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OF SEXUALITY

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*Edited by:*

ROBERT T. FRANCOEUR, Ph.D., A.C.S.

*and*

RAYMOND J. NOONAN, Ph.D.



*Associate Editors:*

*Africa:* Beldina Opiyo-Omolo, B.Sc.

*Europe:* Jakob Pastoetter, Ph.D.

*South America:* Luciane Raibin, M.S.

*Information Resources:* Timothy Perper, Ph.D. &  
Martha Cornog, M.A., M.S.



*Foreword by:*

ROBERT T. FRANCOEUR, Ph.D., A.C.S.



*Preface by:*

TIMOTHY PERPER, Ph.D.



*Introduction by:*

IRA L. REISS, Ph.D.

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CONTINUUM *Complete*  
*International*  
ENCYCLOPEDIA  
OF SEXUALITY

*Updated, with More Countries*

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<i>David L. Weis, Ph.D., and Patricia Barthalow Koch, Ph.D., editors and contributors, with other contributions by Diane Baker, M.A.; Ph.D.; Sandy Bargainnier, Ed.D.; Sarah C. Conklin, Ph.D.; Martha Cornog, M.A., M.S.; Richard Cross, M.D.; Marilyn Fithian, Ph.D.; Jeannie Forrest, M.A.; Andrew D. Forsythe, M.S.; Robert T. Francoeur, Ph.D., A.C.S.; Barbara Garris, M.A.; Patricia Goodson, Ph.D.; William E. Hartmann, Ph.D.; Robert O. Hawkins, Jr., Ph.D.; Linda L. Hendrixson, Ph.D.; Barrie J. Highby, Ph.D.; Ariadne (Ari) Kane, Ed.D.; Sharon E. King, M.S.Ed.; Robert Morgan Lawrence, D.C.; Brenda Love; Charlene L. Muehlenhard, Ph.D.; Raymond J. Noonan, Ph.D.; Miguel A. Pérez, Ph.D.; Timothy Perper, Ph.D.; Helda L. Pinzón-Pérez, Ph.D.; Carol Queen, Ph.D.; Herbert P. Samuels, Ph.D.; Julian Slowinski, Psy.D.; William Stackhouse, Ph.D.; William R. Stayton, Th.D.; and Mitchell S. Tepper, M.P.H. Updates coordinated by Raymond J. Noonan, Ph.D., and Robert T. Francoeur, Ph.D., with comments and updates by Mark O. Bigler, Ph.D., Walter Bocking, Ph.D., Peggy Clarke, M.P.H., Sarah C. Conklin, Ph.D., Al Cooper, Ph.D., Martha Cornog, M.A., M.S., Susan Dudley, Ph.D., Warren Farrell, Ph.D., James R. Fleckenstein, Robert T. Francoeur, Ph.D., Patricia Goodson, Ph.D., Erica Goodstone, Ph.D., Karen Allyn Gordon, M.P.H., Ph.D. (cand.), Eric Griffin-Shelley, Ph.D., Robert W. Hatfield, Ph.D., Loraine Hutchins, Ph.D., Michael Hyde, M.F.A., Ph.D. (cand.), Ariadne (Ari) Kane, Ed.D., Patricia Barthalow Koch, Ph.D., John Money, Ph.D., Charlene L. Muehlenhard, Ph.D., Raymond J. Noonan, Ph.D., Miguel A. Pérez, Ph.D., Helda L. Pinzón-Pérez, Ph.D., William Prendergast, Ph.D., Ruth Rubenstein, Ph.D., Herbert P. Samuels, Ph.D., William Taverner, M.A., David L. Weis, Ph.D., C. Christine Wheeler, Ph.D., and Walter Williams, Ph.D.</i>	
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". . . one of the most ambitious cross-cultural sex surveys ever undertaken. Some 135 sexologists worldwide describe sex-related practices and cultures in 32 different countries. . . . Best Reference Sources of 1997."—*Library Journal*

"What separates this encyclopedia from past international sexuality books is its distinct dissimilarity to a 'guidebook to the sexual hotspots of the world.' . . . An impressive and important contribution to our understanding of sexuality in a global society. . . . fills a big gap in people's knowledge about sexual attitudes and behaviors."—Sexuality Information and Education Council of the United States (SIECUS)

"Truly important books on human sexuality can be counted on, perhaps, just one hand. *The International Encyclopedia of Sexuality* deserves special attention as an impressive accomplishment."—*Journal of Marriage and the Family*

". . . a landmark effort to cross-reference vast amounts of information about human sexual behaviors, customs, and cultural attitudes existing in the world. Never before has such a comprehensive undertaking been even remotely available to researchers, scholars, educators, and clinicians active in the field of human sexuality."—Sandra Cole, Professor of Physical Medicine and Rehabilitation, University of Michigan Medical Center

## 2. The International Encyclopedia of Sexuality, Vol. 4 (Francoeur & Noonan, 2001)

". . . a masterpiece of organization. The feat of successfully compiling so much information about so many countries into such a coherent and readable format defies significant negative criticism."—*Sexuality and Culture*, Paul Fedoroff, M.D., Co-Director, Sexual Behaviors Clinic Forensic Program, The Royal Ottawa Hospital, Ottawa, Canada

## 3. The Continuum Complete International Encyclopedia of Sexuality (Francoeur & Noonan, 2004)

". . . [a] treasure trove. . . . This unique compilation of specialized knowledge is recommended for research collections in the social sciences . . . as well as a secondary source for cross-cultural research."—*Library Journal*, March 15, 2004, p. 64

". . . a book that is truly historic, and in many ways comparable to the great sexological surveys of Havelock Ellis and Alfred Kinsey. . . . Many works of undeniable importance are intended to speak about human sexuality. But in this encyclopedia we hear the voices of a multitude of nations and cultures. With coverage of more than a quarter of the countries in the world, . . . not only will the *Continuum Complete International Encyclopedia of Sexuality* remain a standard reference work for years to come, but it has raised the bar of sexological scholarship to a rigorous new level."—John Heidenry, editor, *The Week*, and author of *What Wild Ecstasy: The Rise and Fall of the Sexual Revolution*

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(CIA 2002)

# Mexico

(*Estados Unidos Mexicanos*)  
(United Mexican States)

Eusebio Rubio, Ph.D.  
*Updates by the Editors*

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## *Demographics and a Brief Historical Perspective*

ROBERT T. FRANCOEUR

### A. Demographics

Mexico, with the official name of United Mexican States, is a country of 761,606 square miles (1,972,550 km<sup>2</sup>) located in North America, bordered by the United States to the north, and Guatemala and Belize to the south. Mexico is bordered on the east by the Gulf of Mexico and on the west by the Pacific Ocean. It is the third-largest country in Latin America, three times the size of the state of Texas, and a republic formed by 31 states and one Federal District. Sandwiched

between the Sierra Madre Oriental Mountains on the west coast and the Sierra Madre Occidental Mountains on the Gulf coast is a high, dry, temperate central plateau. The coastal lowlands are tropical. About 45% of the land is arid.

In July 2002, Mexico had an estimated population of 103.4 million. (All data are July 2002 estimates from *The World Factbook 2002* (CIA 2002) unless otherwise stated.)

**Age Distribution and Sex Ratios:** 0-14 years: 32.8% with 1.04 male(s) per female (sex ratio); 15-64 years: 62.7% with 0.95 male(s) per female; 65 years and over: 4.5% with 0.8 male(s) per female; *Total population sex ratio:* 0.97 male(s) to 1 female

**Life Expectancy at Birth:** *Total Population:* 71.03 years; *male:* 68.99 years; *female:* 75.21 years

**Urban/Rural Distribution:** 72% to 28%. In 2002, 20 million people lived in metropolitan Mexico City, making it the most populous city in the world.

**Ethnic Distribution:** Mestizo (Amerindian-Spanish): 60%; Amerindian or predominantly Amerindian: 30%; white: 9%; other: 1%

**Religious Distribution:** nominally Roman Catholic: 89%; Protestant: 6%; other: 5%

**Birth Rate:** 22.36 births per 1,000 population

**Death Rate:** 4.99 per 1,000 population

**Infant Mortality Rate:** 24.52 deaths per 1,000 live births

**Net Migration Rate:** -2.71 migrant(s) per 1,000 population

**Total Fertility Rate:** 2.57 children born per woman

**Population Growth Rate:** 1.47%

**HIV/AIDS** (1999 est.): *Adult prevalence:* 0.29%; *Persons living with HIV/AIDS:* 150,000; *Deaths:* 4,700. (For additional details from [www.UNAIDS.org](http://www.UNAIDS.org), see end of Section 10B.)

**Literacy Rate** (*defined as those age 15 and over who can read and write*): 89.6% (*male:* 91.8%, *female:* 87.4%), with ten years of compulsory schooling (INEGI 1992a)

**Per Capita Gross Domestic Product** (*purchasing power parity*): \$9,000 (2001 est.); *Inflation:* 6.5%; *Unemployment:* 3% in the urban centers, plus considerable underemployment. Among most of Mexico's rural population and urban poor, who constitute by all measures a majority of the population, the standard of living is close to subsistence. In 1990, 63.2% of adult Mexicans reported a monthly

\**Communications:* Eusebio Rubio, Ph.D., Pestalozzi 1204-705, Colonia del Valle, Mexico D.F. 03100 Mexico; eusebio@internet.com.mx, rubioa@servidor.unam.mx.

income below the minimum wage, a measure of income that in 1993 corresponded to a yearly income of approximately \$3,000 (INEGI 1992a). *Living below the poverty line*: 40% (2001 est.)

## B. A Brief Historical Perspective

Mexico was the early site of advanced indigenous civilizations, starting with the Olmecs (1500 B.C.E. to 300 B.C.E.) and the Mayas, who also began as early as 1500 B.C.E. As they moved north from the Yucatan to Mexico, the Mayas brought with them their advanced agriculture. They built immense stone pyramids and invented a very accurate calendar. Classic Mayan civilization collapsed between 790 and 900 C.E. The Aztecs, who overcame and replaced the Toltecs, built their capital city, Tenochtitlan, in 1325 on the site of present-day Mexico City. The Aztec civilization collapsed following its first encounter with Spanish conquistadors under Hernando Cortes, between 1519 and 1521.

After three centuries of Spanish rule, the people rebelled under the leadership of two priests and a general, the latter declaring himself Emperor Augustin I in 1821. A republic was declared in 1823. At the time, Mexico's territory extended into the American southwest and California. In 1836, Texas revolted and declared itself a republic. After the Mexican-American War (1846-1848), Mexico gave up all claim to lands north of the Rio Grande River. French support helped put an Austrian archduke on the throne of Mexico as Maximilian I (1864-1867), but American pressure forced the French to withdraw. Porfirio Diaz headed a dictatorship between 1877 and 1880 and again between 1884 and 1911.

In 1917, rival forces agreed to social reform and a new constitution. Since then, Mexico has developed large-scale social programs of social security, labor protection, and school improvement, although many segments of the population, including the indigenous natives, barely manage to subsist.

### 1. Basic Sexological Premises

#### A. Character of Gender Roles

Gender roles are changing. Some 50 years ago, gender roles in Mexico could be easily described as the traditional separation, magnification, and stereotyping of male and female differences. Women were dichotomized into the two double-moral-standard subtypes of the princess and prostitute, and men were instructed to be the impenetrable and insensitive provider who exercised his power over women.

Today this is changing. In a sample of 10,142 high school students representative of the whole country, the National Population Council conducted a national survey on various aspects of sexuality (CONAPO 1988). In 1988, 83.1% of the respondents thought men and women had equal legal rights (as they do), 69.7% thought that authority at home should be shared by men and women, and only 13.2% thought housework to be the exclusive responsibility of the woman. In another survey among 2,983 male and female 15- to 24-year-olds, Morris et al. (1987) found that only 6.6% of females and 13.7% of males thought that a woman who works outside the home is deceiving her husband and not fulfilling her obligations as a wife. In 1984, Rubio et al. (1988) found in a sample of 521 first-year medical students that only 17.7% agreed with the statement that women are naturally passive, and 91.3% thought it is equally important for men and women to pursue professional educations.

The process of recognizing the equality of women and men has clearly begun, although it is also true that, in practice, women have more disadvantages than men. Women are overrepresented in the lower-income levels and underrepre-

sented in the higher levels. Only 19.6% of Mexican women are engaged in paid work compared to 68% for males (INEGI 1992b). It is also a fact that most working women have, in fact, two jobs: the paid one and the housework.

#### B. Sociolegal Status of Males and Females

The fourth Article of the Constitution explicitly recognizes the equality of men and women. In 1974, a revision of all legislation was effected to eliminate any gender discrimination, and there are several other laws and a national program aimed at evaluating and promoting the integration of woman in the nation's development. Despite these efforts, there are a number of areas where women are at a disadvantage. The expansion of industrial labor has benefitted males more than women. Inequality also shows in other areas of work: 74.1% of professionals are men, 80.6% of the executive positions in the government belong to men, and only 3.4% of those who work in domestic jobs are men (INEGI 1992b).

Technically, male and female children and adolescents enjoy equal benefits as far as education, healthcare, and social significance go within society and the family. However, gender-dimorphic training begins early. In general, lower-socioeconomic-level families tend to transmit the older values. As the social class and education level of the parents increase, one observes a tendency toward transmitting an egalitarian ideology.

#### C. General Concepts of Sexuality and Love

There have been attempts at picturing empirically the constructs people have of sexuality and love. In general, it can be said that both sexuality and love are seen as positive and desirable aspects of life both for men and women, but ambivalent feelings on sexuality are often encountered. Diaz Loving's (1988) nonrandom sample of 300 individuals in Mexico City found that love, although seen positively, has many interpretations. Romantic love is seen as an idealization, passionate love as being vulnerable. Furthermore, there are important differences in how males and females perceive love: Females tend to see love more positively, while men tend to think of it as genital and sexual; men more often than women see it as an unattainable utopian dream.

In the CONAPO (1988) survey, the participating students thought that the aims of sex were: intimate communication 63%, mutual pleasure and satisfaction 37%, and having children 15.5%. In another survey effected in Mexico City with 613 individuals randomly selected from households, De la Peña and Toledo (1991a) found that respondents mentioned the following objectives for sex: enjoyment 48%, physical outlet 29%, and having children 18%. In a subsequent report (1991c), the same authors reported that, of the sexually active respondents, only 3% of males and 6% of females think of sexual intercourse as something unpleasant or have an indifferent attitude towards it. A survey of medical students found that the majority, 69%, disagree with the statement that procreation is the most important goal of sex (Rubio et al. 1988).

### 2. Religious, Ethnic, and Gender Factors Affecting Sexuality

#### A. Source and Character of Religious Values

There are two sources of religious values in Mexico: European Hispanic Catholicism and the indigenous religions that dominated the area prior to the arrival of the Europeans. Both have blended in the course of almost 500 years of interaction. Religiosity has followed the same pattern of other cultural phenomena in the history of Mexico. Rather than

one system giving up in favor of the other, a complex mixture of both cultures has generated a new and unique culture. In 1990, 90% of the population was Catholic, but the Catholicism practiced is different from the Catholicism of other countries. As with the ethnic blending, religiosity has gone through a process of syncretism. The best example of this is the cult to the Virgin of Guadalupe, which quickly gained popularity because it could be integrated with preexisting cults of Aztec gods.

To complicate the picture, the prehispanic source was not a single one. There were at least four major cultures with important religious differences: Olmec, Toltec, Mayan, and Aztec. The Aztecs dominated much of the land that is now Mexico when the Spaniards arrived, but they were the dominant political power and empire, not the only culture.

The Aztec religion was characterized by a view of the universe where a constant fight for cosmic order took place between the forces of the sun and the forces of the moon and the night. Light, endurance, sobriety, and sexual self-constraint were on the sun's side; cowardice, drunkenness, and sexual incontinence worked for the moon, the night, and the evil forces (Wolf 1975). Sex was seen as something to be controlled, but its value in procreation and as a source of pleasure in both men and women was also recognized. Polygamy was common among the wealthy and divorce rare but regulated.

An interesting aspect in the Aztec religion is the place that childbirth held in the culture. Childbirth was seen as a combat in which the woman was the warrior. A woman who died in childbirth received war honors at burial.

Moderation in every aspect of life, including sexuality, was central in the ideology of the education (Morgan 1982). In other aspects, religion and society were highly repressive: Homosexuality was severely punished, although practiced; the official penalty was death (Lumsden 1991).

The other religious components in this synergistic interaction were the beliefs and behavior patterns brought to Mexico by the Catholic Hispanic conquistadors. Historical documents clearly indicate that the Church teachings were not the norm of behavior among the people. The Council of Trent (1545-1563), a response to Protestantism, served as a basis for the teachings of the clergy in charge of indoctrinating the indigenous population. A document from the 17th century written by Fray Gabino Carta, summarizes the Church's sexual teachings: There were seven ways in which lust could appear, all conducive to mortal sin: 1. simple fornication (intercourse out of wedlock), 2. adultery, 3. incest, 4. ravishment (forcing a woman to participate in sex), 5. abduction of a woman, 6. sins against nature (masturbation, sodomy, which usually meant homosexuality, but sometimes applied also to "unnatural" heterosexual coital sexual positions—different from the man above the woman lying on her back, and bestiality), and 7. sacrilege (Lavrin 1991).

### B. Source and Character of Ethnic Values

The ethnic composition of Mexico is complex. The majority of the population, 55%, is *mestizo* or *mestee*, a mixture of the European, mainly Spanish, with the indigenes that populated the area before the arrival of the Spaniards. Creoles, descendants of persons born in the New World from parents born in Europe, still constitute an important segment of the population, 37.5%. Being European in origin and not racially mixed, they can be considered Caucasian. A third group consists of a very heterogeneous minority called Indians. These indigenes are composed of 56 linguistically differentiated groups. In 1990, the indigenous population was 5,282,347, that is, 7.5% of the total Mexican population (CNP 1989).

It is difficult to pick out a single overriding characteristic in the ethnic values in Mexico. In the background, we have the original cultural sources that still can be observed today in many aspects. However, what is Mexico today only began to constitute itself some hundred years ago. There are many traces of the conquered culture. The resulting culture, best described by Octavio Paz (1950), is hermetic, inscrutable, full of resentment, and searching for refuge and finding it in the Virgin Mother María de Guadalupe-Tonantzin. According to Paz, Mexican culture is also hiding, always behind masquerades like the macho role where men attempt to calm their fears of being penetrated in a sexual way. Yes, but more importantly, Mexicans also hide in their inner self, behind a very sophisticated strategy of simulation and lies. Almost every foreigner soon learns when dealing with people of low social level that words and promises do not mean what they normally mean. When Mexicans lie or simulate they feel protected and safe. The cult of the Virgin of Guadalupe, the macho attitude, the propensity to simulate and to lie are the results of a process lived by a culture that, instead of being eliminated, was dominated.

[*Comment 1997*: In addition to the value of *machismo* mentioned above, Mexican sexual attitudes and behaviors are strongly influenced by three other values—*marianismo*, *ediqueta*, and *pronatalism*—which are commonly shared with some minor variations across the Latino world of South and Central America. To avoid duplication in several chapters, these four basic values are described in detail in Section 1A, Basic Sexual Premises, in the chapter on Puerto Rico. The reader is referred to that material later in this volume. (*End of comment by R. T. Francoeur*)]

But the Mexico of 1995 is by no means well depicted by the above comments. The process of the last two-plus decades has exerted a profound impact on the character of Mexican culture. Proximity to American culture is a major factor. The American dream is at the same time desired, hated, and feared, but the shaking of economic structures during the 1980s has led to a new identity search that is currently in the process of being delineated. This is evident in the sexual attitudes and behavior of people, as can be seen below.

## 3. Knowledge and Education about Sexuality

### A. Government Policies and Programs for Sex Education

In the last five to ten years, the need for sex education has been recognized and accepted by most sectors of the population. There are, however, differences about what this education should include and how it should be effected, depending on the ideology of the subsector of the population one considers. Both the government and the Catholic Church have stated that there is a specific need to pay attention to the educative process of sexuality.

Education in Mexico is centralized. The Ministry of Education is in charge of developing programs for all basic school levels—the first ten years of education. This it implements with free schooling in an extensive system of public schools. Official textbooks are provided for these schools and their use is compulsory. Private schooling does exist, but their programs have to cover the official program material.

This situation has facilitated the inclusion of sex education themes. Since 1974, when the official population policy changed from a pro-procreative to a policy promoting low population growth, sex education has been seen as an important element of this policy. A National Population Council was established to pursue actions necessary to implement the new policy. One of the early programs under-

taken was the National Program for Sex Education. As a result of this program, the content of the official programs and textbooks began to include sex education themes.

Initially, the sexual contents were limited to basic biological information. This raised considerable opposition, but after almost 20 years, the general public has come to accept the need for sex education and to demand more completeness in the program.

Most adolescents, especially females, now have access to information about puberty through the school system. The contents of sexual education programs now include psychological, family, and community considerations of sexual development. Meanwhile, sex education has been integrated into a more general framework of population education (Saavedra Arredondo 1986). The major shortcoming is the lack of adequate training for the teachers who apply these programs.

## B. Informal Sources of Sexual Knowledge

In the last ten years, an increase in the role of parents as reliable informants has been observed. Friends, popular literature in the form of comics with stories, and television and radio constitute the alternative sources of information. Popular literature deserves a special comment because it is probably the material more frequently read by Mexicans. Unfortunately, it is one of the means of perpetuating sexual myths and ambivalence towards sexuality. In the last four years, there has been a growing interest in the mass media to include sexuality themes in their broadcasts. In general, this has become a new source of scientific information for most people.

## 4. Autoerotic Behaviors and Patterns

### A. Children and Adolescents

Children frequently engage in self-pleasuring, but it still causes anxiety in many parents. The exploratory activities of children are well recognized and tolerated, but more explicit practices of sexual arousal are repressed. There are no figures of the incidence of this phenomenon.

Adolescent self-pleasuring is also very common. Reactions to it vary with the social context. In 1984, in a survey of single university students nonrandomly selected for a comparative study with American single students (mean age in both groups 20), Rubio (1989) found an incidence of 50.8% that, interestingly, was not different from the American incidence. In another study among younger students (17 to 19 years of age), Rubio et al. (1988) found a rate of 65% with an important gender difference: 88% for males and 39% for females. In a more recent study among 728 students 17 to 26 years of age, Ordiozola-Urbina and Ibañez (1992) found similar numbers: 83% of males and 22% of females.

Attitudes towards self-pleasuring are not clearly oriented towards accepting or denouncing it, but a tendency to view it as a natural act and not a sick one is clear. Morris et al. (1987) found that 46% of adolescent females and 75% of males said that autoeroticism was OK once in a while, but 34.5% of the females and 49% of the males said that self-pleasuring was bad for the health. Rubio et al. (1988) found less-restrictive attitudes, but the respondents were medical students: Only 29% agreed that self-pleasuring is not a healthy practice.

### B. Adults

There is less systematic information on adult autoeroticism and attitudes about it. Among Mexico City adults, De la Peña and Toledo (1991b) found that 75% of males and 20% of the participating females said they had engaged in

self-pleasuring. Interestingly, more than half of those who were currently engaging in this sexual outlet at the time of the study said they liked it very little or not at all. My own personal experience with the mass media on this issue indicates that self-pleasuring is still one of the most anxiety provoking of all sexual issues.

## 5. Interpersonal Heterosexual Behaviors

### A. Children

Sexual exploration and sex rehearsal play occurs very often in children. There are forms, like doctor's play, which are tolerated and understood. More-explicit sex play is not tolerated and is usually repressed by parents and other caretakers, such as teachers.

### B. Adolescents

#### *Puberty Rituals*

There are no widespread rituals of initiation to puberty.

#### *Premarital Sexual Activities and Relationships*

During early adolescence, 11 to 15 years of age, most adolescents begin to explore in a form of ritualized relationship called *noviazgo*, formally a relationship period prior to marriage. However, during early adolescence, *noviazgos* are commonly established without marriage as a goal. For young adolescents, it is a social way to regulate interpersonal relationships. It appears that the major part of early dyadic sexual exploration takes place in this form, though no formal data exist. At this early age, *noviazgos* are usually of short duration. Once an adolescent has had his or her first *noviazgo*, it is not difficult for either a male or female to continue with subsequent *noviazgo* relationships. Intercourse is usually deferred to a later age.

The possibility of having had the first intercourse increases after 15 years of age: The CONAPO (1988) survey found that the typical age for first intercourse is 14 to 17 years of age for males and 16 to 19 years for females, but only 23% of participants had had sexual intercourse. Figures from other studies are higher: In a 1984 group of unmarried students, Rubio (1989) found a figure of 40%. Also in 1984, among medical students (17 to 19 years of age), Rubio et al. (1988) found 46% had had intercourse (59% of males and 31% of females).

The last decade may have seen an increase in early sexual intercourse, especially in the big cities. In their Mexico City study, Morris et al. (1987) collected information from 2,983 youngsters in 1985 and found among the group of 15 to 19 years: 13.4% of the females and 44% of males had had intercourse, with 39% and 85%, respectively, for the 20- to 24-years-of-age group. More recently, Ordiozola and Ibañez (1992) found among 728 university students that 31% and 74% of males had had sexual intercourse.

### C. Adults

#### *Premarital Courtship, Dating, and Relationships*

De la Peña and Toledo (1991c) studied adults in Mexico City and found that 76.3% of their respondents had had premarital intercourse. In another study by the same authors on adults living in the state of Baja California bordering the United States, the figure for premarital intercourse was 93% for males and 54% for females.

Those who will marry follow a clear set of rules for courtship, with a formal *noviazgo* that includes several assumptions: mutual exclusivity of sexual interaction, regular scheduling of dates, and, when the decision to marry has been taken, many activities to prepare the couple for the common life. Sexual intercourse is common in these adult relationships as the institution of *noviazgo* has gained au-

tonomy in the past 30 to 40 years, and surveillance by an older woman in the family, the *duana*, has declined. In the larger cities, the *noviazgo* often has much less restrictive rules than it did in the past. Economic difficulties may delay or make the marriage plans impractical. One result is that a significant number of persons elect a single life as the style of life, either never marrying or after one or more marriages. These individuals may establish *noviazgos* where marriage in fact is not considered for the future.

Although not prevalent, there are some forms of courtship and premarital sexuality that deserve mention. In many communities, some close to Mexico City, a man and woman may decide to live together, but the man is said to "steal" the woman from her family. Depending on the economic possibilities, the woman goes to live with the man's family or the couple establishes a home of their own. After some years, and some children, the couple may decide to marry, and a wedding takes place, usually with a long series of festivities that may extend to several days. In some communities of the state of Oaxaca, the tradition of arranged marriages persists, many times in a less definitive form because the opinions of the man and woman are considered. In other instances, the man or the woman may spend some time, usually months, living with the family of the spouse-to-be to gain approval of the family to proceed to marriage.

### Marriage and the Family

Two types of marriage exist in Mexico: civil and religious, and, since one type does not have validity in the other domain, people tend to have both types. The 1990 data of the census indicate 45.8% of those 12 years or older are married, 7.4% live together but are not married, 40.6% are single, 1.9% are divorced or separated, and 3.6% are widows (INEGI 1992a).

Mexican families have varied structures, with the extended and nuclear family patterns dominant. Extended families include father, mother, and children with the addition of some other relatives, such as grandparents, uncles, aunts, or others. One form of extended family, characterized as "unstable" because some of its members, aunts and cousins, spend only a limited time with the family, is also very common. López-Juárez (1982) describes this family style as typical. The extended family functions as a social-support mechanism, substituting for other forms of social support that are nonexistent, or exist on a very low scale, in Mexico (e.g., unemployment insurance and care for the elderly). The extended family used to be the norm, but the frequency of nuclear families, groupings limited to father, mother, and children, increases as social class rises higher and urban living spreads. The mean number of household members dropped from 5.8 in 1970 to 5.0 in 1990 (INEGI 1992a).

As indicated above, cohabitation is frequent but not the norm. Monogamy is the rule and bigamy is penalized with jail. Although some individuals do in fact have two or more concurrent marriages, discovery entitles the concerned ones to send the guilty party to jail, and there are cases of this. While there are no recognized forms of plural marriage, it is important to note that this refers to formal marriage. Informal liaisons that include sexual interaction and forms of economic support, and cohabitation where one or both of the concerned have other concurrent liaisons, are not infrequent.

### Divorce and Remarriage

There are two forms of civil divorce: an administrative divorce, where the couple agrees, and the necessary divorce, where one of the spouses has incurred a legally recognized cause of divorce. Divorce statistics are not reliable,

but a general feeling is that it is becoming more frequent than it used to be some 50 years ago. The fate of the divorcee appears to differ according to gender: Males tend to remarry more than females. A trend observed in my own clinical practice is that the stigma and social barriers associated with divorce have decreased in the last ten to 20 years.

### Extramarital Sexual Relations

Marital sexuality, surprisingly, is not the most frequent form of sexuality, at least in Mexico City. De la Peña and Toledo (1991c) found that, of their respondents who had had sex in the month previous to the survey, only 45% were married. In another report (1991d), the same authors found that among the 613 adult respondents in Mexico City, extramarital behavior was reported by 29.7% (50% of males and 10% of females). In a report on the state of Baja California (De la Peña & Toledo 1992b), the figure was 40% of males and 15% of females.

[Update 1997: A form of concurrent liaison that used to be common occurs between a married man and his female lover who, after some time, acquires a higher status than a simple love affair and establishes herself in a separate household, usually helped or totally paid for by the man, who has a kind of second family with her. This relationship may include children and practically all the elements of a family, except for the legality of marriage and for the daily cohabitation, because the previous marriage is maintained. This phenomenon is known as *la casa chica*, literally, "the small home"—the term is also used to refer to the paramour. In January 1997, a prominent Mexico City politician, president of the Democratic Revolutionary Party, may have witnessed a change in public attitude when he called on his fellow politicians to abandon their widely known, and renowned, custom of maintaining several *casa chicas* and commit themselves to marital fidelity.

[Deterioration of economic standards of living seen in the last two decades appears to have made this pattern of liaison less common today than in the past. Mexico's economy shrank by 6% in 1995 when inflation was expected to top 50%, banks were charging an astronomical 70% interest on credit cards, and corporate benefits and largess for executives and middle managers dried up, leaving males unable to support their usual number of *casa chicas* and paramours.

[Although this custom is widely practiced and has a long standing in Mexican culture, such relationships usually leave the woman totally unprotected by the law when it comes to inheritance and separation rights (food, pension, alimony, etc.). While most Mexican wives would likely be happy to see the mistresses out of work, economists are greatly troubled by estimates that tens of thousands of single women who have relied on the *casa chica* tradition for much of their livelihood will be added to the swelling unemployment lines. Most of these women have few if any marketable skills.

[The paramours are taking steps to cope, forming support groups, sometimes called *Las Numero Dos*, to help rebuild their lives and find jobs. Although Mexico's economy remained seriously depressed into 1997 and many middle-class and wealthy males were obliged to reduce the number of paramours they supported in separate houses, the resilience of the tradition and the adaptability of Mexican males is evident in the booming popularity of "pass-through hotels," which charge couples by the hour. However, Carlos Welti, a demographer who has been studying Mexican sexuality for 20 years, reports that the decline of the *casa chica* has been part of an evolution in sexual mores that has followed fundamental changes in the condition of women, in-

cluding increased education and growth in the number of women working outside the home. Also, because of easy access to birth control, the average Mexican woman today bears about three children instead of the 6.8 average that prevailed in 1976 (Padgett 1995; Dillon 1997). (*End of update by R. T. Francoeur*)]

### *Sexuality and the Physically Disabled and the Aged*

The prevailing attitude is that disabled and older persons are nonsexual and have no need for sexual intimacy. Only recently, and then in very small ways, has this public attitude begun to change with a slowly growing awareness of these special populations' needs.

### *The Incidence of Oral and Anal Sex*

De la Peña and Toledo (1991a, 1992a) have provided some information on attitudes toward oral and anal sex: 44% of Mexico City respondents think oral sex is an acceptable practice, 41.2% think anal sex is acceptable. In the Baja California study (1992b), the corresponding figures were 33.3 and 22.2%.

Behavioral information gives similar rates: De la Peña and Toledo (1991ab) report 45.3% of respondents as practicing oral sex: more than 50% of males but only one third of women in the Mexico City study, and 42% of males and 40% of females in the Baja California study. Among Mexico City students, Ordiozola and Ibañez (1992) found that active oral sex was practiced by 21% of females and 51% of males, while 22% of females and 52% of males had engaged in passive oral sex. In a study of younger single university students, I found a figure of 28% (Rubio 1989).

Anal sex is slightly less common than oral sex: 32% of males and 26% of females (De la Peña & Toledo 1992b); 7.4% of female university students and 13.8% of males (Ordiozola & Ibañez 1992); and 18.5% of participants in my study of single university students (Rubio 1989). There are no legal restrictions to practice oral or anal sex.

## *6. Homoerotic, Homosexual, and Bisexual Behaviors*

### **A. Children and Adolescents**

The values of mainstream Mexican culture are highly homophobic, as would be expected in a culture derived from two homophobic precursors, the Hispanic European and Pre-Columbian cultures. There is little evidence of the incidence of homoerotic or homosexual behavior during childhood and adolescence, but it is my clinical impression that these behaviors occur in an important number of people during development, especially during adolescence when identity formation is helped by closeness to same-sex friends in both males and females.

### **B. Adults**

Homosexual behaviors are infrequently studied by Mexican sexual researchers. The studies of De la Peña and Toledo (1991ab) report homosexual behavior in 3.3% of the respondents: 5% of males and 2% of females for the Mexico City study, and 9% of males and 5% of females for the Baja California study. I found a percentage of 6.2% of single students with some form of homosexual behavior (Rubio 1989).

Attitudinal information is also scarce. A tendency toward tolerating the homosexual person seems to be emerging, but few people think this is an acceptable form of sexual behavior. Only 9.9% of males and 9.7% of females in the De la Peña and Toledo (1992) study thought homosexuality was correct. While I found that 58.7% of medical students do not think legal measures should be taken against homosexuals, 40.3% nevertheless think homosexuality is a

degeneration. Still, 58.2% of female and 56.1% of male adolescents in the Morris et al. (1987) study thought it was no problem to have a homosexual friend.

According to my clinical and professional experience, there are no fixed patterns of selection of one of the traditional gender roles in male and female homosexual persons. Lumsden (1991) notes that Mexican homosexuals do not suffer the degree of loneliness typically experienced by American and Canadian homosexuals, because friends and families stay close to the individual.

The courtship patterns in the homosexual individuals have adopted an American pattern: organizing support groups, well-established spots in the cities, specialized bars, and gathering sites. An important number of homosexual and bisexual individuals, however, suffer from the restrictions of a society that is highly homophobic, and undergo a long period of isolation before integrating themselves in the homosexual social network. There are no legal restrictions for homosexual behavior, although lower-level authorities, i.e., local police, sometimes exert repression against the homosexual individuals, a manifestation more of internalized homophobia than institutionalized persecution.

During the past 15 years, homosexual persons have organized a variety of support groups. There are homosexual groups in almost every city of size. These groups work for the recognition of the legal and human rights of homosexual persons, and with AIDS prevention, education, and support.

## *7. Gender Diversity and Transgender Issues*

### **A. Transvestites, Transsexuals, and Transgenderists**

There is no systematic information on the incidence of transvestism, transsexualism, and transgenderism. The three situations do occur and the number of people who have these conflicts is not small. The following comments reflect my impressions.

Transvestism occurs in four distinct forms. First, the fetishistic transvestite, who is generally a heterosexual who cross-dresses to achieve sexual arousal, usually with complicated rituals forming part of the arousal process. When this situation generates conflict with the partner, the individual may seek treatment, usually on an individual basis with a private professional. One private institution offers help at low-cost rates for these and other sexual problems (see Section 13, Research and Advanced Education, below). Second, the professional transvestite, who may be heterosexual or homosexual, who impersonates females working in transvestite shows. Third, the homosexual who sometimes likes to cross-dress as a means of expression of his sexual preference. Some of these individuals find in prostitution a way of living; other male prostitutes just cross-dress in order to gain more customers. The fourth type is the truly gender-conflicted person who finds relief for an internal craving to express his gender identity/role by cross-dressing for variable amounts of time during his daily life. Psychological adjustment of this last subtype varies. These people usually go through a period of high satisfaction cross-dressing and then suffer from various forms of anxiety that make them seek help from a mental health practitioner.

Transsexuals in Mexico suffer from a lack of systematic attention and knowledge on the part of most health professionals. They are often mistakenly diagnosed as homosexuals in conflict; the usual response from the medical profession is rejection. I have participated in the psychotherapeutic treatment of some transsexual individuals,

but, until very recently, I was without any resource in the official health system to offer any help beyond psychological and behavioral counseling. In 1993, one public hospital agreed to pursue the medical and surgical treatment of transsexuals in collaboration with psychotherapeutic supervision by staff at *Asociacion Mexicana para la Salud Sexual A.C. (AMSSAC)*. There are major needs in this area still uncovered by official health policy.

### B. Specially Gendered Persons

Mexican mainstream cultural expectations are very dichotomized in considering individuals either male or female. This is reflected in the difficulties encountered by gender-dysphoric patients described above, and by the lack of any kind of third gender or sex as found in some cultures.

I have one verbal report from a student some 15 years ago that in a region of Oaxaca near the Tehuantepec Isthmus, there are communities where a third gender is considered, with social norms ascribing to the effeminate man activities in the household and prohibiting him from pursuing more-typical male activities. I have not had the opportunity to corroborate this information.

## 8. Significant Unconventional Sexual Behaviors

### A. Coercive Sex

#### *Sexual Abuse and Incest*

All sexual behavior of an adult with a preadolescent (prepubertal) child is considered a crime. Around 1985, the government of Mexico City established special police offices dedicated to working with victims of sexual crimes and to legally prosecuting the perpetrator. Before this change, regular police handled these crimes, and many victims avoided contact with the police fearing further mistreatment. Some other states have adopted this new policy.

Recent information suggests the level of child sexual abuse, although underreporting can be assumed. During three months in 1991 in the Mexico Federal District, 122 cases of sexual crimes where the victim was under 12 years of age were investigated: In 53%, the crime was rape, and in 91%, the aggressor was known previously by the victim (the father was the aggressor in 12% of the cases) (Muñoz Gonzalez 1992).

Incest is a taboo for most of Mexican society. Among some low-level socioeconomic-class communities, it is evident only when the daughter delivers a child fathered by her own father, and this is acknowledged by the neighborhood as one more of the facts of life. Scientific knowledge of this phenomena is very limited and far from satisfactory.

Among some isolated ethnic groups that have conserved their purity of race by not mixing with outsiders, incest may be an acceptable way of organizing and perpetuating society. This is the case, at least, among the Huicholes, a group of some 8,000-9,000 people living in West-Central Mexico. According to Palafox Vargas (1985), various forms of incest are practiced and accepted in the community.

#### *Sexual Harassment*

Sexual harassment is considered a crime only in modifications to the law effected in 1990 after intense participation of feminist leaders. Sexual harassment, both in labor and academic settings, seems to be common, but it has been difficult to document cases. Penalties are possible for sexual harassment, but there is very little experience in applying the law.

#### *Rape*

Rape, forced sexual intercourse with a man or a woman, has long been considered a crime. Recently, the penalty for

rape was increased to seven years in jail, which prevents early freedom for convicted perpetrators. Still, the crime is not adequately or sufficiently prosecuted. In Mexico City between January 1992 and November 1993, 1,645 rapes were reported to authorities (Casorla, in press). This figure of about 900 reported rapes annually in Mexico City is far below the estimates of authorities there of a yearly figure of reported and unreported rapes between 15,000 to 20,000. The figure for the whole country is difficult to estimate, but some authors put the figure at about 60,000 rapes per year (Ruiz Harrel 1979).

### B. Prostitution

Prostitution is a common practice in Mexico. There are no legal penalties for the prostitute, but there are for anyone who exploits her or him. The pattern of prostitute activities has varied with changing policies of the governments. Some 50 years ago, there were zones in the cities where open prostitution was accepted and regulated by authorities. This still is the case for several cities, but in Mexico City, the law now prohibits open acceptance zones. This policy has generated a lack of control of where and when prostitution is practiced.

There are many levels of prostitutes, from the street girl or boy to the sophisticated call girl, and even some specialized services where the contact is established by phone and arrangements made beforehand. Since these more sophisticated and organized forms of prostitution are illegal, it is difficult to find any information on the extent of the business.

In recent years, prostitutes working independently in the streets have organized themselves in groups to fight for their rights. Claudia Colimoro, the leader, now has a full program being pursued in the political arena. She estimates the number of street prostitutes in Mexico City at about 15,000 (Colimoro 1993).

### C. Pornography and Erotica

There are vague legal restrictions to the commercialization of pornographic material, vague because the material has to be considered obscene to be forbidden, and there are no clear criteria for this. Despite restrictions, softcore pornography circulates openly and legally, and hardcore is widely available. Softcore publications are produced in Mexico mainly through joint ventures with large American companies such as Playboy and Penthouse. Hardcore is not produced in Mexico, although American, and sometimes European, videotapes are illegally copied and distributed very efficiently to street markets, making them very easy to obtain. The dimension of this illegal business is unknown to anyone not inside it, but it is certainly a profitable and large business. In the last year, the Playboy subsidiary began mail distribution of legally authorized hardcore videotapes produced in the United States, but for the first time with translations in subtitles.

## 9. Contraception, Abortion, and Population Planning

### A. Contraception

Contraceptives are easily obtained by anyone seeking them. They are offered free of charge through the official healthcare system and can be purchased at any drugstore with few restrictions. This fact speaks about the informal values of Mexican society and the nominally Catholic people: The Catholic Church officially opposes the use of contraceptives, but this opposition is not reflected in the usage rates of the Catholic population. The Morris et al. 1987 study of a representative sample of adolescents in two sections of Mexico City clearly shows that the attitudes of

youngsters do not correspond to Church positions: Only 22.3% of females and 15.5% of males thought God should decide the number of children to be procreated by the couple. The CONAPO survey documented that a majority of youngsters who have had sex actually use contraception: 64.6% of young males and 58.2% of young females, with condoms used by 38.8% and oral contraceptives by 23.8%. Women reported 23.9% using condoms, 23.3% rhythm, and coitus interruptus 21.5%.

Adult use of contraceptives is common. According to the information from the National Survey of Health and Fertility, the percentage of women in a marriage, cohabitation, or other sexually active relationship who use contraceptives is 52.7%, up from 30.2% ten years ago (Secretaría de Salud 1990).

## B. Teenage Unmarried Pregnancies

Adolescent pregnancy occurs frequently. An annual rate of 56 births for each 1,000 women in the 15- to 19-years-of-age group is reported (Urbina-Fuentes 1992). The fate of these pregnancies is not clear. Eskala et al. (1992) followed 189 pregnant unmarried adolescents at one of the main centers of high-risk pregnancy care in Mexico City, reporting that most unwed mothers decided to live with the father of the child. This option was much less popular for mothers with high education expectations. Since abortion is illegal, there is no reliable information on what percentage of pregnant adolescents terminate their pregnancy and what percentage carry through to birth.

## C. Abortion

Voluntary (on request) abortion is not legal in Mexico. The law permits abortion in cases of rape or when the health of the mother is at risk. However, the legal procedure is so complex that in practice it is almost impossible. Illegal abortions are, nevertheless, widely practiced. A source of the Mexican Social Security Institute, a huge social medicine system that provides medical care to everyone who has a formal job, estimated there were about two million during 1989 (IMSS 1990). According to some not-very-systematic reports, abortion is the fourth cause of death, although this does not show up in the official statistics because cause of death is recorded under another category, such as generalized infection (Abasolo 1990). This same source estimated that for each 100,000 babies born, 5.7 women, most of them adolescents, die from abortion complications. De la Peña and Toledo (1991d) reported that a third of their female respondents said they had had an abortion. The National Survey of Health and Fertility reported that 14.3% of Mexican women had had an abortion (Secretaría de Salud 1987).

Abortion is one of the most controversial issues in Mexico. Among the Mexico City respondents of De la Peña and Toledo (1991a), 30.3% approved abortion if there was a medical reason and 28.9% if a woman wishes it for social reasons; 17.1% said they would never accept it. Givaudán and Pick de Weiss (1992a) interviewed 500 persons in two groups in Mexico City and found that most respondents approve the decriminalization of abortion, 60% think abortion is a decision of the woman only, 62% think public hospitals should offer abortions, and 76.2% think legalization would reduce maternal deaths. The opinions of men and women in these studies did not differ significantly. In a second study, Givaudán and Pick de Weiss (1992b) interviewed 300 people representative of the two most important cities in the state of Chiapas where, in 1990, abortion was legalized briefly. After some days, the local congress reversed its position and suspended the new law. While the opinions reported were more divided than in the Mexico City survey,

half of the respondents think abortion is a woman's decision and that the Catholic Church should change its point of view. Half of the respondents also think abortion services should be provided by public hospitals; slightly more than half think depenalizing abortion would reduce maternal deaths.

## D. Population Control Efforts

Official policy is clearly oriented towards reduction of population growth. The policy changed 21 years ago from a pro-growth policy. In 1974, the government recognized that a low population growth would be favorable for national development. As a result, there has been a major campaign to achieve the new goal, and there are many indications that the efforts have been conducive to concrete results. The current population growth rate is 2.6, down from 3.2 between 1950 and 1970. Efforts include actions at many levels: free family planning at public hospitals, education and information programs at many levels, programs for women looking for an increase in the quality of life, and actions to promote a better distribution of population and many others.

## 10. Sexually Transmitted Diseases and HIV/AIDS

### A. Sexually Transmitted Diseases

Evaluation of the available data on the incidence of sexually transmitted diseases is difficult because not all the cases are reported. The data reported by the healthcare system include the following figures for 1991: gonococcal infections: 15,681 cases (18 per 100,000 inhabitants), genital herpes: 3,480 (4 per 100,000), and syphilis: 3,282 (3.8 per 100,000) (Secretaría de Salud 1992). There are no statistics for the other sexually transmitted diseases, except AIDS. Despite the problem of underreporting, investigators have come to some interesting conclusions: The rate for gonorrhoea has been declining, from 230 cases per 100,000 inhabitants in 1941 to the current rate of 18 per 100,000. Researchers who have attempted to document prevalence among these diseases consistently report higher figures, suggesting that the problem is much more frequent than the levels reported by official statistics (Del Rio, in press). STDs are more frequently a problem for males between 20 and 24 years of age and women between ages 18 and 24.

### B. HIV/AIDS

AIDS (SIDA) was first diagnosed in 1983 when 17 cases were identified. Since then, the increase in diagnosed cases can be divided into three phases: from 1983 to 1986, the growth was moderate; from 1987 to 1989, a rapid growth period was observed where cases doubled in only a few months with an exponential increase in identified cases; and from 1989 to the present, when there has been a slower, yet still exponential, growth in the number of cases. As of December 31, 1993, the total number of cases reported to the Health Ministry was 17,387 cases. However, estimates of the real number of cases, correcting for late reporting and underreporting, takes the figure to 27,000 cases (Del Rio, in press).

Another alarming point in these statistics is a doubling of the number of cases in women, from 7.9% of all the cases in 1987 to a current 14.8% of all cases. The current male-female case ratio is 6:1 (INDRE 1994). (Table 1 shows the numbers of reported cases from 1983 to 1993.)

Most of the cases are because of sexual transmission. Thus, it is clear that education is the only preventive measure available. The severity of the AIDS epidemic has not escaped officials, but the effectiveness of preventive measures remains under discussion. Early in the epidemic, the

government set up a special office to deal with the problem: the Consejo Nacional para el Control y Prevención del SIDA (CONASIDA). This agency has launched several campaigns in the mass media to increase the awareness of the general public of the risk posed by AIDS, but the campaigns have been criticized by both those who say they are offensive to the moral conscience of people and those who argue the contents of the messages are not clear enough. There has been an upsurge in the number of independent nongovernmental organizations (ONGs) that devote themselves to preventive and educative work, but their efforts are restricted by financial limitations. In the beginning, these organizations focused their work on the gay community, which was the hardest hit in the early stages of the epidemic. In the recent years, many of these ONGs have included actions to reach all the sexual orientations.

Public attention to the problem has increased considerably in the last three years, and the mass media has both responded and been responsible for these. It is common for radio stations, television, and the print media to devote space to discussions and informative programs on AIDS.

[Update 2002: UNAIDS Epidemiological Assessment: There is some information available on HIV prevalence among antenatal women in Mexico since the late 1980s. HIV testing of antenatal women in Mexico City in 1987 resulted in no evidence of HIV infection. HIV test results from ten states in 1990 also showed no evidence of HIV infection among antenatal women. In 1991, HIV testing in 12 states resulted in a prevalence of 0.1% and, in 1994, 0.6% of antenatal women tested were HIV-positive.

[HIV information among sex workers is available since 1986. Among the major urban areas, HIV information is available from Mexico City, Guadalajara, and, in 1987, Monterrey. Between 1986 and 1996, HIV prevalence among sex workers tested has remained below 0.5%. Outside the major urban areas, HIV information is available from Merida, Acapulco, Tijuana, and the states of Chiapas, Jalisco, and Michoacan from the late 1980s and from the 18 states through 1997. HIV prevalence among sex workers tested in the 18 states reached 1% in 1996.

[In 1995, 6% of intravenous drug users tested in Chihuahua were HIV-positive. In 1997, 1% of intravenous drug users tested in Tijuana were HIV-positive.

[In 1999, the information on HIV prevalence among STD clinic patients resulted in a very high prevalence in one site: males having sex with males (30.0%), male IV-drug users (8.0%), male sex workers (48.5%), as results of patient autoselection.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	150,000 (rate: 0.3%)
Women ages 15-49:	32,000
Children ages 0-15:	3,600

[An estimated 4,200 adults and children died of AIDS during 2001.

[At the end of 2001, an estimated 27,000 Mexican children under age 15 were living without one or both parents who had died of AIDS. (*End of update by the Editors*)]

## 11. Sexual Dysfunctions, Counseling, and Therapies

### A. Concepts of Sexual Dysfunction

The concept of sexual dysfunction as a health problem is only recently gaining acceptance in Mexico. The traditional approach ignored the quality of sexual interaction of people. If one interprets the decisions of the official health system on healthcare policies, attention to these problems was considered either unnecessary or a luxury. The assumptions were that problems of sexual dysfunction were always in the realm of psychoanalysis and traditionally outside the realm of possibilities available to the majority of Mexicans because of the high cost of treatment. Also, emotions of shame and undue guilt prevailed among those who had such problems, preventing any search for help. This panorama has changed in the last 15 to 20 years. I have had the experience of people who at 50 years of age ask for help for problems they have been aware of for 30 or more years, and who express their relief at the change they experienced in society. It is now easier to admit that one has a sexual problem and to seek help. The resources to provide effective help are still limited to a few private organizations with limited resources. I have been in the forefront of this change, because the institution (AMSSAC) where I work devotes its efforts specifically to the treatment of sexual dysfunction among economically restricted individuals, and to providing formal training in sex therapy to professionals.

In the minds of lay people, the concept of sexual dysfunction is still very vague. Most people immediately identify terms such as impotence and frigidity with the lack of ability to complete intercourse and to experience pleasure and orgasm. In more-professional settings, increasing attention is being paid to sexual dysfunction. Medical associations and medical schools are beginning to include themes on sexual functioning in their curricula and in their programs for congresses and professional meetings.

As a frame for clinical treatment and research, the following concept of sexual dysfunction has been proposed: a series of syndromes where the erotic processes of the sexual response occur recurrently and persistently in a way that results undesirably for the individual or the social group (Rubio & Díaz, in press). There is no information on the incidence and prevalence of these problems among the general population, but there are a number of indirect indicators that show the problems to be very common. In six years, the sexual dysfunction clinic set up at AMSSAC has been used by close to 700 individuals, around 30% of whom seek help as a couple. This number is surely much lower than the total number of people seeking help at AMSSAC, because patients requesting treatment are requested to wait a long time before their treatment can begin. The data in Table 2, re-

**Table 1**  
New Cases of AIDS per Notification  
Year and Sex, 1983 to 1993

Year	Cases per 1,000,000	Incidence	Ratio Male: Female	Percentage of Cases in Women
1983	6	0.07	6:0	0.0
1984	6	0.07	6:0	0.0
1985	29	0.3	14:1	6.9
1986	246	2.9	30:1	3.2
1987	518	6.6	12:1	7.9
1988	905	10.6	6:1	13.5
1989	1,607	18.3	6:1	15.2
1990	2,588	31.8	5:1	16.2
1991	3,167	37.9	5:1	15.4
1992	3,220	37.5	6:1	15.2
1993	5,095	58.5	6:1	14.8
Cumulative data from 1983-1993	17,387	200.00	6:1	14.8

Source: INDRE 1994.

ported by González in 1993 and based on 195 initial-intake diagnostic interviews during an 8-month period, give an idea of the relative frequency of the sexual problems encountered at AMSSAC. Generalization, however, is difficult, because the center is a specialized center in Mexico City. Comparative information from other regions of the country is not available.

### B. Availability of Counseling, Diagnosis, and Treatment

Specialized treatment for sexual dysfunctions is available, but the few trained professionals and treatment centers severely limit this. This is particularly true in the smaller cities and rural areas. In the big cities such as Mexico City, Guadalajara, and Monterrey, individual professionals who have obtained specialized training both in Mexico and abroad—mainly the United States—offer sexual therapy privately. However, this is far from sufficient for the size of the population. The situation is more critical in the official health system where sex counseling and therapy is not offered in any systematic way. Some professionals working for the official health system have been trained in sexual counseling, and they do provide this service, but with no organized structure.

As mentioned above, AMSSAC is involved in the training of sex therapists, and some already trained professionals offer their services within the sexual dysfunction clinic at AMSSAC. This clinic, although privately run, serves only patients whose economic situation prevents them from seeking help in a private clinic. Much work is needed before it can be said that the Mexican population has the ability to solve its sexual dysfunctions via professional treatment. Unfortunately, one result of the above situation is the proliferation of street therapists and fraudulent remedies to which many people still look for help.

## 12. Sex Research and Advanced Professional Education

Sexual research is conducted as a formal activity by very few researchers. However, their work is beginning to give a panorama of what goes on in the country. This has reduced the need for constantly referring to foreign research and literature.

There are researchers working now at every level of the sciences that deal with aspects of sexuality. Basic physiological research in animals is conducted following state-of-the-art methodologies in highly specialized centers. Psy-

chological research, conducted basically by a group in the Universidad Nacional Autónoma de México, has produced interesting information on the sexual behavior of young people, some of which is reviewed in this article. Anthropology researchers have also produced original work on gender issues in both the Universidad Nacional Autónoma de México and in El Colegio de México. Clinical research on sexual problems is just starting, but some information is beginning to appear. The systematization of these efforts into a body of sexual science, however, is far from being realized. Sexology, as a formal discipline, is only recently being considered, and this with considerable reticence.

Advanced education in sexology has been offered by private institutions for some 25 years, but these efforts have been concentrated in Mexico City. Recently, a number of private and public universities have opened up the possibility of short programs on sexology, focusing on sex-education issues. The list below reflects the efforts and achievements of the main groups that have participated in the construction of the human sexuality body of professionals.

The Asociación Mexicana de Educación Sexual (AMES), a private nonprofit organization, was the first to offer systematic training in sex education, with good foundations in sexology. This organization has offered courses for professionals—usually professionals trained in other disciplines, such as education, psychology, and medicine—courses of approximately 180 hours, since 1974. Other institutions, such as the Instituto Mexicano de Sexología, followed this pattern, although with modifications in length and format of the courses offered.

Then, organizations with a focus on special problems, such as adolescent contraception, and family planning, followed. Among the latter, the Fundación Mexicana para la Planificación Familiar (MEXFAM) has distinguished itself in systematizing the training in sexuality via postgraduate courses in sex education and sex counseling. This organization has promoted the institutionalization of training in public universities in other cities in addition to Mexico City, in what has become known as the Diplomats in Sexuality.

Training in sex therapy has been available since 1987 in our institution, Asociación Mexicana para la Salud Sexual (AMSSAC). Training includes clinical experience and formal lectures and readings over two years, with 650 hours of instruction.

Official institutions have included courses on sexology in the medical and psychological curricula, but no formal graduate courses are offered, with the exception of the aforementioned Diplomats in Sexuality. No formal degrees in sexology are offered.

**Table 2**

**Frequencies of Diagnosis of Sexual Dysfunction in 195 Diagnostic Interviews at the Sexual Dysfunction Clinic, Asociación Mexicana para la Salud Sexual, A.C. (AMSSAC)**

Diagnosis	Males (138)		Females (57)	
	n	%	n	%
Hypoactive desire	67	26.07	7	29.13
Hyperactive desire	2	0.78	0	0.00
Inhibited excitation	86	33.46	36	28.35
Anorgasmia	10	3.89	38	29.92
Pain syndromes	9	3.50	5	3.94
Premature ejaculation	77	29.96	0	0.00
Sexual phobia	6	2.33	7	5.51
Vaginismus	0	0.00	4	3.15

Source: González 1993. Patients may have more than one diagnosis.

### References and Suggested Readings

- Abasolo, G., Director of Social Communication of the Medical Services of the México City Government. 1990 (June 19). Quoted in a newspaper note: *Uno más uno*.
- Casorla, G. (In press). Conductas sexuales delictivas: Violación, incesto, abuso sexual, hostigamiento sexual y lenocinio. In: Consejo Nacional de Población, ed., *Antología de la sexualidad humana*. México.
- CIA. 2002 (January). *The world factbook 2002*. Washington, DC: Central Intelligence Agency. Available: <http://www.cia.gov/cia/publications/factbook/index.html>.
- CNP—Consejo Nacional de Población. 1989. *Programa nacional de población 1989-1994*. México City: Secretaría de Gobernación.
- Colimoro, C. 1993 (June). Personal Communication. México City.
- CONAPO—Consejo Nacional de Población. 1988. *Encuesta nacional sobre sexualidad y familia en jóvenes de edu-*

- cación media superior*; 1988. Consejo Nacional de Población, México.
- De la Peña, R., & R. Toledo. 1991a (May 26). El sexo en México (Part 1). *El Nacional Dominical*.
- De la Peña, R., & R. Toledo. 1991b (June 2). El sexo en México segunda de cuatro partes: Debutantes y solitarios. (Part 2). *El Nacional Dominical*.
- De la Peña, R., & R. Toledo. 1991c (June 9). Vida ¿en Pareja? El sexo en México. Primer informe (Part 3). *El Nacional Dominical*.
- De la Peña, R., & R. Toledo. 1991d (June 16). El sexo en México. Primer informe. (Part 4): Cuerpos y susurros. *El Nacional Dominical*.
- De la Peña, R., & R. Toledo. 1992a (March 1). Primer informe sobre sexualidad en Baja California. (Part 1). *El Nacional Dominical*.
- De la Peña, R., & R. Toledo. 1992b (March 8). Primer informe sobre sexualidad en Baja California. (Part 2). *El Nacional Dominical*.
- Del Río, C. (In press). Enfermedades de transmisión por contacto sexual. In: Consejo Nacional de Población, ed., *Antología de la sexualidad humana*. México.
- Díaz Loving, R. 1988. Desenredando la semántica del amor. In: *La psicología social de México: 1988*. México: Proceedings of the Congress of Social Psychology.
- Dillon, S. 1997 (January 22). How to scandalize a politician: Bare a love affair. *The New York Times*, p. A4.
- Eskala, E., et al. 1992. La adolescente embarazada y su relación de pareja. *Psicología social de México III. Proceedings of the Congress of Social Psychology*. México.
- Falicov, C. J. 1982. Mexican families. In: M. McGoldrick, J. K. Pearce, & J. Giordano, eds., *Ethnicity and family therapy*. New York: Guilford Press.
- Givaudán, M., & S. Pick de Weiss. 1992. Encuesta de opinión sobre el aborto inducido y su despenalización en el estado de Chiapas. *Psicología social de México III. Proceedings of the Congress of Social Psychology*. México.
- Givaudán, M., & S. Pick de Weiss. 1992. Encuesta de opinión sobre el aborto inducido y su despenalización en la ciudad de México. *Psicología social de México III. Proceedings of the Congress of Social Psychology*. México.
- González, G. 1993. Panorama sociodemográfico del servicio de preconsulta de la clínica de salud sexual AMSSAC. *Gaceta Amssac*, 1(1):2-5.
- IMSS—Instituto Mexicano del Seguro Social. 1990. *Síntesis IMSS*. México.
- INDRE—Instituto Nacional de Diagnóstico y Referencia Epidemiológicos. 1994 (January). *Boletín Mensual SIDA/ETS [México]*, 8(1):2576-2593.
- INEGI—Instituto Nacional de Estadística Geografía e Informática. 1992a. *Estados Unidos Mexicanos: Perfil socio-demográfico XI censo general de población y vivienda, 1990*. México City: INEGI.
- INEGI—Instituto Nacional de Estadística Geografía e Informática. 1992b. *Estados Unidos Mexicanos: Resumen general XI censo general de población y vivienda, 1990*. México City: INEGI.
- Lavrin, A. 1991. La sexualidad en el México colonial: Un dilema para la Iglesia. In: A. Lavrin, ed., *Sexualidad y matrimonio en la América Hispana: Siglos XVI-XVIII*. México D.F.: Grijalbo.
- López Juárez, A. 1982. Familia y sexualidad en México. In: Consejo Nacional de Población (CONAPO), ed., *La educación de la sexualidad humana. Familia y sexualidad*. México City: CONAPO.
- Lumsden, I. 1991. *Homosexualidad, sociedad y estado en México*. México: Solediciones Canadian Gay Archives.
- Morgan, M. I. 1982. La sexualidad en la sociedad en la sociedad Azteca. In: H. Carrizo, ed., *La educación de la sexualidad humana: Sociedad y sexualidad*. México City: Consejo Nacional de Población.
- Morris, L., et al. 1987. *Young adult reproductive health survey in two delegations of Mexico City*. México City: Centro de Orientación Para Adolescentes.
- Muñoz Gonzalez, L. 1992 (October). Departamento de Atención a Víctimas: Procuraduría de Justicia del Distrito Federal. Personal communication.
- Ordiozola-Urbina, A., & B. Ibañes-Brambila. 1992. Actitudes y conducta sexual en estudiantes universitarios. *Psicología social de México III. Proceedings of the Congress of Social Psychology*. México.
- Padgett, T. 1995 (September 18). The end of the affair: Mexico's threat to an institution—Mistresses. *Newsweek*, p. 59.
- Palafox Vargas, M. 1985. *Violencia, droga y sexo entre los huicholes*. México: Instituto Nacional de Antropología e Historia.
- Paz, O. 1950. *El laberinto de la soledad*. México: Fondo de Cultura Económica.
- Rubio, E. 1989. *A cross-cultural investigation of sexual behavior, religiosity and familism among American and Mexican urban single college students*. Doctoral dissertation. New York, NY: New York University.
- Rubio, E., et al. 1988 (March). Caracterización de las opiniones y experiencias sexuales de los alumnos de primer ingreso a la carrera de médico cirujano. *Salud Mental*, 11(1):25-34.
- Ruiz Harrel, R. 1979. Personal Communication. México City.
- Saavedra Arredondo, G., ed. 1986. *La educación en población: Marco de referencia*. México: Consejo Nacional de Población.
- Secretaría de Salud. 1987. *Dirección general de planificación familiar*. México: Encuesta Nacional Sobre Fecundidad y Salud.
- Secretaría de Salud. 1990. *La salud de la mujer en México. Cifras comentadas. Dirección general de salud materno infantil*. México: Programa Nacional Mujer Salud y Desarrollo.
- Secretaría de Salud. 1992. *Compendio de estadísticas de morbilidad 1991*. México: Dirección General de Epidemiología.
- UNAIDS. 2002. *Epidemiological fact sheets by country*. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS/WHO). Available: [http://www.unaids.org/hivaidsinfo/statistics/fact\\_sheets/index\\_en.htm](http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/index_en.htm).
- Urbina Fuentes, M. 1992. Jóvenes reproductores. In: H. Bellinghausen, ed., *El nuevo arte de amar*. México: Cal y Arena.
- Wolf, E. 1975. *Pueblos y culturas de Mesoamérica* (3rd ed.). México City: Biblioteca Era.