HIV prevention among Latina transgender women: Evaluation of a locally developed intervention

OMB 0920-1266

Section B: Supporting Statement

February 10, 2021

CONTACT
Carla Galindo, MPH, CHES
Project Officer
Centers for Disease Control and Prevention
Division of HIV/AIDS Prevention
1600 Clifton Road, NE, Mailstop US8-5
Atlanta, GA 30333
Phone: 404-639-1902
Fax: 404-639-1950
E-mail: cgalindo@cdc.gov

TABLE OF CONTENTS

EXHIBITS

1. Respondent Universe and Sampling Methods

City Selection

The goal of this study is to evaluate the efficacy of ChiCAS (Chicas Creando Acceso a la Salud [Chicas: Girls Creating Access to Health]), a locally developed and culturally congruent two-session Spanish-language small-group combination intervention designed to promote consistent condom use, and access to and participation in PrEP and medically supervised hormone therapy by HIV seronegative Hispanic/Latina transgender women who have sex with men. The prevalence of HIV and other STIs is disproportionately high among transgender women who have sex with men, particularly ethnic minority and younger transgender women. It is estimated that about 1 in 4 transgender women has HIV;[1-3] and the odds of becoming HIV positive are estimated to be 34.2 times higher for transgender women than other US adult populations.[2] As noted by the CDC, because HIV-related surveillance data are not uniformly collected, data on HIV infection among transgender women is lacking.[4] While local surveillance of HIV infection among transgender women in North Carolina is largely inaccurate due to the lack of a specific category for reporting transgender identity in morbidity reports, local samples gathered using convenience approaches suggest high prevalence of HIV infection among transgender women.

The ChiCAS intervention was developed in North Carolina by Triad Health Project in close conjunction with local Latina transgender women. The initial intervention was a compilation of activities partially adapted from other interventions carried out over the last 15 years by a local community-based participatory research (CBPR) partnership that included representatives from Triad Health Project, local health departments, representatives from the Latina transgender community, and Wake Forest University. Our research team at Wake Forest School of Medicine and Triad Health Project has extensive community networks in North Carolina and is very well trusted.

ChiCAS intervention sessions will be implemented virtually and in locations in and around North Carolina that are safe and convenient for participants. Screening of potential participants for eligibility, HIV testing to verify their eligibility, and completion of the informed consent process and baseline assessments may also occur at these locations unless potential participants prefer to complete these processes at another location of their choosing. All locations are owned or operated by organizations with which we have collaborated in the past and provide HIV and STI testing, PrEP, and/or medically supervised hormone therapy, or provide referrals to sources of these services. The locations and the organizations are listed below.

- In Asheville, we will implement the intervention at the Western North Carolina AIDS Project (WNCAP) (#1). WNCAP offers HIV testing, prevention and adherence counseling, PrEP services, and case management for transgender persons. We will also implement at the Western North Carolina Community Health Services (WNCCHS) (#2). WNCCHS offers HIV and STI testing, PrEP services, and medically supervised hormone therapy for transgender persons.
- In Charlotte, we will implement the intervention at the Regional AIDS Interfaith Network (RAIN) (#3). RAIN offers HIV testing, prevention and adherence counseling, PrEP services, case management, and medically supervised hormone therapy for transgender persons.
- In the Triad (metropolitan area of Greensboro, Winston-Salem, and High Point), we will implement the intervention at the Triad Health Project (#4). Triad Health Project offers HIV testing, prevention and adherence counseling, PrEP services, and case management for transgender persons. There are several providers in the Triad area that provide medically supervised hormone therapy for transgender persons on a sliding scale, and for those with insurance.
- In Raleigh, we will implement that intervention at the Alliance of AIDS Services – Carolina (AAS-C) (#5). AAS-C offers HIV testing, prevention and adherence counseling, PrEP services, and case

management for transgender persons. There are several providers in Raleigh that provide medically supervised hormone therapy for transgender persons on a sliding scale and for those with insurance.

- In Wilmington, we will implement the intervention at the Wilmington Health Center (#6) and the New Hanover Regional Medical Center (#7), which offer HIV and STI testing, PrEP services, and transition-related services for transgender women. Several providers in Wilmington provide medically supervised hormone therapy for transgender persons on a sliding scale and for those with insurance.

For the duration of the COVID-19 pandemic, screening, HIV testing, completion of informed consent, and baseline assessments will occur remotely, in a location of the participants choosing, and administered by study staff via telephone and/or video link.

Target population:

This study plans to sample 140 persons living in metropolitan areas in and around North Carolina including Asheville, NC; Charlotte, NC; Research Triangle, NC; Raleigh, NC; Wilmington, NC and Greenville, SC. The target population of interest is HIV-negative Hispanic/Latina transgender women at least 18 years of age who have sex with men and are at risk of HIV infection. We anticipate that study participants will be comprised mainly of racial/ethnic minority participants under 35 years of age, consistent with the epidemiology of HIV infection among transgender women.

Inclusion criteria:

* Aged 18 or over
* Self-identify as Hispanic or Latina
* Self-identify as male-to-female transgender or report having been born male and identifying as female
* Report sex with at least one man in the past six months
* HIV negative based on self-report and verified by HIV testing at baseline
* Fluent in Spanish
* Provide informed consent

Exclusion criterion:

* Participation in any HIV prevention intervention within the past 12 months prior to enrollment

Exhibit 1.1: Summary of Recruitment Targets

Participant Type	**Total**
Transgender women • Adult • Hispanic/Latina • HIV-negative • Have sex with men • Spanish-speaking • Willing to provide informed consent	140
Total study enrollment	**140**

We will recruit transgender women into the study through a combination of approaches, including active recruitment at local gathering places of Hispanic/Latina transgender women such as bars and nightclubs. Participants will also be asked to refer friends or others who may be eligible. Passive approaches include posting study flyers (**Attachment 3a and 3b**) in businesses that serve and/or employ large numbers of

Hispanics/Latinos including tiendas (shops or stores that cater to Hispanic/Latino populations), laundromats, construction sites, hotels, ESL classes, restaurants, housing communities and apartment complexes.

This is an intervention trial which is primarily designed to make comparisons between the pre- and post-intervention group, not to make generalizations to the larger population. Because Hispanic/Latina transgender women are a unique and hidden population for which there is no study sampling frame, we will use multiple convenience and referral-based sampling techniques to identify and recruit participants to the study.

Rationale for proposed number of subjects

ChiCAS study power calculations are based on a sample size of 100 (50 per group). However, to ensure sufficient power to detect effect sizes that may be smaller than our hypothesized effect size, we may re-estimate the sample size in light of interim results during the ChiCAS trial study. In order to avoid increasing the Type I error rate at the time of the final analysis, we will use the sample size reassessment approach of Mehta and Pocock.[5] Once we have recruited and completed follow-up assessments for 80 participants, we will calculate the conditional power based on participant data accumulated by that point. The use of 80 participants will enable us to maximize the precision of our interim estimate. If power based on our review of outcome data is "promising" (defined as greater than 50% but less than 80% based on bounds calculated using formulas from Mehta and Pocock [2011]), we will increase the sample size to a maximum of 140 (70 per group). If the power is "favorable" (defined as 80% or greater), we will continue recruitment to our original sample size of 100. If the power is "unfavorable" (defined as less than 50%) we will also continue to our original sample size. This approach does not discontinue a study due to futility. At a minimum, it continues to the original sample size. Please note that we have strong and diverse experiences with high rates of participant retention using various strategies. Based on our recruitment protocol, 20 additional individuals will have been recruited and will be awaiting follow-up assessments at the time of this reassessment and will therefore be assured follow-up and inclusion in our final analysis.

We will randomly select a subset of up to 30 participants from the total study sample who will be categorized into three groups of 10 persons each based on their self-reported behavioral outcomes relative to those expected from the intervention. We will administer qualitative interviews to these persons in order to obtain information concerning their general experiences while participating in the intervention and intervention outcomes, and any recommendations they may have for improving the intervention content or delivery. We chose this number based on qualitative research literature suggesting that a sample size of 30 is sufficient for our purposes. We describe the categorization of qualitative interview participants in greater detail below.[6]

2. Procedures for the Collection of Information

We will collect four types of information for this study: screening information, contact information, quantitative assessment information, and qualitative interview information.

Interested participants will be screened for eligibility either in person or over the telephone prior to enrollment (**Attachments 4a and 4b**). After potential participants have been identified, screened for eligibility, and confirm their willingness to participate, study staff will schedule a meeting with them to complete an HIV test to confirm their eligibility, administer informed consent and the baseline assessment. The screening form includes a detachable section in which contact information is collected.

(**Attachments 4a and 4b**). By enrolling participants in waves of 20, we expect to avoid long delays between recruitment, randomization, and participation.

Screening, HIV testing to verify eligibility, and completion of the informed consent process and baseline assessments may be conducted remotely at a location of the participants choosing, or at one of the seven community-based organizations (CBOs) or health service delivery organizations in NC that are listed above (see page 4) and have agreed to make their facilities available during the study. All organizations provide spaces that are safe and convenient for participants. Alternatively, if potential participants prefer, these steps in the study screening and enrollment processes may be completed at locations that are selected by the individuals. Examples of alternative locations include private and safe areas of homes, bars and clubs, Hispanic/Latino-owned businesses, and at community events (e.g., gay pride and Hispanic/Latino cultural events) by staff. Immediately following enrollment, participants will be randomized into one of two groups, the intervention or the delayed-intervention group, and interviewers will administer the quantitative baseline assessment to both groups (**Attachments 4c and 4d**). All participants will complete the follow-up assessment (**Attachments 4e and 4f**), 6 months after enrollment. Study assessments will collect information on sociodemographic factors; the primary outcomes (PrEP use, consistent condom use and use of medically supervised hormone therapy); psycho-social factors including awareness and knowledge about HIV and PrEP, barriers to care, condom use skills, healthcare provider trust and communication skills; and other variables including self-reported health status and history of health care use. The assessment also includes a detachable section in which contact information is collected (**Attachments 4c, 4d, 4e and 4f**).

As noted above, we will also identify and explore the strengths and weaknesses of the ChiCAS intervention through the use of qualitative in-depth interviews with up to 30 intervention participants (**Attachment 4e and 4f**). For this portion of the study, we will randomly select and interview three groups of 10 participants each from the intervention group after they complete the 6-month follow-up. These groups will include ten participants who reported an increase in at least one HIV prevention behavioral outcome (PrEP or condom use) and who reported an increase in the use of medically supervised hormone therapy; ten participants who did not report an increase in at least one HIV prevention behavioral outcome (PrEP or condom use) and did not report an increase in the use of medically supervised hormone therapy; and ten participants with mixed results. The qualitative assessment will collect information from selected participants on their general intervention experiences and recommendations, and their experiences and lessons learned regarding PrEP, condom use and use of medically supervised hormone therapy.

Personal identifying information will not be attached to the data obtained from participants during the assessments. Immediately after completing the assessments, personal contact information will be separated from the questionnaire. The signed consent form will also be stored separately. A code will link the two assessments and the consent form. During data collection outside of the offices of the Wake Forest Health Services, completed assessments, participant contact information, and the consent forms will be stored in 3 separate locked boxes to ensure that each participant's information is not easily linked to their responses. The locked boxes will never be left in the car of a data collector overnight. Within 48 hours, all assessments, contact information, and consent forms will be transferred to Wake Forest School of Medicine.

3. Methods to Maximize Response Rates and Deal with Non-responses

We expect attrition in this study to be minimal because studies that are based on community member priorities and planned and conducted in partnership with community members and organizations they

trust (e.g., Triad Health Project) tend to have lower attrition rates.[7-12] We have used this approach in all of our studies. Often assumed to be "unstable" or "in transition," the Hispanic/Latino communities involved in our studies have had low attrition rates, with much of this success due to our community-engaged approach.

In our recent CDC-funded intervention study HOLA en Grupos (U01PS001570; OMB 0920-0942, exp. 3/31/2018) to reduce HIV risk among Hispanic/Latino gay and bisexual men, MSM, and transgender women, we retained 100% of the 304 participants at 6-month follow-up.[11] In another recent study of Hispanic/Latino gay and bisexual men, other MSM, and transgender women (R01MH087339; no OMB number),[13] we had a 95% retention rate at 24-month follow-up; although the numbers of transgender women were low in these 2 studies, there was no difference in retention rates between transgender women and MSM.

We have calculated the statistical power for our study based on a 10% dropout rate at the 6-month post-intervention follow-up. Although we have not experienced such high dropout rates, we have used 10% as a worst-case scenario. Attrition will be followed by the partnership to provide important insights for retention efforts in subsequent studies. We have strong and diverse experiences in participant retention using various strategies.

At the baseline assessment with each participant, we will obtain: current address, personal cellphone number, other telephone numbers, e-mail addresses, the contact information of others (e.g., friends and family) who may know how to find the participant if she becomes difficult to find, and Facebook names/aliases. We will also obtain permission to use these resources to reach the participant if we cannot locate them through other means. Each participant also will be given a toll-free number on a stay-in-touch card that she can call to provide updated contact information (**Attachment 9a & 9B**). If necessary, the 6-month follow-up assessment can be completed by telephone, and the token of appreciation mailed to the participant. We have successfully provided a cellphone number to Hispanic/Latino participants previously, and they have used it to notify us their contact information has changed or if they are temporarily or permanently out of the area.

To enhance retention, we will provide tokens of appreciation for participation in the different stages of the study. We will provide $30 for completion of the baseline assessment, $40 for completion of each of the two intervention sessions, and $40 for completing the 6-month follow-up assessment . In addition, $40 will be provided to those participants from the intervention group who are selected and complete qualitative in-depth interviews. Additional retention-promoting measures will include the following: (1) providing a meal during each intervention session; (2) giving participants Spanish-language appointment cards with the date and time of the next intervention session (**Attachment 10a and 10b**), (3) bags and cosmetic bags bearing the study logo; (4) a two-sided laminated card that will include a toll-free cellphone numbers (answered by the interventionist) to stay in contact with the study and report changes in contact information (i.e., the stay-in-touch card previously described); (5) a graduation dinner upon successful completion of the intervention (pre- and post-COVID only); and (6) a certificate acknowledging completion of the intervention.

Study staff will make a maximum of five attempts to contact study participants to administer 6-month follow-up assessments and the in-depth interviews.

4. Tests of Procedures or Methods to be Undertaken

Study staff have considerable experience collecting sensitive data (including sexual health and risk data and healthcare access) from Hispanic/Latino heterosexual individuals, MSM, and transgender women.[8, 11, 12, 14-56] The interviewers will be trained in issues particularly salient to research with Hispanic/Latina transgender women, and within Hispanic/Latino communities. This training will develop their knowledge of these communities and sexuality within these communities and refine their interviewing skills. Interviewing skills to be developed include asking questions, listening instead of talking, expressing verbal interest in the respondent, and showing interest by eye contact and other nonverbal cues.[57] The grantee study team will facilitate interview role playing with Hispanic/Latina transgender women (N=5) from the steering committee, who represent the target community, and use various challenging scenarios to develop the skills of the interviewers. These mock interviews will be videotaped to allow the interviewers to see and hear how the interview went and debrief with study team leads and learn from the process. Mock interviews will allow interviewers to identify opportunities for silence, probing for detail, etc. Pretesting instruments also will serve as opportunities to refine and practice skills.

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

Exhibit 5.1 below lists the project team members who were consulted on the aspects of research design and those who will be collecting and analyzing the data. Please note: The CDC staff are primarily responsible for providing technical assistance in the design and implementation of the research; assisting in the development of the research protocol and data collection instruments for CDC Project Determination and local IRB reviews; working with investigators to facilitate appropriate research activities; and analyzing data and presenting findings at meetings and in publications. CDC staff will neither interact with nor collect data from study participants. Data will be collected by members of grantee project staff listed. No individual identifiers will be linkable to collected data shared with or accessible by CDC staff, and no individually identifiable private information will be shared with or accessible by CDC staff.

6. Analysis Plan

Individuals who are eligible to participate in the intervention study will be randomly assigned to receive the intervention shortly after collection of baseline data (intervention condition), or to receive the intervention after completion of the 6-month post-intervention follow-up assessments by intervention condition participants and before comparison participants receive the intervention (waitlist comparison condition).

Analysis of quantitative data from baseline and 6-month follow-up questionnaires

Data analysis will involve general descriptions of the study groups and analysis of the intervention effects.

General description of the study groups. Absolute numerical values and percents will be calculated for categorical variables; means, medians, standard deviations, and ranges will be calculated for continuous variables to describe the overall characteristics of study participants and to compare ChiCAS intervention and comparison participants. Correlational analyses will be used to evaluate associations between variables, and nonparametric statistics will be used as appropriate to assess the significance of the observed associations.

Evaluation of intervention effects. The effects of the ChiCAS intervention will be evaluated by comparing use rates for PrEP, medically supervised hormone therapy, and consistent condom use by

intervention and waitlist participants at baseline and six months later. We will adjust for baseline use rates at the follow-up, as doing so has the advantage of being unaffected by baseline differences.

The intervention outcomes will be assessed using an intent-to-treat approach in which participants are included in the analysis as originally assigned to the intervention or comparison conditions, regardless of whether they actually attended their assigned session. Statistical analysis will be performed using generalized linear mixed modeling for binary outcomes, sometimes termed random effects logistic regression. This approach will produce estimates of PrEP use, medically supervised hormone therapy use, and consistent condom use while adjusting for covariates, which will be compared to unadjusted estimates. Individual-level covariates may include age, country of origin, education level, and length of time in US. To assess the importance of covariates, a backwards elimination model building approach will be used, with primary consideration on assessment of confounding on the intervention-group difference. If confounding is present (defined to be greater than a 10% change in the regression estimate of the intervention-group effect), the confounder will be retained in the multivariable model. Interactions with intervention group will be tested first and retained if significant at the 5% level. All analyses will be two-sided.[141]

Adherence. Some participants in rigorous evaluations such as that planed for the ChiCAS intervention study may be "non-adherent;" that is, they do not attend all sessions as expected. This can introduce bias when estimations of intervention effects are based solely on data collected from participants who attend all intervention sessions. The intent-to-treat method described above addresses this bias. In addition, adherence will be assessed by estimating the proportion of participants who complete both of the intervention's two sessions and the average number of completed sessions. In secondary analyses, adherence data will be used as a predictor variable in modeling intervention efficacy. Differences between intervention and waitlist participant outcomes will be assessed at the ≤ 0.05 significance level.

Data management. Study staff will develop a standardized data collection manual/codebook for use with the identical baseline and 6-month follow-up assessment questionnaires. Completed assessments will be reviewed by study staff and entered using TELEform software (Verity, Inc, Sunnyvale, CA).

Analysis of qualitative data from in-depth Interviews

Analysis of qualitative data will include eight analytic steps: (1) After each interview, study staff will document general impressions about its content and potentially emerging themes and new areas of information; (2) They will listen to the digital recording and take general notes; (3) The digital recordings will be professionally transcribed verbatim and then verified, and any personally identifying information will be removed from the transcription; (4) Digital recordings will be erased after verification; (5)Transcriptions will be entered into the NVivo software (Chicago, IL) for purposes of data management; (6) A common coding system and data dictionary will be developed; (7) All transcripts will be coded using this coding scheme, while allowing for new codes to emerge. Similarities and differences across transcripts will be examined and codes and themes revised accordingly. Finally (8), findings will be presented to the Community-Based Participatory Research partnership for final review, revision, and interpretation. We have used this approach to qualitative data analysis successfully previously

Characteristics of study locations. As noted above, the physical study locations are similar insofar as they all have safe community rooms where the intervention can be delivered and provide or provide referrals for HIV and STI testing, PrEP, and/or medically supervised hormone therapy. Data will be analyzed to describe cross-site differences in study outcomes, including differences between virtual and

physical intervention sites; but the study is not sufficiently powered to compare the sites.

Exhibit 5.1: Statistical Consultants

Name	Title	Organization	Phone	Email
Carla Galindo	Project Officer	CDC	404-639-1902	fco4@cdc.gov
Patricia Bessler	Project Coordinator	CDC	404-639-8239	vey4@cdc.gov
Craig Borkowf	Statistical Consultant	CDC	404-639-5235	Uzz3@cdc.gov
Scott Rhodes	Principal Investigator	Wake Forest University	336-713-5080	srhodes@wakehealth.edu
Beth Reboussin	Co-Investigator	Wake Forest University	336-713-5213	brebouss@wakehealth.edu
Amanda Tanner	Co-Investigator	University of North Carolina at Greensboro	336-334-5878	aetanner@uncg.edu
Jorge Alonzo	Research Associate	Wake Forest University	336-713-5048	jalonzo@wakehealth.edu
Lilli Mann Jackson	Senior Research Associate	Wake Forest University	336-716-7441	lmann@wakehealth.edu
Lisa Lewis	Project Manager	Wake Forest University	336-713-5074	Lisa.Lynn.Lewis@wakehealth.edu

References

1. Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. AIDS and behavior. 2008;12(1):1-17.
2. Baral SD, Poteat T, Stromdahl S, Wirtz AL, Guadamuz TE, Beyrer C. Worldwide burden of HIV in transgender women: A systematic review and meta-analysis. The Lancet Infectious diseases. 2013;13(3):214-22.
3. Lippman SA, Moran L, Sevelius J, Castillo LS, Ventura A, Treves-Kagan S, et al. Acceptability and feasibility of HIV self-testing among transgender women in San Francisco: A mixed methods pilot study. AIDS and behavior. 2015.
4. Bandura A. Social foundations of thought and action: A social cognitive theory. Englewood Cliffs: Prentice-Hall; 1986.
5. Mehta CR, Pocock SJ. Adaptive increase in sample size when interim results are promising: a practical guide with examples. Statistics in medicine. 2011;30(28):3267-84.
6. Creswell JW. Qualitative inquiry and research design. Choosing among five traditions. Thousand Oaks, CA: Sage Publications; 1998.
7. Viswanathan M, Eng E, Ammerman A, Gartlehner G, Lohr KN, Griffith D, et al. Community-based participatory research: Assessing the evidence. Evidence Report/Technology Assessment. Rockville, MD: Agency for Healthcare Research and Quality, 2004 July. Report No.: 99.
8. Rhodes SD, Mann L, Alonzo J, Downs M, Abraham C, Miller C, et al. CBPR to prevent HIV within ethnic, sexual, and gender minority communities: Successes with long-term sustainability. In: Rhodes SD, editor. Innovations in HIV Prevention Research and Practice through Community Engagement. New York, NY: Springer; 2014. p. 135-60.

9. Cashman SB, Adeky S, Allen AJ, Corburn J, Israel BA, Montaño J, et al. The power and the promise: Working with communities to analyze data, interpret findings, and get to outcomes. American journal of public health. 2008;98(8):1407-17.
10. Rhodes SD. Demonstrated effectiveness and potential of CBPR for preventing HIV in Latino populations. In: Organista KC, editor. HIV Prevention with Latinos: Theory, Research, and Practice. New York, NY: Oxford; 2012. p. 83-102.
11. Rhodes SD, Alonzo J, Mann L, Song E, Tanner AE, Arellano JE, et al. Small-group randomized controlled trial to increase condom use and HIV testing among Hispanic/Latino gay, bisexual, and other men who have sex with men. American journal of public health. 2017;107(6):969-76.
12. Rhodes SD, Duck S, Alonzo J, Daniel J, Aronson RE. Using community-based participatory research to prevent HIV disparities: Assumptions and opportunities identified by The Latino Partnership. Journal of Acquired Immunodeficiency Syndromes. 2013;63(Supplement 1):S32-S5.
13. Rhodes SD, Daniel J, Alonzo J, Duck S, Garcia M, Downs M, et al. A systematic community-based participatory approach to refining an evidence-based community-level intervention: The HOLA intervention for Latino men who have sex with men. Health Promotion Practice. 2013;14(4):607-16.
14. Gilbert PA, Perreira K, Eng E, Rhodes SD. Social stressors and alcohol use among immigrant sexual and gender minority Latinos in a nontraditional settlement state. Substance use & misuse. 2014;49(11):1365-75.
15. Gilbert PA, Rhodes SD. Psychometric performance of a novel measure of social support among Spanish-speaking immigrant Latino gay men. Hispanic Journal of Behavioral Sciences. 2012;34(4):491-504.
16. Gilbert PA, Rhodes SD. HIV testing among immigrant sexual and gender minority Latinos in a US region with little historical Latino presence. AIDS patient care and STDs. 2013;27(11):628-36.
17. Gilbert PA, Rhodes SD. Immigrant sexual minority Latino men in rural North Carolina: An exploration of social context, social behaviors, and sexual outcomes. Journal of homosexuality. 2014;61(8):1131-51.
18. Martinez O, Wu E, Levine EC, Munoz-Laboy M, Fernandez MI, Bass SB, et al. Integration of social, cultural, and biomedical strategies into an existing couple-based behavioral HIV/STI prevention intervention: Voices of Latino male couples. PloS one. 2016;11(3):e0152361.
19. Martinez O, Wu E, Shultz AZ, Capote J, Lopez Rios J, Sandfort T, et al. Still a hard-to-reach population? Using social media to recruit Latino gay couples for an HIV intervention adaptation study. Journal of medical Internet research. 2014;16(4):e113.
20. Rhodes SD. Authentic engagement and community-based participatory research for public health and medicine. In: Rhodes SD, editor. Innovations in HIV Prevention Research and Practice through Community Engagement. New York, NY: Springer; 2014. p. 1-10.
21. Rhodes SD, Alonzo J, Mann L, Andrade M, Downs M, Villatoro GR, et al. Novel approaches to HIV prevention and sexual health promotion among Guatemalan gay and bisexual men, MSM, and transgender persons AIDS Education and Prevention. 2014;26(4):345-61.
22. Rhodes SD, Alonzo J, Mann L, Downs M, Andrade M, Wilks C, et al. The ecology of sexual health of sexual minorities in Guatemala City. Health promotion international. 2015;30(4):832-42.
23. Rhodes SD, Alonzo J, Mann L, Freeman A, Sun CJ, Garcia M, et al. Enhancement of a locally developed HIV prevention intervention for Hispanic/Latino MSM: A partnership of community-based organizations, a university, and the Centers for Disease Control and Prevention AIDS Education and Prevention. 2015;27(4):312-32.
24. Rhodes SD, Alonzo J, Mann L, Sun CJ, Simán FM, Abraham C, et al. Using photovoice, Latina transgender women identify priorities in a new immigrant-destination state. International Journal of Transgenderism 2015;16(2):80-96.
25. Rhodes SD, Fernandez FM, Leichliter JS, Vissman AT, Duck S, O'Brien MC, et al. Medications for sexual health available from non-medical sources: A need for increased access to healthcare and education among immigrant Latinos in the rural southeastern USA. J Immigr Minor Health. 2011;13(1183-1186).
26. Rhodes SD, Leichliter JS, Sun CJ, Bloom FR. The HoMBReS and HoMBReS Por un Cambio interventions to reduce HIV disparities among immigrant Hispanic/Latino men. MMWR Morb Mortal Wkly Rep. 2016;65(1):51-6.

27. Rhodes SD, Mann L, Simán FM, Song E, Alonzo J, Downs M, et al. The impact of local immigration enforcement policies on the health of immigrant Hispanics/Latinos in the United States. American journal of public health. 2015;105(2):329-37.
28. Rhodes SD, McCoy TP. Condom use among immigrant Latino sexual minorities: Multilevel analysis after respondent-driven sampling AIDS Education and Prevention. 2015;27(1):27-43.
29. Rhodes SD, McCoy TP, Tanner AE, Stowers J, Bachmann LH, Nguyen AL, et al. Using social media to increase HIV testing among gay and bisexual men, other MSM, and transgender persons: Outcomes from a randomized community trial. Clinical infectious diseases : an official publication of the Infectious Diseases Society of America. 2016;62(11):1450-3.
30. Rhodes SD, Tanner A, Duck S, Aronson RE, Alonzo J, Wilkin AM, et al. Female sex work within the Latino community in central North Carolina: An exploratory qualitative community-based participatory research study

Progress in Community Health Partnerships: Research, Education, and Action. 2012;6(4):417-27.
31. Tanner AE, Reboussin BA, Mann L, Ma A, Song E, Alonzo J, et al. Factors influencing healthcare access perceptions and care-seeking behaviors of Latino sexual minority men and transgender individuals: HOLA intervention baseline findings. Journal of Health Care for the Poor and Underserved. 2014;25(4):1679-97.
32. Vissman AT, Young AM, Wilkin AM, Rhodes SD. Correlates of HAART adherence among immigrant Latinos in the Southeastern United States. AIDS Care. 2013;25(3):356-63.
33. Rhodes SD, Bischoff WE, Burnell JM, Whalley LE, Walkup MP, Vallejos QM, et al. HIV and sexually transmitted disease risk among male Hispanic/Latino migrant farmworkers in the Southeast: Findings from a pilot CBPR study. Am J Ind Med. 2010;53(10):976-83.
34. Rhodes SD, McCoy TP, Vissman AT, DiClemente RJ, Duck S, Hergenrather KC, et al. A randomized controlled trial of a culturally congruent intervention to increase condom use and HIV testing among heterosexually active immigrant Latino men. AIDS and behavior. 2011;15(8):1764-75.
35. Rhodes SD, Eng E, Hergenrather KC, Remnitz IM, Arceo R, Montano J, et al. Exploring Latino men's HIV risk using community-based participatory research. Am J Health Behav. 2007;31(2):146-58.
36. Rhodes SD, Hergenrather KC. Recently arrived immigrant Latino men identify community approaches to promote HIV prevention. American journal of public health. 2007;97(6):984-5.
37. Rhodes SD, Hergenrather KC, Griffith D, Yee LJ, Zometa CS, Montaño J, et al. Sexual and alcohol use behaviours of Latino men in the south-eastern USA. Culture, health & sexuality. 2009;11(1):17-34.
38. Rhodes SD, Hergenrather KC, Zometa C, Lindstrom K, Montaño J. Characteristics of immigrant Latino men who utilize formal healthcare services in rural North Carolina: Baseline findings from the *HoMBReS* Study. Journal of the National Medical Association. 2008;100(10):1177-85.
39. Alonzo J, Mann L, Siman FM, Sun CJ, Andrade M, Villatoro G, et al. Perspectivas para mejorar la salud sexual de las minorías sexuales y de identidad de género en Guatemala. Revista Internacional de Políticas de Bienestar y Trabajo Social: Ehquidad. In press.
40. Alonzo J, Mann L, Tanner AE, Sun CJ, Painter TM, Freeman A, et al. Reducing HIV risk among Hispanic/Latino men who have sex with men: Qualitative analysis of behavior change intentions by participants in a small-group intervention. Journal of AIDS & clinical research. 2016;7(5).
41. Cashman R, Eng E, Simán F, Rhodes SD. Exploring the sexual health priorities and needs of immigrant Latinas in the southeastern US: A community-based research approach. AIDS Education and Prevention. 2011;23(3):236-48.
42. Rhodes SD, Hergenrather KC, Aronson RE, Bloom FR, Felizzola J, Wolfson M, et al. Latino men who have sex with men and HIV in the rural south-eastern USA: findings from ethnographic in-depth interviews. Cult Health Sex. 2010;12(7):797-812.
43. Rhodes SD, Hergenrather KC, Vissman AT, Stowers J, Davis AB, Hannah A, et al. Boys must be men, and men must have sex with women: A qualitative CBPR study to explore sexual risk among African American, Latino, and white gay men and MSM. American Journal of Men's Health. 2011;5(2):140-51.

44. Rhodes SD, Hergenrather KC, Yee LJ, Knipper E, Wilkin AM, Omli MR. Characteristics of a sample of men who have sex with men, recruited from gay bars and internet chat rooms, who report methamphetamine use. AIDS patient care and STDs. 2007;21(8):575-83.
45. Rhodes SD, McCoy TP, Hergenrather KC, Vissman AT, Wolfson M, Alonzo J, et al. Prevalence estimates of health risk behaviors of immigrant Latino men who have sex with men. Journal of Rural Health. 2012;28(1):73-83.
46. Rhodes SD, Yee LJ, Hergenrather KC. A community-based rapid assessment of HIV behavioural risk disparities within a large sample of gay men in southeastern USA: a comparison of African American, Latino and white men. AIDS Care. 2006;18(8):1018-24.
47. Rhodes SD, DiClemente RJ, Yee LJ, Hergenrather KC. Correlates of hepatitis B vaccination in a high-risk population: an Internet sample. Am J Med. 2001;110(8):628-32.
48. Rhodes SD, DiClemente RJ, Cecil H, Hergenrather KC, Yee LJ. Risk among men who have sex with men in the United States: a comparison of an Internet sample and a conventional outreach sample. AIDS education and prevention : official publication of the International Society for AIDS Education. 2002;14(1):41-50.
49. Rhodes SD, DiClemente RJ. Psychosocial predictors of hepatitis B vaccination among young African-American gay men in the deep south. Sex Transm Dis. 2003;30(5):449-54.
50. Rhodes SD, Arceo R. Developing and testing measures predictive of hepatitis A vaccination in a sample of men who have sex with men. Health education research. 2004;19(3):272-83.
51. Rhodes SD, Vissman AT, Stowers J, Miller C, McCoy TP, Hergenrather KC, et al. A CBPR partnership increases HIV testing among men who have sex with men (MSM): Outcome findings from a pilot test of the CyBER/testing Internet intervention. Health Educ Behav. 2011;38(3):311-20.
52. Rhodes SD, Hergenrather KC, Wilkin AM, Alegria-Ortega J, Montaño J. Preventing HIV infection among young immigrant Latino men: results from focus groups using community-based participatory research. J Natl Med Assoc. 2006;98(4):564-73.
53. Rhodes SD, Yee LJ, Hergenrather KC. Hepatitis A vaccination among young African American men who have sex with men in the deep south: psychosocial predictors. J Natl Med Assoc. 2003;95(4 Suppl):31S-6S.
54. Rhodes SD, Hergenrather KC, Yee LJ, Ramsey B. Comparing MSM in the southeastern United States who participated in an HIV prevention chat room-based outreach intervention and those who did not: how different are the baseline HIV-risk profiles? Health education research. 2008;23(1):180-90.
55. Rhodes SD, Hergenrather KC, Yee LJ, Wilkin AM, Clarke TL, Wooldredge R, et al. Condom acquisition and preferences within a sample of sexually active gay and bisexual men in the Southern USA. AIDS patient care and STDs. 2007;21(11):861-70.
56. Rhodes SD, McCoy T, Hergenrather KC, Omli MR, DuRant RH. Exploring the health behavior disparities of gay men in the United States: Comparing gay male university students to their heterosexual peers. Journal of LGBT Health Research. 2007;3(1):15-23.
57. Spradley JP. The ethnographic interview. New York, NY: Holt, Rinehart, & Winston; 1979.