Feature

Why Do Young Hispanic Women Take Sexual Risks? Psychological and Cultural Factors for HIV Prevention

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*Young Hispanic women have been particularly affected by HIV. For this reason, we analyzed the influence of cognitive factors, dispositional variables, and gender culture on the HIV risks of two groups of Hispanic women. Young Argentinian and Spanish women (*N = *342) completed the AIDS Prevention Questionnaire, the Spanish version of the Sexual Compulsivity Scale, and the Spanish version of the Sexual Sensation Seeking Scale in order to evaluate knowledge of HIV transmission, HIV, and condom use; self-efficacy; safe-sex intention and safe sex; as well as Sexual Sensation Seeking and Sexual Compulsivity traits. Our findings support a different pattern of HIV risk based on gender inequality, although self-efficacy and sexual sensation seeking seem to have been the main important predictors of unsafe sex and HIV risk. Social and psychological factors should be considered to design HIV prevention strategies aimed at young Hispanic women.*

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Currently, half of the people living with HIV are women and most of them have trouble accessing health care (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2016). However, risk factors for HIV infection have not been studied in depth to deal with this situation, not even in sexual transmission, which is the most prevalent cause for HIV infection in women (Ballester-Arnal et al., 2016; Cianelli & Villegas, 2016).

In particular, women who are socialized in gendered societies, in which cultures give more social power and autonomy to men while delegating a more dependent and passive position to women, experience higher risk for HIV sexual transmission (Giménez-García et al., 2013). For example, in the United States, the rate of HIV in Hispanic women (i.e., with ancestry from a Spanish-speaking country or culture) have more than three times the rate of HIV

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found in non-Hispanic White women (Centers for Disease Control and Prevention, 2015). These rates are higher for young Hispanic women in Latin America, North America, and Europe (UNAIDS, 2016).

Different factors may influence this situation, from social determinants of health to biological predisposition. Regarding personal factors, some studies have emphasized the role of psychological variables such as sexual sensation seeking (having a desire for sexual stimulation and arousal) that may facilitate higher fear of condom negotiation or diminish self-efficacy to refuse unsafe sex (Gil-Llario et al., 2016; Voisin et al., 2013). HIV risk behaviors have also been linked to sexual compulsivity and hypersexuality (Miner & Coleman, 2013). Regarding cognitive variables, factors such as knowledge, attitudes toward condoms, self-efficacy, risk perception, and fear of HIV infection may also promote riskier behaviors in women from Spanish-speaking countries or cultures (Marín, 2003; Villegas et al., 2016).

Culture also plays an important role in sexual health and HIV prevention for women. For example, Hispanic culture maintains some traditions and values, such as Catholicism (Cianelli & Villegas, 2016) or machismo (Bowleg et al., 2000), that facilitate a dependent social position for women who experience lower sexual self-efficacy and perceive higher barriers to negotiate condom use. Hispanic culture seems to increase the risk of HIV infection among women. In particular, this situation prevails in women in steady relationships who mainly report lower perceived HIV risk due to the myth of romantic love (Lara et al., 2008). Another risky situation is alcohol consumption that is normalized in Hispanic cultures. Authors such as Vagenas and colleagues (2013) have emphasized the connection between alcohol consumption and sexual risk-taking in adolescent and young women from Latin American countries.

Despite common traits shared by young women from Spanish-speaking countries or cultures, studies have also shown different risk profiles based on gender inequality, measured by the Gender Inequality Index (United Nations Development Programme [UNDP], 2016). UNDP created this index to assess gender inequality across the world in 152 countries. It has revealed three dimensions of disadvantage in women (reproductive health, empowerment, and the labor market), which ranges from 0 (*equality*) to 1 (*women fare as poorly as possible*) and varies across countries from 0.02 to 0.73. Gender inequality measured at a higher value describes a country with more disparities between males and females, more disadvantages for women, and higher inequality. Spain's gender inequality scores reveal more equal positions between the genders (score of 0.08) than Argentina (score of 0.36). In order to identify the level of gender inequality for Spanish and Argentinian women, we used the Gender Inequality Index (UNDP, 2016). For example, Giménez-García and colleagues (2013) found that Hispanic women who were socialized in a context with more gender inequality, such as Mexican women, revealed a riskier profile than Spanish women, who were socialized in a more gender-equal context. Therefore, women from Spanish-speaking countries may be more diverse than past studies have revealed regarding risk-taking sexuality and HIV infection.

Most of the studies focused on this group of women, however, have not distinguished their possible heterogeneity. For this reason, the main purpose of our study was to evaluate the role of different HIV risk factors (cognitive factors, personality traits as dispositional variables, and gender inequality) in young Argentinian and Spanish women.

Method

We disseminated information about the study during outreach activities addressing promotion of sexual health that were delivered in education centers in Argentina and Spain. When a young woman showed an interest in taking part in the study, we made an appointment with her to visit our lab in order to provide more information about the conditions of participation. We explained that the study was voluntary, and that the data collected would be confidential and anonymous. We also discussed the time contribution needed from her. If the young woman agreed to participate, she gave informed consent. After that, she took self-administered questionnaires, in 30-40 minutes. A trained member of our team supported participants in case they did not understand any of the questions. Our study was in compliance with the ethical standards of the institutional research