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Abstract

In this study we examined the origins and consequences of HIV/AIDS-related stigma on the Mexican–Guatemalan border. To explore these issues, an inductive/deductive approach was taken. Data were collected using qualitative methods including nonparticipant observation, in-depth interviews, and informal conversation. Informants included Central American immigrants, locals, and contextual key informants. Findings reveal that gender, social class, and race/ethnicity function as key determinants of HIV/AIDS-related stigma, but serve also as the basis around which migration-related stigma is constructed within this particular context. These issues need to be taken into account in addressing the vulnerability of mobile populations, as well as the stigma attached to migration and HIV/AIDS. To be effective, responses should be based in the social and contextual realities faced by migrants and mobile populations, and be part of a more general process of empowerment that improves their legal, social, economic, and health status.

Keywords

ethnicity; gender; Guatemala; HIV/AIDS; immigrants; marginalized populations; Mexico, Mexicans; migrants; stigma

Since the start of the HIV epidemic, there has been global concern by governments that migration and population movement are associated with HIV transmission (Duckett, 2001; Gabutti et al., 2000). As a result of these perceptions, several countries have attempted to limit both temporary and permanent migration for people living with HIV. Many countries require a negative HIV test result for residency or a long-term stay. Others obligate and mandate compulsory testing for migrants seeking visas as tourists, students, and short-term workers. At present, and contrary to the advice of the Joint United Nations Program on HIV/AIDS (UNAIDS), more than 60 countries restrict people living with HIV from entering or remaining in the country for any given purpose, with international labor migrants being refused entry or facing deportation if they are found to be HIV positive (Joint United Nations Program on HIV/AIDS [UNAIDS], 2008). With the passage of time, however, there has been growing recognition that mobile populations might be particularly vulnerable to HIV infection and to many of the negative social responses to migration and HIV/AIDS such as stigma, discrimination, and violence (Bustamante, 2006; Erwin, Peters, & Smith, 2004; Leyva, Caballero, Infante, & Bronfman, 2005). The term *mobile population* is used to describe social groups who move across borders. It comprises documented and undocumented migrants, and includes sex workers, domestic workers, truck drivers, and soldiers, among other groups.

Migrants in Asia and Latin America have been documented as facing stigma, discrimination, and greater obstacles in accessing care and support if they are living with HIV (Fletcher & Munroe, 2004; Wolffers, Fernandez, Verghis, & Vink, 2002). The stigma they experience, however, is frequently influenced by factors such as ethnicity, race, social class, and minority sexuality. Individuals might be stigmatized because of their skin color, their indigenous roots, the language(s) they speak, and stereotypes of their links to the transmission of certain diseases such as HIV (Erwin et al., 2004; Infante et al., 2004). Stigma related to poverty and gender has been identified as a key component of social exclusion, with

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important implications for health and well-being (Reuter et al., 2009; Scott, 2009).

Several studies have analyzed the experiences of mobile populations in accessing HIV- and AIDS-related care. They include studies of cross-border migration in the Greater Mekong Subregion (Chantavanich, 2000; Fletcher & Munroe, 2004), of Philippine housemaids in Malaysia and Hong Kong (Skeldon, 2000), of garment factory workers in Cambodia (Forder, 2000), of sex workers and undocumented migrants in transit to the United States from Mexico and Central America (Bronfman, Leyva, & Negroni, 2004; Leyva et al., 2005), and of Vietnamese migrant workers in Korea (Wolffers et al., 2002). Findings highlight the negative effects of migration-related stigma as well as HIV/AIDS-related stigma and discrimination, and identify some of their social determinants—especially gender and marginality. The negative effects of HIV/AIDS-related stigma have also been documented in Mexico and Latin America. Key findings suggest that HIV/AIDS-related stigma negatively influences social interactions with family, friends, sexual partners, coworkers, and health professionals. Some of the consequences described include loss of social support, persecution, isolation, job loss, unequal access to health care, ineffective physician–patient communication, and poor access and adherence to antiretroviral therapy (Campero, Herrera, Kendall, & Caballero 2007; Infante et al., 2006; Vara-Díaz, Serrano-García, & Toro-Alfonso, 2005).

In Mexico, research by Bronfman et al. (2004), Caballero, Dresser, Leyva, Rueda, and Bronfman (2002), and Infante et al. (2004) highlights the vulnerability of undocumented migrants to HIV as a result of social, economic, and political inequality relative to the local population. Undocumented migrants might also become involved in sexual practices that place them at risk of acquiring HIV. Negative attitudes are often displayed by members of the local population toward people living with HIV. In a study conducted on the Mexico–Guatemala border, Infante and colleagues (2004) found that between 70% and 80% of respondents from Ciudad Hidalgo in Chiapas, Mexico, said they would not interact with an HIV-positive domestic worker, an HIV-positive medical doctor, or the children of someone who has HIV/AIDS.

According to Bronfman, Leyva, Negroni, and Rueda (2002), Caballero et al. (2002), and Cuadra-Hernandez, Leyva, Hernandez-Rosete, and Bronfman (2002), mobile populations on the southern border of Mexico are subject to frequent human rights abuse, with women sex workers and undocumented migrants being among the most affected. Within this social setting there is limited legal protection for human rights. As a result, both undocumented migrants and Central American sex workers are persecuted by both the police and migration authorities. Official data collected from the Human Rights Office at the *Casa del Migrante* (Migrant House) in Tapachula, Chiapas, show that 71% of human rights violations enacted on undocumented migrants take place on the Mexican side of the border (Leyva & Quintino, 2007). Casas del migrante are shelters for undocumented migrants in transit through Mexico to the United States. Run by the Catholic Church, they have a long tradition of providing humanitarian support to migrants, who typically spend up to 2 nights there receiving shelter, food, and care.

Despite the fact that several studies of HIV/AIDS-related stigma have been conducted, few go beyond descriptions of individual experience to identify the deeper structural origins of HIV/AIDS-related stigma. Parker and Aggleton (2003) have argued that HIV/AIDS-related stigma nearly always has its origins in deeper structures of inequality—of class, race/ethnicity, gender, sexuality, and age, for example. An analysis of the intersections between different determinants of inequality and social exclusion (e.g., gender–sexuality, race/ethnicity–sexuality, class–gender) holds the potential to illuminate the processes at work, heralding the way for more effective public health and community responses. A similar "layering" of HIV/AIDS-related stigma has been recognized in recent studies by Reidpath and Chan (2005) and Chan and Reidpath (2005), among others.

Although there are general theories of stigma, as well as research on HIV/AIDS-related stigma that can be useful in understanding these negative responses, there is still a lack of understanding regarding the specificities of HIV/AIDS-related stigma and discrimination in migration and other related social contexts. In this article, therefore, we aim to contribute to existing knowledge by identifying and analyzing the structural determinants of stigmatization on the Mexican–Guatemalan border, where social inequality, HIV/AIDS, and migration are important issues to be considered. An analysis of these factors, and their interrelationship with one another, holds the potential to contribute to the implementation of more comprehensive migration and health care programs within this and related contexts.

Methods

Data collection took place in the cities of Tapachula and Ciudad Hidalgo in Mexico and Tecun Uman in Guatemala between January 2005, and June 2005. Ciudad Hidalgo was selected because previous research within this context had revealed how local inhabitants negatively perceived people living with HIV as well as mobile groups (Infante et al., 2004). Findings suggested that

undocumented migrants were particularly vulnerable in this context as well as in nearby Tapachula, where they might be victimized both by immigration officers and *maras* (local gangs).

Prior to data collection, we undertook a broad-based literature review on stigma and discrimination, with a particular focus on HIV and AIDS. Performing a literature review helped us to better understand how stigma in general, and HIV/AIDS-related stigma in particular, are constructed through a social process that produces and reproduces social inequality, and which helps to maintain social exclusion and construct social difference. From this initial understanding, we were able to develop the interview guides for migrants and for local people that were later used in data collection. Fieldwork took place at several locations in and around the towns of interest on the Mexico–Guatemala border. Data collection involved observations, informal conversations and interviews with key informants and migrants, and the analysis of a range of written material including previous research on the Mexico–Guatemala border on issues of migration. Collecting data in this way, using different methods, allowed data triangulation to maximize consistency and increase credibility, dependability, and trustworthiness (Lincoln & Guba, 1985).

A total of 24 community key informants were interviewed. These included people who had established formal sources of support for migrants, those offering informal sources of support, and those involved in commercial relationships with undocumented migrants. Key informants included health care providers, community workers, local priests, people working in local nongovernmental organizations, sex workers, the owners of bars and brothels, *coyotes* (local people who illegally bring migrants into Mexico and sometimes to the United States), and taxi drivers. We also interviewed 7 Central American sex workers in Ciudad Hidalgo and Tapachula. A series of interviews with undocumented migrants in Ciudad Hidalgo, Tecun Uman, and Tapachula was subsequently conducted. A total of 30 migrants (9 women, 21 men) participated in these interviews. Migrants were aged between 16 and 60 years, and came from El Salvador, Honduras, Nicaragua, and Guatemala.

In the interviews, which lasted between 1 and 2 hours, we actively sought out critical incidents and life experiences that might shed light on the nature of HIV/AIDS and migration-related stigma. Stress was placed on engaging with interviewees' concerns, albeit within the context of our foreshadowed interest in understanding the relationship between individual experiences and broader structural factors. All interviews were audiotaped and transcribed in Spanish (all informants were native Spanish speakers). We then translated what we judged to be the most important elements of the interviews into English, with analysis commencing from the very initial stages of the fieldwork. The observational element of the fieldwork included taking long walks, and the first author's immersion over a period of several months within the local community to identify the areas in which social interaction between migrants and local inhabitants took place. Nonparticipant observation also helped elicit information concerning the structural characteristics of the context, including the political, economic, cultural, and social organization of the communities involved.

As the study progressed, fieldwork findings were "entered into dialogue" with the theoretical perspectives, insights, and frameworks identified in the first stage of the study. Although we began the analysis of the research findings in the early days of the fieldwork (as stated previously), findings were subject to constant revision in the light of developing theoretical perspectives and interview and other data.

An initial pilot study completed between March and April 2004, helped firm up the design for the main study. Pilot work helped to establish first contact with the research site and to assess the adequacy of the theoretical framework that guided the study. Green and Thorogood (2004) stress the need to pretest data collection instruments to ensure subsequent data quality, but pilot testing can also assist in developing familiarity with the local culture. This can help avoid causing distress to participants and can identify ways in which respondents can be helped to feel comfortable when talking about potentially sensitive issues such as HIV/AIDS, stigma, discrimination, and migration.

Sampling and Study Participants

We anticipated at the start of the work that mistrust might limit how much informants told us about their experiences because of fear of being identified and deported by the migration authorities. To deal with these problems, the first author became engaged in the everyday life activities at the casas del migrante (through a series of formal contacts, the first author received permission to stay in the Casa del Migrante in Tecun Uman and the Casa del Migrante in Tapachula during data collection). In that way, norms of reciprocity and trust were established. In the Casa del Migrante in Tapachula, for example, he provided basic medical care to migrants in the mornings, and in the afternoons he conducted interviews. With the use of this strategy, we were able "break the ice" with migrants and establish basic levels of trust. By keeping in close contact with the undocumented migrants, we were able to observe particular aspects of their lives, gain their trust, and establish sufficient rapport

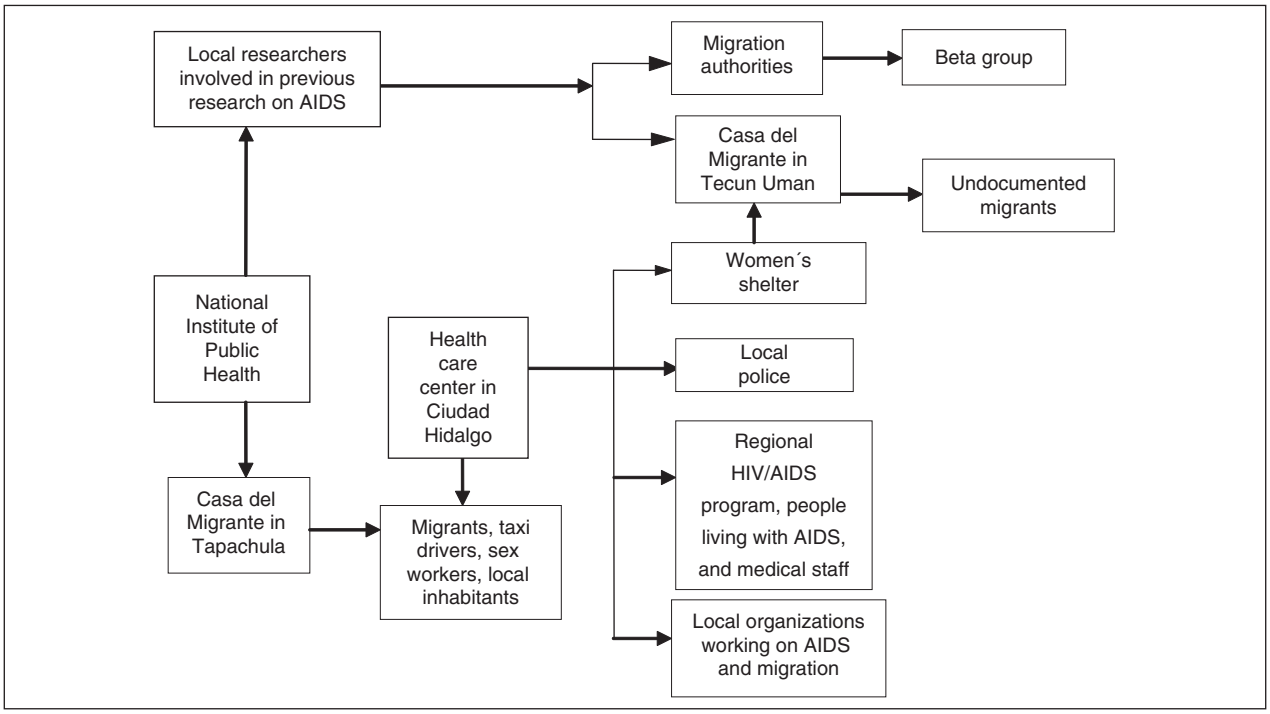

Figure 1. Network of informants

to conduct in-depth interviews. In addition, community activists working with a local nongovernmental organization (i.e., the Beta Group, an organization from the National Immigration Office providing humanitarian assistance and information on human rights to migrants) that had previously provided services to migrants were able to introduce us to possible informants and helped develop rapport with other interviewees.

Figure 1 illustrates how the network of informants was developed and how access was gained through both official institutions and local organizations. Contact was also established with health care officials in Ciudad Hidalgo, who helped facilitate access to local inhabitants. Through these contacts we were able to identify many key informants, including those offering informal and formal support to undocumented migrants.

In the early stages of the work, respondents were purposively sampled to focus on groups, settings, and individuals of interest (Silverman, 2005). Snowball sampling was later used to expand the initial network of key informants (Spradley, 1980). Throughout data collection, members of the research team discussed the content of the interviews to make changes to the interview guide on the basis of information provided by the informants. After several such iterations, further changes proved unnecessary because no new information emerged.

Each person interviewed was made aware of the objectives of the study and the importance of his or her collaboration. We explained that our aim was to understand more about community responses to migration, the impact of HIV and AIDS in the region, and issues of stigma and discrimination. Ethical approval for the study was provided by the Institute of Education, University of London. Informed consent was obtained from each participant and it was made clear to interviewees that they had the right to stop the interview at any time. Subsequent to data collection, respondents were allocated pseudonyms to respect confidentiality. A code was assigned to each interview and a list of pseudonyms was kept separate from transcripts and the audiotapes.

Data Analysis

An interpretivist approach to data analysis was adopted in which emphasis was placed on individuals' understanding and interpretation of the social and physical world in which they lived. Using a broadly inductive approach, we sought to understand individual interpretations and conceptions of the migration experience, and HIV/AIDS-related stigma and its consequences. Other issues focused on included language, culture, and interaction, and their roles in the construction of social reality.

As indicated earlier, initial analysis took place during data collection by listening and relistening to tape recordings, transcribing, and making field notes. As a result of this familiarization process, we were able to identify a number of preliminary themes and categories. Later in the data analysis process we explored the relationship

between informants' experiences and context. We also examined commonalities and contradictions between different types of data collected, and between different types of informants. By searching for contradictions, we hoped to have a richer and more nuanced account of participants' perspectives and experiences.

The topical categories and descriptors employed by respondents were systematically analyzed. Of special interest to us was whether themes and categories emerging in the early stages of analysis remained consistent with later interviews. We remained open to finding new and/or different themes and categories that might even contradict previous ones. To enhance reliability, the coding scheme, the development of themes and categories, and the interpretation of the data were continuously discussed by members of the research team. Atlas.ti computer software (Lewin & Silver, 2009) was used to organize and analyze observation and interview data.

To enhance rigor in analysis, principles of verification were used to test provisional conclusions for their authenticity and trustworthiness with a focus on credibility, dependability, and confirmability (Lincoln & Guba, 1985). Our analysis focuses on the following thematic areas: (a) informants' perceptions of Central American migrants and migration, (b) informants' perceptions of the HIV/AIDS epidemic in Central America and Mexico, (c) migrants' experiences of violence or human rights violations along their journey, (d) employment opportunities for Central American migrants, and (e) experiences of stigmatization and discrimination related to migration and/or HIV/AIDS.

Results

Tapachula and Ciudad Hidalgo lie on the Mexican side of the border, and Tecun Uman is a border community in Guatemala where many Central American migrants stay before crossing illegally into Mexico. Migrants typically stay in the town for 3 or more nights waiting for the train, or for money from relatives to pay a coyote who will help them cross into Mexico. Some undocumented migrants might pay the coyote to travel further—in some cases as far as the United States. The three cities in which data collection took place are in close political, social, and economic relation to one another. The Mexico–Guatemala border is marked by the Suchiate River, which forms a natural border between the two countries. According to local inhabitants in Ciudad Hidalgo, the region is characterized by intense population mobility. Data from the Instituto Nacional de Migración (National Immigration Office; 2008) suggest that the number of people crossing into Mexico from Central America is between 150,000 and 200,000 people each year.

The cities of Ciudad Hidalgo and Tecun Uman rely heavily on each other because of the formal and informal exchange of goods. In Ciudad Hidalgo, there is an important local market where many Central Americans buy Mexican products and sell their own goods. According to local people in both Tecun and Ciudad Hidalgo, this market is the most important on the entire Mexican–Guatemalan border. Another important sector of the local economy includes bars, nightclubs, hotels, and brothels.

To understand the stigma experienced by Central American migrants on the Mexico–Guatemala border, it is important to recognize the influence of geographical, historical, cultural, and structural factors. It is also important to understand the local context of poverty, gender inequality, violence, and unequal access to health care, because this influences vulnerability to HIV. It is important to note that the forms of stigma people experience within this setting have deep roots both in fundamental social inequalities and in everyday social interaction, work, the use of public spaces for recreation, and services such as health care and transport.

Increased Number of Migrants: The Cause of Social Problems

For many people living on the Mexico–Guatemala border, negative perceptions of migrants were explained by recent increases in population movement. The number of people trying to reach the United States through Mexico increases every year. A Mexican man, an immigration officer in Tapachula, said,

> The number of undocumented migrants who go through Mexico to get to the United States has increased considerably. In comparison with last year, it has gone up by 35% percent.

Explanations for this increase are many, but the most common reason given is economic: People want a better standard of living, better jobs, and a better future for their families. A further key reason is security: Some people migrate because of the social climate of violence and the scars left by more than 30 years of guerrilla fighting in many Central American countries.

Data from the Instituto Nacional de Migración (2008) reveal that in 2007, almost 400,000 undocumented Central American migrants entered Mexico through the states of Chiapas, Quintana Roo, and Tabasco, with Guatemalans representing the majority. Of these, 204,000 were detained by immigration officers in Mexico, and an additional 54,000 were detained by immigration officers in the United States. The reported detention of undocumented migrants in Mexican territory rose by 41% between 2001 and 2007. According to immigration

officials from the local Beta Group, the most concerning group is the 400,000 people who enter Mexico as undocumented migrants. Recent increases in the number of migrants have created a climate of social tension in which links between migration and HIV/AIDS, as well as other social problems, have been made in the discourse of local authorities and local people:

> Among local people, there is a preoccupation with the increase in the number of migrants, and there is also a preoccupation with the presence of HIV and AIDS, especially because of the high number of undocumented migrants. We have to keep a close eye on the [emerging] relationship between migration and AIDS.

> Local people are exposed to AIDS. Even if migrants stay for [just] a couple of days, there is time for them to infect locals. The presence of many truck drivers and Central Americans has a relationship to the increase in AIDS cases.

Increases in the number of migrants, sex workers, and indigenous people from Central America hired to work on local coffee and banana plantations have also caused concern. In previous years, the number of migrants was felt to have been manageable, but now migration is felt to be "out of control." Some local people in Ciudad Hidalgo reported that migrants, especially those who had been deported, lived in such poor conditions that they were forced to engage in criminal activities to meet their basic needs:

> Central American migrants come with a bad culture and with no education. I think that they are unstable people who have not accomplished their goals in life. I think that they have not got the courage to settle down in their own countries and get a proper job. Women come and get involved in prostitution and men get involved in crime.

It was apparent that there were felt to have been "better times" in Ciudad Hidalgo. One local man said, "Ciudad Hidalgo was a nice rural town 10 years ago, without drugs, prostitution, violence, and without AIDS." This same informant also commented that Ciudad Hidalgo was expanding because many people from Central America were getting married to Mexicans to gain permanent residency in the country. He made reference to the fact that 10 years previously he had known almost every family in Ciudad Hidalgo, but now (at time of interview) was a very different story. For the local community of Ciudad Hidalgo, the increase in the number of migrants also brought more sex workers to the region:

> There are many women who end up in the bars and the brothels. This is largely caused by migrants, and how easy it is to move along the border. Sometimes this ease of movement is something to be worried about.

Undocumented migrants living and working in Mexico were also aware of the increase in the number of people crossing the border, and thought that another reason for the antipathy shown toward Central Americans by Mexicans might be the large number of Central American women who end up as sex workers on the Mexican side of the border, and the problems that derive from the large numbers of brothels and *cantinas* (bars):

> There are so many brothels, and many Central American women come to work here. Inside the brothels you only find women from El Salvador, Guatemala, Honduras, and Nicaragua. Many of these women are fooled into coming here, others are bought by maras, and they stay because they need the money.

The increase in the number of sex workers has created a fear of infection within the local community. Local people blame sex workers and their clients (mostly truck drivers and Central American men) for the presence of AIDS. Along the border, brothels, hotels, cantinas, and nightclubs have proliferated because of the increased trade and movement of goods.

Race/Ethnicity and Nationality as Structural Axes of Stigmatization

A staff member at a Guatemalan nongovernmental organization working on HIV/AIDS and migration indicated that there is a lot of racism in Central America and Mexico. According to him, "In Guatemala, skin color kills." He explained that this occurs because in Central America there had been many years of guerrilla warfare. This, together with other social and political problems in Central American countries, has created major social divisions:

> There has been much armed conflict between people in Guatemala, El Salvador, and Honduras, as well numerous assassinations and murders in the region. If you have dark skin, people from Guatemala think you come from El Salvador and might harm you because of that. Here on the border, skin color is a reason for many to kill.

According to the local inhabitants of Ciudad Hidalgo and Tecun, men migrating from El Salvador are automatically thought to be criminals, and if the migrant

is a woman then she must be a "whore," because "women from El Salvador like sex," and "if you put walls and a ceiling on El Salvador, it would be the biggest brothel in Central America." Similar views were expressed by other interviewees:

> Here in Guatemala, all the prostitutes come from other countries. Those from Honduras and El Salvador are the hottest, but they also have more AIDS. Honduras is an important country, a "number one" in AIDS cases. Lots of *sidosos* [pejorative term referring to people with HIV] live in Honduras.

> When I go out shopping or even when just walking around Ciudad Hidalgo, even the kids keep calling me "whore." Just because I come from El Salvador, everybody here thinks I am a prostitute, because [in their eyes] all sex workers are Central American women.

The perceptions underpinning such accounts relate not only to nationality and the social identity that is perceived as deriving from being Salvadorans or Hondurans, but also to the linguistic connotations attached to terms such as *sidosos*. In ill-informed conversation, this word is used across Latin America to refer to people living with AIDS. It is a pejorative term, loaded with a negative moral value. Similarly, terms such as *whores*, *putas* (prostitutes), and *mampos* or *putos* (men who have sex with other men and adopt a "receptive" role in sexual relationships) are powerful terms of abuse. Linguistic control is a powerful means of denigrating those affected by HIV/AIDS, especially when enacted toward sexual, ethnic, and racial minorities and migrants who are relatively isolated and powerless in comparison with locals—those who come to define the norms and dictate what is stigmatized and what is not. For a local man from Ciudad Hidalgo, migrants from Honduras and from El Salvador were the worst of all:

> If you get distracted for just a second, those guys from El Salvador will take you for everything and even leave you without cigarettes. I feel sorry for them. They are miserable. The drugs and AIDS in Ciudad Hidalgo are because of the people from El Salvador and Honduras.

According to other local inhabitants in Ciudad Hidalgo, migrants from El Salvador and Honduras are considered thieves, and the most violent ones in the region. Locals also recognized Honduras as the Central American country with the highest prevalence of HIV in the region. Paradoxically, however, whereas local people in Mexico link Central Americans with AIDS, Central Americans link AIDS in their countries to migrants who have returned from Mexico and the United States:

> People from Honduras are not well received in Central America because we have so many AIDS cases. The high number of cases can be explained because there are so many women on the street who offer themselves to men. Those who return from Mexico are seen as a big threat. Many people do not want to go to Mexico because that is where you can catch AIDS, and also from those who return from the United States.

Local people also discriminate against those migrants who come from the indigenous communities of Guatemala to work on the banana and coffee plantations. Although less than 1% of the local population on the Mexican–Guatemalan border has indigenous roots, local people discriminate against indigenous people because of the way they look, their clothing, and their traditions. To local people, any attempt by outsiders to preserve their indigenous or native culture is considered an open act of defiance and a denigration of the host culture. These views were endorsed by a migrant from El Salvador. She described how she and her sister felt when walking around the main plaza in Tapachula, and the efforts they made to be seen as locals:

> We even had to buy clothes at the local market and local stores to wear what locals wear [the same brands]. Nevertheless, we feel watched and that makes us anxious. We even decided for a while to stay at home. Because we are domestic workers we can stay where we work, but I am bored staying the whole week here. I would like to go out, but I feel very anxious when I do. People stare and we think they may even call the police to arrest us.

For migrants, every contact with the host culture and with local people is potentially constraining and anxiety provoking. Another informant, who worked for the United Nations Committee for the Protection of Refugees in Tapachula, commented thus on the stigma related to people from indigenous communities and to Black people:

> A lot of locals reject Black people. It is very difficult for us to find a job for Black refugees. In Mexico, there is a lot of racism and xenophobia. I have even seen the local police detaining some of the Black refugees because locals have asked them to do it, in order, as they see it, to prevent criminal

> acts. Another big issue is the stigma directed toward indigenous people that work in the banana fields. They are stigmatized and discriminated against because of the [traditional] clothes they wear, their skin, and the way they talk, only because they are different [from] people from the city.

Discrimination was also linked to the perception that indigenous and rural people are responsible for the transmission of HIV as well as other diseases such as malaria. Two men working at a public health facility in Tapachula believed that this was because indigenous people have no education, have poor personal hygiene, and lead "promiscuous sex lives." These informants said that, as in the case of malaria, migrants serve as "vectors" of disease. Similar views were expressed by local inhabitants:

> I think that people from the rural areas do not use condoms. Men from the rural areas, when they are in Tecun Uman or Ciudad Hidalgo, have sexual relationships with prostitutes and do not use condoms, and that is how disease spreads. They do not have information or education. They are the ones who go with women to have promiscuous and dirty sexual relationships.

Reference to notions of hygiene here highlights the importance of public health discourses in the construction of a relationship between perceived hygiene and the absence of disease. These last views can be contrasted with those of migrants themselves, who commented that they were not the cause of HIV/AIDS in Mexico. On the contrary, they were frightened of becoming infected on their way to the United States:

> I know that many people may catch the virus while on the journey to the United States. There are many people who just do not care about their lives. I like to be prepared; my wife even gave me some condoms. She told me not to come back infected. I try to behave myself and also it is very difficult to have sexual relations while on the journey. I do not think that Central Americans are the cause of AIDS in Mexico because the Mexican woman will never have a relationship with us. We are on our way and we never stay for long in these Mexican cities.

Central American migrant women who were interviewed perceived AIDS as an important health and social problem both in their country of origin and in Mexico and the United States. They feared becoming infected as a result of rape and sexual abuse, as well as through the work they had to do. Women bar workers, in particular, were acutely aware of their vulnerability to HIV. They reported always using condoms with clients, and receiving information about HIV prevention and condoms from the HIV-prevention program run by local public health authorities.

The Gender and Sexuality Interface: The Sexually Voracious and the Promiscuous

A very substantial proportion of women involved in sex work on the Mexico–Guatemalan border come from Central America, as field observations, the testimonies of informants, and previous studies conducted in the region have revealed. In Ciudad Hidalgo, Tapachula, and in Tecun Uman, there are numerous cantinas and brothels in which Central American women work either as waitresses or sex workers. There are also local myths and beliefs about the sexual behavior of women from Central America:

> In Central America, women start their sexual life at a very early age. They typically start having sex at 13 or 14 years, so by age 18 they have a lot of experience. Unfortunately, many start having sex in exchange for money because people are very poor in these countries. Their sexual history is important, and when they come to Mexico at age 17 or 18 many may bring AIDS with them to Ciudad Hidalgo. Migrants are linked to alcohol, violence, drugs, prostitution, and AIDS.

Both the migrant men and local inhabitants interviewed blamed the presence and spread of HIV on women—especially those who had left their rural home towns, families, and husbands; women involved in sex work; and women from the United States. Migrants as well as local people believed that HIV, like other sexually transmitted infections (STIs), is largely transmitted by women, and that men suffer the consequences:

> I think that you get AIDS by having sex with women on the streets. When going to brothels you need to wear three condoms. Using one is not enough.

> I got gonorrhea at a brothel in Cacahoatan [a Mexican community on the border]. All the Central American women at the bars and brothels have AIDS. I was lucky not to catch it. Those women are infected, but when you get drunk you do not care. I did not always use condoms with sex workers.

Judgments like these are made about individuals and social groups on the basis of the known or presumed

prevalence of HIV within the group to which an individual belongs by virtue of nationality, race/ethnicity, or sexual behavior. In fact, research typically reveals that the prevalence of STIs among Central American sex workers is around 0.6%—not very different from that of the local inhabitants on the Mexico–Guatemala border (Uribe-Salas, Hernandez-Avila, Juarez-Figueroa, Conde-Glez, & Uribe-Zuñiga, 1999; Valdespino-Gomez et al., 1995). A staff member of the public health office in Huixtla commented,

> I think that the HIV epidemic in the border cannot be explained because of the presence of Central American sex workers. They are not responsible for the epidemic because we have rigid control over them and we know that the AIDS cases are not within this group. AIDS is out there in the street, maybe because of migrant men who are promiscuous.

On the Mexico–Guatemala border, behaviors considered "deviant" are socially punished and negatively valued, even regarded as sins. Based on our observations, the information given to local people about HIV and AIDS has reinforced preexisting stigma toward those affected and those displaying stigmatized sexual behaviors. Among those particularly affected were homosexual men. As one local religious leader explained,

> The most common way of transmission is with homosexual sexual relationships. Many homosexuals live their sexuality in a hidden way and with migrants they may find a chance to have sexual relationships in exchange for money or shelter. Some may be infected and may infect these young migrants. I have talked with some local homosexuals and they have told me that they usually have sex with migrants.

A local sex worker put things in the following way:

> They don't let homosexuals work in this bar. They can come here to drink and some may find someone to pick up. There are many mampos here who pay other men to have sex with them. We call them mampos, these homosexual men.

The terms *mampo* and *puto* form part of the everyday discourse of local people. It is significant that mampos' partners are not attributed with any special identity, nor are they stigmatized. On the contrary, their masculinity is actually reinforced through their adoption of the "insertive" role in anal sex. Some Central American men are seen as a good opportunity by local men seeking sex. Central American men are appreciated as homosexual partners, just as Central American women are appreciated by heterosexual Mexican men. According to locals, there is a busy homosexual scene in and around the Mexico–Guatemala border. For medical staff at the AIDS clinic in Tapachula, it is within this context that the main problem of AIDS lies.

Both locals and migrants considered "outsiders," as well as foreigners from more developed countries, as being more open about sex and as having "different" sexual behaviors. According to migrants who had lived in the United States for several years, U.S. women enjoy sex more than women from Central America. It is believed that anal and oral sex are common sexual practices in the United States:

> [AIDS] is a disease one gets from *gueras* or *rubias* [blondes] from the United States. These women are on drugs and alcohol. So, men from Honduras catch AIDS from them. Those Americans like oral and anal sex. In the United States, women are more open and free to enjoy sex. It is very different from back in our countries. (Fieldwork diary, from informal conversations with migrants at the Casa del Migrante)

The supposedly "uncontrollable" sexual desire of Central American women was manifested by Mexican women and both Mexican and Central American men as a risk for HIV infection. There were also beliefs that AIDS transforms women's sexual practices:

> Women with AIDS have an uncontrollable desire for sex. AIDS gets inside their heads, and they may even fuck animals; they are like animals, these women.

> Once a woman has AIDS, she can survive for many years by depositing the virus in another man, so she can fill up with new life. The younger the man, the more life she gets out of him, and that is why they last up to ten years.

According to the narratives elicited, the most visible forms of stigma are reserved for those women who are thought to have acquired HIV through "improper" or "immoral" sexual behaviors, particularly mobile, young Central American women. Local people's concern about sex workers, and especially the beauty of Central American women, is closely linked to Catholic notions of the devil and of temptation. It might be tied to Central American men's perceptions of women as either *madonnas* (women who stay in their home towns and

become housewives) or whores (migrant women or women who have moved from their home towns to the city). Within such typology, one can find different layers of stigma. First, there is the moral stigma that arises from a woman being a sex worker, and second, there is a more general stigma related to gender. A third stigma ties to women's personal responsibility for their infectiousness, since they "knowingly" infect men. This blaming of Central American women seems to work to the advantage of the local community as it seeks to "protect" itself from its deviant members. It also reflects the need of local people, medical doctors, and social workers to establish a boundary between stigmatized Central American women and local men.

Discussion

In making sense of the representative responses included above, it is important to recognize the importance of preexisting stigma related to migration on the border, and the role that newer forms of HIV/AIDS-related stigma have in reinforcing dominant social responses toward mobile groups. Preexisting stigma toward sex workers, migrants, young women, and homosexual men combines with HIV/AIDS-related stigma to create a complex mix of negative responses within this context.

The conceptual framework on HIV/AIDS-related stigma developed by Parker and Aggleton (2003) is useful in making sense of aspects of these responses. Parker and Aggleton were among the first to argue that deep-seated structural factors such as gender, race/ethnicity, sexuality, and socioeconomic status provide the foundations on which HIV/AIDS-related stigma and discrimination are constructed. Their work stresses, however, that HIV/AIDS-related stigma takes its own form depending on the historical, cultural, economic, and political context in which stigma is enacted. Other authors, such as Malcolm et al. (1998), Link and Phelan (2001), and Mahajan et al. (2008), have argued that HIV/AIDS-related stigma reproduces existing social divisions and social inequalities through relations of power and social control. As a result, dominant groups effectively limit the ability of stigmatized groups to resist the social control imposed on them by virtue of their stigmatized and marginal status. The work of these authors also highlights the importance of stigma and discrimination for the production and reproduction of the "social difference" that is so central in structuring race/ethnicity, gender, sexuality, and class relations.

Findings from the present study point to the multiple axes of stigma fueling responses toward mobile groups on the Mexico–Guatemala border. These include gender, race/ethnicity, age, sexuality, and social class. Each axis runs parallel to the other(s), but axes occasionally intersect, reinforcing one another and giving birth to new and often more potent forms of stigmatization. One example of this can be seen in the stigma triggered by population mobility, which is seen as being simultaneously influenced by race/ethnicity (as in comments such as "those Centroamericanos," "Salvadoreños," or "Nicaraguenses"), class ("those no-good layabouts who take our jobs"), gender ("those Central American women who destroy marriages by making themselves irresistible to Mexican men"), and sexuality ("those mampos," "putas," and "putitos"). Figure 2 summarizes Parker and Aggleton's (2003) central argument, but includes the added dimension of migration arising from the present study. The lower boxes signal structural determinants that have their counterparts in the circles (concerning HIV/AIDS) and the upper boxes (concerning migration).

Figure 2 shows how existing structures of class, gender, race/ethnicity, and sexuality serve as the origins from which both HIV/AIDS-related stigma and migration-related stigma are constructed. As a result, AIDS comes to be seen as a disease of women, a disease of the poor, and an affliction of racial/ethnic minorities, to give just a few examples. It is significant that these same structural determinants serve as the foundations in which migration-related stigma has its roots. In the case of migration-related stigma, these factors do not operate in isolation from one another, but intersect, and are, in turn, reinforced by the stigma associated with HIV/AIDS. In consequence, mobile groups such as sex workers and young women are perceived to be a "reservoir of HIV," migrant men are seen as having "promiscuous" sexual behaviors that put them at special risk of acquiring HIV, and mobile groups are viewed as being of lower status than local people. A new form of stigma is thereby produced which can be termed *HIV/AIDS- and migration-related stigma*.

Not only is HIV/AIDS-related stigma itself constructed from deep-seated sociostructural determinants, but also it serves as the basis from which new and other forms of stigma can arise. It is crucial to note that the structural determinants of stigmatization do not operate independently, but rather intersect with one another as shown in Figure 2. The interface between different structural determinants or axes of stigma allows new forms of stigma to be created. The interaction between gender and sexuality, for example, gives rise to myths and beliefs about the sexual behavior of stigmatized social groups. These typically imply transgression of dominant norms of gender and sexuality. When HIV is added to the mix, an explosively negative social response might be enacted toward mobile groups. For local people, both "AIDS" and "migration" carry negative connotations, including

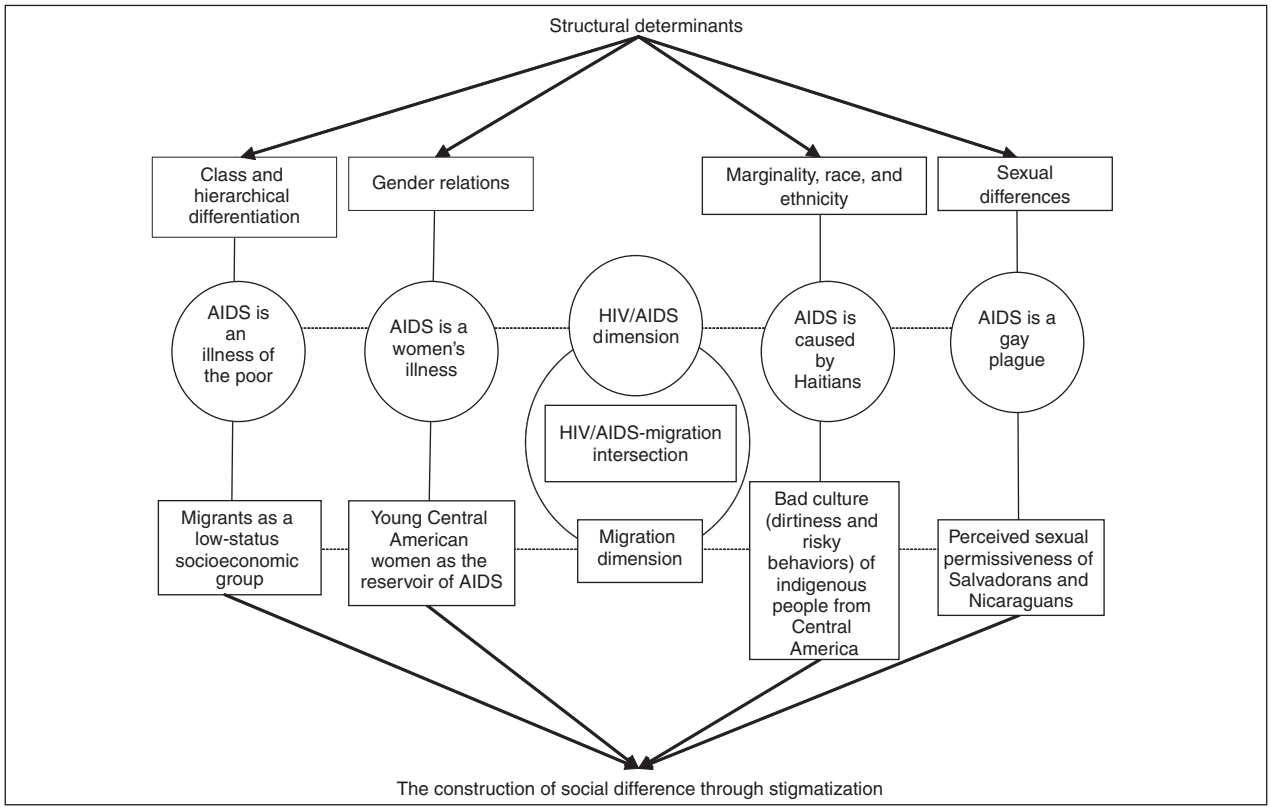

Figure 2. The construction of social difference through stigmatization

the breaking of social, sexual, and religious norms and values. Putting migration and AIDS together and connecting them to a particular social group can have disastrous consequences for the social, economic, and political opportunities available to members of that particular group. In the context of the Mexico–Guatemala border, an understanding of the complexity of HIV/AIDS-related stigma is important. By focusing on the social determinants of race/ethnicity, gender, class, and sexuality it is possible to decode the complex connections between otherwise hard-to-understand forms of human interaction and relationships.

Conclusions

Worldwide, the number of migrants is growing, the dynamics of population mobility are becoming more complex, and the dangers confronted by migrant groups are increasing (Bustamante, 2003). The Mexico–Guatemala border is no exception in this respect, but remains a largely forgotten frontier, a place where human rights violations are routinely enacted against undocumented migrants and other mobile people such as sex workers and indigenous people. Although increasing public attention has been focused on the conditions faced by predominantly Mexican migrants on the United States–Mexico border, much less attention has so far been directed toward experiences on the southern borders of Mexico.

Globally, there is an urgent need for action to address the vulnerability of mobile populations, as well as the stigma attached to migration and HIV/AIDS. This must include HIV prevention, education, access to treatment, and care and support for migrants before they leave their country of origin, throughout their journey, during transit to their final destination, and in communities and countries where they stay (Brown, 2004; Bustamante, 2003; Dworkin & Ehrhardt, 2007; Soskolne & Shtarkshall, 2002). These responses must address social issues such as stigma, discrimination, and human rights violations (Borland et al., 2004). Responses should be based on the social and contextual realities faced by migrants and mobile populations, and should be part of a more general process of empowerment that seeks to improve their legal, social, economic, and health status.

Following Yuen-man Siu (2008), we argue that how we understand stigma will be crucial in developing more responsive public health policy as well as social services support directed toward the most vulnerable social

groups. In the case of HIV prevention, there is global recognition that social, economic, political, and environmental factors directly affect HIV risk and vulnerability (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008). Sustained progress requires that these structural factors be addressed, but until they are it will be difficult to reduce the vulnerability toward HIV of the most disadvantaged groups, such as mobile populations.

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