
Article

Qualitative Research in Latin America: Critical Perspectives on Health

Francisco J. Mercado-Martínez
University of Guadalajara
Guadalajara, Jalisco, Mexico

© 2002 Mercado-Martínez. This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/2.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Abstract

Qualitative research is a field of knowledge and practice that is expanding continuously throughout the health area in Latin America. However, few studies have focused on evaluating qualitative research on health in the region, or on evaluating its theoretical or operational characteristics. This study examines health research in Latin America that has a critical perspective and the way it views qualitative research. Three trends or schools of thought in the health field in Latin America were identified that had both a critical perspective and that use qualitative research: social medicine, participatory action research, and sociocultural studies. Each has been described, including the ways they incorporate qualitative research. Examples of empirical studies are presented, and some criticisms are discussed.

Keywords: Qualitative research in health, critical perspectives, Latin America

An earlier version of this study was presented at the II International Conference for Qualitative Methodologies. International Institute for Qualitative Methodology. Edmonton, Alberta, Canada, February 23—25, 2001.

Acknowledgments: Critical comments received from colleagues who read an earlier version of this article were extremely helpful. Howard Waitzkin made pertinent observations and is to be thanked for his assistance. Thank you to Trudy Balch for translating the article into English.

Introduction

Until recently, social science research and health research in Latin America followed two conflicting paradigms: positivism and Marxism. Positivism was dominated by a functionalist perspective, while Marxism was dominated by an economic-structuralist model. Despite their differences, however, both paradigms rejected interpretive theories and methodologies (for example, symbolic interactionism, phenomenology, and ethnomethodology) as having validity for the study of social and health phenomena (García, 1983). Qualitative research, methodologies, and techniques were usually ignored, rejected, or belittled by the scientific community, no matter the theoretical bent, subject specialization, or discipline involved.

It was not until the early 1980s that qualitative research—in health and in other fields—began to gain acceptance in Latin America. A variety of paradigms and approaches have been used in this region, but all have emphasized certain critical perspectives and—to a lesser degree—phenomenology and symbolic interactionism (Gastaldo, Mercado, Rasmasco, & Lizardi, in press).

To date, both individual researchers and research groups using qualitative methods have made significant contributions in certain areas and topics of health research (Denman & Haro, 2000). Yet until now there has been no systematic evaluation of their work, nor has there been any examination of their theoretical and methodological approaches, topics studied, or experiences in various disciplines, including health. Thus, the purpose of this article is to examine the most important trends in health research in Latin America that have a critical perspective, and to examine the way they view qualitative research.

The trends: Similarities, differences, and assumptions

Given the numerous connotations of the term "critical perspective" among the various sciences, disciplines, and authors included directly or indirectly in this article, we shall understand it as an "umbrella concept." Under this umbrella converge research positions influenced by Marxist and neo-Marxist thought, conflict theory, social critical theory, postmodernism, and poststructuralism. In other words, "critical perspective" denotes a group of approaches that emphasize questioning the status quo. In addition, as noted by Kincheloe and McLaren (2000), these approaches attempt to confront injustice in a particular society or in public life within society.

We shall understand the term "trend" in this article to mean a tendency within a school of thought that appears during a specific time period. It can also refer to the theoretical orientation of a group of people associated with that time period, as well as their ideas, activities, and actions (Moliner, 2000)

Three trends were found in health research in Latin America, all with a critical perspective, that incorporated qualitative methods.¹ These are social medicine, participatory action research (PAR), and sociocultural studies.² Each involves different theoretical, practical, and methodological approaches that are relatively independent of one other. Each has developed differently, and each involves participation by different types of professionals.³ What is most important, however, is that each trend tends to engender a feeling of belonging or identification. We also recognize that certain studies and/or authors may combine elements of two or three trends, which often blurs the boundaries between them. They may share certain characteristics and even have a common background. However, each trend has emerged and developed independently, and all are likely to follow separate trajectories.

Although various types of health professionals—as well as social sciences and humanities professionals—are active in the three categories described, we see the most activity among social scientists, physicians, and psychologists. Nurses, dentists, nutritionists, and social workers—who dominate in terms of numbers—have played a marginal role in all countries but Brazil, where nurses have made notable contributions. We should note, however, that some practitioners have moved from one category to another, while others have tried to combine categories upon acknowledging the criticisms to which they have been subject.

Finally, qualitative research in health has not been conducted on an equal basis in Latin America: rather, it is concentrated in certain countries, particularly Argentina, Brazil, Chile, Ecuador, Mexico, and Venezuela (Mercado, Villaseñor, & Lizardi, 2000). This pattern appears to play out in the trends analyzed in this article, according to the data presented below.⁴

This article cannot come close to presenting a comprehensive view of the qualitative research contributed by each trend. The studies referred to here simply serve to illustrate the points presented. In addition, we

wish to state our agreement with Menéndez (in press), in his assertion that inconsistencies are frequently observed between the theoretical frameworks and the data of qualitative, empirical studies published in Latin America. Although clearly important, this topic will not receive a comprehensive review in this article.

Social medicine

For decades, social medicine has had an important influence on research, teaching, and medical practice in Latin America (Waitzkin, Iriart, Estrada, & Lamadrid, 2001a). It comprises a set of ideas that developed in the early twentieth century and later spread throughout the region, evolving by form as well as content. Thus, we see a number of concepts that have different names but very similar content, among them "collective health," "critical epidemiology," and "community social epidemiology."⁵ However, all of them emphasize social issues, in contrast to such disciplines as public health, community medicine, and epidemiology.

Most authors agree that social medicine began in mid-nineteenth century central Europe. In general, they emphasize the pioneering works of Rudolph Virchow in Germany, who used his studies of the impact of social conditions on health and illness to support his calls for change. Works by other nineteenth- and early twentieth-century authors are cited as well, especially Frederick Engels and his studies of working-class living conditions in England.

Multiple factors have stimulated the introduction and growth of social medicine in Latin America throughout the twentieth century, especially since 1950. Particularly important are the Cuban and Nicaraguan revolutions, and many regional social and political movements, such as liberation theology and the government of Salvador Allende in Chile. In all cases, the key substratum has been the poverty, malnutrition, and unsatisfactory living conditions long experienced by most of the population.

According to Waitzkin, Iriart, Estrada, and Lamadrid (2001b), social medicine generally emphasizes a critical focus that draws on the social sciences to analyze health and illness. Moreover, it reflects a broad spectrum of academic and political approaches that have become obligatory both for analyzing health conditions in Latin America and for exploring public-health alternatives vis-à-vis current government policies. However, Marxism, neo-Marxism, and other similar political and social theories have dominated, which is why social medicine tends to be critical of health conditions, health services, health research and society in general.

Many academics involved in social medicine have made important theoretical contributions, although important work has also been done at the empirical level.⁶ In general, the goals and practice of social medicine have centered on four main areas: the social production of health and illness, the social organization of health services, medical knowledge, and the training of health care professionals. In addition, considerable research has been done on the impact of social and governmental policies relating to health and medical care, as well as on the causes of health-illness, work and its effects on health and illness, and epidemiological profiles by class, social group, and type of society (Nunes, 1986). The categories used most often are means of production, social class, productive and reproductive process, and work process. As we can see, social medicine involves a perspective that focuses on the historical and macro-social causes of health-illness phenomena.

Social medicine practitioners generally emphasize social commitment; that is, they emphasize the need to combine clinical medicine—as well as scientific and intellectual activities—with political activism. Moreover, they tend to give considerable recognition and appreciation to political praxis, understood as the combination of theory and practice in daily life: this is why social medicine usually intertwines

professional medical practice with political activity. For example, political praxis can translate into collaboration with trade unions, community organizations, leftist political parties and governments and, in some cases, with movements aligned with guerrilla groups. Although social medicine practitioners tend to work in universities, they often edge over into government or international agencies, such as the Pan American Health Organization.⁷ Nor is it unusual for social medicine practitioners to be unemployed because of their academic or political stance, with Chile and Argentina being paradigmatic in this regard.

Traditionally, social medicine practitioners in Latin America rarely used qualitative research methods and in fact were rather critical of them (García, 1978; Breilh, 1995). Only recently has much interest arisen, with the focus being on very specific issues. Yet despite such criticisms, many practitioners are using such qualitative approaches as participatory methodologies or discourse analysis.

Since the 1980s, a growing number of academics involved in social medicine have emphasized the need to evaluate its theoretical assumptions, methodologies, and techniques. Some practitioners even believe that social medicine should not only be more open to other theoretical perspectives, but also examine the appropriateness of incorporating other research strategies, such as ethnography, case studies, and grounded theory. Although certain social medicine practitioners have rejected efforts to move in this direction, there have been important advances on various fronts, just as is happening with qualitative research itself.

On a theoretical level, academics such as Breilh propose to analyze the qualitative-quantitative debate as part of a broader-based conflict; that is, at an ideological level. Breilh states that positivism tends to be criticized by various interpretive theories. However, even when he is in agreement, Breilh does not forget that interpretative orientations can also be subject to criticism, both for being over-idealistic and because he believes they form the basis of a hegemonic perspective. For Breilh, the issue of what techniques are used can also be understood on another level, formulated as follows: "There is no single qualitative science, nor is there a single quantitative science, nor are there separate qualitative and quantitative methods. There is a need to incorporate, dialectically, techniques with a capacity for studying qualitative data, and others with a capacity for quantitative data." (Breilh, 1995)

No single theoretical perspective or methodological design for qualitative research has been used in social medicine. One of the most recognized is the "participatory methodology" connected to the Italian "Worker Model," which has been used in numerous studies, particularly those involving health and the work process (Laurell, 1984; Laurell, Noriega, Martínez, & Villegas, 1992). To give one example, Echeverría (1992) favors the use of participatory methodology for studying such topics as work and health risks. According to her point of view, researchers who have a critical orientation must identify the main characteristics of the work process, the way it functions, and the health risks occurring at different stages. They must also formulate questions designed to identify the most important issues. Thus, workers play a key role in identifying the most important labor-related issues, which means that their participation must be more than occasional. Harking back to the Italian Worker Model once again, Echeverría concurs with the idea that the researchers know how and where to measure, but the workers know when to measure. She then acknowledges that the techniques used may vary, depending on multiple factors. For example, individual interviews may be more useful for a study of the fishing process, while group interviews may be more helpful in studying the manufacturing process.

Although social medicine practitioners traditionally were reluctant to use qualitative research, they have more recently begun to use it in certain areas. Today, for example, social medicine practitioners who study such topics as gender, popular participation, or emerging illnesses such as AIDS commonly use qualitative methodologies or techniques, either to obtain data or to analyze it. At the same time, however, challenges and difficulties arise that cannot be overlooked. We cannot lose sight of the urgent discussion

that focuses on broadening the theoretical compatibility of neo-Marxist, post-structuralist, critical-interpretive, or feminist positions, which recognize the utility of qualitative research, as opposed to the orthodox Marxist thought that dominated social medicine for decades and still persists in some circles. In this sense, one of the most formidable challenges is how to articulate the subjective dimension and the symbolic processes, at the micro-level, within a framework that traditionally focuses on macro-social or structural phenomena. (Minayo, 1997). Also unresolved are issues relating to the relevance of techniques and procedures used to obtain and analyze the data in many of these studies. Rarely has there appeared in these studies a "black box" that can specify the steps and strategies used in managing and analyzing data (Mercado, 2000).

Participatory action research

Another critical trend in the health field is closely linked to the popular, campesino, and indigenous sectors in Latin America, and is known by the generic term of "participatory action research." This trend has support from a variety of groups, particularly nongovernmental organizations. These organizations have important internal differences that are expressed in a number of ways; here we shall review only that information related to health research. Many terms are currently in use for this trend, of which we can cite "participatory research," "action research," "alternative research," "participatory diagnostics," and "grass-roots research." In this article we shall use the term "participatory action research" (PAR) because it has attracted the broadest consensus and is used most widely throughout Latin America.⁸

Numerous sources of inspiration underlie the origin and spread of PAR. Indeed, researchers who work in this area do not fully agree on where its origins lie. Nevertheless, and not in order of importance, most emphasis tends to fall on the contributions of Paulo Freire, in his theory of popular education and conscientization (Freire, 1975), followed by Fals Borda (1982), Brandao (1982), and Martín Baró (1983). The work of these authors all combines with Latin America's countless political, social, and religious movements, certain popular movements, and an intellectual climate critical of positivism, which was nourished by social psychology and even orthodox Marxism and dependency theory. Also important was a questioning attitude toward the social sciences and the traditional role played by academics, including many who exhibited a critical perspective, as would be typical of those involved in social medicine.

PAR does not focus primarily on health-related issues. Rather, it tends to focus on projects involving groups, sectors, and specific communities, all within the framework of broader programs related to manufacturing, consumption, or education. These broader programs tend to focus on social change or solving specific needs. Thus, it is not unusual to encounter participants whose backgrounds lie in a variety of disciplines, as well as participants from different academic and political backgrounds. Moreover, the participants are unlikely to focus on the same issues as do academics; in fact, they tend to keep a certain distance from academia.

Moreover, PAR opposes the positivist or traditional model of scientific research as much as it does certain interpretive models so in vogue among intellectuals. This opposition takes a variety of forms, which include questioning and rejecting the dominant role usually played by the researcher during the research process, as well as the researcher's dominant role in defining the problem to be studied, the unequal relationships established by researchers with the participants or informants in the study, and the fate of the results (Hersch, 1987). Regarding the latter point, Hollanda (in press) criticizes traditional practice among researchers and defines his own position as follows: "We do not want to write papers destined for filing cabinets or in order to show off; [rather,] we want our work to coincide with popular needs." Another characteristic of PAR is its emphasis on recovering the perspective and action of the subjects involved in the study, both in production of knowledge as well as transformation of reality. That is, the participants or informants are understood less as objects of study than as social actors capable of interpreting and

transforming the world. It follows that active participation by the population in the process of producing and applying knowledge is a top priority. Yet PAR practitioners do not make a commitment to the entire population. Instead, the groups receiving the most interest and attention are "the majority"; that is, the dispossessed, the poor, or those who are excluded socially and economically. In sum, the focus is on the majority of Latin America's population.

In addition, PAR is characterized by the recognition that problems of health and public health, as well as changes to be implemented, are not usually regarded as purely individual matters. Rather, they are understood within the framework of the material and social conditions of individuals, groups, and the community itself. In this regard, advocates of PAR occupy a position similar to that of social medicine.

Finally, the main focus of PAR is not publication of results or presentation of its theoretical, epistemological, or methodological bases. Rather, it is to transform the social and public-health environment. This explains, in part, PAR's scant theoretical production both in health and in other areas. The lack of interest in theory can also be seen in the tendency to combine participatory techniques for obtaining data, and in the minimal or nonexistent description of the methodology used in research projects, despite the participation of numerous social actors in the research process.

PAR does not have an explicit position regarding qualitative research. However, practitioners are usually favorably disposed toward it, or at least toward the use of certain qualitative strategies and tools. Interest in learning about and researching the perspectives of the community or of the most disadvantaged or socially excluded groups has made PAR practitioners regard qualitative research as a valuable research strategy. Thus, their projects usually incorporate various qualitative techniques—particularly the various types of popular participation, case studies, and ethnographic design—for gathering data.

A study carried out in Guatemala may provide a useful example of the issues that concern PAR practitioners. The goal of Orozco (2000) was to analyze the epidemiological, environmental, and socioeconomic condition of the population, as well as to explore supply and demand relating to health services. The methodology described involves a process that results in a research project different from the conventional academic model, above all in its inclusion of various social actors. According to the author, the study involved eight government agencies and twenty-one nongovernmental organizations, more than one hundred communities in twelve counties, nineteen health-promotion workers, and ten consultants. Data was obtained from group interviews and community workshops conducted by community health workers, as well as from review of secondary sources and interviews with health personnel. Orozco does not explain the issues, mechanisms, and problems that participation by these actors entailed, nor does she discuss the relationships established between the research team and the consultants.

A number of critical observations have been made with regard to participants in studies based on PAR. In addition to scant written dissemination of the results, there is practically no data concerning the support, type, methods, modalities, and characteristics of the strategies used by participants in the process. As stated previously—and in contrast to social medicine—participatory action researchers' commitment to the population and to research practice is usually accompanied by a certain lack of concern for or even omission of theoretical issues. Moreover, not enough data exist regarding the advantages of and obstacles to community participation in PAR, as well as successes and failures. Because qualitative research focuses primarily on the perspective of the study population and on social change, it would seem to be an ideal strategy for PAR projects. However, little is known about how to develop relationships with these sectors or how to develop a work plan to advance these concerns.

Sociocultural studies

The two trends discussed previously—social medicine and PAR—have important internal differences. However, practitioners in both areas tend to downplay these differences whenever they discover any basic internal similarity, because they identify strongly with whichever trend they follow. Those who follow the third trend, which we have designated as "sociocultural studies," are unlikely to perceive themselves as members of a single group, nor are they like to concur intellectually with other authors in the same area. Even so, there are a number of reasons for grouping them within the same category.

The field of sociocultural studies is closely related to the academic world, and its origins lie in educational processes implemented in Latin America beginning in the 1980s. The authors included here agree on a number of points: they are opposed to positivism and Marxist structuralism, they are skeptical of works written by PAR practitioners, and they are also critical of certain interpretive approaches. Moreover, they draw on very diverse disciplines. However, sociocultural studies practitioners have also shown great interest in recent contributions from the social sciences, particularly those connected to certain critical perspectives.

All practitioners of sociocultural studies adhere in different ways to a series of theoretical positions that, in recent decades, have been widely disseminated in developed countries. Particularly important is the renewed attention to the theoretical contributions of certain European thinkers, such as Foucault, Derrida, Vygotsky, Bakhtin, Habermas, Merleau-Ponty, and Bourdieu, to mention those cited most frequently. The theoretical perspectives used most often are postmodernism,⁹ poststructuralism¹⁰ (Gastaldo, 1997), feminism¹¹ (Szas, 1997; da Silva, Lago, and Ramos, 1999), cultural studies¹² (Meyer, 2000), the cognitive social model (Alves, 1993), hermeneutics (Castro, 2000), interpretive criticism (Mercado, 1997), dialectical hermeneutics (Minayo, 1997), and social constructionism (Amuchástegui, 2000). In contrast to practitioners of social medicine and PAR, academics in the field of sociocultural studies concentrate on linking various dimensions of reality, such as micro-social and subjective aspects, with the macro-social dimension, i.e., economic and social structures.

The research topics that draw sociocultural studies practitioners tend to be among the most varied in the health field. Generally speaking, researchers in this area emphasize empirical data as well as theory. Theory appears to be one of the most important contributions of such studies, though we should not ignore those related to methodology. Topics that have been studied repeatedly from this perspective in Latin America include gender, masculinity, violence, AIDS, reproductive health, and adolescent health and its numerous related aspects, such as contraceptive practices, unwanted pregnancy, premarital sex, and abortion. It is not at all unusual for topics in sociocultural studies to attract the concern—and financing—of important first-world organizations.¹³

However, other topics also appear on the sociocultural studies agenda. These include subjective and cultural practices, otherness, reflexivity, corporality, the ethical dimension, commitment to participants, and processes of signification.¹⁴ Everything tends to be framed by concerns related to macroeconomic and social processes, such as social class, social inequality, poverty, or varying access to material, social, and symbolic resources (Grassi, Raggio, and Montes, 1996).

Sociocultural studies encompasses a generation of academics who are relatively younger than those involved in social medicine or PAR, and it also includes professionals who have studied in and/or are in close contact with educational or research institutions in the first world, particularly in English- and French-speaking countries.¹⁵ They have established and reproduce various types of relationships with researchers of such countries, but place the most emphasis on research, consulting, or financing. Thus, their academic profile is usually different from those in the two previous groups. They tend to have more

academic training, as measured by the number who have received doctorates. They are also relatively more productive, as measured both by number of publications and outside financing. Finally, they usually have more access to the support programs for researchers being implemented in a growing number of countries in Latin America.¹⁶

Concern for research and qualitative methods is an inherent part of the epistemological, theoretical, methodological, ethical, and political assumptions of sociocultural studies practitioners. Yet whatever their approach (poststructuralism, feminism, social constructionism, etc.), they all recognize the importance of qualitative data or of combining qualitative and quantitative data within the research process. Moreover, certain funders frequently impose qualitative methods or techniques on the research projects they finance. This results in a position that is not only favorable to but clearly supportive of qualitative research. All of these aspects have created a group with a certain academic weight in Latin America.

Numerous researchers in Latin America have used a sociocultural studies perspective, under the theoretical orientations mentioned previously. They have covered a broad array of topics, including the social construction of medical discourse, maternity, nursing, and chronic illnesses. With support from the Population Council, among others, Amuchástegui (2001) presents a study that barely falls within the scope of sociocultural studies: an examination of the social construction of sexuality in Mexico from a social constructionist perspective. Among other concerns, the author discusses her role as researcher and the power relationships she establishes with her informants during fieldwork, the relationship between her perspective and that of the participants, and the recognition of these participants as social analysts whose position sometimes challenges and contests that of the researcher. Amuchástegui says that she selected the qualitative method for this study because it was the most suited to researching the subjective social processes connected with the construction of meaning.

Authors whose work is based on sociocultural studies have also been subject to criticism. For example, they have been reproached for an overemphasis on academia, for a lack of commitment to the social and economic needs of the majority groups within the total population, for their "apoliticalness" in terms of having few connections with political parties and labor or workers movements, and for being recognized as outstanding academics but with little social commitment. Above all, they have been reproached for their ability to explore the world of everyday, subjective relationships but for being unaware of—or omitting or excluding themselves from—the social, economic, and historical processes of which they are a part. This also applies to the relationships they establish with participants in their studies, as well as with other social actors with whom they have contact in their daily lives.

Final considerations

The purpose of this article has been to present the principal trends in the health field in Latin America whose critical perspective includes qualitative research. A number of final considerations have developed from the findings.

Liberal, progressive, or leftist academics working in the social and health sciences have harshly criticized certain qualitative research models and orientations. Followers of the three critical trends examined in this article have taken note of these criticisms, and have established points of collaboration with qualitative research, though with varying attitudes, emphases, and nuances. None of the trends currently has a unique theoretical position or an empirical working model with regard to qualitative research. However, each has formulated a specific way to include qualitative research within its own working framework.

Certain correspondences and discrepancies among the three trends appear to be important for explaining the special features of the way they use qualitative research. Social medicine, PAR, and sociocultural studies are strikingly alike in their interest for and commitment to society's least favored social groups, as well as in their strong support for social change. There are also certain similarities in their backgrounds and sources of inspiration, among which stand out Marxism, neo-Marxism, and social critical theory. For this reason, some practitioners have moved from one trend to another, or have tried to combine various aspects.

At the same time, these three trends differ in certain important ways, and the differences also appear to influence the way they use qualitative research. One important contrast has to do with the target population. Social medicine tends to be drawn more to social classes or groups and to society as a whole. PAR practitioners are more committed to the community or to the production or consumption group in which they participate. This would include producers of a certain product, or social groupings that want to improve a situation they consider problematic. By contrast, sociocultural studies seems to be concerned more with methodological rigor or with the participants in the study, and less with the community or society as a whole. It also tends to focus on the relationship of the researcher with the association or grouping being researched, be it pregnant teenagers, people suffering from a particular illness, or elderly people that share a specific problem, to name just a few.

There are also other differences in the theoretical interests and practices of each trend. While social medicine practitioners emphasize the theoretical dimension of problems or of social and health processes, PAR practitioners are critical of what they see as an overemphasis on theory in both social medicine and sociocultural studies. For this reason, PAR emphasizes the problems of daily life. Sociocultural studies practitioners stress the theoretical dimension but also emphasize the need for pertinent data on their research subjects, although not necessarily to implement political or social action with specific groups, movements, or social groupings. In addition, sociocultural studies practitioners tend to communicate their findings to other academics with an interest in similar topics.

The contributions of social medicine, PAR, and sociocultural studies have pervaded and enriched the discussion of public health in Latin America, despite the efforts of the medical establishment to belittle or gloss over their criticisms. Moreover, despite differences in theory, methodology, and working methods, the progress of all three to date demonstrates that their use of qualitative research has become a strategy with great potential for promoting changes in public health and health care. This potential is due above all to each trend's emphasis on understanding and incorporating the perspective of the social actors involved, particularly those whose voices have traditionally been excluded.

Given these confluences, as well as the contacts established to date, further research remains to be done regarding whether the points of collaboration between these trends and qualitative research will be consolidated in the future or will dissipate when faced with substantial differences of opinion on theory, work methods, policy, or ideology.

Notes

1. The information available for preparation of this essay consisted of approximately 250 studies, which were obtained from the Medline, Lilacs, Scielosp, Medcaribe, Periódica, and Artemisa databases. In addition to the articles from serial publications, non-serial materials were collected and information was obtained through contact with academics in the region.

2. We chose to focus our analysis on these trends because—in addition to having achieved their own identity over the years—they tend to include professionals from diverse disciplines who participate in

activities outside the academy. Disciplines such as health anthropology, medical sociology, and social psychology could be the subject of a similar study, given their academic contributions to the field. However, we ruled out any attempt to establish a priority based on discipline: our interest centered on the trends we have named because they offered the broadest and most inclusive examples. Our decision does not imply that we have assumed that the people we have identified as practitioners tend to have homogeneous points of view.

3. For a period of months we considered including critical social psychology as a fourth trend. Various reasons forced us not to, with one of them being its focus as a discipline on social psychologists.

4. For reasons that could be the subject of another study, academic production in Cuba has been sparse and marginal in these areas.

5. Here we use the term "social medicine" because it is the term used most widely throughout the region. It has also become known in certain academic publications under the generic terms "applied social sciences in health," or "political economy of health."

6. The University of New Mexico is working on a project that will make some of this work available on the Internet. See: <http://hsc.unm.edu/lasm/index.html>.

7. In mid-2001, two women, both former coordinators of the Asociación Latinoamericana de Medicina Social (Latin American Social Medicine Association, known by its Spanish acronym ALAMES) headed two important government health agencies in Latin America. One was the minister of health in Venezuela, while the other was minister of health for Mexico City. Without entering into the polemic involved in categorizing each government, both were considered center-left or leftist.

8. This study will not review the huge production generated in Latin America relative to community participation or participation by certain social actors. Although these topics are inherent in participatory action research and have attracted the attention of sociologists, social workers, and social psychologists (Sánchez, 2000), we shall put them aside here, because discussion of them would lead to a discussion more closely linked to the academic world than to the actual PAR activities.

9. A school of thought that encompasses diverse authors and positions, but which usually emphasizes the work of Jean François Lyotard. Postmodern social theory builds on modern social theory, rejecting the latter's fundamentalism. Modern social theory tends to take a stance that is relativist, irrational, and nihilist (Ritzer, 2000).

10. An intellectual movement that began in France. It is also recognized as being in the vanguard of postmodernist thought, and as a school of thought that states, among other things, the crisis of reason and knowledge. Foucault, Derrida, and Balleubriand are recognized as postmodernism's most distinguished exponents (Reynoso, 1998).

11. A school of thought consisting of various trends that all emphasize the dominance of men throughout the history of humanity, including in science. Its fundamental concepts include patriarchy, gender, and power. The feminist vision generally involves creation of a world free of oppression. (Spinks, 1999)

12. An intellectual movement that focuses on studying the ordinary culture of the researcher's own society. Its methodological orientation is based on ethnographic techniques, but it uses multiple strategies, given its interest in complex industrialized societies. One of its most well known schools of thought is connected to the Birmingham School, particularly the work of Stuart Hall. This type of research is

characterized by its nature as historic, self-reflexive, critical, interdisciplinary; by its interplay with grand theory; its focus on both global and local themes; and its consideration of everyday, historical, economic, and political discourse (Denzin and Lincoln, 2000).

13. Funders that have supported not only public-health studies in Latin America but also publication of a good number of public-health studies about the region include the Ford Foundation, the MacArthur Foundation, and the Population Council.

14. Many of these theoretical and methodological issues are part and parcel of the issues that concern social scientists, particularly anthropologists, sociologists, and—to a lesser degree—psychologists, on a daily basis. Still, the topic deserves to be the subject of study at another time.

15. A different phenomenon has occurred in the past decade with a growing number of Latin America academics who received their academic training in Spain. For reasons that also deserve study, these academics do not appear to share the essential characteristics of sociocultural studies practitioners.

16. Since the beginning of the 1990s, most Latin American countries initiated programs to stimulate academic productivity. Academics—particularly economists—with access to these programs received various types of support. Starting then, the income of some researchers doubled or tripled. Thus, in order to have access to such programs, researchers must increase or maintain their productivity.

References

- Alves, P. (1993). A experiencia da enfermidade: Consideracoes teóricas. *Cadernos Saúde Pública*, 9 (3), 263-271.
- Amuchástegui, A. (2000). *Virginidad e iniciación sexual en México. Experiencias y significados*. México: Edamex
- Brandao, C. R. (1982). *O que es la educacao*. Sao Paulo, Brasil: Brasiliense.
- Borda, O. (1982). Aspectos teóricos da pesquisa participante: Consideracoes sobre o significado e o papel da ciencia na participacao popular. In C. R. Brandao (Org.) *Pesquisa participante*. Sao Paulo, Brasil: Brasiliense.
- Breilh, J. (1995). *Nuevos conceptos y técnicas de investigación. Guía pedagógica para un taller de metodología*. Quito, Ecuador: Centro de Estudios y Asesoría en Salud.
- Castro, R. (2000). *La vida en la adversidad. El significado de la salud y la reproducción en la pobreza*. Cuernavaca, Mexico: Universidad Nacional Autónoma de México/Centro Regional de Investigaciones Multidisciplinarias.
- Da Silva, A. L., Lago, M. C., & Ramos, T.R. (1999). *Falas de Genero: Teorias, analises, leituras*. Florianópolis, Brasil: Editora Mulheres
- Denman, C., & Haro, J. A. (2000). *Por los rincones. Antología de métodos cualitativos en la investigación social*. Hermosillo, Mexico: El Colegio de Sonora.
- Denzin, N. K., & Lincoln, Y. S. (2000). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.

- Echeverría, M. (1992). *Un enfoque integrador y una metodología participativa frente a la salud de los trabajadores*. Caracas, Venezuela: Memorias de la Asociación Latinoamericana de Medicina Social. 93-105.
- Freire, P. (1975). *La pedagogía del oprimido*. México: Siglo XXI editores.
- García, J. C. (1983). Medicina y sociedad. Las corrientes de pensamiento en el campo de la salud. *Educación Médica y Salud*, 17 (4), 363-397.
- Gastaldo, D. (1997). E a educacao em saude "saudavel"? Repensando a educacao em saude atraves do conceito de bio-poder. *Educacao e Realidade*, 22 (1), 147-168.
- Gastaldo, D., Mercado, F. J., Ramasco, M., & Lizardi, A. (In press). Qualitative health research in Ibero-America: One issue, four topics. *Transcultural Nursing Research*.
- Grassi, E., Raggio, L., & Montes, A. (1996). Normatizacao dos comportamentos reproductivos e paradigmas medicos: Estudo de caso em instituicao de saude para camadas medias. In A. Costa &
- T. Amado (Org.) *Alternativas escasas. Saude, sexualidade e reproducao na America Latina*. Rio de Janeiro, Brasil: Fundacao Carlos Chagas / Editora 34.
- Hersh, P. (1987). Investigación participativa. Una revisión bibliográfica. *Revista Universidad Autónoma Estado de Morelos*, 17, 18-23.
- Hollanda, E. (In press). "Praticas alternativas de pesquisa: alguns questionamentos sobre as potencialidades e limites da pesquisa-acao e pesquisa participante." In F. J. Mercado, D. Gastaldo, & C. Calderon. Guadalajara, Mexico: Universidad de Guadalajara/ Universidad Autónoma de Nuevo León.
- Laurell, C. (1984). Ciencia y experiencia obrera. *Cuadernos Políticos*, 41, 63-83.
- Laurell, C. & Noriega, M. (1990). La experiencia obrera como fuente de conocimiento. *Cuadernos Médico Sociales*, 51, 5-26.
- Laurell, C. Noriega, M. Martínez, S. & Villegas, J. (1992). Participatory research on workers health. *Social Science and Medicine*, 34, 603-613.
- Martín-Bahró, I. (1983). *Acción e ideología. Psicología social desde Centro América*. San Salvador: Universidad Centroamericana "José Simeón Cañas."
- Menéndez, E. (In press). De la reflexión metodológica a las prácticas de investigación. In F. J.
- Mercado, D. Gastaldo, & C. Calderón. *Investigación cualitativa en salud. Una antología Iberoamericana*. Guadalajara, Mexico: Universidad de Guadalajara / Universidad Autónoma de Nuevo León.
- Mercado, F. J. (1996). *Entre el infierno y la gloria. La experiencia de la enfermedad en un barrio urbano*. Guadalajara, Mexico: Universidad de Guadalajara.

- Mercado, F. J., Villaseñor, M., & Lizardi, A. (2000). Investigación cualitativa en salud en América Latina. Un campo en consolidación. *Revista Universidad de Guadalajara* 17, 19-30
- Meyer, D. E. (2000). As mamás como Instituintes da maternidade. Uma história do passado. *Educacao e Realidade*, 25 (2), 145-156.
- Minayo, M. C. (1997). *El desafío del conocimiento. Investigación cualitativa en salud*. Buenos Aires, Brasil: Lugar Editorial.
- Moliner, M. (2000) *Diccionario de uso del español*. Madrid, Spain: Gredos.
- Nunes, D. E. (Ed.). (1986). *Ciencias Sociales y Salud en América Latina. Tendencias y Perspectivas*. Montevideo, Uruguay: OPS-CIESU.
- Orozco, M. R. (2000). *Situación de la salud en el Petén. Diagnóstico participativo*. Guatemala: Consejo Departamental de Salud del Petén.
- Reynoso C. (Comp.). (1998). *El surgimiento de la Antropología Posmoderna*. Barcelona, Spain: Gedisa Editorial.
- Ritzer, G. (2000). *Modern sociological theory*. Boston: Mc Graw Hill..
- Sánchez, E. (2000). *Todos con la "Esperanza" Continuidad de la participación comunitaria*. Caracas: Comisión de Estudios de Posgrado, Facultad de Humanidades y Educación-Universidad Central de Venezuela.
- Szas, I. (1998). Alternativas teóricas y metodológicas para el estudio de la condición de la mujer y la salud materno infantil. In J. C. Figueroa. *La condición de la mujer en el espacio de la salud*. México: El Colegio de México
- Spinks, M. J. (1999). Investigación cualitativa en salud. Superando los horrores metodológicos. In M. Bronfman & R. Castro. *Salud, cambio social y política. Perspectivas desde América Latina*. México: EDAMEX.
- Waitzkin, H., Iriart, C., Estrada, A., & Lamadrid, S. (2001a). Social medicine in Latin America: Productivity and dangers facing the major national groups. *The Lancet*, July 28, 315-323.
- Waitzkin, H., Iriart, C., Estrada, A., & Lamadrid, S. (2001b). Social medicine then and now: Lessons from Latin America. *American Journal of Public Health*, 97 (10), 592-601.