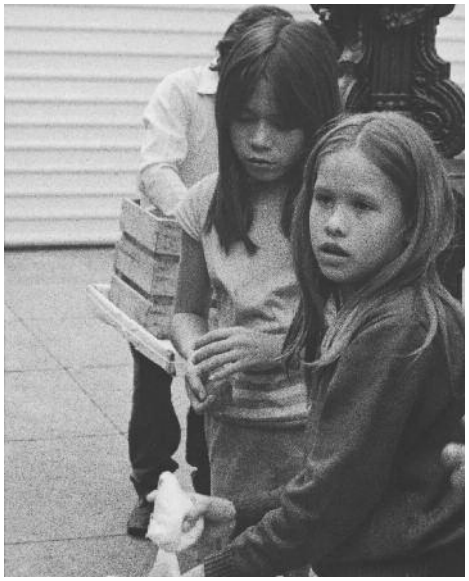
Women and AIDS in Mexico

Celia Bertha Falomir Morales*

Antonio Nava / AVE



Voices of Mexico Archives

Women's right to health in Mexico has been shunted to one side since they have not been considered a high-risk sector of the population.

Overview of AIDS in Mexico

Today, Mexico has the third largest number of AIDS cases of all the countries in the Americas, after the United States and Brazil. Taking into account the yearly rate, it is in fourth place in the hemisphere and 72nd place in the world.

The first cases of AIDS reported in Mexico were in 1983. After that, the epidemic advanced slowly until the second half of the 1980s, when it grew exponentially; from 1994 to 2000, its growth stabilized at about 4,100 new cases a year.

From the beginning of the epidemic until the year 2000, Mexico registered 47,617 cases of AIDS. However, considering belated notification and registration estimates puts the real number of cases at about 64,000 people with AIDS and approximately 150,000 with HIV. Of these, between 42,000 and 60,100, respectively, are men who have sex with men; between 69,000 and 109,350 are heterosexual adults, men and women; between 190 and 200 are women who have been infected by transfusion; between 1,900 and 2,890 are habitual injected-drug users; and between 3,000 and 4,550 are people serving prison sentences.

About 86.7 percent of the cases mentioned are the result of sexual contact, of which 61.8 percent are men who have sex with other men and 38.2 percent the result of heterosexual relations. Of all the cases over the years, 85.1 percent have been men and 14.3 percent women. The male/female ratio is now 6 to 1 (at the beginning of the epidemic it was 25 to 1; in the early 1990s it went down to 11 to 1). This ratio increases to 9 to 1 for cases of sexual transmission (90.3 percent among men and 9.7 percent among women). However, these figures vary through-

* Researcher working in a community program in Cuernavaca that treats children with alternative medical therapies.

out the country; in some states, like Morelos, Puebla and Tlaxcala, the proportion is 3 to 1 and in others, like Nuevo León, it is 12 to 1.

Mexico, then, is a country where the epidemic has been concentrated among men who have sex with other men (homosexuals and/or bisexuals), a trend that has begun to slow in recent years as cases increase among heterosexuals.

Studies indicate a drop in the number of cases of HIV infection through blood transfusions (including cases among children) thanks to the measures adopted in 1986 and 1987, such as obligatory testing for HIV antibodies of all units of blood. The first cases of AIDS reported among women in Mexico were due to transfusions.

Today, we also speak of the ruralization of the epidemic since, despite the fact that the highest number of AIDS cases occur in large cities, the proportion of cases in rural areas with high migration to the United States has increased.

Women and aids in Mexico

The issue of AIDS and women was taken up by doctors, researchers and health authorities toward the end of the first decade of the epidemic, when world trends began to change. According to UN-AIDS and WHO data, the worldwide trend is for HIV to increase among women. It is important to note that 9 out of 10 zero-positive women live in underdeveloped countries. In 1984 in Brazil, women with AIDS were one percent of all those who had HIV, while by 1994, this percentage had increased to 25 percent. About 45 percent of women with HIV in the world are from Africa, the majority of whom were infected by sexual contact.

Beyond the statistics, it is important to ask ourselves what the different biological, psychological, social and cultural conditions are behind this increase in AIDS among women. In other words, why are women vulnerable to AIDS?

Different studies relate the increase in the epidemic among women to their biological, psychological, cultural and social vulnerability; this is where the issue of gender comes into play. This concept is defined as a "symbolic elaboration" that cultures create for the difference between the sexes, in which power is an element in the social differences among men and women.[1] Biological differences should not justify social inequalities between the sexes.

Women's vulnerability with regard to AIDS can be seen in different social phenomena. Some authors call one of them the "feminization of poverty," which means that women from the poorest countries will pay the highest price for the illness since unhealthy living conditions and drug consumption favor the virus' spread, which affects not only prostitutes and drug addicts, but also women who get the virus from their male partner (given male promiscuity).

In addition, cultural factors such as the subordinate role and economic dependence vis-à-vis men that many women still experience. This power imbalance accompanies and propels women's biological vulnerability (which I will deal with later) and leads them to accept risky sexual partners and unsafe sex with their partners.

One of the phenomena that has aided in understanding women's situations is male bisexuality. In Mexico, the cultural roles and ideals that guide the male population's conduct are still rigid and stereotyped, leading to a sexual double standard: they give such an exaggerated value to masculinity ("machismo") that everything that seems feminine, effeminate or homosexual is devalued. This means that it is acceptable for men to have sex with other men as long as they play the "male" role, since this can reconfirm their masculinity and does not threaten their masculine image. A man who allows himself to be penetrated (playing the "female" role) is seen as a homosexual.

Male bisexuality in our society is practiced in secret given the moral double standard which both tolerates and criticizes it. This affects women since men who exercise their sexuality like this are more susceptible to contagion than other sectors of the population because anal sex makes it very easy for the virus to move from one organism to another.[2]

Women's right to health in Mexico has been shunted to one side since they have not been considered a high-risk sector of the population; so, prevention programs have been oriented above all toward sex workers as transmitters of the virus. Most research projects have focused on men and those that dealt with women in the first years of the epidemic limited themselves to studying vertical transmission (from mother to child). Women's specific condition was left out.

Other situations expressed at the International Women's Conference in Beijing showed up the violation of women's human rights in our country: the "cultural obligation" of having non-protected sexual relations (despite the suspicion that the husband might have HIV), as well as women with HIV who become pregnant —whether they know

they are zero-positive or not— because they cannot avoid it given that they have no access to family planning services, and who, if they have an abortion, must do so in secret, putting their lives at risk.

Dangerous abortions and unwanted pregnancies are public health problems that directly affect young women. In undeveloped countries, HIV/AIDS infection among these women is very high. Other social factors that show women's vulnerability to contracting the virus and having an unwanted pregnancy are sexual abuse against young women and girls, early initiation of sexual activity, the lack of access to formal education and reproductive health services, high-risk sexual behavior on the part of their partners and young women's inability to negotiate the terms of their sexual relations.

As I already mentioned, some roles played by women in our society help us to understand their vulnerability. Among them, the traditional role as the main people who ensure cleanliness and sanitation inside the family and the community. They are the ones who take care of the home, the work place, etc., without questioning this role of mothers, grandmothers, sisters, wives, colleagues, etc. In formal health care, women also play an increasingly important role as doctors, nurses, social workers and technicians. Since there are more women than men in this field, the majority of cases of occupational contagion with the HIV/AIDS virus have been among women. Due to the increase of AIDS cases worldwide, the burden of the disease on public health services is so great that community solutions have been sought, which implies non-paid women's work.

In addition to social questions, women are also at risk because of their biological vulnerability. Research has shown that the vaginal epithelium and the rectum are much more vulnerable to infection than the penis and that HIV remains alive for longer in the former. Infections of the reproductive system in women often include open lesions, ulcers, etc., that make it possible for the HIV to penetrate the tissue and bloodstream much more easily. Menstruation is also a risk factor for women if they have relations during that part of their cycle, as are its effects on hormonal cycles which make it possible for the covering of the genitals to be more vulnerable to HIV. Other risk factors are the use of certain kinds of contraceptives, such as the intrauterine device and some spermacides, and complications due to pregnancy, birthing and abortion.

Psychological factors also influence women's not taking preventative measures against AIDS. Some authors consider that they have the psychological need to feel desired and chosen by the male; therefore, often they cannot openly propose the use of a condom to the man because they have to mask their desire. They cannot be too explicit or "barefaced" because this attitude would be an attack on the male's masculinity. (In psychoanalytical terms, this is called "male narcissism" and is related to a "fear of castration." A women who shows that much desire is not wanted by the male because he is frightened that he will not be able to satisfy her.)[3]

From the psychological point of view, women are structured through their desire to be loved, chosen by the other, and only in that way can they love themselves ("female narcissism"). This explains the fact that often they renounce their own personal and sexual demands to please others. At the same time, when a woman demands safe sex, she is announcing not only her own desire, but also her mistrust, as well as exposing herself to the risk of hostility and rejection.

Conclusions

The issue of women and AIDS in our country is complex; for that reason it is necessary to work on different fronts. On the level of public health, specific prevention programs are required for women. For that reason it is essential to not only consider them HIV/AIDS transmitters, but also a population at risk. The gender issue must be taken into account, which would mean carrying out informational and sexual education campaigns directed at women's psychological structure in order to have a positive effect on their daily lives. Profound social and cultural changes must also be promoted to allow women to continue winning spaces of power, flexibilizing roles and stereotypes about both the sexes and strengthening their self-esteem, health and right to pleasure. What is required is increasing consciousness among women themselves so that they can participate in the changes that our society must make in the fight against the growth of this epidemic. VM

Notes

[1] Joan W. Scott, "El género: una categoría útil para el análisis histórico," *El género: la construcción cultural de la diferencia sexual*, Marta Lamas, comp. (Mexico City: Programa Universitario de Estudios de Género de la UNAM [PUEG], 1996).

[2] Ana Luisa Liguori, "Las investigaciones sobre bisexualidad en México," *Debate feminista*, vol. 2, year 6, Mexico City, April 1995.

[3] Ana Luisa Liguori and María Antonieta Torres Arias, "La negociación para la prevención del SIDA: entre el deseo y el poder," *Debate feminista* vol. 9, year 5, Mexico City, March 1994.