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Eduardo Alvarez

Massachusetts College of Pharmacy & Health Science

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Mexicans in the U.S and HIV: Reviewing Social and Cultural Factors

Eduardo Alvarez

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Professor Ginsburg

There are approximately 33.7 million Hispanics of Mexican origin in the United States, and are projected to continue growing for the foreseeable future (Pewhispanic.org, 2013). Sexual health, in particular, exemplifies gaps present between Hispanics of Mexican origin and the general population. Higher rates of Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STI's) highlight health disparities afflicting this community (CDC.gov, 2016). This discrepancy has been the focus of numerous attempts from a myriad of health organizations, but has had little success on reducing contraction of HIV and STIs within the Mexican-origin population in the United States (Hunter, et al., 2007). With the hopes of determining methods to better address higher incidences of risky behaviors that contribute to the transmission of sexually transmitted diseases within the Mexican origin population, this paper will examine Marianismo, Machismo, Familismo, and Curanderismo's influence on gender roles. Understanding the complexity of how attitudes towards sexuality, fidelity, and lay definitions of health within the context of the American health care system is crucial to successfully treat this particular population. Mexican immigrants in the United States continue to face obstacles that disproportionately affect their sexual health, and developing strategies to overcome these challenges should incorporate consideration of cultural beliefs and social constructs that could promote or inhibit accessibility and reception to sex education and treatment.

Distinguishing Mexican-origin communities from a simply Hispanic population is important given that stigmas related to machismo and femininity affect this population differently (Getrich, et al., 2012). Since the 1980's, Mexicans immigrated to the United States in record numbers, with over 66% migrating from 1990 and on. Currently, approximately 11% of the overall population in the United States is Hispanic of Mexican-origin. Los Angeles alone has 4.5 million Latinos, 75% of which are of Mexican origin (Alcala, et al, 2016). Although the rate

of Mexican migrants coming to the United States has started to decrease in the past decade, Mexican Migrants are not leaving (U.S. Census Bureau, 2014). The result is a Mexican Immigrant population that is living in the United States longer (U.S. Census Bureau, 2014). Given this, it's important to recognize that the United States will continue to have a significant portion of it's population originating from Mexico.

However, of the 11.4 million Mexican immigrants in the United States, only 16% have become U.S citizens, 59% have not received a high school diploma, 57% are uninsured, and 27% live in poverty (PewHispanic.Org, 2013). These socioeconomic characteristics reduce healthcare accessibility at the systematic level, discouraging Mexicans in the United States from visiting physicians annually and decrease the rate of emergency services utilized by this population (Alcala, Et al, 2016). Yet, even Mexican-origin communities that are insured, either immigrants, first or second generation, do not make full use of health services available (Bustamante, et al., 2012).

Unfortunately, preventable sexually transmitted diseases within the Mexican-origin community continue to occur at greater rates compared to other racial/ethnic group in the American population (Cancer.org, 2014). Sexual health proves to be a major difference between the general population and the Hispanic population, consistently demonstrating greater rates of HIV, Chlamydia, and other STI contraction (CDC.gov, 2014). According to the Centers for Disease Control, Latinos and Hispanics made up 21% of new HIV diagnoses in the United States, despite making up 17% of the population. (CDC.gov, 2014), Additionally, there are over twice the rate of cases of gonorrhea in this population compared to whites, and almost three times as much cases of Chlamydia (CDC.gov, 2014). The lack of insurance alone cannot account for decreased utilization of sexual health resources (Alcala, Et al, 2016). Even if this population

becomes sufficiently insured, there are still difficulties at the clinical and social levels that maintain sexual health disparities (Bustamante, et al., 2012). Therefore, these factors must be identified and addressed appropriately to improve health service accessibility.

Behaviors that contributed to the development of AIDS among Mexican immigrants were the lack of condom use, engaging in risky sexual behavior, and not having HIV testing (Martínez Donate, et al., 2015). While these risk factors are preventable, religious and social stigmatization present within the Mexican community generate feelings of shame and embarrassment. These feelings discourage Mexican migrants from seeking health services, such as HIV testing. An estimated 20% of HIV positive Mexican migrants are unaware of their condition, and contribute to the spread of the virus (Hall HI, et al., 2013). To further complicate the situation, the lack of healthcare accessibility prevents this population from seeking regular testing, given their higher risk for acquiring the disease. Unfortunately, 43% of Mexican migrants develop AIDS within a year of their HIV diagnosis (Espinoza, et al., 2012).

Marianismo, the social construct that defines a women's role as a caregiver and emphasizes the value of virginity, self-sacrifice, and sexual morality, originates with Mexico's heavy devotion to the Virgin Mary (Hussain, K.M, 2015). This intense following that transcends religious affiliation among the Mexican population as a whole instills values within these communities that are reflective of the religious figure itself (Hussain, K.M, 2015). Because of this, any behaviors that contradict this outline for a good Mexican woman are stigmatized. Yet, behaviors such as not using condoms and avoiding routine testing are still present, and rather than being addressed, they are often ignored out of internalized stigma (Luque, et al., 2014).

In addition to reduced acknowledgement of potential risk factors, resources to receive health services are more than often limited. Transportation, Time, and Money were major

barriers to Mexican Immigrants as a whole (Luque, et al., 2014), but a desire to value their role as caregivers creates an additional problem. Instead of utilizing what few resources are available to them to seek healthcare services, they prioritize their children's needs. While a mother's role as a caregiver is common among other ethnic demographics, Marianismo emphasizes the requirement of Mexican women to be selfless and value children above everything else (Mendez-Luck, et al., 2016).

Because the role of a Mexican woman is heavily shaped by her honor as a virgin or as a woman in a monogamous relationship, contradictory behaviors generate negative perceptions of the value of women, preventing Mexican immigrant women from admitting to risky sexual behavior (Mendez-Luck, et al., 2016). Women who follow the virtues defined through Marianismo gain social status and honor, and those who do not conform face penalizing negative perception from peers (Mendez-Luck, et al., 2016). This social construct, however, does not erase the percentage of Mexican women who become infected with a sexually transmitted disease. While reported rates of risky behavior, such as having multiple sexual partners, are less compared to non-white Hispanics (Lin. L, et al., 2015), higher incidence rates STI's indicate a discrepancy (Luque, et al., 2014). Despite a general tendency of fewer partners reported by Mexican origin women in the United States, there still remains an unusually high rate of STI infection, and HIV is still significantly prevalent among the Latino community living in the United States compared other ethnic and racial groups (CDC.gov, 2016). So, if these women do not share the same risky behaviors at the same degree to other groups, men might be the ones who are contributing to this health issue.

Mexican male gender roles are heavily influenced by Machismo, a social construct that defines men as the decision makers and breadwinners of the household (Arciniega, et al., 2008).

Additionally, it dictates that men must be hyper masculine, encouraging aggressive sexual attitudes and allocating power to men within heterosexual relationships (Arciniega, et al., 2008). Although machismo has been perceived to be simply aggressive behavior and a completely negative aspect a culture, it's is not viewed the same way by Mexican men who tend to value positive attitudes that benefit familismo, spirituality, dignity, responsibility, and hard work (Arciniega, et al., 2008). Recognizing the positive aspects that accompany machismo offers greater insight into the dynamics of Mexican Immigrant men's attitudes towards sexual health and reception to preventative health efforts. Arciniega and others separate these two characteristics of Machismo into Traditional Machismo, which subscribes to notions of hyper masculinity, and Caballerismo, which encompasses the values of "social responsibility and emotional connectedness" (Arciniega, et al., 2008). Regardless of this distinction between the negative and positive values of machismo, they both have influence on the Mexican origin community within the United States.

Feelings of loneliness are prevalent within male Mexican immigrant communities, especially if they leave a spouse in their home country (Zhang, et al., 2016). For some of these men, the desire to have intimate relationships becomes problematic, as they live within communities they are unfamiliar with (Wagoner, et al., 2015). This social environment drives these lonely men to solicit services from sex workers (Zhang, et al., 2016)). In conjunction with lower understandings of correct condom usage, these men are at increased likelihood for contracting an infectious disease (Zhang, et al., 2016). Perceptions of fidelity and not using condoms are due to Mexican origin Latinos interpreting condom use as a lack of trust (Hirsch, et al., 2002). Hirsch concludes, "If infidelity represents a breach of trust—and an STD or HIV is the ultimate evidence of that breach—then every act of sex without a condom is a mutual

performance of trust.” (Hirsch, et al., 2002). Therefore, not only is condom use reduced, seeking HIV and STI testing also brings the potential unraveling of the trusting relationship between Mexican migrant partners (Luque, 2014).

Because immense value is placed on a man’s ability to provide for their family, illness could mean that these men will no longer be able to fulfill this responsibility. Since so much of their male identity depends on their role as a provider, these men avoid seeking services that would categorize them as ill (Sobral, 2004). Should a Mexican man be diagnosed with HIV or AIDS, not only is he subjected to being labeled as sick, but his infidelity is revealed. Both misconceptions about casual contraction of HIV, from public bathrooms, spit, or a mosquito bite (Hernandez, 2012), and contradictions to the responsibility of a man to his wife create intense stigmatization against HIV positive men within the Mexican immigrant population (Arciniega, et al., 2008). The result of these social and cultural frameworks is fear of being tested for STD’s altogether.

Misconceptions about casual contraction of HIV pose a large threat to HIV positive Mexican immigrants because they rely heavily on social support (Alcala, et al, 2016). Without the help of their family and friends, a major source of information and financial support could be damaged due to fear of contracting HIV by using the same bathroom facilities or through contact with spit (Wagoner, et al., 2015). As a result, these individuals are more likely than not to be left untreated and alone (Organista, et al., 1998). Because so many Mexican origin migrants tend to avoid engaging in educational programs offered by Health organizations in the United States, these misconceptions prove to be a difficult hurdle to overcome in the effort to improve sexual health education and provide adequate preventative skills and resources to Mexican immigrant communities (Sanchez, et al., 2012).

For people within this culture, illness is typically defined when pain and discomfort is so great they are no longer able to work or provide for the family (Zoucha, et al., 2003). Good health is awarded by the maintenance of spirituality and faith, and sinful behaviors are met with punishment in the form of illness (Shernoff, et al., 1999). However, there also exists a folk perspective on illness that adds another dimension to the issues of sexual health. Because Mexican immigrants do not have access to health services to the same degree as other groups within the United States, botanicas (Traditional herbal stores) and curanderos (traditional folk healers in Latin America) provide the support this community seeks (Shernoff, et al., 1999). Religious institutions like the Catholic Church deliver morals that tend to ostracize members who diverge from moral sexual behaviors, causing HIV infected Mexican migrants to lose valuable support systems (Shernoff, et al., 1999). Despite efforts from some catholic churches to reach out to its followers suffering from HIV and AIDS, stigmatization from the Latino community diminishes the overall availability for these supportive resources (Shelby, et al., 1999). Instead, curanderos and botanicas serve as support, free from the catholic morals that contribute to judgmental attitudes (Shelby, et al., 1999).

Curanderos and the use of herbal remedies foster a sense of control through their holistic approach to illness (Shernoff, et al., 1999). In the case of HIV, an incurable disease in the current state of medical knowledge, curanderismo provides an avenue of interpreting and addressing the disease without the need of the catholic institution, and other social support networks that are hampered through stigmatization of the disease (Shernoff, et al., 1999). Curanderismo practices and beliefs then become a valuable resource to those seeking some support where others have failed them, and bypass the American healthcare system which requires routine monetary payment and time (Ortiz, et al., 2009). Yet, there is no conclusive understanding of how

widespread the practice is in the United States. Documentation of its use is troublesome, as some reports indicate only around 4.2% of the Latino population have visited a curandero in the previous year since interviewed (Higginbotham, et al., 1990), and still others report 29.1 % surveyed participants have visited one in their lifetime, and 40.7% of them visited one within a year (Padilla, et al., 2001). What's more problematic is the perceived stigmatization on curanderismo practices by the American healthcare system, and people have been found to refuse to report their use of folk remedies and beliefs of illness (Sobral, et al., 2006). Unfortunately, a relevant statistical understanding of the prevalence of curanderismo in the U.S has not been made yet, and despite knowing that individuals with HIV have reportedly turned to curanderos and botanicas for support with their illness, generalizations about how widespread their use is in the United States cannot be made.

While Marianismo and Machismo negatively influence sexual health services and education seeking behaviors throughout the Mexican immigrant population, they also can promote positive attitudes about family, and provide a sense of responsibility and dedication in the right contexts (Arciniega, et al., 2008). Self-sacrifice and prioritizing the wellbeing of the family is the cornerstone to familiarismo, which provides a framework for the values and responsibilities of members of a household to strive to maintain the wellbeing of everyone (Comeau, et al., 2012). It works parallel to both the virgin mother like nature of marianismo and the paternal caballerismo elements in machismo (Arciniega, et al., 2008). The result is intense value on family by Mexicans who follow traditional gender roles, in this case primarily Mexican immigrants in the United States (Comeau, et al., 2012). By understanding this social dynamic, we can potentially develop novel approaches that promote healthy sex behaviors and encourage regular testing.

Instead of making sexual health education programs focus entirely on the details of utilizing services and modes of transmission, it's important to humanize and relate the importance of why preventative efforts and accurate understandings of HIV and other STD's are necessary to maintaining a responsibility to family. Encouraging the use of condoms to protect their spouses from venereal diseases, again fulfilling a responsibility that shapes the male gender role (Arciniega, et al., 2008). Radio dramas and comic strips have been created in the past that successfully increased the use of condoms in Mexican immigrant fathers, highlighting the potential for their family members to become infected if they were to continue engaging in unprotected sex (Organista, et al., 2004). However, it's also important to understand that for many of these migrant men, it can be incredibly embarrassing to discuss the proper use of condoms and modes of transmission of disease, especially if the instructors of these programs are not Latino or male (Wagoner, et al., 2015).

Perceptions of gender influence attitudes about having female Health Advisors or community members lead sexual health programs, motivating participants' desire to have male support networks (Wagoner, et al., 2015). For instance, Male participants in one study worried Latina women would interpret questions regarding sexual health as aggressive (Wagoner, et al., 2015). Because of their reluctance to discuss sexual health resources with women in combination with Latino Immigrant men's reliance on their social networks for information, reliable access to information about healthcare education and facilities is severely limited (Rodríguez, et al., 2009). Unless Males within a Latino immigrant man's social circle are aware and willing to share health resources, access to sexual health services are virtually unavailable (Wagoner, et al., 2015). This emphasizes the need for Male Lay Health Advisors, not only as guides, but also as trustworthy support figures.

Topics involving condom use, sexual behavior, and sexually transmitted diseases were met with opposition and reluctance from participants, but Navegantes (Lay Health Advisors from HoMBReS: Por un Cambio program) were eventually able to build enough confidence within their group to facilitate discussions (Wagoner, et al., 2015). By utilizing incremental steps to build trust, Navegantes successfully motivated participants to become involved and informed (Wagoner, et al., 2015). Without this investment in building relationships that promote discussion, negative attitudes and misconceptions about condom use and sexual behavior cannot be addressed with significant success within male Latino Immigrant communities. Illustrated by the Navegantes Program, initiating community health interventions that may be rejected due to societal norms, such as those established by machismo must be gradually introduced by starting discussions about relevant and non-controversial topics to Latino men. Topics regarding documentation status, job hunting, or even sports were crucial in this case to foster a comfortable climate and trustworthy relationship between participants and the Navegantes (Wagoner, et al., 2015).

Overall, any health programs that are geared towards this community must first establish a comfortable environment for both males and females (Ibañez, et al., 2016). With males, utilizing male lay health advisors has proven to be useful, especially if they are already trusted leaders of the community (Wagoner, et al., 2015). Additionally, these healthcare approaches must invest time developing these relationships to foster trust and ensure that participants have a means of support (Rodríguez, et al., 2009). For many of these Mexican men in the United States, social networks tend to be weaker due to the hyper masculinity element in machismo that has been demonstrated to increase antisocial behavior (Arciniega, et al., 2008), and participants in prior programs have also reported a lack of social support from men in their community

(Wagoner, et al., 2015). After fostering a comfortable environment for these men, gradually transitioning into the topic of sexual health, and ensuring that these men share their understanding and experiences is necessary to understand the specific issues they face.

Community interventions focused around skill development for Mexican Immigrant women have found that education on proper condom usage, conversational skills between women and their partner, and prevention resources made readily available were crucial (Ibañez, et al., 2016). Instead of going in great depth, introductory material and illustrated diagrams about female and male modes of transmission, as well as clear distinctions between HIV and AIDS were voiced by these women as useful to them, as some of their understandings of HIV were incorrect (Hernandez, 2012). While most of these suggestions would be relatively easy to implement, overcoming the discussion aspect of this strategy remains to be the greatest issue (Mitrani, et al., 2013). Because the use of a condom for this community both deviates from religious norms, and implies a lack of trust between both partners, motivating the Mexican migrant community to begin utilizing condoms regularly poses a great challenge (Hirsch, et al., 2002). Interestingly though, *marianismo* and *machismo* compliment one another, so instead of simply focusing on Mexican women when attempting to decrease rates of sexually transmitted diseases, involving men as an active component to preventative efforts may prove helpful. Common goals towards maintaining family and being protective of the members of the family exemplifies the qualities instilled by *familismo*, and emphasis on the necessity for the prevention of illness to ensure that men and women will be able to continue caring for children being able to continue working can be useful (Campos, et al., 2014). These social responsibilities, which hold tremendous value to these individuals, provide an opportunity to develop intrinsic motivation to developing less risky sexual behavior.

Addressing misconceptions about HIV is necessary, while most of the Mexican origin migrants in the United States understand that sexual contact and blood contact are primary modes of transmission for the virus, there are still beliefs that contact with spit or transmission of mosquito bites could infect nearby people (Hernandez, 2012). As a result, HIV positive Mexican migrants are often stigmatized and left isolated by family and friends out of fear (Shernoff, et al., 1999). Because the unique circumstances of these migrants, support systems from healthcare institutions are not the most reliable (Alcala, et al, 2016), and cultural elements, such as religious and moral perspectives on sexually deviant behavior, further ostracize this community (Shernoff, et al., 1999). Therefore, campaigns to humanize and inform these communities about the accurate modes of transmission, while at the same time debunking misconceptions, are necessary to prevent social support from diminishing among the HIV positive Mexican migrants.

Asking HIV positive patients about their interpretations of their state of health could be useful when trying to provide the patient with a means of grasping the concept of the illness (Shernoff, et al., 1999). Because HIV does not necessarily mean symptoms appear, it might be difficult for a Mexican migrant patient to fully recognize that they are ill (Shernoff, et al., 1999), so developing a patient's narrative of the illness could realize this task. HIV's incurability could potentially be challenging for some of these patients to grasp, and if they believe in curanderismo it might be beneficial by providing these patients with a means of finding some semblance of control in addition to using antiretroviral medication (Ortiz, et al., 2009).

When gathering the research to understand how prevalent use of preventative health care among Mexican origin immigrants, many articles were found to generalize Latino and Hispanic populations within the United States. While useful information specific to this sub-population was found, most resources available tended to provide little to no distinction in their data

collection to properly categorize these groups. The reason this is of concern is because these communities are heterogeneous, and truly understanding the specific issues that need to be addressed to particular communities is hindered as a result. Therefore, in addition to supporting the Mexican origin community by considering the social and cultural elements that shape their interpretations of sexual illnesses and their gender, research that properly distinguishes Puerto Rican, Dominican, Cuban, and other Hispanic and Latino communities within the United States when collecting information about HIV or other diseases is crucial.

Although these social constructs and cultural elements have been documented in numerous studies, it's important to understand that these are not indicative that all migrant Mexicans subscribe to these understandings. For the most part, they are present to some degree, but acculturation contributes to changing attitudes overall (Campos, et al., 2014). These gender elements are most relevant to individuals that have been brought up under these traditional definitions of what men and women must be like, which continues through first and second generation Mexican-Americans (Campos, et al., 2014). Spiritual elements, such as Catholicism and curanderismo, also decrease in their influence depending on how much the perspectives of these individuals change once experiencing a new social climate in the United States (Ortiz, et al., 2009). This does not discredit the presence of these elements, but it should serve as a warning against generalizing this population. Again, these social and cultural elements provide an understanding of why certain behaviors might be more difficult for the Mexican migrant population to adopt in regards to sexual health, but each individual must be treated without using these elements prematurely (Shernoff, et al., 1999). Before anything, the individuals, male or female, must define their own perspectives on sexual health, and then healthcare providers must work with those understandings to develop new definitions of healthy sexual behaviors that take

into consideration the social and cultural elements the patient is influenced by, whether they are machismo, marianismo, curanderismo, or familismo.

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