

Prevention of HIV infection among migrant population groups in Northeast Brazil

O papel da migração na prevenção da infecção pelo HIV no Nordeste Brasileiro

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Abstract

HIV infection is spreading among the poor, women, and migrant communities in the interior of Northeast Brazil. The research focused on different configurations, beliefs, representations, and forms of social organization of behavior thought to be associated with the population's capacity to efficiently follow AIDS prevention measures. Participants located in neighborhoods known for having large migrant populations were identified by Family Health Program Workers in Fortaleza and Teresina. The study adopted a qualitative methodology. Several belief-system concepts and values, as well as the social organization of sexuality revealed in the study, represent obstacles both to AIDS prevention and condom use. Hunger, lack of prospects, and fear are associated with a social situation of poverty, exclusion, prejudice, and total absence of basic human rights. When examined together, these elements define different configurations in the migrants' increased vulnerability to HIV/AIDS. The groups' increased vulnerability relates to the socioeconomic complexity that must be considered in HIV/AIDS control and prevention programs.

Acquired Immunodeficiency Syndrome; Migration; Primary Prevention; Vulnerability

Migration and HIV prevention

In Northeast Brazil, the acquired immunodeficiency syndrome (AIDS) is spreading and encompassing strata of society that, until recently, had not experienced the impact of the infection. Socially and economically disadvantaged population groups, women, and hinterland communities have recently begun to experience the presence of AIDS ^{1,2,3,4}.

According to Parker & Camargo Jr. ⁵, structural factors such as economic underdevelopment and poverty, population mobility and migration patterns, social stigma, and gender inequality are heavily associated with the spread of AIDS in Brazil. Interaction between these structural factors increases the vulnerability of deprived groups.

In the past 50 years, one of every three rural Brazilians has opted to migrate to urban areas ⁶. Brazil's 2000 census showed 82% of the Brazilian population living in urban areas ⁷. In the Northeast States of Ceará and Piauí, where this study took place, 72% and 63% of the population live in urban areas, respectively. ⁷ Recent migration patterns have evolved from general migration to the South and Southeast regions in previous years towards migration to larger municipalities of the interior or to the peripheries of State capital cities ⁸.

During the 1980s, the Northeast experienced Brazil's largest urban population increase. In

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1996, cities with populations greater than half a million, such as Fortaleza and Teresina, accounted for 39% of the Northeast's total urban population⁶.

Research in several countries has identified poverty, migration, and mobility as risk factors for HIV/AIDS^{3,9,10,11}. This may explain the upward trend in infection rates among the poor, women, and migrant communities in the interior of Northeast Brazil. Increasing vulnerability of these groups is related to the socioeconomic complexity that must be considered in HIV/AIDS control and prevention programs⁵. To overlook the social conditions of these groups would jeopardize the success of any intervention program, while further excluding the most vulnerable individuals and communities.

Context

The Northeast States of Ceará and Piauí have populations of approximately 7.5 million and 3 million, respectively. Twenty-nine per cent of Ceará's population is concentrated in Fortaleza, the capital city, while 15% of Piauí's population lives in the State capital, Teresina. Large cities like Fortaleza and Teresina offer an enormous contrast to conditions in the interior⁷.

The social context of complete vulnerability and social inequality, rooted in a veritable mosaic of cultural patterns, creates an environment that increases the migrant population's vulnerability to HIV and other sexually transmitted infections (STIs). The urban migrant population in Northeast Brazil should thus be studied in depth in order for adequate preventive measures to be developed. In addition to the above-mentioned objective aspects, numerous other subjective and social aspects, generally overlooked by the health field, will provide the central focus for this paper.

Theoretical Background

The field of prevention, based on social medicine, frequently appears as a set of practices geared towards the acceptance or rejection of behaviors associated with disease. This emphasis on behavioral conduct is based upon functionalism¹², for years enjoying hegemony in the field of investigation, biomedical practice, and social sciences within the Anglo-Saxon tradition. Within this dominant focus, prevention

is represented as a set of practices that essentially act as information directed towards various sectors of the population.

According to Parker & Camargo Jr.⁵ and Heise & Elias¹³, the three-pronged strategy of most AIDS prevention programs (reduction in the number of sex partners, promotion of condom use, and treatment of STIs) fails to sufficiently serve most of the world's women, often poor and powerless to negotiate sexual encounters.

This critical reflection on the underlying orientation in the widespread, standard guidelines currently dominating AIDS prevention campaigns in developing countries, or in countries and sectors of the so-called 'Fourth World'¹⁴, is significant to the extent that it identifies the residual effect of globalization in the development of poverty and marginality, regardless of the geographic region.

The existing literature linking poverty to migration and mobility to AIDS^{1,3,5,9,11} has still not examined the nature of subjective or concrete social factors associated with such living conditions.

Methodology

The basis for this study was a qualitative methodology based on different epistemological principles other than traditional positivist descriptive approaches^{15,16}. The research focused on various configurations, beliefs, and representations and forms of social organization of behavior thought to be associated with the population's capacity to efficiently follow AIDS prevention measures.

Our qualitative methodological study was based on the epistemological principles outlined in the definition of Qualitative Epistemology¹⁷. Key epistemological principles were the *constructive-interpretive* and *dialogical nature* of the processes of knowledge production.

Methods evolved initially from structured interviews to dialogical interviews and from there to conversations without defined limits. This stimulated the participants' active roles in the construction of knowledge, rather than limiting them to previously demarcated responses.¹⁸

Participants located in neighborhoods known for having large migrant populations were identified by Family Health Program Workers in Fortaleza and Teresina. Twenty-six (26) recorded interviews were conducted and subsequent-

ly transcribed. The sample was defined according to the target problem. Interviews were conducted at the participants' residences or places of work. Target issues included belief systems, forms of organization of sexuality, values, and condom use versus non-use. All participants provided written informed consent, and research ethics committees at all study sites approved the study.

Within the research paradigm, construction of knowledge centers on information formed during the process, rather than on classification of the participants' individual responses in categories defined in advance by the researcher. Collected data do not make sense in isolated units. Rather, the results must be interpreted and constructed within their complex system in relation to explicit and implicit indicators arising during the process^{17,19}.

Ethnograph v 5.0 for Windows was used to facilitate analysis of the interviews.

Belief systems related to sexuality and AIDS

Human sexuality is not a simple act of biological expression, but a symbolic, cultural, and subjective organization associated with numerous meanings, including belief systems through which human sexuality is conceived.

Various belief-system concepts revealed by the study pose obstacles to both AIDS prevention in general and condom use in particular.

The responses indicate what is assumed to be a direct link between AIDS and individual physical appearance. Referring to a man who had transmitted HIV to several women, one interviewee (a single female, age 24) claimed, "Women think that if the man's good-looking, sexy, and handsome, just by looking at him, you wouldn't think that he had AIDS." The response clearly demonstrates the belief that a beautiful body is healthy and impenetrable to HIV. Poor populations from other Latin American countries reinforced their conception of AIDS by listing visible characteristic symptoms, such as emaciation and skin lesions²⁰. Lack of awareness concerning healthy-looking HIV carriers was clear²¹. This illustrates a belief system that hinders consistent condom use by participants in "some cases", even in the presence of information about the disease and protective measures, leading to the conclusion that condom use is not part of regular behavior.

A similar belief was illustrated by another interviewee (married male, age 37). When asked, "Do you think people should take pre-

cautions, no matter what kind of sex they have?", he replied, "No, I think... [thinking to himself] I don't think so, because if you know the partner, that she's a *lady* [our italics], that she's not a dirty woman, I don't think you have to take precautions with all of them, do you? [silence] There are some women you can *go to* [sic] with confidence, without precautions, but not with all of them." The expression "dirty woman" has a double meaning here, referring to both personal hygiene as a protective measure against sexually transmitted infections, but also to the degree that a woman is deemed by her partner as sexually safe or unsafe²⁰. This common assumption generally results in unsafe sex not only with the man's current partner, whom he considers to be known and clean, but also with his permanent partner, with whom he believes that no risk of infection is possible. According to another interviewee (married male, age 40), "You only have to take precautions, have sex with a condom and so on, with persons you don't know well, if you don't know who she is. If it were someone I didn't trust, I wouldn't have sex, but when you already have an idea about her, about her life, you can go ahead without a condom." His initial expression explicitly emphasizes the need to use a condom, but later affirms the need for condom use only in situations where the man is unfamiliar with his partner. What actually determines condom use for him is clear. The implicit and indirect elements in the participant's interpretations and responses should be considered, as some may have shaped socially acceptable answers to intimate issues, i.e., the importance of condom use.

An equally dangerous belief is that AIDS has a limited period of transmissibility, that the disease can only be transmitted soon after the individual has had sexual relations. Thus, some women in the study demanded that their husband use a condom when they suspect he may have had sex with another woman. However, on subsequent days they no longer demanded condom use. This belief system presents a mindset that is not objectively associated with the processes involved in transmission and regulates participants' sexual and condom-use behavior. The belief system is part of the social mindset closely linked to other subjective and culturally defined systems that are pervaded by economic and social factors.

Another interviewee (married female, age 23) expressed the relationship between sex and love, indicating another belief that may dictate participants' behavior. She stated, "If my husband has [sex with] another woman, I think,

'With her it's just sex.' With his wife at home, he's making love. That's why I think it's different, very different." Belief that male nature requires several partners and that a husband therefore has needs met outside the family environment is not unusual and enables this woman to worry less about her husband's activities away from home and avoid turning a socially prevalent action into a personal conflict that may disturb her feeling of security. This belief numbs any intolerance she may have towards her husband, thus making it easier for him to have extramarital sex and consequently increasing the risk of disease transmission to her and others.

Other aspects deter condom use by participants, including the belief that a condom can come loose inside the woman. "Well, I was afraid it would stay inside me [laughter]. I didn't accept it before [her husband using a condom], and I don't now" (married female, age 44). Another participant mentioned difficulty in obtaining condoms from health professionals and the embarrassment involved in purchasing them. When asked, "What do you do [to protect yourself against AIDS]?", a participant responded in a hushed voice, "I use the 'thing'" (single male, 25). Another participant stated, "They [health center professionals] didn't give anybody any condoms" (single female, 17). Continued discussion of this issue revealed a strong sense of shame among participants regarding talking about, asking for, or purchasing condoms. "I've never tried [to obtain a condom] because I'm ashamed" When asked if her husband could not acquire the condoms instead, one participant responded, "But he's also too embarrassed." She also mentioned that although she and her husband had discussed using condoms, they could not afford them. Condom unavailability and cost are apparent obstacles to systematic use, especially among very low-income populations.

Condom use patterns are thus not absolutely uniform. Rapid changes in social organization, affecting sexual activity, have been observed in rural areas. Some participants openly referred to the purchase and use of condoms. One reported that, although he had never had sexual relations, his friends openly discussed their use of condoms. A single male age 22 said, "Women themselves talk about buying condoms," although he added that in the State capital this phenomenon is more common, and that women in rural areas are more embarrassed about the issue than men. The same participant said, "People used to go to the drugstore and ask for a load of things and then add...

'Ah! Can I have one of these too?' [a condom]. They didn't say the name. Now people go there and even crack jokes about it." Despite widespread knowledge about condoms, there was a stronger association between condoms and prevention of pregnancy than with STD prevention. In rural areas, such knowledge is generally acquired through television, community health workers, or verbally through returnees from the cities.

One participant commented on the association between condom use and a so-called "sinful" life: "People are quick to learn things that are, so to speak, furthest from God" (single male, 22). He referred to knowledge about condoms and the subsequent sexual activity of friends during trips to larger cities. The notions of sex and sin, and of sex as solely a means of procreation, are historical concepts within the Catholic Church²² that have a strong influence on the population in Northeast Brazil. Such concepts can lead not only to the condemnation of sexuality, as expressed above, but also to the disfavor expressed by a large part of the population towards condom use. One married male, age 35, laughed, "[With a condom], there's no pleasure in being together. It's a woman's vagina against plastic." He reported that while he was still single he never used condoms and that after AIDS came on the scene he stopped going to brothels, since he was afraid and could not bring himself to use condoms. "If a woman wants to do it with me, it has to be without a condom. There's no pleasure if I use one." Another participant stated that using condoms "is no fun. It doesn't feel alive. It [the penis] was not made to be covered. If you cover it [with a condom], it's no fun" (single male, 39).

The significance of sexual values

Values, as opposed to beliefs, are based on systems of socially acceptable norms. As such, they carry emotional significance and regulate an individual's behavior. The religious and political values of today's younger generations are important aspects for understanding sexual activity. Trust is one of the most important values within the Latin American social context, especially among migrants. Trust influences and regulates the non-use of condoms by couples. Some women in the study were very sensitive about their partners' regular use of condoms in their relationship. Referring to her steady boyfriend's regular use of condoms, a single female age 24 said, "I think he's more worried than I am because we'll only have sex with con-

doms. He refuses to have sex any other way. I've even said that I'd go to the doctor for prescribed contraceptives and he said 'No way.' The pressure she puts on her partner to stop using condoms clearly signifies their negative connotation for her. When asked "Were you afraid of getting a disease through sexual relations?", another participant responded, "Not me. I wasn't afraid because I'd never heard anything about his being with another woman, so I wasn't afraid. Not at all." When the interviewer insisted on asking if she trusted her partner, she replied, "I trusted him. When he lived away, twice in São Paulo and Rio de Janeiro, I asked him all about it, what it was like and so on. He told me everything" Men generally report that there is only a certain length of time they can go without sexual relations. Clearly, there exists a concept that a man's 'nature' brings about needs that must be met.

Another important determinant of condom use is the existence of a family and the responsibilities it entails. A married male age 40 stated, "After I got married, I took precautions because I had my family to think of. It's dangerous if the man gets the disease." In this case, family represents a value that caused several participants to worry about their sexual behavior.

Another example is a married male, age 35: "I only cared about parties when I was single. Then I got married, and the party's over. There's no fun now. If you go to a party, you have to spend money. Whatever I spend, I take from my children's mouths, so I prefer to stay at home." This illustrates how in some way or another, values are composed of meaningful elements that relate to the economic situation. To have a family apparently demands more responsibility from these individuals.

A married male, 37, reported that while he was still single he never used condoms. However, after he got married he did use them during extramarital affairs. "Now that I'm married, I take precautions because I have my own family. I have a wife, so it's no good [to take risks]. I have to be careful".

Religion also proved to be an important value that influenced these migrants' expressions of sexuality, besides mediating their dating age, sexual relations, and fidelity. This is apparent in several responses: "We have a very clear concept that you should date only when you have marriage in mind. If someone's not married, it's best if they try and marry first and lead a married life later. She must be a virgin until she gets married" (single female, 17). A single male, 25, said of sex before marriage, "If you're going to get married, you already start by sinning.

You should only have sex after you're married." Religious values have a strong influence on the subjectivity of the Brazilian population. However, as with other values, they may affect some areas of behavior more than others. With regard to AIDS prevention, previous studies of the region's adolescents have shown how religious values can influence an individual's self-regulation of behavior related to increased vulnerability to AIDS. This is especially true at the onset of sexual activity²³.

Socially recognized values associated with prestige and consumerism can generate situations in which lower-income girls have relations with individuals from higher socioeconomic strata. For example, in referring to a friend's comment, a single female age 24 stated, "For many people, what's important is physical beauty. Sometimes they don't even care about intelligence. I also think a lot of people care a lot about cars and money. I have a friend here in Fortaleza who can't see a car without saying, 'Oh my god, what a beautiful car!'" When the interviewer asked if her friend looks at the driver, she replied, "No, I used to say she ran on gasoline. She couldn't see a car [without reacting]. [Her friend] used to say, 'God, I used to go out with that guy just because of his car.'" This illustrates a case of socially dominant values defined by social and economic conditions that entice lower-income women, a situation that can facilitate risky and superficial sexual relationships.

At the root of this type of private response lies the attraction of money and lifestyles that poor people cannot afford. Such lifestyles are fascinating to the social mindset of many sectors of the lower-income population. These socially dominant values can increase vulnerability to AIDS and are defined within a complex social organization of sexuality built on people's economic needs. In many cases this includes subsistence needs.

The living conditions of both rural and urban migrants turn sexuality into a product to be negotiated and lead to behaviors that increase vulnerability to STD/AIDS. The community and families of many girls involved in this informal institutionalization of sexuality grow accustomed (and acquiesce) to these changing behaviors.

The dynamics of rural-to-urban migration is mediated by several factors that intervene in migrants' sexuality. Poverty is a key factor. Many women view relationships with men of higher economic status as an opportunity to improve their own living standards. Such men include those who return to their home town

with the results of better-paid activity outside the community. This is demonstrated in a number of ways in the group studied here. One example was a migrant who struck it rich at gold prospecting in the State of Roraima. He commented that returning to his rural home town after significantly improving his economic status enabled him to engage in behavior involving sex and drugs: "I left [gold prospecting] and came back to my home town just to relax. When I say I relaxed there, it's because I had money from prospecting. We used to make a load of money there, come here and spend it, and then go make some more" (single male, 36 years). Another migrant in similar circumstances said, "When I showed up with some money, I would have a lot of fun, go out with women, go to a motel with a girl, and do everything. I'd never ask [if she had a disease]. It was just a matter of luck" (married male, age 37 years). These comments illustrate how sexuality is mediated by money and that there is little concern for prevention.

For migrant women, on the other hand, lack of money in the cities presents different circumstances and decisions. One participant reported how her impoverishment led her to potentially submit herself (she denied this type of involvement) to the process of exchanging sex for money or for more favorable conditions: "Because I was in such great need, it was very tempting" (single female, 24). She added, "I've never had male 'friends' [who] just show up and do something without expecting anything in return. I lived with my son. I even reached the point of hunger, not having money to pay the rent. There were a lot of men there who really wanted me. They tried to have sex with me. Most of them were married, knew about my situation, and often showed up offering money and wanting [sex] in return." This is an example of a girl facing difficulty in surviving that, for a weaker person, would have been enough to lead to prostitution. This situation can lead both women and men to exchange sex for money, which can be used to buy alcohol and drugs.

Women's economic dependence has been cited as an important determinant in their vulnerability to STD/AIDS²⁴, a fact particularly evident in Brazilian society. The male role is that of family provider and is subscribed to by both women and men. One participant clearly stated that immediately after getting married, her husband took on the breadwinner role and prohibited her from working. He claimed that no wife of his was going to work. She justified the fact that she had migrated with him based on the hope of working and studying. Nevertheless,

once married, her first reaction was to submit to her husband's decision and accommodate herself to the role reserved for many women in Brazilian society. She stated, "I thought [stopping work] was great. When a man really wants to commit himself to a woman, I think that [providing for the family and forbidding his wife from working] is what he should do" (married female, 24).

Women working outside the home reach a level of economic independence and have the ability to meet people outside the household. This is interpreted as an increased 'risk' for infidelity to her husband. One female participant said, "All men whose wives work [outside the home] certainly think about this [the risk of infidelity]. I think that's why he won't let me work" (married female, 24). The man's role as provider is so established and valued that male and female infidelity are viewed very differently. If the man correctly assumes his role, his extramarital affairs are tolerated. If his wife cheats on him, she faces harsh criticism from both men and women. One of the participants gave her opinion about another woman who was cheating on a man who supports her family financially: "She's really arrogant [to cheat on the man]. He works, struggles for this woman, makes all the sacrifices, and she goes and cheats on him. The poor old guy is innocent, so I think she's losing her grip" (married female, 34). Nevertheless, acceptance of male infidelity by women is much more common than the other way around. It is part of the female role to accept male infidelity, as illustrated by this same participant: "Women are weaker. Men cheat on their wives, but women always accept it. Men won't stand for it" From the social and economic perspective, beliefs and attitudes about sexuality have important repercussions on the spread of HIV, especially in transmission of the virus within the family environment, making women extremely vulnerable.

Values generate beliefs, and beliefs are based on sets of values that define complex symbolic systems. A clear understanding of these symbolic systems is required to develop efficient HIV prevention programs.

Social organization of sexuality

The belief systems and values presented above are integral to the social organization of sexuality, a key term for understanding the risk of sexually transmitted diseases in different cultural and socioeconomic contexts. For example, the context of migrants in the cities of For-

taleza and Teresina involves mixtures of people from different origins who generally live in poor, outlying neighborhoods where drugs, alcohol, and violence are part of daily life.

These characteristics are significant to processes of subjectification and appear in different forms associated with the meaning and exercise of sexuality in these population groups. One aspect of sexuality that most intimately affects individuals is rape or sexual harassment of girls by their fathers or mothers' partners. Rape is extremely frequent under the influence of alcohol and/or illicit drugs, creating an association between sexuality and violence and the immediate response of men to sexual impulses.

One participant reported that as a young adolescent, she was thrown out of her home when she rejected harassment by her stepfather. "The guy [stepfather] didn't like me. He harassed me when I was a child, and I never stood for it. I never told my mother. Even if I had, she wouldn't have believed me" (single female, 24). Years later, in her late teens, she had a child and went to live with her boyfriend's parents, where the past repeated itself. "One night, his father [the father of her child's father] arrived home drunk and when I woke up he was trying to touch my breast so I went and got his wife and told her. He got all upset and kicked me out."

Casual sexual relationships, often fueled by alcohol and drugs, generate condom non-use and other high-risk behaviors. Such practices, beginning in adolescence, lead to further spread of disease. A single female, age 24, when asked if men had sex only when they liked the woman, replied, "Men have sex on the spur of the moment. At a party, they meet a woman, chat, have a beer, and go to a motel and have sex. Later they regret it [having done something they would not have done sober]."

The association between alcohol, violence, and sex is evident. This form of violence is manifested in several ways. It can affect all individuals, corrupting men and women. It can also undermine social values and cause family breakdown. This alcohol-associated lifestyle can generate violence and abuse combined with initiation into sexuality, potentially generating deviant sexuality that can facilitate promiscuous behavior and prostitution, perverse and damaging social forms of sexuality.

Another interesting aspect of the social organization of sexuality is how language embellishes ideas of sexuality that are considered outside the norm. One example is the use of the verb 'to play' When speaking about her life when her daughter was still young, a single female, age 24, stated, "I didn't feel very respon-

sible because I think I didn't actually know what it was, all I wanted was to play." When asked to elaborate on the word 'play', she replied, "[To] party, go to parties. I used to drink. I had some crazy friends. I started smoking." Here, playing is distinguished from simply going to parties by the presence of alcohol, smoking, sex, and loss of control.

Several interviews highlight increased opportunities for intimate relationships in the city, ranging from having a more active social life to increased promiscuity and risk of contamination, all permeated by a decrease in the family's control and authority. A single male, age 25, spoke of the control that family, especially women, exert on children in rural areas. "The parents keep a tight rein. They're stricter [in the country] than parents are in Teresina. Here, it's more relaxed. You have more chances."

Sexual activity in the city is more intense and integrated earlier in the relationship. It is much more temporary and lacking commitment to the partner. The practice of 'hanging out' (or literally 'staying' temporarily with someone) is particularly commonplace in the capital city. This practice is defined by one of the interviewees as follows: "To 'stay' is to date without commitment. You can be with someone one day and other times pass them on the street without saying a word to them." A single female, age 17, compared 'staying' in the capital and in rural areas: "Girls [in the country] also 'stay', but here [in the city] it's more common. There, people get involved with each other and stay together for longer. Here, people can 'stay' with one person one night and then never see them again or only during Carnival the following year."

More infrequent social activities, the role of family, and paternal authority can also be responsible for the differences between the rural areas and the capital. According to one interviewee, "Here [in the capital], a girl goes out with her boyfriend, they go to a beach, go wherever they want. Then they can make out and do what they feel like, even have sex, whatever they want." However, another participant (married male, 35) added this description of rural dating: "If you want to date a country girl, you go to her mother's house, sit on the doorstep, and talk until a predefined curfew." Other important differences involve the characteristics of rural communities, which are smaller and have greater social interaction and control. A single male, age 19, said this about dating: "Here in the capital, it's easier to hide who you're dating. But in the country, everybody knows everybody else in a five-block radius."

Still, the family's controlling function – at times paternalistic – is coupled with a lack of dialogue on sex education. The ever-present obligation to marry when sexual activity is discovered by the parents perpetuates poorly structured families. Interest in marrying off children may be due to the parents' wishes to rid themselves of the financial burden.

In relation to the construction of emotional relationships, there are striking differences between the purposes of intimate relationships in the capital as compared to rural areas. A single female, age 24, made this distinction clear: "I think that dating in rural areas leads to marriage, but dating in the city leads people to move in together or get their own respective places." A single male, age 22, added, "[In the country], a guy dates a girl for six months, maybe a year, then they get married. It's a serious relationship."

Conclusions

The HIV/AIDS epidemic, associated with multiple contradictions expressed by the societies in which the virus is spreading, is a social problem that transcends merely the non-use of condoms. Condom use is one measure within a complete system of prevention. As our research demonstrates, sexuality is not isolated from the social context. Rather, it acquires meaning within the set of processes that are part of humans' social existence.

Culture, defined as a set of beliefs and representations associated with different human

practices, strongly influences the development of a set of behaviors that increase vulnerability to HIV/AIDS. As illustrated by our research, a set of representations by both men and women determine irregular and differential condom use, based on local criteria not rigidly applied to HIV-related behavior.

The study draws a clear distinction between two different definitions of poverty. At the economic level, poverty as a variable is susceptible to numerous human relations and behaviors. Poverty can also be defined as the backdrop for highly complex social processes through a diverse and polymorphous web of expressions that are not visible in descriptive appearances and require a constructive effort on the theoretical level.

Family breakdown, dominant gender patterns, the struggle for day-to-day survival, and drug abuse are elements in a particularly detrimental social situation. Hunger, lack of prospects for the future, and fear are associated with poverty, exclusion, prejudice, and a total lack of basic human rights. Taken together, these elements define different configurations in the migrants' increased vulnerability to HIV/AIDS.

In conclusion, the study is intended as a contribution to the involvement of social critique and action in the health sciences. Central aspects associated with dominant power structures, such as health and education, are currently being prioritized with the more traditional macroeconomic and social aspects. Further development of this methodology undoubtedly presupposes overcoming the descriptive models that currently dominate the field.

Resumo

A infecção pelo HIV entre pobres, mulheres e populações migrantes do interior do Nordeste Brasileiro vem crescendo. As diferentes configurações, crenças e representações e formas de organização do comportamento, associadas à capacidade de seguir adequadamente medidas de prevenção, foram o foco desta investigação. Os participantes foram localizados em bairros com altas taxas de migração através do Programa Saúde da Família em Fortaleza e Teresina. Empregouse a metodologia qualitativa nesta investigação. Vários sistemas de crenças, valores e organização social da sexualidade desta população representam obstáculos à prevenção da AIDS e inibem o uso do preservati-

vo. Pobreza, falta de perspectiva e medo estão associados à situação de pobreza, exclusão social e preconceito e à total ausência de direitos humanos. Quando examinados conjuntamente, estes fatores definem diferentes configurações dos migrantes com uma elevada vulnerabilidade ao HIV/AIDS. A alta vulnerabilidade destes grupos, relacionada à complexidade sócio-econômica, deve ser considerada nos programas de prevenção e controle da AIDS.

Síndrome de Imunodeficiência Adquirida; Migração; Prevenção Primária; Vulnerabilidade

Contributors

L. R. S. Kerr-Pontes contributed to the research execution, analysis, and drafting of the article. F. González collaborated in the analysis and drafting of the article. C. Kendall participated in the gathering of bibliographic references, analysis, and drafting of the article. E. M. A. Leão coordinated the field work and participated in the analysis and drafting of the article. F. R. Távora, I. Caminha, A. M. Carmo, M. M. França, and M. H. Aguiar contributed to the collection of bibliographic references and field data, analysis, and drafting of the article.

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