Sexuality, gender and HIV risk perception among Mexican indigenous women[1]

Sexualidad, género y percepción del riesgo a la infección por VIH en mujeres indígenas de México

Mariana Juárez-Moreno[a]
https://orcid.org/0000-0002-6921-4678
Email: maju_84@hotmail.com

Oresta López -Pérez[b]
https://orcid.org/0000-0003-0994-4545
Email: lopez.oresta@gmail.com

Lydia Josefa Raesfeld[a]
https://orcid.org/0000-0002-2589-9628
Email: lydiaraesfeld@gmail.com

Rosa Elena Durán-González[a]
https://orcid.org/0000-0001-8121-5019
Email: rosidurang@gmail.com

[a]Universidad Autónoma del Estado de Hidalgo. Instituto de Ciencias Sociales y Humanidades. Pachuca de Soto, Hidalgo, México.

[b]El Colegio de San Luis A. C. Laboratorio de Interculturalidad, Género y Derechos Humanos. San Luis Potosí, México.

Abstract

This research aims to understand the sexuality and gender practices of indigenous women, their knowledge and perception about HIV infection risk. For this purpose, an exploratory descriptive research was carried out, with a qualitative method, in which a semi-structured interview was applied to indigenous women from rural communities in Mexico. The results show that gender stereotypes mark substantial differences between men and women. Technological changes and migration have led to changes in access to information and family dynamics. Women are provided with more information on sexual and reproductive health in the public sphere, but this is not reflected in the private sphere, where it is difficult for them to discuss these issues with their family members, mainly their partner, which limits their control over their sexual and reproductive health. There is a lack of knowledge about HIV and others STI. Most women do not perceive themselves to be at risk of infection, and, at the community level, people with HIV are segregated. It is necessary to design, in collaboration with them, interventions with an intercultural approach and a gender perspective.
Keywords: Sexuality; Gender Identify; Indigenous Culture; HIV Infections; Perception.

Correspondence
Mariana Juárez-Moreno
Universidad Autónoma del Estado de Hidalgo. Instituto de Ciencias Sociales y Humanidades. Carretera Pachuca-Actopan, km 4.5, s/n, San Cayetano el Bordo. Pachuca de Soto, Hgo., México. CP 42084.

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Resumen

La presente investigación pretende conocer las prácticas en torno a la sexualidad y el género de las mujeres indígenas, sus conocimientos y percepción de riesgo a la infección por VIH. Para ello, se realizó una investigación descriptiva exploratoria, con método cualitativo, en la cual se aplicó entrevista semiestructurada a mujeres indígenas de comunidades rurales en México. Los resultados muestran que los estereotipos de género marcan diferencias sustanciales entre hombres y mujeres. Los cambios tecnológicos y la migración han originado cambios en el acceso a la información y en las dinámicas familiares. A las mujeres se les da más información sobre salud sexual y reproductiva en el ámbito público, pero esto no se refleja en el ámbito privado, en que les resulta difícil hablar estos temas con sus familiares, principalmente su pareja, lo cual impide que tengan control sobre su salud sexual y reproductiva. Existe un desconocimiento sobre el VIH y otras infecciones de transmisión sexual; la mayoría de las mujeres no se percibe en riesgo de infección, y a nivel comunitario se segrega a las personas con VIH. Es necesario diseñar, en colaboración con ellas, intervenciones con un enfoque intercultural y con perspectiva de género.
Palabras clave: Sexualidad; Identidad de Género; Cultura Indígena; Infecciones por VIH; Percepción.

Introduction

Latin America is one of the most unequal regions in the world, where race, ethnicity, gender and social class are relevant factors in determining levels of poverty and inequality. This is reflected in indigenous women, who experience triple exploitation because of race, gender and class (Del Campo, 2012).

Indigenous peoples in Latin America are considered a vulnerable population, due to their high prevalence of diseases, lack of health services, and high morbidity and mortality rates (Karver et al., 2016). 79.3% of the indigenous population in Mexico lives in conditions of poverty and extreme poverty. The municipalities with the highest levels of illiteracy in the country are made up of 40% or more of the indigenous population, and mortality rates from contagious diseases among the indigenous population are double the national average (México, 2012).

Regarding contagious diseases, in Mexico, the AIDS epidemic in rural areas is more recent, with an exponential growth due to the lack or difficulty of access to information, health services and precarious conditions, together with the increase in migration in search of better opportunities for living (Pavía et al., 2012). For Terán, Díaz and Cubillas (2016), the vulnerability of a population facing a health risk is determined by structural inequities, such as sociodemographic aspects, poverty, cultural practices and educational level. Vulnerability in relation to HIV means having little or no control over the risk of infection, and is the result of the interaction of individual, social, cultural, demographic, legal, economic and political factors (Quintal; Vera, 2014).

Physically and socially, women are more vulnerable to HIV infection than men are. Physically, male-to-female transmission during sexual intercourse is two to four times more likely than female-to-male transmission, due to the larger surface area of exposure of women and the higher viral load in semen than in vaginal fluids (García, 2005; Quintal; Vera, 2014). Socially, gender imposes on women a series of assignments that go beyond the biological and reproductive

spheres, assigning them characteristics, functions, responsibilities and rights (Lamas, 1986). In addition, it is a system that regulates and disciplines us (Butler, 2006), causes power relations, which produce and reproduce social inequality between men and women (Segato, 2016), and determines the degree of autonomy of each person in relationships (García, 2005).

Gender, class and race manifest their structures of domination and subordination in sexuality (Ariza; Oliveira, 2005). Gender inequalities are learned in sexual stereotypes, which are social norms that we learn from childhood, are incorporated into our self-concept and become part of our identity; they are generally accepted, little questioned and contribute to the way we express our sexuality (Pérez-Jiménez; Orengo-Aguayo, 2012).

These inequalities mean that men have the power in relationships and in their sexual relationships; for them, sexual relationships represent an affirmation of their sexuality, thus justifying having multiple sexual partners. This means that for many women, the main risk factor for acquiring HIV infection is their partner's sexual behavior. In most relationships, women are unable to negotiate condom use (Gala et al., 2007; Noboa; Serrano, 2006).

In indigenous communities, gender relations have evolved because of political, economic and religious changes, which have led to new forms of socialization (Reartes, 2016). Despite these changes, women still live in conditions of social inferiority, which generate relationships of submission and dependence on men, and the variety of roles they play makes it difficult for them to take care of their physical and emotional health (Noboa; Serrano, 2006). These situations increase their vulnerability to HIV infection impeding them to identify the risk of infection to which they are exposed and the actions that violate their human rights, mainly their sexual and reproductive rights (Karver et al., 2016; Rangel; Martínez, 2017).

The prevention strategies used by the health sector are generalized to the entire population, and these do not work in indigenous communities. We agree with Terán, Díaz and Cubillas (2016) in recommending that before implementing an intervention it is necessary to understand the perspective and knowledge of the population about health care, in order to design the intervention according to their beliefs and customs considering their concerns and involving people from the communities.

In sexuality, risk perception is related to the social constructions attributed to sexuality, which are built from social norms and explanations about the nature and functioning of things in the sexual plane (Gayet et al., 2011); in addition, personality, impulsivity and sensation seeking of each person have to be considered (Murray et al., 2013). In indigenous communities, there is also a lack of knowledge regarding the conceptualization of risk; it is not known if the risk for indigenous people is similar to the one used in science.

Methodology

The objective of the research was to identify the practices around sexuality and gender of Mexican indigenous women, their knowledge and perception about HIV infection risk. The field study was conducted from October to December 2018.

This is an exploratory descriptive research, with a qualitative method, in which a semi-structured interview was used as a data collection tool, in which some trigger questions were asked on the following topics: gender, sexuality and HIV. Fifteen interviews were conducted with indigenous women from rural communities in the states of Hidalgo and San Luis Potosí. In the analysis of the information, some categories were pre-established and others emerged from the discourse of the participants.

Ethical considerations

The project followed the recommendations of the International Ethical Guidelines for Health-Related Research Involving Human Subjects, developed by the Council for International Organizations of Medical Sciences (Cioms) in collaboration with the World Health Organization –WHO– (OPS; Cioms, 2017). The women who were invited to the study received information about the study, about the use of the information, and it was explained to them that they could interrupt the interview if they felt uncomfortable. They signed

the consent form, so that their data were handled confidentially and anonymously.

Results

Characterization of participants

Eight interviews were conducted with women from three rural indigenous communities in the state of Hidalgo, and in the state of San Luis Potosí, seven women from six rural indigenous communities were interviewed, resulting in 15 interviews. The women in Hidalgo belonged to the Nahua ethnic group and in San Luis Potosí to the Nahua and Tének ethnic groups. The age of the participants ranged from 20 to 59 years, with an average of 33.6 years. The characterization of the participants is shown in Table 1.

Table 1 – Characterization of the women participating in the study

Interviewee	Origin	Age	Schooling	Occupation	Marital status
1	Hidalgo	26	Elementary	Homemaker	Separated or divorced
2	Hidalgo	42	Elementary	Homemaker	Married
3	Hidalgo	32	Secondary	Homemaker	Free union
4	Hidalgo	20	Secondary	Homemaker	Separated or divorced
5	Hidalgo	21	High school	Homemaker	N.S.
6	Hidalgo	32	Elementary	Homemaker	Married
7	Hidalgo	59	Illiterate	Homemaker	Married
8	Hidalgo	27	Secondary	N.S.	Separated or divorced
9	San Luis Potosí	34	Graduate	Employed	Free union
10	San Luis Potosí	38	Elementary	Employed	Separated or divorced
11	San Luis Potosí	46	Graduate	Homemaker	Married
12	San Luis Potosí	31	Graduate	Employed	Married
13	San Luis Potosí	47	Elementary	Homemaker	Married
14	San Luis Potosí	25	Graduate	N.S.	Single
15	San Luis Potosí	24	N.S.[1]	N.S.	Free union

[1]N.S.: Not specified

Characterization of the socio-cultural context

In Hidalgo, 51.7% of the population is female, 14.2% is indigenous and 50.6% lives in poverty. In San Luis Potosí, 51.4% of the population is female, 10% is indigenous and 45.5% lives in poverty (Inegi, 2018). In terms of the Marginalization Index (MI)[2], San Luis Potosí and Hidalgo are considered to have a high degree of marginalization at the national level (Conapo, 2015).

In Mexico, one out of every ten people is indigenous. In 2015, 16.3% of the indigenous population did not have access to health services and 38.1% were in school lag, this is equivalent to more than double the country's total population. 17.8% of the indigenous population was illiterate, which is much higher than the national illiteracy rate of 5.5% (Unicef; Inee, 2018). At the national level, 61.5% of the illiterate population is female (Inegi, 2018).

The following are the most important findings in the interviews regarding knowledge and practices on the topics of gender, sexuality, sexual health, contraceptive methods, HIV, and the perception of risk of HIV infection.

Gender

In indigenous communities, gender roles are very marked. Men's space is considered public space and women's space is considered private space. Men are considered the providers of the household, and it is not customary for them to be involved in child rearing or housework.

> *The men's activities are in the fields, or outside, sometimes there are activities for women outside, such as sweeping, but the outside is for the men, because it is hard.* (E3)

> *They only work, bring food, money, take care of their families, but they don't help us in the house, or take care of the children, because they say this is women's work.* (E8)

> *They do things we can't do or go to places where we can't go with them. When I had a husband, we never were together anywhere, he always was with friends and I was with my mom and sisters.* (E9)

Some women recognize that the social practices of the community are sexist.

> *When a man is unfaithful and looks for another partner, he is not badmouthed, but when a woman leaves her husband, then, yes, she is criticized. Older people tell women that even if her husband is with another woman, they have to tolerate it for their children, because they are going to lose their house, they are more interested in material things.* (E5)

> *At about twelve years old they get together* [as a couple]*, and they already have a sex life, because they start having children. When the girl gets pregnant, the men usually go to work, in this case they all migrate to Monterrey, and soon after they come back, but they have another partner and are no longer responsible.* (E12)

> *In my community, women are seen as sexual objects. I have noticed this because my grandfather had many partners.* (E12)

Women's education is not a priority in all families, because in some families their main role is considered homemaker and mother. In the case of women who do not have a partner, they are allowed to work in order to support their children: "*Women only dedicate themselves to the home, only those who have husbands; those of us who do not have husbands must go out and look for work to pay for children's expenses*" (E8).

According to the interviewees' reports, pregnancy in minors is common, and when this happens, the mother is held responsible.

> *Here most of the women get married young... many go to live with a partner or get pregnant in*

2 The MI is a measure used to measure at state and municipal level the deprivations of the population, particularly those associated with schooling, housing, income and residence in small towns (Conapo, 2013).

elementary or secondary school, and we do not study anymore. (E3)

We women dedicate ourselves to housework, we are responsible for our children at school, we are in charge of our children's education, they [men] *don't get involved in that, but if a girl gets pregnant at a very young age, they blame the mother, because the mother doesn't know how to educate her daughter.* (E10)

Among the generational changes that have occurred, women commented that they receive information on family planning and sexuality, something that was not allowed or encouraged in the past.

We talk more about sexuality and pregnancy, they are no longer closed topics, and as a mother I do talk to them [my children] *so they will not experience the same thing I did.* (E5)

Before the women did not talk about their personal things, their sexual life, and now they teach everything in school. That's why there were families with many children in the past. (E8)

My mom never told me anything about it and we couldn't talk about it, because [if we talked] *it meant that we were already dating and...* (E9)

Another issue mentioned was access to education, because priority continues to be given to the education of men in the family, as evidenced in the following report.

My father did not want to let me study, because he said I was going to get married and my husband would support me, but he did not imagine that the father of my daughters would abandon me. (E8)

My father didn't let us go to school, he said that since we are women, we didn't need school to clean the house and take care of children. So we didn't go to school, so we didn't study. (E13)

One of the practices that women consider to have been eradicated is forced marriages, but according to some reports, when an underage girl becomes pregnant, she is forced to marry and it is culturally acceptable.

When girls get pregnant, at first people badmouth them, but then they go away with their partner, with the baby's father, and the rumors stop. (E5)

When girls get pregnant, I have observed most of them are 14 or 15 year old, well, they get together with their partner, I don't know if the parents are the ones who influence them, they force them to get together because they are already pregnant and most of them go with the boy. (E14)

The phenomenon of migration has also changed family dynamics, some grandparents take care of children and adolescents, hampering open discusses about sexuality at home.

I feel that parents in the past were stricter, because they were present, the woman who did not work dedicated herself exclusively to education, and now they are not, grandparents care for children, and they are not open to the doubts of the youngsters. (E12)

Sexuality

When asked what sexuality was for them, they mainly mentioned having sex for reproductive purposes. For most of them, it is complicated to use the words "sexual relations", few women mentioned other aspects: "*Well.... is having sex with a partner*" (E6); "*Sexuality is when a man and a woman have sex, and reproduce, have children*" (E8); "*For me sexuality is when two people have sex and as a consequence sometimes infections or unwanted pregnancies happen*" (E9).

Sexual health

Women who said they received information on sexual health were asked about what information they obtained and where they received it. The information they received are mainly about contraceptive methods, from the health and

education sectors. In their families, they did not receive information about sexuality, except for one woman who received information from her father. Not receiving information within their families can make it difficult for most of them to discuss the topic with their partners, daughters and sons.

> *At the health center, they talk to us about it. They never talked to me about it* [sexuality] *at home, and I talk rarely with my daughter, she asks me, because they talk to her about it... at school, but I almost never talk about it. We don't talk about it with anyone here. My husband talks to my children, he tells my daughter to be careful, to never let anybody disrespect her. He tells my son not disrespect women. I don't like to talk about it.* (E3)

> *My mother never talked to me about this, I know because at school we saw these issues, but I am aware that if we had not gone to school we would never know anything about it. And to my mother, I never talked about these things because I felt ashamed.* (E7)

> *About sexuality, I always talked about it with my dad, my mom tells us things, but only a part of it. He used to say "it is much better that you tell things to me than to a colleague who gives you some bad advice".* (E12)

> *In my community, we don't talk about sexuality or prevention.* (E15)

Contraceptive methods

Two positions were presented regarding contraceptive methods: some women, mainly from the communities of Hidalgo, mentioned that they do not use contraceptive methods in their community. In Mexico over the last few years, health policies and social assistance programs implemented by the government have emphasized the provision of contraceptive methods to women in rural areas in order to improve birth control and reduce maternal mortality. However, as we can see in the speeches, providing only information has not worked for all women, because there is no dialogue with them, the different circumstances that lead women not to use them and the social pressure that falls on them are ignored. This is evident when two women comment that people often say that those who use contraceptive methods "walk around too much", meaning that they must have many partners.

> *After I had my first child they put me the IUD, then I took it out and had my daughter, and I didn't use anything anymore because my husband went to work on the other side* [United States]*. Since he stayed for many months, I didn't use anything. After I got pregnant with my last child, he stayed here. Now I don't use anything, he says I should have surgery, but I don't want to, after all, we rarely have this [sexual relations], he doesn't want to have surgery, because it makes him uncomfortable.* (E3)

> *I didn't use any method to prevent... well, after I had my daughter I started to use the injections, but he* [her ex-partner] *used to get very angry, he used to tell me "You and this injections again! Surely it's because you are meeting a lot of men", he got very angry and I decided to stop the injections.* (E4)

> *At the clinic, they give us workshops, they give us information about contraceptive methods, but we rarely use them here in the community.* (E5)

> *In my community, men are closed-minded. Even when I went for consultations at the health center when I was a teenager, the women use to go with their husbands. If they went for a Pap smear or something else, their husbands would go with them, because they didn't accept the doctor or the nurse seeing their wives... Even contraceptives are still frowned upon, because they say that women who use them will walk around.* (E12)

On the contrary, other women view positively the information they received about contraceptive methods and their use; they consider it helped them to have control over family planning and their menstrual cycles.

At the health center, they tell us how to take care of ourselves and use condoms; women now do not have children like before, they use more contraceptive methods. (E7)

First I had the device, after I got relief I took it out, it was really uncomfortable for me. Then I was using the injections, it helped me a lot because it regulated my menstrual cycle. (E9)

Knowledge about HIV

When asked about what they knew about HIV, most of them mentioned that it is a disease transmitted sexually and by blood. Some women mentioned the meaning of the acronym and that there is no cure. They do not know how the virus acts in the body, the route of perinatal transmission, the treatment and the way to prevent it. This shows us that the health services need to provide more information with intercultural material, adapted to their worldview and their needs: "*It is a disease, a virus that is transmitted sexually or by an infected syringe that is injected.*" (E2); "*Disease where partners are infected... by a wound*" (E6); "*I know that it is contagious by sexual transmission or blood, that it cannot be cured and that it is very dangerous*" (E10).

One of the women related the case of a partner who had HIV and the discrimination she experienced from people in her community for fear of infection. This indicates that there is a lack of knowledge about the ways of transmission.

There are cases of very young people. I saw one, who lives nearby in a village community, the wife was working in Monterrey and she tested positive for HIV, she was pregnant, so she discovered it, and she already had a two-year-old daughter. Of course, they also tested her husband, who also tested positive. They are isolated in the community, just like people with tuberculosis, those with HIV even more so. (E12)

Risk perception of HIV infection

Most women do not consider they are at risk, believing that having sex only with their partner can protect them or that there are no factors in their community that could put them at risk of acquiring HIV infection. The community is seen as a safe place: "*I don't consider I am at risk*" (E2); "*It won't happen to me*" (E3); "*No. I only have sex with my husband*" (E11); "*No, here in my community there is no risk of that*" (E13).

Six of the women admitted feeling at risk of acquiring HIV infection, mainly because of where they work and two of them because their previous partner had multiple sexual partners.

When I knew he was involved with several women, I was afraid, because you can't know if they had any diseases and if I had contracted any, so I separated from him. (E1)

I was at risk of contracting HIV because my current partner had multiple partners and I was on treatment for two years until I was diagnosed as HIV negative. I still consider myself at risk for other sexually transmitted infections, because I'm not sure if my partner has intercourse only with me, and I don't know if he takes care of himself with the others he's with. (E9)

I think so, because of the work as you say, I might be poked, sometimes you get overconfident with samples and patients. (E12)

Discussion and conclusions

The results of the interviews conducted allowed us to have a closer look at the practices of gender and sexuality in indigenous communities. The evidence showed that gender stereotypes are very marked within the communities, public spaces are considered for men and private space for women. Women are the only ones responsible for child rearing and housework. Few women have jobs, and most of those who do have jobs do not have partners. As mentioned by Butler (2006) and Segato (2016), gender roles produce, regulate and reproduce social inequalities between men and women.

In the community, men's opinion is considered the only important one; Karver et al. (2016) obtained

similar results in a research conducted with Oaxacan indigenous women. Women are currently allowed access to education, but priority is given to men, because it is still considered that the main roles of a woman are to be a mother and a homemaker.

In this research, the educational level of the women interviewed was high compared to that of the other women in their community. The results showed that women with higher levels of schooling found it easier to talk about sexuality and had greater knowledge on the subject. Therefore, the results of this study are applicable to indigenous women with access to formal schooling.

Mothers are held responsible for the actions of their sons and daughters, mainly their daughters, as in the case of pregnancy in underage women. It is important to consider that "adolescence" is not a life stage as conceptualized in Western culture, since a large number of women go from girlhood to womanhood when they form a couple or become mothers. In these cases of underage pregnancy, pregnant women are held responsible and socially pressured to join their partner, without investigating if the pregnancy was the result of rape. Women consider that forced marriages are no longer practiced, but pressuring underage girls to live with their partner or aggressor could be considered a forced union.

Regarding couples, men who have several partners or who leave their families and start a new relationship are not punished or criminalized, because people think it is part of men's nature. These beliefs are part of the gender stereotypes that were identified; unlike women who are socially judged and punished.

One of the changes in educational and health environments has been to provide women with information on family planning. However, in private spaces (family and couple), it is difficult to talk openly about aspects of sexuality; one of them is the use of condoms, which is not a viable method for everyone. Some of the women in the communities resort to traditional medicine for birth control, a phenomenon that is little explored and not recognized by Western medicine, but not being recognized does not mean that it is invalid knowledge; more studies are needed.

As mentioned in other research, providing information is not enough. Structural and cultural conditions must be identified in order to design prevention strategies appropriate to their culture, considering the meanings, values, perceptions and practices they have about their body, couple life, sexuality, illness, and the traditional and current ways in which they take care of their health (Quintal; Vera, 2014). The most important thing is to build these prevention strategies in a dialogic way with the indigenous women, so that they can reaffirm their own knowledge and appropriate the strategies they consider adequate according to their worldview.

The migration of men and women in search of better living conditions makes their sons and daughters stay under the care of grandparents, which generates new problems, since it is more complicated to talk about sexuality with older adults. As mentioned by Reartes (2016), political, economic and religious changes have questioned the traditional order of communities, affecting the relationships between men and women, creating new forms of socialization.

During the interviews, we realized that for many women it is very complicated to say the word "sexuality" or "sexual relations". Although they have greater access to information, it continues to be a taboo subject for them, mainly in the family environment (with their partner, sons and daughters). As mentioned by Karver et al. (2016), it is difficult for them to talk about the topic due to fear, embarrassment or lack of knowledge.

It is essential to promote contraceptive methods in a sociocultural context, allowing women to make the decision, avoiding criminalizing them so that they decide to use them, and rescuing their own knowledge of prenatal control using traditional medicine. It is not acceptable that the State continues to implement policies to control the bodies of indigenous women without their consent. Within this research, some women commented that they do not use them because they do not see it as viable with their lifestyle. Others said they were happy to have more control over their bodies, having information and access to contraceptive methods.

For the population in this study, it is not possible to negotiate condom use, because they are not even allowed to discuss this topic with their partner, a result similar to the study by García-Sosa, Meneses-Navarro and Palé-Pérez (2007) that had as participants indigenous women in Chamula, wives of migrants. Therefore, it is important to provide them with other prevention strategies that allow them to have control over their bodies; to explore within their own knowledge other options that are really viable for them.

They identify the ways of sexual and blood transmission of HIV and know that there is no cure. However, there is still a lack of information available to them. Most of the women interviewed do not consider themselves at risk because they believe that being married or having a stable partner protects them. As mentioned by Reartes (2011), the trust factor in a couple relationship generates the certainty of believing that the other person does not have any sexually transmitted infection, and it is considered that condom use could interfere or threaten communication or love. In the research conducted by this author with indigenous youth from the highlands of Chiapas, it was found that HIV infection is not a problem that worries young people when sexual initiation occurs with people from their community. Since this factor provides confidence and the certainty that it is impossible that the other person is ill with a sexually transmitted infection. They also see condoms as an interference or threat to communication and love; and they see the community as an entity that protects them.

It is important to mention that some women did perceive themselves to be at risk of HIV infection, mainly because of accidents in their workplaces or because of the multiplicity of sexual partners that their ex-partners had. In research conducted by Vera and Velázquez (2005) with Mayan women, they found that although most women perceived themselves to be at risk for contracting HIV, they implicitly accepted their partners' extramarital relationships and did not take effective preventive measures because of various sociocultural situations and gender stereotypes.

One of the women interviewed related the case of a family in which both the man and the woman were diagnosed with HIV and she considered that the best way to protect community members from possible infection was to isolate this family. This leads us to reflect that it is essential to continue working on the issue of sexual health and prevention of HIV infection and other sexually transmitted infections. In order to have a real impact on indigenous women, it is necessary to design interventions, in collaboration with them, with an intercultural approach and a gender perspective, allowing them to acquire tools to make self-care decisions (Grimberg, 2002) and control their own bodies and sexuality. In addition, it is important to contribute to the construction of more equitable and favorable public policies for women, based on respect for their sexual and reproductive rights (García, 2005).

One of the strategies that could be used is what Segato (2016) calls "reweaving the community network", in which the private or domestic space can be considered as political space. Another strategy suggested by Terán, Díaz and Cubillas (2016) is to involve women in the generation of knowledge, as well as in the design and implementation of prevention programs; working in a collaborative and dialogic way to build true intercultural knowledge and strategies, considering and respecting their worldview.

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Authors' contribution

All authors conceived the project. Juárez-Moreno designed the article, analyzed and interpreted the data. López-Pérez corrected the writing and style and, together with Raesfeld and Durán-González, contributed to the critical review.

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