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## Introductory Needs Assessment of Latino MSM with HIV or AIDS in Washington: Exploring Needs, Barriers to Care, and Wellbeing

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# **Introductory Needs Assessment of Latino MSM with HIV or AIDS in Washington: Exploring Needs, Barriers to Care, and Wellbeing**

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## Abstract

Although substantial progress has been made in the fight against the HIV and AIDS epidemic in the US, health disparities and gaps in the federal response persist, particularly for African Americans and Latinos. While men who have sex with men (MSM) continue to be the most affected population, subpopulations like Latino MSM and undocumented, foreign-born, and recent immigrant Latino MSM are disproportionately impacted by HIV-related issues. The present study offers an introductory needs assessment of 23 Latino MSM with HIV or AIDS who reside in Washington state. This research aims to analyze the HIV-related needs and experiences of this population and compare outcomes based on legal status and country of origin. The participants were mostly low-income, foreign-born, and Mexican or Mexican American. Quantitative data was primarily gathered through self-administered electronic and paper surveys; several phone surveys were also conducted. Several salient findings emerged from statistical data analysis. Participants indicated that their greatest areas of need were related to low income, dental care, and healthcare costs. There was also a demonstrated need for increased support for undocumented and foreign-born Latino MSM with HIV or AIDS in a service provision context. Compared to their counterparts, these groups present greater need for social support, community involvement, and mental health. They also report more frequent experiences with stigma of various types and in a variety of settings. Implications for further research and service provision are provided.

# Introduction

## HIV Statistics

There are at least 14,000 people in Washington state (WA) who have been diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), according to the most recent data (WA Dept. of Health, 2020). Over half resided within King County, which contains the Seattle metropolitan area; 84% were male, and 61% identified as men who have sex with men (MSM), including gay, bisexual, or other sexual orientations. Of the 410 new HIV diagnoses reported in 2019, foreign-born Latinos were the most disproportionately affected population, with an incidence rate four times greater than that of Latinos born in the United States (US). Additionally, Latinos had the lowest rate of initial linkage to care, a crucial step within the HIV care continuum between diagnosis and receiving medical care and treatment.

These are all long-standing trends that align with national statistics. Of the 30,635 new HIV diagnoses registered in 2020, 71% (21,867) were reported as MSM, and Latinos were one of the most disproportionately affected populations, accounting for 27% of new diagnoses (Centers for Disease Control and Prevention, 2022). Furthermore, although new HIV cases are decreasing overall, cases are on the rise among Latinos. From 2010 to 2020, overall incidence decreased by 6%, but the incidence rate for Latinos increased by at least 14% (Guilamo-Ramos et al., 2019). This alarming data signals the need for increased HIV prevention efforts, identification and mitigation of barriers to HIV care, and improvements to HIV service provision for Latino MSM with HIV or AIDS both locally and nationally.

## Stigma and Barriers to Prevention and Care

Stigma, whether related to HIV status, sexual orientation (SO), or premarital sex beliefs, is highly prominent within immigrant communities. The role stigma plays as a cultural barrier to HIV prevention (including sexual practices and testing behaviors), status disclosure, and engagement with services among Latino and congruent immigrant populations is well documented (Daniel et al., 2022; Jaramillo et al., 2021; Keesee et al., 2012; Lozano-Verduzco et al., 2021; Ramirez-Valles et al., 2010; Ramirez-Valles, Molina, & Dirkes, 2013). HIV-related stigma can come from family and community members, but it is also present within the lesbian, gay, bisexual, transgender, queer (LGBTQ+) community. In one study with Latino MSM, participants presented negative views and possible discrimination towards their HIV-positive peers, which could have been projections of internalized homophobia and personal responsibility beliefs, the idea that people living with HIV or AIDS (PLWHA) are personally responsible for contracting HIV (Ramirez-Valles, Molina, & Dirkes, 2013).

In many Latin American cultures, machismo can produce HIV- and SO-related stigma that conflates femininity and homosexuality, creating another possible barrier (Lozano-Verduzco et al., 2021). These authors argue that, while masculinity notions have traditionally led to risk behaviors like substance use and unprotected sex in general, the impacts of machismo on sexual identity and behaviors are especially prominent for foreign-born Latino MSM, those who grew up outside of the US. They claim it can lead them “to undermine, silence, negate, or repress their homoerotic desires...in an effort to keep masculine image as part of their public presentation and identity” (p. 203). Stigma can thus contribute to an HIV diagnosis feeling like a threat to one’s sense of manhood, which may prevent foreign-born Latino MSM from engaging with HIV services. Additional barriers to prevention and care among Latino immigrants with HIV or AIDS can include language and acculturation differences, information deficits and service perceptions, and fear of deportation (Keese et al., 2012).

## **Health, Wellbeing, and Coping**

Several holistic health studies have been conducted on Latinos who are foreign-born, undocumented, and MSM in the context of HIV prevention and health disparities (Galvan, 1999; Loza et al., 2021; Shedlin & Shulman, 2004; Tabler et al., 2019). One comprehensive assessment of Latino MSM revealed high rates of mental health issues, suicidal ideation and suicide attempts, and substance use—specifically alcohol, marijuana, and tobacco (Loza et al., 2021). Another study revealed that HIV-positive status and perceived discrimination are strongly related to symptoms of depression for Latino MSM but not those who are heterosexual (Tabler et al., 2019). Strengths, values, and positive coping methods in this population are also documented in the literature (Acevedo, 2008; Bok & Morales, 2001; Galvan, 1999; Rowan, et al., 2008).

In one analysis of support networks and meaning making—herein defined as personal significance or benefit-finding regarding HIV diagnosis, in line with Roussi & Avdi (2008)—among Mexican and Mexican American men with HIV or AIDS, several entities emerged including family, friends, and spouse; religion; helping others; and personal growth (Galvan, 1999). Chosen family, a continually evolving concept of nonbiological kinship and family networks within the LGBTQ+ community, was also emphasized (Muraco, 2006). Having a strong support network is vital for coping with illness and adversity in general, but as Galvan (1999) shows in their study on Latinos with HIV or AIDS, support networks can also include physical and abstract sources of meaning and coping. For service providers, supporting clients in identifying these entities and further developing them may help improve their quality of life.

## **The Present Study**

Considering the ongoing, alarming health disparities among Latino MSM with HIV or AIDS locally and nationally, the following exploratory research question is offered: What are the greatest areas of need for Latino MSM with HIV or AIDS in WA, and are there differences based on legal status or country of origin? To begin investigating this topic, a preliminary needs assessment was developed and conducted on the target population in collaboration with a local non-profit organization that has been providing services to PLWHA in the greater Seattle area since the start of the HIV and AIDS epidemic in the 1980s. Needs assessments are a tool used by care providers and researchers from a variety of disciplines to systematically determine areas of need and plan solutions. In line with existing data and literature, it was hypothesized that the greatest areas of need for Latino MSM with HIV or AIDS would be related to income, stigma, social factors, and mental health, with greater need present among those who are foreign-born and undocumented, though the literature on the latter subpopulation is sparse.

## **Methods**

### **Participants**

Twenty-three adult Latino MSM with HIV or AIDS in WA were surveyed for this study. Recruitment and survey design were supported by the aforementioned local HIV and AIDS organization. 90 total agency clients were eligible for the study. 76 were contacted via email with information about the study and a link to an online survey and 14 were mailed a paper survey packet because they did not have an email on file. Waiting room flyers with a QR code for the survey, follow-up emails, and phone calls were additional recruitment methods. Surveys were mostly self-administered; only four were facilitated via phone call. Each survey was prefaced by an informed consent form, and all surveys and recruitment materials were made available in both English and Spanish. Although little to no risk was anticipated, the survey included potentially distressing questions about mental health and experiences of stigma and discrimination, so several resources, including free hotlines and on-demand counselling services, were included at the end of the survey.

### **Survey Questions**

Participants took surveys with questions related to areas of need (insurance, dental care, medication, income, housing, food, and transportation), barriers to care, experiences with stigma and discrimination (related to HIV status, SO, and race or ethnicity), social factors (community involvement, support system strength, and sources of support), and recent

depressive feelings. Demographic information was also collected including gender, race or ethnicity, racial and ethnic subgroup, native language, country of origin, legal status, SO, and age group.

First, participants answered “yes” or “no” to two questions about insurance coverage and dental care (“Do you currently have health insurance?” and “Do you currently have a dentist?”). Those who responded “yes” subsequently answered a follow-up statement about health insurance satisfaction (“I am satisfied with my current health insurance plan”) with “strongly agree,” “somewhat agree,” “somewhat disagree,” or “strongly disagree,” as well as a question about the importance of regular dental care (“How important do you feel it is to see your dentist regularly?”), to which they responded “extremely important,” “very important,” “moderately important,” “slightly important,” or “not at all important.” Because of the way HIV weakens the immune system, making the body less capable of fighting off infections, regular dental care is particularly important for PLWHA.

Next, participants responded to a question about medication adherence (“Which of these best describes your HIV medication adherence?”). They answered the question with one of the following: “I take HIV medication and have not missed a dose in the last month;” “I take HIV medication but have missed one or more doses in the last month;” “I take HIV medication, but I ran out;” “I do not take HIV medication but would consider it;” or “I do not take HIV medication and do not plan on it.” This question addresses a crucial metric for HIV and AIDS service providers that is key for health outcomes, especially viral load suppression. Limiting the presence of HIV in the body can help PLWHA live long, healthy lives and once one’s viral load is low enough to be considered undetectable, they can no longer transmit the virus to others. Then, five statements about areas of need were offered: (“I feel strongly burdened by healthcare costs;” “I am worried about paying next month’s bills;” “I have worried about having enough food in the last month;” “My current housing situation is unstable;” and “I have struggled getting myself to and from appointments in the last month”). Participants answered each of these with “strongly agree,” “somewhat agree,” “somewhat disagree,” or “strongly disagree.”

Then, participants were given two lists of common barriers to HIV care and services: one with six structural barriers (limited knowledge of resources, transportation struggles, lack of health insurance, high costs, long wait times, and legal status or fear of deportation) and one with five cultural barriers (“I rely more on myself or my family for care;” I prefer alternative forms of care and services; language barrier; stigma or discrimination; and cultural beliefs and norms) and asked to indicate which of the barriers (if any) had ever prevented them from accessing HIV care and services in the past.

Participants subsequently reported on the frequency with which they had experienced different kinds of stigma and discrimination in a variety of settings. These included HIV- and SO-related stigma from family members; HIV-related stigma within LGBTQ+ spaces; and stigma and discrimination in public associated with their HIV status, SO, and race or ethnicity. For each of these questions, participants answered whether the event occurred “never,” “sometimes,” “often,” or “most of the time.”

Participants were then given a list of nine supportive entities (“myself;” “partner or spouse;” “immediate family;” “extended family;” “friends or ‘chosen family;” “therapist or other mental health professional;” “coach or mentor;” “support group;” and “other (please specify)”) and asked, “Please indicate up to three of the following entities (if any) that you feel provide the most support to you (whether emotional, material, informational, etc.).” In this section participants also responded to two statements about social factors (“I feel I have a strong support system” and “I feel involved in my community”) with “strongly agree,” “somewhat agree,” “somewhat disagree,” or “strongly disagree.”

Finally, participants completed a questionnaire used in agency assessments on recent depressive feelings. The questionnaire listed ten common depressive feelings (sadness, anger, anxiety, hopelessness, irritability, fatigue, difficulty sleeping, difficulty remembering, difficulty concentrating, and less interest in things you usually enjoy) and asked participants to indicate which of the feelings (if any) they had experienced or felt in the last two weeks.

## **Analytic Plan**

Survey results were manually entered into an Excel spreadsheet for cleaning and the calculation of descriptive statistics. Chi-square tests of independence were conducted to test for significance of relations between most variables, while t-tests were conducted with total barriers to care, sources of support, and depressive feelings. The descriptive statistics and test results were compiled into Tables 2-5, which are organized into three groups: overall (total sample), legal status (undocumented and documented), and country of origin (foreign-born and US-born). This layout was chosen to allow for cross-demographic analysis in line with the research question: What are the areas of need for Latino MSM with HIV or AIDS in WA, and are there differences based on legal status or country of origin?

## **Results**

### **Participant Characteristics**

Of the overall Latino MSM client population at the local agency, the average federal poverty level was 195.2%, which would be considered low-income. While nearly all these clients were housed and had active insurance coverage at the time of data collection (91.1%



and 92.2%, respectively), some still lacked those basic needs. Nearly half of these clients (45.6%) were considered detectable, meaning they did not yet have a low enough viral load to no longer be able to transmit HIV. Additionally, 41.1% had been diagnosed with AIDS.

Demographic characteristics of the study participants are listed in Table 1. Nearly three quarters (70%) identified as Mexican, Mexican American, or Chicano, with South and Central Americans accounting for 17% and 13%, respectively. Foreign-born participants represented 74%, while 26% were US-born. Likewise, documented participants represented 74%, while 26% were undocumented. Spanish was the native language of 74% of participants, while English was the first language of 22% and 4% grew up speaking Portuguese. Finally, the most represented age group was 45-54 (39%), followed by 55 and over (30%), then 35-44 (22%), and finally 25-34 (9%).

**Table 1** Descriptive characteristics (*N* = 23).

Variable	<i>N</i>	%
Gender		
Male	23	100%
Sexual orientation		
Gay /homosexual	23	100%
Race/ethnicity		
Hispanic/Latino	23	100%
Racial/ethnic subgroup		
Mexican, Mexican American, or Chicano	16	69.6%
South American	4	17.4%
Central American	3	13.0%
Native language		
Spanish	17	73.9%
English	5	21.7%
Portuguese	1	4.3%
Country of origin		
US-born	6	26.1%
Foreign-born	17	73.9%
Mexico	10	58.8%
Other	7	41.2%
Legal status		
Documented	17	73.9%
Undocumented	6	26.1%

Variable	N	%
Age group		
25-34	2	8.7%
35-44	5	21.7%
45-54	9	39.1%
55 and over	7	30.4%

**Table 2** Areas of need reported by Latino MSM with HIV / AIDS (N = 23).

Variable	Overall N(%)	Undoc. N(%)	Doc. N(%)	$\chi^2$	Foreign-born N(%)	US-born N(%)	$\chi^2$
Health insurance				9.8**			1.2
Yes	20 (87.0%)	3 (50.0%)	17 (100%)		14 (82.4%)	6 (100%)	
No	3 (12.3%)	3 (50.0%)	0		3 (17.6%)	0	
Dentist				0.68			0.015
Yes	12 (52.2%)	4 (66.7%)	8 (47.1%)		9 (52.9%)	3 (50.0%)	
No	11 (47.8%)	2 (33.3%)	9 (52.9%)		8 (47.1%)	3 (50.0%)	
Health insurance satisf.				2.2			5.3†
Strongly agree	10 (50.0%)	1 (33.3%)	9 (52.9%)		7 (41.2%)	3 (50.0%)	
Somewhat agree	8 (40.0%)	1 (33.3%)	7 (41.2%)		5 (29.4%)	3 (50.0%)	
Somewhat disagree	2 (20.0%)	1 (33.3%)	1 (5.9%)		2 (11.8%)	0	
Reg. dental care imp.				0			1.5
Extremely important	9 (75.0%)	3 (75.0%)	6 (75.0%)		6 (66.7%)	3 (100%)	
Very important	3 (25.0%)	1 (25.0%)	2 (25.0%)		3 (33.3%)	0	
HIV med. adherence				3.6			5.7
Yes (every day)	15 (65.2%)	3 (50.0%)	12 (70.6%)		10 (58.8%)	5 (83.3%)	
Yes (1+ missed doses / last mo.)	6 (26.1%)	2 (33.3%)	4 (23.5%)		6 (35.3%)	0	
No (would consider)	1 (4.3%)	1 (16.7%)	0		1 (5.9%)	0	
Other	1 (4.3%)	0	1 (5.9%)		0	1 (16.7%)	
Health cost burden				1.9			6.5
Strongly agree	5 (21.7%)	2 (33.3%)	3 (17.6%)		4 (23.5%)	1 (16.7%)	

Variable	Overall N(%)	Undoc. N(%)	Doc. N(%)	$\chi^2$	Foreign-born N(%)	US-born N(%)	$\chi^2$
Somewhat agree	8 (34.8%)	1 (16.7%)	7 (41.2%)		7 (41.2%)	1 (16.7%)	
Somewhat disagree	6 (26.1%)	2 (33.3%)	4 (23.5%)		5 (29.4%)	1 (16.7%)	
Strongly disagree	3 (13.0%)	1 (16.7%)	2 (11.8%)		1 (5.9%)	2 (33.3%)	
Other	1 (4.3%)	0	1 (5.9%)		0	1 (16.7%)	
Financial stress				1.3			6.7†
Strongly agree	11 (47.8%)	3 (50.0%)	8 (47.1%)		9 (52.9%)	2 (33.3%)	
Somewhat agree	3 (13.0%)	0	3 (17.6%)		3 (17.6%)	2 (33.3%)	
Somewhat disagree	6 (26.1%)	2 (33.3%)	4 (23.5%)		4 (23.4%)	0	
Strongly disagree	3 (13.0%)	1 (16.7%)	2 (11.8%)		1 (5.9%)	2 (33.3%)	
Food insecurity				2.6			4.1
Strongly agree	4 (17.4%)	2 (33.3%)	2 (11.8%)		3 (17.6%)	1 (16.7%)	
Somewhat agree	3 (13.0%)	0	3 (17.6%)		1 (5.9%)	2 (33.3%)	
Somewhat disagree	6 (26.1%)	1 (16.7%)	5 (29.4%)		4 (23.4%)	2 (33.3%)	
Strongly disagree	10 (43.5%)	3 (50.0%)	7 (41.2%)		9 (52.9%)	1 (16.7%)	
Housing instability				2.8			4.2
Strongly agree	5 (21.7%)	1 (16.7%)	3 (17.6%)		2 (11.8%)	3 (50.0%)	
Somewhat agree	2 (8.7%)	1 (16.7%)	0		2 (11.8%)	0	
Somewhat disagree	6 (26.1%)	2 (33.3%)	5 (29.4%)		5 (29.4%)	1 (16.7%)	
Strongly disagree	10 (43.5%)	2 (33.3%)	9 (52.9%)		8 (47.1%)	2 (33.3%)	
Transport. struggles				0.92			7.7†
Strongly agree	5 (21.7%)	1 (16.7%)	4 (23.5%)		5 (29.4%)	0	
Somewhat agree	4 (17.4%)	1 (16.7%)	3 (17.6%)		1 (5.9%)	3 (50.0%)	
Somewhat disagree	6 (26.1%)	1 (16.7%)	5 (29.4%)		4 (23.4%)	2 (33.3%)	
Strongly disagree	8 (34.8%)	3 (50.0%)	5 (29.4%)		7 (41.2%)	1 (16.7%)	

†  $p < .10$ , \* $p < .05$ , \*\* $p < .01$

**Table 3** Barriers to care reported by Latino MSM with HIV or AIDS ( $N = 23$ ).

Variable	Overall N(%) / M (SD)	Undoc. N(%) / M (SD)	Doc. N(%) / M (SD)	$\chi^2$ / t	Foreign-born N(%) / M(SD)	US-born N(%) / M (SD)	$\chi^2$ / t
Structural barriers				1.4			3.2
Lack of resource knowledge	5 (21.7%)	2 (33.3%)	3 (17.6%)		4 (23.5%)	1 (16.7%)	
Lack of transport.	5 (21.7%)	2 (33.3%)	3 (17.6%)		2 (11.8%)	3 (50.0%)	

Variable	Overall <i>N</i> (%) / <i>M</i> (SD)	Undoc. <i>N</i> (%) / <i>M</i> (SD)	Doc. <i>N</i> (%) / <i>M</i> (SD)	$\chi^2/t$	Foreign- born <i>N</i> (%) / <i>M</i> (SD)	US-born <i>N</i> (%) / <i>M</i> (SD)	$\chi^2/t$
Lack of health ins.	5 (21.7%)	2 (33.3%)	3 (17.6%)		4 (23.5%)	1 (16.7%)	
Long wait times	4 (17.4%)	1(16.7%)	3 (17.6%)		2 (11.8%)	2 (33.3%)	
High costs	2 (8.7%)	0	2 (11.8%)		1 (5.9%)	1 (16.7%)	
Total structural barriers	0.91 (1.04)	1.2 (0.98)	0.82 (1.07)	0.49	0.76 (1.03)	1.3 (1.03)	0.28
Cultural barriers				3.7			6.9
Family-/self- reliance	2 (8.7%)	0	2 (11.8%)		0	2 (33.3%)	
Language barrier	2 (8.7%)	1 (16.7%)	1 (5.9%)		2 (11.8%)	0	
Cultural beliefs / norms	1 (4.3%)	1 (16.7%)	0		1 (5.9%)	0	
Stigma/discrim.	1 (4.3%)	0	1 (5.9%)		0	1 (16.7%)	
Other	2 (8.7%)	1 (16.7%)	1 (5.9%)		1 (5.9%)	1 (16.7%)	
Total cultural barriers	0.35 (0.49)	0.50 (0.55)	0.29 (0.47)	0.44	0.24 (0.44)	0.67 (0.52)	0.11

†  $p < .10$

**Table 4** Depressive feelings and experiences of stigma and discrimination reported by Latino MSM with HIV or AIDS ( $N = 23$ ).

Variable	Overall <i>N</i> (%) / <i>M</i> (SD)	Undoc. <i>N</i> (%) / <i>M</i> (SD)	Doc. <i>N</i> (%) / <i>M</i> (SD)	$\chi^2/t$	Foreign- born <i>N</i> (%) / <i>M</i> (SD)	US-born <i>N</i> (%) / <i>M</i> (SD)	$\chi^2/t$
Depressive feelings	3.00 (2.6)	4.17 (1.9)	2.59 (2.7)	0.15	2.88 (2.5)	3.33 (3.1)	0.76
Felt HIV-related stigma (family)				4.7			5.6
Never	14 (60.9%)	2 (33.3%)	12 (70.6%)		11 (64.7%)	3 (50.0%)	
Sometimes	4 (17.4%)	2 (33.3%)	2 (11.8%)		4 (23.5%)	0	
Often	0	0	0		0	0	
Most days	4 (17.4%)	2 (33.3%)	2 (11.8%)		2 (11.8%)	2 (33.3%)	
Other	1 (4.3%)	0	1 (5.9%)		0	1 (16.7%)	
Felt SO-related stigma (family)				2.9			7.4†
Never	12 (52.2%)	2 (33.3%)	10 (58.8%)		9 (52.9%)	3 (50.0%)	
Sometimes	5 (21.7%)	2 (33.3%)	3 (17.6%)		5 (29.4%)	0	
Often	2 (8.7%)	0	2 (11.8%)		0	2 (33.3%)	

Variable	Overall <i>N</i> (%) / <i>M</i> (SD)	Undoc. <i>N</i> (%) / <i>M</i> (SD)	Doc. <i>N</i> (%) / <i>M</i> (SD)	$\chi^2/t$	Foreign- born <i>N</i> (%) / <i>M</i> (SD)	US-born <i>N</i> (%) / <i>M</i> (SD)	$\chi^2/t$
Most days	4 (17.4%)	2 (33.3%)	2 (11.8%)		3 (17.6%)	1 (16.7%)	
Felt HIV-related stigma/ discrim. (in public)				3.3			1.2
Never	12 (52.2%)	2 (33.3%)	10 (58.8%)		10 (58.8%)	2 (33.3%)	
Sometimes	5 (21.7%)	1 (16.7%)	4 (23.5%)		3 (17.6%)	2 (33.3%)	
Often	3 (13.0%)	1 (16.7%)	2 (11.8%)		2 (11.8%)	1 (16.7%)	
Most days	3 (13.0%)	2 (33.3%)	1 (5.9%)		2 (11.8%)	1 (16.7%)	
Felt SO-related stigma/ discrim. (in public)				6.5†			1.3
Never	13 (56.5%)	3 (50.0%)	10 (58.8%)		10 (58.8%)	3 (50.0%)	
Sometimes	8 (34.8%)	1 (16.7%)	7 (41.2%)		5 (29.4%)	3 (50.0%)	
Often	1 (4.3%)	1 (16.7%)	0		1 (5.9%)	0	
Most days	1 (4.3%)	1 (16.7%)	0		1 (5.9%)	0	
Felt race/ethnicity- related stigma/ discrim. (in public)				10.4*			1.3
Never	14 (60.9%)	1 (16.7%)	13 (76.5%)		10 (58.8%)	4 (66.7%)	
Sometimes	6 (26.1%)	3 (50.0%)	3 (17.6%)		4 (23.5%)	2 (33.3%)	
Often	2 (8.7%)	2 (33.3%)	0		2 (11.8%)	0	
Most days	1 (4.3%)	0	1 (5.9%)		1 (5.9%)	0	
Felt HIV-related stigma/ discrim. (in LGBTQ+ spaces)				1.4			5.7
Never	6 (26.1%)	1 (16.7%)	5 (29.4%)		6 (35.3%)	0	
Sometimes	6 (26.1%)	2 (33.3%)	4 (23.5%)		3 (17.6%)	3 (50.0%)	
Often	3 (13.0%)	1 (16.7%)	2 (11.8%)		3 (17.6%)	0	
Most days	2 (8.7%)	1 (16.7%)	1 (5.9%)		1 (5.9%)	1 (16.7%)	
Other	6 (26.1%)	1 (16.7%)	5 (29.4%)		4 (23.5%)	2 (33.3%)	

†  $p < .10$ , \* $p < .05$

**Table 5** Social factors reported by Latino MSM with HIV or AIDS ( $N = 23$ ).

Variable	Overall $N(\%) / M$ (SD)	Undoc. $N(\%) / M$ (SD)	Doc. $N(\%) / M$ (SD)	$\chi^2/t$	Foreign- born $N(\%) / M$ (SD)	US-born $N(\%) / M$ (SD)	$\chi^2/t$
Cmty. involvement				1.8			10.7†
Strongly agree	3 (13.0%)	0	3 (17.6%)		2 (11.8%)	1 (16.7%)	
Somewhat agree	9 (39.1%)	3 (50.0%)	6 (35.3%)		9 (52.9%)	0	
Somewhat disagree	7 (30.4%)	2 (33.3%)	5 (29.4%)		3 (17.6%)	4 (66.7%)	
Strongly disagree	3 (13.0%)	1 (16.7%)	2 (11.8%)		3 (17.6%)	0	
Other	1 (4.3%)	0	1 (5.9%)		0	1 (16.7%)	
Strong support system				1.5			4.1
Strongly agree	7 (30.4%)	1 (16.7%)	6 (35.3%)		6 (35.3%)	1 (16.7%)	
Somewhat agree	6 (26.1%)	2 (33.3%)	4 (23.5%)		5 (29.4%)	1 (16.7%)	
Somewhat disagree	5 (21.7%)	2 (33.3%)	3 (17.6%)		3 (17.6%)	2 (33.3%)	
Strongly disagree	4 (17.4%)	1 (16.7%)	3 (17.6%)		3 (17.6%)	1 (16.7%)	
Other	1 (4.3%)	0	1 (5.9%)		0	1 (16.7%)	
Sources of support				5.7			8.1†
Friends/ chosen family	12 (52.2%)	3 (50.0%)	9 (53.0%)		9 (53.0%)	3 (50.0%)	
Partner/ spouse	10 (43.5%)	1 (16.7%)	9 (53.0%)		9 (53.0%)	1 (16.7%)	
Immediate family	8 (34.8%)	1 (16.7%)	7 (41.2%)		5 (29.4%)	3 (50.0%)	
Extended family	2 (8.7%)	0	2 (11.8%)		1 (5.9%)	1 (16.7%)	
Support group	1 (4.3%)	0	1 (5.9%)		0	1 (16.7%)	
Coach/ mentor	1 (4.3%)	1 (16.7%)	0		1 (5.9%)	0	
Other	3 (13.0%)	1 (16.7%)	2 (11.8%)		1 (5.9%)	2 (33.3%)	
Total support sources	1.6 (0.89)	1.2 (0.41)	1.8 (0.97)	0.051†	1.5 (0.87)	1.8 (0.98)	0.52

†  $p < .10$

## Salient Findings

### Areas of Need and Barriers to Care

Chi-square tests of independence were performed to examine the relations between areas of need and two independent variables: legal status and country of origin. The relation between legal status and insurance coverage was highly significant,  $\chi^2 (1, N = 23) = 9.8, p = 0.0018$ . Documented participants were more likely than undocumented participants to have health insurance. While 100% of documented and US-born participants were insured, only 50% and 82.4% of their undocumented and foreign-born counterparts were insured, respectively. Nearly all participants with health insurance (90%) reported being at least somewhat satisfied with their plan; a select few (10%) reported being somewhat dissatisfied, but there were no reports of strong dissatisfaction. The relation between country of origin and health insurance satisfaction was nearly significant,  $\chi^2 (2, N = 23) = 5.3, p = 0.071$ . Foreign-born participants were more likely than US-born participants to report high satisfaction with their insurance plan. Regarding dental care, about half of participants (47.8%) reported not having a dentist. That said, 100% of participants with a dentist indicated that seeing their dentist regularly was very or extremely important to them.

While nearly all participants (91.3%) reported taking HIV medication daily or nearly every day (having missed one or more doses in the last month), one opted not to respond and one undocumented, foreign-born participant indicated that they are not taking HIV medication but would consider it. Regarding finances, over half of participants reported being somewhat or strongly burdened by healthcare costs (56.5%) and stressed about finances (60.9%). The relation between country of origin and financial stress was nearly significant,  $\chi^2 (3, N = 23) = 6.7, p = 0.082$ . Foreign-born participants were more likely than US-born participants to be experiencing financial stress. Also nearly significant was the relation between country of origin and transportation struggles,  $\chi^2 (3, N = 23) = 7.7, p = 0.054$ . US-born participants were more likely than foreign-born participants to have difficulty with transportation.

Only about a third of participants reported being somewhat or strongly worried about having reliable transportation (39.1%), food security (30.4%), and stable housing (30.4%). And while participants reported minimal barriers to care overall, structural barriers were reported more frequently ( $M = 0.91$ ) than cultural barriers ( $M = 0.35$ ), on average. The most common barriers to care that participants indicated they had experienced were all structural: limited knowledge of resources, transportation struggles, and lack of health insurance (each representing 21.7% of total barriers). On average, undocumented and US-born participants reported having experienced more structural and cultural barriers to care than documented and foreign-born participants.

### Stigma, Social Factors, and Mental Health

Chi-square tests examined the relations between experiences of stigma and discrimination with the independent variables of legal status and country of origin. The relation between legal status and public race or ethnicity-related stigma and discrimination was statistically significant,  $\chi^2 (3, N = 23) = 10.4, p = 0.015$ . Undocumented participants were more likely than documented participants to have experienced race or ethnicity-related stigma and discrimination. The relation between country of origin and family-based SO-related stigma was nearly significant,  $\chi^2 (3, N = 23) = 7.4, p = 0.059$ . US-born participants were more likely than foreign-born participants to have experienced family-based SO-related stigma. The relation between legal status and public SO-related stigma and discrimination was also nearly significant,  $\chi^2 (3, N = 23) = 6.5, p = 0.090$ . Undocumented participants were more likely than documented participants to have experienced public SO-related stigma and discrimination. Overall, over half of participants (56.5%) reported having experienced public HIV-related stigma or discrimination. Experiences of family-based SO-related stigma and HIV-related stigma and discrimination in LGBTQ+ spaces were both reported by about half of participants (47.8%). Less than half reported having experienced stigma and discrimination in public related to their SO (43.5%) and race or ethnicity (39.1%). 39.1% also indicated they had experienced family-based HIV-related stigma. Two participants (8.7%) indicated that they had never disclosed their HIV status to family or friends.

Chi-square tests examined the relations between two social factors: community involvement and specific sources of support and the independent variables of legal status and country of origin. The relation between country of origin and community involvement was nearly significant,  $\chi^2 (4, N = 23) = 10.7, p = 0.031$ . Foreign-born participants were more likely than US-born participants to be involved in their community. Only about half of participants (52.2%) reported feeling somewhat or very involved in their community. The relation between country of origin and specific sources of support was also nearly significant,  $\chi^2 (4, N = 23) = 8.1, p = 0.088$ . US-born participants were more likely than foreign-born participants to identify immediate or extended family members as significant sources of support, while foreign-born participants were more likely than US-born participants to choose partner or spouse and friends or chosen family. *T*-tests examined the relations between total sources of support and the independent variables of legal status and country of origin. The results revealed the presence of a nearly significant effect of legal status on total sources of support. Documented participants had more sources of support ( $M = 1.2, SD = 0.41$ ) than undocumented participants ( $M = 1.8, SD = 0.97$ ),  $t(21) = 2.5, p = 0.051$ . Regarding the effect of country of origin, US-born participants reported fewer sources of support than their foreign-born counterparts, on average.



T-tests also examined the relations between depressive feelings and the independent variables of legal status and country of origin. Although there were no significant relations, undocumented and US-born participants did report more depressive feelings than documented and foreign-born participants, on average.

## Discussion

It was hypothesized that Latino MSM with HIV or AIDS would report greatest need regarding income, stigma, social factors, and mental health, with greater need present among those who were undocumented and foreign-born. The greatest areas of need that were observed in the introductory needs assessment were regarding income, dental care, and healthcare costs with existing differences based on legal status and country of origin. The hypothesis was thus true for income and the impacts of legal status and country of origin on the needs and experiences of this population.

The results of chi-square tests and t-tests revealed several relations between variables with varying statistical significance. Legal status had a highly significant impact on insurance coverage ( $p < .01$ ) and a significant impact on experiences of public race or ethnicity stigma and discrimination ( $p < .05$ ). Legal status may also impact public SO-related stigma and discrimination and total sources of support ( $p < .10$ ). Country of origin may impact health insurance satisfaction, financial stress, transportation struggles, family-based SO-related stigma, community involvement, and specific sources of support ( $p < .10$ ). Ultimately, more research is needed to investigate these relationships and their significance.

### Areas of Need and Barriers to Care

Financial stress being one of the participants' greatest areas of need was expected, especially when considering the low income of the agency's eligible clients (195% FPL). The nearly significant relation between country of origin and financial stress, foreign-born participants having reported greater worry about their finances may be due to the challenges associated with integration into a new country or limited opportunities for low-skilled immigrants in the formal economy, though more research is needed to examine the HIV-related financial impacts on PLWHA, both in general and on populations with disproportionately low socioeconomic statuses like those in this study. The presence of a highly significant relationship ( $p < .01$ ) between legal status and insurance coverage demonstrates a need for support finding and enrolling in insurance plans among undocumented Latino MSM with HIV or AIDS. Reasons why legal status affects insurance coverage may include lack of knowledge of available plans and resources, fear of disclosure, and service provision issues, but more research is needed to investigate this. There are currently multiple health insurance

plans available to undocumented people residing in WA, though this may not be common knowledge. Given the high costs of healthcare in the US, health insurance is crucial in general. But this is especially true for PLWHA because of the need for regular visits with medical providers, laboratory testing, and expensive medications, as well as the commonality of HIV-related ailments and illnesses including oral healthcare issues.

It is concerning that less than half of participants were connected to a dentist. Because of the way HIV and AIDS weaken the immune system, PLWHA are more susceptible to infections. Healthy oral hygiene habits and regular dental visits are thus particularly important for this population. Although the relationship between country of origin and health insurance satisfaction is not quite statistically significant ( $p < .10$ ), there may be utility in further research on why US-born Latino MSM with HIV or AIDS may be less satisfied with their insurance plans than those who are foreign-born. On a positive note, the participants with health insurance reported exceptionally high satisfaction with their plans, and those with a dentist demonstrated that regular dental care was very important to them. Although less than half of participants indicated concern about transportation, food security, and housing stability, some need still exists in these areas. Finally, overall barriers to care were lower than expected. It was anticipated that participants would have reported more experiences with structural and cultural barriers to care. This raises questions about participants' perceptions of barriers to care and best practices for measuring this concept. Navigating complex healthcare and insurance systems while living with chronic illness, this population is forced to adjust to their circumstances and may not identify experiences with barriers as such. The challenges associated with isolating these specific experiences from their day-to-day reality may make it difficult to recognize and identify barriers to care in needs assessments or similar research. Still, undocumented and US-born participants reporting greater barriers to care than their documented and foreign-born counterparts may warrant further research.

## **Stigma**

Like barriers to care, the overall rates of experiences with stigma and discrimination were lower than expected. It was anticipated that participants would report more frequent experiences of stigma and discrimination. The lower rates may be associated with the methodological challenges of quantifying these difficult experiences in the present study. That said, the overall rates of family-based SO-related stigma and HIV-related discrimination, both in public and in LGBTQ+ spaces, were high enough to be alarming. The latter aligns with the findings of Ramirez-Valles, Molina, & Dirkes (2013), which has important implications for intra-group relations within the LGBTQ+ community both locally and nationally. The presence of a statistically significant relationship ( $p < .05$ ) between legal status and public race or ethnicity related stigma and discrimination signifies that being undocumented may increase

the likelihood of experiencing racial and ethnic discrimination in public for Latino MSM with HIV or AIDS. The impacts of living with multiple, compounding marginalized identities—being gay, undocumented, Latino, older, and HIV or AIDS-positive—in the primarily white city of Seattle (US Census Bureau, 2020) may be one reason that this population reports more frequent experiences with racial and ethnic stigma and discrimination.

The logic of intersectionality and compounding marginalized identities may also apply to undocumented participants reporting more frequent experiences feeling stigmatized or discriminated against in public because of their SO, although this relationship was not quite statistically significant ( $p < .10$ ). Also nearly significant was the relationship between country of origin and family-based SO-related stigma. One reason why foreign-born participants report less frequent experiences of feeling stigmatized by family members due to their SO may be because they are immigrants and might not have as many family members living in their community or even in the country, but further research is needed to better understand this concept.

The fact that multiple participants shared they had never disclosed their status is also concerning because coping with illness alone tends to be much harder than with the support of friends and family. Considering the heightened importance of family in most Latinos' cultures, being shamed or rejected by your own parents and relatives because of your HIV status or SO may have especially devastating impacts on mental health and wellbeing for this population. In line with Acevedo (2008), issues with disclosure and stigma are closely tied to cultural values in Latino communities. Although notable progress has been made in reducing stigma, discrimination, and HIV and AIDS misinformation in the past few decades, these issues persist, so the work continues.

## **Social Factors**

There are several areas of great concern regarding social factors. First, only 52.2% of participants reported feeling involved in their community. A strong support system and community involvement tends to positively impact sense of belonging, mental health, and wellbeing in general, but these social factors are particularly important for Latino MSM with HIV or AIDS (Ramirez-Valles et al., 2010; Tabler et al., 2019). The presence of a statistically significant relationship ( $p < .05$ ) between legal status and total sources of support is also alarming. Reasons why undocumented participants reported having fewer sources of support may include isolation tied to living without papers and the ability to integrate into the formal economy, fear of status disclosure, and having less family residing nearby. Foreign-born participants also reported less sources of support on average than their counterparts; however, a significant relationship between these variables was not present. Not having family nearby may also be a reason why foreign-born participants more frequently indicated friends and

chosen family and spouse or partner as important sources of support. Although neither this relationship nor the relationship between country of origin and community involvement are statistically significant ( $p < .10$ ), they are still strong enough to be worth mentioning and may warrant further research. As Jaramillo et al. (2021) found, Latino MSM may be interested in peer matching based on identities and lived experiences to reduce risk factors and increase socialization, which is particularly important for a population that can feel isolated and stigmatized by friends, family, and even members of their own communities.

## **Mental Health**

The low overall scores for depressive feelings were a pleasant surprise. It was expected that there would be higher scores on the depressive feelings questionnaire. Despite legal status and country of origin not significantly impacting depressive feelings, it is interesting that undocumented and US-born participants reported more depressive feelings on average than their counterparts. Further research is needed to better understand why this may occur. There was statistical significance to undocumented participants' reports of more frequent experiences with stigma and less social support. Considering the ways these issues can impact one's mental health, it would not be shocking if there was a correlation between these variables and other HIV-related issues. Unfortunately, that was not within the parameters of this study, but there could be great utility to further research in line with Loza et al. (2021) analyzing the effects of legal status and country of origin on the mental health of Latino MSM with HIV or AIDS.

## **Limitations**

The greatest limitation to this study is its small sample size and response rate, which together limit the generalizability of findings. Larger-scale needs assessments with Latino MSM with HIV or AIDS at state and national levels could be highly beneficial. A more comprehensive study may deepen knowledge of the disproportionate impacts of HIV and AIDS on this population, their greatest areas of need, and the cultural and structural barriers to care they face. Perhaps most importantly, though, a larger study could have more statistically significant results. This information could be used to develop more effective and culturally informed HIV interventions and prevention campaigns to help reduce HIV incidence in this community and others. A qualitative approach to subsequent needs assessments, such as interviews and focus groups, may lead to greater depth of data compared to what was gathered in this study. Verbatim quotes and content themes, for example, could provide rich insight into the experiences of this population.

While chi-square tests and *t*-tests were conducted, additional forms of statistical data analysis could have provided more accurate, richer findings. The survey questions

utilized in the study were not standardized, so it is not an official measure and does not have tested reliability or validity. That said, several pilot tests of the survey were conducted with agency staff and university peers to revise and implement feedback before beginning data collection. Member checking results may have also improved validity, although findings were triangulated with agency staff and existing literature. There may have been benefits to more people being involved throughout the research process, but the individual nature of this study limited the level of collaboration involved. The researcher did, however, consistently engage in individual and collective reflection, taking thorough research notes and meeting with professors, faculty members, and agency staff throughout the research process. Topics of positionality and bias were frequently discussed during these meetings.

## **Implications**

This study presented an introductory needs assessment with a population disproportionately affected by HIV-related issues and more of its kind should be conducted. There is need for more research in the public health, psychology, sociology, social work, and other social science fields with Latino MSM with HIV or AIDS, including those who are undocumented, foreign-born, transgender, and recent immigrants, as suggested by Guilamo-Ramos et al. (2019). As mentioned, very little research on undocumented Latinos and other PLWHA was found, which may point to a gap in the literature. Considering the issues regarding social factors like community involvement and the support system identified in this study, it may be beneficial to further analyze these concepts as well as coping methods, strategies for strengthening social factors, and how HIV-related issues compound to impact mental health among Latino MSM with HIV or AIDS. There may also be utility in comparative research on foreign-born and US-born Latino PLWHA regarding their pre- and post-migration experiences with HIV-related issues, as initiated by Shedlin & Shulman (2003). Finally, a qualitative approach to subsequent needs assessments may lead to greater depth of data than what was able to be achieved in this study.

Service providers working with foreign-born and undocumented clients with HIV or AIDS would benefit from greater awareness of what resources are available to these individuals in their community. One approach could be the development of community asset maps specific to undocumented clients. These are informative visualizations commonly used by social workers and other service providers to share community resources available for their clients. Additionally, considering that HIV incidence rates are decreasing overall but increasing for Latinos (Guilamo-Ramos et al., 2019), as well as the range of HIV-related stigma identified by participants in this study, there is a serious need for more effective prevention efforts for both HIV and HIV-related stigma aimed at these populations. These campaigns should be culturally informed; community driven, perhaps with the involvement of HIV and AIDS or LGBTQ+ organizations serving Latinos; and implemented at the local, state, and federal levels.

Social workers have an ethical mandate to cultural awareness and competence (NASW, n.d.). Increasingly, these terms are being replaced with “cultural humility and responsibility.” Instead of denoting culture as monolithic, static, and understandable, these new terms encourage caring professionals to reflect (on topics like positionality, identity, and bias) and take tangible action, with the goal of minimizing harm and creating positive change. All practice with highly vulnerable populations should be tailored to individual clients’ experiences and grounded in cultural sensitivity. Considering how service providers work within deeply inequitable and inaccessible systems that were designed by and for a privileged minority, it is crucial to adopt a client-centered, trauma-centered, and anti-oppressive approach to practice; actively work to eliminate barriers to care; and advocate for change at the local, institutional, and systemic levels.

One hope for this study was to gather information for the partner agency and other local service providers to increase awareness of issues that Latino MSM with HIV or AIDS in our community are facing. The more that is heard about these individuals’ cultural values, unique lived experiences, and barriers to care, the more informed and effective interventions with them can be. Among Latinos, safe sex practices, HIV testing behaviors, and connection to care can all be affected by cultural values such as language, family cohesion, collectivism, personalismo, folk medicine, machismo and pride, religion, and sexual silence as well as other systemic factors like poverty, racism, homophobia, and legal status (Acevedo, 2008; Bok & Morales, 2001; Rowan et al., 2008). These authors remind readers that while there is considerable overlap in experiences, Latino culture is not monolithic, and attention must be paid to intergroup differences. They also recommend that service providers working with Latinos acquire at least basic Spanish skills and increase their awareness of Latino cultural values, alternative care preferences, and local resources. And as Shedlin & Shulman (2004) note, HIV service provision with foreign-born Latinos should not only be grounded in cultural norms, but also in multi-dimensional resource networks and experiences in both origin and destination countries.

## **Conclusion**

It is easier to cope with a chronic illness like HIV or AIDS when you have your basic needs met. Improving access to care and eliminating barriers is vital for the health and wellbeing of PLWHA. In the present study, Latino MSM with HIV or AIDS in WA reported that their greatest areas of need were associated with income, dental care, and healthcare costs. The findings also demonstrate a need for increased support for undocumented and foreign-born Latino MSM with HIV or AIDS in a service provision context. Compared to their counterparts, these populations present greater need with social support, community involvement, and mental health. They also report more frequent experiences with stigma of



various types and in a variety of settings. Further research is needed to better understand these populations' experiences living with HIV or AIDS, including needs, barriers to care, strengths, and factors influencing wellbeing. Larger, more comprehensive needs assessments with this population and congruent populations disproportionately affected by HIV-related issues could expand on existing literature and provide useful information for service providers. Additional implications provided include community asset maps specifically for undocumented clients with HIV or AIDS, culturally responsive stigma and HIV prevention campaigns, and greater cultural awareness and humility among service providers working with these populations.

## References

- Acevedo, V. (2008). Cultural competence in a group intervention designed for Latino patients living with HIV / AIDS. *Health & Social Work, 33*(2), 111–120. <https://doi.org/10.1093/hsw/32.2.111>
- Bok, M., & Morales, J. (2001). Latino communities in the U.S. and HIV / AIDS. *Journal of HIV/ AIDS Prevention & Education for Adolescents & Children, 4*(1), 61. [https://doi.org.proxy.seattleu.edu/10.1300/J129v04n01\\_06](https://doi.org.proxy.seattleu.edu/10.1300/J129v04n01_06)
- Centers for Disease Control and Prevention. (2022). *HIV diagnoses*. Retrieved April 16, 2023, from <https://www.cdc.gov/hiv/statistics/overview/in-us/incidence.html>
- Daniel, N. A., Hassan, S. A., Farah, M., Najma, S., Guiomar, B., Schwartz, R., Gebreselassie, B. T., Beyene, Y. K., Gabreselassie, L., Bayru, K., Tadesse, B., Libneh, H. A., Shidane, M., Benalfew, S., Ali, A., Rao, D., Kerani, R. P., Patel, R. C. (2022). Harambee! 2.0: The impact of HIV-related and intersectional stigmas on HIV testing behaviors among African immigrant communities in Seattle, Washington. *AIDS and Behavior, 26*, 149-164. <https://doi.org/10.1007/s10461-021-03396-5>
- Galvan, F. H. (1999). Sources of personal meaning among Mexican and Mexican American men with HIV / AIDS. *Journal of Multicultural Social Work, 7*(3-4), 45–67. [https://doi.org/10.1300/j285v07n03\\_03](https://doi.org/10.1300/j285v07n03_03)
- Guilamo-Ramos, V., Thimm-Kaiser, M., Benzekri, A., Chacón, G., López, O., Scaccabarrozzi, L., & Rios, E. (2019). The invisible US Hispanic/Latino HIV crisis: Addressing gaps in the national response. *American Journal of Public Health, 110*(1), 27–31. <https://doi.org/10.2105/ajph.2019.305309>
- Jaramillo, J., Pagkas-Bather, J., Waters, K., Shackelford, L. B., Campbell, R. D., Henry, J., Grandberry, V., Ramirez, L. F., Cervantes, L., Stekler, J., Andrasik, M. P., & Graham, S. M. (2021). Perceptions of sexual risk, PrEP services, and peer navigation support among HIV-negative Latinx and Black men who have sex with men (MSM) residing in Western Washington. *Sexuality Research and Social Policy, 19*(3), 1058–1068. <http://doi.org/10.1007/s13178-021-00595-6>



Keesee, M. S., Natale, A. P., & Curiel, H. F. (2012). HIV positive Hispanic/Latinos who delay HIV care: Analysis of multilevel care engagement barriers. *Social Work in Health Care*, 51(5), 457–478. <https://doi.org/10.1080/00981389.2012.662208>

Loza, O., Provencio-Vasquez, E., Mancera, B., & De Santis, J. (2021). Health disparities in access to health care for HIV infection, substance abuse, and mental health among Latino men who have sex with men in a U.S.–Mexico border city. *Journal of Gay & Lesbian Social Services*, 33(3), 320–336. <https://doi.org/10.1080/10538720.2021.1885551>

Lozano-Verduzco, I., Cortes, W., Melendez, R., & Gonzalez, V. (2021). Masculinities and biomedical governmentality in the contexts of HIV prevention and treatment for Latinx immigrants. *The Journal of Men's Studies*, 29(2), 194–212. <https://doi.org/10.1177/1060826520946459>

Muraco, A. (2006). Intentional families: Fictive kin ties between cross-gender, different sexual orientation friends. *Journal of Marriage and Family*, 68(5), 1313–1325. <https://doi.org/10.1111/j.1741-3737.2006.00330.x>

NASW: National Association of Social Workers. (n.d.). *Code of Ethics*. Retrieved March 13, 2023, from <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

Ramirez-Valles, J., Kuhns, L. M., Campbell, R. T., & Diaz, R. M. (2010). Social integration and health: Community involvement, stigmatized identities, and sexual risk in Latino sexual minorities. *Journal of Health and Social Behavior*, 51(1), 30–47. <http://www.jstor.org/stable/27800367>

Ramirez-Valles, J., Molina, Y., & Dirkes, J. (2013). Stigma towards PLWHA: The role of internalized homosexual stigma in Latino gay/bisexual male and transgender communities. *AIDS Education and Prevention*, 25(3), 179–89. <https://doi.org/10.1521/ae.p.2013.25.3.179>

Roussi, P., & Avdi, E. (2008). Meaning-making and chronic illness: Cognitive and narrative approaches. *Hellenic Journal of Psychology*, 5, 147–178.

Rowan, D., Furman, R., Jones, A., & Edwards, K. (2008). Social work practice with Latinos living with HIV/AIDS. *Advances in Social Work*, 9(2), 142–156. <https://doi.org/10.18060/144>

Shedlin, M. G., & Shulman, L. (2004). Qualitative needs assessment of HIV services among Dominican, Mexican and Central American immigrant populations living in the New York City area. *AIDS Care*, 16(4), 434–445. <https://doi.org/10.1080/09540120410001683376>

Tabler, J., Mykyta, L., Schmitz, R. M., Kamimura, A., Martinez, D. A., Martinez, R. D., Flores, P., Gonzalez, K., Marquez, A., Marroquin, G., & Torres, A. (2019). Getting by with a little help from our friends: The role of social support in addressing HIV-related mental health disparities among sexual minorities in the Lower Rio Grande Valley. *Journal of Homosexuality*, 68(2), 269–289. <https://doi.org/10.1080/00918369.2019.1651112>

United States Census Bureau. (2020). U.S. *Census Bureau QuickFacts: Seattle City, Washington*. <https://census.gov/quickfacts/fact/table/seattlecitywashington/RHI125221>.

Washington State Department of Health. (2020). *Washington State HIV Surveillance Report*. <https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/150030WAHIVSurveillanceReport2020.pdf>