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UNDERSTANDING THE SEXUALITY OF MEXICAN-BORN WOMEN AND THEIR RISK FOR HIV/AIDS

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Participants in this study were 300 Mexican women of rural origin who were born and raised in villages of that country and who belong to one of three groups: married and living with their husbands in Los Angeles, California ($n = 100$), married to migrant workers but living in Mexico ($n = 100$), and living in Mexico with their spouses ($n = 100$). Trained female professionals conducted face-to-face interviews in Spanish, in Mexico and in the United States. The purpose of this study was to identify specific sexual practices, coping strategies in sex-related situations, and fears and concerns regarding sexual intercourse. This article analyzes how these elements place Mexican rural-origin women at risk for HIV/AIDS. It discusses the need to design intervention strategies to prevent HIV/AIDS that take into consideration the limited power of women in traditional societies and the cultural precepts that promote gender roles characterized by male dominance and female submissiveness in the sexual arena.

Mexican-born people represent the majority of the Latino population in the United States (Immigration and Naturalization Service, 1997). The increasing numbers of Latinos, particularly those of Mexican origin, are the result of a high birth rate and the constant influx of immigrants (Hayes-Bautista, Schink, & Chapa, 1988). In the last decade, other factors such as the implementation of new immigration policies (the Amnesty Program of the Immigrant Reform Control Act; Immigration and Naturalization Service, 1999) have also contributed to the enlargement of the Mexican group. Recent estimates of the Mexican Ministry of the Exterior indicate that there are over 7 million Mexican immigrants in the United States and that this is the youngest of all immigrant groups (Secretaría de Relaciones Exteriores [SRE], 1998).

The majority of Mexicans who migrate to the United States do so at an age characterized by high sexual activity, thus increasing their risk for HIV/AIDS through sexual contact. There are data that support the existence of a relationship between HIV/AIDS and migration to the United States. This relationship is established through the processes of migration and return migration of mostly rural-origin male workers in the United States (Bronfman, Camposortega, & Medina, 1989). For instance, Bronfman and Minello's (1995) findings revealed that, as a result of international migration, Mexican rural men change their sexual habits in the United States and get involved in sexual activities that increase their risk for HIV/AIDS, such as more frequent contact with commercial sex workers and experimentation with homosexual practices, especially when using alcohol. Immigrant women change less, perhaps because of the restrictive environment in which they were socialized in their villages of origin. Salgado de Snyder, Díaz-Pérez, and Maldonado (1996) found that wives left behind by migrant men felt at risk for HIV/AIDS, but did not talk to their spouses about protective behaviors (such as the use of condoms) mostly out of fear of being mistreated or abandoned by their men.

To contextualize the present contribution, it is important to address some issues related to the gender roles assigned to men and women in rural Mexico, which remain extremely traditional (Amuchástegui, 1995, 1996; Rivas-Zivy, 1996). Men still have considerable power and control over their own lives, the lives of their family members, and their goods and resources, whereas women remain passively in the background (Tuirán, 1995). Furthermore, gender bias has fostered an ideology that magnifies

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women's role in childbearing as the one determinant aspect of the female identity (Amuchástegui, 1996; Del Río-Zolezzi et al., 1995). As a consequence, health care services and research in rural Mexico have been addressed primarily insofar as they affect reproduction, reflecting a one-dimensional view of women's roles and needs (Tuirán, 1995).

HIV/AIDS among women in Mexico has seldom been explored in the context of sexual behaviors and preferences, in spite of the fact that records from the Mexican Ministry of Health through its Council Against AIDS (CONASIDA) indicate that the cases of women infected through sexual contact represent 36.1% of the total number of women who have developed AIDS. Through January 1998, the number of accumulated AIDS cases among women was 4,695, representing 14% of the total number of AIDS cases in Mexico (Secretaría de Salud [SSA], 1998). Of all such cases, 55% are sexually active housewives in a monogamous relationship who are of reproductive age and the mothers of small children.

The limited number of studies that have addressed Mexican women's sexual behaviors and risk for HIV/AIDS have provided important insights in this area of knowledge. Through the results of such studies we have learned that Mexican women in general have difficulty expressing their wants and needs to their sexual partners (Rivas, 1996; Rivas-Zivy, 1996). Such difficulty is related to traditional family socialization practices in which sex is still a forbidden topic for women, because sexuality is only dealt with in the context of reproductive behavior (Pick, Givaudan, & Aldaz, 1996). Furthermore, the sexual dominance that men have over women is reflected in the commonly used expression "he used me" (*el me usó*) when Mexican women refer to having had sexual intercourse with their partners (Pick et al., 1996; Rivas-Zivy, 1996; Salgado de Snyder, 1998).

Findings from the National Institute of Public Health in Mexico as well as other studies (Instituto Nacional de Salud Pública, 1996; Salgado de Snyder, 1998; Salgado de Snyder et al., 1996) suggest that the main reason women become involved in sex practices that not only are unwanted but also can place them at risk for HIV/AIDS, STDs, and unwanted pregnancies is the fear of being abandoned, replaced, or becoming a victim of psychological, physical, or sexual abuse. Women fear their spouses might suspect infidelity if they were asked to wear a condom; paradoxically, they trust their husbands would use a condom when having extramarital sex, indirectly protecting them as wives. Finally, some studies have pointed out that adequate information about HIV/AIDS is often mixed with morals, values, religious ideas, and the popularly held belief that HIV/AIDS is a matter of luck, something that is out of the individual's control (Bronfman & Minello, 1995; Pick et al., 1996).

In the United States, in addition to being disadvantaged in terms of income and education, Latinos tend to have less accurate knowledge regarding HIV/AIDS transmission and prevention of HIV exposure (Schoenborn, Mersh, & Hardy, 1994). High numbers of sex-related health problems among poor, young, minority women have been consistently reported in the literature; for instance, unwanted pregnancies, STDs, and HIV/AIDS have been identified as sources of major concern for Latina women (Mays & Cochran, 1988). The origin of many of such problems can be traced to a single high-risk sexual practice: not using condoms during sexual intercourse (Kimball, González, & Zacarías, 1991; Panos Dossier, 1990). Women are afraid of victimization if they request their partners use condoms (Nyamathi, Flaskerud, Bennett, Leake, & Lewis, 1994), whereas men themselves indicate that they might physically injure a close partner if she suggested using condoms (O'Donell, Sandoval, Vornfett, & DeJong, 1994). These findings reflect the vulnerability of women in sex-related situations and further confirm the importance of gender-prescribed sexual behaviors in a particular socioeconomic and cultural context.

Misovich, Fisher, and Fisher (1997), in an extensive review of research on HIV/AIDS risk behavior among diverse populations, provide compelling evidence of the fact that being in a close relationship characterized by trust and exclusivity places both individuals at higher risk for unsafe sex practices, therefore increasing their risk for HIV/AIDS. These authors assembled a body of previously reported data that suggest that individuals engage in safe-sex behaviors mostly with casual sex partners, not with their stable partners. This was true for a variety of groups, including men and women from different ethnic backgrounds, gays and bisexuals, heterosexuals, adults and teenagers, and commercial sex workers.

The work of Misovich et al. (1997) also identifies the psychological processes that underlie risky sexual behavior, and it is evident from this review that, because of the context in which they express their sexuality, women are a vulnerable group for HIV/AIDS. Thus, a better understanding of this topic can only be advanced, first, by taking into account the sociocultural context of feminine sexual behavior and, second, by being aware of and rejecting prevailing false assumptions about female sexuality that have guided past research. For instance, Wyatt and Riederle (1994) have suggested that many misconceptions of female sexuality have their bases in long-standing, widely held stereotypes derived from research on men's sexual behaviors. These authors identified five such assumptions: (a) women have sufficient knowledge to understand their sexual needs; (b) women know how to communicate effectively about sex-related matters; (c) women have sex because they want to do so; (d) sexually active women enjoy sex; (e) if women know how to protect themselves against HIV/AIDS and STDs they will do so. Wyatt and Riederle (1994) debunk such myths using research findings of studies conducted with African American and Mexican American women. These authors suggest a research approach that incorporates the sociocultural con-

text of women's sexual practices; specifically, they recommend that investigators integrate and analyze both the women's knowledge about sexuality and the factors that influence their decisions to participate or not to participate in sex.

The scarcity of empirical data about the expression of sexuality among Mexican women in a cultural context that promotes traditional gender roles limits the possibilities of adequate interventions for rural women who might be exposed to HIV/AIDS. This study conducted with Mexican rural-origin women identifies specific sexual practices, coping strategies in sex-related situations, and fears and concerns regarding sexual intercourse. It further examines how these elements place women at risk for HIV/AIDS.

METHOD

Participants

Participants were 300 women, all born and raised in rural communities of the state of Jalisco, Mexico, which are characterized by their high level of mostly male migration to the United States. Participating women belonged to one of the following three groups. One group ($n = 100$) was composed of Mexican immigrant women who lived with their husbands in the United States (IWUS). These women migrated as adults or young adults and had lived in the United States between 1 and 10 years ($M = 6.7$ years; $SD = 4.7$). Women from the second group ($n = 100$) were married to migrant workers to the United States and were left behind (WLB) in rural "sending communities" of the state of Jalisco, Mexico. These women received their husbands' visits an average of once a year for periods that ranged between 2 and 8 weeks. The third group ($n = 100$) was formed by married women living permanently with their husbands and children in Mexico (WMX) in the same rural villages as the WLB.

Procedure

The IWUS participants were recruited in the office of the Mexican Consulate in the city of Los Angeles and through advertisements in a Spanish-language Los Angeles newspaper. The WLB and WMX participants were recruited using a snowball technique in five rural "sending" communities in Jalisco, Mexico. Participating women in all groups were selected based on the following criteria: (a) born and raised in one of the five rural villages of Jalisco, Mexico, identified as "sending" communities of immigrants to the United States (Arroyo, De León, & Valenzuela, 1991); (b) married; and (c) sexually active (reporting sexual activity with their spouses at least once during the year previous to the interview).

Five trained Mexican adult female professionals (psychologists and social workers) who were already knowledgeable about general interview techniques conducted face-to-face interviews. Additionally, they received specialized training in a 40-hour workshop, conducted over a 1-week period, that included role-playing, audio- and video-taping of mock interviews, and direct field supervision. Data were collected in the participants' homes in Mexico and in a private office provided by the Mexican Consulate in Los Angeles. Prior to the interview, all women were offered an explanation of the nature of the study and the types of questions to be asked. At this point, three questions were asked to select the sample based on the three criteria mentioned previously. Anonymity and confidentiality were assured. In addition, respondents were informed that their participation was voluntary, that they had the right not to answer any of the questions they did not want to answer, and that they were free to discontinue the interview at any point without penalty. None of the women whose participation in this study was requested refused to be interviewed. Because Spanish was the primary language of the sample, interviews were conducted in that language. Respondents received $5.00 or its equivalent in Mexican pesos for their participation in the study.

Materials

Data were collected during 1992 as part of a larger research project on sexual health among rural-origin Mexican women (Salgado de Snyder, 1993). The questionnaire was specifically designed for the study and was extensively pilot tested prior to its use. For the present contribution, which focuses on sexual practices and HIV/AIDS risk, the following sections of the instrument were selected for analyses: demographics, sexual history, sexual behaviors and their cognitive evaluation, HIV/AIDS knowledge, and communication and safe-sex negotiation. It should be noted that the sections appeared in the instrument in the same order presented here. To assess sexual practices, respondents were asked about specific sexual behaviors that they had ever engaged in and the level of tension and pleasure derived from such practices. The behaviors explored were (a) vaginal intercourse, (b) mutual masturbation, (c) receiving oral sex (cunnilingus), (d) performing oral sex (fellatio), (e) anal intercourse, and (f) oral–anal contact (rimming). For each behavior they endorsed, participants were asked on two separate 5-point scales (1 = *not at all* to 5 = *very much*) the perceived level of psychological tension and pleasure associated with the behavior.

HIV/AIDS knowledge was assessed with four open-ended questions: "What is AIDS?" "Do you believe it is contagious?" "What are the means of transmission?" "What are the means of prevention?" Responses for the last two questions were categorized into general content areas. We also asked about the participants' self-perceived risk for HIV/AIDS and why they felt this way. Then, we explored on a 5-point scale (1 = *not at all* to 5 = *very much*) how fearful they were that their husbands could transmit HIV/AIDS to them. Participants were also asked

Table 1

Sociodemographic Characteristics

	IWUS (n = *100*)	*WLB* (n = *100*)	*WMX* (n = *100*)
Characteristics	M (SD)	M (SD)	M (SD)
Age	31.2^{a} (7.7)	35.9^{b} (8.7)	32.5^{a} (8.5)
Education	8.5^{a} (2.9)	5.2^{b} (2.9)	6.7^{c} (3.6)
Years of marriage	7.9^{a} (7.6)	16.2^{b} (8.8)	12.8^{c} (8.8)
Number of children	2.5^{a} (1.9)	4.8^{b} (2.8)	3.6^{c} (2.0)
Spouse's education	8.7^{a} (3.4)	5.3^{b} (3.9)	7.2^{c} (4.5)
Occupational status*			
Housewives (%)	54	61	72
Generate an income (%)	46	39	28

Note: IWUS–Immigrant Women in the United States, WLB–Women Left Behind, WMX–Women in Mexico. Standard deviations appear in parentheses. Means in the same row that do not share superscript letters significantly differ from each other at $p < .001$ in F ratios obtained through one-way ANOVAs.
*$X^2(2) = 7.0$, $p < .05$.

to think about the last three occasions when they had engaged in sexual intercourse with their husbands and to mention their personal concerns about what might occur as a result of intercourse.

Finally, we were also interested in learning how the women in this sample cope with several potentially stressful sexual situations with their spouses. We asked three questions to explore the type of strategies these women use to deal with the following specific situations: communicating about sexually transmitted diseases and safer sex, arriving at the decision of having or not having sex with their spouse, and not wanting to have sex when their husbands demand it.

RESULTS

The sociodemographic characteristics of the three groups of women are described in Table 1. One-way analyses of variance (ANOVAs) were conducted to determine significant differences among the three groups. As can be seen in Table 1, when compared with IWUS and WMX, WLB are older ($F[2, 298] = 8.3$, $p < .001$), have been married for a longer period of time ($F[2, 298] = 23.9$, $p < .001$), have more children ($F[2, 298] = 21.5$, $p < .001$), and they and their partners have less education: themselves ($F[2, 298] = 27.1$, $p < .001$), their partners ($F[2, 298] = 18.1$, $p < .001$). Significant differences were found in the participants' occupational status ($\chi^2[2] = 7.0$; $p < .05$); most were housewives, but as shown in Table 1, many women were employed to generate an income (i.e., domestic employees or small-business clerks).

Sexual History

The women who participated in this study had intercourse for the first time at an average age of 19 years (range 13 to 35). The mean age of first sexual intercourse was 19.2 ($SD = 2.9$) for IWUS, 18.9 ($SD = 3.3$) for WLB, and 19.3 ($SD = 2.7$) for WMX. No significant differences were found for the rest of the variables described in Table 2. The number of sexual partners the participants had in their lifetime ranged from 1 to 6. As opposed to the other two groups, the IWUS reported having more than one sexual partner in their lifetime ($\chi^2[4] = 52.6$; $p < .001$). As to the frequency of sexual contact, no differences were found; the majority of women reported having intercourse with their husbands at least once a week. Also, as can be seen in Table 2, the respondents' degree of perceived satisfaction with their sex lives was somewhat congruent with their responses regarding experiencing orgasm most of the times they engaged in sex ($\chi^2[2] = 15.8$; $p < .001$).

Sexual Behaviors

Table 3 summarizes the data regarding participants' sexual practices and both the pleasure and tension they experienced for each of the identified sexual behaviors.

Vaginal intercourse was reported as the women's main sexual practice, followed by mutual masturbation, and receiving oral sex (cunnilingus) from their partners. Performing oral sex (fellatio) on their spouses was reported for at least one-fifth of the WLB and WMX, whereas the IWUS reported this behavior more frequently. The two least frequently reported sexual activities were anal intercourse and oral-anal (rimming) contact on their partners. Regarding the women's cognitive evaluations of pleasure and tension associated with each practice, as indicated in Table 3, the within-group t-tests conducted revealed that for the three groups of participants the level of pleasure was significantly greater than the level of tension for vaginal intercourse, mutual masturbation, and receiving oral sex. WLB and WMX reported the pleasure associated with performing oral sex as significantly higher than their

Table 2

Sexual History

Variable	IWUS (n = 100) M (SD)	WLB (n = 100) M (SD)	WMX (n = 100) M (SD)
Age at first sexual intercourse	19.2 (2.9)	18.9 (3.3)	19.3 (2.7)
Number of sexual partners*			
1	43.4%	82.8%	83.8%
2	38.4%	9.1%	8.1%
3 or more	18.1%	8.1%	8.1%
Have sexual contact at least once a week	86.9%	85.4%[a]	71.1%
Very satisfied with sex life	63.0%	53.6%	49.5%
Experience orgasm most of the time*	76.8%	62.6%	49.5%

Note: Standard deviations appear in parentheses.
[a]Sexual contact at least once a week when husband is in town.
$*p < .001$.

Table 3

Sexual Behaviors and their Cognitive Appraisals: Means and Standard Deviations

Sexual Behavior	IWUS (n = 100)	WLB (n = 100)	WMX (n = 100)
Vaginal intercourse			
Frequency	100%	100%	100%
Pleasure[a]	$M = 4.2$ (0.9)	$M = 3.7$ (1.2)	$M = 3.7$ (1.2)
Tension	$M = 1.7$ (0.9)	$M = 1.7$ (1.1)	$M = 1.9$ (1.3)
t	16.7**	9.3**	7.7**
Mutual masturbation			
Frequency	67%	55%	50%
Pleasure	$M = 3.9$ (0.7)	$M = 4.0$ (1.2)	$M = 3.9$ (1.1)
Tension	$M = 1.9$ (1.0)	$M = 1.6$ (0.9)	$M = 1.7$(1.1)
t	9.8**	9.6**	7.8**
Receiving oral sex (cunnilingus)			
Frequency	65%	26%	21%
Pleasure	$M = 4.0$ (0.9)	$M = 4.0$ (1.4)	$M = 4.5$ (1.1)
Tension	$M = 2.9$ (0.9)	$M = 2.2$ (1.1)	$M = 2.0$ (1.2)
t	10.2**	4.3**	4.9**
Performing oral sex (fellatio)			
Frequency	61%	20%	22%
Pleasure[b]	$M = 2.6$ (1.0)	$M = 3.0$ (1.2)	$M = 3.6$ (1.2)
Tension	$M = 2.1$ (1.4)	$M = 1.9$ (0.9)	$M = 1.6$ (0.9)
t	1.8	2.5*	4.8**
Anal intercourse			
Frequency	12%	10%	8%
Pleasure	$M = 2.0$ (1.2)	$M = 1.3$ (0.7)	$M = 1.2$ (0.7)
Tension	$M = 3.3$ (1.3)	$M = 3.7$ (1.7)	$M = 3.1$ (1.9)
t	2.2	3.1*	2.6*
Oral–anal contact (rimming)			
Frequency	4%	8%	2%
Pleasure	$M = 3.2$ (1.5)	$M = 4.0$ (0.7)	$M = 3.5$ (2.1)
Tension	$M = 2.5$ (1.9)	$M = 2.0$ (0.7)	$M = 2.0$ (0.0)
t	0.5	6.1**	1.0

Note: Standard deviations appear in parentheses. Within-group t-tests were calculated to find differences between levels of tension and pleasure. One-way ANOVAs were used to find differences among groups in levels of tension and pleasure.
[a]$F = 6.2$ (2,298); $p < .05$, IWUS significantly higher than WLB and WMX.
[b]$F = 6.3$ (2,298); $p < .05$, WMX significantly higher than IWUS.
$*p < .05$, $**p < .001$.

Table 4

AIDS Knowledge and Risk

Variable	*IWUS* (n = *100) %*	*WLB* (n = *100) %*	*WMX* (n = *100) %*
Perceived means of transmission[a]			
Sexual contact	92	86	82
Blood exchange	35	25	27
Needle use	12	5	28
Other means (saliva, physical contact, bathrooms, mosquito bites)	5	10	2
Don't know	3	7	7
Perceived means of prevention[a]			
Use of condoms	63	41	48
Marital fidelity	18	15	16
Sexual abstinence	12	10	10
Education/information	5	4	1
Other	4	6	11
Don't know	6	26	19
Feel at risk for HIV/AIDS			
Yes	26	36	27
No	74	64	73

[a]Participants gave more than one response; therefore percentages do not add to 100.

levels of tension, and they also reported a higher level of tension than pleasure associated with anal intercourse.

To determine differences in levels of pleasure and tension among the three groups, a series of one-way ANOVAs were conducted. Significant differences were found in pleasure associated with vaginal intercourse between IWUS and the other two groups of women. Significant differences were also found in the pleasure associated with performing oral sex, such that WMX reported significantly higher levels of pleasure than IWUS. It is important to point out that all participating women consistently rated anal sex with high levels of tension and low levels of pleasure. Overall, the data reported in Table 3 suggest that a larger proportion of IWUS, when compared to the other two groups, tend to engage in a wider variety of sexual behaviors than their counterparts who live in Mexico.

HIV/AIDS Knowledge

Most of the women in this study (97% IWUS, 95% WLB, and 89% WMX) knew about AIDS and believed it was contagious. Table 4 summarizes participant responses to two independent open-ended questions regarding perceived means of transmission and prevention of HIV/AIDS. The categories are not mutually exclusive; in fact, most respondents gave more than one answer. As can be seen in Table 4, when asked about how the virus was transmitted, participants gave both accurate and inaccurate answers, such as sexual transmission, blood exchange, and the use of needles, as well as saliva exchange and use of bathrooms. In terms of how to prevent transmission, the most common response by far was to use a condom. Other responses given by the participants were having only one sexual partner and sexual abstinence. It is interesting to note that about one-fourth of the women living in Mexico (WLB and WMX) responded that they did not know how to prevent HIV/AIDS.

As shown in Table 4, we found that the majority of women in all three groups *did not* feel at risk for acquiring HIV/AIDS (IWUS: 74%, WLB: 65%, and WMX: 74%). However, it is interesting to note that, when the respondents were asked about the reasons they did not feel at risk for HIV/AIDS, they did not mention at all the use of protection such as condoms during their sexual encounters. Rather, their reasons were based on their belief that their husbands were faithful and that they, the women, did not have sex with other men.

When asked to respond on a 5-point scale about how fearful the respondents felt about the possibility of contracting HIV/AIDS through sexual contact with their spouses, the women reported moderate levels of fear. However, the IWUS ($M = 3.7$, $SD = 1.4$) and WLB ($M = 3.3$, $SD = 1.7$) scored significantly higher than the WMX ($M = 2.7$, $SD = 1.8$) on this scale ($F = 8.9$, $p < .001$).

Women were asked to identify the consequences of sexual intercourse that preoccupied them the most. The majority of participants gave more than one answer. The responses of women living in Mexico (WLB and WMX) were: getting pregnant (47% and 46%, respectively), no concerns at all (36% and 35%, respectively), STDs (29% and 22%, respectively), and HIV/AIDS (26% and 21%,

Table 5

Communication and Sexual Negotiation

Variable	*IWUS* (n = *100) %*	*WLB* (n = *100) %*	*WMX* (n = *100) %*
Who makes the final decision regarding sexual activity?			
He	45	52	37
She	26	18	27
Both	29	30	36
How often does your husband make sexual demands on you?*			
Never	54	45	46
Sometimes	42	29	33
Most of the time	3	23	15
Always	1	3	6
What do you usually do when your husband demands sex and you do not feel like it?			
Give in and have sex	76	64	66
Refuse to have sex	24	36	34
Would ask husband to wear a condom*			
Yes	87	51	61
No	13	49	39
Has asked husband to wear a condom*			
Yes	73	37	49
No	27	63	51
Husband used a condom the last time they had intercourse			
Yes	26	12	18
No	74	88	82

*$p < .001$.

respectively). The responses of the IWUS have a different pattern: STDs (54%), HIV/AIDS (39%), getting pregnant (32%), no concerns (28%), and others (3%).

Communication and Sexual Negotiation

Table 5 describes the women's communication and sexual-negotiation strategies. A large proportion of women from all groups reported that their husbands made the final decision about sexual activity; no significant differences among the groups were detected in this variable. However, when asked how often their husbands made sexual demands on them (*exigen relaciones sexuales*), a significantly higher proportion of WLB and WMX, when compared to IWUS, reported that their husbands made demands most of the time and always ($X^2[6] = 22.6$, $p < .001$).

The third item on Table 5 shows that the majority of participants give in and have sex when their husbands demand it, even if they don't feel like having sexual contact (IWUS 76%, WLB 64%, WMX 66%). Although this finding did not reach statistical significance, it shows a clear pattern in the women's responses.

With regard to communication about safe sex, IWUS were more likely (87%) than the WLB (51%) and WMX (61%) to ask their husbands to wear a condom ($\chi^2[2] = 28.5$; $p < .001$). However, a smaller proportion of women in each group had actually asked them to do so ($\chi^2[2] = 24.7$; $p < .001$). Finally, as shown in Table 5, it is interesting to note that, although not significant, an even smaller proportion of women in each group reported that their husbands had worn a condom the last time they had sexual intercourse (IWUS 26%; WLB 12%; WMX 18%).

DISCUSSION

The findings of the present study indicate that rural women of Mexican birth remain at high risk for sex-related transmission of HIV/AIDS. Our data suggest that the single most important risk factor for HIV/AIDS among this group is that they lack the power to negotiate safe sex practices with their husbands. In traditional societies, such as the setting where the women who participated in this study were raised, cultural norms promote male dominance and female submissiveness, particularly in the sexual arena (Amuchástegui, 1995, 1996; Tuirán, 1995). Our results provide support for Wyatt and Riederle's (1994) contention that woman's sexuality is sur-

rounded by overgeneralizations and many misconceptions that do not reflect the reality of all groups in a society, particularly of those in disadvantaged conditions.

The women who participated in this study had information regarding means of HIV/AIDS transmission and ways of prevention; however, they did not use this information to evaluate their own risk. In fact, most of them indicated not feeling at risk for HIV/AIDS even when their responses to other questions placed them in a highly vulnerable group. The main reason for not feeling at risk was that they were loyal to their husbands and, in turn, assumed fidelity from them. These findings agree with those reported by Misovich et al. (1997), who, in an extensive review of the literature, suggested that being in a close relationship, characterized by commitment, is related to a high risk for sexually transmitted HIV/AIDS.

More than half of our participants reported giving in and having sexual intercourse with their spouses, even when they did not want to. Results from other studies conducted by the National Institute of Public Health in Mexico show that sexual intercourse and pleasing their husbands are a few of the many cultural obligations assigned to Mexican married women (Instituto Nacional de Salud Pública, 1996). It is important to note that a large proportion of our respondents said that their spouses never made sexual demands on them, which was a surprising finding, given that, in a similar study conducted with urban women in Mexico City, they reported frequent sexual demands (*exigencias*) from their partners (Pick et al., 1996). In light of these results, it is possible that the women in this project, because of the rural, more traditional context in which they live, did not perceive their husbands' demands as such, but as part of their obligations as wives.

Participants in this study were not selected in a random fashion; therefore, our findings cannot be generalized to all Mexican women from rural backgrounds. The snowball procedure that we used, however, seemed to be the most adequate approach, given the type of population that we were interested in (women who have been directly or indirectly involved in migration to the United States), the exploratory purpose of this study with rural women, and the intimate nature of the topic. Also, caution should be exercised when interpreting the responses of the immigrant women in the United States (IWUS). This group was socialized in a very traditional context and remain in a disadvantaged position in terms of education, occupation, and so on when compared to other groups in Mexico and the United States. It is possible that, in an effort to appear more similar to urban, more sophisticated women (open or flexible when it comes to sexuality), the responses of the IWUS reflect their desire to be more like urban women rather than their own real behaviors and attitudes.

Other methodological aspects that need to be addressed are that, contrary to our expectations, the women in this study openly discussed sensitive issues, such as details of their sexual lives, preferences, problems, and feelings associated with their sexuality. Further, many volunteered additional information regarding sex-related concerns. It was clear that the women felt comfortable talking with us about their intimate lives. Such disclosure can be caused by the fact that, for most, this was an opportunity to talk confidentially about their private concerns to someone qualified. When initial contact with respondents was made, interviewers introduced themselves as psychologists or social workers from the Mexican Ministry of Health.

Our findings offer some relevant suggestions for the development of intervention programs. First, it is necessary that prevention strategies not separate the risk of infection from the psychological, social, economic, and cultural contexts in which women live. Thus, it is important to take into consideration the wide diversity of beliefs, opinions, and behaviors of women with regard to their bodies and the expression of sexuality that is rooted in their ethnoculture and in the socialization practices in their communities of origin. Scholars must acknowledge and familiarize themselves with research conducted in countries other than the United States. Such knowledge could prove useful to contextualize findings obtained from studies with minority groups in the United States and to better design programs and policies targeted at particular ethnic groups. Moreover, intervention programs for disadvantaged minority women should not be based solely on findings derived from research with young White college females, who are the main participants in psychological AIDS-related attitudes-and-behaviors studies in the United States (Squire, 1993; Ussher, 1993).

Adequate interventions must acknowledge and emphasize the importance of women's role in all societies, not only for their reproductive function but also as productive members of society. Such programs should be realistic and teach women how to cope with stigmatization and their lesser power compared to men in the sexual, social, and economic arenas, as well as to assess their own risk for HIV/AIDS. To pose psychologically empowering cognitive changes like the increase of self-esteem or personal efficacy as the solution to high-risk practices is to ignore the disempowering social constraints that contextualize the lives of poor minority women. As suggested by Deren, Tortu, and Davis (1993), empowerment models may not be functional among groups in which day-to-day living is a constant reminder of disempowerment.

Finally, it is more realistic to think that the successful avoidance of HIV/AIDS risk associated with sexual behaviors will only be possible when women have the economic and social power to say "no" to their male partners without risking their lives for having made such a decision. Unfortunately, the overall dominance of men in traditional societies precludes women from taking control of their own lives, as illustrated by a quote taken from a report by the Women and AIDS Resource Network (WARN): "Females who are powerless in a male domi-

nated society are just as powerless in a male dominated bedroom. . . . With the coming of AIDS, the age-old battle of the sexes is literally becoming a life-and-death struggle for women" (quoted in Lips, 1991, p. 118).

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