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Barriers and Facilitators of HIV Prevention With Heterosexual Latino Couples: Beliefs of Four Stakeholder Groups

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Abstract

Although HIV prevention interventions for women are efficacious, long-term behavior change maintenance within power-imbalanced heterosexual relationships has been difficult. To explore the feasibility, content, and format of an HIV intervention for Latino couples, the authors conducted 13 focus groups with HIV/AIDS researchers, service providers, and heterosexual men and women in Puerto Rico, the Dominican Republic, and Mexico. Reasons that participants thought that men should be involved in prevention efforts included promotion of shared responsibility, creation of a safe environment for open conversation about sex, and increased sexual negotiation skills. Perceived barriers to men's involvement included cultural taboos, sexual conservatism associated with Catholicism and machismo, and power-imbalanced relationships. Participants stressed the need for recruitment of men within naturally occurring settings or by influential community leaders. Participants indicated that couples-level interventions would be successful if they used strong coed facilitators, included both unigender and mixed-gender discussion opportunities, and addressed personally meaningful topics. Implications of these findings are discussed.

Keywords

HIV prevention; heterosexual couples; machismo; heterosexual men; Latinos

Promoting behavioral risk reduction continues to be the most effective strategy to stop the progress of the AIDS pandemic. This is particularly true with young heterosexuals whose main mode of HIV transmission is through sex behavior (Nelson et al., 2006). Prevention efforts with heterosexuals have primarily focused on women. Different interventions have shown that increasing male condom use and decreasing unprotected sex with this population are feasible (Catania et al., 2001; Dancy, Marcantonio, & Norr, 2000; Janz et al., 1996; Kalichman, Rompa, & Coley, 1996; McKay, 2000; Mize, Robinson, Bockting, & Scheltema, 2002). However, sustaining long-term behavior change has been a more difficult task to accomplish (Dancy et al., 2000) because sexually transmitted infections (STI) are

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transmitted in a context of an intimate relationship with another person (Campbell, 1995; Harvey et al., 2004; Mane & Aggleton, 2001).

Interventions aimed at women are based on an assumption that women always have the potential, if not the capacity, to negotiate safer sex practices with men (Campbell, 1995). These interventions have often focused on the provision of information and the development of skills for the use and negotiation of male condoms (Exner, Dworkin, Hoffman, & Ehrhardt, 2003). However, this individual focus on women has treated women's risk behavior as separate from men's, ignoring gender dynamics and the sociocultural context in which heterosexual risk behavior occurs (Amaro, 1995; Campbell, 1995). Indeed, research has indicated that a range of barriers limits women's capacity to negotiate condom use, including unequal gender power, a perception that women do not have the right to refuse sex or insist on condom use, a desire to bear children, male partner violence, and lower social class and poverty (Abdool Karim, 2001; Bedimo, Bennett, Kissinger, & Clark, 1998).

This lack of attention to men also reflects the assumption that they do not care about safer sex and reinforces the idea that safer sex is only a female concern (Campbell, 1995). Nonetheless, research has suggested that men are interested and capable of participating in prevention programs and that promoting safer sex among men is feasible (Exner et al., 1999; Rotheram-Borus, Cantwell, & Newman, 2000). Research further has shown that men also report barriers to condom use, including a belief that condom use is justified only as a pregnancy control method, condoms decrease penile sensation, condoms hinder the "heat of the moment," condoms are not necessary within a trusting long-term relationship, a perception that their partner and themselves are not at risk for HIV/STIs, and a belief that condoms are associated with commercial sex work (Buunk, Bakker, Siero, van den Eijnden, & Yzer, 1998; Seal & Palmer-Seal, 1996).

As a result, a growing number of researchers and institutions have called for a more inclusive gender approach in which men and women can together examine their roles and responsibilities in practicing safer sex behaviors (Abdool Karim, 2005; Amaro, 1995; Campbell, 1995; Exner et al., 2003; Exner, Gardos, Seal, & Ehrhardt, 1999; Gómez & Marín, 1996; Mane & Aggleton, 2001; Panos Institute, 1999; UNAIDS/WHO, 2000; World Health Organization, 2003). A gendered approach consists of recognizing that (a) relationships between men and women are based on an unequal power relationship in which men decide when, where, and how sexual intercourse occurs; (b) unequal power relationship makes men and women vulnerable to HIV and STI; and (c) promoting condom use needs to consider the social and cultural contexts in which sexual behavior occurs (Exner et al., 2003; Gupta, 2000). Based on this approach, some researchers have proposed gender- specific interventions for women (S. Miller, Exner, Williams, & Ehrhardt, 2000), and others have proposed the need to work with couples (El-Bassel et al., 2001).

Whereas many interventions for women have been implemented, efforts with couples have been scarce (DiClemente, 2000; El-Bassel et al., 2001; Harvey et al., 2004; Herbst et al., 2007). We found only two published HIV/STI primary prevention interventions with heterosexual couples. The first study (Project Connect) used an individual couple counseling format and consisted of six 2-hr sessions directed to promote safer sex methods for HIV/STI prevention with an emphasis on communication and negotiation skills (El-Bassel et al., 2001). This intervention demonstrated that recruiting couples was feasible and led to short-term reductions in the number of unprotected sexual acts and a short-term increase in the proportion of protected sexual acts (El-Bassel et al., 2003; Witte et al., 2006). The intervention also resulted in a significant long-term reduction in the number of unprotected sex acts (El-Bassel et al., 2005). Participants expressed satisfaction with the intervention. Participants further indicated that the intervention helped them improve their

communication and taught them new safer sex strategies and negotiation skills (Schiff, Witte, & El-Bassel, 2003).

The second study (The Partners Project) aimed to increase condom use for disease and pregnancy prevention with Latino couples (Harvey et al., 2004). It consisted of a group-based intervention of three 2.5-hr sessions. This intervention showed no significant treatment effect. In both groups (control and experimental), condom use increased and unprotected sexual acts de. Authors concluded that further research with Latino couples is needed to compare the effect of interventions aimed at couples with those aimed at individual men and women.

These findings highlight the need to explore the feasibility and desirability to integrate men into HIV prevention efforts directed toward Latino heterosexuals (Escabí-Montalvo, Serrano-García, & Pérez-Jiménez, 2002; Exner, Gardos, Seal, & Ehrhardt, 1999b; Pérez-Jiménez & Serrano-García, 2002; Seal & Ehrhardt, 2004). The dearth of evidence leaves unanswered the question of whether it is better to integrate men into HIV prevention efforts for Latinos using an unigender intervention format or using a couples-level format that includes both unigender and mixed-gender sessions. To gain insight into this question, as well as to explore barriers to and facilitators of a couples' approach to HIV prevention with Latino heterosexuals, we conducted a preliminary study to gather ideas about these issues as informed by a group of stakeholders.

Method

We conducted 13 focus groups: 5 in San Juan, Puerto Rico; 4 in Santo Domingo, Dominican Republic; and 4 in Mexico City, Mexico. Within each country, at least 1 focus group comprised individuals representing four key stakeholder groups: (a) HIV/AIDS researchers; (b) community-based organization (CBO) staff involved with HIV prevention programming (service providers); (c) heterosexual women who had participated in an HIV/AIDS prevention intervention; and (d) heterosexual men who had participated in an HIV/AIDS prevention intervention. All study procedures and instruments were approved by the Institutional Review Board of the University of Puerto Rico.

Participants

A total of 94 participants attended the focus groups, including 13 researchers, 32 service providers, 21 heterosexual men, and 28 heterosexual women. Of these, 30 participants were from Puerto Rico, 36 from the Dominican Republic, and 28 from Mexico. Table 1 presents key demographics of study participants. As can be seen, slightly more than half (55%) of the participants were women. The mean age of participants was 35.2 years (range: 18–62). Education levels of the study participants ranged from less than a high school degree to doctoral degree and varied widely across groups. About half of the participants were single, and nearly two thirds self-identified with the Catholic religion. Most of them had a part- or full-time job and considered themselves as having little or no risk of becoming infected with HIV.

Instruments

Sociodemographic questionnaire: Before beginning the focus group discussion, participants completed a sociodemographic questionnaire. Three slightly different versions of the questionnaire were used. All three instruments assessed participants' age, gender, nationality, education, religion, marital status, labor status, income, knowledge of someone living with HIV, and risk of getting HIV. These data were used to descriptively summarize the study participants. Additional stakeholder-specific questions assessed the participants'

research areas and funding sources (researchers' version), programs provided by service agencies and participants' role within those programs (CBO version), and sexual behavior and condom use (community sample). This additional information is not presented because it is not relevant for the purpose of this article.

Focus group guide: We used three different focus group guidelines to facilitate the discussions (researchers, service providers, heterosexual women and men). Although most of the questions were similar for all groups, each guide contained a few questions that were stakeholder-specific. In all groups, we explored the following themes: (a) knowledge of prevention programs focused on heterosexual men and women in their countries, (b) beliefs about whether men should participate in prevention efforts directed at women, (c) ideas about the best way to structure a prevention program for women that also includes men, (d) recommendations about the characteristics of a prevention program focused solely on heterosexual men, and (e) cultural issues that need to be considered in a prevention intervention for heterosexual men and women. In this article, we report findings on themes b, c, and e. Participant recommendations about programs for heterosexual men are reported elsewhere (Escabí-Montalvo et al., 2002).

Procedure—The focus groups were held from January through December 2000. In Puerto Rico, researchers were identified and invited to participate by the investigators through personal contact and also with a letter of invitation. Service providers were identified using a service directory that exists on the island and then were invited by letter and follow-up phone calls. The men and women were recruited through community-based organizations (Fundación SIDA de Puerto Rico and Centros Sor Isolina Ferré). The project's personnel administered the screening instrument for these two groups.

In the Dominican Republic and Mexico, participants were recruited by two CBO (Pro-Familia in Dominican Republic and IMIFAP in Mexico). A flier with information about the project was given to potential participants. Those interested in participating were screened by the CBO personnel for eligibility. A consent form was provided to each participant before screening. Personnel of the CBOs were trained to read the consent form to the participants and answer any questions they had. Emphasis was placed on protecting participants' confidentiality and their right to refuse participation.

In all countries, researchers and service providers were required to be conducting HIV-related research or providing prevention services. For the groups of men and women, criteria for participation included (a) participation in an HIV prevention intervention in the past 12 months, (b) self-identification as heterosexual, (c) being sexually active, (d) not using drugs for the past 7 days, and (5) being HIV negative.

Focus groups were audio taped with participant consent and lasted about 90 min. Research staff and community collaborators of both genders moderated the focus groups with researchers and service providers. Focus groups with heterosexual women and men were led by two same-gender facilitators. In each group, one person had primary responsibility for facilitating the discussion and ensuring that every participant had the opportunity to share his or her views. The second facilitator took notes, handled the audio recorder, and helped manage the time allocated to each topic.

Before initiating the focus group discussions, participants were provided details of the study and any questions were answered. Attention was given to clearly explaining the study goals, participant roles, and focus group discussion procedures and rules, including (a) the importance of order and respect toward each other during the discussion, (b) recognition that a diversity of opinions and beliefs was acceptable and consensus between par was not

necessary, and (c) there were no right or wrong answers. After signing informed consent forms, participants completed the sociodemographic questionnaire, after which the focus group discussion was held.

When the conversation concluded, participants were thanked for their collaboration and provided with a $25 incentive, except researchers. Information about the incentive was provided in the consent form and during the recruitment process. Researchers were given a gift worth a similar amount. We also paid an incentive to the collaborating CBOs: $750 to the partner CBOs in Puerto Rico and $1,000 each to the partner CBOs in the Dominican Republic and Mexico. The difference in the stipends is because the Puerto Rican CBOs recruited participants for the men's and women's focus groups only, whereas the other CBOs recruited the participants for all focus groups.

Focus Group Analysis—NVivo 1.1 software (Qualitative Solutions and Research Pty. Ltd., 1998–1999) was used for data management and analyses. Focus groups were transcribed and content coded for emergent themes relevant to our primary questions of interest described above. In accordance with principles of grounded theory analysis (Strauss & Corbin, 1990, 1994), data were initially examined by the analytic team to identify primary coding categories and themes and to subsequently develop a hierarchical coding framework. When suggested by associations, overlap, or diversions in the data, thematic categories were refined, merged, or subdivided. This process continued iteratively until thematic saturation was achieved and the organization of the conceptual coding framework was stabilized. A formal codebook was developed to include themes and illustrative texts. Next, transcripts were formally content coded. To ensure coding reliability, a three-person team comprising two women and one man independently rated all data (Boyatzis, 1998; R. L. Miller, 2001). Interrater discrepancies were discussed and resolved. When consensus about the appropriate coding of a text passage could not be attained, the passage was deleted from further analyses. New categories and themes that did not appear to fit into the conceptual framework were discussed by the investigative team and modifications were made when appropriate. A taxonomy of key themes was assembled for each question of interest, and illustrative quotes relevant to these key themes were extracted from the transcripts through consensus by the three raters. Throughout the analytic process, decision trails were documented to assure that interpretations were supported by the data.

We also explored differences in the patterns of findings across stakeholder group (researchers, providers, female community members, male community members) and across countries (Puerto Rico, Domincan Republic, Mexico). In general, the most salient themes were present in all focus groups, regardless of stakeholder group or country. Thus, we summarized our findings collectively across all groups. When salient differences across stakeholder groups or countries were identified, they are noted in the results.

Results

Male Participation in Prevention Efforts With Women

A majority of participants agreed that it is important to incorporate men into HIV prevention efforts with women. Some of the reasons they offered were (a) HIV prevention is the responsibility of both men and women, (b) it is important to know the opinion men have about sexual negotiation, (c) it is an opportunity for women to tell men how they feel, and (d) it facilitates sexual negotiation. One heterosexual man said,

> My point of view is simple in that we both, men and women, have the same rights so, what is more beautiful than having a sexuality, know everything you can to prevent AIDS, the sexually transmitted diseases, and doing it together. I think that

> makes the relationship stronger and you can enjoy your sexual relations with more happiness, more fun.

A researcher added,

> Well, look, one of the things that women at the workshops that I attended and … coordinated asked for was the participation of their partners, because they left with information, with skills, but the big problem was at home because their husband had other ideas, had other beliefs, had other values, looked at life from their gender perspective, and that hindered the practice of what they have learned at the workshop at home.

Ideas About the Best Way to Structure Prevention Programs for Women That Also Include Men

In all groups, participants generated some strategies to minimize the difficulties of designing an HIV prevention program for couples. Of initial importance was the task of convincing men that the intervention is also for their benefit. One service provider said,

> The main thing is the resistance we are talking about and we have to convince the man that he will also benefit from this, that it will not only benefit the woman, that it will be of benefit to the couple. Because this is what they [men] think, "they're [program staff] going to change my woman and afterward what will I do with another woman here, considering how well I live with her; she does everything I want." … It is very important that he understands that it will also be for his benefit.

Participants indicated a need for specialized outreach efforts to recruit men, as well as a need to identify or create "masculine" environments that could facilitate the organization of culturally sensitive recruitment and prevention activities. Participants recommended seeking places in the community where men naturally congregate, such as bars, community centers, and football or baseball parks. One heterosexual man said, "It would be good first, to penetrate the community. If there [is] a community center inside the community, better, so the same community can see that it is not something that comes from outside, but it belongs to the community." A service provider suggested recruiting men who accompanied female partners to a clinic or prevention program: "I would incorporate him immediately, the minute he comes in the door. Because including a man is like catching a fish with your bare hands."

Participants also felt it would be essential in a couples-level HIV prevention program to give extra attention to the promotion of a trusting atmosphere and the protection of confidentiality. A heterosexual man remarked,

> I think that there should be a special atmosphere before starting. I mean, try to have them [women] feel trust. It could be a group dynamics exercise before [they start] so they feel identified with the persons that are close to them, with the men seated close to them, so they can start talking with no problem, like when youth speak to youth about sexual education in these kinds of exercises, without fear of repudiation or rejection or that kind of thing.

Participants recommended using facilitators who had good understanding of participatory techniques, strong interpersonal and group leadership skills, and who were members of the community. Another suggestion was to use a male and a female cofacilitator, although some participants advocated for two male cofacilitators. One service provider offered.

> I believe that one important thing is that facilitators be men because [men] are not going to listen to women. "A woman is not going to teach me anything." So, it is better that they are

men. That they speak one-to-one, peer-to-peer, and also they can talk about men's things that with another man's woman, or with an unknown woman, they do not dare discuss.

Another suggestion was for facilitators to initiate the program with a discussion of participants' reasons for attending the program, their needs, and what they would like to learn. Participants felt that it would be important to not only focus on HIV/AIDS, but to also give attention to other aspects of sexuality, such as general sexual health and constructions of masculinity. For example, the prevention program could begin with a discussion of gender roles and beliefs about masculinity and femininity. Participants also indicated that it would be important to combine dyadic presentation with interactive group exercises and role plays.

Across groups, participants advocated for an intervention format that allowed for both mixed-gender discussion of couples-related issues and unigender discussion of gender-sensitive topics.

Cultural Issues in Prevention With Heterosexual Men and Women

Participants also perceived barriers to couples-level programs. Three main thematic clusters were identified: (a) Inclusion of both men and women in the groups would inhibit open and natural talk, (b) the manifestation of machismo and power imbalances in heterosexual relationships limit women's alternatives to negotiate safer sex practices, and (c) the conservative normative values regarding condom use make difficult the adoption of positive attitudes for its use.

Inhibition of open and natural talk—A frequently mentioned barrier was that the inclusion of both men and women would inhibit open and natural talk among the group. Participants indicated that it is taboo for men and women to talk openly about sex, especially in front of one's partner. Others said that men's and women's incompatibility with regard to sexuality and gender roles would make it difficult to discuss these issues openly. Service providers and women in the community samples felt women, in particular, would be fearful to express their feelings and ideas in front of their male partner. One provider said,

> My fear is that the woman will be limited to making decisions when the man is present, which is my fear. That is why I believe that the focus of the workshop, when there are men and women and both participate actively, must be dealt with adequately so that this does not occur.

Similar beliefs were expressed by a participant in a community sample of women:

> Yes, that's it; there would be women that would be inhibited because they are in front of men. … There are many women here that are ashamed of going to a gynecologist. They look for a woman. You can imagine starting to talk about sex and AIDS in front of men.

Other participants, mostly men in the community samples, believed that the male partner would have more difficulties express his thoughts and feelings. A male researcher said,

> In some groups of men, women's presence also restrains them. It is hard for a man to talk when he feels restrained about sexual relation. What does a man do, for example, when he has no erection? How can you deal with that? Or when he has premature ejaculation? Or when he feels rejected and doesn't have an erection. … People don't speak about all these things openly, because this threatens their masculinity directly as well as the power that all those who have a penis are supposed to have.

Machismo and power imbalances in heterosexual relationships—Another common set of themes clustered around issues related to machismo and power imbalances in heterosexual relationships. Participants, particularly among the female community samples, felt that men's machismo negatively affected HIV prevention efforts. One service provider said, "Because we know that Latin America is very 'machista'." Then, there is still the issue of, "Well, I am a macho and if I don't want to, I won't use it, you should obey." A heterosexual woman said,

> I think that in a certain way with women, we should talk more about self-esteem and assertiveness, so they realize that they can also decide that their life is worthwhile and that men's machismo must be con. Because being a man doesn't mean that you are going to be in control. I can use condoms, you won't get infected, and you won't infect anybody.

Others believed that gendered power struggles would ensue as men and women attempted to impose their own gendered perspective on each other. One heterosexual male described this struggle as

> [T]he battle of sexes. For me, I think that each sex is going to pull in its own direction. I think that's one of the difficulties one can find. Because each one is going to try to impose its will on the other or each one is going to try to say like "the battle of the sexes."

Conservative normative values—Several participants believed that heterosexual men would not attend an HIV prevention program or allege that they have insufficient time to participate because of negative attitudes toward condoms, lack of risk perception regarding HIV/AIDS, perception of AIDS as a myth, and a perception that AIDS is restricted to homosexuals and drug addicts. One service provider said,

> The spouses who attend with their husbands reject them, the use of condoms, Why? Because condoms have been associated with inappropriate sexual behaviors. Then, if I have my partner, I do not have to use condoms even if we promote the 20 thousand other uses they have, not only family planning, but for all members of the household, I mean using a condom in my house with my partner is to say that I am practicing unacceptable behaviors outside and, in addition, that I am treating her like a prostitute.

Similar beliefs were expressed by a researcher:

> Well, the main thing is that the man says, that's the others' problem and that's a women's health problem. Then, that's the big issue. I think it's important to attack and say: hey, you are also at risk, and you should also be involved in this.

Participants pointed out that men's resistance to participation was linked to conservative ideologies about sexuality. These individuals noted that some heterosexuals rejected condom use as a socially normative behavior and cultural value. This attitude was closely associated with the opposition of the Catholic religion to condom use, a finding that was particularly salient among men in the community sample. One heterosexual man said,

> Then, it may be that we have to work in that area, go deeper into that tradition. If the Pope comes and says that abortions and condoms don't work, our work is lost, and everything we had gained. [It's] so strong that dogma or a sudden comment that can be said at any moment, even if it is said at the Vatican, if it gets here, and the Cardinal repeats it, then women again, nothing about condom no matter how [critical they] could be, no matter how good information programs you have, they get back to faith and your work is lost.

Another heterosexual man similarly observed,

> I think that we must involve priests. Even though they don't have sexual relations, priests are persons that people listen to. In my country, priests are the other side. If I do not achieve change, if the priest does not achieve change, in my country, not even the President can [achieve] change.

Discussion

Understanding and addressing normative cultural influences are of great importance to understanding HIV risk behavior among groups who are disproportionately affected by HIV/AIDS. In our study, the importance of adapting programs to address strong cultural norms and values among Latino heterosexuals was a cross-cutting theme that was interwoven across countries, stakeholder groups, and content areas. One of the most salient cultural norms evident in our study was the dynamic impact of power imbalances in Latino heterosexual couples and the strong influence of conservative beliefs about sexuality and sexual behavior, often attributed to teachings of the Catholic Church. Participants reported that safer sex behavior was often inhibited in heterosexual couples because of compliance with church doctrines against condom use and other forms of sexual risk reduction (e.g., mutual masturbation). More generally, participants believed that heterosexual men would not attend an HIV prevention program because of conservative values, including negative attitudes toward condoms, perception of AIDS as a myth, lack of perceived HIV/AIDS risk, and a perception that AIDS is restricted to homosexuals and drug addicts.

Participants highlighted the importance of developing prevention programs conducted by members of the target community that were embedded within natural community settings in which heterosexual men congregated. They also believed that involving the Catholic Church in prevention activities could strengthen their influence. Rather than rejecting local values, participants advocated building on and using these values to strengthen program acceptability. Similar conclusions have been drawn in other studies. For example, Seal et al. (2000), in an ethnographic study of Puerto Rican men, noted a strong sense of community and neighborhood identification that permeated all aspects of participants' lives and defined men's social networks, family relationships, and emotionally and sexually intimate relationships. These authors advocated building on this strength to promote sexual health. Community members are more likely to trust and attend HIV prevention programs developed and implemented by insiders who share their linguistic, cultural, historical, experiential, and social background.

Limitations of our study include the reporting of data that were collected over 7 years ago from a nonrepresentative sample. However, we note that this limitation is offset to some degree by our assessment of multiple stakeholder groups in three different Latino countries. Furthermore, we have no evidence that cultural norms around gender roles in sexual relationships have changed significantly during this time. Another potential limitation is our uncertainty about the extent to which participants' responses were influenced by social desirability or self-presentation biases associated with the group setting, or to what extent participants' responses reflected public adherence to cultural stereotypes and norms versus their personal beliefs.

Nonetheless, our data have provided insight into barriers to and facilitators of the acceptability and feasibility of conducting a HIV prevention program for Latino heterosexual couples. Through understanding contextual influences, researchers are in a better position to collaborate with community members to develop and implement sexual health promotion programs that are culturally competent and reflect the broader social context of community members' lives. Continued research with larger and more

representative samples is needed if we hope to attain a better understanding of the sociosexual context of sexual risk behavior and optimal strategies for intervention. Researchers also need to consider using members of the prospective community as their frontline field staff so as to be better able to explore the subtle nuances of a culture that are often visible only to "insiders."

Additional research is needed to better understand the interdependence between men and women in their respective notions of gender roles and gender norms, both in general and specific to sexual relationships. Perceptions of opposite-sex partner expectations about gender-appropriate behavior may influence a person's behavior as much as his or her own beliefs, attitudes, and norms. Development of culturally competent couples-level HIV prevention programs must synthesize the perceived gender roles and gender norms that male and female partners bring to a dynamic sexual relationship.

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Table 1

Key Demographics of Study Participants

Participants characteristics	F	%
Participants by group (n = 94)		
Researchers	13	13.8
Staff involved in HIV prevention	32	34.1
Heterosexual men	21	22.3
Heterosexual women	28	29.8
Gender (n = 94)		
Men	42	44.7
Women	52	55.3
Age (n = 91)		
18–25	22	24.2
26–35	29	31.9
36–45	22	24.2
46–55	13	14.3
56–62	5	5.5
Nationality (n = 87)		
Puerto Rican	28	32.2
Dominican	32	36.8
Mexican	27	31.0
Education (n = 86)		
Elementary school	6	6.9
Intermediate school	3	3.5
High school	25	29.1
BA/BS	27	31.4
Post BA/BS	25	29.1
Civil status (n = 91)		
Single	40	43.9
Married	24	26.4
Consensual union	12	13.2
Separate	2	2.2
Divorced	13	14.3
Religion (n = 86)		
Catholic	59	68.6
Protestant	7	8.1
None	20	23.3
Labor status (n = 88)		
Full-time job	48	54.5
Part-time job	26	29.6
Unemployed	11	12.5
Disabled	2	2.3

Participants characteristics	F	%
Retired	1	1.1
Family monthly income (n = 91)		
$0–$500	26	28.6
$501–$1,000	23	25.3
$1,001–$1,500	12	13.2
$1,501–$2,000	11	12.1
$2.001–$2.500	9	9.9
$2.501–over	10	10.9
Risk of getting HIV (n = 62)		
A lot	5	8.1
Regular	18	29.0
Little	30	48.4
None	9	14.5