Published in final edited form as:

J Community Health Nurs. 2010 October ; 27(4): 207–215. doi:10.1080/07370016.2010.515458.

HIV Susceptibility Among Hispanic Women in South Florida

Rosina Cianelli, Natalia Villegas, Rosa Gonzalez-Guarda, Lorena Kaelber, and Nilda Peragallo

School of Nursing and Health Studies, University of Miami, Coral Gables, Florida

Abstract

Hispanic women (HW) are disproportionately affected by HIV, however, little is known regarding their perceived susceptibility for acquiring HIV (SAHIV). We studied predictive factors for perceiving SAHIV among HW. Participants (88.5%) reported not feeling SAHIV. Women who felt SAHIV, had a significant probability of reporting a higher chance for acquiring HIV from their partner's actions (OR 9.75), and a higher probability of not being tested for HIV (OR 2.05). Educational strategies to increase perception of SAHIV and HIV testing knowledge would be beneficial giving emphasis to women who do not perceive to be at risk from their partner's actions.

Currently there are approximately 33.4 million people living with HIV worldwide, a figure that continues to rise as a total of 2.7 million new infections occurred during 2007 (UNAIDS, 2008). Because more than half of all people living with HIV are women, HIV infection poses numerous challenges to women's health providers (UNAIDS, 2008). In the United States the incidence of AIDS is increasing more rapidly among women, compared with men. In fact, if new HIV infections continue at their current rate, women with HIV may soon out number men with HIV in the United States (Center for Disease Control and Prevention [CDC], 2009). Consequently, HIV is increasingly becoming a major cause of death among women, especially among women from racial and ethnic minority groups. Hispanic women account for 15% of estimated AIDS cases (Kaiser Family Foundation, 2009). HIV continues to be a threat for Hispanics; it has been the fourth leading cause of death for Hispanic women ages 35–44 years, with 69% of these women acquiring the virus through heterosexual contact (CDC, 2008a; Kaier Family Foundation, 2009).

HIV/AIDS rates for Hispanics are 3.5 times as high as those of Caucasians (CDC, 2008b). These national statistics are similar to those for the state of Florida, which currently ranks second in the nation for the highest number of reported AIDS cases (Florida Department of Health, 2007). Hispanics account for a disproportionate number of AIDS cases when compared to their overall representation in the US population. Although Hispanics comprise only about 17% of Florida's total adult population, they account for 19% of all people living with HIV (Florida Department of Health, 2004). Miami-Dade and Broward counties have the highest numbers of AIDS cases state-wide. These two counties reported a combined total

Copyright © Taylor & Francis Group, LLC

Address correspondence to Rosina Cianelli, PhD, MPH, RN, FAAN, University of Miami School of Nursing and Health Studies, 5030 Brunson Ave., Coral Gables, FL 33146. rcianelli@miami.edu.

Full terms and conditions of use: <http://www.informaworld.com/terms-and-conditions-of-access.pdf>

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

Publisher's Disclaimer: The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

of 1,758 cases in 2007, or 46% of the state-wide total. In 2007, county-specific AIDS cases per 100,000 indicated that Broward county ranked highest, with a rate of 43.5, followed by Miami-Dade county (39.2) (Florida Department of Health, 2007). Despite these risks, little is known regarding Hispanic women's perceived susceptibility for acquiring HIV.

The Health Belief Model (HBM) was used as a framework to understand why women did not engage in preventive behaviors. This model has been used extensively in HIV research (Institute of Medicine, 2001; Rosenstock, 1974). Rosenstock (1966), the developer of HBM, stated that those individuals who do not have symptoms will take action to prevent or screen for illnesses only when they are ready to take action. An individual's readiness to take action is determined by their feelings of susceptibility to the illness, the extent to which they perceive the occurrence as possible, and an individual's perception of the consequences or severity of that illness. This involves a subjective evaluation of risk (Institute of Medicine, 2001; Rosenstock, 1974) and serves as a stimulus or cue for behavioral change (Rosenstock, 1966; Rosenstock, Strecher, & Becker, 1988). Although susceptibility is hypothesized to provide the energy force for action, diminishing the barriers for behavioral change are thought to provide an accessible path for action (Finfgeld, Wongvatunyu, Conn, Grando, & Riussell, 2003).

Understanding individuals' perception of their susceptibility to HIV and the context of risky sexual behaviors is the first step toward eliciting safer sexual behaviors (Akwara & Madise, 2003). Studies show that individuals are more likely to underestimate, rather than to overestimate, their risk of HIV infection, regardless of the nature of their sexual behaviors (Nzioka, 2001). A high perception of susceptibility may lead to a modification of sexual behavior as is demonstrated by the refusal to have sexual intercourse with a partner. Nevertheless, women generally do not feel susceptible to HIV (Cianelli, 2003; Villanueva, Darrow, Uribe, Sanchez-Brana, Obiaja, & Gladwin, 2010). This is largely due to perceptions that HIV is a disease mostly confined to certain socially stigmatized groups such as men who have sex with men and drug users.

However, some factors have been associated with perceived susceptibility among women. These include: (a) religion, (b) age, (c) living arrangements, (d) number of women currently infected with HIV, (e) HIV susceptibility secondary to partner's behavior, and (f) HIV testing.

Studies have mentioned religion as having a protective effect because it has been associated with a reduction of high-risk behaviors. In the United States, Catholicism is the predominant religion among Hispanics, a religion that places high importance to marriage, fidelity, and family life (Finlay, Trafimow, & Villareal, 2002; Skogrand, Hatch, & Singh, 2005).

Perception of HIV vulnerability as related to age is generally low among women ages 30 years and older. They perceived themselves as not having any chance of being infected with HIV (Adefuye, Abiona, Balogun, & Lukobo-Durrell, 2009). Women who typically live with their partners generally report feeling less susceptible than those that live alone (Lara, Cianelli, & Ferrer, 2008).

Women who estimate that a significant percentage of women infected with HIV reside within their community, also perceive themselves to be at risk. Therefore, estimation by women within their communities provided a sense of vulnerability or risk of acquiring the disease (Cianelli, 2003). It is a woman's general wariness concerning their partner's behaviors, specifically infidelity, that contributes to a woman's increased perception of HIV vulnerability (Sarker et al., 2005). According to Hoffman et al. (2000), a negative HIV test has been identified as a contributing factor to HIV invulnerability.

The purpose of this study is to assess if religion, age, living arrangements, estimation of women infected with HIV, chances of acquiring HIV from their partner's actions, and having an HIV test are predictive factors for perceived susceptibility of acquiring HIV among Hispanic women in Florida.

METHODS

Design

This is a cross-sectional study. We used baseline data from a randomized control trial of Salud, Educación, Prevención y Autocuidado (Health, Education, Prevention & Self-care; SEPA II), a group intervention designed for Hispanic women in the United States to reduce HIV risks ($N = 548$).

Sample and Setting

We used a sample of Hispanic women from southern Florida who met the following criteria: (a) between the ages of 18 to 50 years old, (b) being sexually active in the past 3 months upon initial eligibility screening, and (c) self-identifying as Hispanic. Participants were recruited from the community in Broward County and Miami-Dade County, Florida. A large percentage of the initial sample was recruited from a community-based organization (CBO) that provides social services (e.g., English classes, childcare, job development and placement, health education) to Hispanics and immigrants. Study personnel posted flyers and made presentations at this CBO and other community-based settings (e.g., libraries, community clinics, churches) to inform potential study candidates about the study. Study participants were also encouraged to tell their families and friends about the study (i.e., snowball sampling). Assessments were conducted at the aforementioned CBO and a nearby study office that was rented once study enrollment increased and the demands of the study began to drain the resources of this CBO.

Procedures

Standardized health and behavior measures were administered to participants using face-to-face interviews by bilingual, female study personnel in the participant's language of preference (i.e., English or Spanish). Baseline data was collected between January, 2008 and April, 2009.

Institutional review board approval was obtained prior to beginning recruitment. Candidates interested in participating in SEPA II either (a) gave their names and phone numbers to study personnel and were called by the centralized scheduler eligibility screening or (b) were given a flyer or business card containing the study phone number for participants to call at their convenience. If eligible, candidates were scheduled for the assessment. Upon meeting with the candidates, assessors described study procedures, answered any questions the participants had, obtained informed consent and completed the baseline assessment. Assessments were collected with the assistance of a research management software system (Velos) that allowed assessors to ask participants questions and document their responses on the computer. Baseline assessments took approximately 3hr to complete. Participants received a monetary incentive upon the completion of the assessment to compensate them for their time, travel, and child care cost.

Variables of the Study

Demographics—Demographic information was collected at the beginning of the assessments through the administration of a standardized form specifically designed for studies at the research center in which this study was housed. The demographic form

collected information about the participant's country of origin, the number of years that they had lived in the United States, age, whether they lived with a partner, their marital status, the number of children that they had, their religion, years of education, employment status, family income, and health insurance status. In terms of analysis, the variable religion was dichotomized (0= *Catholic*, 1= *non-Catholic*), and living with a partner (0 = *not living with partner*, 1= *living with partner*). The variable *age* was listed as continuous.

HIV susceptibility to acquire HIV—HIV susceptibility is defined by a woman's perception of her risk for acquiring HIV, "How worried are you about getting HIV," the participant can respond *not at all*, *somewhat*, and *extremely worried for getting HIV*. The data was dichotomized as follows: 0=*feeling susceptible to acquire HIV that include extremely worried* and 1= *not feeling susceptible to acquire HIV that included somewhat or not at all worried for acquiring HIV/AIDS*.

Estimates of women infected with HIV/AIDS in the community—Participants estimated the percentage of women infected with HIV in the community by answering the following question: "In your community, how many women out of 100 do you think are infected by the HIV virus?".

Chances to acquire HIV/AIDS from their partners' actions—The chance of acquiring HIV/AIDS from her partners' actions refers to a woman's perception of her susceptibility for acquiring HIV. This was assessed by asking the participants the following: "What are the chances that a woman in the community could get HIV/AIDS from their partner or partner's actions?" Responses ranged from *very low*, *high*, to *very high*. For the analysis, the data was dichotomized as following: 0 = *low chances of getting HIV from their partner actions* (these include *somewhat* and *not at all worried about acquiring HIV/AIDS*) and 1= *high to very high changes of acquiring HIV*.

HIV testing—This variable assess if a woman has ever been tested for HIV. This variable was dichotomized as: 0 = *never or not been tested for HIV*, 1 = *having been tested for HIV*.

Data Analysis

Data was analyzed using SPSS version 17.0. Descriptive statistics and logistic regression were used in the analysis. Logistic regression was used to predict susceptibility for acquiring HIV. This method was selected to describe the relationship between the dichotomous outcome variable (i.e., susceptible and not susceptible to acquire HIV) and a set of independent continuous variables (age, estimated number of women infected with HIV/AIDS in the community) and independent dichotomous variables (chances to acquire HIV from their partners' actions, religion, if participants were living with their partners, and HIV testing).

The Hosmer and Lemshow statistic allows for the evaluation of goodness of fit by the researcher creating 10 ordered groups of participants and then comparing the number actually in each group (observed) to the number "predicted" by the logistic regression model (predicted).

RESULTS

Demographic Characteristics of the Sample

Table 1 displays detailed descriptive information regarding the demographic characteristics of the sample. Participants reported a mean age of 38.48 years $\pm$ 8.53 (range from 18 to 49

years of age). The majority of the participants were born in Colombia (33.9%), followed by Cuba (12.8%), and Peru (8.2%).

Study Variables

The majority of participants (88.5%) reported not feeling susceptible to acquiring HIV. Ninety-one point four percent (91.4%) of the participants reported a *low* chance of acquiring HIV from their partners' actions, and only 8.6% of the women reported a *high* chance of acquiring HIV from their partners' actions. On average, participants estimated that $19.4\% \pm 21.45$ of women in the community were living with HIV. Furthermore, 9.0% of the participants reported that there were no women with HIV living in their community. Fifty-seven percent (57%) of the participant reported 10 or less women with HIV living in their community. The majority of participants (83.2%) reported that they had been tested for HIV antibodies at least once in their lives, versus 16.8% who reported never having an HIV test. Of those women who had at least one HIV test, 95.2% reported a seronegative result.

Regression Analysis

In this analysis, the Hosmer and Lemshow statistic was not significant $\chi^2 = 5.827$, $p = .667$, indicating that prediction does not differ significantly from the observed. Therefore, the model is appropriate for predicting those participants who "feel susceptible" for acquiring HIV.

Additionally, the overall model fit was assessed using the chi-square test. For this model $LR\chi^2(6,548) = 48.513$, $p < .001$, reflecting that at least one of the independent variables contribute to the predicted outcome. Thus, this model explains from 8.6% to 17.3% of the variation in susceptibility for acquiring HIV (Cox and Snell $R^2 = .086$ and Nagelkerke $R^2 = .173$).

In the logistic regression analysis, the participants' perceptions of their chances for acquiring HIV from their partners' actions and HIV testing were significant predictors of their susceptibility of acquiring HIV, after controlling for age, estimation of women infected with HIV/AIDS in the community, religion, and if participants were living with their partners. Participants who considered themselves susceptible to HIV, had a higher probability of reporting a higher chance for acquiring HIV from their partner's actions (OR = 9.75, CI = 95%), and a higher probability of not being tested for HIV (OR = 2.05, CI = 95%), see Table 2.

DISCUSSION

This study focused on the susceptibility of Hispanic women for acquiring HIV. The findings of this study reveal that the majority of these women appeared not to be aware of their susceptibility for acquiring HIV. Similar studies conducted among low income and minority women showed the same results (Peragallo et al., 2005; Theall, Elifson, Sterk, & Klein, 2003; Villanueva et al., 2010). This finding is worrisome, because these women are mostly unaware of their exposure to high-risk behaviors and are unable to change these behaviors if they do not feel susceptible (Adefuye et al., 2009; Canaval et al., 2005; Ventura-Filipe et al., 2000).

We found that the perception of having a high chance for acquiring HIV secondary to partner behavior was the most important predictor of susceptibility for acquiring HIV among women in this study. As stated in previous studies, this predictor could reflect an open acknowledgment of a partner's infidelity or HIV status increasing a woman's susceptibility of acquiring HIV (Hoffman et al.; Koslofsky, Exner, Yingling, & Ehrhardt, 2000; Maharaj & Cleland, 2005). Furthermore, Maharaj and Cleland recognized the importance of this

factor and translated these concerns from their partner's actions into protective behaviors adding that women who feel vulnerable from their partners' actions are more capable of using condoms, even when their partners have a negative attitude toward condom use.

It is important to note that 83.2% of the women reported having been tested at some point in their lives for HIV. Susceptibility for HIV has been associated with the awareness of the advantages of being tested (De la Fuente et al., 2009). However, we found that HIV susceptibility was associated with a higher probability of never being tested for HIV. This finding is congruent with studies by De la Fuente et al. (2009), and Hoffman et al. (2000).

De la Fuente et al. (2009) reported that women who perceived themselves as low risk had a higher probability of having been tested for HIV (OR = 1.2, CI = 95%). In the study of Hoffman et al. (2000), one of four women cited HIV testing for explaining that they did not feel at risk. We feel that the lack of susceptibility found in this study can be attributed to the fact that the majority of our participants who were tested in this sample had a seronegative status. This finding decreases an individuals' susceptibility of acquiring HIV secondary to a perceived degree of assurance regarding their safety. It is also important to note that the majority of women in this study were immigrants and had to be tested for HIV when they arrived to this country. This is reflective of current public health policies, not necessarily of their perceptions of risk for HIV.

Additionally, women perceived a low estimated mean of Hispanic women living with HIV in their community, and this factor was not a significant predictor of the susceptibility for acquiring HIV. This may be related to the perception that some women tend to associate HIV with some stigmatized groups (Hoffman et al., 2000). Brown, Outlaw, and Simpson (2000) found similar results in a group of college students, reporting that the lack of susceptibility for acquiring HIV was associated with the college student's perception of not being involved with an identified risk group such as gay men or intravenous drug users.

In our sample, individual background characteristics such as age, religion, and living with a partner were not significant predictors of susceptibility for acquiring HIV. These results are probably due to the homogeneity of the variables used in the sample, because the majority of older women are living with a partner and are Catholic. Further studies would be useful in understanding why these predictors, in this population were not significant.

There are several limitations to this study that need to be considered when interpreting the results. One limitation to the study is the issue of self-reporting. Bardon-O'Fallon et al. (2004) stated that the discussion of sensitive issues such as HIV and sexual behaviors, especially those behaviors encountered by partners, may lead to misreporting, inaccuracy, and or incomplete information. In this study, it is important to mention that to protect the sensitive nature of the data and reduce this limitation, a confidential interview was administered with trained bilingual female interviewers or assessor. A certificate of confidentiality was also obtained to protect participants and help ensure them that their individual records would not be shared in the case that a subpoena was issued. Additionally, a causal relationship between the measurement of susceptibility for acquiring HIV and behavioral factors could not be established because of the cross-sectional design of the study. Future research should include longitudinal data that measures a woman's level of susceptibility, because this type of data would enhance the assessment of susceptibility for acquiring HIV.

Study findings may contribute toward the prevention of HIV by analyzing the susceptibility for acquiring HIV and those factors most likely associated with this group of women. Furthermore, these findings reinforce the necessity of preventive education and the importance of susceptibility assessment (Sharnam, Gupta, & Aggarwal, 2001). Future HIV/

AIDS prevention programs should include increasing awareness of how their partner's behaviors can influence their risk for HIV. Program leaders must aim to help women increase their self-esteem, self-confidence, and self-efficacy, as well as to decrease dependence. In addition, including communication strategies and negotiation skills with male partners present would be important in any HIV/AIDS educational program.

Acknowledgments

This research was funded by the Center of Excellence for Health Disparities Research: El Centro, National Center on Minority Health and Health Disparities grant P60MD002266.

REFERENCES

- Adefuye A, Abiona T, Balogun J, Lukobo-Durrell M. HIV sexual risk behaviors and perception of risk among college students: Implications for planning interventions. *BMC Public Health*. 2009; 9(281): 1–13. [PubMed: 19121216]
- Akwara N, Madise J. Perception of risk of HIV/AIDS and sexual behavior in Kenya. *Journal of Biosocial Science*. 2003; 35:385–411. [PubMed: 12887220]
- Barden-O'Fallon J, Degraft-Johnson J, Bisika T, Sulzbach S, Benson A, Tsui A. Factors associated with HIV/AIDS knowledge and risk perception in rural Malawi. *AIDS & Behavior*. 2004; 8:131–140. [PubMed: 15187475]
- Brown E, Outlaw F, Simpson E. Theoretical antecedents to HIV risk perception. *Journal of the American Psychiatric Nurses Association*. 2000; 6:177–182.
- Canaval G, Valencia C, Forero L, Guardela N, Magaña A, Vargas Y. Factores protectores y de riesgopara VIH/SIDA en mujeres de Cali, Colombia [Protective and risk factors for HIV/AIDS in women from Cali, Colombia]. *Ciencia y Enfermería*. 2005; 11(2):23–33.
- Center for Disease Control and Prevention. HIV/AIDS among women. 2008a [Retrieved March 15, 2009]. from <http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm>
- Center for Disease Control and Prevention. MMWR analysis provides new details on HIV. Incidence in U.S. populations. 2008b [Retrieved August 10, 2009]. from <http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/MMWR-incidence.htm>
- Center for Disease Control and Prevention. HIV/AIDS and women. 2009 [Retrieved March 9, 2009]. from <http://www.cdc.gov/hiv/topics/women/index.htm>
- Cianelli, R. Testing and HIV/AIDS prevention intervention for Chilean women. U.S. National Institutes of Health; 2003. RO1 NIH R01 TW006977–05
- De La Fuente L, Suarez M, Belza M, Vallejo F, García M, Alvarez R, et al. Human immunodeficiency virus testing uptake and risk behaviours in Spain. *Journal of Epidemiology & Community Health*. 2009; 63:552–558. [PubMed: 19525249]
- Fingeld D, Wongvatunyu S, Conn V, Grando V, Riussell CL. Health belief model and reversal theory: A comparative analysis. *Journal of Advanced Nursing*. 2003; 43:288–297. [PubMed: 12859788]
- Finlay K, Trafimow D, Villareal A. Predicting exercise and health behaviors intentions: Attitudes, subjective norms and other behavioral determinants. *Journal of Applied Social Psychology*. 2002; 32:342–358.
- Florida Department of Health. Florida HIV/AIDS annual report/epidemiologic profile 2004. 2004 [Retrieved July 21, 2008]. from http://www.doh.state.fl.us/disease_ctrl/aids/index.html
- Florida Department of Health. Florida annual report 2007. Acquired immunodeficiency syndrome/ human immunodeficiency virus. 2007 [Retrieved August 27, 2009]. from http://www.doh.state.fl.us/disease_ctrl/aids/trends/epiprof/mini_aids07c.pdf
- Hoffman S, Koslofsky S, Exner T, Yingling S, Ehrhardt A. At risk or not? Susceptibility perceptions of women using family planning services in an AIDS epicenter. *AIDS & Behavior*. 2000; 4:389–398.
- Institute of Medicine. Individuals and families: Models and interventions. In: Institute of Medicine. , editor. *Health and behavior: the interplay of biological, behavioral and societal influences*. Washington: National Academy of Press; 2001. p. 183–240.

- Kaiser Family Foundation. Women and HIV/AIDS in the United States. 2009 [Retrieved July 21, 2008]. from <http://www.kff.org/hivaids/upload/6092-04.pdf>
- Lara L, Cianelli R, Ferrer L. Comunicación de pareja y VIH en mujeres en desventaja [Partner communication and HIV in low income women]. *Revista Horizonte De Enfermería*. 2008; 19(2): 35–43.
- Maharaj P, Cleland J. Risk perception and condom use among married or cohabiting couples in KwaZulunatal, SouthAfrica. *International Family Planning Perspectives*. 2005; 31:24–29. [PubMed: 15888406]
- Nzioka C. Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Kenya. *Reproductive Health Matters*. 2001; 9:108–117. [PubMed: 11468825]
- Peragallo N, DeForge B, O'Campo P, Lee SM, Kim YJ, Cianelli R, et al. A randomized clinical trial of an HIV-risk reduction intervention among low-income Latina women [Electronic Version]. *Nursing Research*. 2005; 54:108–118. [PubMed: 15778652]
- Rosenstock I. Why people use health services. *Milbank Memorial Fund Quarterly*. 1966; 44(3):94–127. [PubMed: 5967464]
- Rosenstock, I. Historical origins of the health belief model. In: Becker, M., editor. *The health belief model and personal health behavior*. Thorofare, NJ: Charles B Slack; 1974. p. 1-8.
- Rosenstock I, Strecher V, Becker M. Social learning theory and the health belief model. *Health Education Quarterly*. 1988; 15:175–183. [PubMed: 3378902]
- Sarker M, Milkowsky A, Slinger T, Gondos A, Sanou A, Kouyate B, et al. The role of HIV-related knowledge and ethnicity in determining HIV risk perception and willingness to undergo HIV testing among rural women in Burkina Faso. *AIDS and Behavioral*. 2005; 9:243–249.
- Sharnam A, Gupta A, Aggarwal O. HIV/AIDS related knowledge, risk perception, attitude and sexual behavior of working women staying in hotels. *Indian Journal of Dermatology, Venerology and Leprology*. 2001; 67:21–24.
- Skogrand, L.; Hatch, D.; Singh, A. Understanding Latino families, implications for family education. 2005 [Retrieved August 2, 2010]. from http://extension.usu.edu/files/publications/publication/FR_Family_2005-02.pdf
- Theall K, Elifson K, Sterk C, Klein H. Perceived susceptibility to HIV among women: Differences according to age. *Research on Aging*. 2003; 25:405–432.
- UNAIDS. AIDS epidemic update. 2008 [Retrieved August 2, 2010]. from http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf
- Ventura-Filipe E, Bugamelli L, Leme B, Santos N, García S, Paiva V, et al. Risk perception and counseling among HIV-positive women in Sao Paulo, Brazil. *International Journal of STD & AIDS*. 2000; 11:112–114. [PubMed: 10678479]
- Villanueva L, Darrow W, Uribe C, Sanchez-Brana E, Obiaja K, Gladwin H. Ethnic differences in HIV risk perceptions and behaviors among Black 18–39 year-old residents of Broward County, Florida. *AIDS Education and Prevention*. 2010; 22:160–171. [PubMed: 20387986]

TABLE 1Characteristics of Hispanic Women in the Study ($N = 548$)

Variables	M or N	SD or %
Years in United States	11.41	10.34
Number of children	1.61	1.36
Years of education	13.37	3.45
Relationship status ^a		
Single	89	16%
Relationship, not married	141	26%
Married	248	45%
Divorced/separated/widowed	70	13%
Living with partner	380	69%
Employed	180	33%
Family income < \$2000/month	375	68%
Religion		
Roman Catholic	332	61%
Non-Catholic	217	39%
Health insurance	206	38%

Note. Frequency (%) for positive answers shown for dichotomous variables.

^aRelationship statuses are mutually exclusive categories.

TABLE 2

Logistic Regression Analysis Predicting Susceptibility to Acquire HIV Among Hispanic Women

Variable	β	Odds Ratio	95% CI for Exp (b)	
			Lower	Upper
Age	-.01	.99	.96	1.03
Living with Partner	.10	1.10	.59	2.07
Religion (non-Catholic)	.34	1.41	.78	2.54
Chances to acquire HIV from their partners' actions (high)	2.28*	9.75	4.74	20.06
Estimated of women infected with HIV/AIDS in the community	.01	1.01	.10	1.02
HIV Testing (never had a test)	.72*	2.05	1.02	4.12
Constant	-2.75*	.64		

*
 $p < .05$.