INTRODUCTION

Cultural Landscapes and Cultural Brokers of Sexual and Reproductive Health in U.S. Latino and Latin American Populations

M. Idalí Torres
George P. Cernada

This literature review is an attempt to meet the demand for Latin American transnational perspectives of sexual and reproductive health that has surfaced as a direct result of the continuous flow of Spanish-speaking people across the borders of the American Continents. In the absence of true transnational studies, we are examining case studies from both sides of the U.S. border published by the *International Quarterly of Community Health Education* over the past decade, and suggest a future direction to address this area of study in the field of sexual and reproductive health promotion and education at the community level.

As a starting point, in community health promotion and education we must consider the broader context of quality of life indicators for Latin Americans and Latinos. Below the U.S. border, Latin American countries experience the enormous disparity and inequity in distribution of economic resources typical of the "developing" world [1]. The extent to which the so-called "developed" countries, through their greed, contribute to this economic disparity is well documented elsewhere [2]. High rates of infant mortality, maternal mortality, disability, hunger, and premature deaths in many Latin American countries continue to prevent large populations from fulfilling their potential and asserting their basic rights as human beings [3], including access to health education and services. Governments frequently have neglected their fiduciary duties to provide adequate

sanitation, potable water supplies, and access to basic education and health care. The result has been unconscionably high infant mortality, maternal mortality, and communicable disease prevalence, much of which could be eliminated by low technology, low cost community-based health care and preventive services, and adequate provision of resources [4].

In North America, the U.S. "Latino" population also continues to experience inadequate attention in social and health resource allocation despite growing numbers and increasing level of need. The tally of the Year 2000 national census shows a significant increase in the numbers of people in the United States who self-identified as "Hispanics" [5]. In spite of, and perhaps even because of, the rapidly growing numbers of Latino/Hispanic/Spanish-speaking peoples in the United States, access to health care and preventive services is profoundly weighted against a large proportion of the Latino population in the United States as well as the bulk of the population in most countries in Latin America.

A glance at the statistics on health outcomes of sexual behavior gives a panorama of vulnerability to death and disability at an early age. Latin American and Latino women are disproportionally affected by HIV/AIDS [6-8] and other sexually transmitted infections (STIs) [9, 10], cervical cancer [11, 12], and negative pregnancy outcomes [12]. This is attested to by the infant mortality rates in Central America of 28 per 1,000 and South America of 29 with a range of a high of 61 in Bolivia to a low of 12 in Chile [13]. In the case of HIV, although only slightly more than one of ten U.S. residents in 1998, Latinos accounted for nearly two of ten AIDS cases reported to the Centers for Disease Control and Prevention [14].

In light of this disturbing panorama, the dearth of collected readings on community health education program planning, implementation, and evaluation limits the training of a new generation of practitioners and researchers. Since the *International Quarterly of Community Health Education* is one of a handful of U.S. academic journals that have consistently published articles from Latin American countries and U.S. Latino communities, it seems natural that we undertake the task of synthesizing what we have learned over the past decades from the journal and share our thoughts about future directions.

This introductory piece represents an overview of 19 articles on research and interventions conducted in Mexico, Guatemala, Peru, and Puerto Rico and the states of California, Massachusetts, Connecticut, Louisiana, and North Carolina. The essay is organized in two parts. Part 1 is devoted to the spheres of social influence in heterosexual and reproductive health behaviors: male partners, family, and other community structures. Part 2 describes the role of lay health providers and promoters (*parteras, promotoras, poetas*) as cultural brokers in the transmission of information, renegotiation of social and cultural resources in the community, and influence of behavior. Recommendations for a new generation of sexual and reproductive health research and interventions at the community level are presented at the end.

PART 1: CULTURAL LANDSCAPES FOR SEXUAL AND REPRODUCTIVE HEALTH IN LATIN AMERICA AND U.S. LATINO COMMUNITIES

Conceptualizing Culture

Culture is one of the most cited constructs in the health promotion and education literature focused on Latin America and U.S. Latino populations. It is persistently used as a descriptor of individuals, groups, and communities; as an explanation of behavioral differences, negative health outcomes, and statistical variance; as a barrier to preventive health care measures and provider-consumer communication; as a reason for intervention specificity and segmented targeting, and as a justification for failure to meet program objectives or broader public health agenda such as reduction of preventable health conditions. Culture has also been identified as an abundant component of the human capital available in communities to support the promotion of health and well-being. All of these attributions of culture often contain no specifics beyond the surface, pay little heed to how ideas develop and evolve into behavioral performance, and assume that changes in values, norms, and meaning at the macro-level of society are produced by formal education rather than indigenous funds of knowledge acquired from natural observation and imitation in the exchange of relationships among individuals and groups.

Generalizations and oversimplifications of the complexity embedded in the notion of culture at this time when rapid change is forcing people to transcend boundaries of ideology, language, class, gender, ethnicity, nationality, and geography to construct new cultural templates are obfuscating our search for new knowledge to address health problems. Added to this cultural tapestry are layers of political and economic conditions that are not always shared by all Latin Americans in their native or foreign lands, as is the case of the colonial experience for Puerto Rico and indigenous groups in Latin America. Furthermore, when migrants enter into contact with U.S. pluralistic culture, existing templates to reach exponential levels of complexity that are not always captured by the existing tools of public health research.

The study of reproductive and sexual health for education, policy, and other health promotion targets of intervention requires an understanding of the plethora of cultural formulations involved in the development of idea systems and behavioral performance and how these two dimensions are linked up in people's explanatory models used to conceive of, act on, and represent their expressions of sexuality and reproduction. Key to our analysis of the cultural systems for sexual decision making is the lacuna opened during transcultural exchanges that is often filled with new formulations of ideas and behavioral strategies through ongoing negotiation with the intermediate structures of the environment. Because culture as a social process is both tenacious and tenuous, we often observe among Latin

Americans and U.S. Latinos the "old" and the "new" strategically combined in a third way that gives continuation of their history in the culture of origin by embracing cognitive symbols and language that affirm collective identity while meeting the current conditions of the immediate environments by negotiating other social standards [15, 16].

Under this fluidness in the culture of the mesosystem of the Latino experience, social power becomes a function of human agency and the capacity to penetrate community structures. Relevant to this discussion is the suggestion of Minkler and her coauthors that as health educators and health promoters we must depart from the hierarchical dominant models of power analysis to discover opportunities for influence and change in communities [17]. Two examples in this book representing different regions of the Americas suggest a reassessment of women's decision-making power. Co-authored by Bertrand, Ward, and Pauc, Chapter 1 reports on the differences between the descriptions of sexual pleasure obtained from Guatemalan Mayan women for their study and those provided by earlier ethnographic accounts [18]. The women's willingness to share their experiences of enjoyment and pleasure is testimony to the evolution of cultural construction that is not frequently covered in the literature. In the following chapter, Gil presents the differences in sexual negotiation power between women in Puerto Rico and women who have migrated to California from Mexico and Central America [19]. More attention to new constructions of power in gender relations significant to the lives of Latin Americans and Latinos will help test old assumptions about the distribution of social influence in dyads, families, and broader community structures. It is critical that we do not undermine our own efforts to promote sexual and reproductive health education by operating against the evolving cultural and social systems instead of seeking opportunities for influence within the natural flow of change to greater extends.

Cultural Data Gathering Techniques

Searching for the best opportunities for sexual and reproductive health promotion and education across the boundaries of Latin America and Latino communities in the United States entails research approaches with methodologies that achieve the level of comprehensiveness of the "complex whole." In our case, this Taylorian staple of the anthropology legacy refers to the socio-cultural landscape in which expressions of human sexuality are learned and shared through social relations. As Gil reminds us in Chapter 2, "for cogent health education, specifics are necessary" [19]. Specificity in human sexuality can only be found in the interactions between cultural systems (i.e., morality), psychological factors, and biological needs that influence gender and sexual behavioral performance in people's natural forms of social organization.

The collection of works in this book includes several in-depth studies conducted by anthropologists and other social scientists. Among the research methodologies

utilized to gather cultural data are: 1) focus groups with Quiché-speaking male and female Mayas in Guatemala, with women who have migrated from Central America and Mexico to North Carolina and California; 2) life history interviews with female adolescents from second or third generation Central Americans and Mexicans residing across the border in the state of California and some of their male partners; and 3) in-depth focused thematic interviewing sessions with breastfeeding mothers in Lima and Peru and Puerto Rican women in Connecticut, Massachusetts, California, and in their native island of Puerto Rico. Together, these chapters suggest that methods of qualitative research are more successful than quantitative ones in capturing people's experience with sexual and reproductive decision making because of the abundance of data to decipher cultural meaning and the circumstances beneath variation in sexual behavior. As a body of literature, it highlights the interpersonal processes of social relations relevant to sexual and reproductive health promotion.

Reflecting the general literature on sexual and reproductive health promotion and community education, the collaborators of this book focused mainly on women's interpersonal relationships with: their sexual male partners; family members and other significant people in their lives; and community structures involved in the economy, education, religion, and other social influentials. Only two studies include adolescent male participants. One of these also includes adult males, and there is a sole chapter addressing the participation of gay men in sexual health promotion.

Women's Relationships with Male Partners

The role of men in women's sexual decision-making and negotiation receives considerable attention by the collaborators of this book. Writers of the Latin American experience found that gender interpersonal dynamics determined communication with male partners and others and the frequency and circumstances of sexual intercourse and perceptions about contraception technologies. Among Guatemalan Quiché Mayan participants in the study described in Chapter 1 by Bertrand, Ward, and Pauc, men influence the frequency and circumstances in which sex happens [18]. For example, women's refusal to accept men's request for sex when they are under the influence of alcohol results in sexual coercion and other forms of violence. However, the study from Puerto Rico presented by Gil in the second chapter shows a different experience in another part of Latin America [19]. Participants in his Puerto Rican research project characterized their sexual negotiation process as a reciprocal relationship in which both women and men shared decision-making related to the initiation and conditions in which the sexual encounter happened. Whether or not this new gender dynamics is associated with the higher education attainment, increased participation in the labor force and access to structures of political power that women in Puerto Rico have attained during the past 20 years, or the influence of the more fluid gender roles of the

United States, or both is a question for future research. Indeed, the high degrees of autonomy in negotiating sexual matters shown in Gil's study distinguished women in Puerto Rico from the experience of all other Latin American women described in this book.

Some other areas of reproductive health in which the role of Latin American men is prominent are discussed by Oliveros and her collaborators [20], and Rice [21] in Chapters 5 and 8 respectively. The team of researchers led by Oliveros found that Peruvian husbands represented one of the sources of influence in their wives' decision to continue lactation or not during pregnancy. Rice's literature summary reports that men in some Latin American and Caribbean countries oppose contraceptive technological barriers because they fear marital infidelity. Her assessment that limited sex education for adolescents stems from the belief that information becomes a motivator of "sexual promiscuity" is a common theme in all the chapters that include youth. In contrast to this belief are reports that adolescents are engaging in sexual relationships [18] (in Chapter 1, 3, and 8) and in some cases in selling sex for money as described by Burgos and her colleagues [10] in Chapter 7.

Similar patterns of gender dynamics involved in sexual negotiation were found in some of the studies conducted among Mexican and Central American women in the United States. The Gil [19] and Erickson [22] chapters reported a more significant role of the males in seeking, requesting, or initiating sex. There are two chapters addressing the utilization of preventive services, Chapter 4 authored by Wilcher and her research team [11] and Chapter 15 by Guendelman and Witt [23] which found that the attitudes of Mexican and Central American migrant men toward women's pelvic organs contributed to their female partners' underutilization of Pap screenings and prenatal care respectively. The reluctance of U.S. Latina women to expose their "private parts" during pelvic exams required for these preventive measures has been attributed to culture. (We will further comment on the cultural context of these findings below in the section devoted to religious structures.)

Most studies presented in this book agree about the significance of gendered cultural scripts in the perception and use of male condoms as a technology for sexual protection. Notwithstanding these similarities, Chapter 16 by Torres and her team suggests that gender roles are in transition in segments of young Puerto Rican women residing in Western Massachusetts, particularly among those who obtained the cooperation of their male partners to use the female condom during a trial period [24]. When considered in light of Gil's study in Puerto Rico [19] (which documents leadership roles of women in sexual decision making), these findings are suggestive of the need to research decision-making patterns of Puerto Rican women across the Atlantic Ocean. Recent HIV intervention research suggest that Latina women are making strides in their efforts to communicate about sex and sexual protection with their partners and other influentials [25].

As a body of literature, the articles and chapters reviewed above present a picture of a male dominance in sexual decision-making and negotiation that hinders women's ability for self-protection. While there is a small number of males educated about sexuality and sexual health, they engage in sex at a very early age, have more sexual partners during their life time and multiple partners simultaneously, are more likely to have unprotected sex with infected partners and be the carrier of infections to women, and make many decisions about the couple's sexual behaviors with very little information about potential negative health outcomes. At issue here is that the public health response assumes that progress in reducing the incidence and impact of sexual health problems depends on women's success in negotiating safe sex with their partners and places the emphasis on strengthening behavioral capacity of women at the individual level. It is not difficult to see that an unintended repercussion of the exclusion of male partners from health education and health promotion research and intervention projects [25] is the establishment of yet another layer of social support to sustain the cultural constructions that guide women to assume not only the primary responsibility for sexual health protection, but also the burden of negative consequences.

Women's Relationships with Family and Significant Others (Beyond Their Male Partners)

The family (*familia*) continues to be the most powerful social system in the communities described by the collaborators of this book. At the heart of the Latin American family are the values of motherhood and childbearing that preserve the continuation of the structure and its social functions. While women are venerated for their roles as mothers, they are expected to assume the main responsibility for the entire family, even during pregnancy. In Chapter 8 Rice asserts that Latin American women often experience malnutrition and high morbidity during pregnancy due to the multiple tasks they perform to maintain the quality of life of other members of the family, including eating after serving everybody else [21]. However, Chapter 5 by Oliveros and her coauthors shows that the influence of Peruvian mothers in decision-making can be situational and conditional to the type of relationship and the level of persuasion of the others around them [20]. While they were swayed by the attitudes and opinions of family and significant others about breastfeeding in their decision to continue breastfeeding or not during pregnancy, occasionally they gave more weight to their own beliefs and perceptions about health of their toddler, fetus, and pregnancy than to the recommendations (or expectations) of significant others.

Data presented in Chapter 1 by Bertrand and co-writers [18] about mating is consistent with other studies found in the literature and shows that in most Latin American countries there is a tradition of marriage in the adolescence stage for

both females and males that is generally accompanied by high fertility rates. This, according to Erickson's chapter, presents a conflict with social expectation in the United States where teen pregnancy frequently happens out of wedlock and without the social and economic supports of the family that extend into the community as in Latin America [22]. Indeed, the U.S. Latino family structure has evolved from the traditional extended family to what Cordoza-Clayton calls in Chapter 18 a "nuclear and interdependent kinship structure with multiple and mobile networks," referring to the specific experience of California [28]. The diversity of constellations in the structure of the Latino family can also be seen in Puerto Rican communities in the eastern part of the United States as well as on the island of Puerto Rico where there is an emerging matrifocal structure according to recent anthropological work [16]. While there is vast evidence of family values as a strength of the culture, they also can represent a barrier to education efforts aimed at promoting sexual health in families with non-sexual adults and other non-traditional unions as in the case of gay men in Mexico described by Carrillo in Chapter 19 [26].

Regardless of the structural form, its social function of mutual support, reciprocity and loyalty of the *familia* is deeply ingrained into the identity of Latinos in the United States, and serves as the main context for the transmission of cultural ideology and preserver of the ties with the country of origin and associates elsewhere in the world. The significance of the family in U.S. Latino communities is noticeable in the names, orientation, and objectives of the projects described in this book. Chapter 17 by Buchanan and his coauthors [27] describe the decision of program participants to select a name resembling the Puerto Rican family tree of "cepa" (mother) and her "cepitas" (daughters) to give symbolic meaning to their HIV prevention work in the City of Holyoke, Massachusetts. Two other examples of successful models of community interventions built on the interception of culture, health, and social systems, *El Centro Familiar* and *Padres* and *Madres,* are presented in Chapter 18 by Cardoza-Clayton and coauthors [28]. An important consideration in the examination of this triology is that culture is rooted in social institutions beyond the family as we discuss below.

Women's Relationships with Macrostructures of the Economy, Education, Religion, and other Social Influential Sectors

Urban community structures for generation of income and other material resources required to meet basic human needs force adolescent and adult women who are unable to find employment into sex behaviors that place them at high risk for HIV/ STIs, sexual violence, as well as drug addiction and depression. Chapter 19 by Carrillo describes situations in which women in Mexico are coerced into sexual intercourse without a condom for more money or in exchange for drugs to sustain their addiction [26]. In Chapter 6, Romero-Gaza and her anthropologist

colleagues [9] provide a vivid description of how women who migrate from Latin American countries, primarily Puerto Rico, become entangled in a progressive continuum pattern of drug selling, drug using, and sex trading as a means of economic survival in the city of Hartford. The narratives in the chapters mentioned above illustrate the role of government policies for welfare reform and job training in sustaining the contributing factors to women's health problems associated with sexual behavior and drug use. Like the Puerto Rican women in Hartford, the adolescent who sold sex for money in Puerto Rico described by Burgos and coauthors in Chapter 7 had limited access to the health education, STI screening procedures, primary care, and drug treatment services [10].

While discussing health behaviors among Latino adolescents in California, Erickson [22] (Chapter 3) and Chávez and Dorfman [29] (Chapter 12) identified unprotected sex and violence as adaptive responses to long-term economic scarcity in their communities. Inaccessibility to resources appears to be a contributing factor to unprotected sex among Latina adolescents who become mothers. Stress induced by social conditions associated with chronic economic poverty is expressed in violent behaviors at home and outside. In their chapter, Chávez and Dorfman assert that mortality and morbidity statistics show that Latina women experience the greatest impact of domestic violence in the form of physical and mental abuse in their communities. In this context, the authors are not surprised by the high numbers of female-headed families in Latino communities.

Education systems have different standards according to the social characteristics of the population. In the Guatemalan-Mayan context, schools provide more access to sexual health education to males. According to Bertrand and coauthors in Chapter 1, Mayan boys knew more, had more access to information, and spoke more about the body and sexuality at school than the girls of the same age that expressed more interest in these topics [18]. Sexual health education is also restricted by the state in many other ways. Carrillo's chapter [19] provides an example of the impact of the politics of state funding distribution for HIV prevention on community groups that were assuming the primary responsibility for the outreach work in most vulnerable communities in Mexico City [26].

Opinion leaders are key components of social influence for the adoption and preservation of behavior. In health promotion and education we need them on our side to encourage, model, persuade, and support change. Bertrand and coauthors found that social pressures of older men in the community who expected young men to act on their sexual desires contributed to sex initiation at an early age. However, some of the same older men who were community leaders rejected the idea of sex education or discussing sexuality in public forums because they believe that it "stimulates [youth] interest in sex" [18]. However, in the *Cuidaremos* project described by Lorig and Garcia Walters [30] in Chapter 14, opinion leaders were *Chicana* women with extensive social connections in the

community, who served as planners and facilitators of a group-based breast health education program.

At an even broader sphere of the cultural landscape is the notion that "bad" sexual behaviors such as extramarital sex were influenced by the "dominant" culture (*Latino)* and not necessarily emerging from their own group (Quiché Mayan). Despite the interpretation that we give to this finding, it does raise a question about the influence of colonialism in gender scripts. While there is vast documentation of the effect of Spanish Colonialism on reproductive health related behaviors, attempts to understand the influence of other dominant cultures present in contemporary Latin America and their impact on gendered culture are few. Indeed, colonialism and its by-product dependency are identified as structural barriers to healthy communities. Coauthors of Chapter 17 present it as an important contributing factor to risk-taking behaviors that deserve attention from health promoters and educators working in HIV prevention programs in Puerto Rican communities [27]. The combination of colonialism with exclusion from structures of formal economy, gender inequity, and ethnic discrimination is a powerful template for vulnerability to sexual health problems among Latina women.

Various chapters in this book address religion's multiple functions in the development of the ideology that gives meaning to sexuality, reproduction, contraception, abortion, and birth. Religious systems shape beliefs and patterned behaviors associated with human sexuality. Perhaps the greatest effect of religion is in the cognitive frameworks of morality that guide sexual and reproductive behavior. Bertrand and coauthors tell us in Chapter 1 that Guatemalan Mayas believe that sexual desire and pleasure is part of the legacy that God transferred to their ancestors and in turn, to their generation [19]. But God's blessing is for married women because those unmarried feel "ashamed" of their sexual activities. Related to this dichotomy is Rice's observation in Chapter 8 that religion's framing of sexuality as a mechanism for human procreation raises moral dilemmas for women who do not want to become pregnant [21]. The psychological impact of violating religion-established moral premises results in feelings of *verguenza* associated with a combination of shame, guilt, and embarrassment described in the literature [11-12]. As mentioned earlier, and discussed in Chapters 4 and 15, it is believed that these feelings prevent Latinas from seeking preventive services that require health care providers, especially males, to observe and touch pelvic organs such as the vagina. In addition, they serve to sustain views of *fatalismo* or powerlessness associated with negative health outcomes and their own ability to adopt new behaviors to protect their own health. This example of the relationship of culture and behavior highlights the significance of powerful cultural brokers who often can simultaneously negotiate the cultural multi-layered template for the protection of sexual and reproductive health through social relationships and serve as provider and promoter of health in the community.

PART 2: LAY PROVIDERS AND PROMOTERS OF SEXUAL AND REPRODUCTIVE HEALTH AND THEIR INFLUENCE IN U.S. LATINO COMMUNITIES

In Latin America, the most powerful traditional cultural brokers in the promotion of sexual and reproductive health in Latin America are *parteras* and *comadronas* (midwives or Traditional Birth Attendants (TBAs)) and *promotoras de la salud* (health promoters). Less known in the United States are the contributions of the *trabajadores de la cultura* (cultural workers) to health promotion and health education in Latin America. Poets, musicians, actors, and others who promote health through cultural platforms have a long history of disseminating family planning information through performance in the streets as well as in mass media channels. The HIV epidemic in U.S. communities is reclaiming that legacy for public campaigns aimed at preventing HIV/STIs in Latino communities.

Parteras, Comadronas, and other Traditional Birth Attendants (TBAS)

Chapters 1 and 13 of this book highlight the survival of the continuing evolution of lay midwifery in Latin America, a health profession regarded as the oldest in womankind. While researching sexual practices among Quiché-speaking Mayan women, Bertrand, Ward, and Pauc found a predilection for midwives not only for delivery purposes but also during pregnancy for prenatal care services instead of trained medical doctors and nurses in hospitals. Women in the Mayan communities, they observed in Chapter 1, "prefer to use the [prenatal] services of a local midwife who is a well-known and trusted member of the community who, moreover, respects the traditions concerning the birth of a child" [18]. This finding is a testimony of contemporary views about TBAs. By all accounts, lay midwifery interventions are traditionally designed to ensure continuity of care—before, during, and after birth—and meet social, psychological, physical, and spiritual needs of the mother. This support is extended to the father, siblings, and even members of the extended family who are involved in what it is a family-centered social event. There seems to be no systematic, prescribed role for their interventions but rather a person-specific approach in a supportive and intimate environment in which women share decision making of their care. It is precisely this highly personal relationship that gives lay midwives access to the kind of information necessary for needs assessment and places them in a position of influencing health-related behavior in their communities, and, therefore, to impact public health outcomes.

As in other continents, in Latin America the indigenous training of midwives or TBAs happens through longer periods of apprenticeship with senior empirical practitioners who posses extensive expertise in natural methods of diagnosis and

healing (i.e., body massage, binding of the abdomen, herbal remedies, aromatherapy, and even how to prevent a breech birth) during parturition. However, not until they are considered older and in some cases have become grandmothers, which in some countries can be in their 30s, do midwives assume their role and begin their solo practice [31, 32]. By then they are well-known and respected by others, a prerequisite for fulfilling their function as chain-linkers in the social support structures of their communities. Because they are indigenous to their communities and share many of the same lay theories and explanatory models for disease causation, risk management, and treatment as the rest of the women in their communities, they are viewed as partners rather than providers. While the embeddedness of their role into the cultural fabric of their communities facilitates their management of normal pregnancies, in some cases it jeopardizes their ability to incorporate biomedical skills and technologies into their practices, and thus lessens their potential impact on reproductive health outcomes.

Notwithstanding that TBAs generally come from segments of the population with low rates of literacy, economic resources, and access to primary care, formal training efforts in Latin America by international health organizations during the 1970s and 1980s succeeded in building the capacity of *parteras* to use basic biomedical technology that enabled them to serve as the first step in the primary health care system and link their communities with local clinics and regional hospitals. Chapter 13 of this book illustrates one example from Guatemala. O'Rouke's research shows that contemporary Guatemalan TBAs not only referred pregnant women at risk for negative pregnancy outcomes to the hospital but they were also trained to administer oxytocin, a synthetic labor inducer [32]. This example of biomedical interventions reflects a level of receptiveness to new knowledge and practices that is a characteristic of the evolution of the midwifery trade throughout the past centuries. Yet, in this same study, O'Rouke found that training midwives about the potential negative consequences of two common practices during early stages of labor—the traditional practice of coaching women to bear down to push and the biomedical practice of administrating oxytocin—produced minimal change in these practices. Given the adaptive experience of lay midwives historically, one could theorize that the distinct cultural orientations in the development of these two practices may have produced the diminished effect of the training. Implicit here is the notion that no change happens without tensions between perceptions of biomedical domination and the local culture that have successfully sustained the role identity of TBAs as indigenous throughout our history. In addition, transferring new technology and practices from one culture to another not only requires an assessment of the negative impact on health outcomes [33], but also continuity of training and support that has not always been available in most Latin American countries [34].

Promotoras de la salud

While midwives, by virtue of their historical role in their communities, have played a significant role in providing health information, advice and in performing other key health promotion activities, most lay health *promotoras* of reproductive and sexual health in Latin America do not have either empirical or formal training in midwifery. Lay health promoters generally share the same socioeconomic characteristics as their collaborators, TBAs. Both are viewed as natural resources of social support in their communities, volunteer to receive formal training on first aid to diagnose and treat symptomatology for common illness, and function as community health educators supporting primary care systems in government and non-governmental organizations in their communities. Although in some countries *promotoras* receive a more broader training in public health sanitation and nutrition and work under much more supervision from professionals than *parteras*, they also are trained to provide women's reproductive and sexual health education to members of their communities. This trend appears to have continued in the 1990s at least in non-governmental organizations in Mexico that are training both *parteras* and *promotoras* to join other health workers in the implementation of HIV-related programming directed to women in their homes [35]. In addition to HIV and other sexually transmitted infections, *promotoras* are becoming involved in other areas of women's health promotion such as interfamilial violence and social issues affecting general quality of life in their own communities [36]. As Cardoza Clayson and her colleagues suggest in Chapter 18, the long history of *promotoras* sustaining the rural primary care systems in most Latin American countries is being recognized as a cost-effective method to reach underserved segments of the Latino population in the United States.

The role of *promotoras* as agents of social change in their communities is not new and can be traced to the sociopolitical activism generated by popular movements during the 1960s. The seeds sprouted during the 1970s literacy and land reform campaigns in Latin America with community health education components that promoted health as a human right and utilized Freirian methodologies. In what appears to be a reciprocal relationship, lay workers in the health sector extended their activities to the promotion of social change and economic development [37]. These endeavors produced the kind of social change orientation not found in previous generations of Latin American lay health workers. Since then *promotoras* have been key to the integrated development programs aimed at accomplishing the dual goal of public health and economic development in many parts of Latin America. Despite the efforts of the professional elite to minimize their natural role in promoting self-reliance and community strengths, *promotoras* have become a major force in health advocacy for the large number of rural Latin Americans who are disconnected from community structures of primary care help and support.

Approaching health and health care holistically, and relying on mutuality and collaborative relationships, *promotoras* frequently mobilize their community resources to meet people's health needs on a daily basis. For this reason, said Oliveros and her colleagues in their study of social influence in Peru presented in Chapter 5, these health workers are revered and highly influential in their communities [20].

Like many other constructions of Latin American culture brought by migrants to the United States, the traditional personal approach to pregnancy and other areas of reproductive and sexual health represented by *parteras* and *promotoras* became an unfulfilled expectation. Describing prenatal care utilization among Mexican and Central American women residing above the Mexican border in the state of California, Guendelman and Witt [23] (Chapter 15) reflected on how the medicalization of pregnancy and the professionalization of service providers are inconsistent with the experience of most Latin Americans in their countries of origin where pregnancy is viewed as a normal healthy state in the life of women which does not necessarily require special medical care but very personal interventions by trusted members of their community. Public health approaches are seeking to meet this need for social support among Latinas in the United States with community outreach and education workers, which include no birth attendant but a person attending to recreate the symbolism of the lost relationship with the *parteras*. One example found in the anthropological literature is *Proyecto Comadrona, a* community intervention to reduce negative pregnancy outcomes among Puerto Rican women living in the city of Hartford, Connecticut during the 1980s by utilizing indigenous outreach workers to promote prenatal care utilization in early stages of pregnancy [38]. Guendelman and Witt's chapter highlights the importance of reaching Latina pregnant women by health workers from their own community who help navigate the systems of prenatal care [23]. However, most medical institutions serving Latinos have intensified their efforts to reclaim the practice of midwifery for economic reasons, primarily as a cost-saving strategy for healthy pregnancies in birthing centers and obstetrical-gynecological services. These new generations of U.S. midwives are trained in universities with a medical curriculum, have a national organization for credentialing and professional certifications, are controlled by reimbursement policies of health insurance companies, and frequently have no cultural or linguistic capacity to communicate effectively with Latinas. Consequently, they are failing to take advantage of this cultural opportunity and recreate the kind of personal relationships that women develop with their *parteras* and *comadronas* below the U.S.-Mexican border. Instead, what is obvious to those observing the public health system of prenatal care provision in this country is that the only supportive relationships pregnant Latina women are more likely to establish in their encounters in the clinical settings is with the lay health workers who are indigenous to their community and share the same highly personal approach to social relationships.

Several chapters in this book present *personalismo* and *familismo* as requirements for successful provider-consumer relationships in Latino communities and the basis for the potential contribution of *promotoras* to improving health outcomes in the U.S. Latino population. Cardoza Clayson and her writing partners in Chapter 18 noted that California-based *promotoras,* like their counterparts in Latin American countries, work in communities to make health services accessible to those unreachable by system structures because of cultural and class differences. An interesting insight from their description is the underlying belief of the U.S. health care system that the *promotoras* model will adapt to the existing bureaucratic structures and in some cases become part of the feeding or case-finding activities. This, of course will undermine their valuable natural role as educators, advocates, and promoters of family-oriented approaches to health and health care. Among the assumptions of the U.S. system that are not holding true, as the authors so eloquently assert, is the expectation that *promotoras* will eliminate all the access barriers presented by the existing structure of health and human services. In addition, the perception of a cost-saving strategy to have Spanish language capacity without having to hire professional staff to serve the needs of Latinos also is not proving to be correct.

Reductionism in the role of the *promotoras* as community builders through sustenance of social relationships is the result of biomedical models of health promotion and community health education guided by organizational cultures oriented toward individual behavior rather than social change. Consequently, programs are naturally disconnected from the context of people's actions and their collective experiences with the social, cultural, economic, and political conditions. Addressing the limitations of biomedical approaches to health promotion, several chapters in this book present and/or suggest community development interventions that nurture the development of critical consciousness as a human capacity to take control over one's health and well-being. In the words of Minkler and Wallerstein, this process "comes only through social analysis of conditions and people's role in changing those conditions" [39] and it is aimed at building personal and collective capacity. Some of our collaborators on this book believe that the most appropriate theoretical framework and methodology to engage people in their own course of action for capacity building are Freire's models for popular education and popular culture interventions that have been tested since the 1970s in Latin America and other developing regions of the world. A common critique of these models is their inability to produce immediate results as often expected by program evaluators and funders who have very little understanding that the Freirian methodologies view behavior as a human response to environmental conditions developed over long periods of time and are aimed at long-term results. It is in this context that we consider the skepticism about program outcomes expressed by Gil in Chapter 2 [19] and the frustration with the superficiality of some education interventions under the claim of Freirian guidance that Carrillo [26] raises in Chapter 19.

Poetas and Other Promoters of Health through Culture

Supported by the ancient Latin American tradition of lyrical improvisations by street *trovadores* (troubadours), *cantores* (street singers), and *declamadores* (poetry reciters) to problematize social and economic conditions surrounding their lives and the writings of Paulo Freire on cultural action and conscientization [40], Latin American health promoters have been acting on the meaning of the common expression in Spanish, *la cultura cura* (the culture heals), a symbol of the therapeutic effects attributed to music, poetry, and drama throughout centuries. Sometimes called theater of the oppressed and aimed at promoting social change among the most disenfranchised segments of the population, improvizations take place in the street and other public spaces as dramatic representations of people's daily lives and are often interactive motivating spectators. Valente and his colleagues in Chapter 10 describe an example of how this type of street theater is used to address misinformation about family planning in a Peruvian community [41]. As in many other Latin American countries, Peru has a long history of street theater for popular education and recreation. These popular artistic productions reflect the sentiments and feelings of many individual members of a community in one single narrative, transforming personal cognitive maps into public expressions of the collective experience in which spectators can see themselves, their own drama, and the possibilities for change in the performance of the protagonists. Indeed, as Valente and coauthors assert, street theater is a valuable icebreaker to initiate public conversations about health-related topics and to promote new behavioral strategies while appealing to people's aesthetic values and desire for entertainment [41]. It is this kind of soul connectiveness that gives meaning to cultural identity that may have contributed to their finding in Peru that women were more likely to learn family planning information from street performance and act on the information than other members of the community.

The research teams led by Valente [41] and McDonald [42] suggest that street plays, poetry, and other art expressions of popular culture can effectively communicate information about very sensitive and very personal topics such as sexuality and sexual health in a context that is attuned to people's understanding of the human experience in their surrounding world. Other examples from Latin America and the Caribbean support the potential of popular culture for HIV-related work for community health education [43].

Expressions of Latin American people's art transcended the boundaries across the Americas. Indeed, manifestations of shared cultural, linguistic, and mystical histories of the community produce the kind of solidarity irreproducible by any other human interaction in Latin America. In Chapter 9, McDonald and her colleagues remind us of the long and rich history in U.S. Latino communities of the development of lyrics for music, poetry, and drama to promote social consciousness and advocacy for social action [42]. In Chapter 12, Chávez and

Dorfman list several plays (i.e., love and pain, *pesadilla familiar*) aimed at preventing domestic violence that were observed while examining Spanish television news in California [29]. Today it is not uncommon to see artistic expressions of health promotion that make it from the streets to the television and radio. Some examples are the Welfare poets in New York City and the *Pleneros de la Salud* in Chicago. Local poets, musicians, and actors use their cultural platforms to communicate messages about HIV prevention and sexual health protection in Spanish. Communicating information about sexuality, sexual health, and sexual health protection in a context that is attuned to people's understanding of the social experience in their surrounding world is a challenge that artistic expressions of popular culture can effectively address without the social stigma of other public forums.

Notwithstanding the cultural distinctions underlying the social function of mass media as a vehicle for popular but subordinate cultures in Latin America versus a vehicle for the popular dominant culture in the United States [44], most Spanish-speaking *locutores y reporteros* (radio and TV broadcasters) in the United States continue the legacy of media advocacy. According to Chávez and Dorfman in Chapter 12, their high sense of social responsibility make Latino broadcasters natural supporters of media campaigns designed to increase knowledge and awareness about health related topics and/or to mobilize residents for community health actions [29]. Within this context, it is not surprising that the authors observed that *reporteros* of Spanish language television news in California provide more in-depth coverage of the social implications of events than similar programming in English.

Two chapters in this book offer examples of media interventions linked to telephone help lines. Chapters 11 and 19 describe the combination of mass media and interactive telephone lines to promote health and provide information. In Chapter 19 Carrillo presents an HIV prevention government-sponsored media campaign linked to a hotline in Mexico City that included radio and TV commercials and printed materials (i.e., billboards, posters, and pamphlets) in public spaces to promote the use of condoms and sexual health protection behaviors [26]. The success of the campaign was evident in the 3,000 calls received by the hotline each month. Non-governmental organizations (NGOs) partnered with radio broadcasters to produce additional culturally specific messages in the form of *radio-novela* (radio broadcast soap opera) that was reinforced by community outreach workers who provided personal contact for direct information and counseling and access to condoms at the street level.

Spanish language radio interventions also have been conducted in Latino communities located on the east and west coasts of the United States. Anderson and Huerta in Chapter 11 describe a radio intervention tied to a telephone help line for interactive counseling and advice called *La Linea de la Salud* targeted at two metropolitan areas, Washington, DC-Baltimore, MD and San Francisco-Oakland, CA., where immigrants from El Salvador, Peru, Bolivia, and Mexico

have settled [45]. The Spanish radio programming worked simultaneously with a telephone help line to provide information on the prevention, control, and treatment of cancer and other chronic conditions. For immigrants, particularly those undocumented, who are isolated from other structures of communication, radio health programming not only contributes to increase awareness, but also serve as a mechanism for persuading, modeling, and reinforcing behavioral changes. The film developed by the *Cuidaremos* Project described by Loring and Garcia-Walters [30] in Chapter 14 is an example of a media product that approaches breast health education within the context of Latino cultural norms and expectations by placing basic information about self-breast examination in women's daily personal experiences with their health and health care.

SUGGESTIONS FOR THE NEW GENERATION OF RESEARCH AND INTERVENTIONS

In closing this introduction, we propose that the new generation of sexual and reproductive health research addresses transnational factors affecting partnerships or couples rather than continue to examine the experience of a single partner in the dyad on each side of the U.S. border. Such an agenda must be conceptualized within the spheres of influence targeted by ecological models, aimed at addressing the culture of social relations in Latino communities across the borders of the Americas through popular education and popular culture methodologies and brokers such as *promotoras de la salud.*

Public health and social science's fixation with "machismo" as an explanation for cultural and behavioral expressions of sexuality by U.S. Latinos and Latin American men, albeit very little research, deserves a critical examination. The cultural construction of manliness in Latin America represents an amalgamation of cultural scripts, norms, skills, and behaviors that is far from static. Understanding it will be to the benefit of our goals in sexual and reproductive health. There was a time when it was important to focus on women only to address specific research questions and reexamine theoretical frameworks developed without the female experience and perspective. Today we have volumes of data and text on women's experience with sexual decision-making and negotiation and our greatest challenge is our limited understanding of a *couple's* relations with each other and the structures in the other spheres of social influence. Progress in reproductive and sexual health protection in U.S. Latino and Latin American populations depends on how well we can understand and influence change in cultural scripts for learning to perform gender-specific behaviors and for transmitting gender ideology. A circular multi-level social ecological model [46, 47] that places a woman at the center of spheres of primary social relationships with her male partner, the family, and other social structures and captures the multidimensional interaction of influence on individual and collective behavior is

recommended as the best strategy to achieve the level of comprehensiveness of the "complex whole" in sexual and reproductive health in U.S. Latino and Latin American settings.

Similar to the arena of research, we need a new generation of comprehensive interventions aimed at engaging Latinas/os and Latin American women and men in a process of reflection on the acquisition and transmission of knowledge related to the human body and sexuality. In this type of intervention, examination of cultural constructions (ideology, symbols, codes, meaning, and context of power and social control) must be based on the premise that people are actors in their own education process. The goal is to build the capacity of *promotoras de la salud* and promoters of health through cultural manifestations to thin the layers of the cultural template sustaining values and symbols that prevent the adoption of protective sexual and reproductive health behaviors. The best example of this in this collection of case studies is the culture of pelvic organs as a barrier for preventive measures for negative pregnancy outcomes, STIs, and cervical cancer. Pelvic organs, especially the vagina, are one of the most powerful taboo symbols of the legacy left by the Spanish Catholic colonization process in Latin America that still nourishes patriarchal systems of human organization that we see reflected in some of the gender scripts presented in this book. In a culture of highly social connectiveness and tenuous delineations of personal privacy, the restriction of the pelvic organs to selected males serves to maintain gender differences when other distinctions of personal privacy are disappearing. Restrictions give privilege to female body parts involved in human reproduction and access to body organs that sexual prudery and modesty have traditionally restricted to a private relationship, and in turn elevate the social status of men in the community. This helps to explain why, since pre-colonial times, Latin American women involved in birth attendance (*parteras*) have been attributed sacred powers that facilitate fertility and procreation among human beings [48] and why their significant roles have survived to the present time as discussed earlier. That in this gendered cultural context, pregnancy and birth are outcomes of the function of the vagina may also help to explain Rice's finding that Latin American and Caribbean men determine the number of pregnancies a woman has despite the fact that she shoulders the primary responsibility for having and raising the children [21].

Popular education and popular culture interventions that bring together several theories aimed at human liberation, self-reliance, and self-determination can contribute to thinning the cultural symbolic value of the "private parts" for social control of women's health behaviors in the Latin American and U.S. Latino cultures. Freirian approaches are suggested because of their strong foundations in cultural deconstruction and cognitive decolonization in Latin American contexts and emphasis on building the capacity of community residents to assume leadership in actions directed to changing social and cultural landscapes. Building personal and community capacity for *promotoras de la salud* to facilitate

education processes that digest information about the cultural landscapes of sexual behavior combined with opportunities for engagement in popular cultural activities must be the first step in any community health intervention aimed at changing interpersonal relationships in the dyad, family, and socio-cultural structures that place both women and men at risk for sexual and reproductive health problems.

It is important to remember that central to this agenda is our ability to increase people's understanding of the role of culture in the causality of health problems, as well as in the possibility for changing the conditions that affect health and well being, and of building capacity to take action at the personal and community levels. We believe that interventionists, by utilizing popular culture methodologies, will maximize their resources to reach those who have traditionally been isolated from, excluded by, or placed at the bottom of most economic, social, and political endeavors.

Manifestations of popular culture produce the kind of solidarity irreproducible by any other injection of hope in self and collective affirmation of the resilient human spirit and dignity found in this desire and aspiration. Expressions of Latin American people's tradition of lyrical improvisations transcend boundaries and are present in every U.S. Latino community. Crafters of poems, songs, and dramas touch on the cultural liminality lying in between the polarities of the human enterprise: the present and past, the imagined and the real, life and death, joy and tribulations. And it is in this open space of the lyrical narrative that health promoters and health educators can present new ideas, recreate new behaviors, and expand the scope of knowledge necessary to address sexual health in Latin America. This seems to be the one of the best hopes to answer the call for a new sexual health discourse with relevant gestural symbols for protection [49] advocated by Latin American women's organizations that is being echoed in the United States.

Furthermore, the long history of promoting social and cultural change in Latin America through mass communication [50] is yet another tool at the disposition of U.S. Latino health interventionists in sexual and reproductive health. Needless to say, radio *locutores* and TV *reporteros* are community assets that can contribute to develop audio and audiovisual productions for health promotion and education. Both Spanish television and radio provide a forum for bringing into the community view sexual and reproductive health issues affecting the U.S. Latino population: a channel for initiating public discussion as well as for influencing public health policy agendas in a manner that is consistent with people's cultural maps for making sense of their own realities. Linkages between visual portrayals and audio messages communicated through the broadcasting technology, combined with interactive modes of personal communication such as telephones help lines, are consistent with the highly interpersonal cognitive styles of Latinos who are not very likely to be passive recipients of information without reacting to it immediately.

Finally, we must echo the call for meaningful community participation in research and intervention suggested in some of the chapters of this book. Ecological models that require multiple spheres of intervention, combined cultural methodologies, and above all, the active collaboration of community residents will build capacity for the promotion of sexual and reproductive health for all. Researchers and interventionists will be more likely to increase their ability to obtain meaningful cultural data in the primary language and communication styles of the participants and base their intervention on the cultural constructions of people to be reached rather than on their own knowledge tradition and scripts. Local community residents and program participants will benefit from the development of skills and competences they can use for promoting sexual and reproductive health and transfer these to other areas of community life.

REFERENCES

1. *The World Bank Report,* Washington, D.C., 2001.
2. *Dying for Growth,* J. Y. Kim et al. (eds.), Common Courage Press, Monroe, Maine, 2000.
3. *PAHO Annual Report: 2000,* Pan American Health Organization, Washington, D.C., 2001.
4. *World Health Report: 1999,* World Health Organization, Washington, D.C., 2000.
5. First Glimpses from the 2000 U.S. Census, *Population Bulletin, 56*:2, Population Reference Bureau, June 2001.
6. *The AIDS Crisis among Latinos: A Report from the First Unidos Para La Vida Summit,* May 4, 1998, Harvard AIDS Institute, Cambridge, 1998.
7. T. Díaz et al., AIDS Trends among Hispanics in the United States, *American Journal of Public Health, 83*:4, pp. 504-509, 1993.
8. J. Lawrence and R. Crosby, HIV/AIDS in Puerto Rico and the Caribbean: Current Status and Future Directions, *Boletín de la Asociación Médica de Puerto Rico, 91*:1-6, pp. 22-28, 1999.
9. N. Romero, M. Weeks, and M. Singer, Much More than HIV: The Reality of Life on the Streets for Drug-Using Sex Workers in Inner City Hartford, *International Quarterly of Community Health Education, 18:*1, pp. 107-119, 1998-1999.
10. M. Burgos, B. Reininger, D. L. Richter, A. L. Coker, M. Alegría, M. Vera, and R. Saunders, Sexually Transmitted Infections among Street-Based Female Adolescent Sex Workers in Puerto Rico: Implications for Community Health, *International Quarterly of Community Health Education, 20*:3, pp. 253-264, 2000-2001.
11. R. Wilcher, L. Gilbert, C. Siano, and E. M. Arredondo, From Focus Groups to Workshops: Developing a Cultural Appropriate Cervical Cancer Intervention for Rural Latinas, *International Quarterly of Community Health Education, 19*:2, pp. 83-102, 1999-2000.
12. E. Acuña-Lillo, The Reproductive Health of Latinas in New York City: Making a Difference at the Individual Level, *Bulletin, Centro de Estudios Puertorriqueños,* 1998.
13. *2002 World Population Data Sheet,* Population Reference Bureau, Washington, D.C., 2002.

14. *The AIDS Crisis among Lations,* A Report from the First Unidos Para la Vida Summit, May 4, 1998, Harvard AIDS Institute, 1998.
15. R. R. Alvarez, Changing Patterns of Family and Ideology among Latino Cultures in the United States, T. Weaver (ed.), *Handbook of Hispanic Cultures in the United States,* Arte Publico Press, 1994.
16. A. Chaviro Prado, Latina Experience and Latina Identity, T. Weaver (ed.), *Handbook of Hispanic Cultures in the United States,* Arte Publico Press, 1994.
17. M. Minkler, *Community Organizing and Community Building for Health,* Rutgers University Press, New Brunswick, New Jersey, 1997.
18. J. Bertrand, V. Ward, and F. Pauc, Sexual Practices among the Quiche-speaking Mayan Population of Guatemala, *International Quarterly of Community Health Education, 12*:4, pp. 265-282, 1991-1992.
19. V. Gil, Empowerment Rhetoric, Sexual Negotiation and Latina's AIDS Risk: Research Implications for Prevention Health Education, *International Quarterly of Community Health Education, 18*:1, pp. 9-27, 1998-1999.
20. C. Oliveros, G. Marquis, R. Bartolini, G. Ormsby, and E. Rudatsikira, Maternal Lactation: A Qualitative Analysis of the Breastfeeding Habits and Beliefs of Pregnant Women Living in Lima, Peru, *International Quarterly of Community Health Education, 18*:4, pp. 415-432, 1998-1999.
21. M. Rice, Socio-Cultural Factors Affecting Reproductive Health, *International Quarterly of Community Health Education, 12*:1, pp. 69-80, 1991-1992.
22. P. Erickson, Cultural Factors Affecting the Negotiation of First Sexual Intercourse among Latina Adolescent Mothers, *International Quarterly of Community Health Education, 8*:1, pp. 121-137, 1998-1999.
23. S. Guendelman and S. Witt, Improving Access to Prenatal Care for Latina Immigrants in California: Outreach and In-Reach Strategies, *International Quarterly of Community Health Education, 12*:2, pp. 89-106, 1991-1992.
24. M. I. Torres, R. Tuthill, S. Lyon-Callo, C. M. Hernández, and P. Epkind, Focused Female Condom Education and Trial: Comparison of Young African American and Puerto Rican Assessments, *International Quarterly of Community Health Education, 18*:1, pp. 49-68, 1998-1999.
25. H. Amaro, A. Raj, E. Reed, and K. Cranston, Implementation and Long-Term Outcomes of Two HIV Intervention Programs for Latinas, *Health Promotion Practice, 3*:2, pp. 245-254, 2002.
26. H. Carrillo, Another Crack in the Mirror: The Politics of AIDS Prevention in Mexico, *International Quarterly of Community Health Education, 14*:2, pp. 129-152, 1993-1994.
27. D. Buchanan, E. Apostol, D. Balford, C. Claudio, J. Marinoff, N. O'Hare, M. Rodriguez, and C. Santiago, The CEPA Project: A New Model for Community Based Planning, *International Quarterly of Community Health Education, 14*:4, pp. 361-377, 1993-1994.
28. Z. Cardoza-Clayson, X. Castañeda, E. Sanchez, and C. Brindis, The Interception of Culture, Health and Systems in California, *International Quarterly of Community Health Education, 19*:4, pp. 375-389, 1999-2000.
29. V. Chávez and L. Dorfman, Spanish Language TV News Portrayals of Youth and Violence in California, *International Quarterly of Community Health Education, 16*:2, pp. 121-138, 1996-1997.

30. K. Loring and E. Garcia Walters, Cuidaremos: The HECO Approach to Breast Self-Examination, *International Quarterly of Community Health Education, 1*:2, pp. 125-133, 1990-1991.
31. B. Faust, When is a Midwife a Witch?: A Case Study from Modernizing Maya Village, P. Whelehan (ed.), *Women and Health,* Bergin and Garvey Publishers, Granby, Massachusetts, 1988.
32. K. O'Rourke, Maternal Exhaustion as an Obstetric Complication: Implications for TBA Training, *International Quarterly of Community Health Education, 15*:4, pp. 395-404, 1994-1995.
33. I. Estrada-Portales, De Vuelta a los Origenes del Nacimiento, *Perpectivas: Revista de la Organización Panamericana de Salud, 6*(2), 2002.
34. L. Rendón, A. Langer, and B. Hernández, *Boletín de la Oficina Sanitaria Panamericana, 115*:6, 1993.
35. A. M. Hernández and E. Casanova, Las ONG que Trabajan sobre el SIDA y las Mujeres, S. González (ed.), *Las Organizaciones No Gubernamentales Mexicanas y la Salud Reproductiva,* Imprenta El Colegio de Mexico, pp. 97-123, 1999.
36. B. Reyes Nevares, Promotoras Sociales en el Centro de la Vida Comunitaria, *FEM 19*:150, p. 48, 1995.
37. M. Minkler and K. Cox, Creating Critical Consciousness in Health: Applications of Freire's Philosophy and Methods to the Health Care Setting, *International Journal of Health Services, 10*:2, pp. 311-322, 1980.
38. S. Schensul, Science, Theory and Application in Anthropology, *American Behavioral Scientist, 29*:2, pp. 164-185, 1985.
39. M. Minkler and N. Wallerstein, Improving Health Through Community Organization and Community Building (Chap. 12), K. Glanz, F. Lewis, and B. Rimer (eds.), *Health Behavior and Health Education: Theory, Research and Practice,* Jossey-Bass, San Francisco, 1997.
40. P. Freire, Cultural Action for Freedom, *Harvard Education Review, 40*:3, pp. 452-477, 1970.
41. T. Valente, P. Poppe, M. E. De Briceño, and D. Cases, Street Theater as a Tool to Reduce Family Planning Misinformation, *International Quarterly of Community Health Education, 15*:3, pp. 279-289, 1994-1995.
42. M. McDonald, G. Antunez, and M. Gottemoeller, Using the Arts and Literature in Health Education, *International Quarterly of Community Health Education, 18*:3, pp. 269-282, 1998-1999.
43. L. E. Santiago, Theater of Life: Theory, Method and Practice, *Puerto Rico Health Services Journal, 19*:1, pp. 77-82, 2000.
44. G. Yudice, The Globalization of Culture and the New Civil Society, S. Alvarez, E. Dagnino, and A. Escobar (eds.), *Cultures of Politics, Politics of Cultures: Re-visioning Latin American Social Movements,* Westview Press, 1998.
45. D. M. Anderson and E. Huerto, Developing and Evaluating Radio-Linked Telephone Helpline for Hispanics, *International Quarterly of Community Health Education, 19*:4, pp. 341-351, 1999-2000.
46. J. Sallis and N. Owen, Ecological Models (Chap. 19), K. Glanz, F. Lewis, and B. Rimer (eds.), *Health Behavior and Health Education: Theory, Research and Practice,* Jossey-Bass, San Francisco, 1999.

47. K. McLeroy, D. Bibeau, A. Steckler, and K. Glanz, An Ecological Perspective of Health Promotion Programs, *Health Education Quarterly, 15*:1, pp. 351-377, 1988.
48. I. Silverblatt, *Moon, Sun and Witches: Gender Ideologies and Class in Inca and Colonial Peru,* Princeton Press, pp. 29-31, 1987.
49. Irma Palma, *No Hay un Discurso que Facilite et Uso del Condón, Cuadernos Mujer y Salud,* Red de Salud de Mujeres LatinoAmericanas y del Caribe, 1998.
50. J. R. Finnegan and K. Viswanath, Communication Theory and Health Behavior Change: The Media Study Framework, K. Glanz, F. Marcus Lewis, and B. Rimer (eds.), *Health Behavior and Health Education: Theory, Research and Practice,* Jossey-Bass, 1997.