A CULTURAL APPROACH TO

HIV/AIDS PREVENTION AND CARE

UNESCO/UNAIDS RESEARCH PROJECT

CUBA'S EXPERIENCE

COUNTRY REPORT

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Since the mid-eighties, the fight against HIV/AIDS has gradually mobilized governments, international agencies and non-governmental organizations. However, it became evident that despite massive action to inform the public about the risks, behavioural changes were not occurring as expected. The infection continued to expand rapidly and serious questions began to emerge as to the efficiency of the efforts undertaken in combating the illness. Experience has demonstrated that the HIV/AIDS epidemic is a complex, multifaceted issue that requires close cooperation and therefore multidimensional strategies.

The establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1994 initiated a new approach to the prevention and care of this disease. The first requirement stressed was the need for increased coordination between institutions. An emphasis was also made on the need to work on both prevention and treatment while considering the significant social factors involved. As a result UNAIDS was involved in several studies focusing on developing new methodological strategies with which to tackle the issue.

Following a proposal made by UNESCO's Culture Sector to the UNAIDS Programme, on taking a cultural approach to HIV/AIDS prevention and treatment for sustainable development, a joint project "A Cultural Approach to HIV/AIDS: Prevention and Care" was launched in May 1998. The goals were to stimulate thinking and discussion and reconsider existing tools with a cultural approach.

Taking a cultural approach means considering a population's characteristics - including lifestyles and beliefs - as essential references to the creation of action plans. This is indispensable if behaviour patterns are to be changed on a long-term basis, a vital condition for slowing down or for stopping the expansion of the epidemic.

In the first phase, of the project (1998-1999) nine country assessments were carried out in three regions: Sub-Saharan Africa (Angola, Malawi, South Africa, Uganda, Zimbabwe), Asia and the Pacific (Thailand and bordering countries) and the Caribbean (Cuba, Dominican Republic, Jamaica). The findings of these studies were discussed in three subregional workshops held in Cuba, Zimbabwe and Thailand, between April and June 1999. All country assessments as well as the proceedings of the workshops are published within the present Special Series of Studies and Reports of the Cultural Policies for Development Unit.

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Research Team:

By the Center for the Prevention of STD/AIDS:

Dr. Rosaida Ochoa Soto. Doctor, specialist second degree in Epidemiology. Director of the Center for the Prevention of STDs/AIDS.

Lic. Manuel Hernandez Fernandez. Licenciate in Sociology.
Dr. Irina Hernandez Cuesta. Doctor, first degree, specialist in Epidemiology.

For the Province of Villa Clara:

Lic. Marina Ariz Pupo. Lic. In Psychology. Lic. Angela Olaechea Lozano. Lic. In Psychology. Dr. Isa Alvarez Leon. Doctor, specialist in Epidemiology.

For the Province of Holguin:

Dr. Apolonio Reyez. Specialist in Sexual Education for Health.

SOCIO-CULTURAL APPROACH TO THE PREVENTION OF SEXUALLY TRANSMMITED DISEASES AND HIV/AIDS IN THREE REGIONS OF THE COUNTRY

I. INTRODUCTION

The challenge that mankind faces is that of adopting a new way of thinking, acting and organizing, in sum, ways of living to enable an increase of its quality in life and thus, to improve its health.

Many are the factors intervening in this process, economic, cultural and social ones, that is why the study of each one of them offers a stream of knowledge from which to chose the strategy to follow.

Among the aspects mentioned, the cultural factors are fundamental variables in explaining the different stages of the changes required to the extent that the attitudes and styles of living have an impact on the well being of individuals and communities.

AIDS is no different from other health problems. The way in which people in different cultures react allows us to realize the complexity and variety of different approaches. Each country, each group, each person has its own image of the disease, which not only depends of its dissemination and on the number of victims it causes, but also on the reactions and adapting to it, thus the importance of incorporating socio-cultural perspectives in the prevention strategies.

Cultural factors have an incidence in the health of a population and in the values, attitudes and reactions that favor the physical environment, as well as family and personal values which characterize and consolidate a society are seen.

It is not only a question of determining the negative elements that intervene in the problem but also of identifying the good practices linked to culture and to promote them, an aspect that can become a significant step forward in prevention and on which human development should be based.

In the approach to AIDS, we grant special attention to the concept of culture that defines it as the “way of living together” and how it influences people’s style of living. Within this process “to increase people’s options” giving an importance not only to collective capacities, but also to the capacities of individuals to develop into healthy, educated, productive and creative persons has been a very debated approach where education and communication constitute an important element.

II. GENERAL INFORMATION OF THE COUNTRY

The Republic of Cuba is located in the Caribbean Sea, made up by an archipelago formed by the Island of Cuba, the largest, the Isle of Youth and over 1,600 small islands and keys.

The extension of the Cuban archipelago is of 100, 860 square kilometers and the extension of the Island of Cuba measured by its mean axle is of 1200 kms.

It has a tropical climate greatly influenced by the sea in its meteorological variables, the annual mean temperature is of 24,5 EC with highs of 39 EC and lows of 5 EC.

The main export commodities are sugar, tobacco, nickel, and citrus fruits and in recent years tourism has increased at an accelerated rate.

The estimate of the country's population for 1996 was of 11,005 866 inhabitants. The distribution by sexes is of 5 529 000 for males (50.2%) and of 5 509 000 for female (50.0%). The City of Havana is the capital, having 2 204 000 inhabitants.

According to the last Population and Housing Census of 1981, 69.0% of the population was urban and 31.0% rural. Regarding the percentage in the distribution of persons in ethnic groups, 65.9% of the population is white, 12.0% black, 21.8% mixed and 0.14% Asian.

The Populations' Health Conditions

Cuba has made achievements in the field of health at international level which are reflected in indicators such as mortality rate, proportion of child deliveries attended by specialized personnel and immunization among the infant and adult population against preventable diseases with the use of vaccines. Cuba has reached figures similar to those of industrialized countries in the birth rate, the global fertility rate and life expectancy at birth. Cuba is above the indicators of Latin American, the Caribbean and other developing countries in indicators such as infant mortality, mortality rate in children under 5 years, mother mortality rate and low birth weight. [1]

In 1997 the main causes of death among all age groups were: heart diseases, malignant tumors, brain and vascular diseases, accidents, influenza and pneumonia.

A special impact has occurred with the Mother-Child Program, improving indicators every year and having already reached the goals set out by the World Summit for Children for the Year 2000. Particularly in 1997 the infant mortality was the second lowest of all times, which places us among the 28 countries with the lowest infant mortality rates in the world.

The aims are to maintain the infant mortality rate under 10 for every 1000 live births, at the end of 1997 the rate was of 7,2 per 1000 live births, compared to 9,4 for the same period during the previous year, to reduce the maternal mortality rate to under 3,0 per 1000 live

[1] Source: National Statistics, ministry of Health, Cuba, State of the Infant World, 1995, UNICEF

births, it is currently at 2,4, to maintain the current limits regarding low birth weight Index (at present in 7,9) and the mortality rates of pre-school and school children at 6.1 and 0.4 per 1000 inhabitants in the respective age groups.

In that sense, priority will continue to be placed on pregnant women, on measures related to nutrition and attention at maternal homes, and the necessary actions are taken, from the technical point of view, to guarantee the control and development of this programme, which constitutes a genuine pride for our people.

In the field of transmissible diseases, a group of infectious-contagious diseases, such as autochthonous malaria, polio, difteria, human rabies and infant tetanus have been eradicated. Small pox, has been abolished since July 1996, while in 1997 both rubella and pharodititis were eliminated; reports of whooping cough as well as deaths due to this disease have seen scarce.

Leprosy has not been a health problem in the country since 1993, as the rates are under 1 per 10 000 inhabitants.

After massive vaccination campaigns against meingococ diseases, there has been an important reduction in the number of sick people and deaths due to them.

Sexually transmitted diseases, especially syphilis and gonorrhea have shown increases in recent times. In 1997 the rates of syphilis and gonorrhea were of 143.3 per 100 000 inhabitants and of 302.7 per 1000 000 inhabitants respectively, that is why the strategies of the Ministry of Health it has been decided to make these diseases a priority issue.

While the life expectancy of Cubans has increased, being today that of 75 years, non transmissible diseases and other forms of health threats increase and even change their behavior, heart attacks vascular-brain diseases, high blood pressure, diabetes, bronchial asthma, cancer and accidents, among others, which constitute the first causes of death in the country. As a result of this, the Ministry of Public Health established, in 1992, the “Objectives, Proposals and Directives to Improve Health in the Year 2000”.

The Health System in Cuba is based on the **Family Doctor and Nurse program**. Since 1985, its coverage has had a sustained annual increase which reaches since 1997, 97.6% of the population nation wide.

The Family Doctor and Nurse is the population’s first contact with health services and provides a natural entrance to the system. This system provides medical attention in general practice, it attends the patient in his or her home, in day-care centers, schools, the work place and guaranties the continuation of the care whenever other specialized attention is required. This doctor that practices scientific and human medicine, has a deep social orientation, he is actively involved with the community, influences and participates in the modification of the problems that affect man and his physical and social environment.

This medical team of the doctor and the nurse works in small consultation houses, built in the same zone where the populations they attend live, being part of the team formed by

Polyclinic. In their training, through the system of residency and from their own working places, these doctors become specialists in Integral General Medicine, the foundation on which other medical specialties are formed.

The system has 281 hospitals, 442 policlinics, 168 stomathology clinics, 49 Centers and 134 Hygiene and Epidemiology Units, as well as Health Polytechnic Institutes, Enterprises producing and trading medicine, Electro-medicine Centers and an important number of units, among them, 6 Cardiocenters, 34 Intensive Care Units for children and 49 for adults, distributed homogeneously throughout the national territory. The healthcare system is completed with a wide network of units and services throughout the country, which totals approximately 53,952 real beds with an occupational rate of 73,2.

Education and Culture

Among the achievements attained in terms of human development, during the revolutionary period, the advances in the field of education are outstanding.

Since 1959 actions have been taken with the purpose of guaranteeing access to education for all citizens through the extension of the educational services throughout the country and to all the social sectors, the establishment of new class rooms, the National Literacy Campaign, the nationalization of private schools, the establishment of the national scholarship plan, the beginning of systematic adult education, the accelerated formation of teachers and professors and the university reform.

The celebration of the National Literacy Campaign in 1961 was without a doubt an important development in the progress attained in these years, illiteracy was eradicated in a short period of time. This colossal task was carried out on the basis of a movement of voluntary and massive participation on the part of the population. The ‘literacy force’, of approximately 270 thousand members, was made up of students, teachers and workers.

Thanks to the campaign more than 700 thousand persons, mainly in rural zones, learned to read and write in less than a year. The illiteracy rate was reduced from 23.1% in 1958, to 3.9% of the total population in 1961.

Currently, the global rate of literacy represents 96.7% of the population within the ages of 10 or more years of age. The other 3.3% is composed of persons that due to their ages or physical or mental problems could not be educated to this end.

The above-mentioned facts are based on the implementation of the principle of education for all. The Law of the Nationalization of Education, apart from establishing the function of education as a duty of the State, guarantees the right of all the citizens to receive education free of charge, without distinctions or privileges.

A systematic increase in the range of persons that the Cuban Educational system reaches has been achieved and currently 2.3 million students are enrolled in school, over 20% of the population.

A significant result in the improvement of education in Cuba has been the generalization and perfection of adult education, which has resulted in a massive increase of the education level of the population and at the same time has allowed to solve the society's needs in the field of labor force.

Likewise, the means of access to higher-level education has been diversified for young people with vocational and training level studies as well as for workers, house wives, etc.

The increase in the quality of education in Cuba can be doubtless seen in the high indices of students staying in school.

The country's labor force has a high level of technical qualification. Of each 100 workers, 7 are university graduates and 13 are middle technicians.

As a result, the Cuban education system has fulfilled the objectives and goals contained in the Main Education Project for Latin America and the Caribbean, as well as those agreed upon in 1990 in the Action Plan as a result of the Education for All World Conference of Jontien, (Thailand) regarding the coverage of the basic education and illiteracy.

Culture

From the Cultural point of view, significant transformations have also taken place which reach diverse fields of spiritual and intellectual life of society.

The literary development has had its main corner stone in the establishment of the system of publishing houses, supported by the State and with the capacity to satisfy in a growing way the interests of the readers. This situation has contributed in a significant way to the revaluation of both the national and universal cultural richness.

In addition, a network of libraries has been established, that permits to increase cultural work in all the sectors of the population.

In the field of art, the establishment of a network of low fee cultural facilities is outstanding, as well as the quality of its services. This has promoted a massive participation in cultural activities and has achieved the participation of workers, peasants, students, and particularly, that of young people and children.

The development of sports has been another achievement, today more than 2 500 000 children and youngsters receive physical education, from the pre-school level up, 40% of the Cuban population practices physical activities regularly and 20% occasionally.

At the community level, there are also activities such as: festivals, tournaments, gatherings, etc. In the rural areas, together with the construction of rural sports facilities and the holding of traditional activities for those areas, the incorporation of professors of physical education has been achieved. Sports and recreation have become main sources of spiritual richness of the different sectors of the population.

III. CURRENT SITUATION OF SEXUALLY TRANSMITTED DISEASES (STDS) AND HIV/AIDS

Currently HIV/AIDS and the STDs (Sexually Transmitted Diseases) are the most frequent group of infectious illnesses of compulsory declaration in the majority of the countries, especially among persons between 15 to 50 years. Its control is of vital importance for all countries due to the high incidence of acute infections, complications, sequels and deaths, as well as the socio-economic impact of these diseases.

STDs are hyper-endemic in many developing and developed countries, the classic bacterial ones (syphilis and gonorrhea) have relatively diminished to give way to others like chlamydia trachomatis, genital herpes, papiloma virus and HIV/AIDS.

HIV/AIDS:

During the 1986-1997 period, 1,831 persons were detected with HIV, observing that the rate of detection increased in 1991 to fall during the next three years with an increase as from 1996.

Until September of 1998, 209 new cases of HIV have been detected, this makes a current accumulated total of 2,040 persons infected, of which 768 have developed the AIDS disease and 547 have died due to it.

When analyzing the behavior of the epidemic, one can observe a general sustained growth in the detection of HIV infected persons, particularly in homosexual and bisexual men who are in turn inciting an increase in the incidence of HIV positives females.

The provinces with the highest rates during 1997 were: Havana City, Pinar del Rio, Havana and Matanzas in the western region and Las Tunas, Holguin and Guantanamo in the eastern region. In 1997 56% of the HIV positive persons detected in the country were to be found in Havana City.

Like other sexually transmitted diseases, the most affected persons are those who are more sexually active, observing throughout this period that the highest rate is among those between 20-24 years of age, followed by the group of 25-29. Around 80% of the cases are in persons between 15-29 years of age.

Syphilis:

During the past 10 years, an ascending trend has been witnessed in the occurrence of this disease throughout the country, with rates that are progressively increasing, from 84% per 100,000 inhabitants in 1987 to 127, 9% in 1995 and 143,3% during 1997.

The age groups with the highest rates of incidence of syphilis, as well as gonorrhea and AIDS, are young people between the ages of 15 and 24 with a higher incidence in males.

Gonorrhea:

The falling trends of 1997 have been maintained, a phenomena that is being evaluated in all the provinces.

In September of 1998, 2,680 less cases were reported than in that same period in 1997.

The results obtained through epidemiological surveillance, show that 7,7% of notified cases were in the student group, the higher rates being in the group between 15-24 years of age. A perception of low risk was detected through opinion polls and the low use of condoms apparent in this high-risk group makes it in a target population of extraordinary importance for our prevention and promotional actions, both interdisciplinary and intra-sectoral.

The struggle against Sexually Transmitted Diseases and HIV/AIDS surpasses the field of Health becoming a problem for the whole of society, thus requiring for its solution, the efforts of all the State Institutions and mass organizations.

To achieve a modification of the trends and a reduction of the transmission of these diseases actions of health promotion are required in order to promote safe sexual habits and conducts of lesser risk, that will surely have a middle and long term impact.

In 1972 the Programme of Prevention and Control was established for syphilis and gonorrhea, and in 1985 the Program for the Prevention and Control of HIV/AIDS was established and is coordinated by the Ministry of Public Health. The Program includes the following issues:

- Education
- Epidemiological surveillance
- Medical Assistance
- Laboratories

The initial strategy of the Programme in the Struggle against AIDS has a strong sanatorial focus. As of 1993 the System of the Ambulatory Assistance began for those infected and sick, this offers patients with HIV, who have proved to be consequent with their health and the health of others, the possibility of returning to society, where their living conditions are guaranteed.

Since these programs were established, as a priority for the health authorities, there has been intensive work in the strengthening of the educational component, mainly aimed at youth and other vulnerable groups, as well as in the sale of condoms.

IV. OBJECTIVES

General Objectives

Strengthen the socio-cultural approach in projects planning and evaluating the prevention of STD/AIDS in three regions of the country.

Specific Objectives:

- Further explore the cultural factors, values, traditions and practices associated with the prevention of STDs/HIV/AIDS among youngsters between the ages of 15 and 24 vulnerable to HIV/AIDS in three regions of the country.

- Present guidelines for the development of research on vulnerable groups.

- Implement methodologies for intervention projects in vulnerable groups.

V. METHODOLOGY

The population that has been the focus of study was formed by youngsters between the ages of 15 to 24 from the provinces of Havana City, Villa Clara and Holguin.

The method used was that of discussions in Focal Groups, that enabled us to find richer answers, original ideas, giving us the opportunity to observe the debate, facilitating a qualitative and interpretative reading for the understanding of the emotional aspects giving us a clue of the cultural aspect to be explored. This technique was both low cost and time efficient.

The number of groups and their composition of the groups were established through the following socio-demographic variables being organized in the following way:

AGE: it gives different answers based on the experiences of the life cycle of the persons. The sexual activity in these groups of ages (15-19/20-24) and the way of expressing their sexuality are different.

SEX: both sexes. The social background or the gender roles influences perceptions, beliefs and behavior.

GEOGRAPHIC REGIONS: The provinces considered were the Eastern (the province of Holguin), Central (Villa Clara), and Western provinces (Havana City), and among these the rural, urban and sub-urban regions, as perceptions, beliefs and behaviors vary from one region to the other due to economic, socio-cultural factors which have an influence in the answers.

HIGH-RISK GROUPS:

- **Men that have sexual relations with other men without the use of condoms:** The current profile of the disease in our country shows a larger incidence in this population group. Preventive messages have not been directly aimed at this group. There is no tradition of preventive work with this group.

- **Women with risk behavior:** Women with occasional sexual partners or without stable partners and not using condom. Preventive messages have not been directly aimed at this group. There is no preventive work tradition with this group.

- **Migrants:** Men living outside their provinces for less than 5 years that are in a boarding system in working contingents. Migrations are favorable to the concentration of large numbers of men than women, giving way to high-risk sexual behavior.

Determination of required groups

The sample for the study was intentionally formed in the following way:

15-19 years	8 groups of the rural areas (4 female and 4 male)
15-19 years	8 groups from the sub-urban areas (4 female and 4 male)
20-24 years	8 groups from rural areas (4 female and 4 male)
20-24 years	8 groups from the sub-urban areas (4 female and 4 male)

As we can see subgroups were established according to age and gender.

High-Risk Groups

Two focal groups of men having sexual relations with other men in Havana City and Villa Clara (urban and sub-urban areas)

Two focal groups of women with high-risk behavior (urban and sub-urban area)

One focal group of men working in contingents (migrants)

These are defined through the above-mentioned variables, the ages of the persons forming the groups ranged between that of 15 and 24.

A total of 37 groups were formed. Being the number of participants of 9 to 10 per group. This number was established to allow a larger period of time for individual participation and to favor a less direct style of moderation. With these elements a better quality of information was found as well as more profound replies.

The length of each session was of one hour and a half to two hours.

In order for discussions to run smoothly and be rich in content, an effort was made to avoid interruptions, and assure the necessary privacy and confidentiality. In this sense, work with high-risk groups was carried out in neutral surroundings. Participation was voluntary. The places where the sessions were held were chosen with consideration to their potential accessibility for participants.

The moderation of the groups was the responsibility of biomedical and psychology experts, with experience in group sessions. An observer on content was included in each session.

For the process of elaborating the guidelines the following steps were followed:

The project group met in order to define the objectives of the research and the information was required. A list of thematic fields of general issues was drawn; later on the non-essential thematic areas were eliminated. For this process the results of previous research in the field were taken into account.

Two different instruments were constituted: A discussion guide of for youngsters in general, a guide for men having sex relations with other men. It was semi-structured in order to allow a larger freedom for discussion.

The guides included questions for the deepening of knowledge, perception, beliefs and practices regarding the prevention of STDs and HIV/AIDS. In its elaboration free association and projective, interpretative and directed questions were used. (Annex). The thematic contents of he main document sent by UNESCO were consulted.

Information gathering and analysis process

The information was gathered through tape recordings of the sessions; observations of the non-verbal expressions (body language, gesticulations) made were also noted.

Each session was transcribed and then printed out with the use of personal computers, the moderators and observers were responsible for this task which was meant to allow for a up to date approximation of the issues discussed.

With the printed content, each text was reread to facilitate its understanding. With the information already printed, a key was drawn up of the categories that were constant and common to all the groups, the various stands were outlined, differences were identified, and each group drafted a brief version of the contents.

On close observation it was discovered that certain attributes related to the beliefs of syncretic cults were indirectly related to the findings of other authors that relate these types of beliefs with certain values promoting risky conducts. Among these is the frequent change of sexual partners in men as a symbol of manhood.

VI. CONCEPTS

On the one hand, we departed from the approach that actions towards the prevention of STD/AIDS in the exercise of sexuality do not occur naturally but rather have been conditioned by historical and cultural factors.

On the other hand, identical sexual acts may have significantly different subjective or social meanings, depending of how they are defined and understood by different cultures.

Cultures construct different categories, schemes and names through their communication of information that frame sexual and affective experiences.

Information on sex

As information on sex we understand all those ideas, principles, notions, myths and symbols used by different cultures, in different spaces and times.

As individuals become socialized, they learn of the cultural-sexual constructs of their society through information and messages, scientific or not, that are communicated to them.

This culture of sexuality is understood as the information (messages) on issues of sex and sexuality that young people receive, including the contradictions that they contain, the resistance that they instigate and the way that they are entrenched through "oral information transmission". These are understood as being the exercise of power of communication and related behavior.

A series of non-information factors are also part of the culture of sexuality, such as the economy, technology, the body and, other factors that are conceived of as community resources (favorable setting or not) that help to construct a particular culture of sexuality.

The specific sexual behavior of an individual, in a certain culture, is in part the result of the interpretation that he/she makes of this information.

Information on sex is translated into messages. They can be formal, in the sense that they are promoted by official institutions, or informal.

Among the formal informative discourses are those that the sciences promote and among the informal ones we have the gender messages, which enhance the establishment of male and female sexuality. The latter comprises different attitudes, behavior, duties and rights active in relations between men and women, those of romantic erotic love, among others.

Sex information is also exchanged in the interpersonal space and can be immediate, as in face-to-face communication or established in the family, through friends, the couple, etc.

Information on sex is socially normative, its goal is to define the meaning of sexuality, explain its significance, regulate the context in which it manifests itself and prescribe the

why, where, when, for what and with whom of sexual relations. They provide the explanations, the sense of sexuality and relate it with other realms of social life. Some attempt to give more complete explanations regarding the finality of sexuality than others, as is the case of the religious discourse where "the purpose is established by God".

Coercive discourses, discourage, forbid and censure all that does not go coincide with their principles and norms. Some have mechanisms of more global control and others have subtle ones based on affective elements of group acceptance. These more subtle approaches are the ones that are interiorized and become part of the personal psychic of individuals.

Discourses on sex and sexuality often derive from an ideology or vision of the world that goes beyond sexual life. They are part of a philosophy of life that sees sexuality as part of a greater whole. In the case of the Christian discourse, for example, sexuality is seen as an integral part of its vision and significance of life and death. The religious discourse in Cuba that is derived from syncretic cults expresses sexual models that are greatly linked to macho images which reinforce attitudes in this regard.

The gender-based information originates from a system of patriarchal denomination that exploits women and not only in the field of sex.

Science also promotes various discourses according to its conception of the personality of the individual or society. Information is also exchanged and shared between different discourses, that is to say a specific issue can be treated in differently, in either a contradictory of complementary manner. The information provided can be discontinuous, such that there is no natural union of the parts forming the whole, at other times it is in the form of a series of segments that promote specific behavior, beliefs, attitudes and values around various areas or issues. The messages that are disseminated in both an explicit or implicit way are both important, what is said is as important as what remains unsaid, as the latter equally molds our experience. These messages are dynamic and hence change in time and space. One discourse or piece of information develops differently in different places. The gender-related discourse has very different forms in urban or rural zones and in the different generations. These are not neutral discourses, to each segment of information that is promoted is attached a knowledge and power relation.

Gender, Identity and Sexual Roles

There is information on gender that, being based on physical attributes, ascribes different conducts and activities to men and women. Gender is the psychological, social and cultural constructions imposed on what are biologic differences. Inserting itself in cultures through their communication and information exchange practices.

Sexual roles and orientations are the two most important elements. Sexual roles are the different constructions imposed on men and women, dictating how they should act, feel and express themselves. They have a double function: on the one hand they serve as a mechanism of domination, by barring women from the most important activities; on the other hand, they are instrumental in permitting the assimilation of these attitudes. Sexual

orientation is the practice of pairing men and women in a complementarily and excluding all other alternatives, practices and identities not reflected by this dichotomy.

Gender as a system is also sustained by non-information related practices, such as the control that men have over socio-economic resources.

The assimilation of information is conceived of as a cyclical process: information foments a given culture of sexuality and this in turn reproduces the discourses on sex. In this way culture creates a sexuality that reflects its framework of thoughts, and the resulting attitudes reflect the cultural structure that is formed. In this process the actors promoting the information (mainly the family) impose their vision of sexuality through different means, from the repetition of messages, emotional manipulation, and censorship, to more subtle forms of control.

The gender system is imposed on people by a group of institutions and through messages in the mass media, even if this process begins with the family, other actors are also involved in implanting their perceptions of gender on individuals (friends, partners, etc.)

The young first learn of their gender role in the home, women as well as men personalize the feminine and masculine role models that they see here. This is a process is both conscious and unconscious. Men and women have stereotyped ideas of gender and attach specific meanings to this: they thus perceive women as passive and men as active.

It is of particular significance for our study to pay close attention to the current problems surrounding couple relations and the scientific information on the topic. The dichotomy between the scientific discourse on sexuality and the popular information on the topic leads young people to compartmentalize the information this in turn results in a lack of true understanding.

The scientific discourse on the topic has never so expounded a model of the couple so different from that of the church as it does today.

Several events and factors have taken part in the emergence of this situation. One of these, was the Sexual Revolution of the 60´s, which in trying to encourage the attribution of new meanings to the couple meanings, made it possible to speak about sexuality with greater freedom. This movement vindicated the sexual pleasure of women, generated the progressive decrease in the perception of virginity as a value, lead to an increase in pre-marital sexual relations, the trend towards the non-exclusivity of sexual partners, the manifestation of group sex, couple exchanges, the perception of marriage as a kind of trial, an opening towards homosexuality. In sum it lead to a significant transformation of people's sexual and love lives.

The feminist movement revolutionized female identity formation and sexual behavior, this in turn has accentuated women's autonomy vis-à-vis men and their questioning of relationships.

The traditional criteria for a quality marriage and couple relation have changed. Stability, for example, is challenged in the face of facilitated divorces, weak institutional coercion towards remaining in a marriage, and an increased mobility and population density which intensifies interpersonal contacts.

Today the hope of a lasting relation clashes with the value of individual liberty, making unacceptable the couple based of possessiveness and the annihilation of the self for the benefit of the couple.

The high rate of divorce and the instability of the bonds between the couple, indicates its weakness, which is also associated, among other factors, with the difficulty of interpersonal communication and the lack of adequate communication skills.

The transformation of customary sexual behavior and its impact in the life of the couple has been influenced by biological factors such as the acceleration of puberty in the face of an improved quality of life. Partly as a result of this, individuals begin having sexual relations at an earlier age than before going through a sufficient personal psychological development that would allow the individual to self regulate his/her sexual life.

The Technological and Scientific Revolution has also influenced the stability of today's couple, the advances in contraception and in surgical sterilization, in antibiotics and the means of preventing and treating sexually transmitted diseases.

Scientific theories on the function of perception as a psychological phenomena that condition individual conduct is one element that science offers as an explanation of how individuals choose, or not, to adopt a healthy conduct.

Some researchers maintain that a healthy conduct is adopted when the individual perceives that him/herself as being susceptible to the disease (perception of risk) and if the illness is perceived of as being sufficiently severe (perception of severity) so as to become a serious problem (Model of Health Believes). However, as perception is in turn influenced by other factors, both internal and external to the individual, reality does not always coincide with scientific theory.

In HIV infection, the time that elapses between the infective sexual contact and the first symptoms of illness is relatively long, hence, the individual losses the cause-effect relation.

Once AIDS appears in a person it results in serous apprehension and worry. At this stage, individuals tend to seek information on the disease in order to evaluate the risks that they face and make the relevant changed in their behavior patterns. However another reaction is that of denial, by which the infected person refuses to think about their situation or accept that it is affecting them.

In our analysis the category Ways of Reacting and its relation to AIDS, is very important.

Lazarus defines the process of coping with the illness as both the effort aimed at acting as well as the intra-psychic pressure. Often the attempt to manage the personal and social demands, as well conflict between these exceeds the person's means.

AIDS generates conflict between the above-mentioned demands. It includes the internal ones, that is to say the need to live without major concerns, to maintain formed habits and customs, the possibility of the self-determining when and how to do things, including the need of sexual satisfaction. These elements are more than enough to consume the persons emotional resources, provoking fear, excitability, guilt and causing the individual to feel threatened. This situation demands a redefinition of models of life, and often implies a challenging psychological process of revision which can lead individuals to distort their images of reality in order to be able to face this threatening situation.

Gallport points out that in deciding what we choose to see, we are on the lookout for specific suggestions and are indifferent or on the defensive towards other suggestions. Perception is not passive, but rather satisfies our needs to an extent so that we may find a certain degree of security, tranquility, affection and prestige. Thus, according to Gallport, "the best way to face the world can be by ignoring certain stimulus, to modify our interpretation of others and to combine the new meanings with our habits, current needs and future orientations".

Generally our strategy for facing extreme situations is very primitive in structure and essentially permits us to minimize the existence of a serious predicament.

Even if the scientific information that advocates individual responsibility were to obtain positive results, AIDS would still give rise to a situation of maladjustment that begins with the avoidance and only slowly results in an evaluation of the real threat.

Master and Johnson described the social reactions provoked by AIDS in the homosexual community where intense fear and discouragement prevailed. Such a state was at the origin of significant changes in the sexual habits of some of the members of this community, reactions that went as far as the practice of sexual abstinence. However, the interpretation of scientific information of today, with the appearance of multiple therapies has changed this panorama, since the results are different, this is to say that it is interpreted as the cure for AIDS, thus the previous habits of non-safe relations, are once again starting to prevail among this population group.

In this way, a style of opposition that denies the importance of HIV/AIDS or that minimizes risks can be an obstacle to a reasonable protective conduct.

The processes of opposition are related to the cognitive appraisals that are the products of evaluative perceptions, thoughts or assumptions. The perception that the individual is infected and of the risks of contracting the disease, will have an enormous influence on determining how the individual confronts it.

An analysis of human behavior allows us to hypothesize that it is more probable that people will change their habits by adopting better health practices rather than by practicing abstinence which would imply a breach of deeply rooted habits.

The psychological nature of each category of persons susceptible to the epidemic is reflected in the attitude and behavior of the individual in coming into contact with the virus.

People can have more or less risky behavior and thus be susceptible to AIDS, each person has a perception of his/her position in the world, and thus each individual has a certain perception of their susceptibility to AIDS.

For the purpose of our study we are thus interested in the analysis of the "self-valuation" category which is directly linked to self-esteem.

According to F.L. Gonzalez Rey, self-valuation is a subsystem of personality that includes a series of needs and motives, together with different modifications of conscience. The way in which the integral elements of self-valuation are essentially expressed, is through a both concrete and generalized concept of the self. This integrates a group of qualities, capacities and interests, which are active in determining the integral motives and gratifications that form the guiding trend of the personality and are committed to the realization of the dearest wishes of the person. A truly evaluative function of self-valuation could potentially exist in a system in which persons' activities are constantly regulated, in which not only is the correspondence between the individual's conducts are analyzed, but also the integral qualities of self-valuation, as well as the qualities and elements that relate to future life. In such a system, a person could make a true self-evaluation by comparing the qualities he/she believes him/herself to have, with the actual demands of daily life and his/her wishes for the future.

Auto-valuation also has a regulating function, derived from the above-mentioned process of evaluation. This construction of a self-image is essential to the decision making process which leads people to choose between more and less risky conducts and hence the use of condoms – an action which is often perceived of as lacking in dignity.

The messages received through the information about sex, whether scientific or not, mark the emotional development of individuals and has repercussions on their behavior and determines the adoption of healthier or riskier attitudes. Therefore, if this information devalues the individual and induces a negative self-image during its development, it is probable that the person will not have the emotional or intellectual resources to interpret the scientific discourse of preventive measures accordingly when it comes to HIV/AIDS.

VII. INTERPRETATION

A. MEN THAT ENGAGE IN SEXUAL RELATIONS WITH OTHER MEN

In sexual relations between men, there is an acceptance of the scientific information regarding protection from STD/HIV/AIDS. However, this has its limitations, as the information available focuses on the generally accepted sexual practices and does not necessarily centre on practices of homosexual men. As a result there is some confusion around the ways that the disease can be transmitted. One belief expressed was, for example, that "I believe that until the man ejaculates there is no danger" (this includes in anal or oral sex). This confusion and lack of information exists throughout this group.

We see relatively primitive scientific information regarding body care that does not go beyond endorsing personal hygiene.

The results of quantitative studies in this population group show a high degree of information on the universal preventive measures that have been disseminated by the medical and scientific communities since the outbreak of AIDS, such as stable relations, the use of condoms and the infrequent change of the sexual partners. However, there is a sectioning off of the information which provokes a dichotomy, one hand the scientific information is available, yet we find that no limits are established in actual sexual behavior, and the necessary resources to induce a real control and avoidance of the infection are not made available.

The perception of risk in this group is mediated by primitive representations of AIDS, greatly influence by social beliefs that are shared among the members of this social group. Many of these beliefs are based on discriminated information that was disseminated during the first stage of the outbreak of the epidemic and transmitted by the mass media.

There is also the issue of subjectivity in the criteria expressed on the effective measures to adopt in order to avoid infection (selection of a partner). The same behavioral alternatives are disseminated in this group as are presented to the general public, thus in the midst of this contradiction certain behaviors, such as frequent and abrupt changes of partners, go uncensored. This behavior is expressed as follows: "Currently there are no stable couples, but rather a constant change being with one today and another tomorrow", "among homosexuals the same type of sex is tiresome", "that is what is modern".

The messages that this group has been exposed to through campaigns has not mobilized it positively, they inspire comments such as: "(they) are for professionals", "the messages are aired at times when they are already on the streets", or "facts and figures of little interest are abused". On another side, all those practices that are associated with high-risk behavior are described as "exploring the unknown, immediate pleasure, new sensations ore even progress", there is a predominance of *eros* over whatever message might that implies a reduced possibility for pleasure.

The ethnographic information gathered through observation of this group showed the presence of religious beliefs deriving from the syncretic cults but this did not seem to be associated with attitudes towards sex and gender roles.

Certain behavior patterns were observed that are given a great deal of importance and that reaffirm the of the group, for example: “I find great pleasure in seducing a man that have never had a sexual relation with other men”, “we know how to win them over, especially those that have had disappointments, live in difficult social conditions, or are curious to know what a homosexual is”. This increases the risk of unprotected sex and can a change in the pattern of the disease by spreading it among heterosexuals.

There are stereotypes regarding the profile that has been made of homosexuals (negative valuations), evidencing the same construction that society has placed on them due to the existing prejudice towards this population group.

Individual cases show a poor self-image based on low self-esteem, and the socialized construction of feelings, regarding negative self-image. This can be seen in expressions such as: “we are promiscuous, unstable”.

These elements that go beyond the available information provoke a discourse that is not very prevention oriented, making this group more vulnerable to STDs and HIV/AIDS.

There is a defeatist attitude within the homosexual community regarding the difficulty of maintaining stable relations or of remaining mutually loyal. The justification given for this is the impossibility of finding an adequate living space, due, they claim, to intolerance and lack of material resources. In this regard Master and Johnson refer in their book to the fact that the lasting homosexual relations are scarce because they are less visible than heterosexual ones. Bell (1978) observed that the relative instability of homosexual relations is due in part to the fact that society does not promote homosexual unions. Socialization tends to orient heterosexual or homosexual men towards variety in their sexual relations while women, of one or the other condition, are orientated towards monogamy. As a result many men often choose to have a high number of sexual partners either male or female. Homosexual couples are also unstable because of the lack of social models guiding them towards strong interpersonal relations.

Findings show that there is a stereotype social representation of homosexuals that is prejudicial and devaluing to this group and is usually transmitted by the family. There are negative experiences regarding the family that act as repressing and discriminatory agents, thus creating a difficult space in which to deal with these experiences, including the sexual ones. As a result, friends become a space in which to find support and understanding.

Less risky behaviors are not adopted because the question of infection is seen in part as a question of luck. The social rather than scientific discourse on sex predominates here and leads to attitudes such as: “there are those that are lucky and experiment sexually and nothing happens to them”.

There are not favorable attitudes towards the use of condom, and its use evokes negative connotations. If we add to this attitude the fact that a majority of this group is in search of immediate pleasure and does not practice much auto-control whatsoever, it seems very remote thus to assume that they will be able to negotiate or come to an agreement with sexual partners in order to practice safer sex. The risk is simply assumed.

Lastly, it is interesting to see how this group perceives the medical personnel are in charge of assisting persons with STDs or HIV/AIDS. They are usually perceived as being un-trust worthy on the issue of discretion. As a result of this, many men prefer to medicate themselves despite knowing that they run the risk of "saturating their bodies".

B. WOMEN WITH RISKY BEHAVIOR

In this group we find that the women assume that infection is the result of an individual act and that the responsibility lies in the person. This group is generally informed on the existing healthcare messages and the use of the condom is acknowledging as a method to prevent infection of STDs or HIV. However, it is interesting to see that the scientific information that this group has contains important gaps regarding the effectiveness of its use, "the least that can happen to you is that you can get a pelvic inflammation".

The risk of not using condoms even with the "stable" couple is recognized, but protection is not practiced in this type of relation. In this respect it was observed that a care-free attitude was assumed in relations with other Cubans and the women said that they only used condoms with foreign partners, even if its use tended to be circumstantial, and depended on whether or not there was penetration, on the demands of the foreigner for its use, and on the negotiated price. They also state that after the lapse of a certain period of time with the same partner they stop using condoms because of a certain degree of confidence in the partner. Hernández Manuel and collaborators, 1996, show in a study that the use of condoms among the female and male population, whether they have practiced commercial sex or not, is based primarily on the alleged confidence of the couple.

It is interesting to see that in the popular imagination of this group there is the belief that in order for tourists to be allow into de country, they must submit their "health certificate" or that "if they are sick, they wont be allowed in". There is an acceptance of the scientific and healthcare information disseminated and specifically of the information concerning the new control programme that has been created in part as a mechanism for calming tensions on the subject.

There is a representation of AIDS that only portrays the sick as such with specific external manifestations of the illness which can be seen but no attention is given to the asymptomatic carriers.

This groups recognizes that it is a high-risk group for contracting STDs or HIV/AIDS due to their sexual practices; as a result it is startling that they adopt passive roles in the face of pressure from foreign partners and show total confidence in Cuban partners. There is a

modern discourse that judges male infidelity negatively and that does not judge women with more than one sexual partner as severely as in the past.

The reasons offered for the frequent change in partners are very much related to a poorly structured image of life or one which is based on poor values of couple relations.

There is a negative attitude towards the issue of infidelity in that it is seen as something that is in the end unavoidable, that has to happen or that is determined by a certain duality, for instance “you can be with your husband and a tourist comes and you have to do it”. There is a social group mandate that conditions the sexual practices and options that leads to having multiple partners. It is recognized that there are no signs of avoidance, mainly because the economic motivations for unprotected sexual relations are much stronger than those for protection.

It is known that among the socially disadvantaged groups, the issue of marginality plays a very important role in the tension that between social reality and sexual practices. Women seem to expect solutions that correspond to their perceptions of “salvation”. The contradiction that we find between what is professed and what is practiced by these women is in part due to the perception of the “lack of alternatives” as a result of the existing emphasis on material rather than the spiritual values. Having neither structural nor hierarchical resources for the “romantic” and scientific information.

There are experiences that lead to evasive conducts and that might create bad feelings, such as: “sleeping with an undesired client”, where there is neither pleasure nor enjoyment in the relation, “you lose your shame”.

As in the case of men that have sexual relations with other these women see the medical personnel that assists patients with STDs or HIV/AIDS as being unreliable and they prefer self medicate themselves despite knowing the risks that they run.

This group generally has a psychological history of violent experiences concerning sex and a deficient education regarding sexuality, this is partly due to the fact that passed on in the context of dysfunctional families.

The groups of women questioned that had not had commercial sexual relations, there was once again the belief that people do not protect themselves because they do not feel vulnerable to HIV.

There is a significant dichotomy between the scientific information and contemporary popular beliefs and information. Scientific information identifies safe practices in order to avoid contracting HIV, this mainly involves promoting the use of condoms, and it also places the responsibility for prevention on the individual. The fact that the general external appearance of a person does not reveal whether they are sick or not is known and understood, however, experiences show that ultimately people trust their potential partner to tell them whether or not they are seropositive. Clearly, this is a practice that involves a high risk.

There is a duplication of gender related information in this group which once again is permissive with certain conducts in men, such as infidelity, yet places the responsibility for hygiene and general body care entirely on women. These opinions, regarding the different roles for each sex when protection is concerned are conditioned by traditional patterns assigned to each sex and that are active in this group.

There is a general opinion that it is through periodic analysis that the infection and its transmission is controlled, in addition some women were, of the opinion that the use of the condom is not adequate protection as they are "very bad".

The family accepts the practice of commercial sex when women are involved however they do not justify such a practice in the case of homosexuals who they consider to be "dirty".

It is interesting to note that the motive given for such conduct is that of "need" according to their value schemes while those established by the society's discourses d such as marriage, pregnancy, are seen as problems.

C. MIGRANT MEN

In this group we find that there seems to exist a critical perception of the situation in which these men can find themselves on a daily basis, a situation that incites risky sexual conducts, thus increasing the risks of HIV infection. We should remember that these men are far away from their families and regular partners, if they have, and that while they condemn homosexuality they engage in occasional transitory homosexual encounters.

As in the case of the two previous groups, there is an awareness of scientific information expressing alternatives to the messages found in the mass media, such as the need to use condoms in order to protect oneself, however, they also adopt other behavioral alternatives which do not necessarily protect them from STDs/HIV (periodical analysis, a great deal of hygiene, etc.). In this way practices such as systematic screening are placed above other more efficient measures. This is how this group conceptualizes a "healthy body".

Pleasure and its ways of being manifested in traditional sexual practices is often placed above preventive scientific messages. Thus even if a sexual encounter is considered the responsibility of the individual and even if there is an awareness of the danger of becoming infected they accept that when they meet a girl on the streets and have the possibility of having sex with her, they do not use the condom. The justification for this type of behavior is based on physical elements (unpleasant characteristics of the condom) as well as other difficulties such as the negotiation of preventive practices, and they give way easily when the partner exerts pressure to not use condoms. The action of proposing the use of a condom is seen as a demonstration of a lack of confidence, this is the principle argument expressed for not proposing its use even if it is recognized as an essential preventive measure.

For this group the possibility of having a steady relation or of having a sexual relations with only one partner, as encouraged by the traditional preventive discourses and religious information, is not seen as a real option. In this respect, having multiple partners is accepted

as something natural, and stability in a couple as something that "religious people can do, if its not impossible". There are values and patterns shared by this group that would appear to justify a regular change in partners, but there is also a justifications based on experiences and "material deficiencies", or a perception of gender related advantages "there are more women than men" or based on the life cycle: "immaturity of the young".

The variety of other practices that imply a safe sex are neither acknowledged nor accepted, practices concentrate on penetration, those not involving this are not considered important.

Even if it is not necessarily expressed as a personal experience, it is recognized that persons are afraid of knowing that they are HIV-positive because they fear "isolation", this is related to the historical memory of the diffusion of information on the relevant health-care treatment required.

As a result, persons treat themselves for STDs by using different plants (coconut water, kerosene, banana water) because they are ashamed or in order not to involve the partner. There are a series of prejudices linked to sexually transmitted diseases, related to what is moral or not, what is forbidden or condemned, which is typical to the religious diatribe. This can often act as a barrier to the practice of preventive measure.

The medical personnel that work in STDs and HIV/AIDS are not seen as trustworthy in terms of discretion. Faced with this situation people prefer to self medicate despite knowing that this can be dangerous.

D. MEN AND WOMEN (SUBURBAN AND RUAL ZONES)

Province: VILLA CLARA

Among the men and women of these two categories, no differences were noticed according to geographic factors, however, there were noticeable differences regarding gender information and experiences.

The high academic levels in the country, the massive preventive programs and the means of social communication that reach people even in the remotest places, allows us to infer that for both zones scientific information is available and an emphasis is placed on the prevention of HIV/AIDS.

Men

The different body fluids where HIV can be found are identified, however, there is no distinction is made between them to say which of them is more infective. Saliva, for example, is wrongly placed on the same level as blood, semen, and vaginal secretions, while maternal milk is not mentioned.

They recognize that HIV can be present in a person that shows no symptoms, however, some men said that they had overheard other men and in particular the young saying that it was possible to tell if a person is HIV-positive by their external experience.

They see HIV as a threat, and judge those that do not share this opinion as being either irresponsible or because they practice "safe sex", however, this attitude does not correspond to their use of condoms as a preventive measure, despite considering it as the most efficient method, because they perceive it as the most difficult one to apply. The difficulty and negative criteria are both physical and social, as is the ability to negotiate the use of condoms. The use of condoms in this group is determined by the degree of confidence in one's partner and by other external characteristics.

The frequent change of sexual partners is viewed as a way or experimenting or of seeking new experiences in affective relations, but this is unrelated to the risk of being infected, there selective segmentation of the information that places the erotic over the scientific. In this sense, the perception of risk is low and is mediated by the conducts proper to the youth, where exploration in this area is common. Stereotypes also exist in this group and they often lead to contradictory situations. On the one hand men advocate loyalty and stability in relations, yet on the other hand they find it difficult to assume the complimentary behavior and then while recognizing it as wrong they justify it by saying that "the majority of the people do so".

The traditional gender-related information again establishes permissive valuations in the frequent change of partners for men, while women that do the same are labeled "prostitutes or sluts". Men are seen as "seekers", that need "to know that they are liked" or "desired" and their unstable conduct and the impossibility of their having stable relations is justified by their living conditions and other conditions of daily life that are influenced by the current economic and social changes which leads to the establishment of mechanisms of evasion, as a means of relief.

For many men, infidelity is a source of pleasure, in this same way matrimony is perceived as being "boring", and the stable couple is represented as a "sacrifice". This is a machist attitude is present in every association made by the group.

Again, the medical personnel which has to assist in the treatment of STDs and HIV/AIDS is seen as untrustworthy, hence they prefer to medicate themselves.

Women

The majority of women expressed that in their experiences with men, men want women to be responsible for proposing of the use of condoms. However, the attitude towards these remains negative, as they are "uncomfortable and cause irritation"

Women seem to have had negative experiences in couple relations and this has resulted in their having negative attitudes towards marriage, pregnancy, the family and its stability.

Province: HOLGUIN

In the groups that have been worked with, no differences were observed in the answers and experiences among the youngsters of the suburban and rural zones.

The members of both of theses groups shared the criteria that protection in sexual relations is very important, expressing stable couple relations as an alternative. However, condoms are not mentioned as a preventive means despite their being the most adequate means of prevention particularly in adolescents and young adults who are in a stage in their lives of significant sexual experimentation.

There is a very limited conception of body-care which is principally perceived of as 'maintaining hygiene' and is not related to the self-image.

There is an adequate knowledge of the symptoms and characteristics of some STDs and AIDS, and no specific group is identified as running a higher risk of infection, as "everybody runs the risk". However, the discourse that attempts to explain why it is particularly among the young that infection rates are highest, calls our attention to the fact that they link high-risk behaviors to irresponsible persons in particular those (male or female) that practice commercial sex. A transfer of the risks is projected on prostitutes and homosexuals resulting in the perception that "having AIDS is not a thing for men".

There are a great deal of prejudices towards those sick with a STDs, HIV positive or with AIDS for it is perceived as being shameful, this element creates feelings of fear within the family, which thus becomes a difficult a space difficult space in which to discuss these problems.

Both women and men reject the use of condoms with claims that they are uncomfortable or burn, or because of the difficulty in proposing their use and assuming assertive stances in this respect or due to the lack of socio-psychological resources. Confidence in one's partner is also expressed as a motive for not using condoms.

For this group the option of participating in risky sexual practices or not is mediated by a group mandate or by the lack of self-confidence in decision making. In this sense, the frequent change of partner is accepted while in the case of women it is either censured or criticized. The fact that men do not maintain a stable couple is blamed on women: "they make men loose their heads".

VIII. CONCLUSIONS

With the majority of the individuals in each of the groups studied we observed that in their personal experiences, the scientific discourse prevails as a source of information, especially those related to basic prevention messages for the transmission of STDs and HIV/AIDS mainly issued by the national program and its education strategy. However, there is an interpretation of these scientific messages that is conditioned by other meanings that place pleasure above the risk of infection. The factual information available is adequate but does not necessarily imply the practice of less risky conducts. There is a very limited generalized conceptualization of body-care, seeing it only as the need to "maintaining hygiene" and it is not related to self-image.

In the behavior of these groups a reproduction of sexist sexual roles could be observed, in spite of the achievements made by Cuban women since the revolutionary process on the issue of equal rights. This sexism has been integrated in the socialization process itself, which is why there is a social mandate by which machismo is manifest and there is a radical difference between the sexual behavior accepted in men and women. There does nevertheless exist a modern discourse on gender roles but it rudimentary.

For every age bracket of the groups studied the intra-personal means which enable self-control are very primitive, including poorly structured tools for intra-personal confrontation which tend to result in denial or rationalized in order to alleviate tensions which facilitates the adoption safer sexual practices.

Without taking into account geographic area nor sexual orientation, the sexual roles adopted by men and women hinder any type of negotiation in sexual relations, including the use of condoms.

For all the groups and especially in the groups of women studied contradiction, frustration and even resistance was observed linked to couple relations. For many, the traditional concept of the couple (monogamy) as dictated by society is not seen as a realistic model.

This representation of the couple was found in all groups and did not differ among the different ages, sexual orientations or between persons living in urban or suburban areas.

Although close observation revealed that high-risk groups were occasionally related to sincretic cults and their attributes, there was no evidence of this being related with certain high- risk conducts, as was the case in other studies.

There is evidence that among the groups studied, migrant men and men that have sexual relations with other men run the highest risk of infection. This is due to the intra-personal relations that emerge from their way of life and the segregation of the different sources of information on the subject of prevention. In the case of men who have sexual relations with other men, other important factors are their self-valuations and their low power image, both of which increase the chances of risky behavior.

IX. METHODOLOGY FOR ACTION

The lessons learnt through this study allow us to make certain reflections that can lead to the establishment of appropriate methodologies in the work of the prevention of HIV/AIDS. In this sense, we can say that there are both similarities and differences in the sexual conduct of the individuals, which is evidenced in the process of interpretation of the discourses, which are assimilated in a different way. Depending on gender, sexual orientation and vital space, among others, people will be faced with restrictive and contradictory information, as long as the preventive messages do not take into account these differences.

It is necessary to take the contradictions into account as well as the resistance which people face in order to help them choose alternatives in a more rational and effective way. The approach of empowerment would thus be a more viable strategy rather than factual information alone. This will allow the identification of obstacles and the development of a conscious decision making process.

Different intervention programs are necessary in order to take into account the gender perspective, the sexual orientations and the geographic space where they develop, marginal and non marginal populations, as the interpretation of the problem and its meanings will be different from one group to the next.

The impact of interventions and education in this area should begin from very early on, putting forward gender information that promotes tolerance and respect to children in order to enable prevention further along the line. If girls develop a critical sense and take awareness of the social stereotypes of women, they will develop a stronger self-esteem, which eventually will be much more useful to them than universal prevention messages.

If we depart from the fact that if boys could be made to understand why masculinity is something important to build on and that being a man is not only determined by hormones or other mandates, then they could have more respect for women and feel less pressures form this discourse which poses one of the most important obstacles for prevention.

We should also take into account that for every methodological proposition, people as such play an important role in the modification of the information and in negotiating new interpretations of contradictory mandates. When the public perceives the mandates as undesirable, these are set aside for new interpretations or conducts that are opposed to the intended results.

Educational strategies should not only be centered around the idea of the information transmitter as the "expert" in health, thinking that in this way people will be convinced to change their behavior in favor safer sex. This strategy alone is hardly enough; it has been demonstrated that people can come to distrust or be bored with those messages that originate in authority figures such as ‘experts’

Lastly, it is necessary to intervene and take prevention information to places that society has determined as being erotic, such as discos, bars, beaches, concerts and other areas, for it is

here that preventive messages are most absent and where young public are most disposed to eroticism.

It is also evident that educational strategies for the prevention of HIV/AIDS should be linked to other education and development programs. Programs aimed at enriching the cultural life of the persons are often the most efficient vehicles for the incorporation of preventive messages.

For the persons and especially for young persons in high-risk groups, HIV is one of the many problems that they have to face, and in many cases it is not felt as being the most immediate one. Other significant concerns were evidenced in this study: the intolerance to talk about sex in the family, the association of certain behaviors that for some were unavoidable due to a lack of adequate accommodation for couples, discrimination due to sexual orientation, or a distorted perception of the economic needs of those that have practiced commercial sex. If these problems are not adequately taken into consideration then interventions on the basis of information will hardly have an impact.

Thus, it is important to create favorable parallel environments if we want preventive actions to be efficient.

X. DEVELOPMENT PROJECTS

- Family, Society and HIV/AIDS
- Gender, Women and Culture of Health
- AIDS and Human Rights
- Culture, Health and AIDS
- Culture, Health and Human Development
- Prevention of STD/HIV/AIDS in Vulnerable Groups, (men having sexual relations with other men, migrants, women with conducts of risk)
- Cultural Approaches to HIV/AIDS
- Bio-ethics and STDs/HIV/AIDS

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