From Oaxaca to California: Vulnerability and HIV/AIDS in Indian Migrants

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ABSTRACT

The migration of ethnic groups from Oaxaca to California happens in a context of adversity and social inequality, in their place of origin as well as at their destination; this has consequences for their capacity for social response. AIDS is added to the pre-existing stigma towards migrants, which contributes to an increase in their segregation and rejection, already existing before AIDS.

The purpose of this work is to analyze the perception that Zapotec migrants have of HIV/AIDS and the response of social and governmental organizations in the social space called *Oaxacacalifornia.* For this, a qualitative study was carried out, in Zapotec communities of Oaxaca, Mexico and Fresno County in California.

Information on HIV/AIDS has been broadly disseminated among the Zapotec population. Women who are partners of migrants perceive the risk of infection with HIV/AIDS as associated with their partner's migration. The use of health services by Zapotecs in California is perceived as a risk of being deported, while in Oaxaca it exposes them to maltreatment. The Zapotec migrant organizations have developed an integral response including communication, cultural integration and social welfare, with an emphasis on reproductive health, prevention and healthcare for HIV/AIDS. Nevertheless, gender differences persist, among other differences, which are obstacles to the effectiveness of the response.

Key words: Migration, HIV/AIDS, Ethnic Group, Zapotecs, Social Response

Introduction

"I don't know who he is – he insisted – but whoever he is, he's on his way".
García Márquez G. *Cien Años de Soledad* (*A Hundred Years of Solitude).* Commemorative Edition, 2007. p. 52

Migration, as a demographic and social phenomenon, is a process with implications for health profiles in countries of origin, as well as in those of destination. The dynamics and composition of migration have become more complex, not only because of the purposes, the characteristics of migrants, the spaces and intensification of fluxes, but also because of policies to contain population mobility which frequently have negative social and health effects for migrants (Castillo MA, 2005).

Although migrants are not a homogenous group, they share a common characteristic— they are "the others," in their places of origin as well as in those of destination (Haour-Knipe y Rector R, 1996). In the case of Indian groups, who are segregated in their places of origin, they add their migrant condition to the set of social, cultural and economic factors which determine their link to society in conditions of inequality. In Mexico, unequal treatment of Indians is expressed even in the methodology employed in census and national surveys, in order to recognize or identify the indigenous population, so that numbers of Indians and their adscription to determined ethnic groups may vary substantially according to the sources that are consulted (Castro R., et al.,2007).

In the international migratory process from Mexico to the U.S., a consolidation has been observed of participation of indigenous groups, above all towards the region of California (López F., y Runsten G., 2004; París M., 2005). For them, incorporating into migration implies a process of reconfiguration of their individual and collective identities which may create a tension in their sense of solidarity and belonging to their community; but in the case of migrant Indians from Oaxaca, this has allowed them to strengthen symbolic and material elements that function as a link between their present place of residence and their origin (Fox J. y Salgado G., 2004; Velasco L., 2002; Murphy A., et al. 1999). The concept of *Oaxacacalifornia* is the best expression of links and differences among the migrant ethnic groups: it is place, time and people in movement, in two contexts that are more than 4,000 kilometers apart, but profoundly articulated through the constant exchange of symbolic and material goods that maintain strong links between the people who are moving and those who remain at their places of origin. In this aspect, the grassroots organizations have played a relevant role in stimulating participation for the improvement of the community at the places of origin and destination (Fox, J., 2005).

For the Zapotecs of the Central Valleys of Oaxaca, migration to California is a strategy that has allowed them to satisfy different needs in contexts of social inequality and inequity, in their place of origin as well as at their destination. In this last one, problems pertaining to health, housing, work, among others, are situations that have to be tackled in a

new context, with new rules and social actors. Among health problems, special attention has been given to sexually transmitted infections (STIs) and HIV/AIDS, associated to the migratory processes, which are defined by the new conditions and forms of social interaction and changes in their sexual practices at their destination (Bronfman M., y Minello N., 1995). AIDS is added to the pre-existing stigma against migrants, which may contribute to increasing practices of segregation and rejection that existed prior to AIDS.

In the Central Valleys of Oaxaca, cases of Indian males have been identified who have a migratory background, and of pregnant women who are partners of migrants that are HIV carriers or have developed AIDS. In the same way, in California, an increase has been recorded in the number of seropositive migrants of Mexican origin (Sánchez M., et al. 2004) although there is no information on their ethnic background. In spite of the information limitations, the condition of dual social inequality (as Indians and migrants facing other migrants and U.S. residents) makes them one of the most vulnerable groups for risk management and prevention and with lesser capacity to use the healthcare services.

In this work, an analysis is done of factors and processes related to the vulnerability of these populations with respect to HIV/AIDS and other sexually transmitted infections, as well as their capacity for social response to these health problems. In the first part of the work, the migratory dynamics are described and health conditions of the Zapotec population in their places of origin and destination. Later, the perspective of different social actors is analyzed, on STI/HIV/AIDS, and finally, the social response when facing these health problems, as it has been developed by diverse governmental and civil organizations in Oaxaca and California.

Method

A qualitative and ethnographic study was carried out in Fresno county, California, in 2003, and in the municipalities of San Pablo Huixtepec, Ciénega de Zimatlán and Teotitlán, located in the Central Valleys of Oaxaca, in 2004. In these contexts, 53 in-depth interviews were conducted that were applied to members of four groups: migrant Zapotec men (19); Zapotec women who were partners of migrants (12); governmental health organizations (12); and civil organizations related to the STI/HIV/AIDS and migration topic (10).

Selection criteria for the Zapotec men and women who were interviewed were: declaring they spoke the Zapotecan language, or having parents who spoke it; having been socialized in the traditional ways of community organization; being a woman whose partner had migrated to the state of California or being a migrant male with a background of residence in the U.S. during the five years prior to the study. The civil organizations were identified by their activities to support Indian migrants and also their work related to STI/HIV/AIDS. Governmental health organizations were also included, that offer healthcare services and treatment for STI/HIC/AIDS at the places of origin and destination.

Contact with the people and organizations participating in the study was established through social organizations representing Indians in California and Oaxaca. The interviews were carried out in different social spaces (migrants' homes, places of work, health centers

in Oaxaca and California). These were recorded with informed consent of the interviewees. For each interviewed group, a guide was used that was adjusted to each actor (migrants, women partners of migrants and representatives of Zapotec social organizations). Information was obtained on the migratory process and insertion of migrants in the place of destination, particularly with respect to the search for and obtainment of work, access to information on prevention of STI/HIV/AIDS, as well as on health services. With the social organizations, emphasis was placed on programs or actions developed to facilitate access to health services or to disseminate information on prevention for the management of STI related risks.

Data obtained through the study were analyzed in three great categories: information and perceptions on STI/HIV/AIDS, access to health services, specifically for the prevention and care of HIV/AIDS, and the participation of social organizations representing the interests of ethnic groups, as well as of governmental organizations from California and Oaxaca.

Contexts of the study

The municipalities of San Pablo Huixtepec ("Hill of Huizaches"), Ciénega de Zimatlán ("Place of Swamps") and Teotitlán del Valle ("At the Foot of the Hill) are located in the Central Valleys of Oaxaca, a territorial extension concentrating the greatest population density in the state, the greatest number of cases of HIV/AIDS, and with the highest intensity of migration towards the U.S. (DIGEPO, 2004; COESIDA, 2005). The first two municipalities, which belong to the district of Zimatlán, are governed by a regime of political parties, with mestizo population and that of Zapotec and Mixtec origins. Economic activity concentrates in the primary sector (agriculture and cattle raising). Teotitlán del Valle is the municipal capital of the Tlacolula district and is governed by community "uses and customs", that is, a form of government organization where the community decides the forms of election, duration of posts and who votes (Sierra T., 1997). In this locality, the population is distinguished by its Zapotec and Huastec ethnic adscription, and by the carrying out of activities related to agriculture for self-consumption and handicrafts such as weaving and pottery.

In this region, broad sectors of the population live in poverty. More than half of the population (57%) earns less than two minimum salaries and faces considerable deficiencies in housing conditions, health and education. Although the Central Valleys concentrate 30% of the total state population, the number and quality of health services is still lagging considerably. It is estimated that 70% has no access to social security institutions, a situation that is more predominant in Indian communities governed by "uses and customs" (Ruiz M., y Campechano M., 2006).[1]

[1] According to an analysis of the health of Indians in Mexico (R. Castro, J. Erviti y R. Leyva, 2007), based on data from the 2000 National Health Survey, "the proportion of insured users of social security in the population that does not speak an Indian language is 2.6 higher than the population speaking an Indian language, at the national level; but this proportion grows to 3.25 times in the States of Hidalgo and San Luis Potosí, and to 4.9 in the states of Oaxaca and Chiapas.

In the studied Oaxacan municipalities, the health infrastructure is composed of a clinic and doctor's office belonging to ISSSTE, a rural hospital belonging to IMSS-Oportunidades, and an SSA Regional Hospital. This health service infrastructure is considered insufficient, since 40% of the population has to travel more than two hours to reach the nearest hospital, and frequently the services are considerably limited in their physical resources, availability of medicines and materials, and they do not have a translator of Indian languages (Castañeda M., 2004). Together with the lack of public services, the Oaxacan Indians face, on a daily basis, the consequences of the decapitalization of the rural areas, violence, lack of employment and precarious incomes (París M., 2005). Under these conditions, migration to the U.S., and particularly to California, is one of the few options for the Zapotec population, to guarantee their survival (López y Runsten, 2004; Arellano E., 2004; Morales R., y Pacheco R., 2004; Mendoza C., 2004).

The U.S. Population Census (2000) showed that, in spite of subrecording problems, the Zapotecs and Mixtecs are the most numerous ethnic groups in California, with a population of 154,362 people (Huízar J., y Cerda I., 2004). They are present in considerable numbers in the Fresno metropolitan area—Fresno and Madera counties— located in the San Joaquín Valley, the most important agricultural region in the U.S. (Martínez J., 2004).

Although the initial Zapotec migrants had the purpose of inserting themselves in the Californian agricultural labor force, over the course of half a century this phenomenon has become more complex and has developed networks and organizations that broaden the possibilities for establishment in urban areas and incorporation into labor niches of the service sector (Fox J., y Rivera-Salgado, 2004; López F., y Runsten D., 2004; París M., 2005).

Nevertheless, Indians are still one of the most vulnerable groups at the places of destination, where they face the consequences of labor segmentation and find greater obstacles to access to basic public services; under these conditions, they face discriminatory and abusive practices in different public life spaces (Fox J., y Rivera-Salgado, 2004, París M., 2005; Castañeda X., y Zavella P., 2004). [2] In California, the Zapotecs generally earn low salaries, which makes it more difficult for them to acquire a health insurance (Solorio R., Currier J., y Cunningham W., 2004); this situation is emphasized among agricultural workers. The undocumented condition is translated into exclusion from social services and in this context of marginalization, people are reluctant to use the health services because of the risk of deportation (Bronfman M., y Minello N., 1995). Also, frequently, the clinics do not have Spanish-speaking health personnel, much less anyone speaking the Indian languages; this is an important barrier to the use of health services (Nagiecki J., 2002).

[2] Xóchitl Castañeda and Patricia Zavella (2004: 81) report that "the Mexican rural communities have become ejectors of agricultural laborers who emigrate to the U.S., specially to California, where 92% of agricultural laborers are Mexican (…); in this state, workers come more and more from Indian communities in Mexico. Agricultural workers live in conditions of poverty and marginalization; for this reason, they are at greater risk than the population, of contracting infectious diseases".

Magnitude and Distribution of HIV/AIDS in Oaxaca-California

In Oaxaca, the distribution of the HIV/AIDS epidemic has extended among the communities. In 1998 there were 220 localities that reported AIDS cases; this number increased by 23% in 2005 (COESIDA, 2006). With respect to the number of cases, according to data of the National Registry of AIDS Cases, in this locality a total of 3,278 AIDS cases were identified between 1983 and June 30, 2006. 1,304 people were diagnosed as being infected with HIV during the 1995-2006 period (CENSIDA, 2007). Under these conditions, Oaxaca is in the ninth place in the table of accumulated incidence at the national level and in the second place among the southeastern Mexican states. Also, data from the National Population Council (2000) show that in Oaxaca, rates of incidence of other STIs, such as urogenital candidiasis, trychomoniasis, syphilis and gonorreah, are higher than the average recorded for the country.

The health system in Oaxaca lacks systematized information on migratory background and ethnicity of the people affected by the HIV/AIDS epidemic (Gómez A., 2006). In the same way, the record of AIDS cases in California does not allow to identify the ethnicity of people living with AIDS (PLWAIDS); however, the California Health Services Department reports that the proportion of AIDS cases among hispanics, with respect to the general population, has increased from 36.5% in 1995 to 47.7% in 2000 (Sánchez M., et al. 2004).

In this context of international migration, AIDS emerges as an additional element that may contribute to the strengthening of antimigratory policies and social segregation, but it is also an example of the social capacity of the most vulnerable groups to respond to adverse situations in contexts of social inequality.

Results

Information on and Perceptions of STI/HIV/AIDS in Oaxaca-California

Couldn't this man be sick and later I'll be paying for what he did over there? (Evangelina, Teotitlán del Valle)
When I'm over there, I always do it using a condom or abstinence, because in the U.S. it's riskier than here. (Luis, Teotitlán del Valle)

The insertion into the migratory process may propitiate a reconfiguration of the cultural tradition or heritage with respect to STI/HIV/AIDS, through daily interactions with friends, relatives, the media, governmental health organizations or civil society organizations. Zapotec men and women participating in this study identified AIDS as "*the most feared of all sexual diseases because it is incurable*". In general, they have some knowledge on the means of transmission of HIV and references to other STIs are limited or null.

Stories told by migrant Zapotec men show that, independently of their generation, they perceive that during their stay in the U.S. they are at greater risk of acquiring HIV, syphilis and gonorreah, since the probability of having multiple partners increases, as does the demand of sexual workers. Also, they highlight the importance of condom use as an

effective prevention method. It seems that most of them got information on AIDS and condoms at their communities of origin, mainly through the media, talks with family and friends, and sometimes at school.

In spite of the fact that the men generally acknowledge the preventive importance of condoms, their use is more consistent during their stay in California and, to a lesser degree, with their partners who stay in their places of origin.

Before I came to California, I listened to cases of men who came to the U.S. and returned with an infection; they already had the disease. So I got afraid and that is why I always use a condom when I'm here. Here I get them at the health vehicles that go around the barrios, but I haven't been given any other information (Luis, 28 year old migrant, Fresno, California).

During the migratory circuit, some Zapotec men have received new information (printed materials on the use of syringes associated with addictive substances and HIV transmission) on HIV/AIDS at their workplace in California. Nevertheless, testimonies show that sometimes, during their stay in the U.S., language barriers make it difficult for them to understand the information on prevention, *"since over there it is not very easy to understand the information, if we're lucky it's in Spanish, but frequently it's all in English and we don't understand a thing (…) but in a talk we were told we have to protect ourselves with condoms, and also not use drugs because the syringes can also transmit the disease."* (Javier, 58 years old, Oaxaca).

On the other hand, the Zapotec women maintain marital links at a distance, *"have heard about AIDS"*, and practically do not know about other STIs. With respect to the means of transmission of HIV, they mainly mentioned the sexual route, to a lesser degree the blood route and not one mentioned the perinatal route. For most of the interviewed women, HIV/AIDS is *"a disease that one gets"* from having multiple sexual partners, acknowledging that both men and women can be subjects of transmission. Nevertheless, of the fourteen interviewed women who were partners of migrants, only two said they had had two sexual partners (spouses), and the rest emphasized that their "husband had been their only sexual partner". For this reason, they frequently associate having a STI with "the return from the U.S." of their partner. As a response to this problem, most of the women went to the local health center, or to a private doctor; however, nobody was able to, or chose to mention the name of the infection.

When I had been with my husband for two years, we got an infection, but I think he brought it from over there, because I got very sick, felt burning in my abdomen and we had to go to the doctor; they gave me a lot of medicine; he was the one who infected me, and the (woman) doctor said I had to bring him too (…). The doctor only told me it was an infection, I don't know which one, but this infection was transmitted by him, because he's the one who's sick. (Guadalupe, 43 years old, Oaxaca).

From this perspective, the woman who is a migrant's partner is the one who suffers from the infection, and the man who is a migrant is the one who is sick and the carrier of the infection.

With respect to the spaces for socialization where they have obtained information on HIV/AIDS, the interviewed women said they had received informational talks and/or materials at the community health services. The interaction at these spaces has promoted the common knowledge that reinforces the perception of risk with respect to HIV/AIDS, allows for a better understanding of this health problem and of the strategies for its prevention. For example, Teresa, a 43 year old Zapotec woman considers that *"the talks have been very good to know how to protect oneself of a disease because the men over there do not stay still"*. Some women seemed convinced of the preventive effectiveness of the condom; however, they have null or reduced margin to express their perception of risk of acquiring HIV and negotiating conditions under which sexual intercourse takes place. For them, the return of their partner means, among other things, *"having to fulfill my obligations as a woman and nothing else, because if I ask, I will only get scolded and it's better if I think he's not doing anything bad"*. For this reason, the women repeatedly suggested that the preventive information given at the health centers should also be offered to the male population. Other women, young and adult, expressed little belief on the effectiveness of condoms, or they only believed in their contraceptive function, *"since the truth is, I don't know how effective it might be; now I think it's only good for marriage and when you don't want to have many children"*. (Margarita, 20 years old, Oaxaca).

HIV/AIDS Prevention in Oaxaca-California

In Oaxaca, the main interest is to formulate and implement preventive actions for HIV/AIDS, for the people who—directly or indirectly— are immersed in the dynamics of population mobility. This is greatly sustained by the diagnosis of seropositive people with backgrounds of migration to the U.S. and the gradual acknowledgment of the condition of vulnerability and risk of women who are partners of migrants.

Governmental health institutions have strived to strengthen prevention processes through the promotion of informational talks, mainly directed to the female population, *"since they are the ones who mainly use the health services and are at greater risk because their husbands are gone for long periods"* (Health Center, Zimatlán). From this perspective, in the last years they have tried to respond to the needs of mestizo and Indian partners of migrants, through actions that complement clinical care, such as educational activities that are in their presence and have a short duration. In these spaces, information is given on means of transmission of HIV/AIDS and the use of contraceptive methods, and barrier contraceptive methods are promoted. We need to point out that, in spite of the fact that Oaxaca is a state characterized by its pluriculturality, health providers believe that the inclusion of the ethnic variable in prevention activities is not adequate.

From the perspective of health professionals, preventive interventions have had a positive effect, since women may *"count on specialized references on STI/HIV/AIDS and the protection offered by the use of male condoms"*. Also, the timely diagnosis of HIV in migrant men has been promoted, as a preventive strategy for the women. Among the health professionals, there is consensus that the preventive strategies directed towards the female population have important limitations, since in the local context, meztizo and Indian women are not able to propose condom use. In general, *"men do not go to the health*

services much, they do not agree with having an HIV test done and they refuse to use condoms. This is why women have suggested that the information be given to the men, as they arrive". (Doctor, Zimatlán-Oaxaca).

Another limitation to achieving efficacy in the preventive campaigns is the restriction existing at the family planning programs for the enrolled couples. They are given, free of cost, twelve condoms per month. *"The couples who are in the program may have access to these condoms; we know they are not enough but we tell them to use them during the fertile days, although the risk of STIs still exists* (Doctor, Teotitlán-Oaxaca). This way of having access to condoms at the health services may exclude young single people, who are a large proportion of migrants.

In Fresno, California, health providers consider that in the area of sexual and reproductive health for immigrant population, the problems that have been a priority are child and maternal morbidity and mortality, cervical-uterine cancer, as well as breast and prostate cancer; only in recent years has it been considered important to promote actions for the prevention of STIs/HIV/AIDS. For this, health services have designed informational materials – written in Spanish- on means of STI transmission, identification of symptoms and preventive methods. Some informants acknowledged that it is important to incorporate other dissemination strategies directed towards the illiterate population, which could be for example, audiovisual materials. There was no mention of designing materials for people who only speak an Indian language.

This pamphlet talks about the STIs, for example, chlamydia, herpes, genital warts and HIV. It also talks about the importance of prevention during pregnancy. It talks about the PAP smear and we teach them to do a breast self-exam (…). When we read this pamphlet to them, we take the opportunity to also give a talk to the men. We try to teach them how they must take care of themselves and how to detect cancer in the testicles. We see that men are very afraid to talk about this. Also, the pamphlet always promotes protection through condom use; that is why I believe it is a good source of information. (Informant. Health Clinic. Fresno, California).

Also, health organizations carry out some coordinated actions with other agencies linked to the migratory dynamics. For example, agencies offering healthcare to Mexicans who do not have social security have made agreements with the Mexican Consulate to install tables with information on STI/HIV/AIDS. These actions are relevant to the Zapotec population, since although there are no precise data on their ethnicity, this Consulate *"is responsible for eight counties, it provides service to two and a half million people of Mexican origin or ancestry (…) and in the operational area of the information tables, the greatest number of people are from Michoacan, Jalisco and Oaxaca"* (Informant, Mexican Consulate in California).

Here in California, many groups focus their efforts on people of Mexican origin who do not have access to medical services. We establish contact with information agencies and jointly promote health projects. The health program called, "Health Around the Corner" was started, consisting of the installation of information tables outside the consulate where approximately 250 people receive information every day. At these tables, information is offered on sexually transmitted diseases and family planning. This is done while they wait for their turn to process their document. (Informant, Mexican Consulate).

Another significant intervention related to health and migration is the promotion of the Binational Week, where representatives from California and the states of Michoacan, Guanajuato and Oaxaca come together. These are the states with a strong migration towards this U.S. region. In this space, efforts have been made to strengthen the information, education and communication processes for the prevention and diagnosis of STIs/HIV/AIDS.

HIV/AIDS and Access to Health Services in Oaxaca and California

Since 2000, the health governmental institutions operating in Oaxaca, have detected Oaxacan Indians who are HIV carriers or who have developed AIDS, and have a background of migration to the U.S., as well as cases of Indian women who are partners of migrants. According to healthcare professionals, a frequent phenomenon has been identified, where seropositive men go to the services in terminal phases of the disease. From their perspective, the migrants *" practically come here to die";* and the women learn about their seropositive state during pregnancy (Zimatlán, Oaxaca, Health Center). This situation has negative implications for costs of care, but above all, for the prevention of dissemination of the infection.

Facing this situation, the Oaxaca State Council for the Prevention and Control of HIV/AIDS (COESIDA) started a process to deal with the HIV/AIDS and migration link. In 2003, 200 HIV tests were done on pregnant women, partners of migrants and, to a lesser extent, on migrant men, in order to detect the magnitude and association of the impact in the places of origin. We need to point out that in these tests, the ethnicity variable was not included and positive cases were not identified. What was observed was that "*men were more resistant to having the test done, compared to women"* (Zimatlán, Oaxaca, Health Center). With respect to the installed capacity and the coordination of care for people living with AIDS (PLWAIDS), important limitations were recognized in the infrastructure and in the trained personnel for an adequate handling of HIV/AIDS.

In California, as in Oaxaca, healthcare providers mentioned that, until 2003, it was difficult to know the number of seropositive Mexicans and even more difficult to know their ethnicity, since in the information they are classified as "hispanics". Nevertheless, the informants from the AIDS Office in Sacramento said they had detected PLWAIDS among the Indians from Oaxaca. *"About a year ago, an Indian couple from Oaxaca came, we examined them, tests were done and both turned out positive (…) in general, these people work in the small villages"*. To offer healthcare services to migrant Mexican groups working at the agricultural fields, the California Health Department and health agencies have promoted some actions for diagnosis, carrying out laboratory tests and offering free treatment for STI/HIV/AIDS. From the perspective of these officials, the epidemiological problem does not affect this population in an important way. They believe that: "Fortunately, there are very few sick people at the fields". (Department of Health, Fresno, California).

In California, HIV tests and treatments are free, independently of the migratory condition; however, requests for these medical services may add to the obstacles to obtain citizenship. *"The service is free; what happens is that if you want to obtain citizenship, the U.S. government will demand that you have not requested or received free medical services, so many Mexican people are afraid and don't do it"*. Department of Health of the State of California, AIDS Office. Sacramento). This context is only a example of the meaning and adverse consequences that the use of health services may have for the undocumented migrant population, independently of their ethnic condition. Besides, we must also consider that although certain components of the health service are free, others aren't and, in general, the expense may be considerable, for lab tests, medicines, etc. *"Everything is very expensive now, the laboratory tests, medicines, condoms are four dollars or more, the HIV treatment is free, it doesn't matter if they're from Mexico because here there are intervention programs"*. (Department of Health of Fresno, California).

Social Networks for HIV/AIDS Prevention in Oaxaca-California

The various civil, social and political organizations in *Oaxacacalifornia* (Rivera-Salgado, 1998) have sought to build strategies responding to the different causes and needs of people involved in the migratory phenomenon. In this process, a fundamental aspect has been the promotion of actions to face the needs of the Indian population immersed in the transnational migratory phenomenon, with respect to health in general and particularly to STI/HIV/ADIS.

In the sphere of the grassroots organizations working for Indian women, the Rosario Castellanos Women's Home (Casa de la Mujer Rosario Castellanos) operating in Oaxaca, has established collaboration agreements with the State Council for the Prevention and Control of HIV/AIDS (COESIDA) and the United Nations Population Fund (FNUAP), seeking to have an influence on the municipalities with highest migratory indexes, mainly in the Mixteco and Zapotec regions of the Central Valleys. Based on this, the organization carries out actions to promote sexual health, directed to migrant Indian women who are day laborers and to those who are partners of migrant men and stay at their places of origin. From their experience, the preventive interventions of the civil and governmental organizations should sustain an intercultural health perspective and include men and women in an equitable manner.

In the program for agricultural day laborers, we promote the prevention of maternal death. We also train health promoters and the compulsory theme has been the means of transmission of HIV and promotion of condom use. When working with women, the demand arises as a clamor, for organizations and the government to create policies for the men (Informant. RC Women's Home, Oaxaca).

In the sphere of organizations directed by migrant Indians in California, one that stands out, among others, is the health project promoted for a decade by the Binational Oaxacan Indian Front (FIOB). The project is formed by three components: health education, including the HIV/AIDS problem, which is dealt with through workshops, health fairs and

distribution of printed materials; sensitization and intercultural education for doctors and nurses; also, facilitating access to health services, according to the real life situation and the cultural tradition or heritage of Indian migrants. *"We support people so that they will have access to healthcare services because they frequently don't know about the family health programs; we help them get appointments, fill out the forms, and provide them with an interpreter because sometimes they don't speak Spanish.* (Informant FIOB, California).

From this perspective, the FIOB has taken advantage of autonomous public spaces to promote health education actions in *Oaxacacalifornia.* The celebration of the "Guelaguetza" ("Reciprocity" or "Mutual Help") in California, is a festive space for the affirmation of ethnic identity. At this party, public health education has been promoted, including information on STI/HIV/AIDS, through the active participation of groups belonging to all generations:

In the case of the Guelaguetza (…) we use the space of the "calendas" to invite people to the party; people go and there's music, people decide to go; but when they come to us, what we're going to give them is information on reproductive health, violence, prevention of sexual diseases, of AIDS, cervical-uterine cancer, family planning, breast cancer, healthy pregnancy. (Informant. FIOB, California).

The migrant Indians from Oaxaca have also been able to have an influence on the media, some local and others binational. Since 1990, the project entitled "Bilingual Oaxacan Radio" ("Radio Bilingüe Oaxaqueña"), operating from California, has extended its transmission to Oaxaca and Baja California. In its programming, diverse problems of the Oaxacan Indian reality are dealt with, like the lack of access to health services and education *"always asking what benefits undocumented people have, talking about the problems related to payments and lack of access to hospitals, because there only the dying receive care"*. (Informant R.B.O., California). This radio station acknowledges the importance of talking about STI/HIV/AIDS among the Indian groups, since the agricultural male day laborers who *"arrive alone"*, are in a state of *"greater vulnerability to the infection"*. For this reason, this means of communication also seeks to contribute to the prevention of the epidemic, providing information on routes of transmission of HIV and promoting condom use.

Also, during the Mixtec Hour, we have played themes on AIDS, because this is one of the problems happening now that is very serious; what happens is that those who are most affected are the men who arrive alone at the agricultural fields, live in places that are much more marginalized, outside the city (…); we know that tuberculosis has been detected, and venereal diseases are more frequent because they go to the prostitutes frequently and don't know how to take care of themselves. Several AIDS cases have been detected. For this reason, on the radio, every three months we talk about health topics and AIDS, and we strive to inform on how to prevent the diseases (Bilingual Oaxacan Radio).

Conclusions

The insertion of Zapotec Indian groups and individuals in the transnational migratory process that takes place between Oaxaca and California, has transformed the social trajectory of these people. In contexts of inequality and inequity, new interactions are generated which define their condition of risk and vulnerability to sexually transmitted infection and HIV/AIDS. In the same way, in the places of origin and destination, networks

gradually consolidate and the available means are used to promote intervention for prevention, diagnosis and care of these health problems of the local migrant population. However, there are still limitations in the interest and commitment to developing integral policies for sexual and reproductive health that respond to the needs and reality of the Oaxacan Indian groups.

The scarcity of permanent health services, low frequency of notification, low attendance and lack of an intercultural health perspective to regulate the relationship between healthcare providers and users in Indian zones, are all structural factors that limit the impact and scope of the interventions (Lerín S., 2004). In the study, multiple difficulties were observed that are encountered by migrants when they try to have access to health services at their places of origin, transit and destination. According to the results of other studies (Solorio M., et al 2004; Bronfman M., and Minello N., 1995; Paris M., 2005), the undocumented migratory condition, fear of deportation, unemployment, lack of social security and high costs, are all factors which become obstacles to the use of health services in the U.S. On the other hand, in Oaxaca, the problem of access is given by the scarce installed capacity to tackle the relationship between migration and HIV/AIDS. In both places, the language barrier is identified as an obstacle for the use of services by the Indian population and for providers to offer adequate care (Solorio R., Currier J., Cunningham W., 2004). However, the meaning and consequences are different in one or the other space: while in California the use of health services may mean risk of deportation, in Oaxaca it may mean lack of understanding, maltreatment or segregation. In Oaxaca, healthcare providers frequently consider that the inclusion of the ethnic variable may lead to these services being less universal; thus, possibilities are reduced for an equitable and respectful interaction that takes into account economic and social differences, but above all, cultural differences (Lerín S., 2004).

On the other hand, the study allowed us to see the perceptions of risk of STI/HIV/AIDS, of Zapotec men and women who are immersed in the transnational migratory dynamics. A constant in the migratory contexts that were studied was the lack of preventive and educational actions directed towards the male population; this situation, together with the adoption of risky sexual practices during the migratory circuit, increases the vulnerability to STIs and HIV/AIDS (Bronfman y Minello, 1995; Bronfman M., et al. 2003). The interviewed Zapotec men go on their journey with certain references on means of transmission and prevention strategies for HIV infection; they tend to use condoms more consistently and adequately during their stay in California, and there is practically null use with their partners who stay at their places of origin. For the women who are partners of migrants in Oaxaca, the perception of risk is shaped in a scenario of change and continuity of the forms of family organization, where there is a strenthening of the marriage link at a distance, that is, maintenance and reproduction of material and symbolic interactions between the migrant husband and his woman and children, who remain at their places of origin (D´Aubeterre M., 2000). The Zapotec women who have had access to local health services have received certain information on prevention of STI and AIDS; however, you could say that for them, condom use and the tests to detect HIV are distant realities, which is evidence of, as was shown by other studies, inequitable gender relationships increasing the condition of vulnerability of women who are partners of migrants. (Herrera, C., et al. 2002; Bronfman, M., et al. 2003; Pérez H., et al. 2004; Leyva R., et al., 2005; Indignación

A.C. 2006). For this reason, involved actors, mainly the women themselves, consider that health education actions for the male population must be intensified.

At the same time, the study tackled the process of consolidation of social networks that synthesizes the work of diverse organizations that share goals and develop common actions to respond to the migrant Indian population's needs related to STI/HIV/AIDS (Leyva, R., et al. 2005). Governmental health organizations operating in Oaxaca and California have started to promote actions for the prevention, epidemiological surveillance, diagnosis and care of PLWAIDS. However, it is still necessary to develop strategies that include the diversity of experiences, interests and demands of Indians who are in the territory called *Oaxacacalifornia.* On the other hand, there are multiple references that have systematically examined the Oaxacan Indian communities as groups that have been able to consolidate fundamental spaces of transnational collective action (Fox, J., and Rivera-Salgado., 2004; Velasco L., 2002; Maldonado C., and Artía P., 2002; Leal A., 2001). As Jonathan Fox pointed out (2005), the Zapotec and Mixtec Indians have faced adverse life conditions and participate in the most relevant matters of their communities of origin through the establishment and articulation of grassroots organizations (clubs, associations, labor, community and religious organizations); they also have certain spaces in the media (newspapers, radio programs, independent videos and discussion forums); they have consolidated non-governmental organizations working with or conducted by migrant Indians and they have autonomous public spaces.

These spaces show the capacity for social response in order to improve living conditions, as a part of a defense of their rights, in contexts of adversity and social inequality. At the same time, these are key elements that contribute to the reduction of social vulnerability, increasing the capacity for prevention and handling of health risks, specifically when facing problems like STI/HIV/AIDS. This perspective of a context approach to health problems has been proposed by authors (Delor and Hubert, 2000; Bronfman et al. 2005) as a social strategy to tackle health problems in groups with high vulnerability. Its incorporation into governmental projects and programs for health promotion and care for migrants, as well as for those who stay in their places of origin, requires changes in the understanding and attitudes of healthcare providers when working with vulnerable groups, but also an improvement in the installed capacity of healthcare services at the places of origin and at those of destination, that is adjusted to the sociocultural context of Indian groups.

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