Dedication

This thesis is dedicated to my mother, Arlene Freidus, whose spirit of courage, strength, compassion, and perseverance guides me everyday. It is also dedicated to my father, Kip Freidus, who has always encouraged me to live life full and follow my dreams.
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Cuidate: Tourism, Drugs, Sex and HIV among Young People in Monteverde, Costa Rica

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Abstract

The main goal of this thesis is to understand a community’s perceptions of the potential impact of tourism on the spread of sexually transmitted infections (STIs) including HIV/AIDS in Monteverde, Costa Rica. In particular, I examine the ways in which globalization and increased travel affect the overall health and behavioral patterns among young people from a community reliant on tourism. The impact of migration and population movement on the spread of infectious diseases has already been well documented. Moreover, there is a clear understanding of the impact of sex tourism on the spread of STIs. However, this project seeks to understand the impact of tourism on a local population that does not have a formal commercial sex industry. Instead, the majority of sexual interactions between young local men and visiting women reflect more of an attitude of adventure and tend to be romantic in nature. Local men are inclined to have casual sexual relations with female tourists because foreign women are perceived as more liberal and sexually adventurous. Visiting women are attracted to the idea of an exotic, sexual relationship while on vacation. The interactions that result from these
mentalities often lead to risky sexual behavior that could facilitate the transmission of STIs.

This project was exploratory in nature. Data were collected from various sectors of the Monteverde community with a focus on their perceptions of the role tourism plays on changing local behavior. This project also seeks to understand the current level of sex education and STI prevention among the youth of the community. These data were used to create targeted interventions within the community in recognition of World AIDS Day on December 1, 2003, and can inform the design of future education and prevention programs that are culturally appropriate.
Chapter 1: Introduction

When HIV exploded onto the scene in the early 1980s, many researchers and scientists scrambled to understand the epidemiology and pathology of this fatal, contagious virus. Eventually, transmission was determined to occur through the exchange of body fluids and quickly linked to certain “at risk” segments of the population including hemophiliacs, homosexuals, intravenous drug users, and prostitutes. In particular during the onset of the epidemic, unprotected sexual activity, especially homosexual activity, was identified as the primary culprit in HIV transmission in the United States. Researchers speculate that initial HIV spread may have been linked to a Canadian homosexual flight attendant. Thus, the role that population movement and behavior could play in the spread of HIV became a major focus of study. Subsequent research has shown how high rates of HIV in Africa are directly tied to the routes of truck drivers who were presumably soliciting prostitutes while hauling their goods. Additionally, Paul Farmer’s (1992) dynamic publication, *AIDS and Accusation,* implicates homosexual tourism as the main factor responsible for the introduction of HIV from the United States to Haiti. Therefore, population movement, including tourism, has long been associated with the spread of HIV and the growth in globalization poses and even greater threat to increasing the pandemic. “Globalization refers to three distinct but interrelated and dynamic phenomena: increasing cross-border flows of goods, services, finance, people and ideas driven by technology changes and decreasing communication
costs; the opening of national economies to such flows; and the development of international rules and the institutional architecture governing these cross-border flows” (Drager et al. 2001). Globalization is a phenomenon that has contributed to the spread of HIV and STIs and has the potential to introduce the epidemic to new populations at a rapid rate.

This thesis is based on an internship experience undertaken from August 2003 to December 2003 through a grant awarded by the Globalization Research Center at the University of South Florida, to Dr. Nancy Romero-Daza. Since 2000, the University of South Florida in conjunction with the University of Illinois at Chicago and Mount Holyoke College has run a six-week Globalization and Community Health Field School in the Monteverde region of Costa Rica. This field school is designed to train students in qualitative and quantitative research methods in community health. The Monteverde Institute, a nonprofit institution, hosts the field school every summer. In 2000 and 2001, meetings were held with community members to identify the health issues of utmost importance to the community. These issues have been addressed through the field school research component and through independent projects. Community members identified HIV and other Sexually Transmitted Infections (STIs) as a growing concern. In 2002 and 2003, students from the field school undertook preliminary studies exploring HIV/AIDS knowledge and attitudes in the area. The continual interest of community members in examining HIV/AIDS suggested the need for a more in-depth study with a special emphasis on the impact of tourism on local risk behavior.

Romero-Daza, one of the field school directors, developed an exploratory pilot study to assess the community perceptions of the potential impact tourism may have on
the spread of STIs, including HIV/AIDS, in the rural mountain town of Monteverde, Costa Rica. The project had five main objectives: (1) to understand the general characteristics and changing nature of tourism in Monteverde (2) to assess the perspective of different segments of the local population about the potential role of tourism in the spread of STIs, (3) to assess tourists’ perceptions of HIV risk, especially associated with changing behavior while on vacation, (4) to understand the level of knowledge and community satisfaction with existing education and prevention activities, and (5) to identify new strategies for educating and disseminating information about STIs.

Using a political economy and critical medical anthropology framework, the project focused on the ways in which increasing globalization can affect the health of Costa Rica’s population. Data were collected from various sectors of the population using a multiplicity of tools including in-depth interviews, surveys, focus groups, and observations. However, the data presented in this thesis are limited to focus group discussions, observations, and educational activities and discussions, which took place in several of the local schools. This thesis also reports on a public health education campaign that was designed and run the first week of December 2003 in commemoration of World AIDS Day. While this thesis could be considered a “nested qualitative study”, on occasion, reference will be made to the overall general study. Because there had been little research done on STIs/HIV in the area, this project was mainly exploratory and will provide the basis for future interventions.

**The Situation in Costa Rica**

The Republic of Costa Rica is located in Central America nestled between Nicaragua to the north and Panama to the south. Both the Pacific and Atlantic oceans
flank the country offering two distinct coastlines. Costa Rica is a small country encompassing approximately 19,000 square miles with a population of close to 4 million people. San Jose is the capital city with close to 2.1 million residents. Spanish is the official language; however, English is spoken in many areas. The majority of Costa Rica is Roman Catholic (76%) with other religions growing; especially Evangelical churches (14%) (CIA 2005a).

Costa Rica’s most violent period was the Civil War in 1949. However, because of this war one of Costa Rica’s most influential political leaders Jose Figueres Ferrer emerged to establish a strong democracy and initiate social reforms. Ferrer served three terms as president (1948-1949, 1953-1958, and 1970-1974). He is credited with re-introducing democracy, creating equality in terms of voting rights for women and blacks, extensive social reforms, developing the Pan American Highway, nationalizing the banking system, creating the National Institute of Housing and Urbanism, and abolishing the army in 1949. These radical reforms are attributed to today’s relatively stable economic and political situation, which promoted the growth and development of the middle class. The middle class was only able to flourish because Ferrer freed up money and resources through these policies and focused them on developing a more

*Map taken from centralamerica.com*
inclusive health care system, better social services, and strong public education programs.

Costa Rica’s economy is one of strongest in the Central American region. The average per capita income as of 2003 was $4,193 with an unemployment rate of 6.7% (CIA 2005a). Tourism accounts for 21.3% of Costa Rica’s GDP, which is second just behind industry (which includes food processing, textiles, and cement) accounting for 22.4% of the Gross Domestic Product (GDP) (CIA 2005a). Agriculture, once the main economic activity, now accounts for only 10.1% of the GDP (CIA 2005a).

**HIV in Costa Rica**

Although HIV/AIDS has not reached epidemic proportions in Costa Rica, it nevertheless poses a major public health concern. As of the end of 2003, rates of HIV infection were estimated at 0.6%, with a cumulative 12,000 people infected (including 4,000 women and 320 children), and 900 AIDS-related deaths during 2003 alone (UNAIDS 2004a). Given that the main route of transmission is changing from homosexual sex to heterosexual sex, all segments of the population are at risk of infection. However, teenagers and young adults appear to be especially vulnerable.

**HIV and Young People in Costa Rica**

At present those between 15 and 24 years of age account for over 10% of the total infections in Costa Rica (UNAIDS 2002a). Research indicates that, while the rates of premarital sex are reported to be on the increase among young people, as a group they exhibit considerably lower levels of knowledge about HIV transmission and prevention than older adults (Schifter and Madrigal 2000). Schifter and Madrigal’s (2000) study of HIV in Costa Rica revealed that many young Costa Ricans are engaging in unprotected
sexual activity. For example, 18% of unwed mothers are 19 years of age or younger and half of all pregnancies are unwanted (Schifter and Madrigal 2000). Only 13% of men and 18% of women report using contraception during their first sexual experience. This is particularly disturbing as a woman’s first sexual contact often involves tearing and bleeding which increases exposure to STI/HIV. Education about HIV and STDs is limited among Costa Rica’s youth. In a survey on AIDS in Costa Rica, nearly half of males (ages 15-24) said they received the majority of their sex education on the street (Schifter and Madrigal 2000). Moreover, 44% of females were not aware that correct condom use could reduce the rate of HIV transmission. Population reports (2001) on sexual activity among men in Costa Rica show that 42% of men 15-19 and 76% of men 20-24 report premarital sex.

Costa Rica continues to have culturally rooted gender roles, which can partially be described as “machismo” and may place young people at an increased risk of transmitting HIV. Machismo is the pervasive attitude that “males are expected to begin sexual activity early in adolescents, and to have multiple sexual partners both before and after marriage, while females are expected to refrain from sexual activity prior to marriage. Within the system of machismo, women exercise few if any rights in relations to male sexual expression, while men exercise almost absolute power in controlling women’s sexual behavior” (Parker 1996:62).

**HIV Prevention**

The Roman Catholic Church has strongly opposed efforts by the Costa Rican Ministry of Public Health to develop and implement HIV prevention and sex education programs (Van der Linde 2001). The Church “deemed the condom campaign to be
immoral” (Schifter and Madrigal 2000:2) because Catholicism supports the ideology of abstaining from any premarital sexual relations. The Church believes that married couples bear no risk of contracting an STI because adultery is strictly prohibited (and therefore believed to occur rarely, if ever, among practicing Catholics). Promotion of a condom distribution program, or sex education for that matter, would be conflicting with Church doctrine and in turn “Divine Rule.” However, statistical information concerning the onset of sexual activity and the context under which it occurs, conflicts greatly with the ideas of the Church. The Church has been highly successful in impeding these strategies and today “sex education is not compulsory in Costa Rican secondary schools, and …its presence in the curriculum depends upon individual schools and teachers” (Schifter and Madrigal 2000: 10; Van der Linde 2001). This suggests a crucial direction in which the Ministries of Public Health and the Catholic Church should be moving to prevent a catastrophic pandemic from eliminating the most productive and vibrant segment of the population. The danger of asserting abstinence as the only HIV prevention message is demonstrated by current and past trends. For example, approximately half of the 333 million new cases of STDs are in young people less than 25 years of age (Mendoza 1998). Despite the growing numbers of HIV infected persons in Costa Rica, the Ministry of Public Health has done relatively little to combat this potentially devastating pandemic.

Tourism and Sex Tourism in Costa Rica

From 2003 to 2004, Costa Rica experienced an urban annual growth rate of 2.82 percent compared to a rural growth rate of only .57 percent (UNPD 2004). Much of this migration is attributed to the growing tourism economy, which is Costa Rica’s number
one commodity. Costa Rica’s attractive ecotourism industry resulted in an 11% increase in international arrivals in 2003 with an estimated total of 1,239,000 tourists (World Tourism Organization 2005). An estimated 600,000 Americans visit Costa Rica yearly and upwards of 20,000 U.S. citizens now consider Costa Rica their primary place of residence (CIA 2005a). Costa Rica is attractive to tourists because of its biodiversity (25 National Parks and 8 Biological Reserves) with an abundance of varied flora and fauna as well as its stable democracy and overall low crime rate. Costa Rica offers access to both the Pacific and Caribbean coasts with numerous beaches for surfing, sailing, diving, fishing, windsurfing, and relaxing. There are also eight active volcanoes, and the jungles boast numerous species of birds, butterflies, orchids, and mammals. Moreover, the adventure industry is growing rapidly with whitewater rafting, kayaking, zip lines in the rainforest, horseback riding, bungee jumping, mountain biking, and sport fishing booming. A tourist can engage in numerous activities and adventures within a short plane ride from the United States, and at very economical prices.

In the developing world, a shift from rural regions to the urban and tourist meccas is a trend fueled by globalization and world market systems in conjunction with images of western lifestyles and commodities (Forsythe et al. 1998). Today there are a growing number of young people seeking job opportunities in urban and tourist meccas in hopes of economic gain not realizable in traditional agricultural lifestyles (Forsythe et al. 1998). This population mobility within a country in conjunction with the movement of tourists has long been implicated in the facilitation of HIV transmission through a proliferation of the commercial sex industry (Farmer 1992) as well as the creation of illegal child trafficking (UNICEF undated). Costa Rica has legal prostitution for those
over the age of 18 (U.S. Department of State 2004a) and promotes commercial sex to tourists through various web pages that detail access to massage parlors, steam baths, escort services, and nightclubs. Prostitution is evident in the capital city as well as in major tourist centers especially in beach communities. One taxi driver explained to a reporter from the British Broadcasting Company (BBC), “When tourists arrive from other countries and get into my taxi, the first question they ask is, 'Where are the girls? Where are the little girls?’” (Wright 2004). Costa Rica is considered a “destination and transit” country for children and women trafficked from Colombia, Dominican, Republic, Eastern Europe, and Nicaragua (U.S. State Department 2004b). Costa Rica has recognized the problem of child prostitution and initiated legislation to punish offenders, who may serve up to 10 years in prison if convicted of having sex with a minor (U.S. Department of State 2004a).

Sex tourism is on the rise due to a significant portion of the population (18%) living in poverty (CIA 2005a). The greater the poverty level is in a country, the bigger the workforce available for the commercial sex industry. The situation in Costa Rica is compounded by high rates of poverty in neighboring countries. In Nicaragua, 50% of the population is living in poverty (CIA 2005b) and in Guatemala, 75% (CIA 2005c). Out of desperation, many women and children

Figure 2. View from Monteverde
migrate to Costa Rica in search of work, which often ends in prostitution or some other form of exploitation.

**Study Site: Monteverde, Costa Rica**

Monteverde is a rural area in the Tilaran mountain range in the northwestern highlands of the Puntarenas province 167 kilometers from San Jose, the capital city. Santa Elena is considered the heart of Monteverde and the most popular tourist destination in the region. Santa Elena is located at 1300-1400 meters above sea level and has an estimated population of 6,000 permanent residents. It was originally an agricultural and dairy farming community with an emphasis on coffee. However, today tourism has superseded agriculture as the number one economic activity in the area.

Quakers from the United States settled in the area during the 1950s, leaving the States as conscientious objectors to legislation that initiated the draft of the Korean War. They were attracted to Costa Rica because there was no national army (Mader 1990). With their settlement, 3000 acres, dairy farming and cheese production was introduced into the area. The Quakers also bought a large section of rainforest in an effort to protect the watershed. Much of this land is now part of the Monteverde Reserve. The reserve encompasses 10,400 hectares and is “one of just 12 rainforests left in the world where there is still primary forest: trees
that have never been cut” (Monohan 2004: np). A definite rainy season begins in May and lasts until October dumping upwards of 100 inches of rain. The dry season lasts from January to April and coincides with the high season of tourism Monteverde is characterized by its biodiversity with estimates of over 400 bird species (among these 30 types of hummingbirds) including the resplendent quetzal, 2,500 plant species (420 types of orchids), and over 100 mammal species.

Today the primary industry is tourism with visitors traveling to the area for a variety of activities including bird watching, hiking, horseback riding, canopy tours, butterfly gardens, and RV rentals. An estimated 250,000 people visit Monteverde annually (Monohan 2004). Because of the bombing tourist industry there is a constant influx of young people from different parts of the country looking for work opportunities.

Santa Elena is a rather small community with only one major supermarket and bank. There are a numerous restaurants around the town center, which serve a variety of foods. There are also several tourists’ shops, which sell Costa Rican grown coffee and foods along with other mementos and souvenirs. The Catholic Church is located in the middle of the town square with an adjacent community-meeting hall. Several small hotels in the center tend to cater to the backpacking crowd. One main bar, mainly frequented by locals, is in the town center with the tourist bar just up the road toward the reserve area. In addition,
there is a large soccer field and basketball court on the outskirts of town.

The one public health center, a government clinic, is located up the road from the field and serves Monteverde and the smaller surrounding communities. There are various smaller private practices in the area as well as a few dentists. However, the majority of locals seem to frequent the public clinic. In addition, there are several schools in the area, both private and public. It is important to note that the area of Santa Elena and Monteverde is growing rapidly due to the influx of tourists and capital into the area. Therefore, it is not surprising to see many new facilities under construction and certain to change the face of the community in radical ways.
Applied Medical Anthropology and HIV Research

Medical anthropology, a subfield of cultural anthropology, has been defined as “an academic discipline devoted to a comprehensive, cross-cultural, systematic understanding of human health, illness, illness prevention, and curing. Its major focus of interest and analysis is health-related knowledge, beliefs, practices in medical systems of both non-Western and westernized, industrialized societies” (Gwynne 2003:248). There has been a movement in anthropology away from simply studying and analyzing culture to using these data in an effort to change or solve human problems. This shift within the field of simply gaining knowledge to using that knowledge in a pragmatic, problem-solving way led to the development of “applied medical anthropology.” Some argue that medical anthropology by its very nature is applied as “all research in medical anthropology has direct or indirect applications to human health and medicine” (Whiteford and Bennett in press) Therefore, some researchers trace the earliest roots of applied medical anthropology back to the early 1900s when “social observers”, including physicians, examined the behaviors and ideologies of different cultural groups throughout Africa and in the New World. For example, these early observations led one anthropologist/physician to incorporate a new understanding of stress and anxiety into medicine through his identification of what is today referred to as Post Traumatic Stress Disorder about World War I soldiers (Whiteford and Bennett in press).
Gwynne (2003) defines applied medical anthropology as “the use of theories, methods, and accumulated data of medical anthropology to address specific health-related problems and achieve specific, practical, health-related goals” (2003: 249). Joralemon (1999) explains three characteristics of medical anthropology that make it an effective science able to study, understand, and promote health within and among different cultures. First, medical anthropology utilizes a wider temporal and geographic scope than other social sciences. Therefore, medical anthropologists are able to examine the variety of global forces, especially economic and political structures that influence health patterns in local communities. For example, many scholars now recognize the impact of capitalism on health (Farmer 1992, 1996, 1999, 2003; Romero-Daza and Himmelgreen 1998; Singer 1989, 1990, 1994, 1998). Economic inequality is a natural extension of global markets resulting in a wide gap between the health outcomes of the poor and the rich. Medical anthropology examines these health outcomes within the context of a particular community’s ties to the global market system. Secondly, medical anthropology considers both cultural and biological patterns of disease (Joralemon 1999). This biocultural perspective allows researchers to understand the cultural context within which biological disease and illness manifest themselves. Whiteford and Bennett (in press) explain that the “biological synthesis” refers to the ability of medical anthropology to “think about the ways in which cultural rules about disease recognition and treatment intersect with germ pathology of disease.” This understanding is particularly useful for developing illness prevention and education programs. For example, Whiteford and Bennett (in press) demonstrated the effectiveness of implementing a “Community Participatory Intervention” (CPI) Model to prevent the spread of Cholera in rural
Ecuador. This project was successful because researchers incorporated local ideas about risk, disease, and behaviors while encouraging community leaders to direct and implement prevention and education in the region. There were 25,547 fewer cases of cholera after one year following the initiation of the CPI model. Finally, anthropology brings a research strategy that involves multiple qualitative and quantitative methods (Joralemon 1999) such as informal and formal interviews, focus groups, participant observations, life histories, and surveys. This approach allows for a more in-depth, holistic understanding of the cultural, ecological, and biological environment within which illness occurs.

Applied medical anthropology is particularly useful in understanding and preventing HIV/AIDS. HIV/AIDS is spread through direct contact with infected blood and body fluids. Possible routes of transmission include unprotected sexual contact with an infected person, infected blood transfusions, sharing infected syringes and needle stick injuries, and vertical transmission from an infected mother to her baby (CDC 2003). HIV transmission patterns vary among different cultures and populations. For this reason, HIV prevention is particularly challenging. For example, in Brazil HIV transmission is most common among Injection Drug Users (IDUs) and homosexuals; however, heterosexual transmission is now on the rise (UNAIDS 2004b). In the U.S., men who have sex with men (MSM) and ethnic minorities have the highest rates of HIV transmission but rising rates among women and especially minorities are occurring (CDC 2005b). In Costa Rica, the epidemic began among men who have sex with men with over half of AIDS cases between 1998-2002 among MSMs (UNAIDS 2004a). However, today, there is an increase in heterosexual transmission. This trend may be a result of
contact with tourists and MSMs who are bisexual. The difficulty in controlling HIV results from the diversity of circumstances and environments within which it spreads. However, the majority of transmission is the direct result of human behavior and the ability or inability to make decisions to protect against the disease (there is very limited transmission of HIV from blood transfusions). Anthropology examines these varied settings and different mechanisms at work driving human behavior and decision-making. With its unique focus on studying human behavior through an examination of individual cognition as well as the relationship of a community to larger macrolevel processes, anthropology can inform theory about human behavior and risk-taking, and can contribute to the development of cultural relevant and efficacious prevention and education programs in diverse settings

**Anthropology and HIV Research**

Anthropologists offer an alternative to biomedical prevention by examining the multiplicity of factors that lead to risk behavior and addressing these underlying cultural constructions as well as the global forces that lead to risky sexual behavior. Anthropological research on HIV transmission and prevention is prolific in both the U.S. and abroad. Researchers in the U.S. have focused studies primarily on populations identified as “high risk” including: injection drug users, minorities, sex workers, and men who have sex with men (MSM) Whereas those studying HIV in developing countries face a very different epidemic whereby entire communities, and not simply subpopulations, are infected. Both groups of researchers examine HIV within the context of larger political, economic, social, and historical forces.
Injection Drug Users

Injection drug use is defined as any action that manipulates a syringe to inject drugs into the body and is not limited to those who inject only into veins. Injection drug use continues to be a major source of newly acquired HIV infections in numerous countries. For example, in some parts of Brazil there is a prevalence rate of 42% among Injection Drug Users (IDUs) (UNAIDS 2003). There is growing concern of the increasing rates of HIV among IDUs in Asia. China’s IDU population has an estimated prevalence rate of 40% (UNAIDS 2003). Vietnam and Thailand report 80% and 85% HIV prevalence rates, respectively (UNAIDS 2003). The Ukraine reports the highest HIV prevalence rate among IDUs in all of Europe at 74% (UNAIDS 2003). In the United States, the Centers for Disease Control (CDC) reports that of the 42,156 new cases of HIV identified in 2000, 28% were associated with IDU’s (CDC 2002). The work of anthropologists such as Romero-Daza and colleagues (1999, 2003, 2005), Himmelgreen and Singer (1998), Singer (Singer et al 1995), Weeks (Weeks et al 2002), Trotter (1995, 2000) and Bourgois (1998, 1999) has been instrumental in providing insight into the multiplicity of variables including poverty, street violence, domestic and international forces, and involvement in social networks which coalesce to result in high risk behaviors among IDUs.

In an effort to design and implement effective HIV education programs among IDUs it is important to understand both the micro and macro-level environments within which IDUs function and the impact these forces have on their individual decision-making and behavioral patterns. IDUs are at risk for infection when they expose themselves to the virus through infected blood or other body fluids. The appearance of
“shooting galleries,” where drug users meet to inject drugs together, correlates with increased rates of HIV transmission among IDUs (Bourgois and Bruneau 1999). In these galleries, IDUs often share needles and other paraphernalia, such as cookers, wash waters and cottons (pieces of cotton used to trap drug particles that do not dissolve) that are capable of transmitting HIV, among other blood borne infections (Bourgois 1998; Koester et al. 2005; McCoy et al. 1996, Riehman 1996). Understanding the variety of reasons that lead IDUs to share needles can be difficult. This makes ethnography an indispensable methodological technique. IDUs report needle sharing because they do not have access to clean syringes or materials for sterilizing their equipment (Bourgois 1998). In many instances, IDUs report fear of being caught with syringes because in many states it is illegal to carry drug paraphernalia. Therefore, there is a scarcity of needles resulting in risky sharing behavior (Carlson et al. 1996; Koester 1994). Some IDUs may believe sharing is safe because they do not feel the others they are injecting with are infected or they are simply too high to think about the consequences (Bourgois and Bruneau 1999). In addition, IDUs report sharing paraphernalia and needles when they jointly purchase drugs, and therefore inject with each other (Koester et al. 2005). There are even scenarios whereby individuals share needles out of a sense of camaraderie and view drug injecting as a social activity (Koester et al. 2005), although this has been disputed because it can be seen as victim blaming.

Anthropological research has focused on understanding the specific social networks, both personal and larger structural networks, within which IDUs participate (Singer et al. 1995, Weeks et al. 2002). IDUs are at a particularly high risk of HIV transmission because of the heterogeneity of their different social networks. This
heterogeneity makes it difficult for public health officials and community health workers to reach at risk groups with general HIV prevention materials. For example, Weeks and colleagues’ (2002) analysis of high-risk sites concludes that there are different ethnic and economic micro-networks of drug users, but that there are “bridging links” which bind these peripheral networks together into a larger macro-level network. The authors surmise that by identifying individuals who are strategically located within the macro-level networks and training them with culturally relevant prevention information, there is a greater possibility of reaching a wider range of individuals. A more focused, culturally relevant approach needs to be undertaken. Ethnographic research methods allow researchers to understand “the clients’ point of view, their understanding of events and behaviors, and the meanings they derive from them, as well as indigenous knowledge, values, and past experiences” (Singer et al 1995: 247) which impact the efficacy of intervention and prevention programs such as Needle Exchange Programs.

Sterk and Elifson (1999) support the conclusion that there are select influential individuals within drug using social networks. Their research shows how central individuals are able to influence others within the social network from switching from heroin injection to heroin smoking. As Weeks and colleagues state (2002: 203), “With knowledge of social ties and structural linkages among drug users and their contacts, we can begin to move beyond individual-centered, behaviorist explanations of HIV risk, transmission, prevalence, and formulas for prevention.” Trotter’s research (Trotter and Mora 2000) further emphasizes the importance of understanding complex social networks. His research demonstrates that individual’s assess the impact their behaviors have on their social network. These data suggest that by being armed with this
information public health and community health programs can better devise effective HIV prevention programs.

It is important to note that labeling an individual “IDU” may result in ineffective HIV education because general public health programs assume homogeneity within this “risk” category (Singer et al 1998). Therefore, not educating about other routes of transmission or addressing other structural determinants may result in a lack of attention being given to possible alternative risk factors such as violence, lack of education, poverty and prostitution faced by IDUs. For example, Gorman and colleagues (1997) reveals the importance of addressing the dual risk faced by IDU’s who are also gay men (DU-IDU), especially those who frequent “party” circuits, with targeted and culturally appropriate prevention and health care services.

Singer and Romero-Daza (1999) introduced the concept of the “SAVA syndemic” which is an acronym for substance abuse, violence, and AIDS and suggests a relationship between these variables that directly affect women, particularly those engaged in sex work in the inner-city (Romero-Daza et al 2003, 2005; Singer and Romero-Daza 1999). Many women are involved in sex work because of a drug addiction and face violence daily, for these women “it is necessary to break the vicious cycle of violence, drugs, and prostitution that is perpetuated by the oppressive social, economic, and political reality of the inner city (Romero-Daza et al 1999: 255).”

**Sex Workers and HIV**

Prostitutes, female prostitutes in particular, are often seen as vectors of disease transmission and not as victims of larger structural flaws. However, anthropological research has contributed to the understanding that prostitution is often the result of
structural barriers that prevent both men and women from providing for themselves and their families (Farmer 1992, 1996, 1999, 2003; Kreniske 1997; Romero-Daza et al 1999, 2003). Research has identified women as particularly vulnerable to relying on prostitution as their only means of economic survival because of gender inequality causing limited education, joblessness, submission to males or household breadwinners, and limited access to health care (Farmer 1996). In reality, anthropologists maintain that women are more likely to become infected than they are of infecting others (Farmer 1996; Schoepf 1991). Several researchers identify inequality as a cofactor in infection.

Research has identified variables that lead women, men, and children to prostitution for economic survival including racism, sexism, political violence, drug addiction, and poverty (Farmer 1996; Romero-Daza et al 1999, 2003, 2005). Moreover, sex work results when there is a significant demand for such services. Common environments that encourage prostitution include development or construction projects that rely on cheap, migrant laborers (whereby workers are separated from their families), free trade, or industrial zones, areas with large numbers of military personnel, urban centers that traditionally have a large gap between the rich and poor, and tourist areas. For example, in the case of the Dominican Republic research shows “low incomes and unemployment coupled with inflation – particularly of the prices of essential items- serve as strong motivators for sex work” (Kreniske 1997:36). In Haiti, Farmer (1992) examines how the corrupt political system in conjunction with a fledging economy resulted in a large, extremely poor lower class. He then concludes that inequitable power and economic distribution results in the poor being forced into occupations (the sex
industry) to serve the desires of a powerful elite (traveling westerners or local aristocracy).

Women working as prostitutes are particularly vulnerable to HIV for numerous reasons. For example, women are often exposed to other sexually transmitted infections (STIs) because of their high levels of sexual contact with multiple partners. HIV transmission is facilitated by the presence of other STIs, which are common among prostitutes (Asthana and Oostvogels 1996; UNAIDS 2002). In addition, research has shown that sex workers are particularly vulnerable to violence, and therefore HIV transmission, while working as prostitutes (Romero-Daza, et al 1999, 2003, 2005).

Violence, such as rape, physical abuse, and sexual abuse, are often commonplace and considered “occupational hazards” which place both women and men at an increased risk for HIV infection (Jackson et al 2001, Romero-Daza et al 1999, 2003, 2005). Moreover, many clients will pay prostitutes more money to have sex without a condom. Unfortunately, many of these women comply with their requests because poverty is the motivating factor for them being involved in prostitution (Jackson et al 2001, Karim et al 2001). Women report being afraid to negotiate for condom use because they fear violence or abuse by their clients if they suggest using protection (Karim et al 1995; UNAIDS 2002). Unfortunately, there has been little research done on the perspectives and motivations of commercial sex clients. Because of the nature of their activities, many clients prefer hiding their identities and are not accessible to researchers (Esu-Williams 1995).

The spread of HIV has been linked to prostitution and migration throughout the world since the beginning of the epidemic. For example, the original outbreaks of HIV in
Africa occurred via heterosexual transmission along long haul truck driver routes whereby truckers visit prostitutes on their journey (King 2002; Schoepf 1991). The phenomenon of rural-to-urban to rural migration among those working as prostitutes needs to be addressed as a factor increasing the risk of HIV transmission. Research documents women working in tourist areas in Thailand and the Dominican Republic as being part of this migratory pattern in search of occupational opportunities (Singhanetra-Renard 1997; Skoczen 2001). Women and men who migrate to tourist areas working in prostitution often have regular partners in their rural hometowns. When these sex workers become ill, often with STIs and/or HIV, they often return home to recover. It is common for sex workers to have unprotected sex with their regular partners while at home (Jackson et al 2001, Karim et al 1995; Skoczen 2001). Both women and their intimate, steady partners prefer to have sex without using a condom because it separates their occupation from their personal lives and women report feeling more emotionally attached to their partners, which is why they tend to not use condoms (Jackson et al 2001, Karim et al 1995; Kerrigan et al 2001). This has been identified as a common route of transmission and one that is rarely addressed by education and prevention programs (Jackson et al 2001; Karim et al 1995; Kreniske 1997).

Research examining male prostitution and the transmission of HIV are less extensive despite the high rates of HIV reported among this population. For example, in 1993 rates were as high as 29.4% in one study population of male prostitutes (Elifson et al 1993). Because of the biological nature of same sex intercourse between men, which often entails a high rate of blood and semen exchange during anal sex between partners, MSM are at high risk of infection (Elifson et al 1993). Anal sex, particularly for the
receiving participant, often results in some tearing of the anus, which then becomes a vehicle for HIV transmission. Moreover, male prostitutes exhibit higher rates of STDs, which, especially if there are open sores, is associated with HIV transmission. There is research showing that males often enter into prostitution because of the need to support a drug habit. Male prostitutes who also inject drugs are particularly vulnerable to HIV because they expose themselves by multiple routes of transmission. Interestingly, men, like women, are at an increased risk of HIV transmission with non-paying partners because condom use is less common (Elifson et al 1993).

In order to prevent HIV among sex workers structural characteristics such as poverty, gender inequality, limited access to resources and education, and sexism, which force women into sex work, need to be addressed. Researchers suggest increasing gender equality though advocacy, education, legal rights, and equal opportunity as an essential first step (Farmer 1999, 2003; Romero-Daza et al 1999). In addition, health care systems must insure quality treatment and accessibility for sex workers including the treatment for both HIV and STDs (Farmer 1996:35). Universal HIV education and stigma reduction focusing on educating young people about the connection between HIV, poverty, and gender inequality must be undertaken (Farmer 1996). Support services for sex workers must include the following components: self-esteem building, education to increase employment possibilities, empowerment, sex education, drug rehabilitation (when appropriate), and general health education (Romero-Daza et al 1999). Moreover, women must be aware of the risk they face in their home lives when having unprotected sex with their significant others.
Education and prevention must not simply target sex workers, but their clients as well. Mandating condom use throughout the legal commercial sex industry has proven effective in places such as Thailand and the Dominican Republic should be expanded, especially with the growth in sex tourism (Kerrigan et al 2001; UNAIDS 2000).

**Trafficking for Sexual Exploitation**

Child trafficking refers to the movement of children that is “inextricably associated with their subsequent exploitation by others in a way that violates their human rights –usually by being forced to make money for them by working, but in the case of babies who are trafficked for adoption and young women trafficked for marriage, to satisfy the demands of those who take control of them in other ways” (Dottridge 2004:17). Child trafficking is illegal with underground networks shuffling children within and between countries, because of the secretive nature of the business it has been difficult to estimate the total number of child working in the commercial sexual exploitation industry. The International Labor Organization estimate of 1.8 million trafficked children in 2000 might be a conservative figure (Dottridge 2004).

Women and children who are trafficked often find themselves forcibly working as domestic servants or in various industries because they are sources of cheap labor. Others find themselves in forced marriage arrangements or working as sex slaves. The widespread use of the internet, advertisements geared toward sex tourists, and increasing child pornography have all been implicated in expanding the market for child prostitution (UNICEF undated). Child trafficking and prostitution is a growing phenomenon particularly in areas of heavy tourism activity. For example, in Mexico there are an estimated 16,000 children working as prostitutes predominantly in the tourist sector.
Women are often deceived by false promises of better job and educational opportunities. Children may be abducted, sold by poor parents, or their parents deceived by false promises of a better life for their children in a new country.

“Traffickers use coercive tactics including deception, fraud, intimidation, isolation, threat, and use of physical force, and/or debt bondage to control their victims” (Human Rights Watch 2004). Researchers have also found many children, especially orphans and street children, engage in “survival sex” (Lockhart 2002). Street children in Tanzania are forced into street sex because of dire economic and social conditions as well as the need to maintain some sort of “hierarchy of power and authority characterizing their relationships with one another” (Lockhart 2002).

HIV/AIDS is not just a result of child exploitation, but also a cause. Children are particularly vulnerable to exploitation when they are orphaned by both parents, which are becoming more prevalent due to the HIV/AIDS pandemic. Children and women are susceptible to becoming victims of this same pandemic because the sexually exploited are at an increased risk for HIV transmission. Children are biologically susceptible to transmission, and both women and children are at an increased risk due to the violent nature of many of their forced sexual experiences. Moreover, with the growing HIV/AIDS epidemic, male clients of commercial sex workers are beginning to show a preference for younger sex workers because they believe there will be a smaller chance of him/her being HIV positive (Dottridge 2004). In some cultures, there is still the insidious mentality that sex with a virgin will cure HIV/AIDS (Amnesty International 2005; UNAIDS 2002; Dottridge 2004) which increases the demand for child sex workers.
Trafficking of women and children is not only illegal, but also an outright violation of basic human rights. Unfortunately, there is not an easy solution because the problem is rooted in larger, structural flaws that force women and children into desperate situations because of larger inequalities and discrimination. Women and children are vulnerable to trafficking because they often are not awarded any form of self-determination and suffer from a lack of education, minimal resources, and no power or voice. As Farmer explains, “civil rights cannot really be defended if social and economic rights are not” (1999:9).

**Men Who Have Sex with Men (MSM)**

Men who have sex with men (MSM) in the United States continue to account for the highest number of new HIV infections each year. The CDC reports that in 2000, there were 13,562 AIDS cases among MSM (CDC 2002a). In the U.S., HIV was discovered in the gay population living in California and was quickly attributed to high rates of casual sex with multiple, often anonymous, partners in notorious bathhouses. In fact, HIV was originally termed “GRID”, Gay Related Immune Deficiency until the virus was found to have contaminated the blood supply and infecting people who were not part of the homosexual community. However, the MSM community continues to be the hardest hit by the epidemic and despite decreasing rates over the past few years, there seems to be a shift in the mentality of young MSM, which is resulting in a reemergence of HIV and STIs (Ekstrand et al 1999; Rofes 1998; Sheon and Crosby 2004).

Many homosexual men, especially following the emergence of HIV, do consider themselves part of a larger unified, homosexual community. However, it is important to note that MSM do not constitute a homogenous community or group. There are a
significant number of individuals who self-identify with different social and cultural
groups or communities and would not consider their activities homosexual in nature. For
example, some men, especially Latino men, mask their homosexual activities because it
is not acceptable in their communities that promote “macho” attitudes; therefore, many
fear discrimination and stigmatization or cognitively do not view their behavior as
homosexual in nature (WHO 2000). Some men who only penetrate their partners and are
not receptive during anal or oral sex may also not identify as homosexual (Asthana and
Oostvogels 2000). Men who are substance abusers may sell sex in order to make money
to supply their habits. These men may not consider themselves homosexual either.
Many of these men are often bisexual and pose a particular risk for HIV transmission
because they hide their activities and are difficult to reach with HIV/STI prevention
materials. Moreover, some of these men might maintain regular sexual relationships with
wives, girlfriends, or others who are unaware of their activities, which places their
partners at an increased risk of contracting HIV (Andalo 2003).

Individuals who do self-identify as homosexual and are active in the homosexual
community are facing a different epidemic today than those members who were active
during the initial outbreaks. Researchers have identified new attitudes emerging,
especially among younger members of the gay community, following the initiation of
HAART (highly active antiretroviral therapy) in 1996 (Rofes 1998). The original
frenzied attitudes surrounding the AIDS crisis have diminished as more and more HIV
positive men are surviving and even thriving with the help of protease inhibitors. Today,
HIV is not the death sentence it was in the past. Rofes (1998) explains that as the number
of obituaries of AIDS victims decrease, AIDS hospices close, and fewer visual signs of
the disease are seen, the idea of “crisis” diminishes. Attitudes are becoming more lax or outright ambivalent concerning HIV in some segments of this population, which has resulted in increasing rates of HIV and STI transmission among young MSM (Sheon and Crosby 2004).

Another contributing factor to the rise in HIV rates is the attitude by HIV negative gay men that they are somehow isolated from the gay community simply by their seronegative status. Some men report feeling “less gay” when they cannot participate in discussions about HIV medications or health issues (Sheon and Crosby 2004). In some segments of the gay community, the idea of having to maintain safe sex practices for the rest of their lives is overwhelming, disheartening, and exhausting and therefore some men engage in barebacking. “Barebacking is the slang term used to describe sex that occurs without the protection provided by a condom and is usually a term reserved for reference to anal intercourse between gay men” (Gauthier and Forsyth 1999:86). Moreover, there is a new phenomenon within the younger, gay community that has been facilitated by the widespread use of the internet and is referred too as “bug chasing.” “Bug chasing is the term used to refer to the act of barebacking when the participants include both HIV-positive and HIV-negative gay men, and the latter is knowingly seeking infection from the former” (Gauthier and Forsyth 1999:86). Gautier and Forsyth (1999) identify other major reasons why some HIV negative men actively seek to seroconvert and include not wanting to live in fear of conversion, becoming positive will provide some relief, risk taking is exotic, wanting a sense of group solidarity and community, and rebelling against homophobic culture. These feelings coupled with the attitude that HIV seroconversion is inevitable lead to increased HIV risk taking behaviors.
Minorities

The CDC reports that in 2003, 31% of reported AIDS cases were among Caucasians, 48% among African Americans, and 18% among Latinos (2003). African Americans are the hardest hit with an estimated 368,169 AIDS cases, which accounts for 40% of all cases, since the onset of the epidemic (CDC 2005c). Latinos represent the second highest rate of HIV diagnoses for all racial and ethnic groups (CDC 2005b). Latinos accounted for 20% of AIDS cases among adults and adolescents in 2003, and African Americans accounted for 42% (CDC 2005c). The CDC is careful to report, “race and ethnicity are not, by themselves, risk factors for HIV infection” (CDC 2005c). However, there are risk factors that are disproportionately affecting these populations and placing them at a higher risk of HIV infection including: substance abuse in general, and injection drug use in particular; higher rates of sexually transmitted diseases especially gonorrhea or syphilis; higher levels of poverty which limit access to healthcare, education, and prevention resources; and finally denial of homosexual or bisexual activities due to cultural constructions of gender roles that prohibit or stigmatize same sex relations. Despite these similarities, researchers have also found profound differences between different ethnic populations that result in high-risk behavior. Anthropologists have undertaken in-depth studies in the U.S. among various populations, however, studies on Latino populations (Hirsch et al 2002) and among African American women (Sobo 1993, 1998) are some of the most comprehensive.

Individual ethnic groups have their own cultural constructions of marriage, love, sex, and intimacy. Therefore, understanding risk behavior must be placed within the
context of each individual cultural groups ideals. Added to this complexity is the affect of globalization, which often separates families for extended periods as young people migrate to urban areas, often in other countries, for jobs or other economic pursuits. A classic example is the influx of Mexican migrant workers who flood into the United States everyday. Many of these workers are young men who have left behind wives and girlfriends in Mexico. Because of the difficulty of the journey, and often high expenses of paying “coyotes” to cross into the U.S., many migrant workers remain in the U.S. for extended periods. This isolation from their sexual partners places them at higher risk for contracting and transmitting HIV and other STDs. Hirsch and colleagues (2002) explain that “Mexican migrants relative youth, their loneliness and social isolation, and the fact that many are single or traveling without their spouses may make them likely to seek sexual activity, and low levels of education and limited English may make it harder to reach these migrants with messages about HIV prevention” (1229). Researchers also found that women in rural Mexico are not likely to require condom use when their partners return ignoring the possibility of infidelity in an effort to encourage the ideal of sexual intimacy and trust. Hirsch (2002) found that many women recognize the fact that men who travel for work are engaging in extramarital activities, however, they maintain that their partner is “the exception to the rule.” Finally, there is the age-old complaint that sex with a condom denies trust and is less pleasurable.

Sobo (1993) found that African American inner-city women held similar ideals as their ethnic minority counterparts about the ideal of monogamy and not the reality of men having multiple partners or engaging in unsafe high-risk activities. Women who

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1 “Coyote” is slang for a paid guide who smuggle illegal Mexican immigrants into the U.S. for a substantial fee, sometimes upwards of $1,000 depending on preferred destination in the U.S.
engage in sex with “high risk” partners are often opposed to wearing condoms because they feel it takes away from their intimate and trust relationship. Some impoverished women are economically dependent on their partners and suggesting the use of a condom might threaten their financial resources. However, research has found that inner-city women tend to engage in unsafe sex for a plethora of other reasons which are more dominant than the idea of financial dependency. In fact, Sobo points out those inner-city African American men are often an unstable source of money and resources because of high rates of unemployment, drug addiction, homicide and the greater likelihood of them being incarcerated. Therefore, inner-city women are often forced to be self-reliant. Sobo (1998) attempted to uncover the other myriad of reasons women engage in unsafe sex. She discovered that “women actively use unsafe sex as part of a psycho-social strategy for building and preserving an image of themselves as having achieved the conjugal ideal” (Sobo 1998:79). Moreover, women are more dependent on men for self-esteem building and increasing status. Sobo concluded that condomless sex among black women had more to do with “love, not money” and that it is more about a psychosocial connection.

Preventing HIV transmission among ethnic minorities is a difficult task because accessing these populations can sometimes be a challenge due to language barriers, illegal immigrant status, and high levels of mobility. Additionally, many traditional education campaigns have focused on “empowering” women to negotiate for condom use. However, the larger structural barriers such as poverty and social inequality are not being addressed. Hirsch and colleagues (2002) maintain that “to suggest that we can help married women protect themselves by ‘empowering’ them to negotiate for condom use is
to suggest that we can change the outcome of gendered inequalities in power without
doing anything about the actual inequality” (1233). We are therefore only placing a band
aide on a much bigger problem. Whiteford and Vittuci (1997) claim that federal policy
requiring drug tests for incarcerated, pregnant women unfairly targets the marginalized
and suggest that “social values about sex, class, ethnicity become institutionalized in law
and medicine in ways that unfairly stigmatize and jeopardize low-income women of
color” (1371). Such policy blames these women so we do not have to examine, criticize,
and blame our own society. It is easier to pick on the vulnerable than to initiate policy
and programs geared toward ending structural violence. Clearly, changes must be
mandated at the policy level as well as in the community. Finally, research undertaken in
the U.S. clearly demonstrates that strategies are ineffective when they do not address the
psychosocial elements of risk behavior.

**Globalization and Tourism**

Globalization refers to three distinct but interrelated and dynamic phenomena:
increasing cross-border flows of goods, services, finance, people and ideas driven by
technology changes and decreasing communication costs; the opening of national
economies to such flows; and the development of international rules and the institutional
architecture governing these cross-border flows” (Drager et al. 2001). These cross-
border movements facilitate HIV and STI transmission. The 15th century expeditions of
Columbus to Haiti resulted in the transmission of syphilis from “native women” to sailors
and subsequently from sailors throughout Europe thus documenting one of the earliest
impacts of travel on STD transmission (Memish and Osoba 2003). Therefore, it is not
surprising that HIV/STI transmission is increasing along with globalization. Infectious
disease specialists are cognizant of the rapid growth in international tourism. For example, in 2003, there were 691 million international travelers (World Tourism Organization 2005). Central America played host to some 4.9 million of those travelers, which is an increase from the previous year’s estimate of 4.7 million (World Tourism Organization 2005). The Caribbean is now one of the most popular tourist destinations playing host to some 17.1 million visitors in 2003 (World Tourism Organization 2005). Tourists are attracted to cheap rates, all inclusive resorts, and beautiful sandy beaches. It is not a coincidence that the Caribbean also boasts the highest rates of HIV outside of Africa (Skoczen 2001; UNAIDS 2005a) with a 2.3% adult prevalence rate (UNAIDS 2004b) the majority of which are spread through heterosexual transmission.

There has been a proliferation of sex tourism, especially with the explosion of the internet. Sex tourism is defined as traveling to a foreign country with the intent of paying for and engaging in any variety of sexual activities. In many countries, prostitution is legal and sex tourism is promoted in order to boost the economy. Countries such as Thailand, South Africa, Greece, Costa Rica, and Dominican Republic, all promote the development of their tourism industries, including the promotion of sex tourism. Hannum (2002) suggests that the explosion of sex tourism is primarily limited to developing countries because there is a readily available workforce. Men and women in poorer countries are more likely to engage in sex for money because they have limited occupational opportunities. World Vision (2004) reports that “sex tourists travel to countries such as Cambodia, Thailand, Costa Rica, Mexico and Brazil, expecting anonymity, low-cost prostitution, easily accessible children and impunity from prosecution.”
There are numerous studies, which examine the transmission of HIV from tourists to commercial sex workers (Forsythe et al 1998; Kerrigan et al 2001; and Skoczen 2001). It has been suggested that commercial sex workers are one avenue for the spread of STIs/HIV into the interior or rural regions of these countries through unprotected sexual activity with regular partners or close relationships located away from the service sector. Therefore, it is not surprising that HIV rates are now escalating in once untouched areas. However, little has been done to examine informal sexual relationships between tourists and locals that are not connected to the commercial sex industry. In reality, these informal sexual contacts may be at an even greater risk of STD/HIV transmission.

Tourism has long been associated with HIV transmission through sexual contact between visitors and locals in a variety of contacts including both formal, paid relations and through informal relationships. The vacation atmosphere is conducive to casual, often risky sexual relationships for numerous reasons because tourists perceive their environments and social roles differently while on vacation. McKercher and Baur (2003) explain tourism as a liminal state whereby vacationers escape their normal roles and can engage in activities outside normal gender and societal constraints. Moreover, the environment within which tourists find themselves facilitates risky sexual encounters. For example, many tourist destinations are exotic or romantic in nature with many similarly aged people mixing including tourists and locals working in the service industry (McKercher and Baur 2003). Research in the Dominican Republic has shown that those working in hotels as entertainment staff or waiters are most likely to engage in casual sex with tourists (Forsythe et al 1998). Moreover, younger travelers and students report changing their behavior while on vacation, possibly due to feelings of anonymity while
away from home. Tourists often take on a new set of social norms while on vacation that can include binge drinking, drug-use, and adventure or risk-taking activities including casual sex (Josiam et al 1998; McKercher and Baur 2003; Pruitt and La Font 1995; Smeaton et al 1998).

A newer phenomena noted by researchers is that of “romance” tourism whereby foreign women develop relationships with local men while on vacation. Many of these women do not intend to develop relationships prior to traveling; however many often find themselves with locals. This type of tourism is different from sex tourism because the woman does not view herself as paying for services (although indirectly this may be the motivation of her local partner) but rather being involved in a “love” relationship (Pruitt and La Font 1995). Local men have discovered their “attractiveness” to foreign women and have begun to take advantage of these relations for economic gains as well as sexual adventure (Herold et al 2001). Foreign women traveling to the Caribbean or Latin America are often attracted to local men who exude an “otherness” that they consider “exotic.” For example, some women refer to local men as “Latin lovers” or having “Rasta appeal” because they model masculinity, which is often associated with the erotic (Herold et al 2001; Pruitt and La Font 1995). Western women, especially blonde women, are considered exotic and attractive to locals (Meisch 1995). Moreover, the idea that American women are sexually liberated is attractive to men who are hopeful something physical might ensue (Meisch 1995). Finally, some women whose body shapes fall outside western ideals may be regarded as more voluptuous and sexy when they travel to other countries and therefore receive more attention and feel more attractive to locals (McKercher and Baur 2003). For example, Meisch (1995) explains how this interaction
unfolds in Ecuador between indigenous Otavalenos and American women, in particular, “the ideal body type [in Ecuador] is more womanly than the impossibly slim American ideal, so that young women who consider themselves fat or otherwise unattractive suddenly discover that they are considered beauties, and the experience is heady” (451). In addition, local men who seek out relationships with foreign women for sexual and economic gain mention targeting overweight women because they are aware of the likelihood that such women are less popular in the U.S. where a thin figure is considered more attractive; these women are therefore more receptive to their advances (Herold et al 2001).

“Adventure tourism” is also on the rise and includes such activities as whitewater rafting, mountain climbing, ropes courses, trekking, ballooning, spelunking, biking, sailing, diving, etc. The basic premise is that tourists seek high levels of risk for a thrilling, exciting, and often dangerous experience (Flucker and Deery 2003). Many younger travelers are attracted to these types of experiences. Flucker and Deery (2003) report on how this type of environment within the white water rafting community facilitates sexual liaisons with river guides. For example, they explain that tourists are often dependent on guides for leadership, safety, and protection. Guides are a skilled, “outdoorsy”, and usually physically fit which may be attractive to clients. Moreover, clients are enmeshed in a setting of risk and adventure in an “environment steeped in imagery” leading to a desire to engage in sexual activities with guides to continue this sense of adventure and atypical behavior (Flucker and Deery 2003).
Tourism and Prevention

In many countries reliant on tourism for a significant amount of their GNP, government authorities and the Ministries of Public Health and Tourism, do not promote aggressive, visual HIV/AIDS prevention campaigns. Economics is the driving force behind virtually all policy therefore, “many governments fear that the HIV/AIDS epidemic will hinder the development of their tourism industries and refuse even to discuss it” (McEvoy 2000: 231). Stigma is still a persistent force when addressing the issue of HIV and STIs in many countries reaching far into the bureaucratic machinery running the country. Therefore, many prevention strategies face opposition when targeting the tourist industry. The misconception by national governments that prevention campaigns are detrimental to tourism is unfounded as demonstrated by the aggressive 100% condom programs now running in Thailand. The tourist industry in Thailand has not felt any negative repercussions due to their 100% condom education and prevention programs, and in fact, report increases in tourism (McEvoy 2000). In addition, preliminary interviews of tourists visiting the Dominican Republic reveal that most individuals support public HIV prevention campaigns (Forsythe et al 1998). In fact, many tourists feel these campaigns are beneficial and prove the Dominican Republic’s commitment to a cleaner, safer environment (Skoczen 2001).

Sexually Transmitted Infections: Latin America

The rapid spread of Sexually Transmitted Infections (STIs) including HIV/AIDS, has become one of the major public health concerns in Latin America and the Caribbean. The World Health Organization estimates that, by the end of 1999, there were approximately 18.5 million people in the region who were infected with STIs other than
HIV/AIDS. This number reflects a prevalence rate of 71 per 1,000 (second only to Sub-Saharan Africa) (WHO 2000). In 1996 alone, over 2.2 million people in the area were infected with preventable STIs (VPS 1997). In women, untreated STIs can lead to Pelvic Inflammatory Disease, infertility, cervical cancer, ectopic pregnancy, and spontaneous abortions. Babies of infected mothers may face complications such as pneumonia, prematurity, low birth weight, blindness, and stillbirth. More importantly, STIs, especially those associated with ulcers and open sores; provide an easy medium for the transmission of HIV/AIDS.

As of the end of 2001, the rate of HIV infection in Latin America and in the Caribbean was estimated to be 0.5% and 2.3% respectively. There are approximately 1.5 million people in Latin America and 420,000 in the Caribbean who are currently living with HIV (UNAIDS 2002a). The epidemic spread of STIs in general, and HIV/AIDS in particular, is especially alarming among young people (those younger than 24). It has been estimated that 100 million young people around the world become infected with HIV each year (UNICEF et al. n.d.), and that about half of all new infections occur among them (UNAIDS 2002a).

**HIV and Adolescents**

“On average, 57 per cent of those infected globally are between the ages of 15 and 24” (UNAIDS 2005a). “Of the 30 million people that live today with HIV at least 1/3 is between 10 and 24 years of age.” (Mendoza 1998). An estimated 2.6 million new infections a year occur among young people (7000 taking place daily around the world) (Medoza 1998). There are numerous reasons that HIV has begun to impact young people at a disproportionately high rate as compared to all other demographics. The
period of adolescence compounded with mixed media messages, a shifting economy and
globalizing world, urbanization, tourism, and a lack of education are all factors, which
create an entire demographic group at an increased risk of STI and HIV infection. “In
the regions of the Americas, one in every 200 persons between the ages of 15 and 49
years of age is HIV infected” (NewsRX: 2001). However, the majority of HIV/AIDS
cases are not reported or discovered until up to 10 years after initial infection. Therefore,

it can be assumed that many infections occur during the teenage years (Schifter and
Madrigal 2000). Moreover, HIV is becoming the leading cause of death among the 25-
40 year age category (Schifter and Madrigal 2000). It is not surprising that young people
are less informed about HIV and STIs than any other demographic group. Many young
people receive information concerning HIV from their peers or on the “streets.”
Transmission of often false information leads to risky sexual activities and beliefs. An
efficacious combatant to this epidemic is the utilization of educational materials that
systematically explain HIV prevention techniques and provide individuals with the
resources and tools to protect themselves.

Adolescence, a period marked by curiosity, discovery, and exploration, is a stage
often times associated with initial sexual experiences as well as experimentation with
drugs and alcohol. These activities often contain added risks of contracting an STI,
including HIV, if uneducated individuals are not given the necessary preventative tools
to protect themselves. Biologically “young people are physically more vulnerable to
HIV as their skin tissue is softer and tears and damages more easily during sexual
intercourse, allowing for greater HIV transmission.” (Save the Children 1999: 19). Sobo
(1995:11) notes, “teen-aged girls are in a particularly vulnerable position biologically
because their vaginal linings are not as thick as those of mature women. Furthermore, they are vulnerable from a socio-demographic point of view because they often have sex with older men – men who have had more opportunity for acquiring HIV infection.”

Additionally, the media barrages young people with images that promote sex as a glorified activity often associated with alcohol consumption and tobacco use. There are mixed messages promoting sexual activity: robust male vs. virgin females. The implication of these contradictory messages is witnessed in the disproportionately high rates of females who are uneducated about HIV as well as the negative stigma surrounding an open discourse about sex and sexuality among young women.

In the developing world, a population shift among young, mobile populations from rural regions to the urban and tourist meccas is a phenomenon fueled by globalization and private market systems in conjunction with images of western lifestyles and commodities. Today, many young people seek urban job opportunities in hopes of economic gain not realizable in traditional agriculturalist lifestyles. Furthermore, many parents encourage children to seek work in urban centers as commercial farming and other market pressures are preventing successful family farms from prospering.

The risky behavior of young, mobile populations has been well-documented (Forsythe et al 1998; Hirsch et al 2002; Nishigaya 2002; Davis et al 1992) and demonstrates the susceptibility young people face as they migrate to urban centers. “For example, businesses with a workforce that is young, single, mobile, and poorly educated about HIV/AIDS prevention measures are probably at a disproportionately high risk of becoming infected.” (Forsythe et al 1998:278). This, juxtaposed to the statistic that
young people compose nearly 30% of the developing worlds’ population, paints a rather daunting picture. Moreover, it has been predicted that five new cases of HIV occur each minute among young people (Mendoza 1998). In many areas of the world undergoing rapid change, young people are caught between globalization and traditional beliefs.

**College Students in the United States**

Research on the sexual behavior of young people in the U.S. has mimicked that of HIV research among the general population focusing on “risk” populations and not on the general population of young people. Some research has been done on college campuses in an effort to understand general patterns of risk and sexual behavior among young people; however, these data are not generalizable to all young people. There is even less research on young people who travel and their sexual activities while on vacation. However, there are some studies examining the behavior of college students while on Spring Break. However, these data are valuable and presented to give an idea of how some young people while traveling on vacation to Costa Rica or other locations may behave.

**College Students: Alcohol, Drug Use and Sex**

By simply following popular media, it is easy to see that college campuses are replete with the use and abuse of both alcohol and drugs. Underage drinking is a common practice of which underclassman tend to partake because of less parental supervision and more freedom and accessibility. Research has shown that the most popular drug of choice for students is alcohol, followed by marijuana (Presley *et al* 1994). Additionally, binge drinking or heavy drinking, defined as having five or more drinks in a row at a single event, is a common problem on the majority of college
campuses (Kapner 2003; NIAAA 2002). Kapner reports that 44% of college students would define themselves as heavy drinkers (2003). Additionally, in a 2002 National Institute of Alcohol Abuse and Alcoholism (NIAAA) study, researchers found that two out of five college students reported binge drinking within the previous two weeks (2002).

Excessive drinking and the use of drugs, which is associated with the college lifestyle, have implications for risky or casual sexual activities. Several studies document that when drunk or high there is an increased likelihood of unprotected sex (Bon et al 2001, Gordon and Carey 1996, Testa and Collins 1997). Furthermore, mixing alcohol and marijuana leads to slightly higher risk of unprotected sexual activity (Bon et al 2001). Hingson and colleagues examined the effects of alcohol use on college campuses with multiple health outcomes (2002). Some of their more alarming findings deal with sexual behavior, violence, and risk of HIV transmission. In 2002, they estimated that over 70,000 students were victims of sexual assault or date rape (Hingson et al 2002). Additionally, 400,000 reported having unprotected sex with 100,000 of those reporting not remembering if they consented (Hingson et al 2002). Any unprotected sexual encounter allows for the possibility of infection. Therefore, statistics such as these certainly raise red flags and suggest an alarming trend to parents, health workers, educators, and researchers.

**College Students: Sex, Condoms and HIV**

An estimated 50% to 80% of unmarried college students are sexually active (Murstein and Mercy 1994). Of those sexually active, 25% of women and 60% of men report having casual sexual relations (Dunn et al 1992). In addition, reports suggest
women are more sexually responsible than men are, and more likely to insist on condom use (Lance 2001). Knowing actual rates of HIV seropositives among college students is virtually impossible; however, in 1997 the CDC reported that an estimated 1 in 500 students could be HIV positive (CDC 1997). Therefore, the risk of HIV transmission is a very real possibility among young people.

Young people in the U.S. and college students in particular, have a very high level of knowledge about HIV and its potential modes of transmission. However, they simply do not perceive themselves as being “at risk” despite their participation in certain identified risky behaviors. For example, Lance (1995-1996) found that students were very knowledgeable about condom use protecting against HIV, with 85% to 90% of those surveyed correctly answered the questions pertaining to safe sex practices (Lance 2001). However, 51% reported that they either “always” or “sometimes” had unprotected sex (Lance 2001). Clearly, young people do not perceive themselves as susceptible to HIV infection. In a similar study, McCormack reports that 75% of heterosexual college students do not feel at risk for HIV infection (1997). Some of these students may feel like they are not at risk because of being in “monogamous” relationships. However, reports suggest that 25% of heterosexual students are dishonest about their sexual faithfulness (Stebleton and Rothberger 1993). There seems to be a clear fissure between what college students know about HIV transmission and their perception of being at risk. Students seem to understand what behaviors lead to transmission, yet when they are involved in those activities (even if rarely), they do not feel at risk.
College Students: Sex and Vacation

Some research has begun to address changing behaviors among college students and young people while on vacation, but anthropology has contributed little to this body of knowledge thus far. Maticka-Tyndale and colleagues (1998) have done some basic quantitative research, primarily using questionnaires, among Spring Breakers to understand their sexual behavior while on vacation. They discovered that men have much greater intentions than women do when it comes to “hooking up” or engaging in casual sexual relations. However, casual sex occurred much less frequently than the men would have hoped. In a particular study she found that between 25% and 28% of students on Spring Break did engage in casual sexual relations (Maticka-Tyndale et al 1998). Interestingly, they found that men are more influenced by their peer groups and expectations while women are less affected by the group mentality (Maticka-Tyndale et al 1998). Researchers have found that many students disregard their normal personal codes; however, very little has been done to examine why such behavior modification exists.

Critical Medical Anthropology and Political Economy

Anthropologists, sociologists, public health workers, and other scientists have long examined human behavior and culture through a theoretical lens developed in the mid-1800s by Karl Marx and Fredrick Engels that is today referred to as political economy. In the critical publication in 1845, The Condition of the Working Class in England (1962), Engles examines how economics impact the working conditions of the poor in Germany recognizing that macro-level processes (capitalism) and an oppressive
class system which resulted from capitalism cause increased disease and earlier death among the poor working class (Singer 1998). Virchow furthered these ideas by analyzing a typhus outbreak in East Prussia and examining what he believed to be the principle social causes of disease identifying unemployment, malnutrition and hunger, inadequate housing, and overcrowding as the real culprits in the epidemic (Singer 1998). These pivotal discussions moved health and illness rhetoric beyond the biological and physiological realm and into a discussion of the larger, more complex systems at work that impact health and wellness. Today, political economy is referred to as “valuing the description and analysis of social phenomena in relation to political, economic, and historical relations, in both a local and a global sense” (Carlson 1996:268). Singer (1989, 1990, 1995) has incorporated the theory of political economy into a more focused approach to understanding health experiences through the development of Critical Medical Anthropology (CMA). Singer (1995) defines critical medical anthropology as,

“a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interactions between the macro level of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behavior, and meaning, human physiological, and environmental factors.” (81).

CMA recognizes disease as a social product, and not just a physical manifestation intimately tied to complex macrolevel systems that reinforce poverty through politics and economics. Singer and others developed CMA as a response against traditional, clinical medical anthropology. Medical anthropology is accused of being “the handmaidens of biomedicine” because it perpetuates the power structure of those working in biomedicine
above those patients seeking treatment (Singer 1995). In addition, according to CMA proponents, medical anthropology is guilty of cultural bias when analyzing health in the developing world using a Western biomedical paradigm (Singer 1990). Moreover, Singer (1990, 1995) criticizes medical anthropology of being too myopic and focusing only on the micro-level structures and individual behaviors that impact health and illness and not identifying larger structural determinants such as gender inequality, poverty, and social stratification. Singer complains, that medical anthropology “assumes the autonomy, self-regulation and boundedness of local groups in local settings and fails to consider the processes that transcend separable cases” (Singer 1990: 180) resulting in the inability to identify root causes of illness at the macro-level. Therefore, any transformation that is promoted by medical anthropology is only at the local level resulting in superficial change or health improvement and ignoring larger, structural inequalities. Additionally, by focusing solely on the individual and their behaviors there is a natural tendency toward victim-blaming. Whiteford and Vitucci’s (1997) examination of how policy and practice marginalize poor, inner-city pregnant women brings to light the effectiveness a CMA approach can have in identifying the effects of how macro-level structural barriers can result in institutionalized racism and sexism. Moreover, Whiteford and Vitucci (1997) maintain that by not looking at the macro-level researchers may in effect be ignoring or furthering an environment of marginalization. In the example of poor, inner-city women who are unfairly targeted for drug-testing the authors state “by focusing on pregnant women who use drugs, policy makers and the public have found a convenient scapegoat, and thus avoiding facing the larger issues such
as the effects of racism, classism and sexism on members of U.S. society” (Whiteford and Vitucci 1997:1373).

Singer (1990) demonstrates how victim-blaming manifests itself when medical anthropology is rooted in a medical ecology paradigm. Medical ecology promotes the idea that cultures exist within a constricted, defined environment and must adapt to certain environmental pressures in order to survive and thrive. Illness, then, is the result of an individual’s inability to adequately adapt to the environment and is therefore in some way at fault for their weakness. Political economy and CMA avoid this mistake by maintaining an “abiding holism that encompasses not only that which is immediate and visible but also that which ‘cannot be seen’ at the microlevel, namely the class relations that structure the local environment” (Singer 1990:180). It is deficient to study only the local context without understanding the forces that have shaped and continue to shape the environment within which people survive, especially in a world that is becoming more connected, through globalization, daily.

Without revealing social inequalities that result from capitalist market systems and political maneuverings, there will be a continuation of the poor and powerless being oppressed. In addition, as the former director of the World Health Organization Dr. Gro Harlem Brundtland (2005) states, “poverty breeds disease and disease breeds poverty.” Political economy and CMA have both identified the impact of capitalism as a catalyst for developing a highly stratified class system with a wide gap between the rich, powerful upper class and the powerless poor. As globalization and technology increase and the rise of multinational companies expand, wealth will continue to be inequitably distributed. The trend of the poor growing poorer and the rich growing richer will
continue. In 1998, UNDP reported that combining the wealth of the 225 richest people in the world is equal to combining the wealth of the poorest 2.5 billion (UNDP 1999). The poor have limited access to job opportunities and advancement, education, nutrition, and health care. Therefore, it is not surprising that poverty is one of the most significant indicators of adverse health effects and is a risk factor for HIV transmission.

CMA, with a political economic context, is able to identify and address many of these structural barriers that affect health. Through an understanding of the interconnectedness of multiple variables, CMA moves beyond narrow-minded biomedical understanding of “disease” being simply the result of a pathogen attacking the body. Instead, CMA examines social origins of disease, which can include a variety of variables including: political unrest, social upheavals, malnutrition, hegemony, economic insecurity, lack of political power, and overcrowding, to name a few. CMA can change and empower communities, which is what conventional medical anthropology has failed to do thus far. Singer (1995) explains how CMA recognizes the historical role culture plays in shaping human behavior. For example, pointing out how “machista” attitudes in Latin America might prevent men who have sex with men as identifying themselves as homosexuals because historically it is not an accepted sexual orientation in many Latin cultures.

In addition, CMA examines behavior from the “emic” or insider perspective. Researchers attempt to understand behavior and cognition from the perspective of the individual and the cultural environment within which they identify. This perspective allows for the development and initiation of health education and health care that is culturally relevant and encourages self-determination. For example, HIV/AIDS
campaigns developed in Haiti following CMA principles address some of the cultural ideas about transmission and the role of witchcraft. Additionally, CMA examines local contexts in relation to global forces, especially economic, affecting these communities. For example, understanding how the interplay of capitalism, changing economies, and rural-to-urban migration patterns is changing sexual behavior among migrant workers and increasing HIV transmission. Furthermore, CMA identifies and challenges inequalities by sharing this knowledge with local communities as well as policymakers, and advocates in an effort to educate and empower. These are just some ways CMA is able to understand health and illness at the local level and within the context of macro-level forces.

It is important to consider the infancy of CMA when compared to some other theoretical orientations and realize it is an evolving theory that will take time to fully develop. A new “phase” of CMA began emerging in the mid 1990s with a key component being the movement out of academia into a theory of action and advocacy. Singer (1995:81-82) explains,

“One of the issues under examination in this new phase is the ability of critical medical anthropology to move beyond the academy, the scholarly conferences, and the academic journal into the applied field of clinics, health education and development projects, federal health research institutes, international health bodies, private voluntary organizations, health movements, and community-based agencies.”

For these reasons, CMA is an effective theoretical orientation for applied anthropologists as it integrates both theory and praxis.

**Structural Violence**

What has analyzing health outcomes from the theoretical perspective of critical medical anthropology and political economy uncovered? Researchers have found that
negative health outcomes at the local or individual level are tied to global systems, such as economics and politics, at the macro level. One of the most devastating outcomes of these global processes is poverty. Those living in poverty are denied basic human rights: food, clean water, shelter, security, education, and health. In addition, as Paul Farmer (1996, 1999, 2003) explains, human rights can only advance when economic and social equality is realized because all of these factors are interrelated and working to create the system of deprivation that exists today. Poverty, a result of structural violence, is not randomly distributed, but rather continuously disenfranchising particularly vulnerable populations. Poverty, in turn, breeds poor health, which directly fuels the HIV pandemic. We cannot simply address one of these issues, but must look at the interplay of all of these systems, which Critical Medical Anthropology allows us to do. Without profound institutional change and radical social progress, gender-based and poverty driven violence will continue. Farmer (2003) explains how this institutionalization of violence or “structural violence” is manifested today,

“…as a host of offensives against human dignity: extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontested human rights abuses, some of them punishments for efforts to escape structural violence (8).”

Farmer (2003) goes on to explain that violence results from inequalities resulting from the interplay of historical and economic conditions pitting the powerful against the weak. Clearly, structural violence begins at the macro-level of political and economic systems; however, it materializes at the local level in abject poverty.

CMA also recognizes that historical cultural ideologies influence health outcomes, particularly in societies that perpetuate gender and social inequalities. The
majority of the world’s poor live in the “developing” world, which tends to be patriarchal in nature. Males being the heads of households and often the primary breadwinners characterize patriarchal societies. The majority of Latin American cultures continue to be characterized as “machista.” Machismo refers to how “gender relations are organized in terms of prescribed notions of male activity or dominance, on the one hand, as opposed to female passivity and submission, on the other hand” (Parker 1996:62). Therefore, there is a clear imbalance favoring the males in the communities. Furthermore, boys tend to be educated longer than girls are. In the majority of these societies, women have more traditional domestic roles such as keeping the house and children. Men’s authority over women is perpetuated through these traditional structures and ideologies. A classic example is found in Lesotho where women are considered “minors” by law their entire lives and given no authority to vote or access credit (Romero-Daza and Himmelgreen 1998). These are just some examples of how politics, economics, class structure, traditional beliefs and norms, and environmental factors all function to institutionalize poverty and gender inequality in many developing countries. Gender inequality translates to negative health outcomes among the oppressed. This is the case for women who have little or no power, especially visible in the “feminization of HIV/AIDS” being seen around the world. Today, women account for 3 out of 4 cases of people between 15-24 years of age living with HIV in Sub-Saharan Africa and the Caribbean (UNAIDS 2004e). CMA provides an ideal framework to examine the interplay of variables that result in an increase in HIV susceptibility including low socio-economic status, lack of education, lack of access to health care, gender-based violence, and sexism in an effort to

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2 Not surprisingly, HIV rates in Lesotho are some of the highest in Africa with rates among adults reaching 32% (UNAIDS 2004d).
advocate for progressive social change. “In short, disease must be understood as being as much a social as a biological product” (Singer 1990:182).
Chapter 3: Methods

This chapter will provide a description of the different data sources and methodologies used throughout the project. Although this thesis is based only on data collected through focus groups, educational sessions, and participant observation, I have included information on the methods used in the overall project, to offer the reader a wider context for the interpretation of my results.

The study began in July 2003 and lasted approximately one year. I was in the field from July 2003 until December 2003. I returned to the field during the summer of 2004 to complete one more focus group and short-term quantitative surveys.

Research Team and Tool Development

Data were collected over a five-month period, August 2003 to January 2004. In addition to Nancy Romero-Daza, the Principal Investigator, the team was comprised of four other individuals who were stationed in the Monteverde area for the duration of the project. Sophia Klempner, Academic Director of the Monteverde Institute, was the co-Principal Investigator and oversaw the daily activities of the research team in the field. Noe Vargas, a resident of the region who has extensive experience working with health related projects in the community, was also responsible for data collection. Noe and I had similar research responsibilities including arranging and conducting interviews with community members, facilitating focus groups, and leading group discussions in the public and private schools. In addition, I collected most of the survey data because the
majority of participants were English-speaking. Cristina Calderon was another key addition to the research team. She is a Washington D.C.-based HIV educator who volunteered to help with the development of an educational campaign as well as note taking during focus group discussions.

The design and conduct of this research were done in collaboration with local community members, from the initial selection of the topic to the design and implementation of the project itself. Community input was obtained through the presentation of the proposed study to the “Red Familiar”, a community committee. Red Familiar was developed to address community issues concerning the physical, emotional, and social well-being of the families living in Monteverde. At the time of the study, committee members included both locals and foreigners who live in Monteverde and was comprised of medical personnel, women’s rights activists, teachers, housewives, clergy, and community volunteers. The committee provided general feedback assessing the most appropriate culturally sensitive techniques and channels for the collection of information from different segments of the community.

**Sampling and Informed Consent**

This project was exploratory in nature and the overall population of the region is small; therefore, the researchers used a simple clustered convenience sample. The research team identified different community sectors of interest such as educators, guides, waiters, etc. After identifying potential contacts in each of the sectors, the two field researchers contacted these key individuals through phone calls or by visiting local businesses. Participants were given the Institutional Review Board consent approved by the University of South Florida in Spanish or English, depending on their language of
preference, and then interviewed. Several participants mentioned other community members who might be interested in participating or whom they felt might share different insight. We followed some of these referrals for additional interviews.

Written informed consent was obtained from all participants (Appendix A). Those under 18 years of age who participated in the focus groups or educational discussion sessions had to present written proof of parental consent prior to participation.

Research Methods

Qualitative and quantitative data were collected through individual in-depth interviews, focus groups, short surveys, and participant observation. However, this thesis will report data and results derived only from the focus groups, educational campaigns that included discussions in the schools, and participant observations. Reference to the overall project will be used to contextualize the data and results when necessary.

The research instruments included open-ended and semi-structured interview guides (Appendix B), focus group discussion guides (Appendix C), and short close ended surveys (Appendix D) and was pilot tested prior to the beginning of the study.

In-depth Interviews

Local community members and long-term visitors are more accessible for longer periods and therefore more in-depth, hour-long interviews were considered appropriate to explore the perceptions of this population. In-depth interviews began immediately after field testing the instruments and lasted until late December, 2003. A total of 57 in-depth, face-to-face interviews were conducted with a variety of individuals who live in the Monteverde area, and who represented different segments of the community. Individual interviews ranged from 45 minutes to over two hours. Interviews were conducted in
either English or Spanish as determined by the respondent’s preference. Interviews were
tape-recorded if the interviewees gave consent. Several of the in-depth interviews were
transcribed or partially transcribed. The remaining interviews were written up from the
researcher’s notes. Data reported from these interviews will be limited in this paper. The
following is a breakdown of each sector and explanation for inclusion in the study:

**Tourism Sector**

Researchers attempted to interview as many individuals as possible who had a
direct involvement in the tourism industry. Thirty-eight people were interviewed and
included those who provided direct services (e.g. canopy tour guides, taxi drivers,
waiters), owners of establishments that cater to tourists (e.g. hotels, bars, internet cafes),
those involved in the administration and regulation of tourist services (e.g. members of
the chamber of tourism), and tourists themselves, especially long-term tourists (i.e., those
who remained in the Monteverde area from three months to several years).

**Education Sector**

Another purpose of this project was to determine what types of HIV/STI
education and prevention activities currently exist in the Monteverde area. Additionally,
the growing literature on HIV/STI transmission trends in Latin America suggests that
adolescents participating in unprotected, heterosexual sex are at a disproportionately high
risk for contracting HIV/STIs (Shifter and Madrigal 2000). “In the regions of the
Americas, one in every 200 persons between the ages of 15-49 years of age is HIV
infected” (NewsRx: 2001). Furthermore, drug and alcohol use in conjunction with early
sexual initiation greatly increase the risk of transmission (Bon et al., 2001). Education is
a key determinant of risk-taking activities and one that is easily addressed. Moreover,
young people are particularly vulnerable to outside influences, which are evident in the influence tourists have on local populations. The school system provides an accessible channel whereby HIV/STI educational can be disseminated to young people.

Researchers sought to interview those individuals who have an intimate knowledge of and experience in the local education system. We were interested in learning about the extent of the problems associated with sexual risk taking among young people and to determine culturally appropriate ways to providing STI/HIV education to students. Eleven in-depth interviews were conducted in the three junior high and high schools in the Monteverde area. Seven of these interviews were done with teachers from both private and public schools (including two sex education teachers), and three with the directors of each of the schools. Finally, an instructor who worked with young, adult, foreign students was also included in the sample. This group included both Costa Rican and American instructors with extensive experience in the educational field.

**Government Sector**

Researchers interviewed political leaders and those involved in the local government because they have extensive knowledge of the community and the positive and negative changes associated with the growth in tourism. Interviews were conducted with a local police officer, a municipal government employee, and a member of the local development agency.

**Religious Sector**

Monteverde has three main religious organizations/churches: the Quaker community, the Catholic Church, and the Evangelical church. Researchers attempted to conduct interviews with religious leaders and congregation members from all groups
because previous research demonstrates the significant role religious groups can play in shaping community attitudes about sex, risk behaviors and stigmatization (especially concerning HIV and STIs) (amfAR 2004; Shifter and Madrigal 2000). Additionally, education campaigns, especially in Latin America, can be shaped by religious ideals if the church is highly visible in the community (amfAR 2004; Shifter and Madrigal 2000). Unfortunately, researchers were able to interview only three individuals who had strong religious affiliations. All three individuals were members of the evangelical church and included the Pastor, a congregation member, and an involved youth member. It is important to note that this is a small community and many individuals who would have been considered respondents for a different sector, such as tourism, may have been involved members in a certain religious group. We attempted to interview the Catholic priest in the area, but he did not return our numerous phone calls. However, he did allow us to use the church hall for our HIV education campaign and community presentation. In addition, the youth leaders in the Catholic Church refused to be interviewed. Finally, we were able to interview a few members from the Quaker community; however, their answers reflected their profession rather than their religious orientation.

**Health Sector**

Finally, researchers felt it was important to interview the primary healthcare providers in the region. There is only one public clinic in Monteverde with a small staff of service providers. The clinic provides basic HIV education through school fairs and organized community functions. Community members can access STI/HIV prevention materials and free condoms if they make an appointment to meet with a healthcare provider. Additionally, the clinic does offer HIV testing for a small fee or sometimes
free. All pregnant women are offered the test. However, the clinic reports that few people actually ask to be tested. One of the main reasons may be the system of testing. A blood sample is drawn from a patient and sent to a laboratory at the regional hospital in Puntarenas, which is located several hours away from Monteverde. Negative test results are reported back to the clinic in Monteverde. Positive test results are given directly to the patient. Therefore, the clinic is able to discern who tests positive if they do not receive a negative result. This system may prevent community members from being tested due to a lack of privacy. Costa Rica does have an extensive public health care system and is one of the few countries in Latin American that offers the three cocktail antiretroviral treatments to all HIV positive patients (Agua Buena 2005; amfAR 2004). However, patients in Monteverde have to travel to Puntarenas to receive the medicine because the local clinic does not offer treatment.

**Surveys**

Short-term visitors are more difficult to interview for an extended period time than are local residents. Therefore, quick, 5 to 10 minute close-ended questionnaires were designed to access the most amount of information in the shortest amount of time. Researchers conducted these interviews with short-term visitors (i.e., those who visited the area for less than one week) at popular locales frequented by tourists such as internet cafes and bus stations.

The survey instrument consisted of 19 questions asking about basic demographic information, travel routes, and STI risk behaviors (e.g., observed drug-use, alcohol-use, and sex with locals, and condom availability in Monteverde). Over 150 surveys were collected from August 2003 to August 2004.
**Focus Groups**

Focus groups and open discussions are effective techniques in soliciting information because they provide an environment that promotes open discussion and debate allowing researchers to listen and probe for specific themes. The data presented in this thesis are taken predominantly from focus group discussions. The research team utilized focus groups with the younger participants because we felt it would help create an open, comfortable, directed discussion whereby participants are encouraged to debate and discuss various issues. Focus groups were conducted in November and December 2003 following the preliminary analysis of in-depth interviews. The preliminary results allowed us to target specific themes, which began to emerge in the interviews. Focus group participants were recruited in several ways. I contacted the coordinator of volunteers at one of the schools and arranged a focus group with young, female teachers and school volunteers. The woman’s soccer coach also organized a focus group with players on the team. Additionally, long-term visitors who worked at the Monteverde Institute were recruited to participate in focus group discussions at the end of their stay in the area. Finally, through community contacts I was able to organize a men’s focus group and a long-term female visitor focus group. These focus groups were conducted either in the respondents’ place of work (if it was a quiet and relatively isolated location) or in private, residential settings.

Overall, the research team carried out six focus groups with over 35 individuals participating. Focus group questions were open-ended with the facilitator directing the discussions, which lasted between one and one and a half hours. The focus group tool (Appendix C) is centered on the following major themes: tourism, changing local
behavior, STI/HIV risk behavior, risk groups, local prevention, and possible arenas for more in-depth STI/HIV prevention. Five of the six focus groups were audio taped and transcribed. The Spanish focus groups were not translated to English in an effort to preserve their meaning. The groups were designed to reach the perceptions of different segments of the community and included:

- One group discussion with young adults between the ages of 18 and 30 years who would be classified as long-term foreign female visitors to the Monteverde region. This group discussion was arranged through a private school in the area known for recruiting foreign teachers, particularly from the United States and Canada, to either teach for a year or volunteer doing various activities including grounds keeping, assisting teachers, and coaching or tutoring students. The background of this group was varied; however, the majority was younger women who stayed in the area anywhere from six weeks to over a year depending on their role in the school. All teachers and volunteers begin their time in Monteverde doing community homestays. However, at any point they have the freedom to move into either a different homestay, different local community, and/or live independently.

- One group discussion with young, foreign women in the area who worked at the local pension or had recently worked there. The pension is a low cost hotel with shared rooms that is frequented by backpackers who are looking for low budget accommodations. Additionally, the pension is the closest hotel to La Taberna, the most popular bar in the area for young people, which is known for facilitating relations between locals and tourists. The women who participated would
identify themselves as full-time residents of the community. All had dated or were involved in relationships with local Costa Rican men at the time of the study.

- Two group discussions with local Costa Rican women. One focus group was organized with the help of a local female soccer coach and wilderness guide who had developed strong relationships with women in the community. A local Costa Rican woman who worked for a non-profit organization in the community organized the other focus group discussion. The majority of female participants were single and between the ages of 18 and 30.

- One group was conducted with local Costa Rican men between the ages of 25 and 30 who worked in tourism and have had multiple relations with foreign women. These included a two wilderness guides, a hotel receptionist, and internet employees.

- Finally, a focus group was conducted with young adults, both men and women, between the ages of 19 and 25 who were participating in an eight-week biology course in the area. All the participants were living with local families and had frequent contact with Costa Ricans and other tourists.

**Participant Observation**

Participant observation is a common technique in anthropology to gather data by experiencing local culture through interaction and observation. Participant observation was ongoing throughout the research project beginning in June of 2003 when the field school began. I left the area in December 2003; however, I returned on several trips including March 2004, May 2004, and August 2004. Additional observations were
carried out on these subsequent visits. A written record of observations was maintained in a field journal. Data were collected in many of the settings where tourists and locals congregate including bars, discos, restaurants, and internet cafes.

In August 2003, when the project officially began, there were four major bars/discos in the Monteverde region. Two of these bars catered to a mixed crowd of young locals and tourists. Locals predominantly frequented the other two bars. The majority of late night interactions between locals and tourists took place in the disco located near the Santa Elena town center. This bar was open from lunchtime until 3am and played a variety of dance music including local salsa and merengue music as well as American dance music. Local drug dealers are known to sell marijuana to tourists in and around the bar. I spent time at the bar, usually in the later hours of the evening when the crowds were larger, and observed interactions between locals and tourists. I am considered a long-term visitor and treated like many of the other tourists. For example, many of the local men were flirty with me and often asked to dance or meet up with them for drinks. Therefore, it was easy to understand the dynamics between locals and tourists because I personally experienced many interactions with locals.

Internet cafes were also conducive to observation. Many of the cafés are owned and operated by young locals and mainly frequented by tourists. I was able to observe interactions and hear numerous conversations while working at a computer. Specific restaurants were also good places to observe interactions especially between the wait staff and tourists. It was not uncommon for waiters to make plans to meet up with tourists at local nightclubs after the restaurant closed. All of these settings were useful in assessing
behaviors (e.g., drinking, use of drugs, and “hooking-up” with potential sex partners) that may contribute to the spread of STIs, including HIV/AIDS.

During my stay in Monteverde, I coached the girl’s soccer team, Feminino Monteverde. Local women and girls provided a different perspective of tourism and sexual behavior especially since our interactions occurred when men were not present. I also attended the local gym, which was frequented by locals and long-term tourists. I was able to witness and hear about relationships between locals and tourists. Finally, I occasionally worked at a local restaurant that was known for selling marijuana (which I did not know at the time I began working there). Through this, I was able to witness a small segment of the drug scene. These contacts and interactions allowed me to become a more trusted and integrated community member. I did not write down specific conversations, only brief descriptions, or summaries of conversations and interactions with community members and tourists. In my notes, I do not include real names, but give individuals pseudonyms to protect their identities.

**High School Discussion and Education Sessions**

The researchers facilitated five group discussions in three schools, both private and public. The purpose of these discussions was to understand the perspective of young people because they are at an increasingly higher risk of contracting STIs and HIV due to a boost in risky sexual behavior and earlier onset of initial sexual activities (Schifter and Madrigal 2000). Furthermore, we hoped to understand the breadth of their STI/HIV knowledge and to determine the efficacy of existing programs. The format included a forty-five minute discussion period whereby students were separated into smaller groups and given specific themes to discuss. The topics were similar to those addressed in focus
groups and included: local perceptions of tourism and HIV risk behavior, common nighttime activities for young people, drug and alcohol use among young people, education and prevention strategies currently employed in the schools, and efficacy of these strategies. We facilitated each group encouraging open and honest discussion and directing the participants toward relevant themes when they were sidetracked. Participants were brought back together into a single group following the discussion. They were then asked to write down any questions they might have regarding HIV/STI transmission and prevention. Our motivation for asking students to write down questions as opposed to raising their hands was to ensure their anonymity. We brought both groups together so that collectively they could hear the questions of all their fellow classmates. A sample of the questions posed is included in Appendix E. We answered as many questions possible in a thirty minute time period and handed out HIV prevention materials at the end of the session.

We visited three high school principals to ask for permission to conduct these discussion sessions. All three agreed and directed us to high school teachers who helped distribute and encourage the signing of informed consents. Teachers were present during two of the five discussion sessions. We recorded but did not transcribe the discussion sessions. Three sessions were conducted with students from the two private schools in the area. Participants were separated by gender for the discussion segment. Two additional groups in the public high school were conducted; however, because of the small sample size the groups were mixed gender discussion.

Data collected from the focus groups, participant observations, and education sessions will be the focus of this thesis. The data collected from the interviews and
surveys will be used to provide context to my results. I choose to focus on these methods because I believe focus groups conducted with individuals who are participating in risky sexual behavior will be helpful in assessing the reality of the situation, beyond the speculation of those in the community who have no first hand experience. Furthermore, they will help identify personal reasons for taking risk. This information will help guide future research and aid in the development of STI/HIV education and prevention programs targeting specific segments of the population.

Data Analysis

All but one focus group session was recorded and then transcribed. Education sessions were not recorded because of the participation of students under 18 years of age. However, observations were noted and questions of the participants in the education session recorded. Interviewers took extensive notes during the in-depth interviews, even if the interviews were recorded. We expanded on the notes by typing them up as soon as possible after the interview. This allowed us to fill in any missing data that we were not able to write in at the time of the interview. Quantitative data were inputted in excel files to be analyzed. All the data were saved in multiple locations and the original interview write-ups were stored in locked filing cabinets at the Monteverde Institute separate from signed consent forms.

We conducted a preliminary analysis of completed in-depth interviews in late September 2003. The data were analyzed using basic content analysis. Major themes were extrapolated and then further analyzed through word searches to recognize patterns in these themes. Each of the interviewers performed independent analysis on the interviews they individually conducted. We then met and discussed the themes we had in
common or any notable discrepancies. At this point, we made minor changes to the interview tool. We added probes for condom availability, condom use, and the definition and prevalence of “machismo”. We did not use computer analysis because some of the data were in Spanish and some in English, and neither of us is proficient in this type of software. Furthermore, we did not have consistent access to qualitative data analysis programs while in the field. Final analysis was conducted in May of 2005 using the same methodology utilized for the preliminary analysis. Preliminary results have been presented to the community. The researchers conducted community presentations with families that host students and volunteers in their homes. Additionally, three short dramas in the communities of San Luis, Monteverde, and Santa Elena in November 2003 were performed to demonstrate strategies for talking with students and tourists about safe sex.

Study Limitations

This study was exploratory in nature with the main objective of identifying cultural domains (Schensul et al. 1999:262). Researchers wanted to reach a point of “informational saturation” (Schensul et al. 1999:262) that is demonstrated by “sufficient redundancy” (Trotter and Schensul 1998). Overall, sample size was small because the study was designed to provide background information for a larger study in the future. Because sampling was not done in a randomized way, the results might not be representative of groups other than the ones included in the study and might not be generalizable to other settings.

In an effort to reduce interviewer bias, both researchers conducted several initial in-depth interviews together, one researcher leading the interview and the other taking
notes. Following these interviews, techniques were discussed and analyzed to establish a homogenous interviewing style. However, some bias may be inherent because of the sensitive nature of the subject coupled with the fact that I am not a local resident, am female, and Spanish is my second language. For example, my gender and nationality may have resulted in some interviewees altering their responses or silencing some perceptions that they may have been more inclined to share with Noe, or another local interviewer. However, we attempted to mediate this potential bias by building rapport with the participants. Moreover, the researchers did not ask any direct, personal questions concerning the interviewee’s sexual preferences or activities. Questions were based solely on individual perceptions.

Participants were originally compensated for their involvement; however, during the initial interviews several respondents stated that they preferred not to be compensated and wanted to participate because they were aware their information would be useful to the community and not for economic reasons. Researchers are not new to Monteverde and continued research in the future in this region seems certain. Therefore, community members felt that using monetary compensation would be detrimental to the community in the end because it would become an expectation. The negative consequence of such a trend might lead to the disinterest of community members from becoming involved in worthwhile studies if there is not a monetary reward. Therefore, the researchers did not provide monetary compensation to participants (a change in protocol that was approved by the USF Institutional Review Board). This change did not seem to effect overall participation.
Finally, it was difficult to quantify the total number of responses per theme because of the focus group methodology employed. The format was an open discussion with individuals within the groups responding and others disagreeing or agreeing with their responses. However, results presented were confirmed through triangulation with other individual interviews, surveys, or participant observation. Due to the sensitive nature of the subject, participant observations were particularly valuable in witnessing local and tourist interactions, especially in the nightlife scene. Observations in the field, especially concerning such activities as excessive alcohol use and public displays of affection, helped to confirm what some respondents mentioned, as well as actions or activities that some may have been too embarrassed or ashamed of admitting.
Chapter 4: Results and Discussion

“There’s A LOT, A LOT, A LOT, A LOT of sex out there, on this mountain, like it happens unbelievably. I mean it is more that I have ever seen than in any other small community.”

This chapter presents the main results and discussion obtained through the “nested” study. Each research objective is stated followed by the major themes that emerged. In addition, there is a brief discussion of the data and pertinent background information. It is important to note that because the data presented here derive from focus group discussions, it is impossible to report on specific numbers of responses. Rather, the results are presented in the form of general recurring themes.

RESEARCH OBJECTIVE 1: Understand the general characteristics and changing nature of tourism in Monteverde.

When asked to comment on tourism in Monteverde, the majority or respondents mentioned the growth in tourism as well as the changing demographics of those visiting the region. Moreover, respondents felt the addition of long-term visitors plays an important role in boosting the economy, and influencing behavior among the local youth. Long-term tourists are defined at those individuals who visit the region for an extended period of time ranging anywhere from six weeks to several years and often include language students, university students, teachers, teaching interns, and community volunteers with various organizations such as Habitat for Humanity and the Butterfly Garden.
Changing Tourism in Monteverde

Monteverde has always been a popular tourist region in Costa Rica. Of particular fame are the various Reserves and Naturalist Programs that are well known internationally among ecotourists, biologists, birdwatchers, and naturalists. Tourism is currently Costa Rica’s greatest economic resource and all respondents noted the growth of tourism in the Monteverde region.

Additionally, an interesting trend that was identified by the majority of the local residents interviewed is a shift in the type of tourism that now visits Monteverde. Respondents explained that while in the past, the tourism industry targeted naturalist and birdwatchers that usually visited the area with their families, today there is a new focus on the younger, adventurous, budget traveler backpacking across Central America or throughout Costa Rica. Focus group participants referred to this type of traveler as “adventure” tourists. In an effort to increase this type of tourism in the region new attractions have been developed in Monteverde and include canopy tours (i.e., zip lines that allow tourists to fly through the rain forest canopy), horseback rides, 4-wheeler tours, butterfly gardens, and insectariums. One respondent explained this shift in tourism as follows:

“before 100% of the tourists that came to Monteverde visited the Monteverde Reserve, but now close to 200,000 tourists come each year and only 60,000 visit the Reserve, the rest is adventure tourism.”
Respondents noted a change in the types of accommodations available to tourists. Several people explained that in the past there were fewer hotels and that the majority was geared toward families and eco-tourists that traveled the difficult road up to Monteverde and were willing to pay a higher price for better accommodations. However, today, a backpacker can arrive on inexpensive public transportation. A bus ticket from the capital to Monteverde is less than $5.00 and tourists are able to spend the night at any number of “pensiones” which cost only $7 to $15 a night. A “pensión” refers to a small hostel or hotel that has scant accommodations and is geared towards frugal travelers. One of the most popular backpacker hotels is the Pensión Santa Elena. This hostel charges only $5 to $7.50 a night. Rooms are sparsely decorated and guests have bunkmates and share bathroom facilities. However, many backpackers prefer this type of lodging for the cheap price and for the opportunity to socialize and meet other travelers along the way.

Many respondents identified these young, adventure tourists, or backpackers, between the ages of 16 and 30, as one of the demographic groups particularly vulnerable to HIV transmission because of their age and vacation mentality. Many young people mention “vacation-mode” as the tendency to increase alcohol and drug consumption as well as behave less responsibly while on vacation because they feel less inhibited and
free from normal, everyday constraints. It seems that visitors are more likely to cheat on their significant others while on vacation because they have the sense that they are less likely to be caught. One respondent mentioned,

“What happens in Costa Rica stays in Costa Rica.”

Additionally, some respondents felt that these younger tourists with a vacation-mode mentality could be responsible for bringing HIV to Monteverde. One respondent explained,

“Drugs, for example, it seems that [tourists] introduce many things here that worry me a lot...yes, drugs. Drugs are related to tourism. Also, there are things, for example diseases, that are able to be introduced with tourism. There have been some people, not a lot, that have arrived here with STDs or AIDS.”

There are no specific statistics that mention the number of HIV positive people in Monteverde. Opinions within the community range from virtually no cases to an overabundance. Unfortunately, records on HIV and STDs are not kept at the community level and provincial records are incomplete due to a lack of testing and inadequate reporting (Personal Communication Nurse at Health Clinic)

Long-term tourists/students

Another factor that plays a vital role in shaping the social and economic scene in Monteverde is the proliferation of longer-term visitors (i.e., those who remain in the area for 6 weeks or longer). Monteverde is host to numerous institutions that bring foreigners to the area for an extended period. For example, there is a Spanish language school in the area, which maintains a high turnover of students. These students not only come to Monteverde to study Spanish, but also to have a “cultural” experience and therefore spend their time living with local Costa Rican families. Students can be in the area anywhere from several weeks to several months. These students often migrate between
several different sites within the country. The Monteverde Institute runs similar college
course/education programs
whereby students stay with
families in the community
anywhere from six weeks to
six months. These students
often develop strong ties with
their host families and their
local peers within the
community.

The Creative Learning Center (CLC), the Friends School of Monteverde, and the
Butterfly Garden all host volunteers and teachers. These foreigners often spend a longer
amount of time in the community with some volunteers living in Monteverde for several
years. The two private schools, the CLC and the Friends school, recruit teachers from the
United States to come to the region on year long contracts. The administrators at these
institutions noted that the majority of volunteers who come to the area are young women
from the United States (between the ages of 17 and 25). None of the respondents was
able to give a reason for the marked difference between the number of male and female
volunteers. Several respondents noted that when younger students come to Monteverde,
particularly those under the drinking age in the U.S. and without the supervision of their
parents, they behave in ways that might increase their risk of HIV/STI transmission
including drinking heavily, using drugs, and “hooking up” or becoming sexually involved
with local Costa Ricans. One respondent explained:
“the majority [of tourists/students] want to do everything that is possible. It’s interesting with the students, they come very young, and they take advantage of their time here. Supposedly in the U.S. they are not allowed to go into bars before they are 21, therefore, they arrive here and it is incredible to see how they start drinking, smoking...they seem like Ticos [lay term for Costa Rican] who are 13 or 14, and in the stage of craziness and experimentation.”

The vast majority of students from the language programs and the Monteverde Institute participate in family “homestays” whereby they live with a local family for all or part of the duration of their visit. Local respondents were therefore able to provide comments based on their observations of the behavior of these long-term visitors. The purpose of the homestays is to provide students with a “hands on” cultural experience that allows them to partake in the daily lives and activities of the local population. Respondents reported that the homestay experience often facilitate sexual relationships between locals and tourists because it brings young people into constant contact with each other. Many homestay participants identified negative, disrespectful behavior of visiting students;

“The students, during the day, do their projects, and then they arrive at the houses in the afternoon and at least one day a week, during the night, they go to La Taberna, it is the preferred place...the majority of them want to do everything possible. It is interesting with the students, the ones that come are very young, and they take advantage of their time here. Supposedly, in the United States they do not have permission to go to the bars until they are 21. Therefore, they come here, and they are 18, but act like 13 or 14 year olds and they want to experiment in the craziness of the nightlife. And it is incredible how they drink, and smoke and do other crazy things...experimenting.”

However, they felt that the positive aspects to hosting students outweighed the negative.

For example, many families felt hosting students would improve their English speaking skills and those of their children. However, one of the main incentives for hosting
students is the added income local families receive. The Monteverde Institute (MVI) pays families $12 per night, for three meals and lodging (laundry services by family are optional). Similar rates are paid by the The Centro Panamericano de Idiomas (language school) (Sophia Klempner, personal communication). Therefore, the majority of families are welcoming to students in spite of the act that many worry about the influence foreign students might have on local youth as one respondent explained,

“for me, the thing that worries me the most are the homestays...it is a more serious problem because the students stay directly with families and there is a direct impact, and they have more liberal sex education. If a young person stays with a family, well, they are going to impact the local adolescents that live here.”

Many of these long-term visitors intend to remain in Monteverde either permanently or for an undetermined amount of time. Several respondents mentioned that because of their lengthy stay in the area these visitors directly influence the behavior of the local youth especially through their established friendships. For example, several locals mentioned a group of “hippies” who have taken up residence in San Luis, which is a community located a few kilometers outside of Monteverde. San Luis does not rely on tourism, but is predominantly agricultural. However, the MVI has recently begun using San Luis as a homestay community for some of their students. Until this time, San Luis has been isolated from outside influences. Many of the residents seem to prefer a more traditional lifestyle. Therefore, there was some controversy generated by the presence of a small group of Americans who were hoping to move into their area and host a music festival. There was a town meeting to attempt to block this group from buying land in the region because the locals felt they would be a negative influence. In one focus group a local participant said,
“there is a group that has come to San Luis and they look very strange, it is group of people that they say walk around naked in their bus and in the farm, these are the things that are coming and disturbing the peace of the pueblo.”

RESEARCH OBJECTIVE 2: Assess the perspective of different segments of the local population, about the potential role of tourism in the spread of sexually transmitted infections (STIs).

Changing Family Dynamics

According to respondents, changing economics in the Monteverde region can be associated with behavioral changes that are directly influenced by the influx of tourism and money. Many respondents noted the fact that families are now investing more resources, especially labor, as demand for services geared toward tourism increases. For example, many residents, both men and women, are now working as guides, bartenders, waiters, and hostesses. Moreover, several respondents mentioned the trend within the community to convert part or all of their personal residence into “pensiones” to provide accommodations for the thrifty travel. In addition, many families have converted part of their porches or the back of their homes into small eating establishments where the women in the house provide meals directly from their personal kitchens.

In the past, Costa Rican families demonstrated a traditional family structure in which the male in the home was the primary breadwinner and the woman maintained a more domestic role as housekeeper and primary caregiver to the children. However, today in Monteverde both men and women are entering the job market. With such trends, many of the younger children, especially teenagers, are no longer under adult
supervision. According to respondents, this lack of adult supervision and involvement in the lives of their children can lead to risky behavior. As one respondent explained:

“There is a large enough population in which the wife and the husband work outside the house and the kids go to school alone and they leave them alone after school...and the kids do what they want because the parents don’t have time for the kids and they lose their authority, their respect...the parents don’t have time or energy to dedicate to the kids”

Likewise, as more employment opportunities are available during the high tourist season (mid December to early April) more teenagers are leaving school early to fill these jobs, which pay fairly well. Therefore, young locals are in more direct contact with tourists during the high seasons. Many of these tourists are known for inviting tour guides, waiters, receptionists, and others working in the tourist industry to socialize at night in the local bars and clubs. Respondents noted that as young people work in the tourist industry there is potential for them to be invited out for drinks or drugs, which are activities that tourists on vacation are more apt to be involved. Moreover, during the high season locals are earning more money that allows them the opportunity to socialize and purchase drugs and alcohol with their own resources. Many older respondents cited this trend of independence and exposure to tourists on vacation as causing an emersion into the party scene increasing immoral and disrespectful behavior. According to older respondents, this exposure to increased resources and interaction with the party-scene has led to a disruption of traditional values and morals resulting in what the older population would consider unacceptable behavior.

“Many parents and older people say that younger people are no longer respectful, and they do not wait. They have a boyfriend and the next week they are sleeping together. This is what I hear from parents and grandparents, that today it is only about sex and not about love.”
Changing Behavior: Alcohol and Drugs in Monteverde

Overall, there appears to be a consensus among different sectors of the community about the clear effect of tourism on life-style changes that may increase the risk for STIs among local people. Behavior change is particularly apparent among adolescents and young adults who are believed to be much more vulnerable to outside influences. Respondents implicated tourists in a wide variety of local behavioral changes from the increase and acceptance of homosexuality in the area to changing ideas about tattoos, hairstyles, body piercing, clothes, and music preferences. All of the groups represented in our sample mentioned increasing rates of alcohol and illegal drugs. In particular, respondents connected the increasing party scene associated with tourism and vacation as directly affecting local attitudes about alcohol and drug consumption. Participants believed that regardless of the type of drug and the mode of ingestion, increased consumption of illegal substances is closely tied to higher rates of “risky” sexual behavior. Many of the respondents mentioned that locals, especially young people, are frequently involved in unprotected casual sex while under the influence of alcohol or drugs with tourists whom they barely know. One interviewee explained,

“In the nightlife places there are all types of tourists. In these tourist places, there are a lot of very pretty, very sexy girls. For the men it is a game during the night to try to conquer the best girl. In reality, all the Costa Rican men have opportunities. What I have seen in La Taberna is that there are a lot of men waiting for a girl to be alone so they can invite her to dance and invite her for 2, 3, or 4 beers. After that they are very drunk and then men take advantage of this.”

Finally, respondents identified the growing economic independence of young locals as being a factor in increased alcohol and drug use because they now have the resources to purchase drugs and alcohol.
While many individuals believe that the drug problem involves only marijuana, participant observation and interviews with those directly involved with drug use and dealing revealed different trends. Drugs that were mentioned included: marijuana, crack cocaine, cocaine, acid, mushrooms, and a local drug called “reina de la noche” (queen of the night). There are no reports of injection drug use in the area although this may soon follow especially since injection drug use is on the rise in San Jose. Riehman (1996) for The World Bank (1996) reports that in Costa Rica there is approximately 33 Injection Drug Users (IDUs) per 100,000 residents and HIV transmission among IDUs has been identified. These data are originally from 1992, so it can be estimated that these numbers have increased.

In addition, contrary to the belief expressed by many that tourists bring in drugs with them, when other drugs are available it is often local Costa Rican dealers who bring them and supply a group of local regulars and tourists. The majority of the tourists interviewed reported that drugs were purchased in Monteverde as opposed to being carried into the area from other parts of the country, the United States, or their country of origin. Participant observation revealed that there is a steady drug flow to the area and local dealers are distributing these drugs in a select few locations frequented by tourists. In addition, one dealer was known to approach tourists and directly offer and supply them drugs, as opposed to tourists having to seek out sources. Focus groups with students revealed that the majority of participants were aware of the drug scene and many could even identify one of the more public dealers in the area. One respondent answering the question about drug buying explained:

“Yeah, they only got like one guy who’s dealing and like everyone knows him...I know other tourists who buy from this guy.”
Changing Behavior: Sex

Local respondents noted an increase in casual sexual relations and many implicate tourism as the catalyst for this change. Reportedly, the majority of casual sex is between local men and foreign women. Foreign women are perceived as being more sexually liberated than local women and therefore more desirable. Moreover, local men who tend to seek out foreign women explain that local women are too difficult and controlling whereas foreigners are more trusting, independent and carefree. Therefore, local men feel less pressure when they engage in sexual relations or romantic relationships with foreigners. Some local Costa Rican men perceive foreign women as more interesting and exciting than local women. Moreover, the preference local men show for foreigners may be changing the behavior of local women. For example, one respondent said that foreign women are more sexually aggressive often kissing and being physical in public with Costa Rican men. She also said they have more freedom and fewer inhibitions. Therefore, local girls are starting to mimic sexually liberal tourists. One respondent explained,

“I don’t know if it is because of tourism or the social development that is happening, but the issue is the sexual confusion there is with both sexes. Perhaps it is with couples that have had diverse sexual experiences that is making the people change their morals concerning sexual behavior. Therefore, already there are changes in homosexual and heterosexual behaviors.”

The early onset of sexual activity in the region has been noted by those working in both the public and private education systems who have witnessed growing numbers of teenage pregnancies in Monteverde. Several informants identified the problem of girls dropping out of school at increasing rates due to
pregnancy. In addition, a counselor in one school mentioned increasing number of girls asking to be put on birth control. One respondent explained,

“…there are many girls who have to leave high school because they are pregnant. There are mountains of cases, but not just students, there are other young girls that aren’t in school and they also [end up in the same situation].”

Another alarming trend noted by many respondents is the pervasive mentality that the most important reason for using condoms is to prevent pregnancy and not sexually transmitted infections. Many informants, within the school system and those working in tourism, suggested that using other forms of contraception such as the pill or injections often leads to a decrease in the use of condoms.

Moreover, as reported by many respondents, in some more conservative segments of the population, especially the more devout Catholic and Evangelical families, there is hesitation in openly discussing sex and sexuality. Respondents felt that sex is still a taboo subject for older people who continue to believe young people should be virgins until they are married. Several respondents explained that parents would be against young people having condoms because it is suggestive of what they perceive to be immoral behavior. One young woman explained that if her mom found a condom in her purse or bag she would “kill me!” Another explained,

“…before [our culture] was accustomed to young people being virgins when they got married. But now it is not like that although parents continue to have the idea that their children are not having sexual relationships when they are single. However, in reality young people are having sex from when they are 13 years old and it is costing us to not open our eyes to it.”
In one of the focus groups, there was a brief discussion of local men having sex with minors in the community. This issue is currently under investigation in the community and local authorities are aware of the accusations.

The data also indicate that same-sex relations and group sex do occur in the area and are often associated with a “party” atmosphere although there are incidences where this is not the case. The majority of respondents identified homosexual and bisexual relationships as being predominantly among women. Group sex can involve one woman having sex with several men one at a time, or with several women with a group of local males. However, there have been scenarios reported where “couples” engage in group sex or swapping. In one focus group, the participants answered the question:

Interviewer: “Do you think that there is sex with multiple people going on in Monteverde?”

“OH YEAH!”
“Sure, absolutely”
“I mean all of a sudden there are seven people in a room, or three people, or four people, wanna buy a vowel?”
“There is almost always one gringa and 4 tico boys”
“Yes, Yes, there is definitely a lot of people sharing...like with friends”

One group of respondents mentioned the impact stigma plays in masking homosexual and/or bisexual relationships. Costa Rica still maintains a traditional culture that does not openly embrace homosexuality or bisexuality. Locals suggested that tourism plays a role in increasing the numbers of homosexual and bisexual couples. Many respondents felt that the majority of these alternative lifestyles were among foreigners, but did note changing behaviors among locals. For example, one woman identified the problem of local married men being homosexual and having male partners, but hiding this behavior. This mentality can be dangerous in terms of addressing HIV
and STI risk behaviors, especially among those who do not consider their behavior risky or are driven to hiding their activities. One respondent explained,

“There is also a lot of bisexuality happening, but here they mask it by bringing in one woman and four guys. It is just something that I have seen over and over again, where they say that there is a lot of bisexuality and curiosity and they mask it because there is stigma, because they don’t want to be labeled that way. It is fine if you participate, but you don’t want to be labeled that way.”

It is not uncommon for foreign women living in the area for an extended period to develop relationships that are more serious with locals. In some situations, foreign women have married local men. However, in the majority of relationships local men will focus their attention on one woman until the end of her stay. Then when she leaves the country, he will move onto a different woman. Some of these women take the relationship seriously, viewing it as a committed, trusting, monogamous relationship with deep romantic feelings, and may be less likely to use a condom. Participant observation revealed that many of the foreign women who had decided to permanently move to the area did so because they were in relationships with a local man. Men who were in these relationships reported a decreased use of condoms because they themselves view it as a “trust” relationship, for however short a period they might find themselves with that particular woman. For example, one male respondent explained,

“It [the use of condoms] depends on the girl. If all of a sudden one night you meet some chica in La Taberna [one of the main bars in town] and the same night you are going to have sex with her, you worry about having a condom available, but if she is a girl that you have a more established relationship with, say like for 15 days or a month, then you are both able to know each other better and have more faith in them.”

Interviews and participant observation revealed the growing trend among the young local males of being fathers to children from pervious, short-term relationships with foreign
women. Many of these men have never physically met their children who often live overseas, but only communicate with them or their mother’s via the internet and phone.

**Condom Use and Availability in Monteverde**

Respondents identified the preference of many local men to have sex without a condom as one of the major factors leading to unsafe sexual activities. Many of the focus group participants reported that using a condom decreases pleasure. In addition, as reported, asking to use a condom is viewed as suggesting that someone in the relationship is “sick” or is cheating. In one focus group, women reported that local men sometimes claim that they are sterile or that they have already tested negative for HIV as a means to influence a woman against using a condom. One respondent explained:

“they’ll [local men] use anything. They’ll use anything to get away without [using condoms]. Then they will even throw it on you, 'how come, I’m not sick, are you sick, do you have something to hide...why do we need too? If I’m not sick and you’re not sick then what’s the problem?’”

Lack of condom availability was also cited as a reason for risky sexual behavior. Participant observations and interviews uncovered the fact that condoms are not available in bars, discos, or other places where casual relations are initiated. They are available from the local clinic for people who have a doctor’s prescription. However, interviewees felt that it was predominantly local women going to the clinic for women’s health exams who would ask for condoms or other forms of contraception. Local men said that they rarely, if ever, used the clinic to obtain condoms because they do not like the quality of the condoms supplied. Condoms are available in the local supermarket and some convenience stores, but accessibility after hours is very limited. All of the stores in the area are closed by 8 o’clock at night. There are no condoms available in the most popular
tourist bar, or in any of the hotels. The one bar that does have condoms available is the disco frequented by older locals and very few tourists. The condoms at this bar are behind the counter and a customer would not be able to purchase them in a subtle manner. This bar closes at 11 o’clock, which is much earlier than the tourist bar. In one focus group, the women said that men were never prepared before they went out at night. However, if the woman supplied a condom then the man will wear it. One respondent explained what often happens,

“I don’t know what it is. I don’t know if they assume that they don’t need [condoms], or you know what I mean, 9 times out of 10 the girl will be so drunk she will just give in to them.”

Additionally, local men expressed concern over the quality and effectiveness of available condoms. Some men mentioned that not having money to buy condoms was a factor in their limited use. In addition, responses from students and other local men revealed that younger people might be more embarrassed to buy condoms than older ones. Since Monteverde is such a small community, it is likely a young person will know someone standing in line or the cashier and they fear their actions may be reported back to their parents. One respondent explained,

“You have to understand certain aspects of our culture or our religion. The fathers and mothers don’t accept that their children carry around condoms. They don’t accept that young people have [sexual] relationships…”

“The culture is changing a lot and it is difficult to get the adults to open their eyes. For example, before we were accustomed to people getting married as virgins and now it is not like that, but the parents still hold onto the idea that their kids don’t have sex when they are single.”

Some local women were also hesitant to use condoms, especially if they were involved in what they perceived as trusting, monogamous relationships. One local woman explained,
“The only protection would be to use a condom, but excuse me, to use a condom is the saddest thing. It is like eating a banana with the skin on, nobody likes it, very few people like it.”

**Prostitution and Gringeros**

There were no reports of sex tourism in the area, although this is a flourishing industry in other regions of the country. One informant who previously worked as a taxi driver in the capital city explained prostitution as a flourishing industry with some women making more in one night than what most people make in an entire week. He mentioned that when he was in San Jose he would drive clients to known locations where prostitutes work, and was aware of several locations specific to transvestite prostitutes. He felt it was only a matter of time before prostitution would make its way to Monteverde. A few respondents mentioned a select few cases of local prostitution; however, they noted that it was contained only within the community and did not involve tourists.

However, an interesting phenomenon described by many respondents was the existence of “gringeros”. These are young Costa Rican men, between about 16 and 30 years of age, who actively seek sexual relations with foreign, especially American women (commonly called “gringas”). Several respondents felt that local men dating and having sexual relationships up with foreign women for extended periods was a form of prostitution because these men often lived off the women’s money or were motivated by the possibility of traveling with the woman to the United States or getting a green card. Other respondents felt local men pursued American women because of the possibility of going with them back to the United States. In one focus group one respondent explained,

“A friend of mine, we were in Manuel Antonio [a popular beach on the west coast of Costa Rica], she met a guy and for the rest of the
trip he was with her, staying with us. He did not have 1 colon [the
local currency] the entire trip. She paid for everything. And she
rationalized it, ‘I’ve never had an orgasm like that before.’ He was
traveling all around the country with her, he just went along, the
WHOLE time’!

Another respondent followed with the following remark:

“Oh God, that happens all the time!”
“ALL the time!”
You see it happen here [Monteverde] ALL the time!”
“Because this [the hotel they work at] is like ‘the place’ for guys to
do this.”

Conversely, many respondents felt the motivation was strictly sexual adventure as locals,
both men and women, hold the belief that American women are less sexually inhibited
than Costa Rican women, and therefore are more interesting sexual partners. Similarly,
they noted the ease of being involved with women for short periods of time, which
limited commitment and allowed for a higher turnover of sexual partners. Many
respondents recognized these behaviors as forms of prostitution. For example, one
woman explained,

“Literally, I have [Costa Rican] friends who make a living, MAKE A LIVING, off
hooking up with tourists, just one after another and they get to go to the beach,
get dinners paid…”

Machismo

Machismo is a term that traditionally refers to male behaviors and attitudes, which
suggest the man is the “head” of the house and has authority over all others. Machismo is
often defined as a somewhat pompous attitude whereby men consider themselves
superior, especially to women, and therefore given the ability to make all major decisions
for both themselves and their family with little to no input from others. Additionally,
being “machista” or “macho” means that the man has more sexual freedom and little need
to justify actions or behaviors to his family. The idea of the male being in control is tradition, but seems pervasive in the area. Female participants in one focus group mentioned this attitude as impeding condom negotiation between themselves and their partners. One respondent explained:

“There is a lot to be seen with the pressure to ‘be a man’ or ‘be a woman’. For example, when you are in bed and at the point (of having sex), for the woman to ask that a condom be used is something outside of what should happen, it is not supposed to be like that...I think that there is pressure, for the men to be a certain way and for the women to be a certain way [where women are submissive and men are in control]...and in a situation that intimate there exists a pressure that we continue in traditional patterns.”

Many respondents feel machismo still exists in Monteverde, which can lead to infidelity. Women, in particular, felt that because of traditional machista attitudes men continuously sought new sexual partners to prove their manhood. Moreover, a machista attitude is also associated with strength. Those who are strong are healthy and not susceptible to injury or illness. This attitude is relevant to ideas about condom use and HIV transmission. Some respondents did not see themselves at risk because they consider themselves young and indestructible. One of the local nurses explained the difficulty in educating men in general,

“The majority of those that DON’T come [to the clinic] are men. Also, when we go to the houses to give information [about health issues in general], or to do anything related to health, you never find the men [willing to listen]. Why don’t the men come? They think they are healthy and that nothing is going to happen to them. They say, ‘I AM HEALTHY’ And if I have something, the flu, I am just going to wait it out in the house.’”

Interestingly, several male respondents believed that local women were becoming machista. They stated that local women are learning the liberal, independent attitudes
common among many foreign visitors and beginning to demand their own autonomy and independence. Local men often stated this as a negative impact on the community. They mentioned that women were getting jobs and working outside the home. This new financial freedom allows them the ability to socialize at night at local bars and restaurants. Many older respondents looked negatively on this trend and felt that local women who went to bars were a disgrace and a disappointment and at greater risk of contracting HIV or having an unwanted pregnancy. One interviewee explained,

“Now there are a lot of young [local] women working in tourism. They are moving out of their houses with a lot of money and looking for cheap places to live. They live in groups. This [situation] facilitates [sexual] relations with men. When they are no living together with their families they are at greater risk. For this reason, pregnancies are increasing too much here.”

Conversely, women who are independent were excited about the way gender roles have been changing and felt that their economic, social, educational, and political freedom was a necessary, positive step forward although they identified the stigma placed on them because of their new gender roles. Interestingly, American women noted the double standard emerging within the community. They noted that American women are desirable to local men because of their independence and “liberal” attitudes whereas Costa Rican women attempting to reach a similar level of independence are chastised.

“I mean you can walk into [the bar] on an average night and you can point out the Ticas that are there by themselves and you know basically, if you ask around you’ll hear all kinds of shit about the girls that are there on their own…
“Because of a negative stigma?”
“Oh YEAH!”
“Oh yeah, you know she does DRUGS, she SLEEP AROUND, she’s a SLUT, she’s a WHORE, you know? And then if you talk to the girl she’s just an average girl, you know?”
Mobility

Respondents did not directly identify population mobility as increasing HIV or STI risk. However, research has already shown how population movement affects HIV (Forsythe et al 1998; Memish and Osoba 2003) and locals did mention various types of migration, of both locals and tourists, that should be considered. Participant observation and interviews did identify the common phenomenon of locals who travel to other regions for work, especially in the slow tourist season. For example, one local informant traveled to the beaches during the rainy season to work as a waiter, and then returned to Monteverde during the busy season working in whatever position he could find. Moreover, several locals mentioned traveling to beaches or other tourist destinations for fun and relaxation when the season was slow.

Interviews and participant observation also revealed the vast number of different vacation spots visited by tourists and long-term visitors. Many make multiple stops during their stay in Costa Rica visiting a variety of beaches on both coasts. Foreign students in the area often take advantage of their weekends and make short excursions to different parts of the country. Finally, some students are purposely moved between different locations to allow them a more diverse experience while in Costa Rica. For example, the culture on the Caribbean side near Limon is English-speaking and has a more Jamaican feel than the Pacific coast. In addition, some students wish to visit the hot springs and volcanoes, while others prefer the beaches for surfing, fishing, or scuba diving. Costa Rica’s diversity and relatively small size encourages travel within the country to different ecosystems, which offer various adventure activities.
RESEARCH OBJECTIVE 3: Assess tourists’ perceptions of HIV risk, especially associated with changing behavior while on vacation

These data come specifically from three focus groups that were conducted with tourists and students visiting the area. Some respondents were new to the area and others consider themselves residents or “long-term” tourists who have no specific departure date and are working in the area, either in tourism or in the schools. Additionally, data from in-depth interviews with long-term tourists and students were conducted to gain a better understanding of individual perceptions.

Vacation Mode and Latin Lovers

Most respondents noted the change of behavior that many people undergo while on vacation termed “vacation-mode” (see above discussion). Additionally, cultural stereotypes may facilitate some “risky behaviors.” As previously mentioned, foreign women are considered “easy” by local standards. Therefore, local men are under the impression that casual sex is easier with tourists and therefore make more of an effort or be more aggressive with foreigners. Many respondents, both local men and women, mentioned that foreign women are more liberal. Additionally, foreign women have the stereotype of local men being “Latin lovers.” The idea of Costa Rican men being exotic and better lovers than men from other countries can also lead American women to be more curious about Costa Rican men and lead to casual sexual encounters out of that curiosity and vacation mentality. One respondent explained her experience,

“Yeah, when I came back from my vacation I told all my friends I had a two week romance with a Latin guy. They all said, ‘I would trade EVERY sexual experience of my life for two weeks with a Latin guy, in paradise, you know?’”
Female respondents perceived Costa Rican men as particularly attractive, especially when compared to other Latinos they have met in their travels. Costa Rica is one of the wealthier countries in Latin America, and Monteverde has a stable economy with regular tourism and coffee exports. Moreover, Costa Rica has social health care for all residents. Therefore, it is not surprising to find that local men are healthier, and possibly better groomed than men in poorer communities. One respondent explained,

“You know you travel to other countries in Central and South America where [there] is a much larger line of poverty and you don’t feel that as much here. Even the [men] that don’t have a lot of money they still take a lot of time to take care of themselves because they don’t have much…so they take good care of what they have. They have a lot of self respect and stuff going on, and that’s really really attractive.”

Another female respondent stated:

“I mean obviously they [Costa Rican men] aren’t ALL full of self respect but there’s definitely a presentation much more so than in Nicaragua or Guatemala, Mexico, Panama or Colombia, or wherever, you know? Much more so and that’s really attractive, it feels safer, it feels like you are taking less of a risk, you know?”

The “riskiness” of these sexual encounters for Americans is attributed to multiple factors. First, condoms are not available in the evenings. Americans are accustomed to condoms being available at all hours (in bars, grocery stores, gas stations, etc) and may not realize that they are not available in Monteverde late in the evenings until they are already engaged in risky behavior. Additionally, many respondents mentioned the fact that local men do not carry condoms with them. Therefore, if foreign women expect men
to be prepared, as they often are in the United States, they will be surprised to discover that Costa Rican men are not carrying condoms.

Long-term visitors identified increased consumption of alcohol as directly related to clouded judgment leading to greater incidence of casual, unprotected sex. Many respondents recognized the fact that drinking increases considerably while on vacation. The drinking age in Costa Rica is 18; however, participant observation and interviews revealed that for tourists this law is not enforced at local bars and stores. Therefore, students or visitors who are underage still have access to alcoholic beverages. Respondents felt that many students who are underage have little experience drinking and therefore noted an increased likelihood of them abusing alcohol and becoming intoxicated.

“\textit{I would say there is more casual sex with students than anyone else because of the length of time they are here, as well as their age. When a student comes and they are just out of high school they are more likely to act a little crazy, like flash their boobs in a bar or a public place, because they have less experience away from mom and dad and are more likely to cut loose because they are away. They are also feeling less responsible for their actions and are not recognizable or don’t feel accountable for their decisions, therefore, they make poor decisions, most likely involving a [Costa Rican] in their 20s.}”

Respondents also noted that the drinks in Monteverde are cheaper than they are in the United States and therefore may lead some tourists to drink more.

“\textit{When you are a tourist you save money to go blow on having fun, like so you go to the bar and you're not going to care if you have to spend like whatever, you know?}”

“\textit{Yeah, so you drink four of them [drinks] rather than like one, or eight instead of four, you know, whatever.}”
Some respondents felt that there is a language barrier that may be difficult to overcome in relations between foreign women and local men. A number of local men speak limited English and may find themselves with foreign women who are unable to speak Spanish. This might be a major obstacle in terms of condom negotiation and addressing any sensitive sexual issues. Interestingly, the women interviewed agreed that communication was NOT much of an issue while the men interviewed were more likely to identify it as a barrier.

Finally, the nightlife environment in Monteverde is conducive to initiating relationships between locals and tourists. In particular, respondents, both local and visiting, identified one bar in the area as a notorious place for local men to try and “pick up” visiting women. There is a notable lack of nightlife in the area so the majority of visitors and locals congregate at one particular bar. At the entrance to the bar, there is a piece of art, which has symbols of men, and women scattered throughout insinuating a variety of possible sexual combinations. For example, in one quadrant, there are two male symbols, in another there is just a male and female, and in yet another there is a group of male and female symbols. Above and below the depiction are the words “sex and freedom.” The scene inside the bar is typical of U.S. bars. However, respondents noted that there is a
variety of music played shifting between popular American music and local dance music. Respondents, especially women, mentioned the aggressiveness of local men while in the bar. They gave examples of various pick up lines used. In addition, many women explained that being asked to dance by local men was very common. Many of the visiting women are not familiar with local dances such as the salsa and the cumbia; however, local men would offer to teach them the dances. It was not uncommon to see local men and visiting women dancing provocatively. In addition, participant observation confirmed that many local men escorted visiting women away from the bar at the end of the evening.

Unfortunately, this type of environment may breed sexual assaults that go unreported. There was one known incident during the initial phases of the project when a foreign woman who was under the influence of alcohol and was attacked by a local. However, the victim did not want to report the attempted assault because she was embarrassed about putting herself in such a compromising position. Furthermore, she feared repercussions from the academic program in which she was participating. Finally, she was not aware of local law and protocol, which intimidated her and prevented her from reporting the incident. This may be a common problem in the area, however, no interviews or discussions made direct statements concerning sexual assault.

RESEARCH OBJECTIVE 4: to understand the level of knowledge and community satisfaction with existing education and prevention activities

HIV and HIV Testing

Respondents had different perceptions about the extent of HIV in the local population. Some people felt that the rates were extraordinarily high quoting numbers of
incidence as high as 500 cases. Others felt that there were only a few cases, which were public knowledge. Several stated that they did not want to know about the actual incidence of HIV in the community. There still exists strong stigma in Monteverde and many feel that if someone in the community contracted HIV they would be outcast out of fear. Those within the community did identify married local women as being at risk for HIV. Women felt that there was risk when their partners were unfaithful and possibly infecting them without their knowledge. As one woman stated,

“\textit{There are many women who could be infected and they don’t know it because their partners are able to have sexual relationships outside of their marriage.}”

The majority felt that an increase in HIV was inevitable in all segments of the population because of the increase in casual sex, lack of adult supervision, and inadequate education.

One respondent explained,

“\textit{[An increase in HIV] is going to be very serious in Monteverde. You are going to see an increase until the young people start to be educated then the level would be able to fall significantly. BUT, now it is growing more and more.”}

Another interviewee added,

“\textit{People are starting very young and are already beginning to play with sex. All they want is bodily pleasure. The problem is this: a lot of people are leaving their kids and going out so their kids are growing up bad because the parents aren’t involved in their lives. The following generations are going to suffer because of the behavior of people today. Now there are young people that are involving themselves in drugs, sex, etc.”}

As described in Chapter 3, HIV testing is available in Monteverde, but few people actually take advantage of it because they fear stigmatization, or discrimination should their results come back positive. Some simply prefer not to know, because not knowing is better than finding out you are HIV positive. One informant said, “I would rather jump off a bridge than live with HIV…because people with HIV don’t really have a life
anyway.” Others report that they feel and look healthy therefore being tested is not necessary. In addition, there is very little privacy within the community because everyone knows everyone else. If someone went to be tested, it is likely that somebody would see them or hear about it resulting in rumors being spread.

“[getting tested for HIV] is not something the people here are doing. The people are not going to stand in line at the window for AIDS tests where all the world can see you. All the people are going to automatically believe that you have AIDS. People are afraid of what other will say, they need something more private.”

There are some misconceptions about the actual HIV test. For example, one respondent felt test results were often inconsistent resulting in numerous false positives or false negatives, and therefore the test itself causes too much anxiety for some community members.

**Current Sex Education**

Overall, there is very little done to raise awareness about STI/HIV or to provide prevention messages in places where tourists and locals socialize. The great majority of the tourists in our project reported that they had not seen any flyers, pamphlets or any other educational material in any of the places where they socialize with locals, and where sexual relations are easily initiated. Only a few respondents reported hearing commercials for condoms on the radio, but no other educational materials of significance on either the T.V. or the radio. This is an alarming fact given that a great proportion of visitors/tourists in our study reported that they had casual sex with Costa Ricans. While the likelihood of casual sex increases with the length of the stay in the country, casual sex was reported among both short term and long-term visitors. One respondent who works in tourism explained,
“Now there is much more sex in Monteverde and more with the young people. The majority of those [locals having casual sex] are with those who come to visit. There are so many young local men [having casual sex], and why? Because more than anything there are foreign women traveling to [Monteverde] and the local men know how to romance them saying, ‘your hair is so pretty...your eyes are so beautiful...those pants look so cool.’ In addition, the foreign women hear that local men are ‘hot’ [and good at sex] and VERY friendly. Then when the foreign women leave and get to the United States they talk about the local men and how they found local men very ‘hot’ and very good at everything including sex and then those girls come with knowledge of local men and want to try it out for themselves.”

There is a major gap in the provision of sex education to young people in the area. Our data indicate that, while some adolescents have appropriate knowledge of STIs/HIV, the great majority exhibit major deficits. For example, in the high school discussions students asked a wide range of questions. Many students lacked basic knowledge about HIV and STI transmission and prevention strategies. Other students had more specific questions suggesting that they had some level of knowledge.

Only one of the three high schools in the area has a permanent sex educator, while the other two do not offer any such instruction in their curriculum. School directors mentioned the difficulty in developing a comprehensive program because of stigma that still exists in the community. They mentioned difficulties in hiring local teachers who would be willing to broach the subject in a complete, continuous manner. Parents, teachers, and students all stressed the need for comprehensive education that addresses not only basic sexual matters, but that also stresses STI/HIV and pregnancy prevention. It was also suggested that education begin early and demonstrate some form of continuity. Many complained of the current education being disjointed with students being taught sex education only once or twice in all their middle and high school years combined. Educating children early and continuously revisiting the topic as they mature.
and develop was very important to both adults and children. The high schools students who participated in our focus groups especially emphasized the need to adapt an interactive format of education that actively involves the students in the learning process.

Some respondents did feel that there was adequate education, but in their opinion, the real problem was that young people feel invincible, and will therefore continue to engage in risky sexual activities. Nevertheless, these respondents also provided some suggestions for improving HIV/STI education. Respondents felt vivid visual materials showing the initial stages of HIV infections when an individual appears healthy to their ultimate painful death might be effective. Several community members felt a presentation or discussion by someone who had contracted HIV would also be effective. Another innovative suggestion was using the popular Latin American media of the “telenovela”, which is similar to the U.S. soap opera, as a means of representing HIV to local populations possibly by having a character contract the disease. In addition, all groups felt that condoms need to be made more available and suggested the need to install condom-dispensing machines in the bathrooms or other more conspicuous locations.

There is also a lack of knowledge among the older population, and parents in particular. An informal conversation with a local father revealed that he had false information about condom effectiveness. He was under the impression that condoms were not effective because the virus is so small it can pass right through. Respondents mentioned that education needs to also target parents so they can openly communicate with their children. Respondents felt that communication between parents and children needs to improve on all levels, and this change would encourage a more open discussion.
about sex, sexuality, and safe sex practices. The more sex is discussed the less taboo it becomes. One respondent explained that it would be easier to buy condoms or talk about safe sex if it became a normal topic of discussion.

**Lack of Activities for Young People**

High school discussions revealed that the majority of young people are interacting regularly with tourists at local bars and “dicotecas.” They explained that there is not much to do in Monteverde at night other than frequent these bars. Participant observation confirmed these statements as many underage locals were regularly seen at bars at night. The laws prohibit minors, those under 18, from being in bars; however, there is little enforcement of these laws. Occasionally the local police would enter bars and check identifications making local minors leave the establishment. However, police were never seen asking tourists for identification. Moreover, young people who are underage have access to alcohol. One local student jokingly said alcohol is easier to come across than water in Monteverde.

The majority of respondents recommended that some type of program be developed to engage young people to participate in activities other than going to bars to drink, dance, and use drugs. Many suggested developing centers for young people where they could play sports, learn art techniques, language courses, and drama classes. In fact, the co-principal investigator on this project was concerned with the lack of activities for young people and therefore teamed up with a young local Costa Rican to develop a meeting place called CLAVE, which is an acronym for “Culture, Language, Arts, Vision, Energy.” This cultural center provides a place for young people to get together and
partake in various activities including dance lessons, language courses, music classes, and art projects.

**RESEARCH OBJECTIVE 5: To identify new strategies for educating and disseminating information about STI infections to both tourists and locals.**

**Targeted Education**

Many respondents from different segments of the community also mentioned the need to develop education/prevention strategies that target groups other than the youth. Special emphasis was given to the need to target single men and women as well as married couples. This latter group was believed to be at high risk due to the reported high rates of marital infidelity. Respondents felt that anyone working in tourism should be targeted with HIV education materials because they were more likely to have casual sex with foreigners. For example, naturalist guides, Sky Trek guides, hotel receptionists, waiters/waitresses, and bartenders were identified as a particularly high-risk group. The majority of respondents did not think local women were at risk of contracting STIs from tourists, but rather from their local partners. One local nurse reported,

“Now there appear[to be]? a lot of housewives with various sexually transmitted diseases because the husband is behaving badly. We have a lot of cases like that where the husband is infected and sleeping with other women and bringing infections to his wife who is faithful at home.”

Foreign “long-term” tourists, especially women under 30 years of age, are considered the highest risk and in need of a reminder about STI prevention. Suggestions for reaching tourists and foreign students with HIV education materials include running sex education and HIV prevention seminars through the institution sponsoring their trip, printing materials in guidebooks such as the Lonely Planet, and passing out free condoms. Other
groups that were identified as needing special education are migrant farm workers (Nicaraguans, in particular), and those who do not access the public system of health care.

Like all the other sectors of the community, government and business representatives were very aware of the possible impact of tourism on the spread of STIs/HIV and expressed their strong support for education campaigns that target not only locals but also tourists. Contrary to what we originally thought, those directly involved in the tourism industry were not concerned about the possible negative impact that overt HIV prevention campaigns could have on their business (that is, provide an image of Monteverde as having a serious HIV problem, thus scaring potential tourists). Rather, they all stressed the desirability of offering education through different channels to protect the health of both Costa Ricans and foreigners.

**Sex Education and Religious Considerations**

Not surprisingly, representatives from the religious sector were somewhat more reserved in their endorsement of STI/HIV education. The members of the Evangelical church who were interviewed expressed their support for abstinence only messages, but did not directly voice their disapproval of any other education efforts. Although we were not able to conduct formal interviews with leaders of the Catholic Church, data obtained from a participant in a pre-marital counseling sessions show that the Church is incorporating a discussion of condoms, if only as a means of birth control. In our interviews with parents and other members of the community, there was overall support for sex education that moves away from the abstinence-only message. Interestingly, this support was found regardless of the religious affiliation of the parents interviewed.
Chapter 5: Conclusions

This project attempts to understand community perceptions regarding the impact of tourism on changing local behavior, especially increased risk behavior associated with HIV and STI transmission. Many of the findings were not surprising and were supported by previous research in similar contexts. For example, the connection between tourism and changing behavior, particularly among young people working directly with tourists, is a commonly identified phenomenon (Forsythe et al 1998; Skoczen 2001; Taylor 2001).

The increase in “high risk” sexual activities in Monteverde, especially resulting from an increase in drug and alcohol use tied to the “party” scene have also been identified in many other tourism areas and directly linked to HIV and STI transmission (Josiam et al 1998; McKercher and Baur 2003; Pruitt and La Font 1995). Also, the idea of the “exotic” other whereby tourists and locals share a mutual fascination and attraction to each other has been cited as a reason for increased casual sexual liaisons. These encounters are particularly risky because of different cultural norms and expectations along with the possibility of language barriers preventing condom negotiation (Herold et al 2001; McKercher and Baur 2003; Meish 1995; Pruitt and La Font 1995).

So far, Costa Rica has not demonstrated particularly high levels of HIV prevalence. However, traditional ideas of machismo (which prevent men from carrying condoms or accessing resources and materials from the local clinic), in conjunction with limited access to condoms and sex education that lacks continuity places young locals in
a particularly vulnerable situation as they attempt to negotiate the new economic and social environment emerging in this once rural, quiet community.

This research suggests numerous emerging topics concerning the impact of tourism and HIV that need more in-depth study. Many of these issues are the direct result of increasing globalization, which has facilitated an explosion in population movement. For example, the new demographic group of single, young, female students and volunteers who live with families for an extended period is of particular concern because they are most likely to develop relationships with locals. These relationships place both local men and foreign women at risk because, despite women’s knowledge about HIV and STIs, they often become lax in their safe sex practices and change their normally careful behavior resulting in decreased condom use.

Moreover, growth in tourism leads to profound changes in communities as their economies shift and adjust to this increase flow of capital. For example, tourism in Monteverde has resulted in the movement of some young locals into the area, but more significantly shown a shift of young people out of schools and into the tourist industry. The importance of economic growth and the earning power of young people in this area supersede the desire for education, which specifically disrupts sex education. Many residents noted that as young people become more economically independent and more integrated into the tourist and nightlife scene, they lose their morals and become active in “high risk” activities that could easily result in the spread of STIs.

In addition, parents are engaging more in the tourist industry resulting in less child supervision. Many young people, when left to their own devices and with few recreational alternatives, find themselves engaging in activities revolving around the
nightlife perpetuated by the tourist industry, which includes alcohol and drug use as well as casual sexual relationships. Moreover, condoms are not easily accessible to either locals or tourists as stores selling condoms close early. These trends together with the fact that there is a lack of adequate education and prevention materials, especially targeting young people, can easily facilitate an explosion of HIV and STIs.

Another surprising finding is the idea of “romance” tourism that has been given limited attention thus far (Meisch 1995; Pruitt and La Font 1995). Many local men are involved in “serial monogamy” whereby they develop relationships with long-term tourists for the duration of their stay (sometimes lasting months at a time), and then begin new relationships as soon as their previous partners leave the area. This is of concern as many of the locals, and the foreign women involved, perceive these relationships as trust relationships and therefore using a condom is not necessary. This trend is different from that reported in research that examines local men using foreign women for money, passports, or other forms of economic gain (Forsythe et al 1998; Herold et al 2001), because the local men and tourist women in Monteverde, for the most part, do not seem concerned with issues of money or passports. The women seem involved for reasons of “romance” and the men for sexual adventure. This dynamic often leads to increased risky sexual behavior due to the dangerous combination of negative male attitudes toward condom use coupled with female perceptions of being in a “trusting” and “exclusive” relationship. This thesis has examined the various trends and attitudes that have emerged in Monteverde, as tourism has become the essential industry. Unfortunately, these current attitudes and behaviors observed and reported can easily culminate into a
disastrous HIV or STI epidemic if they are not addressed quickly. Fortunately, current rates appear to be low, and education is a proven mechanism for preventing HIV.

**Recommendations**

Currently, there is not an extraordinarily high reported rate of HIV in Costa Rica. In fact, compared to other Latin American countries the rates seem rather low. However, this apparent trend may not be accurate as reporting and testing is limited within the country in general and very low in the Puntarenas region in particular. However, historically HIV transmission has been associated with tourism and migration, which suggests a potential explosion of the disease in Costa Rica. All factors including traditional values of “machismo”, tourism, early onset of sexual activity, limited education, and limited access to resources including condoms suggests the potential for a terrible situation to develop in the region. Addressing the potential spread of HIV through prevention as opposed to treatment for the disease is the most cost efficient and easiest avenue for halting the spread of HIV. Recommendations stemming from this project are geared toward the following interested parties in Monteverde: health care workers in the clinic, educators, people dealing directly with tourists (Chamber of Commerce), and local institutions working with long-term visitors.

**Health Care Workers**

Health care workers in Monteverde should be more proactive in educating about STI transmission and prevention. They should employ an outreach program that focuses on educating men away from the clinic setting since the majority of men tend to shy away from visiting the clinic on a regular basis. Moreover, there seems to be a consensus among those interviewed that going to the clinic for condoms is too time intensive
because it requires a prescription. Therefore, a better system for distributing condoms needs to be developed. In addition, many residents complained about the quality of the condoms the clinic distributes. It is recommended that the clinic upgrade their condom selection to include condoms that are preferred by locals. Finally, many residents avoided being tested because of the lack of anonymity they associated with using the local clinic. Clinicians therefore need to develop a system that is will ensure privacy of all patients.

**Educators**

A major criticism noted by many respondents is the lack of consistency in the sex education programs in Monteverde. It would be beneficial if all the schools, both public and private, developed and approved a mandatory curriculum of study that began at an early age and continued through high school. Students should be taught about all aspects of sexual relations including biology, sexually transmitted infections, condom negotiation techniques, and other prevention techniques including abstinence and condom use. School clinics should be an avenue whereby students can anonymously seek information, counseling, and condoms. Community involvement in the creation of this curriculum would be advantageous because it ensures a culturally relevant approach to education while including parents and community leaders who can then reiterate the knowledge students’ gain at school in the home environment as well. Furthermore, presentations, classes, or projects that are more interactive such as poster or writing competitions on the subject of HIV and STIs, role plays or dramas, or creating their own telenovelas (popular Spanish soap operas), jingles, or commercials would help students feel less of a stigma associated with STIs, thereby encouraging more open and honest discussions with parents
and teachers. Finally, bringing in HIV positive speakers who can give their life histories and explain the impact of the disease on their everyday lives will help make the reality of HIV more evident.

**Tourism Sector**

Those working in tourism especially owners of local backpacker-style hotels should make HIV materials and condoms accessible to tourists. There was little to no opposition from the community and local tourists to aggressive, visible HIV prevention campaigns. Therefore, during the high season local organizations should engage in these types of education campaigns focused on tourists and visitors in the area. Moreover, there are numerous local groups for those working in tourism, such as the Wilderness Guide Association. These groups should provide HIV education to incoming members as well as continuing education for established members. In addition, tourist companies, such as Canopy Tour Operators, should provide some education for their new guides during training. This would be particularly useful because many of these new employees are young men who are no longer in school and therefore not receiving any sex education. In addition, they were identified as one of the more at risk groups because of their age and direct contact with adventure tourists.

**Local Institutions**

The local institutions that host long-term students should incorporate a discussion of appropriate behavior and safe sex practices into their student orientation sessions and in their handouts. Many students are aware of safe sex practices; however, a simple reminder may be effective in encouraging them to be prepared and aware of the potential risk situations that exist in the area. Furthermore, during meetings with potential
homestay families these institutions should address the need for open and honest discussions concerning appropriate behavior and family expectations with the students who are assigned to their homes. Instituting an evaluation system whereby homestay families are able to express concern or report inappropriate behavior observed back to the sponsoring institution may help curb risk behavior.

**Suggestions for Future Research**

This was a short-term pilot study meant to grasp a basic understanding of the way in which tourism is influencing local behavior. The findings are significant, and disturbing, enough to warrant a more in-depth study before HIV significantly affects the community of Monteverde. Moreover, as international travel increases, more rural communities that have had limited contact with international travelers will face similar economic and social changes. Understanding how and why the behavior of young people is changing may serve to prevent an HIV explosion in currently healthy communities.

Dr. Nancy Romero-Daza is currently working on developing a larger grant to continue this work in Monteverde. As a first step, she secured funding from the Globalization and Research Center at the University of South Florida to develop awareness materials specifically targeting those sub-groups considered at high risk including; long term visitors, youth, and men. This pilot intervention program was conducted from November 2004 to April 2005 and included participatory action research with forty rural women to culturally appropriate HIV prevention materials to be distributed throughout the community. For example, in one town the participants developed address/phone books, especially geared to young women. In another community, they created key chains with HIV messages for both men and women. In the third town, women
developed a 12-page calendar meant to educate the whole family. Finally, in Monteverde they developed two posters specifically geared to tourist (especially young women) emphasizing the importance of condom use.

Specifically, it would be worth undertaking a more in-depth study of the reasons foreign women who travel are more lax in their safe sex practices. In particular, exploring the idea of “romance” tourism which thus far has had limited study might be insightful and beneficial in curbing the spread of HIV and STIs. In addition, it would be fruitful to examine the ways in which an influx of female tourists who regularly engage in sexual relationships with local men influences the behavior and ideas of local women concerning sex and relationships. Finally, a more in-depth study of local men working in tourism and the affect casual sexual liaisons with tourists has on their ideology of marriage, trust relationships, and safe sex, with both local women and foreigners.

**Contributions to Theory, Applied Anthropology, and Public Health**

Critical medical anthropology provides a useful theoretical framework for this thesis because it effectively ties in larger global forces, which in this case would include globalization and capitalism, to their impacts at the community level, which in this case is risk behavior between international tourists and young locals in the community of Monteverde. Globalization has facilitated the movement of people across the world (Drager et al 2001). As technology and innovation increase, the price of travel becomes more reasonable. Today, people are able to travel to places that were once outside their sphere of possibility either due to such constraints as travel costs or lack of efficient transportation. More and more young people, with a spirit of adventure, are taking advantage of these international travel experiences. Popular destinations now include
places in Africa, Asia, the Middle East, and Latin America that are economically
considered “third” world or developing. In an effort to take advantage of the tourist
industry, many national governments are supporting and advertising their countries as
places of beauty and adventure. Costa Rica is a very popular tourist destination that has
been highly successful in promoting eco-tourism (World Tourism Organization 2005).
Unfortunately, they have also encouraged sex tourism, which has resulted in the
proliferation of the child sexual exploitation industry (U.S. State Department 2004b;
Write 2004). Tourism has become one of the most important economic pursuits in Costa
Rica and many communities, such as Monteverde, have become dependent on tourism for
survival. This dependency results in an inequitable distribution of power between locals
and tourists (Taylor 2001). How does Monteverde illustrate this dependency theory?
One example to illustrate how these forces are at work in Monteverde would be the issues
of the “homestay” experience. Throughout this research, community members identified
the homestay experience as a key element in increasing risky sexual behavior between
local youths and foreign women, which many felt results in the degradation of family
values and young people’s morals. If this is the case, then why do families in
Monteverde continue to invite these students into their homes? In this case, the economic
gain in participating in the homestay experience is substantial and families are willing to
take in students at the risk of “moral” degradation and HIV transmission because they
have become reliant on the income that these homestays produce.

Another important question to ask is why sexual risk-taking occurs in
Monteverde? There are numerous reasons that were identified throughout this thesis, and
it is prudent to analyze these local manifestations by looking at the larger macro-level
processes at work to influence community-level and personal decision-making. Clearly, the phenomenon of globalization results in significant economic and social change, which is influenced by historical processes. Farmer’s (2003) discussion of structural violence is important in understanding contemporary Monteverde, and who is at risk for HIV, and why. Historical structures sustaining machista attitudes continue to exist in Costa Rica. Therefore, it is more common to find men working in tourism and women maintaining their traditional roles in the domestic sphere. However, this trend is slowly changing possibly because of western influence and ideas of feminism and female independence to which local women are exposed because of the increase in young, independent females to the area. Nevertheless, in general, men are more in contact with tourists. In addition, men are permitted to be more sexually aggressive and the idea of having multiple sexual partners is more acceptable for local men than for local women. Finally, machista attitude suggests that men are untouchable, indestructible and demonstrate high levels of virility. Therefore, men tend not to perceive HIV infection as a real possibility. These ideologies about gender roles and masculinity clearly create an environment that increases susceptibility to HIV transmission. Furthermore, should the virus take root in Monteverde, the “feminization of AIDS” (which refers to the disproportionate growth in AIDS among women compared to men and is due in large part to gender inequality, poverty and marginalization) is a likely outcome due to persistent gender inequality in Latin America. This means that local women, particularly housewives, can be expected to be at high risk for contracting the infection from unfaithful husband or boyfriends, as is being seen in other HIV affected populations.
Finally, an examination of the political environment suggests reasons for increasing tourism and in turn increasing HIV risk behaviors in Monteverde. First, the stable political scene in Costa Rica makes travelers feel at ease and comfortable traveling to and within Costa Rica. The disbanding of the army and relatively consistent, agreeable relations between the Costa Rican and U.S. governments may also encourage travel. This political environment in conjunction with Costa Rica’s insufficient sex education and HIV prevention and testing policies have created a space whereby locals are not fully educated but constantly exposed to possible routes of infection. Clearly, the critical medical anthropology perspective is valuable as it allows an examination of the political and economic influence at the international, national, and local levels and how this shapes community and individual level behaviors and ideals, and in this case, resulting in a scenario ripe for the transmission and explosion of HIV and STIs.

The purpose of applied anthropology is best described by the past president of the Society for Applied Anthropology, Dr. Linda Whiteford when she wrote that applied anthropologists are those who use “the application of scientific principles for the improvement of peoples’ lives and the resolution of human problems” (Whiteford 2004: 408). Anthropology is well equipped for such an undertaking because of its unique blend of qualitative and quantitative methodology grounded in strong theoretical orientations. Applied medical anthropology seeks to gain knowledge of human behavior and decision-making which includes an investigation into local underlying ideologies, both conscious and unconscious, for the ultimate purpose of understanding health, health beliefs, wellness, and healing. These data can be used to guide policy, practice, education, prevention, and intervention to improve human health and wellness. This project was
designed with the purpose of engaging in anthropological fieldwork to understand HIV and STI risk and ultimately design an intervention to protect the health of all impacted groups. Therefore, the collective team was able to identify risk groups and creatively consider ways to educate them with specific materials and techniques. For this reason, following preliminary analysis while in the field we designed a public health HIV prevention campaign with numerous components individualized to address different risk groups with culturally relevant and acceptable materials and resources. Using these methodologies to gather, analyze, and interpret data with the ultimate goal being to “resolve” potential problems or prevent potential threats from harming a community is the goal, the essence of applied anthropology.

Following the main phase of data collection the research team decided to undertake various activities in an effort to become involved in prevention and education. The team recruited Guillermo Murillo, a Costa Rican HIV positive activist and educator from San Jose to visit
Monteverde during the first week of December to commemorate World AIDS Day (December 1st). Guillermo Murillo is assistant director of The Agua Buena Human Rights Association (http://www.aguabuena.org/ingles/) which is an activist organization focusing on securing health benefits including antiretrovirals for people living with HIV throughout Latin America. During his visit to Monteverde, Guillermo Murillo, gave one community talk and several informational sessions in the local high schools. He addressed a variety of issues including routes of transmission, ways to prevent transmission, and commonly held myths. He also included a demonstration of how to properly use a condom. He concluded his talks with a question and answer session.

Additionally, the team designed and posted educational banners in a public place in the community. The banners had a variety of messages including the following information posted on different days:

Day 1: HIV/AIDS: There are no symptoms, it results in death, take the test, there is treatment

Day 2: Prevention: Abstinence, using a latex condom correctly before contact. Get tested!

Day 3: You cannot contract HIV/AIDS through casual contact. Yes, you can hug, share food, swim, kiss and touch someone infected.
Day 4: You can prevent HIV/AIDS! The virus can be transmitted by sex and injection Drug use. It lowers the body’s defenses causing susceptibility to other diseases.

THERE IS NO CURE!

Day 5: Drugs + Alcohol = Casual sex without protection. Take care of yourself!!!

Additionally, many young community members helped distribute free condoms during the weekend of Guillermo Murillo’s visit. T-shirts were designed that read on the front, “What are you able to get for free? HIV/AIDS, Syphilis, Gonorrhea, Herpes, Chlamydia, or…” In addition, on the back read, “a condom, ask me for one.” Over five hundred condoms of a variety of flavors, gels, and female condoms were distributed along with a small handout that contained information on how to properly use a condom with photos on one side, and facts about HIV/AIDS transmission, prevention, and rates in Costa Rica on
the other. There were a noticeable number of local women asking for condoms during the weekend distribution campaign. Overall community support for the project was very positive. We printed more shirts than were needed; however, locals requested the left over shirts because they felt the message was important. There were no complaints received from any of the local religious institutions. Moreover, several community members requested the education and condom campaign be repeated annually.

Similarly, the community identified long-term female visitors as at a disproportionately high risk group and asked for education material aimed at this demographic. Therefore, Cristina Calderon, a volunteer on the project who has extensive HIV education experience working with Spanish-speaking populations in the Washington D.C. area, and I developed an educational PowerPoint and held a group discussion during the orientation at the Monteverde Institute for students involved in an eight-week biology course. This session included a discussion of our results and recommendations for appropriate behavior while in Monteverde. Feedback was requested following the presentation. The students found the presentation insightful and a valuable component to their overall orientation. The only additional recommendation they made was to include a handout with Spanish phrases that would facilitate a discussion of safe sex practices with a non-English speaker.

Finally, a community health facilitator and I developed and performed a drama during the annual orientation meetings for new homestay families in the three communities of Monteverde, Santa Elena, and San Luis. The drama demonstrated a generalized scenario of the “nightlife” of Monteverde and provided examples of how homestay families can discuss issues of safe sex and proper behavior with students.
Following the drama information printed in Spanish was distributed to the families with the suggestion that they use these materials to initiate discussions with the students who stay in their homes. Homestay families recognized the need for addressing the issue of casual sex between students and locals. Several women asked to be a part of the study because of experiences or knowledge pertaining to the subject. Clearly, the people of Monteverde are aware of the impending negative health consequences that result from risky sexual behavior, and realize that now is the time to act to preserve their health and well-being. This thesis should be used to address some of their concerns and help mold or influence future public health prevention efforts.
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Appendices
Appendix A
Informed Consent (English)

**Name of Project:** Perceptions of Sexually Transmitted Infections (STIs) in the community of Monteverde, Costa Rica

This is an exploratory project to determine the perceptions of STIs, including HIV/AIDS, in the community of Monteverde, Costa Rica. We are specifically interested in what the people think of the impact tourism can have on the transmission of these infections. The information that you provide will help to determine how serious the problem of HIV is in the community and what needs to be done to fight it. If you do not mind, we would like to record your responses for data analysis purposes. Your answers will be maintained in complete anonymity and we will not use your name or any other information that could identify you in any reports or presentations. This consent form will be filed separately and locked in the Institute of Monteverde. The only people who have access to this information are the investigators on the project. The tapes will be destroyed three years after the project is finished. Your participation in this project does not have any physical or psychological risk. Please remember that we will never ask about your personal behavior, only your ideas and opinions on the theme. We expect that the interview will last between 45 minutes or an hour depending on how much information you would like to share.

Your decision to participate in this interview is completely voluntary. You have the freedom to participate or not participate. You can suspend your participation at any moment. If you decide not to participate or to suspend your participation, there will be no consequence. You can refuse to answer any question you feel is inappropriate or you can terminate the interview at any time.

This project is being sponsored by the University of South Florida, under the direction of Nancy Romero-Daza, telephone number in the United States (813) 974-1205. If you have any questions about the project, please contact Sofia Klempner at the Institute of Monteverde, telephone number 645-5053, ext 111 or 645-5365 or 645-5219.

___ I certify that I have read the information about the project and that I am willing to participate.

___ I give permission for the interview to be recorded.

_____________________________   ___________________________      __________
Name               Signature                Date

**Affirmation of the Investigator**
I have carefully explained to the participant the meaning of the above document. I affirm that to my best understanding, the signed participant understands the nature, expectations, risks and benefits associated with participating in this study.
PROYECTO ETS
Guía de Entrevista Semi-Estructurada

Gracias por acceder a hablar con nosotros. Estamos entrevistando a varias personas de la comunidad para saber sus percepciones acerca del impacto que el turismo tiene en la salud en general en Monteverde y específicamente en la transmisión de enfermedades sexuales incluyendo el VIH/SIDA. La información que Usted nos brinde nos ayudará a determinar que tan serio es el problema de VIH en la comunidad y que se debe hacer para prevenirlor. Sus respuestas serán completamente anónimas y no usaremos su nombre ni ninguna otra información que lo pueda identificar en nuestros reportes o presentaciones. Por favor recuerde que puede rehusarse a contestar cualquier pregunta que considere inapropiada.

INFORMACIÓN SOCIO-DEMOGRÁFICA:

Primero voy a hacerle unas preguntas generales sobre Usted y su trabajo.

1. ¿Qué edad tiene? _______________
2. ¿Dónde vive? _______________
3. ¿Cuánto tiempo lleva viviendo en esta área? _______________
4. ¿Cuál fue su último grado de estudio? _______________
5. ¿Cuál es su ocupación principal actual? _______________
6. ¿Cuánto tiempo lleva en este trabajo? _______________
7. Por favor describa su nivel de contacto/interacción con turistas:

8. ¿Con qué tipo de turistas se relaciona mas frecuentemente? También, había tenido o tienen estudiantes/voluntarios en su casa? (edad, sexo, tipo de turismo, etc.)

9. ¿Según su experiencia en el turismo, cómo ha cambiado el tipo de turista que llega a la zona en los últimos 5 años?

PERCEPCIONES SOBRE EL IMPACTO DEL TURISMO:
Ahora queremos saber lo que Ud. piensa sobre el impacto del turismo en la salud de las personas y la comunidad de Monteverde

10. Algunas personas piensan que el turismo trae cosas positivas para la salud general de la comunidad. Por lo que ha visto en Monteverde, ¿qué piensa Ud. sobre eso? (probe for specifics)

11. Al mismo tiempo, se dice que el turismo puede afectar la salud de la comunidad de una manera negativa. ¿Qué cree usted? (probe for specifics)

12. En muchos países donde hay industria de turismo la gente se preocupa por el impacto que los turistas puedan tener en la transmisión de enfermedades sexuales incluyendo el VIH. ¿Usted qué cree acerca de esto?

13. En su opinión, ¿qué impacto podrían tener los turistas en el comportamiento sexual de la gente que vive aquí? (probe for specifics: sexo casual, sexo con multiples personas, prostitución, etc.)

14. ¿Qué impacto piensa podrían tener los turistas en el uso de drogas y alcohol aquí en Monteverde?

15. ¿Qué efecto tendría estos usos de drogas y alcohol en el riesgo de contraer enfermedades sexuales?

16. Si hay algún impacto del turismo en el comportamiento sexual o en el uso de drogas, ¿cuáles son los grupos más afectados? Porqué?

17. ¿Cuáles son los menos afectados? Porqué?

PERCEPCIONES SOBRE MEDIDAS QUE SE DEBE TOMAR

18. En su opinión, ¿qué tan serio es el problema del VIH/SIDA u otras enfermedades sexuales en Monteverde?

19. ¿Qué tan serio cree que vaya a ser el problema en el futuro?
Appendix B (Continued)
Open-ended Interview Guide (Spanish)

20. ¿Qué se está haciendo en este momento para educar a la gente de Monteverde sobre las enfermedades sexuales y el VIH/SIDA?

21. En su opinión, ¿qué tan adecuados son los programas que existen?

22. Si usted pudiera diseñar/modificar programas para jóvenes ¿como los haría?

23. ¿Cómo haría para educar a las mujeres?

24. ¿Cómo haría para educar a los hombres?

25. ¿Qué se debe hacer para educar a los turistas?

26. ¿Quién debe tomar la iniciativa para estos programas? ¿Quién debe pagar por esos programas? (porqué estas son las mejores personas y/o instituciones)

27. ¿Qué mas se debe hacer para hacerle frente a las enfermedades de transmisión sexual y el VIH/SIDA?

28. Por favor digame si hay algo mas que Usted quisiera comentar sobre el tema de enfermedades sexuales o el HIV/SIDA en Monteverde

Muchas gracias por su tiempo y la información que nos ha dado. Esperamos presentar estos datos en forma general a personal de la clínica y otras personas interesadas a principios del próximo año (febrero/marzo).
Appendix C
Focus Group Interview Guide (English)

Thank you for agreeing to talk with us. We are interviewing long-term visitors to the Monteverde area to find out what they think about the impact of tourism on the spread of HIV/AIDS. Please note that we will not ask you about your own sexual or drug-use behavior, but rather about what you have seen during your stay in the area. Your answers will help us determine the extent of the HIV problem in the region and what can be done at the community level. The information you provide will remain confidential, we will not use your name or any other identifying information in our reports. Please remember that you have the right to refuse to answer any questions you consider inappropriate.

1. How would you describe a typical Friday night in Monteverde to a friend back home who has never visited Costa Rica?

2. Do you think HIV/STDs are a serious problem in the region of Monteverde? Do you think there will be a problem in the future or how serious of a problem do you think it will be in the future? Why?

3. Many people believe that tourism plays a major role in the spread of HIV and other STDs. What do you think about that?
   
   Probe: vacation-mode.
   
   Probe: people say that tourists tend to have casual sex with locals.
   
   Based on what you have seen or heard when you go out, how true do you think this is in the Monteverde region? (probe for unprotected sex, multiple sexual partners, prostitution).

4. Which groups would be the most affected? Why?
   
   Probe: young, old, guides, gender, taxi drivers, etc.

5. In your opinion, what impact, if any, could tourism have on the use of drugs and alcohol here in Monteverde? How could this impact the risk for HIV/STDs? Which groups would be the most affected?

6. Is there another way in which tourism might contribute to the spread of HIV/STDs?

7. Based on what you have seen in the community: bars, discos, schools, hotels, clinic, etc., how much do you think is being done to educate people about HIV or other STDs?
   
   Probe: posters, flyers, etc.

8. How effective do you think existing educational/ prevention programs are?
9. What is the most effective way to educate young people about HIV? Women? Men? Is there another group that you could identify which might be at a higher risk and might have a greater need for education?

10. How, When, Who should be responsible for local education?

11. Is there something that should be done to work with the tourists that come into Monteverde? Who should take the initiative? Who should pay for such programs?

12. Is there anything else that should be done to confront the issue of HIV/STDs in this region?

13. Is there anything else that you would like to add concerning any of these issues?

GRACIAS POR SU PARTICIPACION
Appendix D
Short-Term Visitor Survey

Thank you for agreeing to talk to us. Your responses will help to inform a research project looking at local perceptions of STDs and HIV. We will not ask you about your personal behavior, but rather about your perceptions based on what you have seen or heard during your stay in Monteverde. We refer to Monteverde in this survey in a broad sense to include the various communities involved in tourism in this area. Your name or other identifying information will not be used when presenting results. This should take about 8 minutes.

A. Background Info
1. How old are you? ________  Code for gender _______
2. Where are you from? _______________________
3. How long have you been in Monteverde? ________ days / weeks / months
4. Where else have you visited in Costa Rica on this trip? For how long were you in each location?
5. Where else do you intend to travel while in Costa Rica? And for how long do you intend to visit those locations?
6. Where are you staying?
   __ Local family
   __ Hotel
   __ Rented cabin or house

B. Travel specific
1. Why did you come to Monteverde?
   __ Vacation
   __ Studies
   __ Other: _______________________
2. Who are you travelling with? ______________________________________
3. How many times have you gone out to discos or bars during your time here? ______

C. STD risk behaviors
1. Which places have you noticed tourists and Costa Ricans socializing the most together in Monteverde?
   __ Bars         __ Discos
   __ Restaurants __ Local homes
   __ Other: _______________________

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Appendix D (Continued)
Short-Term Visitor Survey

2. People say that tourists like to go out on dates with Costa Ricans. How many tourists or foreign students do you know of who have dated a Costa Rican while here? _______

3. How many tourists or foreign students do you know of who have had sexual relations with a Costa Rican while here in Costa Rica? ______

4. How many tourists or foreign students do you know of who have had sexual relations with a Costa Rican while here in Monteverde?

5. Based on what you have seen, how common do you think the use of alcohol is in Monteverde?
   ____ Very common  ____ Common  ____ Not too common  ____ Rare
   ____ Don’t know

6. Based on what you have seen, how common do you think the use of drugs is in Monteverde (including alcohol)?
   ____ Very common  ____ Common  ____ Not too common  ____ Rare
   ____ Don’t Know

7. How readily available do you feel condoms are in Monteverde?
   ____ Very available
   ____ Available
   ____ Somewhat available
   ____ Hard to find
   ____ Impossible to find
   ____ No idea or Not applicable

7. How much have you seen in terms of HIV educational materials such as posters or flyers in places such as discos and bars?
   ____ A lot  ____ Some  ____ A little  ____ None  ____ Don’t know

If you have seen them, where was that? ______

8. What do you think would be the best way to reach tourists with HIV prevention messages?

   __________________________

9. Please add any other comments you consider appropriate

   __________________________

Thank you for participating
Appendix E
Sample of Questions from High School Discussions

- If two people do not have sex, are they still able to catch AIDS?
- Who is more likely to be infected, men or women?
- Is there a cure for HIV?
- Why isn’t there a cure?
- Are there other fatal STDs?
- What is gonorrhea? Is it worse than syphilis?
- What are the other types of STDs?
- What is the probability of being infected with HIV?
- What methods of protection are 100% effective?
- How are you able to tell if someone you had sex with is infected with HIV?
- What methods prevent HIV and what is the correct way of using them?
- If you use a condom, are you still able to catch a STD?
- Can someone infect someone else by kissing them?
- Can you catch HIV from having oral sex?