated with \$35 gift cards to a local grocery store.

Data Management and Confidentiality:

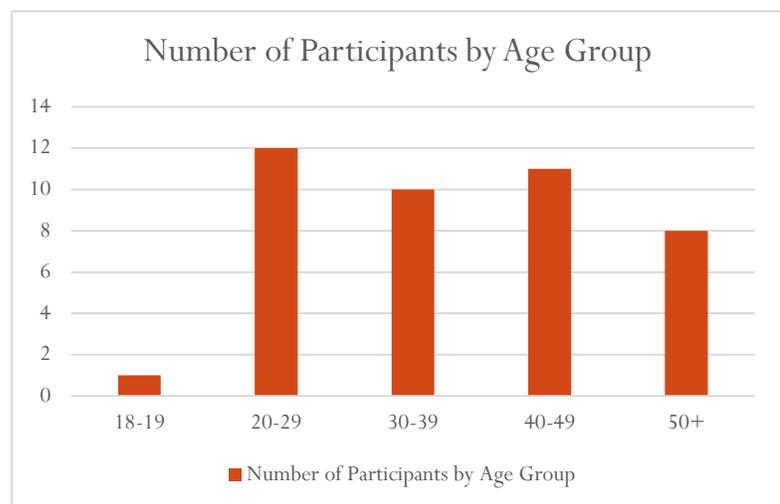
We worked with our partners to ensure that this study respected the sensitive nature of discussing sexual and reproductive health with a vulnerable population. To ensure the confidentiality of participants, several measures were implemented:

- **Partner organizations:** we partnered only with trusted organizations that already had established relationships with the local Latino community. These organizations were the only ones other than us that had access to the names and contact information of participants.
- **Focus group moderation:** Data was collected by trained bicultural and bilingual moderators and note-takers. They avoided using the full names of participants during the audio-recorded part of the focus group session and full names were not recorded on the notes.
- **Transcription and translation:** The audio recording produced during the focus group was transcribed and translated by a third-party company not affiliated with the local community.
- **Data storage:** Focus group notes and transcripts were stored in paper and digital form. Digital copies were kept on a secured server and paper copies were kept in a locked file cabinet inside a locked office at Willamette Neighborhood Housing Services.
- **Data sharing:** Data was only shared with individuals participating in the data analysis process (the study coordinator and select representatives from Oregon Health Authority).

Analysis

Study Participants

Our study included 42 participants, divided into five focus groups. Three groups were hosted with females, two with males. Groups also took place in urban areas (two in Corvallis and two in Albany) and rural areas (one group in Philomath, rural Benton County). Approximately 58% of the participants were female, and 65% of the participants reported being raised outside of the United States.



Themes

- **Resources** – Sources of information about sexual and reproductive health and related health care services
- **Barriers** – Factors that make it hard for Latinos and Latinas to access health information and services
- **Interpretation and Privacy** – Key concerns among Latinos and Latinas when seeking health care services
- **Stories** – Past experiences of Latinos and Latinas while accessing sexual and reproductive health services

Resources

Two main types of resources were mentioned by study participants: 1) places or people that Latinos can use to find information on sexual and reproductive health issues, and 2) places or people that able to provide needed health care. In terms of finding health information, participants indicated that they asked questions to health care professionals (such as doctors, nurses, and health navigators); they talked to friends or siblings; and they researched using the internet, brochures, or books. Regarding the places where they accessed health care, they mentioned county health departments, community health centers, private health care providers, and the local university/college student health center.

Both men and women participating in this study indicated that they preferred to speak to a health care professional in order to get health information. Most participants agreed that a health care professional is someone whose knowledge they can trust and who can be a reliable source of information. However, it is important to note that the participants who were more inclined to seek health information from health care professionals also indicated that they had established relationships with these professionals. This reflects two key aspects of most Latino cultures – *respeto* and *personalismo*. *Respeto* relates to the value of respect for individuals, especially for figures of perceived authority (such as highly trained medical professionals) while *personalismo* refers to the importance of developing trusting, warm, friendly, and personalized social interactions with others (Kaiser Permanente Diversity Council et al., 2000). These key cultural values shape how Latinos and Latinas interact with health care professionals and how much trust they place on the information provided by them. It is also key to consider that interactions with health care professionals depended on a participant’s access to either private or government-sponsored health insurance. Therefore, foreign-born undocumented Latinos or those working lower paid jobs with few benefits were less likely to be able to have access to a health care professional even if that was their preferred source for health information.

Among women – and especially younger women – friends and older siblings were also key sources of sexual and reproductive health information. This can also be understood as a reflection on the value of *personalismo*, as relationships with close friends and siblings are often trusting, warm, and personalized. One college-aged woman said that her friends who were sexually active were often a source of answers to her sexual health questions: “I have noticed that sometimes we open up among women... And if we have questions or answers, we share them from one to another.” Another young woman described practical reasons for these interactions:

“I’m thinking about my sister or younger people that I know. But at [the age of] 18, you’re still living in your parents’ house, and sometimes you don’t work yet. [...] Sometimes they would use me as their resource, or other girls would use their older sisters as a resource. Because I had a job, they would ask me to go buy things for them.”

Some women reported talking to their friends about their sexual and reproductive concerns first, and then following up with a visit to a health care professional if they felt the need for additional information. This two-step process was also common among men; however, instead of seeking advice from friends, men more often searched the internet or books prior to meeting with a health care professional. The internet was mentioned by both men and women as a source for guidance and a means to access many sources of information; however, many participants also mentioned concerns regarding how reliable and trustworthy were these internet sources.

Barriers

Study participants discussed at length many of the barriers that prevent them from accessing sexual and reproductive health information and health care. They identified a series of barriers, most of which fall within one of the following categories: cultural barriers, service barriers, and economic barriers.

* * *

Culture encompasses a collection of shared beliefs, values, and customs that shape the ways people from specific ethnicities or nationalities think, communicate, or behave. **Cultural barriers** to healthcare, therefore, are related to differences in the cultures of patients and health care providers.

In many Latin American cultures, sexuality is a taboo subject and discussing sexual behaviors can be a source of shame and embarrassment. “We come from countries where sexual education is very limited because we have taboos that limit us to ask questions about that issue,” said one foreign-born middle-aged woman. This can be particularly challenging for young, unmarried, child-free women, as another participant explained:

“I think that women without children would feel more embarrassed because they don’t feel confident or they don’t have the liberty to say that they are having sexual relations, compared to a married woman who can go to the clinic if she is sick or anything like that because she has a partner, while men or women who are single feel more limited to do that. Mostly because they feel embarrassed.”

Men of all ages also face cultural barriers – in the sense that they are not usually expected to seek sexual and reproductive health care for themselves. According to one middle-aged man, he only ever accessed this type of health care when his wife was pregnant.

“I never went to the doctor while I was single to ask about that information, never. And now that I’m married, every time we went to the doctor was because my wife was pregnant, I mean, the appointments with the gynecologist when she was going to deliver the baby, and we always talked with the doctor. And he asked us if she was going to use a device or something to prevent another pregnancy or what method to use. [...] But that was when we got married, never as a single man.”

Participants of both genders and all ages also mentioned the potential shame associated with receiving sexual and reproductive health care. They reported that being tested or treated for a sexually transmitted infection or seeking birth control methods were behaviors that could be perceived as an indication of promiscuity, which goes directly against religious and conservative family values. Even participants who did not personally subscribe to those cultural beliefs reported being affected by them, as one foreign-born woman in her 40s explained:

“I think that the Latino society, in general, it is a little bit more closed, more conservative, and more Catholic. And that is the education that has continued to be taught – of things that are not correct for you to do. If you’re a woman it’s not right to lose your virginity before marriage. [...] I am from Mexico City, which is a little bit more open minded than [other places]... And even then, I had a hard time with my mother. I think that Mexican society, the Catholicism, the religion, and everything around – the idea that you get from it is that [sex] is wrong and embarrassing. Even when lots of things have changed, we still have that culture.”

* * *

Service barriers are those related to how sexual and reproductive health services are structured, and how these factors may limit opportunities to access these services. Study participants identified service barriers related to both the structure of sexual and reproductive health services in Linn and Benton Counties and characteristics of the health care providers themselves.

According to the Healthy People 2020 website, access to comprehensive, quality health care services depends on 3 key components: insurance coverage, health services, and timeliness of care. In this section, we will discuss the last two components, and discuss insurance coverage under economic barriers.

Several study participants indicated that they were unable to access sexual and reproductive health services because they were not aware of many locations that offered services in Linn and Benton counties.

“Most of our people don’t know where to go because they are not informed and that’s the reality. Maybe only 1 or 2 of the people present here don’t know where to go, but outside maybe 80% of the people don’t know where to go.”

“I think there are very few services in [this] community. Honestly, they mentioned about two or three, or something like that, maybe there are more, but most of us have children and the services we have received have been during our pregnancy, and when you don’t have any more children you can’t go to this clinic or to that other one...”

“[Services are] very limited, you need a referral from your doctor in order to go to a specialist if [your consultation] is about a condition that he is not available to cure. But it is very limited, and I believe if that’s limited to me even when I’m very connected with so many doctors, that would be even more for the people who don’t know that much.”

In addition to that, many study participants were concerned that existing service providers were unable to offer them timely appointments; sometimes, the hours of service also clashed with their work or family obligations:

“The problem with clinic X is that you have to wait around six months to get your appointment, and sometimes, when I call because I’m not feeling well, they send me to the emergency room.”

“For example, clinic Z is only open until 5:00pm, and people work until later so they don’t have time to go.”

“Most of the time, people work from 8am to 6pm and that is when they offer the clinic hours, so you have to ask for that day [with the late hours] in order to get any test done.”

“[Late hours] are perfect for the summer because the day is long, but in the winter when the day is shorter and darker, we can’t drive because we can’t see well. And many people don’t have a license so they can cause an accident.”

Finally, many participants were concerned that they could not see health care providers that matched their needs and preferences. Women often preferred female doctors, males often preferred male doctors. Some participants also indicated they would prefer doctors and nurses who could communicate with them in their native language, or to see the same provider on a consistent basis to ensure the quality and continuity of their care.

“I believe it would be important to know if you’re going to have a female or male doctor. And if you have a preference and it’s not met, that is something that might cause someone to stop going to the doctor.”

“I feel more comfortable when a female doctor is present. [If one is unavailable] I try to make another appointment there or I go to another clinic.”

“I would like to see the same doctor always instead of seeing different doctors. [...] Sometimes they lose important information when you’re not always assisted by the same doctor. You have to repeat your story again and again to the different doctors.”

“Regarding the language, I prefer to go to the clinic X because they understand my Spanish much better. The problem is that I have gone to other clinics – my insurance covers any other clinic – but they only speak English [in those].”

Economic barriers prevent people earning lower incomes from affording sexual and reproductive health services. Study participants indicated that economic barriers often were due to lack of health insurance coverage, the high cost of health care services, or their need to prioritize their work rather than accessing needed health services.

Men and women across all age groups were concerned with the high cost of health services; sometimes, simply the perception that the services would be expensive was enough to deter them from seeking health care.

“If the prices were not so expensive, I would like to see the same gynecologist who has assisted me during my pregnancies. I would like to see her for my annual checkup.”

“I have two friends – [for them] it is about money. Because it is true that living in the United States is very expensive. And simply they are like, I don't go [to the doctor] because I will end up paying a fortune. People are afraid of getting those services, even in those 24-hour clinics, not even urgencies. One friend was in need of going so I told her, ‘why don't you go there?’ ‘I won't be able to pay for it,’ she told me. I believe it is the fear of how much it may cost. Only the doctor's appointment by itself, let alone if they need something else. It is the terror of knowing that they won't be able to pay for it.”

“At the clinic they told me that if I scheduled another appointment they were going to charge me \$150.00 just for – like, what is this called? [...] I mean it wasn't a proper appointment. Just to come in and get information. For that I would have to pay \$150.00.”

Lack of insurance – which is more prevalent among foreign-born undocumented Latinos and those who work lower income jobs with few benefits – contributes to the high cost of health care and the perception that seeking health care will be unaffordable. That is worsened by a lack of understanding of the inner works of health insurance and health policies.

“One of the barriers is the medical expense. Sometimes people are eligible for a percentage of discounts in some clinics and the same thing applies to insurance companies. The insurance companies tell you that you're eligible for this service, but unfortunately it does not cover this other aspect. And this other aspect is the expensive part of the medical services. So, when you know that, you don't even make the appointments, right?”

“We don't have insurance, and that is the problem. That is the reason why many people do not get medical attention. Due to the high costs. [...] Especially in hospitals. For example, I am going to get a couple of tests, I am going to get an endoscopy and a colonoscopy. Those exams are very expensive, but I require [them]. So, when I went to a private clinic, my doctor told me that since I didn't have insurance – that I couldn't make an appointment to get tested there.”

Finally, a few study participants indicated that they were likely to prioritize their work or family responsibilities over health care. If faced with the choice of taking time off from work to go to the doctor or working through an illness, they were likely to choose the latter.

“I know some people that because they don't want to miss a day at work or because they are single mothers and they need to work, they don't make the appointments. Sometimes, at work, they tell you that if you miss a certain number of days they will suspend you or you will lose your job. That is another reason why they don't search for assistance.”

“With our culture, our way of thinking, is that we come here to work, support your family, and also send money to Mexico, so that would be an obstacle too, the money. We always think, ‘No, it’s going to be very expensive, I’ll lose a day of work.’ Everything counts.”

Interpretation Services and Perceived Privacy Issues

The National Cultural and Linguistic Appropriate Services (CLAS) Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations; they require, among other things, that health care providers:

- 1) Offer language assistance to individuals who have limited English proficiency at no cost to them, to facilitate timely access to all health care and services;
- 2) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing;
- 3) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided; and
- 4) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Some participants reported being aware of the existence of CLAS Standards:

“I recently learned that when you go to a clinic, you have the right to demand having an interpreter. In the past, we didn't know that we had that right. Nowadays, we do – even now, my personal doctor needs to have the interpreter there for me. In case I don't understand something, he needs to be there interpreting.”

Other study participants, however, reported a range of experiences that fell short of these requirements. Examples included not having an interpreter available on-site or using relatives, friends, volunteers, other staff, and otherwise untrained interpreters during consultations.

“I know one person who had an experience like that. He went to his doctor appointment, and since there weren't interpreters available, the doctor told him to cancel his appointment and get an interpreter.”

“Some people went through that but was because the interpreter didn't appear and they didn't have any other, so they have to cancel the appointment.”

“And as you have said, people don't know about their rights. I was volunteering at a hospital, and I didn't know that I wasn't supposed to be translating... It was a big hospital, and they had me translating for Hispanics.”

“I noticed one time that the first language of the volunteers [interpreters] was not Spanish, and they were students learning Spanish. I was sitting down while one of them was interpreting and a lot of the things that he was saying were not the same thing. [...] Then, I decided to get in there and started translating to avoid misunderstandings between the patient and the doctor and to give him a more accurate diagnosis instead of being confused. So, I think that's another issue, having volunteers and sometimes not having the level of Spanish to be able to translate for patients.”

“I remember that at the big clinic – I remember that they would have the cleaning lady translating. The doctors would call her so that she would translate, and she would say, ‘I'm cleaning the rooms.’”

Concerns about using interpreters to access sexual and reproductive information and health services were very common among study participants. Interpretation of medical terms can be challenging, and many study participants worried that important information could be lost in translation.

“There are some times when a son or a daughter can say more [than you can], they can interpret things. But there are some words that doctors use that a kid won't know how to translate. Or a word that doesn't have a translation, or a professional word that they don't know used by a doctor...”

“Sometimes you understand a little because you know some English so you tell something to the interpreter and you realize that the interpreter is translating wrongly. ‘I didn't say that. I said this,’ because I understood what the interpreter was saying and it was not exactly what I had said.”

“I went with my mom to a gynecologist appointment, and they had an interpreter. And I was there, and the interpreter was saying what the doctor was telling [to] my mom. And I was listening to what he was saying, and a lot of those things were not correct. But I didn't say anything, I was just listening in silence. And my mom was a little embarrassed of being like that in those clinics. And I could see her blushing. After the appointment, I told my mom – he didn't say many correct things. So, after the appointment, I was telling her more.”

“I have even seen written translations which are not very understandable, and when they interpret they make mistakes, and sometimes the interpreter doesn't explain to the patient what the doctor is telling him in the same way. Sometimes the information is not translated correctly.”

To a large degree, study participants were concerned not just about the quality of the interpretation, but also about possible violations of their privacy. Considering that discussing sexuality and reproduction can be a source of shame and embarrassment to Latino patients, ensuring privacy was at the forefront of their concerns – and privacy is increasingly harder to achieve when informal interpreters are involved in health care.

“We don't want to communicate our problems and if we have to explain it to a second person it's even more complicated for us.”

“Well – when you I get the Pap smear – I mean, I do find it quite embarrassing to have someone other than the doctor there watching me. I mean, it's just embarrassing.”

“I know very little English and I don't know how to express myself. Lately on Clinic X I have a nurse who helps me with the interpretation but you don't have privacy. There are many people and you're not in a private place with the doctor.”

“[Interpretation] would be a barrier for my mom. On top of that, she doesn't like talking about those things, having me on the room where that conversation was going to take place – she would tell me to leave.”

“If they are asking you in front of your wife, and the question is about the number of people with whom you have had intercourse [...] it is obvious that you won't be one hundred percent honest.”

Especially in places where the Latino community is small or close-knit, participants worried that others would find out about the sexual and reproductive health services that they received.

“[Young people who are] under their parents' medical plans, they don't want to use those medical services because they think that their parents are going to learn about something they don't want them to know.”

“[My sister] was always scared of being seen by someone she knew while being there. And she was also scared of them saying that she liked being with many people.”

“Something I have heard from some people here is that some men say they don't go to the clinic because this woman or this man is working there, and here we all know each other...”

“You tell it to one person and a while later everybody will know about it.”

“Maybe they don't want others to know, such as the compadre, friend, neighbor, that they have a disease. ‘Why did they have that disease? I know him, he is married and a good person.’ You don't want to be exposed to other people's judgement. There is a fear in Latino people, fear of what they will say something and maybe they're going to disclose it.”

There was also very real concern on the part of undocumented participants that the information that they provided during their medical consultations could be used against them.

“Now people think that if they go to some places [these places] will provide information to Immigration.”

“When you go to the clinic they always ask your information, name, where do you live, and I believe that excess of information scares people because those without papers. What are they going to write down? And if they have my information, what if they provide that information to third parties? So I believe the excess of information is something that intimidates people, for those without papers.”

“That's what I've watched while people fill out the documents, specifically if they are asking for a social security number, they don't feel comfortable saying they don't have it, but every time the document says ‘social security number’, and it doesn't say ‘if you have one’, or if that's not mandatory... It doesn't look like optional, so you interpret that you need one to get the services.”

Stories

Finally, study participants shared several stories that illustrate how the themes discussed in the previous sections shape their interactions with health care providers in either positive or negative ways.

*“I accompanied a woman who came from Mexico who lost her child. She didn't know how to read, she didn't know English, and she had worked in the fields her whole life. [...] When I took her to the doctor they told her, ‘Haven't you seen the brochures there?’ But the lady didn't even know how to read, she didn't know how to drive, she didn't know anything. **So, there are services that are not available for everybody. You must find out what person you're dealing with when you provide a service.**”*

This story was told by a U.S.-born woman who was trying to assist a foreign-born acquaintance. She indicated that health services providers need to take into account the special needs of some of their Latino patients, and that their interactions need to be tailored in order to ensure equitable treatment.

“I had a very good experience. The doctor that I got **was very kind** and she **made me feel very safe**. [...] I even forgot that I was embarrassed. And they try to give you information. There are many times where you haven’t asked anything and they are giving you information. **And in the end they ask you, “Do you have any questions?” And you can ask anything.** I went in for a pap smear and they gave me information and they also tested me for STDs. They performed **both of these tests at the same time**. I filled an application so they could **cover some percentage of the bill**. So, I didn’t pay much. [...] I first got my IUD after my son was born. When I used to go to the checkup for the change of IUD and I got a male doctor. It was Dr. A.; **He speaks Spanish and he is very kind**. [...] And the **procedure was very quick** and I was like, “Wow.” I liked him a lot. He is a male doctor and it was the first time I saw him but **I didn’t feel uncomfortable**. [...] That is why they call him **‘the doctor for the Latinas.’**”

This story, told by an immigrant woman, demonstrates the importance of the cultural value of *personalismo*. The doctors and office staff were perceived as good because they were kind, patient, and devoted time to interact personally with the patient. They made her feel safe, communicated in her preferred language, addressed her concerns, and made effective use of her time and resources. This story also speaks to the power of word-of-mouth in the Latino community.

A college-aged, U.S.-born woman describes the importance of providing trauma-informed care. Her perceptions of being judged by her ethnicity – whether true or not – negatively influence her interactions with health care providers.

“The doctor I had – because of the age I [was], I needed the Pap smear. I told her I didn’t need it yet because I wasn’t sexually active – and she wouldn’t believe me. She would keep saying that it was very important for me to have the Pap smear test if I was sexually active. And I would keep telling her that I wasn’t. And **I am also a survivor of sexual abuse**, for many years. I hadn’t told her about that, but it told them that I was completely celibate, that **they should trust me**. [...] But they told me that they were going to deny services for me, access to birth control, if I didn’t have my Pap smear. [...] It’s traumatic to have a test when... a stranger – I don’t want them to touch me or anything. And every time I need to be giving explanations, and they don’t believe me... **Sometimes I felt that because I am Latina, they thought I was promiscuous**. That I was doing those things even when I told them that I wasn’t. [...] I didn’t even want to go after that...for nothing at all.”

“I was **very uncomfortable** because they didn’t say anything, the doctor was checking, and suddenly she touched me [in my genitals], and without anticipation, she was touching me there. And I was like, ‘What is going on?’ [...] **I was expecting for her to let me know**, ‘I’m going to touch you here.’ But that wasn’t the case. I know it is her job, but I believe she has to tell you if she has to touch private parts.

A middle-aged man describes his uncomfortableness when medical procedure is not clearly explained, which was worsened by the fact that his health care provider was female.

A foreign-born undocumented woman on her late 20s describes experiences of perceived discrimination and neglect when she was pregnant for the first time.

“When I became pregnant for the first time, I was 20 years old, and although I have been living in the United States since I was 1, **I didn’t have my license or documents or anything like that**. [...] So when I was two or three months pregnant, I started feeling pain in my stomach and I called clinic X and told them ‘I think it’s something urgent,’ [but] they told me they couldn’t be of much help so they sent me to emergency room. [...] **I would have liked someone to assist me, I was very nervous, this was my first pregnancy**. I don’t remember if it was that same night or the following night when I experienced a miscarriage. I thought that they could have helped me. [...] I think they **prefer to provide more assistance to English-speaking people** than to the Latino community.”

Recommendations

General Recommendation	Policy Examples
Invest in culturally-appropriate care	<ul style="list-style-type: none"> • Hire Latino(a) staff to fill positions at all levels of the organization • Train non-Latino(a) staff across the organization on cultural norms; ongoing training is better than a single training • Employ community health workers, health navigators, and other similar positions; capitalize on their close relationships with the community and their ability to promote culturally-appropriate care
Invest in linguistically-appropriate care	<ul style="list-style-type: none"> • Ensure that interpreters already have or can receive proper training in medical interpretation; avoid utilizing untrained interpreters • Guarantee that all written materials are translated by a competent translator and are written following health literacy standards • Display written materials in Spanish prominently • Ensure that patients receive written materials in their preferred language
Communicate health information in many different ways and places	<ul style="list-style-type: none"> • Consider sharing sexual and reproductive health information in unconventional places (workplaces, community centers, etc.) • To the biggest extent possible, allow patients to receive information in the way that is most comfortable or useful for them <ul style="list-style-type: none"> ❖ Example: In this study, female participants tended to value face-to-face interactions with caring professionals, while male participants tended to prefer the anonymity of brochures, websites, and other written materials
Ensure that patient's privacy and confidentiality is respected	<ul style="list-style-type: none"> • Clearly indicate on written forms what information is optional • Explain to patients that there are rules (i.e. HIPAA) that provide data privacy and security provisions for their medical information • Health care professionals should reinforce to patients that information shared on consultations is confidential • Health care professionals and interpreters should act to the best of their capability to ensure that patient information is indeed kept confidential

References

- Clinical and Translational Science Awards Consortium. (2011). Principles of community engagement. Rockville, MD: US Gov. Printing Office.
- Gurman, Tilly A., and Davida Becker. "Factors affecting Latina immigrants' perceptions of maternal health care: findings from a qualitative study." *Health Care for Women International* 29.5 (2008): 507-526.
- Kaiser Permanente National Diversity Council. (2000). A provider's handbook on culturally competent care: Latino population. Oakland, CA: Kaiser Permanente.
- Regional Health Assessment Linn, Benton, & Lincoln Counties, Oregon. (2015)

Appendix

Partner Organization Responsibilities

In exchange for a \$2500.00 stipend, we ask that partner organizations commit to assisting us with items 1, 2, and 3; there is an additional \$500.00 stipend for those who wish to assist with item 4 as well. A contract will be drafted if terms are agreeable.

- 1) Feedback on research materials (anticipated time commitment is 2-3 hours)
 - a. Partner organization should revise materials used in the study and provide feedback if appropriate or needed.
- 2) Recruitment (anticipated time commitment is 20-40 hours)
 - a. Partner organization staff will use the **Recruitment Guidelines** to reach out to a pool of potential participants (clients, community members, etc.).
 - i. The goal is to recruit enough participants to fill 1 or 2 focus groups with 6 to 10 participants each (a total of 8 to 16 participants total)
 - ii. Please aim to recruit roughly equal numbers of men and women, unless this proves impossible.
 - iii. Notify study coordinator as soon as you have enough participants to host a focus group.
 - b. Partner organization staff will keep track of the contact information of potential participants using the **Potential Participant List**.
 - i. The list should be printed and kept private.
 - ii. The list should be kept in a safe, locked location.
 - iii. The list should be destroyed after focus groups take place.
 - c. Partner organization will notify participants of the time and location of their focus group at least one week ahead of time, and remind them within 24-48 hours of it.
- 3) Focus Group (anticipated time commitment is (2-3 hours)
 - a. Partner organization should help the study coordinator identify appropriate spaces and times to hold focus groups in their area.
 - b. Partner organization may provide childcare during the focus group, if they are insured to do so; the organization will be compensated appropriately, and this would be in addition to the partnership stipend.
 - c. Partner organization staff that reached out to participants should arrive at the focus group location 30 minutes before the group starts to ensure that doors are open, childcare providers can access the building, and food can be delivered.
 - d. Partner organization staff should interact with participants and focus group moderator for the first half hour of the group; please introduce people to the moderator, and make them feel comfortable. The staff should leave within 30 minutes so that the structured data collection can begin.
- 4) Dissemination of results - OPTIONAL / ADDITIONAL STIPEND AVAILABLE (anticipated time commitment is 5-10 hours)
 - a. Partner organization should help the study coordinator identify appropriate spaces and times to hold a community meeting in their area; this meeting will be used to report on study results to the local community.
 - b. Partner organization should assist with outreach and promotion to Latinos in their area in order to encourage their attendance.
 - c. Partner organization should attend the community meeting.

Study Coordinator Responsibilities

- 1) **Research materials:**
 - a. Develop and design all research materials that will be used in the study.
 - b. Provide all materials to partner organizations in a timely manner.
 - c. Incorporate feedback received from partner organizations to improve materials.
- 2) **Recruitment:**
 - a. Assist partner organizations as needed for recruitment.
 - i. Provide instructions on how to use the forms.
 - ii. Offer technical assistance regarding recruitment guidelines.
 - iii. Answer questions about the study.
 - b. Study coordinator should NOT interact in person with the potential participants or have access to any of their personal information.
- 3) **Focus Groups:**
 - a. Focus group organization:
 - i. Study coordinator will work with partner organizations to identify appropriate spaces and times for the focus groups.
 - ii. Study coordinator is responsible for reserving spaces, and paying for it.
 - iii. Study coordinator is responsible for securing childcare if the partner organization declines to provide it, and paying for it.
 - iv. Study coordinator should arrange for food to be delivered and picked up at the focus group location, and paying for it.
 - b. Focus group protocol:
 - i. Study coordinator will identify and contract with trained moderators and note takers to run the focus groups; background checks will be conducted prior to contracting with these professionals.
 - ii. Study coordinator will develop and design all materials that will be used in the focus group, and will provide them to the moderators ahead of time.
 - iii. Study coordinator will ensure that moderators have access to all the necessary equipment to conduct the focus groups.
 - iv. Study coordinator will ensure that incentives are available to each participants at the end of the focus group.
 - v. The study coordinator should NOT be present at the focus group session in order to ensure privacy and confidentiality of the participants.
 - c. Data management:
 - i. Study coordinator will arrange for the de-identified focus group audio recording to be transcribed by a third-party unrelated to the community.
 - ii. Study coordinator will arrange for notes and transcripts in Spanish to be translated to English.
 - iii. De-identified audio recordings, transcripts, and notes will be digitally stored in the secure server of Willamette Neighborhood Housing Services; study coordinator will destroy them at completion of the study.
- 4) **Dissemination of results:**
 - a. Study coordinator will work with partner organization to identify appropriate spaces and times to hold a community meeting in their area
 - b. Study coordinator is responsible for reserving spaces, and paying for it; all other logistical arrangements will be made by the study coordinator
 - c. Study coordinator should assist with outreach and promotion to the community.
 - d. Study coordinator should attend the community meeting.

Recruitment Guidelines

When recruiting participants for the study, whether by phone or in person, please follow the instructions below. You do not have to follow them word by word, but all of the key elements must be present on the conversation.

- 1) Introduce yourself and give your affiliation: “Hello, my name is [NAME] and I work for the [PARTNER ORGANIZATION]. Is this a good time to talk to you?”
- 2) Explain the reason for the call: “I am calling to invite you to participate on a study that the Linn Benton Health Equity Alliance is conducting.”
- 3) Describe the study briefly:
 - a. They want to learn about: 1) how Latinos in Linn and Benton counties get their health information, 2) what barriers they face when trying to access health services, and 3) what are their experiences while receiving health services. The focus is specifically on sexual and reproductive health (sexually transmitted infections, birth control and family planning, etc.).
 - b. The results of the study will help improve sexual and reproductive health services, so that they can meet the specific needs of our local Latino community.
 - c. We would like you to participate in a focus group (a group conversation) with other 5-9 people of your same gender; this will last about 2-2.5 hours, will happen on an evening or weekend, there will be childcare and food, and we will pay you \$35.
 - d. Your participation should be completely voluntary, and will not affect any of the services that you receive from us or the Linn Benton Health Equity Alliance. If you decide to participate, all of the information that you provide will be kept confidential. We will not be collecting your name or any other private and identifiable information during the focus group itself.
- 4) Give the potential participant a chance to ask questions and answer them: “Do you have any questions about the study? Are you interested in participating?”
- 5) If the potential participant is interested in the study, collect their information: “I need to collect some information from you now so that I can contact you when we schedule the focus groups. This information will not leave [PARTNER ORGANIZATION], and I will destroy it after we complete the focus group. If you are uncomfortable answering some of these questions, just let me know. Is that ok?”
 - a. First name only (no last names needed)
 - b. Gender (no need to ask if you know their gender)
 - c. Age (an age range, i.e. 30-40 years old, is fine)
 - d. Preferred language (English or Spanish)
 - e. Method of contact (a phone number or email where they can be reached)
- 6) Closing section:
 - a. **For those interested in the study**: “Thank you for your time, we really appreciate your help. I will contact you once we schedule your focus group. We look forward to seeing you there. Please feel free to contact us if you have questions.”
 - b. **For those NOT interested in the study**: “Thank you for your time. Can I leave my contact information with you in case you change your mind? And even though you don't want to participate, do you know another person (man or woman) who might be interested?”

Voicemail or other Message - If you must leave a message (in a voicemail box or with someone else), please follow this script: “My name is [NAME] and I work for [PARTNER ORGANIZATION]; I am trying to reach [PARTICIPANT] to talk about a study that they may be interested on. Please call me back/email me at [CONTACT INFORMATION].”

Oral Consent Card

PLEASE MAKE SURE THAT:

- 1) **People understand they are taking part in a research project.** They understand what you are asking of them, and they freely consent to participate. You have their permission to use the information you gather about them in the ways you intend.
- 2) **People understand what kinds of information you are collecting** and what materials you will be carrying away from your interactions with them (notes and audio recording).
- 3) **People know that we do not intend to collect personal identifying information** about them and that we will strive to keep their identities confidential.
- 4) **People know they do not have to share anything they do not want to**, and they are free to remain silent any topic.
- 5) **People understand the risks they incur in participating in your research** and what you are doing to minimize them (not collecting identifying information, keeping audio and notes in a safe location, destroying the audio and notes after the study).
- 6) **People know they can opt out of your study at any time**, and that they can request that their information be destroyed to the largest extent possible. There will be no consequences for withdrawing.
- 7) **People know that there is someone they can ask** if they have any questions or concerns about your research.

Study Contact Info:

Clarice Amorim Freitas, Linn Benton Health Equity Alliance Coordinator
Address: 257 SW Madison Ave, Suite 113, Corvallis OR 97333
Telephone: 547-752-7220 (extension 315) / 541-714-3216
Email: LinnBentonHEA@gmail.com

Oral Informed Consent Script

As you know, I we are here to have a conversation about how you find information and access health services related to your sexual and reproductive health; we are also interested in some of the experiences you may have had while using these services.

I would like to record our conversation, and my colleague, [NAME OF NOTETAKER] will be taking some notes; this is so that we can get your words accurately. If at any time during our talk you feel uncomfortable answering a question please let me know, and you don't have to answer it. Or, if you want to answer a question but do not want it recorded, please let me know and I will turn off the machine.

Your participation in this study should be completely voluntary. If at any time you want to withdraw from this study please tell me and I will make good effort to eliminate your comments from the final transcript. Your decision to not participate in this study will not affect any of the services that you may receive from [PARTNER ORGANIZATION] or the Linn Benton Health Equity Alliance.

I will not reveal the content of our conversation to anyone other than the study researchers, whom I trust to maintain your confidentiality. I will do everything I can to protect your privacy, but there is always a slight chance that someone could find out about our conversation.

Do you agree to participate, and to allow me to record our conversation?

Focus Group Guide

MODERATOR NOTES: GENERAL PROBES (Use probes as needed when vague or ambiguous answer arise. Use them to clarify or encourage more specific and in-depth responses)

- Would you give me an example?
- Can you add more details?
- I'm not sure I understand what you're saying.
- Is there anything else?
- I would like to hear more
- Tell me more about ____
- When you said _____, I wasn't sure what you meant. Could you tell me a bit more about that?"
Use if answer is: ["good," "bad" "normal" type of answers]

RECOMMENDED INTRODUCTION:

The purpose of our meeting is to learn about the knowledge, needs, and barriers to accessing reproductive and sexual health services among Latino people you know, like your family, friends, and neighbors. Information shared in this meeting is confidential. Feel free to share your experience as you feel comfortable but you can also say "I know someone who...." if that is a more comfortable way to share information. Please do not mention specific people in your community by name.

These following questions ask about how people in your community get information related to sexual and reproductive health – information about sexually transmitted infections, HIV or other STDs such as gonorrhea or chlamydia, birth control, pregnancy tests, family planning and other related health issues.

Questions about access to information

1. When Latino people you know have a health question related to sexual and reproductive health, how do they usually get that question answered? Where do they feel comfortable going to?
 - ❖ **Prompts:**
 - Some examples of where people might go are people, places (including the internet).
 - What are some of the different sources of information used by Latinos and Latinas that you know? How are they different for men compared with women? Younger adults compared with older adults? Unmarried compared with married? Those with children compared with those with no children?
 - What are some reasons why people may be more comfortable with certain resources rather than others?
 - How accurate do you think the information is? What makes the information accurate or inaccurate?
 - How would we get accurate information out to the community?
2. Thinking about Latino people you know, how aware are they of the healthcare services and options related to sexual and reproductive health that are available to them?
 - What can we do to increase awareness of these services?

Questions about access and barriers to services

3. What are some reasons that Latino people you know may not use a public or community health clinic (such as WIC) if they have concerns about family planning, birth control or their sexual health?
 - Are there concerns about private information being shared?
 - Do they prefer to go to their own provider?
 - How have the clinics been sensitive to cultural customs? How have they tried to accommodate cultural values?
 - What is the impact of having an additional person in the room to interpret? How does it make care easier or more difficult?
 - Which traditional cultural beliefs or religious beliefs can encourage or discourage the use of a local clinic for sexual or reproductive health information or services?
 - Are there different reasons for young people? Men vs. women?
4. What are some specific reasons why you think Latinos who were raised outside the United States may not use such a clinic if they needed one?
 - How is someone's legal status a barrier?
 - What could clinics do to make them more welcoming and safe for community members raised outside the US?
5. Do Latinos you know experience any language barriers to getting information and services, including interpretation services? If so, please describe.

Questions about experiences with sexual and reproductive health services

6. Tell us about an experience when you or someone you know received sexual and reproductive health services.
 - Where did they go?
 - What made it a good or bad experience?
 - Some examples to comment on are: service hours, costs, transportation, interactions with clinic staff, having a male or female provider, language, birth control supplies, etc.
 - What would have made it a better experience or made the experience more comfortable?
 - Why were you (or someone you know) satisfied or dissatisfied with the visit?
7. What would make it easier for Latino people you know to get family planning services or testing for HIV or other sexually transmitted infections, like Gonorrhea or Syphilis?

General/Other Questions

8. What would Latino people you know tell you were the reasons they didn't want to go to a local clinic for sexual and reproductive health services?
9. If you have one suggestion or advice about what could be done to improve the sexual and reproductive health services for Latinos in your community, what would it be?
10. Is there anything else you would like for us to know about the sexual and reproductive health needs of the community or anything else we talked about today?

[Conclude, Collect Demographic Info, Distribute Incentives, Thank Participants]

Demographic Information

Please complete the following information:

1. I identify my gender as:

- Male
- Female
- Another identity _____
- I do not wish to identify

2. Age:

- 18-19
- 20-29
- 30-39
- 40-49
- 50 and over

3. I was:

- Raised in the United States
- Raised outside of the United States
- I do not wish to respond