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Cultural Conceptualizations of HIV and AIDS Among Female Mexican Immigrants

(Under the Direction of ELOIS ANN BERLIN)

This thesis explores the cultural conceptualizations of HIV and AIDS among women who are immigrants from Mexico and currently living in Athens-Clarke County, Georgia. Thirty-four women who are immigrants from Mexico were interviewed in several communities in Athens-Clarke County. Interviews included questions about conceptualizations of HIV/AIDS and beliefs about gender roles and infidelity. Cultural conceptualizations about HIV/AIDS and gender were analyzed using content analysis and cultural models. Analysis of free-list elicitation and multiple response questions included counting frequencies of items. Findings suggest that study participants have a basic understanding of currently presented public health messages about HIV and AIDS, but that they also have divergent beliefs about HIV/AIDS. Furthermore, findings suggest that beliefs about gender roles may possibly pose barriers to prevention.

INDEX WORDS: HIV, AIDS, Mexican Immigrants, Gender, Women, Cultural Models

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by

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TABLE OF CONTENTS

Page

CHAPTER 1

INTRODUCTION

On June 1, 1981, the Centers for Disease Control (CDC) published findings regarding some of the first cases of an illness that soon became known as AIDS (Acquired Immunodeficiency Syndrome). This year, on June 1, 2001, the CDC published a report documenting trends in HIV (Human Immunodeficiency Virus) and AIDS over the past twenty-years (MMWR). Trends published in this document include declines in AIDS incidence and in deaths and increases in the number of people living with AIDS. As the number of people living with HIV and AIDS increases, risk behaviors carry an increased risk for HIV infection. The CDC reports that AIDS still affects mostly men who have sex with men and racial and ethnic minorities. Still, while the number of white, non-Hispanic males with AIDS has decreased in the 1990s, the number of minority females with AIDS has increased. Additionally, while some regions of the country have seen a decrease in the number of people with AIDS, the South has experienced the sharpest increase in people with AIDS.

HIV and AIDS disproportionately affect both Hispanics and women living in the United States. Complex reasons exist for the unequal effect of HIV and AIDS on these populations, including unequal access to health care, social roles, cultural beliefs, health patterns, and lower socioeconomic status and lower education levels compared to non-Hispanic whites and males.

This thesis looks at the cultural context of HIV and AIDS among adult female immigrants from Mexico currently living in Athens-Clarke County, Georgia. Specifically, in researching this topic I have sought to answer questions about ways in which adult female Mexican immigrants in Athens-Clarke County conceptualize HIV and AIDS and how they conceptualize certain gender characteristics of men and women that

may possibly influence behavior related to HIV risk. In the thesis I document and analyze opinions, perceptions, and knowledge about AIDS definitions and characteristics and about male and female behavior and attributes that were shared with me by a group of thirty-four Mexican immigrant women in several communities.

Recently, the Northeast Health District in Athens-Clarke County began specifically targeting HIV prevention efforts in mostly Spanish-speaking communities in the county. One of the first major public health initiatives to discuss this issue within these communities occurred on the heels of my research for this thesis. Thus, this health district is in the beginning stages of major outreach efforts to the Hispanic community. I hope that this thesis will serve as one of the steps in understanding the complexity of commonly held beliefs and knowledge about HIV/AIDS in Athens-Clarke County's Spanish-speaking immigrant community.

Thesis Overview

This thesis consists of seven chapters. Chapter 1 is this introduction. The second chapter presents background information and a review of relevant literature that will establish the context within which the present project takes place. Specifically, topics covered in Chapter 2 include demographics of Hispanic immigrants, general health characteristics of Hispanic immigrants, Hispanic women and HIV/AIDS, gender and HIV/AIDS, risk factors affecting Mexican immigrants, cultural conceptualizations of HIV/AIDS among Hispanics, and sources of knowledge about HIV/AIDS.

Chapter 3 presents the theoretical framework of this project and the research methods that I used to gather information and analyze data. The basic theoretical framework of the research is disease ecology and is supplemented by theory and methods of cultural models. The chapter also includes a discussion of the location of the research site, a description of the human subjects approval needed to conduct the research, and a discussion of my sampling method, interview procedures, the interview instrument and data analysis.

Chapter 4 presents general characteristics of the group of women who participated in this project. Specific information includes age, time in United States and in Athens, education, marital status, English language ability, employment status, primary income, whether participants have health insurance, health care providers visited in Athens-Clarke County, and percentages of women who received HIV/AIDS information from their health care providers.

Chapters 5 and 6 present the results of my analysis. Chapter 5 explores respondents' knowledge and beliefs about AIDS. The chapter presents respondents' concern about AIDS, sources of knowledge, cultural models of AIDS and data from free-list elicitation and from multiple response questions. Topics include definitions of HIV and AIDS, transmission, risks, prevention, condom use, symptoms, and severity. Chapter 6 presents respondents' beliefs about gender roles and infidelity and includes discussions of opinions about ideal versus actual qualities of men and women, infidelity, and responses to infidelity.

Chapter 7 concludes the thesis. In this chapter I discuss the major findings of my research. Additionally, I present ideas about how these findings might contribute to future prevention efforts and ideas about possible future research on the topic of HIV and AIDS in the Mexican immigrant community.

CHAPTER 2

BACKGROUND AND REVIEW OF LITERATURE

There are currently more Spanish-speaking people in the United States than live in many Hispanic countries. In 1999, almost thirty-two million Hispanics lived in the U.S., and two-thirds of these were of Mexican descent. The Hispanic population faces higher rates of unemployment and poverty and lower levels of education than their non-Hispanic White counterparts. Additionally, they have higher rates of certain diseases than Whites.

This chapter addresses some of the complex issues concerning the effects of HIV and AIDS on the Hispanic population in the U.S. and, within this group, female immigrants from Mexico specifically. Topics include demographics of Hispanic immigrants, general health characteristics of Hispanic immigrants, Hispanic women and HIV/AIDS, gender and HIV/AIDS, risk factors affecting Mexican immigrants, cultural conceptualizations of HIV/AIDS among Hispanics, and sources of knowledge about HIV/AIDS. This information will establish a basic understanding of the issues related to HIV/AIDS faced by Hispanic immigrants, especially those from Mexico, and will help to place the results of my research in context.

This chapter is a survey of the literature on HIV/AIDS in Hispanic communities and includes literature from anthropology and other relevant sources, e.g., public health and medical sources. Within these bodies of literature, I will focus on Hispanic immigrants in the United States and specifically female immigrants from Mexico, but I also will look at various populations, both Hispanic and Non-Hispanic, living in the United States and in other parts of the world, as the literature informs the topic of the thesis.

Demographic Characteristics of Hispanic Immigrants in the United States

Only Mexico, Argentina, Columbia and Peru have larger Spanish-speaking populations than the United States (Singer et al. 1990). According to the U. S. Census Bureau, the estimated population of Hispanics in the United States reached 31.7 million in March 1999[1] (Ramirez 2000). Almost two-thirds of this population were of Mexican origin.

According to this census, 27.8 percent of the Hispanic population twenty-five years of age and older had less than a ninth grade education, 56.1 percent had a high school diploma or higher level of education, and 10.9 percent had graduated from college[2]. Within the Hispanic population, people of Mexican origin had the lowest proportion with a high school diploma or more education (49.7 percent) and the lowest proportion with a bachelor's degree or higher education (7.1 percent).

A larger percentage of Hispanics aged sixteen and older than non-Hispanic Whites of the same age group were unemployed by the civilian labor force (6.7 percent versus 3.7 percent). The unemployment rate for both Hispanic men and women was higher than for non-Hispanic Whites[3].

Hispanic families were more likely than non-Hispanic White families to be headed by a female householder with no spouse present. Of all Hispanic households, 23.7 percent were maintained by female householders with no spouse[4]. Families maintained by a single male householder also represented a higher percentage than in non-Hispanic white families[5]. Furthermore, Hispanics were also less likely to be married than the comparison group[6].

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[1] This number, which does not include Puerto Rico, represents 11.7 percent of the entire population.
[2] At the same time 4.5 percent of non-Hispanic Whites had less than a 9th grade education, 87.7 percent had a high school diploma or higher level of education, and 27.7 percent had a bachelor's degree or higher level of education.
[3] For men, 6.0 percent compared to 3.8 percent and for women 7.6 percent compared with 3.3 percent.
[4] Compared to 13 percent of the comparison group
[5] 8.2 percent compared with 4.8 percent
[6] 33.9 percent compared with 24.4 percent had never married.

Another important finding is that Hispanics were three times more likely than non-Hispanic Whites to be living below poverty level[7]. Hispanics represented 23.4 percent of the population living in poverty while they represented 11.7 percent of the total population. Hispanics of Mexican origin had the second highest poverty rate among all Hispanic groups, with the poverty rate for this group at 35.4 percent. (Ramirez 2000; for more detailed socioeconomic status and demographic information, see Bustamante et al. 1998). As Singer et al. (1990) note, Hispanics in the U.S. have watched much of the rest of the population "participate in an economic recovery that has failed to reach them." The authors link poverty and other unequal conditions, such as lower levels of education and substandard housing, to structural forces such as racism.

The U. S. Census findings point to the problem of unequal access to resources and other challenges faced by many Hispanics in this country. Additionally, when considering information from the U. S. Census, one must consider the possibility that the data do~~es~~ not adequately represent the entire population of Hispanics living in the U.S., especially undocumented immigrants who may be less likely to participate in government surveys due to fear of deportation. These same people may potentially face even greater challenges.

Health Characteristics of Hispanic Immigrants

Several infectious diseases cause excess morbidity in the Hispanic population. These include AIDS, chlamydia, cysticercosis, gonococcus, hepatitis A, meningitis, pneumonia, septicemia, syphilis, tuberculosis, and typhoid fever (Guendelman 1998, Sumaya 1991, Tomes 1997). Chronic illnesses among low-income Hispanics include diabetes, hypertension, cardiopulmonary problems, allergies, liver disease, and stroke (Guendelman 1998). This population also experiences high rates of alcoholism (Tomes 1997). Youth have high rates of teenage pregnancy and sexually transmitted diseases (STDs), including HIV (Guendelman 1998).

[7] 25.6 percent compared with 8.2 percent

Paradoxically, overall Hispanics have lower than or comparable rates of mortality due to several kinds of cancer and heart disease compared to non-Hispanic Whites, even though chronic illnesses affecting low-income Hispanics include hypertension and cardiopulmonary problems (Guendelman 1998)[8]. Compared to non-Hispanic Whites, more Hispanics die from homicide and accidents during adolescence and young adult years.

Reasons cited for these poor health conditions include poverty and related socioenvironmental problems, low education, barriers to health care services and health insurance, and importation of infectious diseases from the country of origin (Guendelman 1998, Sumaya 1991). Lower education levels and higher rates of poverty negatively affect access to health care, including problems such as lack of knowledge of the public health care system and inability to afford private healthcare. Immigrant status may pose a barrier to publicly funded health care and resources. Health is negatively affected by these substandard conditions, leading to higher rates of certain diseases and "higher infant mortality rates, lower life expectancy and a higher prevalence of morbidity of all kinds than most other subgroups in this country" (Singer et al. 1990, p. 74). As Singer et al. note, "collectively these factors constitute the social context of the AIDS epidemic among Hispanics and contribute directly to many of the special features of the disease in this population" (p. 74).

Guendelman (1998) relates some health risks to acculturation. Using women as an example, she explains that acculturation leads to health risks such as smoking, alcohol consumption, illicit drug use, and poor diet. Furthermore, she explains that Mexican women begin to take these risks only five years after moving to the U. S. Her study (Guendelman and English 1995, cited in Guendelman 1998) found that immigrants living in the U. S. for five or more years were more likely to smoke, have unplanned

[8] Guendelman reports that comparably low rates of deaths from diseases such as heart disease and lung, breast, prostrate, and colorectal cancer represent part of an epidemiological paradox for Hispanics in the U.S., considering their socioeconomic status.

pregnancies, have pregnancy complications, and deliver preterm and low birth weight infants compared to immigrants residing in the U. S. for less than five years. Acculturation has also been positively correlated with increased HIV risk factors (Sabogal and Catania 1996).

HIV/AIDS and Hispanic Immigrants

Migration and HIV/AIDS

There are overarching conditions affecting the relationships between HIV infection and migration. Haour-Knipe and Rector (1996) outline several ways that this disease affects all migrants differently. As migrants move from one location to another, they are affected by differences in disease patterns and prevention efforts. Furthermore, migrants with a low level of awareness of disease patterns who are living in locations with a high prevalence of HIV face increased risk of infection. Also, this population may be have an increased risk of getting HIV due to lifestyle consequences associated with lower socioeconomic status and insufficient access to health care and information. Migrants may also be affected by legal or financial difficulties that may potentially lead to high-risk behavior, such as restrictions on migration of spouses. Finally, this population can be affected by educational, linguistic and cultural difficulties that hinder understanding of prevention and health care messages and increase chances for misunderstandings with health care personnel in the host country. These conditions act in addition to specific cultural factors that may contribute to the effects of HIV and AIDS within specific cultural groups, including gender and other social roles. Additionally, migration has been acknowledged as an independent risk factor for HIV and other STD transmission, due to the high incidence of STDs in migrant populations (Viadro and Earp 2000).

Immigrants from Mexico to the United States encounter each of these difficulties. Mexico has lower rates of infection and less public health information than the United States (Castro, et al. 1998, Bronfman and Moreno 1996, Guendelman 1998, Mishra et al.,

1996). Mexican immigrants are also coming into a society that typically has more open sexual customs than those in the country of origin (Bronfman and Moreno 1996). Mexican immigrants are also affected by unequal access to health care and health services, as well as other social inequalities, such as lower levels of education, linguistic barriers and cultural difficulties (Brown, et al. 1998, Guendelman 1998). It is commonly known that often the first members of families to migrate are men, who later or never bring spouses, children, and other family members (Mishra et al. 1996). Finally, as noted in the previous section, several STDs are included in the group of infectious diseases that cause excess morbidity among Hispanic immigrants.

Migrants and host countries are also affected by the country of origin's HIV and AIDS rates and issues. Though Mexico has fewer reported cases of AIDS than the United States, it is currently facing growing numbers of AIDS cases. The country has experienced a twenty-three percent increase in AIDS cases a year for the last seven years. The head of a Mexico City public AIDS clinic reported that 42, 672 Mexicans have been diagnosed with AIDS but that the actual number of cases may be significantly higher (JAMA 2000). One current issue relating to HIV infection in Mexico is secretiveness about the disease by infected persons and their families. Castro, Orozco, Aggleton, Eroza, and Hernández (1998) report that many families' reactions to HIV seropositivity include covering up the fact that a family member has the disease and, for families whose infected member is homosexual, hiding the infected person's homosexuality. Reasons cited for secretiveness include fear of violence and loss of social status.

Prevalence of HIV/AIDS among Hispanics in the United States

Though the number of AIDS cases in the United States is currently declining, there is an increase in the number of people living with HIV. Thus, risk behaviors for contracting HIV carry an increased risk for infection with the disease (CDC 1998). Furthermore, while the number of AIDS cases is declining, the disease disproportionately affects certain groups. One group disproportionately affected by AIDS is Hispanics living

in the U.S. According to the Centers for Disease Control and Prevention (CDC), Hispanics in the U.S. accounted for twenty percent of persons diagnosed with AIDS in 1997, while in the same year, they made up only thirteen percent of the population (1999; see also Harvard AIDS Review 1999). Twenty-three percent of pediatric AIDS cases, seventeen percent of adult male AIDS cases and twenty percent of adult female AIDS cases were Hispanic in 1997.

While people born in Mexico represent one of the lowest rates of reported AIDS cases, Van Oss Marín and Gómez (1999) report that it is likely that there may be underreporting of cases due to immigration policy that excludes HIV-infected individuals from entry and residency in the United States (see also Sumaya 1992). Under the same policy, illegal aliens who are infected with HIV can be required to return to their country of origin. The highest rates of reported AIDS cases among Hispanics in the U.S. are among Puerto Ricans, who have status as U. S. citizens and have no restrictions on travel within the U. S. and to Puerto Rico (Van Oss Marín and Gómez 1999). Another author has also suggested that CDC data misrepresent actual cases of AIDS due to underdiagnosis and underreporting of peoples who are medically underserved (in Rhatigan, Connors, and Rodriguez 1996), and Mexican immigrants are one of the groups that are medically underserved (see "Health Characteristics of Hispanic Immigrants" section of this chapter).

Hispanic Immigrants in Georgia and HIV/AIDS in Georgia

The Hispanic population is continually increasing in Georgia[9] (US Census 2000). According to research at the University of Georgia, this state has the fourth fastest growing Hispanic population in the country (Williams 2000). The population more than doubled in the 1990s, with the majority of the population migrating from Mexico (see also Bixler 2000 for current issues relating to this population). The researchers cite substandard housing, lack of transportation, language barrier, and insufficient access to

[9] There were 220,312 Hispanic residents in 1998, a 17.57% increase from 1996.

health care and education as major problems facing this population. These factors may significantly affect this population's response to health problems such as HIV and AIDS and the effects of these diseases on this population. Substandard housing has been linked to increased stress, which has in turn been linked to increased risk behavior for HIV infection (Mishra et al. 1996). Lack of transportation may lead to lack of access to health care facilities for education, testing, and treatment. Language barriers may prevent this population from learning critical public health messages and may also make this population reluctant to seek care due to communication issues with health care personnel.

Georgia ranks number nine in the top ten states reporting the highest number of AIDS cases among residents (CDC 2000). Additionally, between 1991 and 1995, the greatest increase in rates of AIDS by region was in the South (JAMA 1997). As the Hispanic population grows and as this population acculturates, the high number of AIDS cases in this state and region will impact Hispanic risk for HIV transmission (see section below on risk factors).

Hispanic Women and HIV/AIDS

Incidence and Risk of HIV/AIDS Among Women in General

The incidence of HIV and AIDS has risen in the female population in general[10]. In 1993, AIDS Alert reported that worldwide, women were infected three times as often as men (Loustaunau and Sobo 1997). HIV/AIDS was the third leading cause of death for US women of reproductive age in 1996 (CDC). In 1998 most women reported with AIDS were infected with HIV during heterosexual sex. The second most common route of exposure was by injection drug use (CDC 1999). The CDC also reports that drug use puts women at risk not only by sharing needles but also by having sex with injection drug users (IDUs). Worldwide, ninety percent of AIDS cases among women are caused by heterosexual transmission (1997).

[10] From 1992 to 1997 the proportion of people living with AIDS who were women rose from 13.8% to 19.1% (CDC 1999).

Loustaunau and Sobo (1997) report that women are more vulnerable to heterosexual HIV transmission than men for biological and sociological reasons. As the receiving partner in heterosexual intercourse, women have a greater risk of contracting the virus than the male (penetrative) partner. When women are forced to have sex and vaginal tissue is torn or when women are experiencing vaginal infections, HIV infection is even more likely. Vaginal lining is thinner in younger women than in older women, adding to biological vulnerability. Many sociological reasons also make women vulnerable for infection. For women having sex with older men, there may be increased likelihood that the male partner has contracted the virus, depending on previous risk behavior. Women who have anal sex in order to protect virginity or as a means of birth control also have higher risk of infection. Multiple sexual partners increases chances for contracting HIV and other STDs. Presence of STDs in turn can lead to increased risk of HIV infection. Additionally, the authors explain costs versus benefits of HIV risks that may affect some women:

> [T]he the benefits of heterosexual interaction and of possible pregnancy and childbearing outweigh the risk of disease, when not risking disease could lead to more immediate consequences such as verbal or physical abuse, the loss of a partner, or childlessness. (p. 172)

Giachello (1994) reports several additional reasons for increased incidence of AIDS among women. AIDS is still considered by some people to be a homosexual or drug related disease affecting mostly men. Furthermore, women are often misdiagnosed or diagnosed late due to unequal access to health care and different manifestation of the disease compared to men. Also, women's customary role in many families is that of caretaker; thus, some women may not attend to their symptoms until the needs of the family are met. Women tend to discover seropositivity late in the progression of HIV. Women diagnosed with HIV/AIDS have unequal access to health care and clinical trials. Finally, many women diagnosed with HIV cannot afford medical treatment (see also Schneider 1991).

Hispanic Women and HIV/AIDS

Hispanic women are among the four groups of women affected disproportionately by HIV, accounting for twenty percent of all women in the U.S. reported to have HIV (CDC 1999, Guendelman 1998; see also Skjedal, Mishra and Benavides-Vaello 1996, Blea 1992). AIDS affects Hispanic women at a rate six to eight times higher than that of white women (Philips 1997, Singer et al. 1990)[11]. Main transmission routes in this population are heterosexual contact and heterosexual contact with an IDU. Singer et al. (1990) note that heterosexual contact with IDUs has been reported for far more cases of AIDS among Hispanic women than among White or African-American women.[12]

Multiple and complex reasons exist for the skewed rates of Hispanic women infected with HIV (see section on prevalence and risk for women, above). Reasons cited for the increased rates of HIV and AIDS among Hispanic women specifically include social and cultural patterns (such as gender roles and traditional sexual values, discussed in the following two sections of this chapter), unequal access to health care and additional health resources, and unequal access to knowledge about HIV/AIDS compared with Hispanic males and with Whites (Castro-Vázquez 2000; Guendelman 1998; Singer et al. 1996, Skjedal, Mishra and Benavides-Vaello 1996; Schneider 1991; Simmons, Farmer, and Schoepf 1996; Worth 1990). Also, Guendelman notes that Hispanic women have limited knowledge of HIV/AIDS and HIV prevention and that cultural norms limit condom use (1998).

Lack of communication has also been cited as a reason for relatively high rates of HIV/AIDS among Hispanic women and adolescents. Both young female and male Hispanics report having low levels of communication with adults regarding sex and sexuality (Guendelman 1998; see also Singer et al. 1990). Adult women report feeling

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[11] Most recently, Unidos Para la Vida and the Harvard AIDS Review report that Hispanic women and children are seven times more likely to have AIDS than non-Hispanic White women and children (2000, 1999).

[12] Twenty-nine percent of Hispanic women with AIDS were reported as having transmitted HIV from sex with an IDU, versus 12% of White women and 17% of African American women.

unable to discuss issues of sexuality due to fear of being perceived as disrespectful (see "Gender and HIV/AIDS" sections, below). These communication patterns within families and communities and communication difficulties between Hispanics and health care professionals put the Hispanic population at increased risk of contracting the virus due to lack of awareness (Guendelman 1998).

Another concern cited for HIV/AIDS risk among Hispanics is presence of certain other diseases that lower immunity. In particular, tuberculosis and syphilis have been linked to HIV transmission and illness complications. The prevalence of both of these diseases is significantly higher among Hispanics than among Whites (Guendelman 1998, Sumaya 1991, Tomes 1997). In a study of health and social service organization representatives who worked with Hispanic farmworking people, presence of sexually transmitted diseases and tuberculosis were indicated as main risk factors for contracting HIV (Mishra et al. 1996). Genital ulcers present with syphilis (which, although open sores, often do not cause pain and therefore may not be noticed) enhance HIV transmission (Gendelman 1998).

Hispanic women are also affected differently by HIV/AIDS for reasons described in the previous sections of this chapter. Additional risk factors affecting Mexican women are discussed in a later section of this chapter.

Gender and HIV/AIDS

The potential effects of culturally defined social roles on HIV/AIDS are well documented in anthropological, sociological and health related literature on many different populations and cultures. Gender roles and expectations influence men and women on many social and economic levels and in complex ways. Writing about the experiences of women and children with AIDS, Schneider (1991) explains that interactions among race, class and gender affect experiences with AIDS, reactions to the disease and to infected persons, institutional practice, and dynamics of change in society. Furthermore, she states that race, class and gender determine health status and well-

being: "In concert, they will affect perceptions of health and illness, kinds and availability of care, modes of delivery, anticipated illnesses, and discourse and interaction patterns of doctor-patient relationships" (1991, p. 135). Farmer also relates race, class and gender to AIDS, stating that "the majority of women with AIDS had been robbed of their voices long before HIV appeared to further complicate their lives. In settings of entrenched elitism, they have been poor. In settings of entrenched racism, they have been women of color. In settings of entrenched sexism, they have been, of course, women" (1999, p. 62).

Specific examples of gender affecting health, HIV infection and HIV/AIDS experience have been recorded for many populations. One component of gender identity discussed in anthropological literature is male domination and female silence. For example, Schoepf discusses the power differential between men and women in Zaire, stating that informants in her study expressed the need to prevent abuse of power by men and legally support women's right to say no in sexual relationships (1995). Male dominance at the institutional level is also discussed in Obbo's study on Ugandan women. The dominant voices of men in patriarchal institutions in Uganda teach women to be "good" wives and "good" mothers in order to prevent AIDS rather than use condoms, which are considered to encourage promiscuity (Obbo 1995). Gender roles affecting individual risk taking in Brazil is discussed by Paiva.

> Condom use confronts the basic notion of virility which asserts that *being a man* is to possess less control over one's sexual and aggressive impulses – to feel them more strongly than a woman. To wear a condom, to rationalize or rule one's sexual drive, or to take the female partner into consideration is to betray one's masculine nature. *Being a woman* is to be more fragile, less aggressive and to be able to control one's sexual drive – to be ignorant about sex until one gets married, and then to conform to one's husband's desires. (1995)

Thus, for different reasons, there are strong barriers for both men and women against using condoms. The author explains that social and cultural costs of using condoms outweigh the risks of possible HIV infection.

Beliefs held by and about women, norms for women, and socio-economic status of women have also been shown to affect women's HIV risk in the United States. For example, in her study of the links between condom use and inner-city women's experiences with poverty, racism and cultural ideals of love and heterosexual relationships, Sobo found that many inner-city African American women who choose not to use condoms do so as an expression of love and trust for their partners. These women typically have little social support (often due to lack of employment) outside of their conjugal relationships and therefore may try to idealize their conjugal relationships and thus deny their health risks. Sobo suggests, "ideological constructs regarding heterosexual relations mediate the impact of political and economic forces on women's sexual decisions" (1998, p.99; see also Loustaunau and Sobo 1997).

Gender Roles Among Hispanics

Gender differences and health among immigrants from Mexico were discussed in Margaret Clark's first book on Mexican-American culture and health, published in 1959. Clark did not study gender differences in depth as they relate to health but mentioned them as part of family life. She also stated that though there were some differences, such as men taking the dominant role in the family, there were also instances when women and men seemed to have more equal roles in relationships. The same is true today, of course; there are no rules involving gender that Mexican culture follows all of the time. Still, there are enough differences in gender roles and expectations that the topic is covered in much of the literature about Hispanics and health, especially sexual health.

Gender roles among Hispanics are often framed within the context of *machismo* and *marionismo*. *Machismo* is the "exaggerated sense of being male (1990, p. 116)" (see also Lopez 1999). From an early age, males are socialized to practice dominance in their relationships with females and within families and are rewarded solely for being male. Additionally, *machismo* is associated with risk taking, low sexual control and having multiple sexual partners (Díaz 1998). According to Díaz, part of the socialization process

includes teaching boys that “manhood is neither biologically given nor environmentally acquired, but rather must be ‘proven’ from an early age with ‘macho acts’ congruent with the culture’s definition of masculinity” (1998, p. 4). One ‘macho act’ is proving virility by performing penetrative sex, especially as it can lead to pregnancy. Thus, sexual abstinence and condom use may be perceived as unmanly. As both authors discuss, risky behavior by males must be considered in the cultural context of norms of masculinity and femininity.

Marionismo is the female counterpart to *machismo*. The term derives from the Virgin Mary, the mother of Christ in Judeo-Christian tradition and highly valued figure in the Catholic Church. Girls are socialized to be chaste, docile, and subservient to all males and to believe in their own inferiority and weakness compared with their male counterparts. Additionally, they are rewarded for submissiveness and physical attractiveness (Worth 1990). The concept also includes the idea that women must be “morally and spiritually superior to men and have the ability to endure any kind of suffering promulgated by men” (Singer et al. 1990, p.93, citing Stevens 1973).

There have been several recent studies on the effects of traditional gender roles on sexuality and sexual risk among Hispanics. In a survey of ten U.S. states that have the highest numbers of Hispanics, sixty-nine percent of unmarried Hispanic adults agreed with the statement, “men want to have sex more often than women,” while fifty-one percent disagreed with the statement, “men can control their sexual desires as easily as women.” Findings also suggest that traditional gender roles support sexual coercion, defined by lying by men to get sex and by men’s insistence on women to have sex (reported in Van Oss Marín and Gómez 1999).

Castro-Vázquez explains that Mexican women’s subordination to their partners makes the possibility of assessing risk and negotiating prevention difficult (2000). The author also describes a study on the reproductive rights of women that found that respondents considered sexual activity to be something to be decided upon by males,

alien to females, and closely tied to Catholic doctrine of "marriage debt," or sexual obligation within marriage (Ortiz et al. 1998, in Castro-Vázquez 2000).

Skjerdal, Mishra, and Benavides-Vaello's 1993 study involving health and social service organization representatives who worked with Mexican migrant workers and HIV/AIDS found that ninety-eight percent of the representatives considered the largest barrier to women's prevention of HIV to be cultural patterns in relationships, including male partners' demands, women's inability to negotiate sex and condom use with partners, and women's lack of knowledge of partners' risk behaviors.

In a study on HIV risk behaviors and health beliefs, Neff and Crawford (1998) tie limited labor participation and larger families of Mexican women in the United States to traditional gender roles. The authors explain that traditional gender roles promote naivety and lack of communication regarding sexuality and may lead to low access to U. S. culture and limited exposure to HIV/AIDS knowledge. They also explain that while these factors may lead Mexican women to engage in fewer high risk sexual behaviors than White and African-American women, they also may hinder safe sex within their relationships. These factors may also lead to the likelihood of less knowledge of partners' risk behaviors (Neff and Crawford 1998, Viadro and Earp 2000).

As Clark briefly mentioned in 1959, there is considerable individual and group differentiation of gender roles and attitudes regarding gender roles due to several factors, including changing social contexts, education, employment and level of acculturation (Singer et al. 1990, Valentine and Mosley 2000). There are also differences between expressed beliefs and actions. All of these issues and the reality of the current social situation (as described in previous sections of this chapter) need to be considered when dealing with the effects of gender roles on AIDS (Singer et al. 1990).

Risk Factors Affecting Mexican Immigrant Women

This chapter has reported on several risk factors for HIV/AIDS that may affect Mexican immigrant women. Risk factors outlined above include those related to

sociodemographics, biology, and culture. This section presents several additional studies that have reported risk factors associated with Mexican immigrants that may affect Mexican immigrant women.

When considering women's risk for infection, one must also consider risks that women's sexual partners take. A recent study comparing the sexual behavior of unaccompanied versus accompanied Mexican immigrant men currently residing in North Carolina suggests that unaccompanied married men who migrate behave sexually in ways that increase risk not only for themselves but also for their spouses in Mexico (Viadro and Earp 2000). These findings are consistent with data from other countries that show that unaccompanied migrants are more likely to engage in high-risk sexual activity. Compared to accompanied men, unaccompanied men reported having over twice the number of sexual partners throughout their lives and were more likely to report having over twenty sexual partners throughout their lives, having extramarital sex, and having sex with prostitutes.

Thus, added to the problems of women's inability to negotiate safe sexual relationships with their partners (discussed above) is the issue of lack of knowledge of their partners' sexual activities while they are separated and the increased possibility that male partners may take risks and become infected with an STD, including HIV. It is important to keep in mind that wives often join previously unaccompanied men when financial or legal issues preventing them from migrating are resolved. Women presently accompanying their spouses were also interviewed for this study. Interestingly, though several of them reported uncertainty of their husbands' risky behavior, none reported that risk of STD transmission is relevant to their lives (Viadro and Earp 2000).

Another recent study also looked at men's sexual behavior. Bronfman and Moreno (1996) compared migrant and non-migrant men's reported sexual activity. Respondents for their study reported change in sexual practices due to migration. More migrants than non-migrants reported having multiple sex partners, including sex workers.

Migrants also reported changes in sexual acts, such as an increase in oral and anal sex. Though more migrants than non-migrants used condoms, both migrants and non-migrants reported very low condom use. Reasons for not using condoms included beliefs that partners are "clean" and monogamous, difficulty of using condoms, fear that condoms could remain inside the vagina, and change in physical sensation when having sex with condoms. Again, these results suggest increased sexual risk that may affect migrant and non-migrant women as well as men.

Sabogal and Catania (1996) surveyed 4, 390 heterosexual Hispanics (including 3,105 of Mexican or Central American ethnicity) living in the United States regarding risk factors, condom use, and HIV testing. The authors report that 16.4 percent of 4,390 heterosexual Hispanic respondents reported an HIV risk factor. The percentage of Mexican/Central American respondents to report a risk factor is slightly lower than the average[13]. Risk factors reported included multiple (two or more) sexual partners in the past year (sixty-four percent); risk due to a primary partner's risk factor, such as seropositive status, recent IDU, nonmonogamy, transfusion recipient or hemophiliac (twenty-six percent); blood transfusion before 1985 (seven percent); and intravenous drug use during the past five years (three percent). This study also found acculturation to be positively correlated with increased risk, including multiple sex partners, drug use, increased alcohol use, and increased use of alcohol prior to sex. Among those with a risk factor, only 35.3% had been tested for HIV.

While acculturation also corresponds positively to higher condom use, respondents in this study reported low condom use during vaginal sex. Only 22.4 percent of those with risk factors reported using condoms with primary partners. As described by other studies (see Van Oss Marín and Gómez 1999), condom use is more frequent with secondary partners (44.7 percent for the present study). The percentage of Mexican/Central American respondents reporting condom use was lower than the

[13] 15.3% of the Mexican/Central American group reported risk factors.

averages for the entire sample[14]. Respondents with middle income and a high school diploma reported higher condom use with primary and secondary partners (Sabogal and Catania 1996).

Based on the results of this study, Sabogal and Catania explain that heterosexual Hispanics may have a false sense of protection from HIV and may believe that they are at lower risk for contracting HIV because they are in relationships. The authors also explain the vulnerability of Hispanic females to HIV transmission:

> Because married Hispanic men are more likely than non-Hispanic men to have multiple sex partners outside their primary relationship, because Hispanic women are less likely than non-Hispanic White women to have sex partners who always use condoms, and because some Hispanic men are more likely to engage in high-risk sexual behaviors, Hispanic women in stable relationships may be more vulnerable to HIV heterosexual transmission because they are the least likely to protect themselves with STD preventive methods. These observations are consistent with the disproportionately high prevalence (seven times higher than for non-Hispanic White women) of AIDS among Hispanic women due to mainly heterosexual contact with an at-risk sexual partner. (p. 384)

Cultural Conceptualizations of HIV/AIDS Among Hispanics

Several authors note that adult Hispanics hold beliefs about HIV and AIDS similar to the general population of the United States (Singer et al. 1990; Hines and Graves 1998; McQuiston et al. 1998). Though studies have shown that Hispanics know about the biomedical model of transmission, the same studies have shown that this population believes in casual transmission of the disease. For example, McQuiston et al. (1998) report that more than other ethnic groups, Hispanics believe that HIV can be spread by contaminated "saliva, toilet seats, mosquitoes, being coughed or sneezed on, sharing eating utensils, or living near someone with AIDS." Other modes of transmission reported include donating blood, eating in a restaurant where a cook has AIDS, touching urine or feces, living near a hospital that treats patients with AIDS, and touching a person who is HIV positive (Singer et al. 1990) These beliefs vary by level of education and acculturation. McQuiston et al. and Singer et al. report that among Hispanic groups,

[14] 18.6% for primary partner condom use and 38.9% for secondary partner use

Mexican Americans are the most likely to have beliefs divergent from the biomedical model. Though Hispanics are more likely than other groups to believe in transmission through casual contact, which would seem to support ideas about increased probability of contracting HIV, many (seventy-three percent) do not feel that they can get HIV (McQuiston et al.1998).

Singer et al. report additional misconceptions about HIV and AIDS that are prevalent among Hispanic adults. A 1989 study conducted in San Francisco found that almost half of Hispanic respondents did not realize that a person could test positive for HIV and not have AIDS. The study also found that only half of the respondents knew that a person could be HIV positive and still look healthy. Additionally, recent studies have found that far fewer Hispanics than African Americans and Whites knew that HIV can be prevented by using a condom[15]. Also, a smaller proportion of Hispanics compared to African American and White respondents were aware that avoiding anal sex will protect against infection[16].

Additionally, according to Hines and Graves (1998), researchers of high-risk sexual behavior have consistently found that perception of risk is not related to safer behavior. Hines and Graves' study on AIDS protection and contraception among African American, Hispanic, and white women found that though each of these groups of women were aware of ways to prevent AIDS, their behavior did not reflect their knowledge. In this study, Hispanic women were the least likely to use condoms[17], though many of the Hispanic women (69.8 percent) expressed concern about AIDS. The authors relate the low use of condoms and other effective means of birth control to several factors, including religiosity, gender roles and expectations, and lack of knowledge due to

[15] Thirty-six percent of Hispanic respondents knew that the use of a condom was one way to prevent infection, versus 80% of African American and White respondents.
[16] Two-thirds of Hispanics, versus over 80% of other groups, made this association between anal sex and HIV infection.
[17] 29.7% of Hispanic women versus 57.6% of African American women and 54.8% of white women had used condoms in their most recent sexual experience.

language barriers with the public health system. They also note that these women may be at a higher risk due not only to lower rates of condom use but also to cultural norms, including sexual involvement with nonmonogamous men who do not use condoms with the primary partner (1998; see also Van Oss Marín and Gómez 1999).

In their cross cultural study involving Hispanic informants from Mexico, Guatemala, and two locations in the United States, Trotter, Weller, Baer, Pachter, et al. (1999) used the cross cultural consensus model to determine shared cultural beliefs among four Hispanic populations. All respondents knew about HIV/AIDS and most could give descriptions of risks factors that were comparable to the biomedical model of HIV/AIDS. Agreement was most high for risk factors. Risks agreed upon by respondents included sexual transmission, multiple partners, high-risk groups such as homosexuals and prostitutes, and contact with contaminated blood and syringes. There was also a high degree of agreement concerning symptoms, though most agreement was on symptoms not occurring with AIDS. All groups reported five symptoms of AIDS: weight loss, weakness, susceptibility to other illnesses, fever and body aches. Finally, there was also high agreement regarding treatments and sequelae for AIDS. All groups believed that people with AIDS will die within a few years of contracting the virus. They also agreed that there is no cure for AIDS, that the best person to see for treatment is a doctor, and that infected persons who do not seek treatment will die sooner than those who get treatment.

For all questions asked, inter-group consistency and biomedical accuracy was higher in locations that had higher prevalence of AIDS. The results of this study suggest that information about HIV/AIDS has disseminated rapidly over a multitude of locations and that much information is shared across populations, regions and ethnicities (see also Weller and Baer 2001). According to Weller and Baer (2001),

> The remarkable rapidity with which AIDS information has diffused across the continents also reflects a major source of this information – the media. People are more informed about causes of AIDS, most likely because they

> have heard about these, but they are less informed about symptoms, presumably because they have not actually seen the disease. (p. 218)

Organista and Organista (1998) present similar findings regarding knowledge and beliefs about HIV/AIDS among female Mexican migrants. The authors relate that though female Mexican migrant laborers were knowledgeable about major modes of HIV transmission (such as blood, vaginal fluids, and semen), many respondents thought that HIV could be contracted from sources such as mosquito bites (43.8 percent), public restrooms (37.5 percent), kissing on the mouth (37.5 percent), and the AIDS test (21.9 percent). Twenty-five percent of respondents believed that AIDS is a problem only for homosexuals and drug addicts, and 21.9 percent thought that it is possible to know if a person has AIDS based on appearance. Additionally, two-thirds of respondents answered "yes" or "don't know" when asked whether Vaseline is a good lubricant for condoms and whether a condom should be unrolled before putting it on the penis. Respondents also reported that there would be negative social reactions to women carrying condoms. The authors report that similar results have been presented by other studies of Hispanic migrant workers. (see also Organista, Organista, García de Alba G., Morán, and Carrillo 1996).

In another study of migrant workers, Skjerdal, Mishra and Benavides-Vaello (1996) report similar findings for women. The authors found that seventy-two percent of respondents believed that they cannot get AIDS because they are faithful to their husbands, fifty-two percent believed that AIDS only affects homosexual men, fifty percent believed that they can tell if their partners are clean, forty-eight percent believed that a person can catch AIDS when donating blood, forty-one percent believed that a person can catch the disease for mosquitoes, and thirty-seven percent believed that AIDS only affects men.

Zhao, Ashery, Wild and Young (1996) report that Hispanic female sexual partners of IDUs in Mexico, Puerto Rico and the United States also have misconceptions about

the possibility of casual transmission of HIV and report very low condom use[18]. Though women in the U. S. sample reported higher rates of HIV/AIDS information, there was no significant difference in condom use than other locations that reported lower rates of information. Many of these women also reported drug use, suggesting additional risk. Drug use was significantly higher in the U.S. for all drugs except alcohol. Between 3.3 percent and 23.3 percent of the women had traded sex for drugs and between 10.8 percent and twenty-nine percent had traded sex for money. More women in the U. S. had traded sex for money or drugs, compared to women in Mexico and Puerto Rico.

Sources of HIV/AIDS Knowledge

A few publications have addressed the topic of sources of knowledge about HIV/AIDS for Hispanics. SIECUS reports that in 1997, 85.1 percent of Hispanic females and 86.6 percent of Hispanic males reported learning about HIV and AIDS in school, and 64.7 percent of females and 57 percent of males reported discussing HIV and AIDS with parents or other adult family members. The nature of these discussions was not reported, nor was an indication of these respondents' current knowledge and beliefs. Additionally, the SEICUS findings regarding communication about HIV/AIDS conflict with other studies that suggest that there is minimal communication regarding sexuality among Hispanics (see "Hispanic Women and AIDS" section of this chapter; Guendelman 1998; see also Singer et al. 1990). One possibility for this apparent conflict is that there are discussions of HIV/AIDS that do not heavily involve the topic of sexuality.

At least two recent studies have suggested that Hispanics most often learn about HIV/AIDS from watching television. Weller and Baer (2001; see above) note that media is responsible for the dissemination of HIV/AIDS information, as suggested by the large amounts of shared knowledge among Hispanics in several countries and cultures. Bronfman and Moreno (1996) also report media as the primary source of HIV/AIDS information. They relate that migrant Mexicans typically learn about HIV/AIDS from

[18] 9.3 percent had used condoms in the month before the survey.

television. Respondents in Bronfman and Moreno's study considered television to be the most reliable source of information, especially when people with HIV or AIDS were shown on television. According to the researchers, seeing sick people added credibility to the television programs.

Conclusion

This chapter has illustrated some of the major considerations related to Hispanics and HIV/AIDS, especially as these issues affect female Mexican immigrants. When considering the presence and prevention of HIV/AIDS in the Mexican immigrant community, one must take a holistic view and consider interactions among many factors, including current prevalence, biological susceptibility, presence of additional diseases, socioeconomic status, access to resources, culture, knowledge, and beliefs.

CHAPTER 3

THEORY AND METHODS

Theoretical Framework

Disease Ecology

Disease ecology provides the basic theoretical framework for this research. Disease ecology focuses on interactions among the pathogen, the human host, and environment. This perspective takes a broad view of "environment," including not only natural environment but also human-made environments, human interactions, and culture. Disease ecology is biocultural, considering both the biology of health and disease and the cultural contexts in which health and disease occur. Additionally, disease ecology views the range of components that affect disease experiences holistically. Disease ecology has a stated focus on the specifics of particular diseases and their interactions with their hosts on multiple levels (Brown, Inhorn, and Smith 1996).

The three levels of disease causation delineated by Brown, Inhorn and Smith in their discussion on disease ecology follow:

> (1) a microbial level, in which agents of disease act within the human body;
> (2) a cultural ecological (or microsociological) level, in which individual behaviors, encouraged or constrained by sociocultural context, put people at risk for contracting particular diseases; and
> (3) a political ecological (or macrosociological) level, in which historical factors involving interactions between human groups shape people's (often differential) access to resources and their relationship with the physical environment. (1996, p.189)

Medical anthropologists have explored disease-host interactions on one or more of these levels for various illnesses, including genetic diseases such as sickle cell anemia, nutritional deficiencies, occupational-related illnesses, and infectious diseases such as schistosomiasis, tuberculosis, malaria, and AIDS (see examples in Brown et al. 1996 and

Brown 1998). Disease ecology provides an ideal framework for anthropological study of HIV/AIDS as each of the three levels of causation plays a large role in the prevention and spread of HIV and in HIV/AIDS care (see Farmer, Connors, Simmons 1996; Singer 1998; Sobo 1998; among others). As Singer (1998) notes, cultural, social, epidemiological, and biological factors all contribute the effects of this disease.

The main focus of my research is on the second level of disease causation, the "cultural ecological level." I focus on documenting cultural conceptualizations of HIV and AIDS that may influence individual behaviors of female immigrants from Mexico. While I do not assume behaviors based on what respondents report about the nature of HIV/AIDS, their backgrounds, and their beliefs about gender roles, I do assume that each of these components may play a role in behavior. This research also considers the macrosociological level of causation by noting issues related to access to public health resources, including knowledge about HIV/AIDS, and by documenting beliefs about gender roles and how these roles may change due to migration.

Cultural Models

In examining cultural conceptualizations of AIDS and gender, I am working from the base of thought arising from linguistics and cognitive anthropology that has developed into current work on cultural models. Cultural models are representations of culturally shared, assumed sets of interrelated facets of cognition that are held by individuals and that help shape meaning of the world and motivate behavior (Blount 2001, D'Andrade 1995, D'Andrade and Strauss 1992, Quinn and Holland 1987). Though I have not asked respondents about individual behaviors, the cultural models presented in this thesis may identify part of the cognitive foundation that can influence possible risk or prevention behaviors related to transmission of HIV.

Methods

Location of Research Site

The research for this thesis was conducted in Athens-Clarke County, Georgia. Georgia ranks number nine in the top ten states reporting the highest number of AIDS cases among residents (CDC 2000). The Georgia Department of Human Resources reported in 1997 that as many as 27,000 people in Georgia may be infected with HIV and that the average annual cost for treatment and medical care of "a full blown case of AIDS" is $38,000.

The Hispanic population is continually increasing in this state (220,312 residents in 1998, a 17.57% increase from 1996) (US Census 2000). Hispanics of Mexican descent make up the majority of Hispanic immigrants in the US and in Georgia (Ramirez 2000). As of September 1999, 402 cases of AIDS among Hispanics had been reported to the Georgia Department of Human Resources (1999). Still, this number may not represent the actual number of AIDS cases among Hispanics nor does it illustrate the number of Hispanic people infected with HIV. Due to unequal access to health care resources and other issues discussed in the Background and Literature Review of this thesis, Hispanics may have unequal access to HIV testing. Still, AIDS is the fifth leading cause of death for Hispanic men and women 20 to 44 years of age in Georgia (Georgia Department of Human Resources 2000). While similar research has been conducted in other states, a literature review of the subject has uncovered no anthropological studies of HIV/AIDS among female Mexican immigrants currently residing in this state.

In Athens, most of the interviews (35 of 37 interviews) were conducted in two neighborhoods, Pine Wood North and Garnet Ridge. Both of these neighborhoods are filled primarily with residents who are immigrants from Mexico. Also living in both neighborhoods are African Americans (between approximately ten and fifteen percent) and very few Caucasian residents from the U. S. During the times that I was present, the culture of the communities seemed to be most heavily influenced by the Mexican

community members. Mostly Mexican children played outside. In the late afternoons, Mexican men gathered in groups talking, working on cars, and drinking beer. The women seemed to stay inside mostly, except when talking with friends and neighbors, sitting with very young children, or tending small flower or vegetable garden plots. Most of the language heard outside in the communities was Spanish. On many afternoons, I saw men in both neighborhoods pushing small ice cream carts and honking hand-held horns. These vendors sell “paletas” that are common in Mexico, and, though produced in Georgia, the ice cream is packaged in a style like those in Mexico, with all language in Spanish.

Human Subjects Approval

Permission was given to conduct this research project by the director of the Human Subjects Office of the Institutional Review Board in the end of April 2001. Written consent was not obtained from the participants since the process of consent might pose a risk to the research participants for several reasons. Research participants may not be familiar with this type of process of consent. Current research with this community (in professor Elois Ann Berlin's Hispanic Health course during 2001 Spring term) has shown that some participants do not understand why they are signing the form and that some participants seem bewildered or afraid when presented with a form to read (or have read to them by the researcher) and sign. Additionally, some research participants may not be literate in English or in their primary language. Therefore, they may not feel comfortable with the process of signing a form, even if the researcher reads the material on the form aloud to the participant. Finally, some research participants may be illegal immigrants. They may fear that signing this form could put themselves at risk of deportation or maltreatment.

Participants were given an information form that included the purpose of the study, risks and benefits of participation, the researcher’s name and telephone number, and the name, title and phone number of the director of the Human Subjects Office. Interviews were confidential, and no names were recorded on paper or on cassette.

Sampling

Ideally, a random sample of female immigrants from Mexico currently living in Athens-Clarke County would have been taken, but that was not practical for several reasons. First, a detailed census has not been taken to determine how many female immigrants from Mexico currently live in the county. The most current U.S. Census information on the number of Hispanic immigrants in Athens-Clarke County conflicts with the number recently reported by a demographer for the same population. The U.S. census reported in 1998 that there were 2,600 people who identify themselves as Hispanic living in Athens. Doug Batchel, a University of Georgia demographer, estimated that there were 8,000 Hispanics living in Athens in 1998 (Gurr 2000). Furthermore, neither of these estimates specify the portion of the Hispanic population that are first generation immigrants, nor do the reported estimates give numbers reflecting country of origin or sex. Thus, I have no way to accurately determine the number of adult female immigrants from Mexico and therefore do not have a sampling frame.

I selected participants for the research using purposive sampling (Bernard 1995). Purposive (or judgment) sampling was the best way for me to select respondents since I sought a specific type of respondent for this research (female immigrants from Mexico) but was unable to take a random sample. I recruited participants for this study by spending time in communities in Athens-Clarke County that I knew have high proportions of residents from Mexico. In the communities, I went door-to-door and asked to speak to Mexican women eighteen years of age or older. I interviewed all such women who agreed to participate during the research period (see section below for more detail).

Interview Procedures

During the entire month of May 2001, I conducted in-depth, qualitative interviews with 37 women in one clinic and three neighborhoods (Nurses' Clinic, n=1; Garden Springs, n=1; Garnet Ridge, n=16; Pine Wood Estates North, n=19). Originally, I had planned to conduct all interviews in local clinics, thinking that I may have a better chance

of talking to women in privacy and that the setting that would be conducive to discussions about health. My experience was that the health clinic was not an ideal environment for conducting interviews. Clients seemed preoccupied before their appointments and ready to leave the clinic afterward; thus I had very little success in recruiting participants. I decided to seek participants by visiting neighborhoods and found that this was a much more successful strategy for this project. I was able to conduct the interviews in private because partners were at work, outside, or in another room and most older children were at school or outside of the house. Participants seemed comfortable and most seemed to speak frankly about issues that were important to them.

In the neighborhoods where the majority of the interviews were conducted, I walked door-to-door seeking participants who were female Mexican immigrants of at least 18 years of age. Approximately three-quarters of the interviews were conducted immediately upon request when women agreed to participate. The rest of the interviews were scheduled and conducted the following day at a specified time. Interviews lasted approximately 30 to 60 minutes, were conducted in Spanish, and were recorded on cassettes for transcription. Interviews were confidential, and no names were recorded on paper or on cassette.

Three respondents were dropped from the analysis, either because the interview was compromised or the respondent was not from Mexico. Two additional interviews ended at approximately the middle of the interview due to participants' time constraints; however I use available material from both of these interviews in the analysis.

Instrument

The interview instrument included questions related to demographics, access to and use of health care resources, knowledge and beliefs about HIV/AIDS, and beliefs and opinions about gender. Demographic information included topics of age, education, language, place of origin, time in U.S. and Athens-Clarke County, marital status, and employment status. Related to health care resources were questions about specific types

of providers visited in Athens, presence or absence of discussions related to HIV/AIDS with providers, and language used to communicate with providers. Regarding knowledge and beliefs about HIV/AIDS, participants answered questions about sources of knowledge, general concern about the virus, definitions of HIV and AIDS, perceived transmission routes, and perceived risk factors and behaviors. Discussions of gender included topics of ideal qualities of men and women versus perceived actual qualities and expectations of women and men regarding sexual behavior.

Interviews were standardized, in-depth, and qualitative. They included closed-ended questions, open-ended questions, multiple response questions (yes/no/unsure), and free-list elicitation. Questions about HIV/AIDS and gender were framed in indirect ways rather than direct inquiries about the informants' behaviors. For example, instead of asking, "What are some reasons why *you* may not want to use a condom?", I asked, "What are some reasons why *a person* may not want to use a condom?" Interview questions were written in English, translated by me, and then back translated and edited (Marín and Marín 1991) by a local public health worker who is from Mexico, who worked as a physician in Mexico, and who has interviewed numerous people in Mexico for several large scale research projects related to health. Though the instrument included questions that differentiated HIV from AIDS, most participants did not differentiate between terms and throughout the interview used the word “SIDA” (the acronym for the Spanish translation of Acquired Immunodeficiency Syndrome). Therefore, after asking questions specific to HIV, I also used the term “SIDA” throughout the interview.

I field-tested the interview instrument on five respondents. After the field test, I edited the instrument based on whether questions were understood and on new insights gained from the five respondents. Changes to the instrument included the addition of several questions regarding the comparison of AIDS to other illnesses and whether there exists a vaccine for AIDS. Responses from four of these first five participants are included in the analysis for questions that remained unchanged in the interview schedule.

Analysis

I transcribed each of the interviews and added at the end of the transcriptions any explanatory and other additional notes that were taken during or after each interview.

Demographic and Health Resource Information

Following transcriptions, I entered data regarding demographic and health resources into Excel. I then used Excel to analyze this data using simple, descriptive statistics, including averages and frequencies, and to make representative tables and figures of this information, which are presented in Chapter 4.

Free lists and Multiple Response

Frequencies of items mentioned in free-list elicitation exercises indicate salience of particular items mentioned for each question asked, with those items mentioned by the highest number of participants having the most salience (Weller and Romney 1988). For free list data, I counted participants who mentioned each item to compile a table of frequencies of responses, which I present in Chapter 5. If different words were used to describe the same item, I chose the most commonly used word to present the item in the table and included the other words in the frequency count for this item.

Multiple response questions regarding HIV transmission and risk were based on current scientific knowledge regarding HIV and AIDS. I counted the frequencies of each response (yes/no/unsure) for each question. In chapter 5, I present the total numbers of responses for each question in descending order based on “yes” responses.

Content Analysis of HIV/AIDS and Gender and Cultural Models of HIV/AIDS

I analyzed the content of text relating to HIV/AIDS and gender by first coding key words and phrases that were central to respondents’ discussions. These key elements guide discourse and organize “encyclopedic content that an individual brings to bear on the world in relation to the terms” (Blount 2001). Since the interviews did not produce large amounts of text, I used a word processing program to code words and phrases. I

then analyzed the content of the interviews based on patterns and trends that emerged from repeated key words and phrases.

Based on this analysis, I present (in Chapter 5) models of AIDS to represent the discourse on this topic. The cultural models represented in these figures are hierarchical, with higher-level models at the top of the figures and lower level-models descending from the top. Essentially, the lower-level models are comprised of even smaller "packages" of cognition and interrelate to form the higher-level models (Blount 2001).

In Chapter 6, I present the analysis of the text on gender. Analysis of this information was the same as the analysis of information about HIV/AIDS, including key word and phrase coding and search for emergent patterns and trends, but is described without the use of figures. The descriptions of gender presented in Chapter 6 are still representations of higher-level cultural models of gender, but the type of hierarchical figures used to model AIDS in the previous chapter did not match well with this discourse.

CHAPTER 4

PARTICIPANTS

This chapter presents general information gathered about participants, including demographic characteristics and data relating to access to health care and HIV/AIDS information. While this information is not used for purposes of analysis in this thesis, it does describe some of the attributes of the group of women who participated in this project.

Eligibility requirements for this study were that the participants be female immigrants from Mexico and at least eighteen years of age. The sample of participants whose interviews are included in the results consists of thirty-four women. The mean age of the respondents is approximately thirty-two years of age. On average, study participants had been in the United States for about five years and in Athens for about three and a half years (Table 4.1).

Table 4.1
General Characteristics of Participants (n=34)

	Mean	Range
Age (yrs)	**32.12**	**20-61**
Time in U. S. (yrs)	**5.02**	**0.4-20**
Time in Athens (yrs)	**3.44**	**0.4-10**

Education

Figure 4.1 presents highest level of education completed by participants. Two of the sample have no formal education. Six participants had attended “primaria” (elementary school) but had not completed primaria. Twelve of the sample completed “primaria” (the sixth grade). Two participants had attended but not completed

"secundaria" (middle school), and six completed this level of education. Two participants completed "preparatoria" (high school), and four had attended a higher education institution.

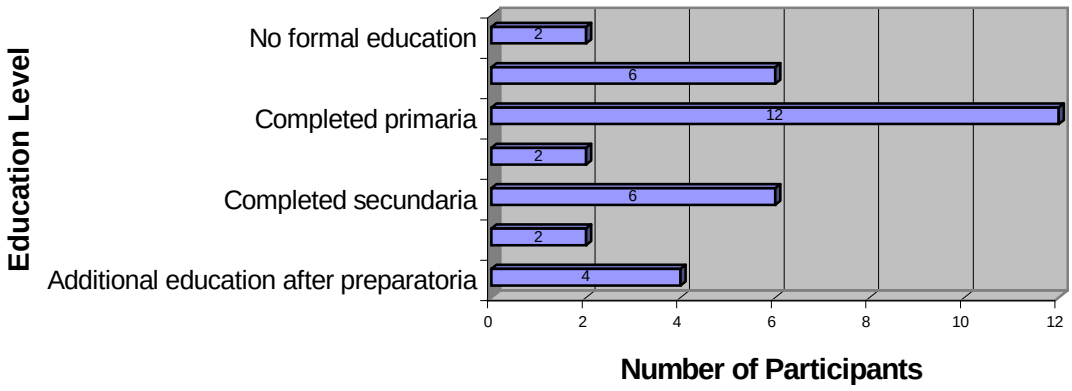

Figure 4.1. Highest Level of Education Completed By Participants

Marital Status

Twenty-six respondents reported being married (Figure 4.2). Five reported living with a partner in a civil union. Respondents who said that they live with a partner in a civil union, referred to their partners as husbands. For this reason, the terms "husband" and "spouse" are used in this thesis to describe both legally married and civil union male partners. Three women reported being single (one of these reported being a widow).

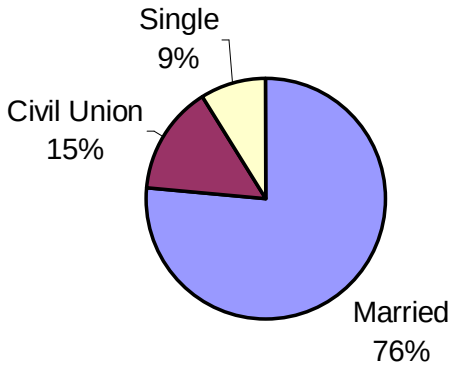

Figure 4.2. Marital Status

English Language Ability

Twenty-four participants reported speaking no English (Figure 4.3). Three reported speaking "very little" and six reported speaking "a little" English. These numbers are combined below and shown as "some" in the figure. One respondent (who has been in the U. S. for twenty years) speaks English.

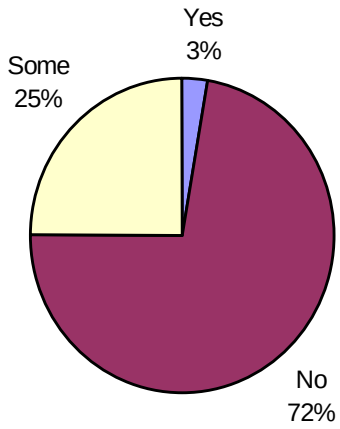

Figure 4.3. English Language Use

All but one respondent reported that it is difficult to impossible to communicate with health care providers in English. Many respondents said that they see only providers who either speak Spanish or have a Spanish-English translator or said that they take a spouse, child or other family member with them to translate.

Employment Status of Participants and Spouses

Eighteen respondents reported that they do not have a job (Figure 4.4). Ten reported working in a "pollera," or poultry processing business. Three reported working in childcare. Each of these three respondents works in her home, taking care of neighbors', friends', and/or relatives' children. Two respondents reported working in textile manufacturing. One reported working as a cook.

All respondents' spouses except for one are employed. The most common jobs for respondents' spouses are poultry processing, manufacturing and construction (eight spouses work in each of these fields) (Figure 4.5). Other jobs worked by spouses of respondents include mechanic, cement, day laborer, food service and maintenance.

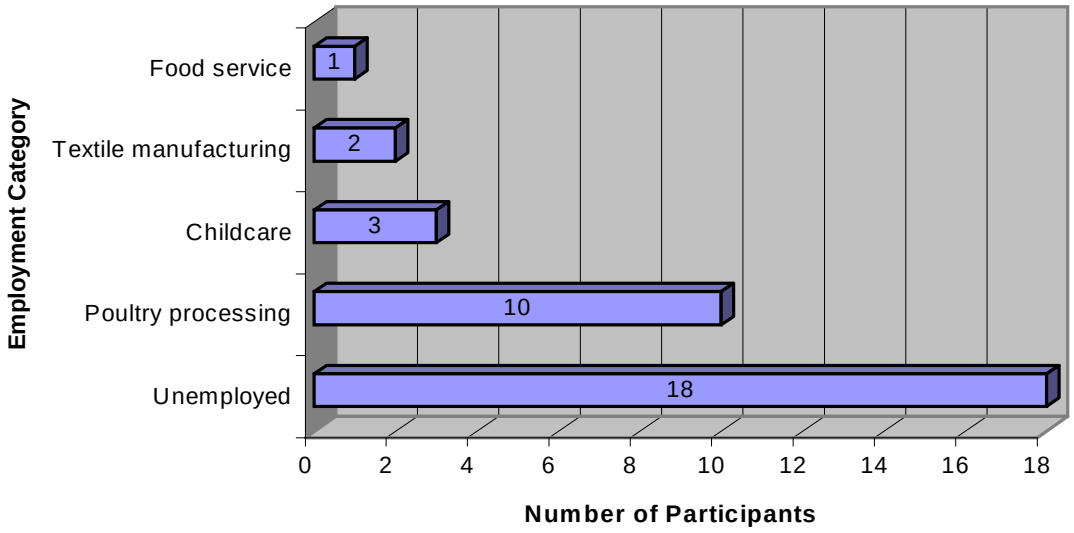

FIgure 4.4. Employment Status and Type of Work

Figure 4.5. Spouses' Employment Status and Type of Work

Primary Income

Twenty interviewees (figure 4.6) reported that their spouses provide the principal income to the family. Nine said that they and their spouses provide the principal income.

Two interviewees reported providing the principal income themselves. Two respondents reported that their siblings bring the principal income. One said that herself and her parents supply the principal income.

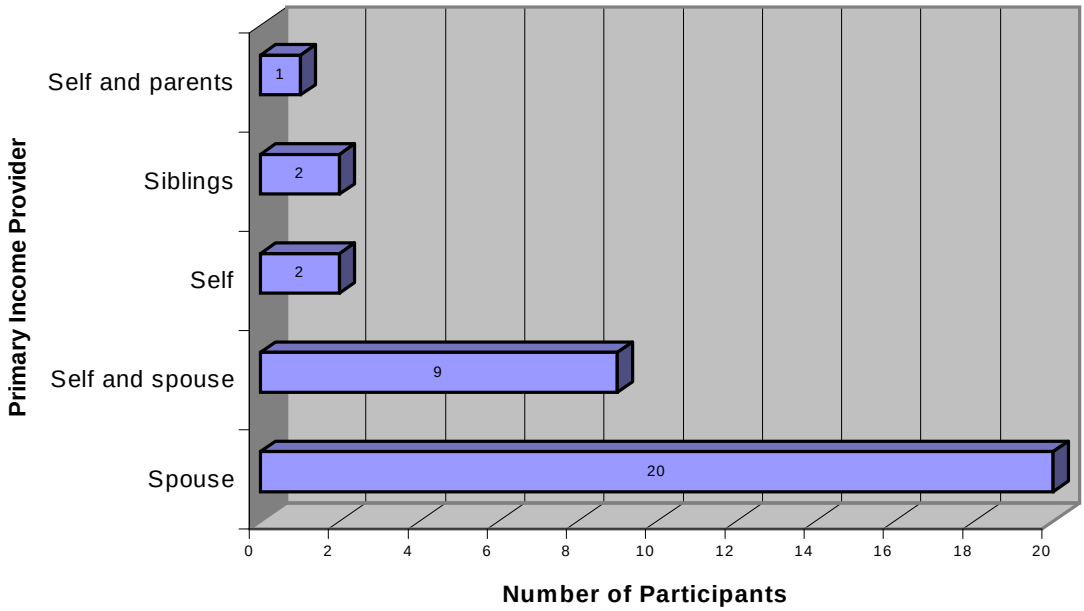

Figure 4.6. Providers of Primany Income in Household

Health Insurance

Twenty-two interviewees said that they do not have health insurance (Figure 4.7). Nine reported having health insurance. Three responded that they do not know whether or not they have health insurance.

Of the nine interviewees that have health insurance, six reported that this insurance is enough to cover the costs of health care, one reported that the insurance is sometimes enough to cover health care, and two said that the insurance is not enough to cover health care costs.

Twenty interviewees (including those who are insured, uninsured or do not know whether they are insured) reported that their income is not sufficient to cover health care. Eleven said that income is sufficient to cover health care. One reported that income is

sometimes enough to cover health care. One reported that she visits the health department exclusively in order to avoid health care costs that she cannot afford. One indicated that she does not know if income is enough to cover health care.

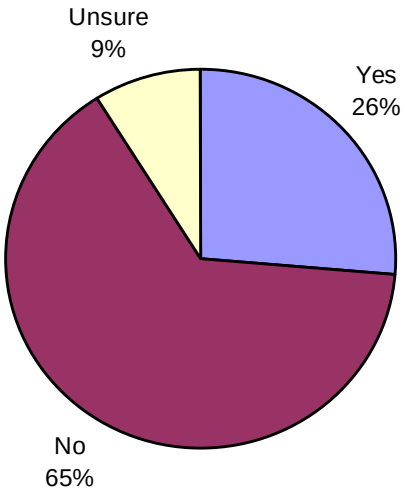

Figure 4.7. Presence or Absence of Health Insurance

Health Care Providers

Respondents reported visiting the following health care providers since moving to Athens-Clarke County, Georgia (Figure 4.8). The most commonly visited health care

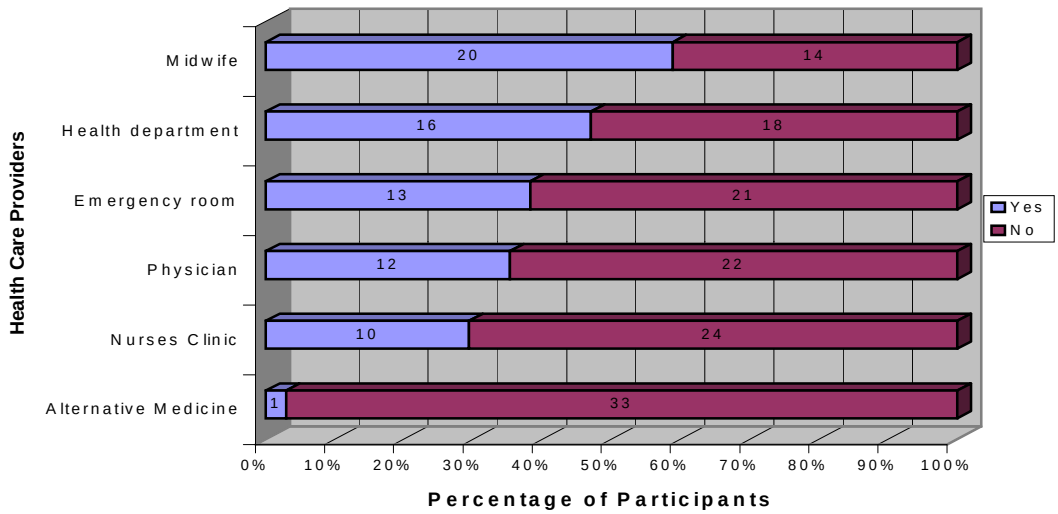

Figure 4.8. Health Care Providers Visited By Participants

providers are midwives at the Midwifery Clinic, who have cared for twenty of the respondents. The next most commonly visited health care provider is the Athens-Clarke County health department (sixteen respondents). Thirteen respondents have visited an emergency room. Twelve respondents reported visiting a physician. Ten respondents said that they have visited the Nurses Clinic, a local free health clinic. One respondent reported seeking help from a traditional healer in Athens-Clarke County. Four respondents reported not having visited any health care provider. Each of these four respondents has lived in Athens less than a year and a half (mean time = 1.04 years).

Health Care Providers Who Have Given Participants HIV/AIDS Information

Of the thirty respondents who have seen a health care provider while living in Athens, Georgia, twenty said that they were not given any information regarding HIV and AIDS by the health care provider. Two of these respondents reported that they were given an HIV test but were not given any information regarding the disease. One said that she was asked whether or not she has AIDS but was not given an HIV test or given any information. Ten respondents reported having been informed about HIV and AIDS by a health care provider in Athens-Clarke County. Of those who received information from a health care provider or reported having been tested, all but one had also seen a midwife. Several people mentioned that it was a midwife who gave them information, and this makes sense considering that HIV-antibody tests are typically given to pregnant women.

Conclusion

As shown by the data presented in this chapter, respondents tend to be young and married, with few years spent in the United States and in Athens-Clarke County. While few respondents have no formal education, many have not completed high school. Also, most speak little to no English. Over half of the respondents are unemployed but almost all of their spouses work. The most common job for women and men is poultry processing. Generally, male spouses provide the primary income. Many respondents do not have health insurance, but most have visited some type of health care provider since

coming to Athens-Clarke County. Health care providers do not seem to be primary providers of HIV/AIDS information for this group of respondents. The topic of sources of HIV/AIDS information is dealt with more fully in the next chapter.

CHAPTER 5

RESULTS: KNOWLEDGE AND BELIEFS ABOUT AIDS

This chapter presents respondents' concern about AIDS, sources of AIDS knowledge, and cultural models of AIDS. The models are supplemented by data from free list elicitation and multiple response questions. Rather than use "HIV" and "AIDS" in this section, I use the term AIDS exclusively when presenting study results for two reasons. First, respondents used this term throughout the interviews. Additionally, when asked the question, "what is HIV?", almost all respondents replied that HIV is AIDS or said that they do not know what HIV is.

Respondents' Reasons For Concern

When asked if AIDS is a concern, the majority of respondents said "yes." Of thirty-four respondents, twenty-seven said that AIDS is a concern for the Latino community, and thirty said that they worry about AIDS. The main reasons given for concern about AIDS centered around transmission of AIDS, severity of the disease, prevalence of AIDS in the United States, concern for youth, and lack of information.

Most of the respondents' concerns focused on transmission of the disease. Ten respondents mentioned transmission in relation to AIDS as a concern in the Latino community, and seventeen mentioned transmission in relation to their own worries about AIDS. Within the subtopic of transmission, respondents most typically discussed either the ease of transmission or risk of sexual transmission. According to six respondents, AIDS is highly contagious. Two lines of thought are that AIDS is very contagious and that people do not know how contagious it is. Sexual transmission is a concern because, according to several respondents, people do not protect themselves. Several respondents related their presence or absence of personal worry to sexual transmission via their husbands. For example, one respondent confided, "I worried more in Mexico because

there my husband had sex with other women, and here he does not. Here [life] is more tranquil than in Mexico. But in Mexico, he contracted some illness through sexual contact – gonorrhea." Another woman stated that she worries because her husband has other sexual partners and "one doesn't know who has [AIDS]." Absence of concern was most often related to respondents' and their husbands' sexual fidelity.

Another main cause for concern about AIDS is severity of the disease. As will be discussed below, severity of the disease was related in terms of both personal danger and public concern (i.e. prevalence). Responses include that the disease is dangerous, incurable, and mortal and that the disease is everywhere and everyone is exposed to it. Specifically, high prevalence of the disease in the United States worries interviewees. According to one respondent, "It doesn't exist in Mexico. Here there is a lot of it because nobody protects themselves."

The women who participated in this study also expressed concern for youth. This concern was expressed in terms of personal concern for one's children in light of the severity and prevalence of the disease and in terms of uneasiness due to children's behavior and lack of knowledge that could lead to them contracting the illness. A few respondents related the belief that people have sex at a very young age and are ignorant about the disease and about the need to protect themselves.

Ignorance was also discussed more broadly. Several respondents stated that people lack necessary information about AIDS, about transmission, and about who has the disease. According to one woman, "People are not informed. They are embarrassed to ask." Another stated, "Adults, like the children, don't have sufficient information. We are ignorant of the risks of AIDS."

Sources of Knowledge About AIDS and Perceived Need for Knowledge

As stated above, several respondents expressed the opinion that they do not have sufficient information about AIDS. Most of the women interviewed for this project claimed to know nothing about AIDS at some point in the interview, but all of them went

on to say something about the illness. Those who said the least about the disease included one or both of two beliefs about AIDS: the disease is spread through sexual contact and people who have the disease become very thin. Every one of the interviewees expressed some beliefs about the disease and had some knowledge about the disease that is consistent with current biomedical knowledge of HIV and AIDS.

Each interviewee told where she learned about AIDS. The majority of this sample first learned about AIDS through the popular press. The most common first source of knowledge is television, including news programs, popular talk shows, soap operas, and programs about the disease. A much less common source of information is magazines and books. Also, none of the women said that they learned about the disease by listening to the radio.

The second most common first source of knowledge about AIDS is health care providers. Nine interviewees stated that they learned about the disease from a doctor, midwife, or health clinic. Several of the women stated they had been tested for HIV when visiting a midwife in Athens-Clarke County, Georgia. Of these, a few said that though they have been tested, they were not given information about the disease at the time of the test. Less common sources of knowledge include school (3 respondents), formal presentations about AIDS (2 respondents), family or friends (2 respondents), and learning about the disease through knowing someone who has AIDS (1 respondent).

When asked where they most typically hear about AIDS now, most respondents (24/34) said that they hear about it most on the television. In both communities satellite dishes are common, giving many residents access to Spanish language television from Mexico and the U. S. Only one home that I visited did not have a television in the living room, and most of the televisions were on before the interview or/and during the interview. Several respondents showed me various channels from Mexico or U. S. based Spanish language channels that they frequently watch, and a few of the women explained that television is how they “keep up” with places of origin. Thus, television seems to

have a central place in the lives of many of the women interviewed for this project, several of whom told me that they have no friends in the U. S. and/or that they do not typically leave their neighborhoods without their spouse unless going to work. It makes sense, then, that television is a primary source of AIDS information. Several women stated that they hear about the disease much more in the United States than in Mexico. One woman said that she has noticed that in the United States there is more "culture about [AIDS]" than in Mexico.

Respondents also told what they consider the most valid source of information about AIDS. Eleven respondents cited health care experts as the source of the most valid information about AIDS. Nine respondents said that television offers the most valid source of information. As stated above, television seems to be the most central source of information. One woman explained that for her, television is the best source of information because she does not leave the house. Another said that television was the most informative source because people do not have time to learn from other sources. Several respondents stated that they do not know which source of information is the most valid, and a few believe that all sources are valid. "Almost all of the information is certain," said one of the women. Another said that any form of information is good.

While all of the respondents indicated that they have heard something about AIDS, almost all said that their communities need to know more about this disease. Two interviewees said that they do not know whether their communities need to know more about the disease. None of the interviewees stated that their communities do not need to know more about AIDS. Principal reasons for community need for information include a general perception of ignorance about the disease, a need to protect children, and a need to teach men. Women expressed that they do not know about the disease and that other people in the community do not know, either. Several stated that nobody in their communities knows anything about the disease. Children and men were most often mentioned as people who do not know about AIDS and take risks. One person explained,

"many people do not know. Principally, men do not know. Many do not know nor believe. Men do not pay attention like women. There are many women who – yes, we pay a lot of attention to things."

When asked how often they discuss AIDS, most women told me that they do not discuss AIDS in their communities, in their homes, with their spouses, or with their friends. Discussions with spouses are limited and take place infrequently and most often in response to television or to the woman's AIDS test when pregnant. Several respondents mentioned a reluctance to discuss this topic with their children because they think that their children are too young to hear about AIDS.

The stated absence of discussions about AIDS is interesting for two reasons. First, even in the absence of discussions among female peers, consensus is high in this group regarding concern, reasons for concern, and much of the knowledge and beliefs about AIDS. Knowledge and beliefs, then, might be shared more through media and visits to health care providers than through person-to-person communication within social groups. The absence of discussion is also interesting in light of the expressed concern about AIDS, particularly concern for men and children. Based on responses to interview questions, it seems that although these women worry about the disease and its potential effects on men and children, they are not communicating this concern. Possible reasons for lack of communication include the stated feeling of ignorance about AIDS or potentially feelings of discomfort about broaching the topic and personal concerns. Discomfort about approaching the subject could potentially be due to a variety of personal or cultural reasons.

Cultural Models of AIDS

The following cultural models related to AIDS derive from responses to open-ended questions about HIV and AIDS. The models presented in Figures 5.1 and 5.2 are hierarchical in that items at the top of the figures are higher-level models than those

below[19]. Explanations are supplemented by responses to free list elicitations and multiple response (yes/no/unsure) questions where available. Though specific interview questions guided responses to a certain extent, the models reflect the main themes that interviewees chose to discuss when asked general questions about HIV and AIDS.

Basic Model of AIDS

The higher-level model of AIDS is related to the concept of HIV only in that, for those who have an understanding of HIV, HIV is the same thing as AIDS (Figure 5.1).

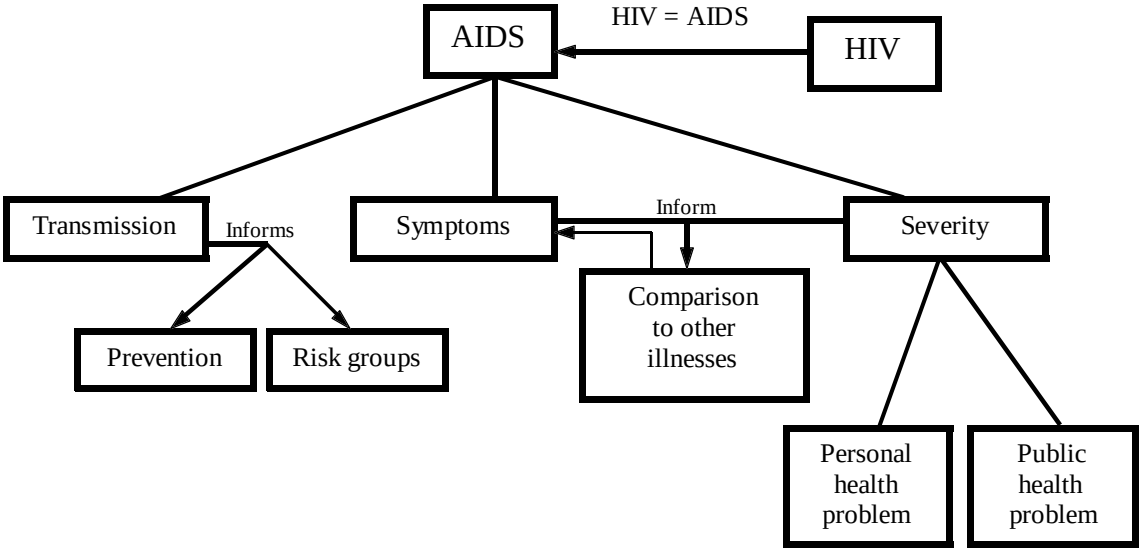

Figure 5.1. Basic Model of AIDS

About one half of respondents reported that they do not know what HIV is, and another half of respondents said that HIV is AIDS. There does not seem to be a separate cultural model for HIV, nor do the lower-level models of AIDS necessarily apply to the understanding of HIV directly.

Mid-level models of AIDS for this group of women included three primary concepts: *transmission*[20], *symptoms*, and *severity*. That is, when respondents were asked, "what is AIDS," most responded by explaining transmission, symptoms, and severity of the condition. Throughout the interviews, respondents repeated the same themes.

[19] The size of the boxes in these models does not signify importance. Boxes are sized to best fit the text within them.

[20] Names of models are italicized in this thesis.

Transmission includes lower level models as presented in Figure 5.2 below. The model of transmission informs *prevention*, though it may not necessarily motivate prevention

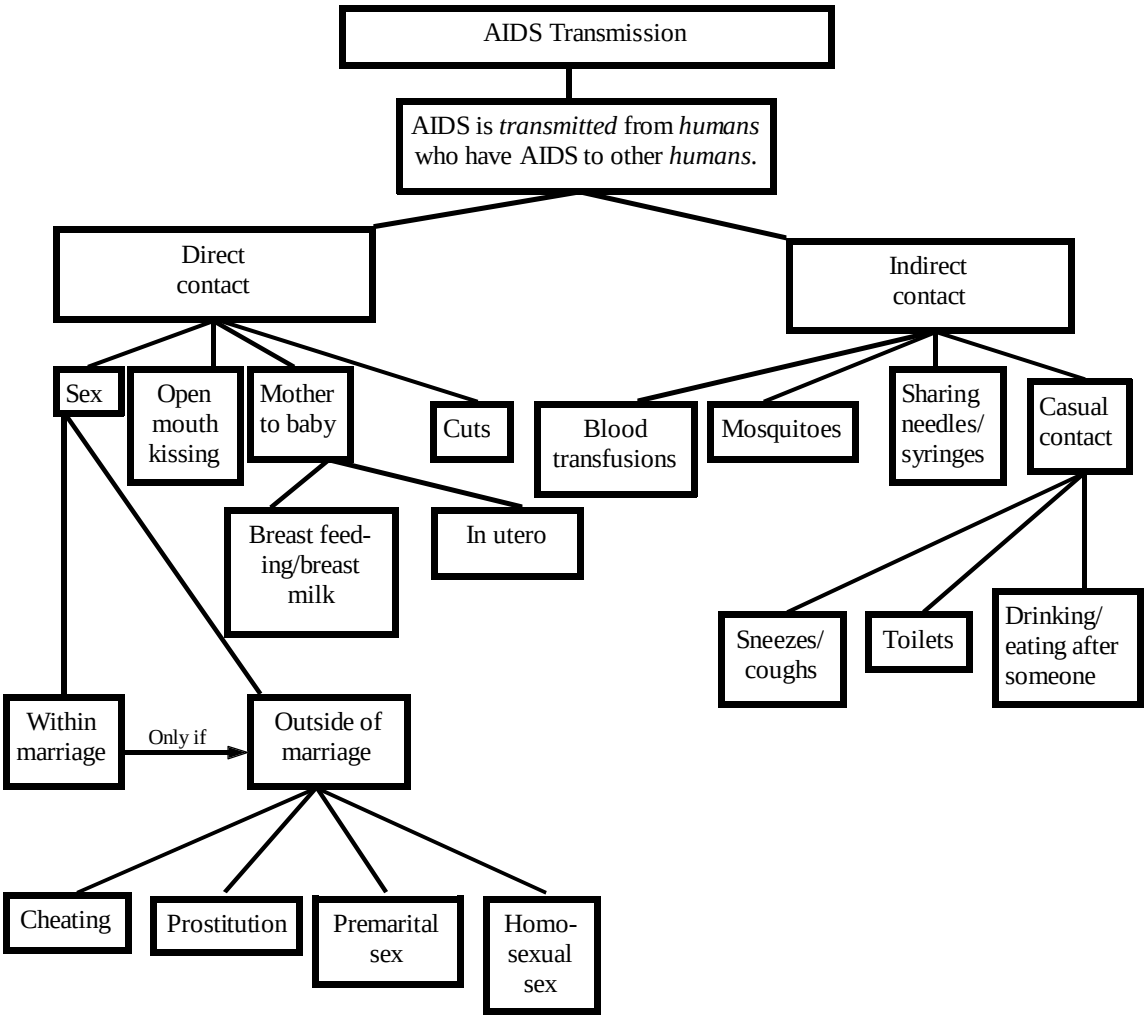

Figure 5.2. Model of AIDS Transmission[21]

behavior for this group. Beliefs about transmission also influence ideas about *risk groups*, or those people or groups of people who are more likely to have AIDS. *Symptoms* and *severity* inform ideas about AIDS as compared to other illnesses, though understandings of other illnesses may also inform supposed symptoms of AIDS. *Severity of AIDS*

[21]In public health and other biomedical literature, the most commonly cited actual transmission routes are sex (vaginal, oral, and anal) with an infected person, sharing needles or syringes with an infected person, and from an infected mother to her baby during pregnancy, birth, or breast-feeding. The body fluids that spread HIV are blood, semen and pre-ejaculatory fluid, vaginal fluid, and breast milk. Casual contact does not spread HIV, nor do mosquitoes, and nor does saliva.

includes two lower-levels models: AIDS as a *personal health problem* and AIDS as a *public health problem*. Presented below are discussions of each of the mid- and lower-level models of AIDS.

Transmission of AIDS

Figure 5.2 above presents the mid-level model of *transmission.* All respondents expressed an understanding of AIDS as transmitted from humans who have the disease to other humans, directly or indirectly. Thus, the AIDS *transmission* model includes a model that *AIDS is transmitted from humans who have AIDS to other humans*. Assumed in this idea is that AIDS is transmitted. It is not a condition produced by alternative factors, such as genetics, stress, or diet. Also assumed is that AIDS affects humans and is spread by humans[22]. No one presented an understanding of AIDS as a disease that affects other animals or as a condition produced by environmental factors. Specific routes of transmission from humans to other humans included direct and indirect transmission.

Direct transmission routes are those where direct contact with another human results in spread of the disease. *Direct contact* includes lower-level models of specific transmission routes, including *sex*, *open-mouth kissing*, *mother to baby*, and *cuts*. The most commonly discussed transmission route is sex. Additionally, sex was the most frequently mentioned route of transmission in the free list elicitation (33/34) (Table 5.1) and was said to be a route of transmission by all participants when asked to respond to a list of possible transmission routes (Table 5.2). Sex includes two lower-level models, both framed within an assumed norm of marriage: *sex within marriage*, which is considered absolutely safe *unless* there is also sex outside of marriage, and *sex outside of marriage*. Respondents discussed several types of sex outside of marriage.

The most commonly presented type of *sex outside of marriage* and the one that seems to concern women most is *cheating*. A number of respondents discussed their

[22] The only exception here is that AIDS can be transmitted by mosquitoes. Mosquito transmission was presented as a form of indirect contact, similar to infection by a "dirty" needle, as discussed below.

personal concern for AIDS by describing the presence or absence of extramarital sex in their relationships. Several women told stories of husbands' infidelities. Cheating by women was discussed mostly in vague terms of whether or not women cheat. None of the women discussed personal sexual experiences outside of marriage. *Prostitution* is a related type of sex outside of marriage, though this is typically considered to be sex for pay with a woman who works in a house of prostitution or one who "walks the street."

Table 5.1.
Frequency of Mention of Transmission Routes in Free List Elicitation

Transmission Routes	Frequency
Sex	**33**
Blood	**17**
Cut	**10**
"Intimate parts" (penis/vagina)	**8**
Saliva	**7**
Blood transfusion	**6**
Used needles/syringes	**6**
Drinking/eating after someone	**5**
Drugs	**5**
Mouth	**5**
Breast feeding	**3**
Kiss	**3**
Semen/ejaculation	**3**
Vaginal fluid	**3**
Sneeze	**2**
Surgery	**2**
Anus	**1**
Bathroom	**1**
Being near someone	**1**
In hospitals	**1**
In utero	**1**
"Other contact with people"	**1**
Prostitution	**1**
Sweat	**1**
Urine	**1**

Table 5.2.
AIDS Transmission Routes Ordered By Frequency of "Yes" Responses
(Added to questionnaire after first five interviews. N=30)

Transmission Routes	Yes	No	?
Can a woman contract AIDS by having sex with a man with AIDS?	30	0	0
Can a man contract AIDS by having sex with an infected woman?	30	0	0
Sharing infected needles and syringes to inject drugs	30	0	0
Sharing tattooing needles with a person with AIDS	30	0	0
From an infected mother to her baby during pregnancy	30	0	0
Having sex without a condom with an infected person	29	1	0
Sharing infected needles and syringes to inject medicine	29	1	0
Can a man contract AIDS by having sex with an infected man	29	0	1
From blood transfusions	28	1	1
Can a woman contract AIDS by having sex with a woman with AIDS	28	0	2
Sharing infected needles and syringes to inject vitamins	27	2	1
Piercing ears (with shared needles)	27	1	2
From an infected mother to her baby during breast feeding	27	0	3
Having anal sex with a person with AIDS	26	0	4
Having oral sex with a person with AIDS	25	2	3
Donating blood	22	7	1
From toilet seats	22	8	0
From the urine of an infected person	22	1	7
From the saliva of an infected person	22	7	1
From the feces of a person with AIDS	20	3	7
From mosquitoes	20	4	6
Open-mouth kissing with a person with AIDS	19	6	5
From other insects (like fleas or ticks)	19	4	7
When blood is taken for examination	18	9	3
From water from swimming pools	17	7	6
Sharing drinks or foods with a person who has AIDS	15	12	3
If a person with AIDS sneezes	14	12	4
If a person with AIDS coughs	14	13	3
From baths or showers	14	11	5
From sharing eating utensils, glasses, or plates with a person with AIDS	13	12	5
Kissing with the mouth closed with an infected person	9	17	4
From water fountains	9	18	3
Eating foods prepared by a person with AIDS	6	17	7
From the tears of an infected person	6	17	7
When a child plays with a child who has AIDS	4	23	3
Kiss on the cheek	3	26	1
Being beside a person with AIDS	3	25	2
Caressing a person with AIDS	3	25	2
By hugging a person with AIDS	3	25	2
Greeting a person with AIDS	1	27	2
Touching a person with AIDS	1	28	1

Several respondents discussed men's sexual access to prostitutes in brothels in Mexico. As mentioned above in the section on concern about AIDS, for some women there seems to be less of a threat extramarital sex in the United States than in Mexico, even though there seems to be a higher threat of AIDS in the U.S.

Another type of sex outside of marriage is *premarital sex*. Several women mentioned concern about youth and premarital sex. Lack of knowledge about AIDS and unprotected sex are considered to put youth at risk. Several interviewees alluded to the idea that "kids today are not as well behaved as we were." There seems to be a shift in children's beliefs about accepted behavior, especially for youth in the United States, according to respondents.

The fourth type of sex outside of marriage is *homosexual sex*, specifically men having sex with other men. The interview included a discussion of a scenario in which a Mexican man who has immigrated to the United States without his family gets drunk and has sex with another man. When asked if this scenario is common, about half of respondents indicated that it is common or that they have heard of it happening. Reasons cited for married men having sex with other men include the inability to find a female sexual partner, loneliness and depression when men migrate without women, and alcohol use. This scenario is considered to happen more in the United States than in Mexico because it is here where the men experience loneliness after migrating without spouses. Homosexual sex outside of marriage does not seem to be a salient personal concern for respondents. This makes sense in light of the fact that married interviewees were women who have immigrated to the United States with their partners, and therefore may perceive little or no risk of their partners behaving homosexually.

Another low-level model of direct transmission of AIDS is *open-mouth kissing.* In response to open-ended questions about AIDS, a number of respondents stated that kissing could transmit AIDS. In free-list elicitation (Table 5.1), three respondents

reported that kissing could spread AIDS, seven said that saliva could spread AIDS, and five said that the mouth could spread AIDS. Additionally, when asked to respond with "yes," "no," or "unsure" to a series of questions about transmission and risk, nineteen respondents said that open-mouth kissing could spread AIDS and an additional five said that they were unsure about whether open-mouth kissing could spread AIDS (Table 5.2). In contrast, nine respondents said that closed-mouthed kissing could spread AIDS and four were unsure of this possible transmission route.

Mother to baby is another low-level model of transmission by direct contact that was mentioned by several respondents during general discussions about AIDS. Respondents noted two primary ways that a mother can infect her baby: through *breast-feeding* because the baby drinks its mother's breast milk and *in utero* because the baby shares blood with the mother. Though in utero transmission was not a salient item in free list elicitation (Table 5.1), all respondents agreed (when asked directly) that an infected mother could transmit AIDS to her baby during pregnancy and twenty-seven said that a mother could transmit AIDS to her baby when breast feeding (Table 5.2).

A fourth low-level model of AIDS transmission under *direct contact* is *cuts*. A number of women used *cuts* as an example of how blood can transmit AIDS. Generally these examples included briefs statements about a person having a cut or wound and bleeding on another person. When asked if the blood would need only to touch the skin of the other person, most respondents explained that the other person would also have to have a cut and that blood would have to be shared. Ten respondents mentioned cuts in the free-list elicitation exercise.

Indirect contact transmission routes occur when a person with AIDS does not directly contact another person (Figure 5.1). Instead, something from the person (i.e. blood, saliva, or other bodily fluid) is passed to the uninfected person through some other vehicle (i.e. a needle, insect, or the air). The model of *indirect contact* also contains several lower-level models.

The most often mentioned transmission route included under *indirect contact* described by participants is *blood transfusions.* Many respondents discussed the risk of having blood transfusions when responding to open-ended questions about AIDS. Additionally, twenty-eight of the respondents said that blood transfusions could spread AIDS in the multiple response exercise.

Mosquitoes and *sharing needles/syringes* are closely linked concepts. Respondents explained that mosquitoes spread the disease in the same way that shared needles transmit AIDS; infected blood remains in the needle or "stinger" and is then injected into a person when a needle is shared or mosquito bites another person. Another possible explanation for the belief that mosquitoes spread AIDS is that mosquitoes are vectors for certain other known diseases.

Several types of *casual contact* were said to transmit AIDS. To varying degrees, sneezing or coughing by an infected person, using toilets that have been used by infected persons, and eating and drinking after infected persons were thought to transmit AIDS. As with mosquito transmission, these ideas may be cognitively linked to perceived transmission of other illnesses. Also related to the connection between mosquitoes and needles, respondents may make logical connections between routes that share common body fluids (blood in the case of mosquitoes and needles and saliva in the case of kissing, sneezing, coughing, and sharing food and drinks).

Supplementary Transmission Data

Tables 5.1 and 5.2 above present data from a free list elicitation exercise and a multiple response exercise, both related to transmission and risk. Participants gave lists of transmission routes after a series of open-ended questions about HIV and AIDS. After a series of free list questions, interviewees responded "yes," "no," or "unsure" to a pre-generated list of possible routes of transmission[23]. In addition to informing the

[23] Most elements included on this list are possible transmission routes that are presented in the educational brochure "Family Guide for HIV/AIDS Prevention" published by the American Red Cross.

presentation of the cultural model of AIDS transmission, the data from these exercises identify other perceived transmission routes and further understanding of participants' concepts of transmission.

For the free list exercise, respondents listed ways that AIDS can be transmitted and body parts and body fluids that they believe spread AIDS. The number of respondents who said each item was counted to provide the list of frequencies in Table 5.1. Based on responses in this exercise, the domain of "things that can transmit AIDS" is rather small for this group. Possible reasons for this include the following. Many respondents did not feel confident with their knowledge about AIDS, and therefore might have very few items that they felt comfortable mentioning. Additionally, most respondents learn about AIDS from limited sources (i.e. television and health providers) and not from personal or community experience, so beliefs may not be shared within communities. Finally, the actual routes of transmission for this illness are limited, and presentation of AIDS by health providers and television most likely reflects this actuality. The most salient item is "sex," with thirty-three of thirty-four respondents mentioning this transmission route. Other items are mentioned much less frequently than "sex": "blood" (17/34), "cut" (10/34), " 'intimate parts' (penis/vagina)" (8/34), "saliva" (7/34), and so on.

After the free list exercise, respondents were asked to tell whether each item in list of possible transmission routes could spread AIDS. Table 5.2 (above) presents the responses to this exercise, ordered by number of "yes" responses. Responses for this exercise did not correspond well to the free-list responses. For example, while only six people mentioned "used needles/syringes" during the free list activity, all respondents said that "sharing infected needles and syringes to inject drugs" could spread AIDS.[24] One possibility for this difference is that responses listed during the free-list activity are

[24] Twenty-nine agreed that sharing infected needles and syringes to inject medicine could spread AIDS, and 27 agreed that sharing infected needles and syringes to inject vitamins could spread AIDS.

most salient personally for this group of respondents at the time of the interviews, while items on the multiple response exercise may have been evaluated based on respondents current general knowledge about AIDS and potentially about other infectious illnesses.

The most widely shared knowledge on the "AIDS Transmission Routes" Table is generally true. Those transmission routes that are agreed to spread AIDS by twenty-five or more people are almost all the same transmission routes cited by epidemiologists in the United States. The one exception to this is "blood transfusions," which since 1985 has been considered very low risk in the United States[25] but in Mexico accounts for twelve percent of HIV infections (Daley et. al 1999). At the point where the number of positive responses decreases by three on the table ("donating blood"), the actual risk also decreases sharply. None of the transmission routes from "donating blood" to the bottom of the table are mentioned in current public health literature as transmitting HIV. For responses below the inserted black line on Table 5.2, two trends can be seen. As consensus decreases for positive response to items, level of contact with bodily fluids tends to decrease. Also, items toward the upper half of this section of the table tend to be those that are commonly perceived as potentially spreading other infections, while those toward the bottom of this section are not commonly indicated as spreading other infections.

Perceived Risk Groups for AIDS

Perceived transmission seems to influence beliefs about risk groups, as indicated by an arrow from *transmission* to *risk groups* in the basic model of AIDS (Figure 5.1). The most commonly cited risk groups are those who risk activity is sex, which appears to be the most complex lower-level model. Twelve respondents explained that people at risk for AIDS are those who sleep with various partners. Specific references to the sex of people who have multiple sexual partners was about equal; thus, it does not appear that this group of respondents perceives males or females who have multiple sex partners as

[25] Beginning in 1985, all blood donations in the U.S. are tested for HIV antibodies (Donegan 1999).

more likely to be at risk. Several people identified prostitutes and/or homosexuals as at-risk groups. A number of people indicated that anyone could potentially contract the virus. For example, one respondent said, “I think that this illness does not distinguish.” Several others indicated that all people who are not careful are at equal risk

Prevention of AIDS

The *transmission* model of AIDS also appears to inform perceptions about *prevention* (see Figure 5.1). When asked how a person can prevent becoming infected with AIDS, responses tended to follow most salient transmission routes. Respondents had the most developed explanations of ways that people can prevent infection due to sexual transmission. Most commonly stated was the need to use condoms. Other responses included avoiding sex with an infected person, only having sex within marriage, not having sex with a person without knowing him or her, and more vague answers such as not having “sex with just anybody” and being careful when having sex. Avoiding used needles (for injecting drugs, tattoos, ear piercing, and blood tests) was another popular response. Several interviewees related the importance of “being careful” as a way to prevent AIDS. “Being careful” was most commonly used for avoiding transmission when receiving blood transfusions, having sex, being in hospitals, and going to the bathroom. Other responses mentioned included avoiding kissing and having more information about AIDS.

Condoms

The issue of condom use was specifically explored during interviews, through general questions about AIDS and prevention and several questions specifically related to condom use. Interviewees responded to questions about whether people use condoms, reasons why some people may not use condoms, and whether men think it is less macho to use condoms. Responses yielded the following observations. About half of all respondents believe that many people use condoms and about half believe that people do

not use condoms. Within the context of these interviews, the assumed primary use of condoms is for prevention. Thus, various reasons for using condoms were not explored for the purposes of this project. Follow-up responses to positive answers about whether people use condoms included that condoms are used by single men and by men who have sex with many women.

Reasons for not using condoms can be described in six general categories. Below is an outline of reasons with illustrative statements from the interviews.

Stated reasons for not using condoms:

1. **Doubt and mistrust of partners**

> "Those that use [condoms] are people who sleep with many women. But they don't use condoms when they trust the woman . . . and they don't use them when they don't want the woman to distrust them . . . [condoms] cause doubt."

2. **Religion**

"Much of it is religion. Religion does not permit them that protection."

3. **Lack of information/education**

"We don't have sufficient education. In Mexico there is hardly any education about AIDS."

4. **Lack of pleasure**

"They don't like to use them because it's not the same. It doesn't feel the same."

"They think that they don't have the same satisfaction."

5. **Discomfort or pain**

"They don't like to use condoms because they are plastic. Many times, I think, they irritate the skin."

"They say that [condoms] turn the skin red. They burn."

"[Condoms] can stay inside and infect the woman."

6. **Machismo and beliefs held by men**

"[They don't use condoms] simply because they are machistas."

> "The Mexican man is afraid to use condoms because they say that they will lose their potency if they use them."
>
> "They think if they use condoms they are not men."
>
> "Perhaps simply because they don't put their fluid into the woman [if they use a condom].
>
> "Men are so strange. They have their beliefs, they are machos, they do what they want, and that's it."

More respondents indicated lack of feeling, discomfort, and machismo than other factors associated with reasons for not using condoms. While machismo was explored as a standard question, respondents mentioned this issue before the topic was specifically addressed during the interview. When asked if men think that using condoms is less macho, sixty percent of respondents responded positively, versus thirteen percent of respondents who said that they do not think that men think this[26].

Vaccine for AIDS

One topic of prevention that does not seem to be informed by the model of transmission is existence of a vaccine for AIDS. Each respondent answered a question about whether an AIDS vaccine exists. About forty-seven percent of the group said that there is a vaccine, twenty-three percent indicated that they do not know whether a vaccine exists, and thirty percent said that there is no vaccine for AIDS.

Symptoms and Sequelae of AIDS

Many respondents defined AIDS by describing a number of *symptoms* that they associate with this disease (presented in Figure 5.1 as a mid-level model of AIDS). As shown below (Table 5.3), respondents identified a variety of perceived symptoms and sequelae for AIDS. While many of the items shown in the table are commonly presented by biomedical experts as effects of HIV infection, several of the items are uncommon. For example, foot problems and dryness are not commonly presented in literature on HIV and AIDS. Other common symptoms that are typically present in HIV/AIDS literature,

[26] The rest of the respondents said that they do not know if men think that it is less macho to use condoms.

such as diarrhea, fever, flu-like symptoms, were not mentioned by this group. Other common symptoms, including swollen lymph glands, vaginal discharge, and memory problems are not present on this list. Sources of knowledge may influence types of knowledge and whether beliefs are consistent with commonly presented biomedical information. Lack of personal or community experience with AIDS may account for low frequencies of items named as symptoms and sequelae of AIDS.

Table 5.3.
Frequency of Mention of Symptoms and Sequelae of AIDS

Symptoms and Sequelae	Frequency
Thinness	**10**
Hair loss	**6**
Spots/marks on skin	**5**
Immune system deficiency	**4**
Attack by other illnesses	**3**
Debilitation/Weakness	**3**
Paleness	**3**
Yellow skin	**2**
Affects the feet	**1**
Bone pain	**1**
Diarrhea	**1**
Dryness	**1**
Eye problems	**1**
Eyes swell	**1**
Fever	**1**
Flu	**1**
Headache	**1**
Lack of desire to do anything	**1**
Loss of blood cells	**1**
Loss of appetite	**1**
Sweating	**1**
Vomiting	**1**

Relationship Between Perceived AIDS Symptoms and Other Diseases

There appears to be some relationship between some of the symptoms and sequelae of AIDS and other diseases (Figure 5.1). A number of respondents compared AIDS to cancer. According to one person, "[A person who has AIDS] becomes dry, loses blood cells . . . I think that this illness is like cancer." Another respondent replied to the question of symptoms in this way: "I imagine that [AIDS makes] hair fall out. Is that it? Or is it with cancer?" The belief that AIDS causes hair loss is common according to Elvia Uribe-Martinez, an employee at the Athens-Clarke County Public Health District (personal communication, May 2001). Based on her experiences as an HIV/AIDS educator and counselor to numerous people from many ethnic and cultural backgrounds, Uribe-Martinez thinks that this belief is cross-cultural and related to a perceived result of cancer[27]. Three other diseases that were associated with AIDS are diabetes, anemia and hepatitis. When asked what diseases are similar to AIDS, one respondent replied "illnesses that affect the feet and eyes" and later noted that AIDS is like diabetes. Another indicated that AIDS is like anemia because both cause a person to become pale. Hepatitis was also associated with changes in skin tone:

> "The bad yellow, that is AIDS, no? There are two types. One is AIDS and the other, the bad yellow, is hepatitis. A person gets AIDS and turns yellow. Also, hepatitis makes a person turn yellow."

While there was no consensus for most of these examples, a number of respondents compared AIDS to other illnesses based on symptoms. What is not clear is the direction in which these connections are made; respondents could associate AIDS with other illnesses for various reasons and therefore believe that symptoms must be the

[27] I propose that one additional possibility that hair loss is indicated as a result of AIDS is that media portraits of individuals with HIV/AIDS may include individuals who have experienced hair loss due to a number of reasons related to HIV infection. Though hair loss is not commonly described in public health literature as being a sign for HIV or AIDS, the American Academy of Dermatology (2000) notes that people with HIV infection may suffer from a number of skin and hair disorders. Additionally, it makes sense that due to nutritional disorders often associated with HIV infection, hair loss may occur.

same or respondents could group illnesses based on shared beliefs about symptoms. For this reason, the Basic Model of AIDS (Figure 5.1) shows both possibilities.

Severity of AIDS

A third mid-level model of AIDS (Figure 5.1) is *severity*. *Severity* includes the gravity of AIDS as a personal health problem and as a public health problem. According to several women, AIDS is a disease that "destroys" and "kills" and is "incurable," "mortal," "tremendous," "terrible," "dangerous" and "bad." Additionally, AIDS is said to "kill 90% of Latinos," "affect many people," and be an "epidemic."

Relationship Between Perceived Severity of AIDS and Other Diseases

The perceived severity of AIDS also appears to inform the comparison of AIDS to other illnesses, specifically cancer. When asked to name some illnesses that are more serious than AIDS, about thirty-seven percent of respondents compared AIDS to cancer. Of these, several said that cancer is more serious than AIDS, several said that AIDS and cancer have the same level of seriousness, and several said that both are equal in severity except for that there is a cure for cancer. In another section of the interview several people related cancer and AIDS, based on the belief that neither are curable. Diabetes, leukemia, and hepatitis were also related to perceived severity of the illnesses.

Conclusions

The results presented here point to several important areas of consideration about this group's conceptualizations of AIDS. First, based on respondents' expressed views and opinions, this group of women is concerned about AIDS. Concern is for themselves, their partners, their children and their communities and is based on perceived ease of transmission, symptoms and severity of AIDS. Additionally, while many respondents claimed ignorance about AIDS, all of them know something about the disease, including at least one way that the disease is transmitted. Furthermore, while there is apparently little to no discussion about AIDS in households and communities, public health messages about the disease seem to be disseminating.

Still, there are some gaps in understanding about HIV and AIDS that could potentially pose risks if combined with high-risk behavior. While respondents expressed concern about AIDS, they also indicated that they do not discuss this topic, even with those people about whom they have the most concern. As previously mentioned, potential reasons for absence of discussion include opinions about inadequate knowledge, lack of comfort discussing this topic, and a variety of other personal or cultural reasons. Although media and health care providers seem to be disseminating adequate knowledge about transmission, this knowledge does not seem to be complete and may or may not affect behavior.

Lack of clear ideas about HIV transmission and prevention could potentially mislead some people to think that they have very little control to prevent infection. Beliefs about transmission of AIDS via routes such as mosquito bites, saliva, and toilets could potentially lead some people to think that individuals have little or no control to prevent infection. This belief could in turn lead to lack of motivation to prevent HIV transmission by practices such as safe sex and avoidance of the use of shared needles.

Finally, while commonly held knowledge in this group includes information about transmission via sex and use of condoms to prevent the spread of AIDS, expressed beliefs indicate that taking preventive measures such as using condoms may not be common. Furthermore, other beliefs about preventive measures may not lead to adequate protection. For example, preventive strategies including avoidance of sex with an infected person and having sex only with a person that one knows well would not necessarily protect an individual from infection since HIV-infected persons can look and feel well and may choose to hide their seropositivity status if they know it.

The results presented in this chapter support many of the findings from studies presented in the literature review of this thesis. The results of the present study support previous findings about types of knowledge and sources of knowledge. As Trotter, Weller, Baer, Pachter, et al. (1999) and Organista and Organista (1998) found in their

studies, there is high consensus within this group regarding risk factors for AIDS, though many of the commonly shared beliefs do not reflect accurate information regarding transmission. Many of the inaccurate transmission routes delineated by participants of the present study are those that have been cited as transmitting HIV/AIDS by participants in other studies. For example, McQuiston et al. (1998) also report beliefs about inaccurate beliefs regarding transmission by saliva, mosquitoes, and toilet seats. According to Organista et al. (1996), these misunderstandings may be more common when respondents do not personally know people with HIV or AIDS.

The results of this study also support previous results regarding sources of knowledge, communication, and beliefs about symptoms. As Weller and Baer (2001) report, much of the information regarding HIV transmission seems to be disseminating from media sources such as television. Also, lack of communication about HIV/AIDS has been cited as problematic and relating to risk (Guendelman 1998 and Singer et al. 1990). Also similar to previous findings (see Trotter, Weller, Baer, Pachter, et al.'s 1999 study), weight loss / thinness seems to be the most widely recognized symptom of AIDS for the participants in the present study and participants did not mention many actual symptoms.

Finally, lack of condom use and negative factors associated with condom use were addressed by participants in the present study and have been addressed in several studies presented in the literature review of this thesis. Two of the negative consequences of using condoms that have been suggested by previous studies and the present study include change in physical sensation and physical harm caused by condoms (for example, see Bronfman and Moreno 1996). Also, as Diaz (1998) and other authors have suggested, condom use seems to be negatively associated with masculinity. Additional beliefs about gender that may potentially impact possible transmission and prevention ideas and behavior are presented in the following chapter.

CHAPTER 6

RESULTS: BELIEFS ABOUT GENDER ROLES AND INFIDELITY

This chapter presents results to several questions related to gender. Specifically, these questions addressed respondents' opinions about ideal versus actual qualities of men and their perceptions of men's opinions about ideal qualities of women versus actual qualities of women. Additionally, there were questions about multiple sexual partners and primary partners' responses to infidelity. The purpose of these questions was to explore opinions about norms of gender behavior that could potentially influence thought and behavior related to HIV transmission and prevention. As will be shown, information derived from these questions shows that, in the opinion of most respondents, there are different norms for male and female roles and different expectations of men and women within relationships.

Opinions About Ideal Versus Actual Qualities of Men

Ideal Qualities

In response to a question about ideal qualities of men, the women in this study presented several characteristics that they believe are important within the context of relationships. According to interviewees, ideal qualities include responsibility, respect, non-violence, abstinence of alcohol and drug use, fidelity, and kindness. Several of these characteristics seem to connect closely with one another.

A number of women discussed the importance of responsibility. Most respondents who mentioned this characteristic said that men are responsible for their wives and families. For example, one person said,

> "In Mexico many people have the mentality that a man is responsible for everything, for the woman and the family. So, he has to have a clear responsibility of the family and a very firm moral quality."

In this example, responsibility is connected to moral character. Other respondents related responsibility to help within the household, abstaining from drinking, and hard work (presumably outside of the home).

Another frequent response was that men should have respect. Men should respect their wives, families and themselves. This quality relates to several other qualities, including non-violence and fidelity. Women explained that men should show respect by not being violent toward women and that men should respect the relationship by abstaining from extramarital sex. For example, one interviewee said that men should "respect women and not beat them" and another said, "they should respect them – treat them well. They should not hit them. They should not yell at them." Another, comparing past and present values, explained,

> "Today, no man is perfect. All are unfaithful. None have values, no men. They are very different . . . The values from the past are different from the values of today. Above all, men and women respected their partners. This was the most important value."

Also highly salient to this group as a desired characteristic in men is abstinence from drinking alcohol, using drugs and smoking. As stated in the in the previous two paragraphs, abstinence from alcohol use is related to responsibility and respect. Drugs and alcohol are also related to violence:

> "Alcohol is a problem [and] drugs – they shouldn't do them, but, well, they do them . . . today, there are men that drink and do drugs and later come home and beat the woman."

Mention of alcohol use and violent behavior (i.e. beating, hitting, and yelling) were commonly close together in these interviews.

Interviewees also considered fidelity to be an important attribute for men to have, though not as many women mentioned fidelity as mentioned respect, responsibility, abstinence from alcohol, and non-violence. Fidelity seems to link to morality, as suggested in the following example: "Emotionally, be a good person, be moral, do not

cheat." The connection between morality and fidelity is also related in the example above regarding the idea that men currently lack values and are unfaithful.

Kindness and related qualities are also important characteristics for men to have. Kindness is often related to mention of friendship and helping within the household, specifically with children and household chores. Other characteristics mentioned in conjunction with kindness are love for wife and family, enjoyment of spending time with family, trust, communication, and respect. Kindness also has connections to non-violence and respect.

Actual Qualities

In contrast to desired qualities, women's expressed opinions are that men are not responsible, do not show respect, are violent, use alcohol excessively, and are unfaithful. Several women expressed the belief that men are "machistas" and related this opinion to the above qualities. Almost all of the women interviewed for this project expressed disappointment in men's behaviors and attitudes.

Women related men's irresponsibility to money. For example, one respondent said that often when women work, men use their own money to buy beer and expect their wives to pay bills with their money. She also noted that men do not like to help within the home. According to another respondent,

> "I have known, for example, in my family, my brother and my uncle treat women poorly – like they were servants. They want [women] to pay for everything and they don't treat them well . . .. And they drink. They are not responsible with money."

As seen in both of these examples, irresponsibility with money is often associated with alcohol. Irresponsibility also relates to infidelity, as suggested here:

> "Some are responsible. Others are not. They sleep with many women. They are married and they give illnesses to their wives or girlfriends. There are many who drink, many."

Disrespect also relates to alcohol use. According to one woman,

> "Some know how to respect the family. [But] there are various cases when the man likes to drink and it does not matter to him that his children see him, that he is an example for his children."

While respect was clearly related to non-violence as ideal qualities for men, the connection between disrespect and violence was not as strongly suggested in opinions about actual qualities that men possess. Still, violence was mentioned by a number of women as a concern and was often linked to alcohol. In explaining how men are different from her ideals, one respondent said, "They are different. Some drink, fight with their spouses—beat them."

Mention of infidelity was also common during interviews. Several women said that men come to the United States from Mexico to work, leave their wives in Mexico, and have relationships with other women while here.

> "Mexicans are very different because many are married and have sex with other women – almost all Mexicans, all Hispanics. Sometimes they have wives in Mexico and here they sleep with other women."

Not surprisingly, considering respondents' consistently expressed concerns, the problem of alcohol was also mentioned in conjunction with the problem of infidelity.

While the majority of women expressed general disappointment in men, several women were not entirely negative about men. When asked what percentage of men were "moral" and "responsible," one women said,

> "Those that I know, yes, half of the men that I have known have good qualities, are of good moral quality. I have known very good men."

Several women explained that all men are different, and several stated that their own husbands are "good men."

Opinions About Ideal Versus Actual Qualities of Women

Ideal Qualities

Respondents also answered questions about ideal versus actual qualities of women. Interviewees were asked what they think men think are ideal qualities for women to have. While respondents listed some of the same qualities for women that they had

listed for men (i.e. fidelity, responsibility, and respect), there were three additional characteristics that they believe are important to men: virginity, hardworking in the home, and service to men.

A number of women said that men prefer women who are virgins. One respondent said,

> "Still in Mexico, they want a virgin wife . . . a good woman should be a virgin and should be a person that does things for her family."

Another explained that men who are "machistas" want women who are virgins. She further stated that for many men, virginity is the most important characteristic for a woman to have.

Mention of virginity was often close to mention of work within the home. Several respondents mentioned virginity first and then followed this response with the idea that women should stay in the home, work hard in the home, and take care of the children. Specific work within the home includes cleaning and preparing meals, though many respondents expressed that women do everything in the home or that their job is "to keep the house together" or be the "homemaker." In addition to these responsibilities is that of serving men. Several women stated that men want women who "attend to them" or "serve them well."

Actual Qualities

Regarding qualities that women have in reality (versus perceptions of men's ideals), respondents tended to have a broader perspective of women than of men. Answers ranged from, "one hundred percent, the Hispanic woman has been perfect" to the belief that few women are good people. In general, however, the women who participated in this study expressed one of three ideas: that all women are different, that women closely match the "ideal," and/or that life is changing for women who move to the United States.

Several people expressed simply the idea that there are many different types of women. As one respondent explained,

> "There are various classes of women, right? For example, a woman that knows how to behave . . .and women that don't know how to behave."

This respondent said that about half of women behave well, while the other half do not. Other women expressed similar views about different characteristics. There seem to be fewer generalizations about women than men, which makes sense in light of the fact that all of the respondents are women and may be less able to generalize about their own sex.

A number of interviewees expressed that women in actuality match closely to the ideals that men have. As noted above, one woman indicated that Hispanic women are perfect. Another said that Mexican women are homemakers, that they love houses and homes. Others said that women have more respect than men, are hardworking, and that they "carry the cross for both" the man and the woman within the relationship.

The third idea expressed by many respondents is that women change when they migrate to the United States. While several respondents viewed some of the changes as negative, others related positive experiences for women in the United States. One view is that Mexican women in the U. S. are sexually more liberal: "Here in Athens, many Mexican women have sex with other men . . . many change." Another respondent described a more general sense of liberty:

> "I think that it is more liberal [here] than in Mexico. In Mexico, [women] are more reserved, more humble. And in the U. S. they earn a living, they feel equal, with more rights, and they do what they want."

When asked whether men accept these changes, one woman explained,

> "Many times they do not accept it. It is difficult for them to accept it, but they are going to accept it, little by little . . . it is a very slow change."

Issues of Infidelity

Another topic explored in the interviews is infidelity. Women answered questions about whether it is common that men and women have more than one sexual partner, why people are unfaithful, and how women and men react to infidelity. As with general

gender characteristics, respondents expressed different views of men and women regarding infidelity.

Cheating Behavior and Reasons for Infidelity

Thirty-two respondents were asked questions about infidelity. Of those, thirty said that men have sex outside of their primary relationships, while fourteen said that women have sex outside of their primary relationships. Reasons for infidelity differed for men and women. According to women who participated in this study, men cheat because they are "machistas," because infidelity is a custom, because their wives are not here, because they are more attracted to other women, because they enjoy having sex with various women or simply because they are Mexican. Other reasons cited seem to place responsibility for this behavior more equally on both partners. A few women said that men cheat because problems arise within their marriages, including lack of communication or loss of love.

According to respondents, women cheat because their husbands mistreat them, because they marry too young, because they change when they come to the United States, because more Mexican men than women live in the United States, or because of lack of morality. Absent from the reasoning is any idea related to cultural norms for female sexuality that "permit" infidelity. Instead, cultural norms are used as reasons for women's sexual fidelity. Several respondents reported that women do not cheat because the custom is for women to have only one man; because when women marry, they marry for life; and because women want to show love to one man. Other reasons given for women's fidelity include family concerns. Several respondents said that women do not cheat because of their need to take care of family, because cheating could harm their children, or because women are too busy with homes and family to have time to cheat. Also expressed were several social reasons, including that women have to respect themselves so that others will respect them, because women are more reserved, or simply because "they should

not" cheat. One woman explained that women do not have sex outside of marriage because they do not enjoy sex as much as men enjoy sex.

Reactions to Infidelity

Respondents also told their opinions about what men and women would do if they found out that their partner had been unfaithful. While there were mixed beliefs about whether women would separate or stay if they discovered their partner's infidelity, the response for men's reaction was clearer and typically included violent behavior.

Opinions about women's reactions to partner's infidelity were mixed, with about half of the sample saying that the woman would separate or divorce and the other half saying that the woman would stay with her partner. Several interviewees indicated that though some women in this situation would prefer leaving, often they cannot leave. For example, one respondent said,

> "There are many people who separate, but there are other people that – for example, many people who come from Mexico are not able to do this. Even though they don't want to, they have to stay with their husbands many times, because sometimes they don't know people or they have children."

A few women spoke from personal experience and said that they did not leave their husbands when they found out about infidelity, whether the couple lived in Mexico or in the United States.

Options for women who stay with their partners include talking with the man about the problem, trying to understand and/or forgive the man, or simply accepting the infidelity. Several respondents indicated that women accept infidelity because that is the custom: "Many women accept it as part of their tradition, that the woman should accept what the man does." Several interviewees mentioned the issue of disease transmission, though not specifying AIDS. These respondents said that if a woman discovers that her partner has had sex with another person, the woman should get tested for illnesses and try to protect herself. Interestingly, this response was mentioned only in conjunction with

statements about staying with the partner, rather than being suggested as something that women should do even if they leave.

Opinions about men's reactions to female infidelity differed sharply from opinions about women's reactions. Almost all respondents said that men would leave their wives, and roughly half of the respondents mentioned some form of violence, from hitting to killing. When asked what a man would do if he discovered that his partner had had sex with another person, one respondent laughed and then said,

> "Something different [than what a woman would do]. Because, like we say, those from Mexico, Mexican men are machistas. He would leave and look for another woman."

Another explained,

> "It's worse [compared to women's reactions]. They are machistas. I think that the majority would not pardon the woman. They would beat her and leave her."

A number of women said that the man would "kill" his partner. According to one respondent, "He would kill her! It is very difficult for a man to accept that his wife has been with another person." While this response may be an exaggeration of what the man would actually do, several women explained that there are cases of men killing their partners upon discovering infidelity.

Conclusions: Gender, Behavior, and HIV Risk

This chapter has presented respondents' beliefs about gender, including opinions about desired versus actual qualities of men and women, opinions about infidelity and reasons why people cheat, and beliefs about how people react to infidelity. One of the obvious conclusions regarding respondent's beliefs is that for each of these topics, men and women differ in unique ways. The expressed beliefs also indicate potential behaviors that may increase risk for HIV infection. As presented in the literature review, several authors have linked gender to potential risk due to various factors such as men's behavior, women's inability to negotiate prevention and lack of communication (for examples see Castro-Vázquez 2000; Skjerdal, Mishra, and Benavides-Vaello 1993; and

Neff and Crawford 1998). The present research suggests similar relationships between gender and potential risks.

If men do have sex outside of their primary relationships, use alcohol excessively, and act violently, as women say they do, then they may be acting in ways that directly or indirectly increase the likelihood that they will contract HIV and transmit the virus to their primary partners. Sexual risk for HIV transmission increases as the number of sexual partners increases. If sexual behavior with multiple partners (female and/or male) is more likely for men who have immigrated without their spouses, then there may be additional risks for migrating men. Alcohol use may impair thinking and therefore lead to behavior that could increase risk. For example, sexual inhibitions may decrease and safer sex may become less likely if the impaired person cannot function well enough to use a condom correctly. Excessive alcohol use and violent behavior may pose strong barriers against communication about risks and prevention with primary and other partners. Irresponsibility and disrespect, both related to alcohol use, may also pose barriers against communication.

Ideal and actual attributes of women may also affect possible prevention and risk behavior. The ideal of woman as virgin, homemaker and servant to man may lead to cultural and social expectations that could prevent important communication about HIV risk and prevention. Women who do not adhere to these ideals also face potential risks. Changes in sexual behavior due to acculturation or any other factor may lead to increased risk for infection. Further, there is the potential that while women change certain aspects of their behavior and ways of conceptualizing their lives, they may not change other ingrained beliefs. For example, one possibility could be that there is change in behavior that includes having multiple sex partners but no change in behavior or beliefs related to communication or prevention practices. Sanctions against women who behave in ways that are deviant from norms may also create circumstances that could potentially increase risks.

Issues specifically related to sexual infidelity raise obvious concerns related to HIV infection. If the belief expressed by most of this sample regarding men's infidelity is true, then many men have multiple sexual partners. As previously stated, risk for infection increases as number of partners increases. As men's risk for infection increases, so does the risk for infection of their sexual partners. If infidelity is a "custom," as women in this sample indicated, then men may be expected to have multiple partners and women may be expected to accept this behavior. If women do accept this behavior "as part of their tradition," then they may not be able to communicate about their concerns or protect themselves from risk of infection. Even if women do not accept the behavior, some may still face difficulties in changing it or protecting themselves. As indicated by several interviewees, women may not be able to change the situation or leave due to various reasons, such as inability (perceived or real) to care for their children or themselves without their male partner.

Finally, answers to questions about gender and other questions in the interviews point to the ideas of *machismo* and *marionismo*, as defined in the literature review. Participants specifically mentioned at various points in the interviews that men are "machos," or "machistas" or that men act in certain ways because of "machismo." Though participants in this study did not specifically mention *marionismo*, they did identify or allude to several ideal and actual characteristics of women that have been previously used to describe *marionismo*, including virginity, service to men, forgiving and understanding of men, and moral superiority.

Though this study included questions that are different from those in studies presented in the literature review, the results of the present study support previous results regarding gender and potential risks. These conclusions point out only a few of a multitude of issues that women and men may face in regard to gender, sexual behavior and HIV/AIDS. While several respondents indicated changes in women and

characteristics in men that are benign in relation to HIV risk, cultural conceptualizations of gender may continue to enhance risks for many.

CHAPTER 7

SUMMARY AND DISCUSSION

This thesis has presented a discussion of cultural conceptualizations of HIV and AIDS and gender among adult female immigrants from Mexico who currently live in Athens-Clarke County, Georgia. Chapter 1 introduced the topic and the major questions asked in the thesis. The second chapter presented background information and a review of relevant literature that established the context of this project. Based on reviewed literature, some of the specific issues potentially facing immigrant Mexican women include barriers to health care resources, differences in health patterns, low education, lack of English language skills, high rates of poverty, issues associated with cultural and social factors (such as gender) and issues related to migration and acculturation.

Chapter 3 discussed theoretical perspectives of disease ecology and cultural models, the research methods that I used to gather information and analyze data, and the location of the research site. Chapter 4 presented general information about the research participants, including demographic information and data pertaining to health care resources. The chapter addressed the fact that this group tends to be relatively young, new to Athens-Clarke County, married, and primarily Spanish-speaking. While about half of the sample works, less than half of them contribute largely to household income. Also, while most of the sample have visited some kind of health care provider, few of these women have health insurance and few have had discussions with their health care providers about HIV and AIDS.

Chapters 5 and 6 presented the results of my analysis. Chapter 5 explored respondents' knowledge and beliefs about AIDS. The chapter presented respondents' concern about AIDS, sources of knowledge, cultural models of AIDS and data from free-list elicitation and from multiple response questions. Topics included definitions of HIV

and AIDS, transmission, risks, prevention, condom use, symptoms, and severity. While respondents expressed concerns for themselves and their communities regarding AIDS, many indicated that they do not discuss this concern with their partners, families, friends or other people within their communities. Although respondents indicated that they feel ignorant about this disease, they tended to know about the main facts regarding HIV and AIDS. Still, their beliefs and knowledge diverged from factual information about HIV/AIDS regarding certain topics, including certain aspects of transmission, prevention and symptoms. Additionally, respondents presented opinions and beliefs about prevention that indicated that there may be strong barriers against HIV preventive measures, such as using condoms.

Chapter 6 presented respondents beliefs about gender roles and infidelity and included discussions of opinions about ideal versus actual qualities of men and women, infidelity, and responses to infidelity. This chapter showed that most respondents have very different beliefs about men and women and that acceptable gender roles differ sharply. Gender norms may potentially lead to activities that are known to increase risk for becoming infected with HIV and may potentially pose barriers to prevention. Norms for men, including having multiple sex partners, excessive alcohol use, and violence may all contribute to risk behavior, directly (as in the case of sex with various partners) or indirectly (as in cases of alcohol use leading to impaired thinking or violence leading to problems with communication about important issues). While women may less frequently behave sexually in ways that would increase their risks, they may not be able to fully address their own risks in light of their partners' behaviors or cultural norms for women. Ideals of virginity, homemaker and subservience to men may contribute to possible barriers to communication about sexual concerns. Women who migrate may experience conflicting behaviors and beliefs that could also contribute to increased risk. Sexual infidelity, especially within these particular social and cultural contexts of differing expectations for men and women, increases the risk that men could contract

HIV and then infect their wives. Lack of communication may pose strong barriers against prevention.

Taken all together, the results of this project lead to several important questions that may be better answered in a future study. First, to what extent do already existing cultural models of illness and disease shape the model of AIDS? Based on responses to general questions about HIV and AIDS, free list elicitations, and multiple response questions, participants in this study make logical connections between AIDS and other illnesses and these connections help shape their definitions and explanations of AIDS. Also, does culturally shared knowledge about AIDS motivate behavior? The results of the present study suggest that this knowledge is not the only motivator of behavior, including behavior related to sex and communication. Finally, do culturally shared beliefs and realities regarding gender motivate behavior more than knowledge about AIDS motivates behavior? The results of this study suggest that culturally defined gender roles may be primary motivators of behavior and that behavior may also be affected by other cultural ideals more so than knowledge about AIDS.

While the present project has addressed several issues related to conceptualizations of HIV/AIDS and gender and one may conjecture possibilities of behavior based the study results, this thesis cannot accurately predict risk or behavior. In order to get a better understanding of risk and behavior, more studies should address barriers to prevention, including cultural barriers such as gender conceptualizations and norms for behavior, as well as other potential barriers, including differential access to resources. In order to get a better understanding of these barriers, a possible study would address not only knowledge about beliefs but also how this population behaves in situations of possible risk and possible prevention. One potential study might include a group of both female and male participants and investigators and would be conducted over several years. A study period lasting several years would help investigators build rapport that may lead to more openness from participants when reporting sexual

behaviors and other personal issues. Also, a longitudinal study could trace any progression in behavioral change or changes in conceptualizations about HIV/AIDS and gender that may occur as immigrants acculturate and/or are affected more by public health education efforts and impact of HIV/AIDS on their communities.

As other authors have previously suggested, public health prevention efforts should address cultural and social realities of targeted groups. Ideals and norms should be discussed with participants, with an emphasis on how these ideals and norms affect behavior and communication. The American Red Cross already has prevention programs that focus on Hispanic and African American participants and the specific cultural and social factors that may affect these groups. Along with teaching about HIV and AIDS facts, public health educators should also focus heavily on behavior change. For example, a prevention group that includes male Mexican immigrants could concentrate on the meanings of masculinity and ways of "being masculine" that do not include risky sexual behavior. Females from the same cultural group could concentrate on ways of negotiating safe sex. Together, males and females could practice communication skills that are conducive to lowering risks and addressing important issues, not only within sexual relationships but also with family and friends.

We cannot know the exact numbers of Mexican people directly affected by HIV and AIDS in Athens-Clarke County, Georgia. Considering some of the cultural and social factors affecting health that are presented in the background and literature review chapter of this thesis, it seems highly likely that numbers of undocumented cases of HIV and AIDS within this population may be higher than for many other groups in the county.

I hope that this thesis will be useful for public health educators in their efforts to educate and to gain a better understanding of cultural and social factors that affect female Mexican immigrants as they face the realities of HIV/AIDS in their communities. A key finding in the thesis is that this population has learned the major messages about HIV and AIDS commonly presented by public health educational efforts through various paths.

While there are some misperceptions about HIV and AIDS regarding transmission, prevention, and symptoms, the results of this study suggest that female Mexican immigrants have a strong foundation of basic facts. What is needed, then, is an ability to incorporate this knowledge, additional AIDS-related knowledge, and cultural and social realities into potential prevention-related behavior.

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