Published in final edited form as:

Cult Health Sex. 2008 April ; 10(3): 297–306. doi:10.1080/13691050701861439.

HIV prevention and low-income Chilean women:

machismo, marianismo and HIV misconceptions

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Abstract

Socio-cultural factors and HIV-related misinformation contribute to the increasing number of Chilean women living with HIV. In spite of this, and to date, few culturally specific prevention activities have been developed for this population. The goal of the present study was to elicit the perspectives of low-income Chilean women regarding HIV and relevant socio-cultural factors, as a forerunner to the development of a culturally appropriate intervention. As part of a mixed-methods study, fifty low-income Chilean women participated in a survey and twenty were selected to participate in prevention, in-depth interviews. Results show evidence of widespread misinformation and misconceptions related to HIV/AIDS. Machismo and marianismo offer major barriers to prevention programme development. Future HIV prevention should stress partner communication, empowerment and improving the education of women vulnerable to HIV.

Keywords

HIV/AIDS; women; prevention; Chile; machismo; marianismo

Introduction

HIV and AIDS are health concerns in all parts of the world. Women now comprise 57% of all new HIV cases. In developing countries, nearly all the women have been infected through heterosexual intercourse with their husbands or regular partners (UNAIDS 2006). In 2001, more than 1.7 million people in Latin America were living with HIV, approximately 95,000 died from AIDS and 240,000 contracted the HIV infection (UNAIDS 2006).

By 1984, the HIV epidemic had reached Chile and for the first five years almost all reported cases were homosexually active men. In the last decade, however, HIV has spread rapidly to women. Between 1985 and 1990, the proportion of men to women infected with HIV was 15:1, but by 2003 this proportion had changed to 5:2. The feminization of AIDS in Chile is both a problem for women's health and a signal that the epidemic is spreading within the general population.

HIV most often affects economically disadvantaged women. New cases are most often reported among young women (20–49 years old) who live in poverty, have only an elementary education and are unemployed housewives (CONASIDA 2003). In most cases, women have become

infected through sexual contact with their husbands or other partners. Infection rates continue to rise and the development of effective programmes for low-income Chilean women has become a serious public health concern.

Gender inequalities, socio-economic disadvantage, violence, substance abuse, inadequate prevention messages and inappropriate programmatic responses to the epidemic have been identified as factors that increase women's vulnerability to HIV infection throughout the world (Schneider and Stoller 1995, Buzy and Gayle 1996, Patz, Mazin and Zacarias 1999, Gilbert and Walker 2002, Peragallo *et al.* 2005). In general, women who are vulnerable to HIV do not perceive themselves at risk. They believe that HIV is something that happens to homosexually active men or to other women, not something that happens to women in a stable relationship. Women may not acknowledge that their partners might have other sexual partners. Therefore, they do not view their partners as a possible way of acquiring HIV (Guimaraes 1994, Pesce 1994, Cianelli 2003).

Central to the reproduction of gender inequalities in Latin America are concepts of *machismo* and *marianismo*. *Machismo* is related to the social domination and privilege that men have over women in economic, legal, judicial, political, cultural and psychological spheres. Ideas about *machismo* can be explicit or not; however, they contribute to discrimination against women. Boys typically grow up learning that they are strong and can obtain their goals by being aggressive. They also learn that in the future they must be the 'protector' of their wife and family (Strait 1999, Gilchrist and Sullivan 2006). As noted by Gissi (1978), in a *machista* society the macho man is strong, active, independent, polygamous, unfaithful and sexually experienced. It is expected that such men have multiple partners before and after marriage and this increases the risk for acquiring HIV (Marin *et al.* 1993, Sabogal and Catania 1996). Men in return expect an affectionate, submissive and faithful woman who plays a passive and dependent role in the sexual sphere and who is able to work inside and outside of the home as necessary (Rosenbluth and Hidalgo 1978).

The complement of *machismo* is *marianismo* (Pinel 1994), with the submission of women to men being a significant component (Pesce 1994). This produces a double standard whereby women are placed either in the category of good mothers and wives or in the category of bad women who are sexually available and knowledgeable (Raffaelli and Suarez-Al-Adam 1998). In a context of *marianismo*, girls learn that they must be good wives and mothers and be respectful of and dependent on men (Peragallo 1996). Under the influence of *marianismo*, the most important values for women are chastity, motherhood, submissiveness, self-sacrifice and care-taking (Strait 1999). In the psychological sphere, submission is expressed by constrained ideas, opinions, choices and feelings. In the physical aspect of submission, the body of the woman is considered an object for the pleasure of men. Women must subordinate their pleasure to the decisions and feelings of men. This hierarchical structure supports discrimination, sexual harassment and the economic manipulation of women (Pinel 1994).

Other factors that place women at risk are lack of HIV knowledge and misconceptions and myths that women have about this disease, particularly about how it can be transmitted, acquired or avoided. It is important to learn more about women's sources of HIV-related information because these can be the source of lack of HIV knowledge and misconceptions. The general awareness that women have about HIV transmission is often not enough for them to perceive themselves as being at risk because of their partners' behaviour (Praca and Gualda 2000).

Methods

Design and setting

A mixed-methods design was used to elicit a reasonably comprehensive picture of the HIV-prevention needs of low-income women in an urban area in Chile. Data was collected via a survey of 50 women and 20 in-depth interviews conducted at a community clinic located in La Pintana County in the southeast of Santiago. The area is considered one of the most socio-economically disadvantaged communities in the city, with 31% of the 190,000 inhabitants living in poverty (Gobierno-Region-Metropolitana 2003, Metropolitana and Chile 2003). In addition, the area has a high incidence of alcohol and drug abuse, adolescent pregnancy and sexually transmitted infections (CONACE 1998, 2002, CONASIDA 2000, Ministerio-Educacion-Chile 2005).

Purposeful sampling was used to select the research respondents (Bernard 1995, Patton 2002). Quantitative data was collected from a survey of 50 women. Qualitative data from in-depth follow-up interviews with 20 women was sufficient to reach saturation (National Institutes of Health and Office of Behavioral and Social Sciences Research 2001). Inclusion criteria for the study specified that respondents should be Chilean women: (1) aged 18 to 49 years old, (2) sexually active with a male partner during the last three months, (3) living in La Pintana County of Santiago, Chile and (4) receiving care at a community clinic.

The Office for the Protection of Research Subjects at the University of Illinois at Chicago and the Ethics Committee at the Pontificia Universidad Católica de Chile approved the study. Recruitment of participants at the community clinic consisted of having the researcher personally ask women in the waiting area whether they would like to participate. Snowball recruitment was also used. Women who agreed to participate were invited to a private room within the clinic where inclusion criteria were assessed.

The survey consisted of 20 demographic items and 22 true-false statements to assess HIV-related knowledge. Participants took approximately 50 minutes to complete the survey with the assistance of the researcher. Twenty of these women then participated in a two-hour face-to-face semi-structured follow-up interview, which explored women's views on *machismo*, *marianismo* and HIV/AIDS. Data was collected during October 2003.

Quantitative data were analyzed descriptively. A database was developed to facilitate the processes of data storage, coding, retrieval and analysis using the statistical software SPSS version 11. Content analysis of the qualitative data was based on verbatim transcriptions of the interviews imported into the N5 (Nud*ist 5) programme. Memos with observations and notes concerning the interview were incorporated into the programme by the researcher. Content analysis was used to recognize, code and categorize patterns from text data (Patton 1990).

Results

The mean age of the sample was 31 years ($SD=\pm 9.7$) with a mean of six years of formal education. A quarter of the women were currently living with a spouse or partner and 42% were legally married. The mean number of years living with a spouse or partner was 3.1 ($SD=1.8$). Two-thirds of the participants identified themselves as Roman Catholic. The mean income per person per month was US\$ 54, with a range from US\$ 19 to US\$ 189. Nearly all (82%) of the participants were economically dependent housewives.

HIV-related knowledge

Quantitative analysis of the responses to the survey questions indicated that most participants were knowledgeable about HIV and AIDS, in particular about the virus being sexually

transmitted. The questions related to the statements on this topic were answered correctly by 60-98% of participants. Statements related to condom use were given correct responses by 90% of the participants, but 64% did not recognize abstinence as a means of protection against HIV. The statement, 'HIV/AIDS cannot be transmitted by using public toilets' was given an incorrect response by 40% of participants. Twenty percent of the women gave an incorrect response to the statement 'A pregnant woman who is infected by the AIDS virus can transmit the AIDS virus to her unborn child?'

Participants were asked to estimate the percentage of women infected with HIV in the community by answering the following question, 'In your community, how many women out of 100 do you think are infected by HIV?' The estimates ranged from 0-80, the median was 10 and the mean was 16.2 (SD=16.5). Eight participants (16%) estimated that no women locally were infected with HIV. Eighteen (36%) of the respondents estimated that HIV infection rate among women was between 1 and 10%. There is no accurate report in relation to the number of women infected in Chile.

The results for questions associated with discrimination or stigma are presented in Table 1. The participants believed that homosexually active men (88%) and sex workers (86%) were the only people to have HIV. Fifty-four percent of the women checked 'true' to the question 'All women infected by the AIDS virus have many sexual partners' and over half (36%) indicated 'true' to the question, 'Most people who are infected by HIV look sick.'

Knowledge scores on the surveys were not reflected by the qualitative analysis of in-depth interviews, which revealed that lack of understanding was a major barrier to HIV prevention. Misinformation from various media sources, fear and lack of knowledge about transmission and effective prevention measures were recurrent themes. Gaps in understanding were identified, connected with the fact that women are afraid of knowing more:

'I learned about this disease from the TV, but sometimes the information is contradictory, so I feel confused. Ignorance related to AIDS is big: people do not ask about this disease, they prefer to not know.' (Maria, 24 years old, seamstress)

Critically, women did not understand the difference between being HIV infected and having AIDS:

'You can meet a man that looks clean and respectable, but you do not know if he has some infection after you go to bed with him, because he is not going to tell you.' (Isabel, 32 years old, clerk worker)

Instead, they believed that AIDS is a dangerous and painful illness, like being condemned to death. They believed that there is no available cure for this disease and that treatment is only there to decrease the pain.

Overall, interviews revealed that women's understanding of HIV transmission and prevention is very limited. When asked about HIV prevention some women mentioned condoms but many of the responses reflected myths and misconceptions common among community members such as the importance of having a stable partner, proper hygiene, the use of birth control pills and intrauterine devices. Pregnancy and breastfeeding were not mentioned as a way to transmit the infection to children.

Socio-cultural factors: machismo and marianismo

All of the respondents mentioned the concept of *machismo* when referring to their partners and/or other men (e.g. fathers, brothers, fathers-in-law). Women described *machismo* in different ways. The majority of the participants said that *machista* men believed in their superiority:

‘When a man is a machista, the couple’s relationship is centered on him. This means that everything the woman does must be for him.’ (Maria, 24 years old, seamstress)

Almost all participants said that *machista* men expected women to do everything for them:

‘My neighbour is a machista man who likes everything done in his house by 11 am. When he needs something, he just gives the order to his wife [my friend] and she runs to do what he wants.’ (Carmen, 42 years old, baby sitter)

Sixteen women mentioned that it was common for *machista* men not to allow their partner to work outside the household, study or have friends. Women must ask them for permission to participate in activities outside of the home.

A greater challenge is the risk of HIV infection for women as a result of their partner’s behaviour. Forty percent of the women believed that they were at risk for HIV because of their partner’s behaviour: lack of condom use, infidelity, non-injecting drug use and/or daily alcohol consumption that may result in risky sexual behaviours. Women mentioned that most men in the community do not feel at risk for HIV because they believe that it is something that happens to other people but not to themselves. Male infidelity, related to the culturally accepted idea that men should have more than one sexual partner, was clearly identified as a potential risk factor for HIV. Infidelity was justified or tolerated by the majority of the women. To be unfaithful is part of the culture of *machismo*. Women usually forgive their husbands after they have an affair. As a consequence, women recognize that male infidelity tends to be repetitive. Moreover, some women even blame themselves for their partners’ infidelities:

‘Women accept and forgive men’s infidelity. This is like a vicious circle between men’s infidelity and women’s forgiveness.’ (Patricia, 33 years old, baby sitter)

Women indicated that women are intimately involved in perpetuating *machismo* because they are the ones who teach their children to follow the traditional *machista* system:

‘We [women] are responsible for having machista men, because, we raise and educate our children differently, depending on whether they were girls or boys.’ (Sandra, 28 years old, waitress)

Women also recognized that spousal abuse affects their HIV risk. Domestic violence, primarily sexual violence, is prevalent in the local community:

‘Domestic violence is very common in my community. When you suffer partner aggression, you feel like you are dying, but you are still alive. However, something inside of me is dead.’ (Patricia, 26 years old, seller)

Participants drew a connection between sexual violence and HIV. Over half of the women in this study reported abuse by their current partner. They pointed out that not accepting male infidelities could result in violence against a woman.

While women do not talk overtly about *marianismo*, its effects are clear. All of the women interviewed perceived their role as centered on the household and taking care of their children. Their partners were the ones who make all the decisions, including those that had to do with women’s aspirations and goals in life. Some of the participants mentioned women’s rights being violated by the men in the community. During the interviews, all women described themselves as ‘good women’ because they cared and were concerned about their children, partners and families in general. Participants mentioned that men did not recognize this dedication because caring is seen as part of the woman’s role:

‘I take care of my husband; however, he does not recognize this.’ (Rosa, 39 years old, warehouse worker)

Taking care of children was mentioned by all participants as the most important responsibility that women have:

'We [women] give all our time to our children sometimes ... we cannot work because we have to stay home to take care of them.' (Angelica, 20 years old, factory worker)

All of the women stated that men have more rights and privileges than women and this is something that women have to deal with and tolerate every day:

'Males are more liberal; they can do everything they want. But women cannot do what they would like to do.' (Marta, 29 years old, housewife)

According to ten interviewees, women's infidelity is present in the community, but is of lesser proportion than that of men. In addition, women's infidelity remains secret for two main reasons; the fear that husbands may find out and because women do not want their children to know about their situation:

'Unfaithful women try to cover their infidelity, especially thinking about their children.' (Patricia, 26 years old, seller)

Condoms were mentioned as being used by women when they had sexual intercourse outside their marriage, but only to avoid unwanted pregnancies, not to protect themselves from sexually transmitted diseases such as HIV:

'My female friends told me that sometimes they use condoms with other sexual partners to avoid getting pregnant, but not with their husbands.' (Claudia, 35 years old, housekeeper)

Discussion

Data from this study offers insight into Chilean women's knowledge of HIV and AIDS and what this disease means for them. Findings from in-depth interviews indicated misconceptions and confusion about AIDS. Common misconceptions include the lack of distinction between HIV and AIDS; the mechanism by which the virus is spread; and how a person looks if he/she has HIV infection. This led to confusion about prevention strategies and how to challenge stereotypes of people who were HIV-positive. Women expected the person who had HIV to look sick. Thus, if they had sex with someone who looked healthy, they did not believe they would be at risk.

Women had common misconceptions about HIV transmission. Participants identified the use of public toilets and shared tableware as well as lack of good genital hygiene and deep kissing as possible means of HIV transmission. During interviews, none of the women mentioned breastfeeding as a source of newborn infection with HIV. This is an important consideration for developing prevention programmes because it is a common practice among Chilean women to use a 'substitute mother' to breastfeed their children, which may elevate the risk of HIV infection for the newborn child.

It was clear that mass media played an important role in diffusing information about HIV to women in this community. However, sometimes the information produces confusion and the messages are contradictory. Television soap operas, television medical reports and the radio were the main sources of information about HIV mentioned by the women.

Machismo and *marianismo* present significant barriers to HIV prevention. In Latino culture, *macho* men represent male domination and women are under their power. As a result, women lack the ability to make personal decisions and have difficulty adopting effective preventive actions (Peragallo *et al.* 2005). The socio-cultural factors expressed as *machismo* and

marianismo include gender inequality, lack of communication between partners about sexuality and violence in relationships.

Domestic violence and gender roles, particularly male dominance, are important factors placing women at risk for HIV. Gender roles have been identified as barriers to HIV risk reduction among women (Gupta and Weiss 1993, Heise and Elias 1995) and specifically among Latino women (Gomez and Marin 1993, Amaro 1995, Peragallo *et al.* 2005). Women do not perceive that they have the support and the strategies for changing a situation considered normal in their community. Similar findings have been reported by Davila and Brackley (1999) and Del Rosario Valdez (2001).

In general, women continue to tolerate abusive situations. A few women indicated that they are trying to change the situation with their partners. However, for the majority of the participants, resignation was a significant characteristic. The absence of choices for women in a community is the clearest expression of *machismo* and *marianismo*. As a result, women lack the ability to make personal decisions and have difficulty adopting HIV effective preventive actions. These findings are consistent with those of Peragallo *et al.* (2005).

The number of women infected with HIV is increasing globally and Chile is no exception to this trend (CONASIDA 2003). Within the context in which the present study took place, future actions must take into account the socio-cultural factors specific to this group of women (Cianelli 2003, Ferrer, Issel and Cianelli 2005, Peragallo *et al.* 2005). In low-income urban areas such as those investigated in this study, women experience male dominance that often translates into violence, lack of opportunity for personal development, economic dependence and inability to negotiate with partners. Within this context, empowerment must be an important component of future HIV-prevention efforts. Programmes are needed to increase women's self-esteem, self-confidence and self-efficacy, as well as to decrease their dependence and depression. In addition, training in communication strategies and negotiation skills with male partners is important.

Acknowledgements

Support for this study was provided by UIC AIDS International Training and Research Program, Fogarty International Center, Grant # D43 TW01419, National Institute of Health Grant # 1 R01 TW006977 and Grant # 1 R03 TW006980.

References

- Amaro H. Love, sex and power: considering women's realities in HIV prevention. *American Psychologist* 1995;50(6):437–447. [PubMed: 7598292]
- Bernard, H. Research methods in anthropology. Altamira Press; Walnut Creek, CA: 1995.
- Buzy, J.; Gayle, H. The epidemiology of HIV and AIDS in women. In: Long, L.; Ankrah, M., editors. *Women's experiences with HIV/AIDS: an international perspective*. Columbia University Press; New York: 1996. p. 181-204.
- Cianelli, R. HIV/AIDS issues among Chilean women: cultural factors and perception of risk acquisition. University of Illinois; Chicago: 2003.
- CONACE. Estudio nacional de drogas en la población general de Chile, 1998. 1998 [Accessed March 15 2006]. Available from: http://www.conacedrogas.cl/docs_obs/est_pobla_general/poblacion_general1998
- CONACE. Sexto estudio nacional de drogas en la población general de Chile. 2002 [Accessed March 15 2006]. Available from: <http://www.conacedrogas.cl>
- CONASIDA. May 11, 2001 Bulletin ETS (STD bulletin) # 2. 2000 [Accessed April 15 2002]. Available from: <http://www.minsal.cl/iniciativas/Conasida/bolets/boletinets.htm>

- CONASIDA. Resumen de caracterización epidemiológica del VIH/SIDA en Chile al 31 de Diciembre del 2003. Ministerio de Salud de Chile; 2003 [Accessed December 15 2006]. Available from: <http://www.minsal.cl/iniciativas/Conasida/conasida.htm>
- Davila YR, Brackley MH. Mexican and Mexican American women in a battered women's shelter: barriers to condom negotiation for HIV/AIDS prevention. *Issues in Mental Health Nursing* 1999;20(4):333–355. [PubMed: 10624236]
- Del Rosario Valdez M. A metaphor for HIV-positive Mexican and Puerto Rican women. *Western Journal of Nursing Research* 2001;23(5):517–535. [PubMed: 11482055]
- Ferrer L, Issel M, Cianelli R. Stories from Santiago: HIV/AIDS and needed health systems change. *Advances in Health Care Management* 2005;5:31–72.
- Gilbert L, Walker L. Treading the path of least resistance: HIV/AIDS and social inequalities: a South African case study. *Social Science & Medicine* 2002;54:1093–1110. [PubMed: 11999505]
- Gilchrist H, Sullivan G. The role of gender and sexual relations for young people in identity construction and youth suicide. *Culture, Health & Sexuality* 2006;8(3):195–209.
- Gobierno-Región-Metropolitana. Diagnostico del territorio de la región metropolitana de santiago, Resumen Ejecutivo. División de Análisis y Control de Gestión, Departamento de Ordenamiento Territorial y Medio Ambiente, Proyecto OTAS, Universidad de Chile: Instituto de Asuntos Públicos; Santiago: Gobierno de Chile: 2003.
- Gissi, J. El machismo en los dos sexos. In: Covarrubias, P.; Franco, R., editors. *Chile mujer y sociedad*. Fondo de las Naciones Unidas para la Infancia; Santiago, Chile: 1978. p. 550-573.
- Gomez, CA.; Marin, BV. Can women demand condom use? Gender and power in safer sex; Paper presented at the IXth International Conference on AIDS; Berlin, Germany. 1993;
- Guimaraes, C. Male bisexuality, gender relations and AIDS in Brazil. In: Wijeyaratne, P.; Roberts, J.; Kitts, J.; Arsenault, L., editors. *Gender, health, and sustainable development: a Latin American perspective*. International Development Research Center; Ottawa: 1994. p. 26-34.
- Gupta GR, Weiss E. Women's lives and sex: implications for AIDS prevention. *Culture, Medicine and Psychiatry* 1993;17:399–412.
- Heise L, Elias C. Transforming HIV prevention to meet women's needs: a focus on developing countries. *Social Science and Medicine* 1995;40:931–943. [PubMed: 7792632]
- Marin BV, et al. Acculturation and gender differences in sexual attitudes and behaviors: Hispanic versus non-Hispanic white unmarried adults. *American Journal of Public Health* 1993;83(12):1759–1761. [PubMed: 8259813]
- Metropolitana, GRR.; Chile, UD. Diagnostico del territorio de la región metropolitana de santiago, Resumen Ejecutivo. División de Análisis y Control de Gestión, Departamento de Ordenamiento Territorial y Medio Ambiente, Proyecto OTAS, Universidad de Chile: Instituto de Asuntos Públicos; Santiago: Gobierno de Chile: 2003.
- Ministerio-Educación-Chile. Estrategia de promoción de la permanencia de las adolescentes embarazadas y madres en el liceo, 2005. Nivel de Enseñanza Media, Programa Liceo para Todos, Unidad de Apoyo a la Transversalidad; Mineduc: 2005.
- National Institutes of Health and Office of Behavioral and Social Sciences Research. Qualitative methods in health research: Opportunities and consideration and review. 2001 [Accessed February 24 2002]. Available from: <http://obssr.od.nih.gov/Publications/Qualitative.PDF>
- Patton, M. *Qualitative evaluation and research methods*. 2nd ed. Sage; Newbury Park, CA: 1990.
- Patton, M. *Qualitative research and evaluation methods*. Sage; Newbury Park, CA: 2002.
- Patz, D.; Mazin, R.; Zacarias, F. Women and HIV/AIDS: prevention and care strategies. PAHO. 1999 [Accessed October 2 2001]. Available from: <http://www.paho.org/search/DbSRReturn.asp>
- Peragallo N. Latino women and AIDS risk. *Public Health Nursing* 1996;13(3):217–222. [PubMed: 8677238]
- Peragallo N, et al. A randomized clinical trial of an HIV-risk-reduction intervention among low-income Latina women. *Nursing Research* 2005;54(2):108–118. [PubMed: 15778652]
- Pesce, L. AIDS research from a gender perspective. In: Wijeyaratne, P.; Roberts, J.; Kitts, J.; Arsenault, L., editors. *Gender, health and sustainable development: a Latin American perspective*. International Development Research Center; Ottawa, Canada: 1994. p. 19-25.

- Pinel, A. Besides carnival and soccer: reflections about AIDS in Brazil. In: Wijeyaratne, P.; Roberts, J.; Kitts, J.; Arsenaault, L., editors. *Gender, health, and sustainable development: a Latin American perspective*. International Development Research Center; Ottawa, Canada: 1994. p. 61-71.
- Praca N, Gualda D. A cuidadora e o (ser) cuidado: uma relação de dependência no enfrentamento da AIDS. *Revista Paulista de Enfermagem* 2000;19(1):43–52.
- Raffaelli, M.; Suarez-Al-Adam, M. Reconsidering the HIV/AIDS prevention needs of Latino women in the United States. In: Roth, N.; Fuller, L., editors. *Women and AIDS: negotiating safer practices, care and representations*. Haworth Press; New York: 1998. p. 7-26.
- Rosenbluth, C.; Hidalgo, C. La mujer desde una perspectiva. In: Covarrubias, P.; Franco, R., editors. *Chile Mujer y Sociedad*. Fondo de las Naciones Unidas para la Infancia; Santiago, Chile: 1978.
- Sabogal F, Catania A. HIV risk factors, condom use and HIV antibody testing among heterosexual Hispanics: the national AIDS behavioral surveys. *Hispanic Journal of Behavioral Sciences* 1996;18(3):367–391. [PubMed: 12320746]
- Schneider, B.; Stoller, N. Introduction: feminist strategies of empowerment. In: Schneider, B.; Stoller, N., editors. *Women resisting AIDS: feminist strategies of empowerment*. 1st ed. Temple University Press; Philadelphia, PA: 1995. p. 339
- Strait S. Drug use among Hispanic youth: examining common and unique contributing factors. *Hispanic Journal of Behavioral Sciences* 1999;2(1):89–103.
- UNAIDS. Informe sobre la epidemia mundial de SIDA 2004. 2006 [Accessed December 5 2007]. Available from: http://www.unaids.org/en/HIV_data/2006_GlobalReport

Table 1

Number and percentage of women responding 'True' to questions of relevance to HIV-related discrimination and stigma ($n=550$)

Question	<i>n</i>	%
Only homosexual men can be infected by the 'AIDS virus' (f)	44	88.0
Sexual workers (prostitutes) are the only women who get HIV/AIDS (f)	43	86.0
All women infected by the 'AIDS virus' have had many sexual partners (f)	27	54.0
Most people who are infected by the 'AIDS virus' look sick (f)	30	36.0

Note: (f)=false