

Predictors of HIV Testing and Intention to Test Among Hispanic Farmworkers in South Florida

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ABSTRACT: *Context and Purpose:* This study examined the predictors of HIV testing and factors associated with intention to accept a free HIV test among 244 Hispanic migrant/seasonal farmworkers in South Florida. *Methods:* Time and space sampling procedures were used to recruit participants in public venues. Bilingual staff interviewed eligible respondents in these settings. *Findings:* Despite high rates of sexual risk, only 21% of respondents had been tested for HIV. The majority of those tested were females tested during prenatal care. In multivariable logistic regression analyses, being female (odds ratio [OR] = 3.73), having at least 12 years of education (OR = 4.46), earning more than \$201 per week (OR = 2.76), and ever having used marijuana (OR = 3.31) were positively associated with having been tested for HIV, while not being documented (OR = 0.24) and having rated one's health as "very good" or "good" (OR = 0.42) were negatively associated with testing. The multivariable predictors of intention to accept a free HIV test were having visited a health care provider and/or an emergency room in the past 12 months (OR = 1.97), having been tested for HIV (OR = 2.36), preferring an HIV test that used a finger stick for specimen collection with results given in 30 minutes (OR = 4.47), and worrying "some" or "a lot" about getting HIV (OR = 3.64). Women (OR = 0.52) were less likely than men to intend to accept a free HIV test. *Conclusions:* Our findings highlight the importance of routinely offering HIV testing to sexually active individuals in high HIV prevalence areas. They also suggest the need to make testing more accessible to migrant and seasonal farmworkers.

transmission.² By linking prevention and care, HIV testing can help reduce this burden. Through early diagnosis and treatment, testing leads to improved clinical outcomes.³ It also reduces the risk of transmission since there is growing evidence that compliance with antiretroviral treatment causes individuals to be less infectious⁴ and data suggest that many people reduce their sexual risk behavior after testing positive for HIV.^{5,6} To achieve these benefits, it is critical to promote HIV testing among understudied groups at increased risk of infection, such as Hispanic migrant/seasonal farmworkers.⁷

Hispanic migrant/seasonal farmworkers consistently report low rates of condom use.⁸⁻¹³ For instance, 64% of sexually active, single Hispanic males in one study¹⁰ and 66% of males and females in another study⁹ had never used a condom. Sixty-six percent of sexually active respondents in another study had not used condoms in the last 12 months.⁸ Furthermore, differences in the predictors of condom use between occasional and regular partners have been reported.¹² Multiple sexual partnerships and high rates of lifetime sexually transmitted infections (STIs) have also been documented.⁸⁻¹⁰ In a study of drug-using migrant

Promoting early detection of HIV infection has been an important public health priority. Despite these efforts, it is estimated that 300,000 persons in the United States are living with HIV and do not know it.¹ Late detection of HIV infection is a burden for both individuals and society since it is associated with increased morbidity, mortality, and probability of

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workers in the DelMarVa Peninsula, 33% had a lifetime history of STI, and 16% reported having more than 1 sex partner in the past 30 days.¹⁴ Males consistently report considerably higher numbers of lifetime partners than females.^{9,14} Although few recent studies have examined HIV prevalence among migrant/seasonal farmworkers, the data available suggest prevalence rates are higher among those in the East Coast than those of the Central and West Coast.¹¹

Furthermore, lifetime rates of use of prostitutes are high,^{8,11,14,15} ranging from 18%¹⁶ to more than 40%.^{11,14} In a more recent study, 19.3%⁸ of the sample reported paying or having been paid for sex in the past 12 months. Although the frequency of prostitute use did not vary by marital status, married men were less likely to use condoms with prostitutes than single men.¹⁵ Active solicitation in the migrant camps by prostitutes and norms supporting prostitute use have been reported.^{11,17} Ford et al⁹ found that 72% of males discussed visiting prostitutes with friends, and 85% reported being urged to visit prostitutes.

Rates of illegal injection drug use among Hispanic migrant/seasonal farmworkers are relatively low.^{11,15} However, therapeutic injections of vitamins, antibiotics, hormones, pain killers, and steroids have been reported.^{11,16,18} Since transmission of infectious pathogens is likely when shared injection equipment is not properly sterilized, these therapeutic injections have been suggested as contributing to elevated risk in the population. Similarly, high rates of alcohol use among both males and females have been documented. Males reported higher consumption and more frequent use of alcohol than females.⁹ Given these high rates of HIV risk behaviors and the potential benefits that can be derived from early detection, it is important to promote HIV testing among migrant/seasonal farmworkers.

Although there is a large literature on HIV testing, we found no study that examined HIV testing behaviors and intention to accept an HIV test among Hispanic migrant/seasonal farmworkers. In other populations, higher perceived risk,¹⁹⁻²¹ higher rates of sexual HIV risk,^{21,23} being a man who has sex with men (MSM),^{21,24} having a provider recommend testing,^{2,8,19} and being of younger age have been found to predict testing.^{21,26-29} It is important to examine whether these factors are also associated with testing behaviors and intention to accept an HIV test among migrant/seasonal farmworkers.

The goal of this exploratory study was to examine the predictors of HIV testing and the factors associated with intention to accept a free HIV test in a community sample of 244 Hispanic migrant/seasonal farmworkers recruited in South Florida, an area with one of the highest AIDS rates in the nation.¹ In 2000, the tricity

area known as "South Florida" had the following AIDS case rates per 100,000 population: 59.3 (Miami-Dade County), 57.8 (Monroe County), and 54.4 (Broward County).¹ We hypothesized that younger age, higher education, higher income, being female, having higher levels of HIV knowledge, higher HIV risk perception, having a history of STI diagnosis, exchanging sex for drugs or money, higher number of sex partners, low rates of condom use, and using drugs would be positively associated with HIV testing and intention to accept a free HIV test. The results of this study may be used to develop tailored interventions to promote early detection of HIV infection among this understudied, at-risk group.

Methods

Participants. From February to June 2002, we recruited a community sample of 121 male and 123 female Hispanic migrant/seasonal farmworkers to participate in a study of HIV testing. The study was conducted in southern Miami-Dade County, Florida. This area is significant because it has a large, stable population of farmworkers who are permanent residents as well as a large, transitory group of migrants who come to work the fields during the winter and spring each year. We included both seasonal and migrant workers in the sample so that our findings would be generalizable to farmworkers in South Florida. Participants were (1) 18 years of age or older, (2) self-identified as Hispanic/Latino, and (3) employed as farmworkers. Permanent residents comprised 47.5% of the sample; the remaining 52.5% were migrants. To facilitate entrée and access to the study population, we collaborated with MUJER (Mujeres Unidas en Justicia, Educación y Reforma), a community-based social service organization that serves farmworkers in the area. This collaboration contributed significantly to our high response rate.

Sampling. We used time and space sampling procedures^{30,31} modified for use with this population. Instead of conducting observational studies to identify the list of potential venues, MUJER staff assisted us to identify the venues. The potential venue list included work sites, camps, fields, parks, markets, and other public venues where farmworkers congregated. From the list of potential venues identified, we systematically rotated recruitment sites to ensure that our sample included as broad a representation of Hispanic migrant/seasonal farmworkers as possible. For each venue, we specified time periods of maximum activity and randomly selected sampling events (days and blocks of time when recruitment occurred) from these

periods. In camps, parks, markets, and other such sites, we defined a specific geographic area and systematically approached individuals who entered the area. In the fields, we systematically defined an area, and approached every person working in the area. Men and women were screened for eligibility and, if eligible, invited to participate. Approximately 99% of eligible respondents agreed to participate.

Data Collection. Trained, bilingual staff administered structured interviews after obtaining verbal informed consent. Items were read to participants and responses were recorded on scannable forms created with Teleforms®. Interviews were completed at the time of recruitment and lasted approximately 35 minutes. Respondents were given \$25 in cash as compensation. The protocol was approved by the institutional review boards at the University of Miami and the Centers for Disease Control and Prevention.

The data collection instrument consisted of simple questions, the majority of which had dichotomous response categories. The following factors were assessed:

Demographics. Participants reported their gender, age, education, marital status, average weekly income, and country of birth. They reported whether they were citizens, were permanent residents, had an active visa, or were undocumented.

Health Care Status/Utilization. Participants were asked if their health was “very good,” “good,” “neither good nor poor,” “poor,” or “very poor.” Participants indicated whether they had health insurance and whether they had sought medical care at an emergency room or from a health care provider in the past 12 months.

HIV Testing History. Participants stated whether they had been tested for HIV as well as the reason for taking the test. Individuals who had not taken an HIV test were asked if they had ever been offered testing and whether they would take the test if it were recommended by a medical doctor.

HIV Testing Intention. Participants were asked whether they would be willing to accept a free HIV test if one was offered on the day of the interview.

HIV Test Preference. Participants were presented with 4 hypothetical testing scenarios and asked to select their preferred option. The 4 choices were (1) oral mucosal swab with results in 10 days, (2) oral mucosal swab with results in 30 minutes, (3) finger stick with results in 10 days, and (4) finger stick with results in 30 minutes. We controlled for order-of-presentation effects by counterbalancing the order in which the options were presented. Individuals who did not indicate a preference were coded as having no preference.

HIV Knowledge. We used 5 true/false items to assess general knowledge of HIV: (1) Can a pregnant woman who has HIV give HIV to her baby? (2) Can you get HIV from having sex without using a condom? (3) Is there a cure for HIV? (4) Can a person have HIV for a long time and not know it? and (5) The way a person learns if they have HIV is to get an HIV test. For these analyses, we collapsed the number of correct responses into 2 categories: “little” or “no knowledge” (0–2 correct responses) and “some” to “a lot” (3–5).

HIV Risk Perceptions. Participants reported whether they worried about getting HIV “not at all,” “a little,” “some,” or “a lot.” They also stated whether they knew someone who has HIV/AIDS.

Perceived Partner Risk. For the past 12 months, participants reported whether they had sex with someone who they knew or suspected (1) was having sex with other people, (2) had injected drugs, (3) had an STI, (4) had been in jail, or (5) was HIV positive. We compared individuals who stated they had at least 1 perceived partner risk (eg, endorsed at least 1 item) with those who stated that they had no partner risk.

Drug Use. Participants reported whether they had ever used alcohol, marijuana, crack/cocaine, heroin, or inhalants and whether they had ever injected drugs or shared needles. For each affirmative response, participants stated whether they had used the substance during the past 3 months. Rates of injection drug use were <1%; as a result, we did not conduct analyses on this risk behavior.

Sexual Behaviors. Participants reported the number of male and female sex partners they had during the past 12 months, how many were “main” partners, and how many were “casual” partners. Respondents stated the frequency with which they engaged in vaginal or anal sex during the past 3 months and the number of times a condom had been used for each type of sex act. They reported whether they had exchanged money for sex or sex for money in the past 12 months.

History of STI. Participants stated if they had ever been diagnosed with an STI by a health care provider.

We defined 2 dichotomous dependent variables: (1) history of HIV testing and (2) intention to accept a free HIV test on the day of the interview.

Analyses. To describe the characteristics of the sample, we calculated means, medians, and percentages. For the first set of analyses, we compared individuals who had ever been tested for HIV ($n = 51$) with those who had never been tested ($n = 193$). For the second set of analyses, we compared individuals who stated they would accept a free HIV test on the day of the interview if one was offered ($n = 94$) with those who would not accept a test

($n = 150$). Univariable logistic regression was performed on theoretically relevant factors to examine the relationship between each factor and each dependent variable. Chi-square statistics and odds ratios were generated with 95% confidence intervals to guide interpretation. Following the recommendations of Hosmer and Lemeshow,³² factors with P values of .20 or lower in the univariable analyses were included as candidate predictors in the multivariable analysis because use of more traditional significance values (ie, .05) might fail to identify important relationships. Candidate predictors were simultaneously entered into a multivariable logistic regression. Predictors not significant at the .05 level or lower were eliminated from the model one at a time, deleting the one with the highest P value at each step. Variables meeting criteria were simultaneously entered into logistic regression analysis.

Results

Sample Characteristics. The average age of participants was 28.4 years ($SD = 9$, range 18–62). Males constituted 49.6% of the sample. The majority (65.2%) of respondents had 6 or less years of education, 69.7% were single, and 63.1% earned \$200 or less per week. Eighty-two percent of the participants were born outside the United States, primarily in Mexico (63.1%) and Guatemala (14.3%). Sixty-six percent were undocumented. Few of the participants (8.6%) had medical insurance. Only 32.8% of the sample had seen a doctor or visited an emergency room in the past 12 months. The majority (57%) rated their health status as “good/very good.”

Twenty-one percent (51/244) of the sample had been tested for HIV. The primary reason given for having been tested was that the test was given as part of routine obstetrical care. Almost 39% of the sample (94/244) reported that they would accept a free HIV test if one were offered on the day of the interview. Among individuals who had never been tested, almost 81% (156/193) had never been offered an HIV test, and 69.4% (134/193) would accept a test if it were recommended by a provider. No clear preference for type of HIV test emerged; responses ranged from 16% for no preference to 23.4% for the oral mucosal swab HIV test with results in 30 minutes. Sixty-nine percent of respondents answered 3 or more HIV knowledge items correctly, and 26.6% worried “some” or “a lot” about getting HIV. Twenty percent of the sample indicated knowing someone with HIV. Sixty-six percent of participants had not used a condom in the past 12 months, and 33.6% reported having more than 2 sex partners in the same time period. Sixteen percent of

respondents had at least 1 STI diagnosis in their lifetime. Nineteen percent of the sample had either paid for sex or been paid for sex in the past 12 months. Lifetime alcohol use was reported by 62.3% of respondents. Seventeen percent of the sample had used cocaine and 23.4% had used marijuana at some point in their lives.

Univariable Predictors of Ever Having Been HIV Tested and Intent to Accept a Free HIV Test. Older age, being female, having more education, having higher income, being US born, having seen a medical provider and/or visited an emergency room in the past 12 months, having health insurance, having higher HIV-related knowledge, knowing someone who has HIV, having had sex with a risky partner, having engaged in unprotected sex in the past 3 months, having had an STI diagnosis, and ever having used alcohol, marijuana, or cocaine/crack were positively associated with having been tested for HIV ($P < .05$). Being undocumented was negatively associated with having been tested. In addition to these variables, we included as candidate predictors in the multivariate analyses for ever having been tested health status ($P = .11$) and number of sex partners (.10) because their significance level was $P < .20$.³²

The significant univariable predictors ($P < .05$) of intent to accept a free HIV test were having seen a medical provider and/or visited an emergency room in the past 12 months, preferring an HIV test that used a finger stick for specimen collection with results given in 30 minutes, and worrying “some” or “a lot” about getting HIV. Having 7 to 11 years of education, lifetime use of marijuana, and cocaine/crack use were negatively associated with intention to accept a free HIV test. In addition to these variables, we included as candidate predictors marital status ($P = .20$), health status ($P = .08$), health insurance ($P = .17$), ever tested for HIV ($P = .08$), and number of sex partners ($P = .06$) because their significance level was $P < .20$.³²

Logistic Regression Models of Ever Tested and Intent to Accept a Free HIV Test Predictors. The table presents the multivariable models for ever having been tested for HIV (model 1) and intention to accept a free HIV test (model 2). The significant predictors of having been tested for HIV were being female (odds ratio [OR] = 3.73), having at least 12 years of education (OR = 4.46), earning more than \$201 per week (OR = 2.76), and ever having used marijuana (OR = 3.31). Undocumented respondents (OR = 0.24) were less likely to have had an HIV test than documented respondents. Respondents who rated their health as being either “very good” or “good” (OR = 0.42) were less likely to have been HIV tested

Logistic Regression Models of Ever Tested and Intent to Accept a Free HIV Test Predictors*

	Model 1 Ever Tested			Model 2 Intent to Accept Free HIV Test		
	OR	95% CI OR	P level	OR	95% CI OR	P level
Demographic						
Age	1.02	0.98–1.07	.257	†	†	†
Gender						
Female	3.73	1.42–9.76	.007	0.52	0.27–0.99	.049
Male (reference)						
Education						
12+ years	4.46	1.37–14.55	.013	0.43	0.13–1.36	.431
7–11 years	1.04	0.391–2.81	.926	0.43	0.19–0.97	.435
0–6 years (reference)						
Marital status						
Not married	†	†	†	0.85	0.41–1.74	.666
Married (reference)						
Income						
\$201+	2.76	1.09–6.99	.032	†	†	†
\$0–200 (reference)						
US born						
Yes	0.30	0.08–1.07	.064	†	†	†
No (reference)						
Residency status						
Undocumented	0.24	0.08–0.69	.008	†	†	†
Documented (reference)						
Health status/health care utilization						
General health						
Very good/good	0.42	0.19–0.91	.029	0.67	0.37–1.23	.203
Neither good/poor, poor (reference)						
Seen health care provider/ visited ER in past 12 months						
Yes	1.48	0.59–3.71	.396	1.97	1.00–3.88	.048
No (reference)						
Any type of health insurance						
Yes	0.768	0.19–3.00	.704	1.79	0.52–6.15	.349
No (reference)						
HIV testing history						
Ever HIV tested						
Yes	†	†	†	2.36	1.03–5.42	.042
No (reference)						
HIV test preference						
Oral mucosal swab HIV test: 30 minutes	†	†	†	1.85	0.66–5.19	.241
Oral mucosal swab HIV test: 10 days	†	†	†	1.14	0.40–3.19	.804
Finger stick: 30 minutes	†	†	†	4.47	1.60–12.49	.004
Finger stick: 10 days	†	†	†	1.02	0.37–2.77	.968
No preference (reference)						
HIV knowledge						
Some/a lot	1.65	0.51–5.32	.397	†	†	†
Little/none (reference)						

Continued

	Model 1 Ever Tested			Model 2 Intent to Accept Free HIV Test		
	OR	95% CI OR	P level	OR	95% CI OR	P level
Personal risk perception						
Know someone who has HIV						
Yes	1.48	0.49–4.48	.481	†	†	†
No (reference)						
Worry about getting HIV						
Some/a lot	†	†	†	3.64	1.81–7.33	.000
Not at all/a little (reference)						
Sexual behavior						
Perceived partner risk						
1+ item(s)	0.83	0.25–2.70	.760	†	†	†
No items endorsed (reference)						
Number of sex partners in past 12 months						
2+	1.78	0.55–5.77	.335	0.90	0.42–1.94	.801
0–1 (reference)						
Unprotected sex in past 3 months						
Yes	0.92	0.36–2.36	.878	†	†	†
No (reference)						
Ever diagnoses with an STI						
Yes	1.36	0.43–4.23	.592	†	†	†
No (reference)						
Lifetime drug use						
Alcohol use—lifetime						
Yes	0.92	0.33–2.56	.873	†	†	†
No (reference)						
Marijuana use—lifetime						
Yes	3.31	1.06–1.031	.038	0.74	0.27–2.04	.567
No (reference)						
Cocaine/crack use—lifetime						
Yes	0.78	0.22–2.70	.703	0.40	0.12–1.32	.135
No (reference)						

	Model 1 Ever Tested	Model 2 Intent to Accept a Free Test
Model coefficients		
χ^2	66.72	56.90
Degrees of freedom	19	16
Significance	.000	.000
Model summary		
–2 log likelihood	183.445	268.38
Cox and Snell R^2	0.239	0.208
Nagelkerke R^2	0.373	0.282
Overall % correct	84.8%	74.2%

* CI indicates confidence interval; OR, odds ratio.
 † Not theoretically or statistically significant.

than those who rated their health as being either “neither good or poor” or “poor.”

This first multivariable model, with the covariates shown, was reliably different from the intercept-only model ($\chi^2 = 66.72$, $df = 19$, $P < .000$) and correctly classified 84.8% of the respondents. Nagelkerke’s R^2 value, a statistical measure that estimates variations in outcome variables explained by a logistic regression model, was utilized to determine how effective the model explained the variance in the dependent variable.³³ Nagelkerke’s R^2 value was 0.373. This indicates that the model explains 37% of the variance among those individuals who had been HIV tested.

The significant predictors of intention to accept a free HIV test were having seen a health care provider and/or had an emergency room visit in the past 12 months (OR = 1.97), having been tested for HIV (OR = 2.36), preferring an HIV test that used a finger stick for specimen collection with results given in 30 minutes (OR = 4.47), and worrying “some” or “a lot” about getting HIV (OR = 3.64). Women (OR = 0.52) were less likely than men to intend to accept a free HIV test. Because women were significantly more likely than males to have been tested for HIV, we tested for 2-way interactions between gender and testing history in the intent-to-test analysis. The interaction between these 2 factors was not significant. This second multivariable model ($\chi^2 = 56.90$, $df = 16$, $P < .000$) correctly classified 74.2% of the respondents. Nagelkerke’s R^2 value was 0.282, indicating that the model explains 28% of the variance among those who intended to accept a free HIV test if one were offered on the day of the interview.

Discussion

In this paper we report on HIV testing behaviors and intention to test in a community sample of Hispanic migrant/seasonal farmworkers recruited in an AIDS epicenter. Our exploratory study is noteworthy because of its relatively large sample size, equal distribution of males and females, sampling methods employed, and use of multivariable analyses. We know of no other recent study that examines the predictors of HIV testing and intent to accept a free HIV test in this at-risk, understudied population.

It is troubling that despite high rates of sexual risk behaviors, only 20.9% of the sample had ever been tested for HIV. The majority of those tested were women, and the primary reason for testing was that the test had been offered during prenatal care. Thus, it is not surprising that being female was significantly associated at both the univariable and the multivariable level with having been tested. These data are indicative of the widespread adoption of the recommendation to

include HIV testing as a part of standard obstetrical care.³⁴ They also lend support to the potentially important role that routine offering of HIV testing to sexually active persons living in high HIV prevalence areas can play in promoting early detection of HIV infection.

Despite their greater likelihood of having been tested, females were significantly less likely than males to report a willingness to accept a free HIV test if one were offered on the day of the interview. Since there were no significant interactions between gender and history of HIV testing in the intent-to-test analyses, these findings may suggest that, for females, having a health care provider offer testing in a clinical setting may play a role in their decisions to accept HIV testing. Thus, *who* offers the test and the *context* in which the test is offered may be important determinants of test acceptance. Future studies should examine the role that these 2 factors play in promoting early detection of HIV in this population.

Another possibility is that because HIV testing is routine practice in obstetrical care, there is less stigma or negative perception associated with being tested in this setting. One strategy for promoting early detection of HIV infection in high-seroprevalence areas, such as Miami-Dade County, is to encourage providers to routinely recommend HIV testing to all sexually active patients. The efficacy of this approach is evidenced by the dramatic reductions in perinatal transmission that have occurred since the practice was implemented in obstetrical settings. Routine offering of testing by physicians in urban urgent care clinics in Atlanta during a 24-week period yielded double the number of newly detected HIV infections and twice as many seropositive patients entering care than during the same period in the previous year.³⁵ Many researchers have identified health care provider endorsement as a significant predictor of testing.²⁴ Since 69.4% of never tested individuals in our sample said they would accept a provider-endorsed test, it is possible that this could also be true for migrant/seasonal farmworkers. Unfortunately, our study assessed willingness to accept a provider-endorsed test only for individuals who had never been tested. Therefore, we could not include provider endorsement in the multivariable analyses. Future studies should examine the role of provider endorsement on test acceptance in this population and explore strategies for promoting routine offering of HIV testing in both clinic and community settings.

We did not find the hypothesized association between higher perceived risk of HIV infection and HIV testing that had been previously reported in the literature.^{8,19,20} However, higher perceived risk of HIV infection was strongly associated with intention to

accept a free HIV test. In a previous study with Hispanic males, we found a similar association between worrying “a lot” about being infected with HIV and future testing intention.^{8,20} This suggests that worrying about HIV plays a role in migrant/seasonal Hispanic farmworkers’ intentions to seek future testing. It could be that heightening awareness of HIV risk may be another strategy that could be used to persuade this population to consider and perhaps actually seek testing.

Unlike the results of other studies, sexual risk behaviors (eg, number of sex partners, condom use in the past 3 months, history of STI) were not associated at the multivariable level with HIV testing or intention to accept a free HIV test.^{19,20} Because 65.2% of the sample had 6 or less years of education, it could be that they did not fully understand the relationship between engaging in sexual risk behavior and the importance of being tested for HIV. Alternatively, because of the extreme poverty of the men and women in the sample, it is possible that HIV ranks low in their hierarchy of life concerns. Not surprisingly, as in other studies,²⁰ HIV testing history was significantly associated with intention to accept a free HIV test. Although the social psychological literature supports the link between intentions and behaviors,³⁶ our study would have been strengthened had we offered the men and women a free HIV test at the conclusion of the interview.

An interesting multivariable finding from the intention to test analysis is that test preference was significantly associated with intention to test. Individuals who preferred a test in which the specimen was collected via finger stick and the results were given within 30 minutes of testing were 4.47 times more likely to intend to test than those who did not have a testing preference. This suggests that the type of test that is offered and the waiting time for test results may play a role in promoting testing. It is possible that the recently approved noninvasive, rapid HIV test (OraQuick) could provide an efficient tool for increasing HIV testing rates and knowledge of HIV serostatus in this population.

Even though our study is cross sectional and its generalizability is limited to farmworkers in South Florida, our findings suggest several strategies for promoting early detection of HIV infection in this population. First, screening for HIV should be incorporated into routine medical practice, particularly in high HIV prevalence areas. Physicians and other health care providers can play a critical role in promoting early detection of HIV infection and entry into care for their patients. Second, effective, culturally sensitive HIV prevention interventions that promote HIV testing and are tailored to the different realities of

male and female Hispanic migrant/seasonal farmworkers must be developed and tested. Given the documented HIV risk in this group, the lack of efforts to promote early detection of HIV for this population is unfortunate. HIV is rapidly becoming a disease of the poor and disadvantaged in the United States, particularly those living in the Southeast. Preventing HIV transmission in these populations is a priority. Third, public health officials are encouraged to incorporate rapid testing in their HIV testing programs. Free, rapid HIV testing should be offered in nontraditional venues (eg, barber shops, hair salons, sporting events, social clubs, street corners, and so on). Testing should be made available during nontraditional working hours, including evenings, nights, and weekends. Links to ensure follow-up care for anyone who tests HIV positive should be established and solidified prior to initiating such community testing programs.

In conclusion, our study is one of the first to document low rates of HIV testing in the presence of high rates of HIV risk behaviors among a community sample of male and female Hispanic farmworkers. By identifying the significant predictors of HIV testing history and intention to accept a free HIV test, this study provides a foundation that could be used to guide efforts to promote early detection of HIV in this population. Our findings point to the importance of routinely offering HIV testing to sexually active individuals who live in high HIV prevalence areas. They also suggest the need to make testing more accessible to migrant/seasonal farmworkers. Future research to develop and test novel, culturally sensitive strategies to promote early detection of HIV infection in this at-risk population is needed.

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